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INDEX

Articles are, in many instances, listed in this Index under more than one heading. All Original Articles are listed under the heading "Original Articles" with the author's name. Marriages, Deaths, Therapeutic Notes, Hospitals and Medico-Legal Items will be found under those respective headings. All Medical Societies' reports will be found under Societies.

E

EDITORIALS IN OUR JOURNAL—

EDITORIALS FROM OTHER MEDICAL JOURALS—

EDITORIALS FROM THE LAY PRESS—

H

HOSPITALS—

M

MARRIAGES—

MEDICO-LEGAL ITEMS—

MISCELLANEOUS ITEMS—

ORIGINAL ARTICLES—

R

REPORTERS—

S

SOCIETIES—

County Medical Societies—

Local Societies—

State Societies—

Medical Society of New Jersey—

See Transactions—pages 307-332.

National and International Societies—

T

THERAPEUTIC NOTES—

W

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THE UNDERLYING CAUSES OF THE NARCOTIC HABIT.*

By Alexander Lambert, M. D.,
President of the American Medical Association.
New York City.

To understand the underlying causes of narcotic addiction one must go deep into the personality of each individual. Social customs permitting the use of certain narcotics in moderation have covered over the real causes why these same narcotics are used to excess.

Most people think of drug addicts and drunkards as a class and mass of humanity, but unless they are taken as individuals and their individual problems studied, the underlying causes of their excessive indulgences in narcotics will never be understood.

For centuries, alcohol has been interwoven with our social customs to such an extent, that it is difficult for us to think in terms of hospitality and leave out the use of alcohol. This fact, I think, as much as any other, has tended to hide the real reasons for over-indulgence in alcohol.

There is no intention to deliver now an address to you on alcohol or alcoholic indulgence, but you cannot understand drug addiction unless you couple it with your knowledge of alcoholic intoxication and realize that the excessive use of both opium derivatives and alcohol, is often for the same purposes and frequently exerts the same effects on personality. In youth it is for the inflation of personality and the endeavor to feel and enjoy life more abundantly. In later years of life it is usually to forget things that one is unwilling to face or cannot face in consciousness, and something must be found to benumb the mental suffering. From time immemorial all nations have sought something to help celebrate their joys, or something wherewith to cut the keen edge of sorrow.

Let us consider first what are the effects of these different drugs on the human organism. Alcohol first paralyses the judgment and inflates personality. That is, as the judgment atrophies the self-conceit hypertrophies. Difficulties diminish or vanish and physical and mental enjoyment of life is greatly intensified. If the paralysis of mental function continues and increases we come to the stage of perversion and stupid distortion of mentality and finally forgetfulness and obliteration of consciousness. All this is familiar to you in the early exhiliration by alcohol, and later the narcotic stupefaction.

Cocaine is not a narcotic but is a pure exhilirator; it stimulates the mental and physical functions; it intensifies the accuracy of the senses and the mental enjoyment of them. It renders the senses not only more alert, but intensifies the rapidity of the physical response to action, so that men think and act quicker. It distorts the judgment and blunts the sense of proportion and destroys the ethical and moral sense. It produces a contented certainty of mind that all one dreams and hopes for will surely come to pass. Among the early symptoms of its poisoning, are ideas of persecution and suspicions in resentment against which the cocainist is quick to act. The cocainist is prone to carry weapons to defend himself against imaginary injuries or persecutors and is therefore a menace to his environment, especially as increased liability to act is coupled with distorted judgment and blunted sense of responsibility. The intensity of the action of cocaine has its equal reaction in the intense nervousness and depression of its deprivation. The further excessive use does not produce sleep or a narcotic action as alcohol. There is no narcotic action in cocaine.

*Read before the New Jersey Sanitary Association, Lakewood, N. J., December 5, 1919.

Heroin is not an alkaloid found naturally in opium but is built up synethetically from substances found therein. Its effect is to inflate personality, giving the exaggerated sense of egotistical importance, soothing hurt feelings and disappointments and benumbing judgment. It acts similarly in many ways to cocaine, while its action is not so intense, neither is its reaction and depression so distressing; the effects lasting longer than cocaine the dose does not have to be so often renewed. It does not produce the mental degeneration and distortion with delusions of persecution as cocaine, and it does relieve pain and bring on narcotic sleep and forgetfulness when taken in doses beyond the stimulating amounts.

The stimulating and pleasing effects of small doses of morphine, its ability to relieve physical pain or mental suffering and the degenerating and narcotizing effect of its continuous use are too well known to need repetition here.

From whatever cause the habit of taking these drugs may originate, it is the continued use over a certain length of time of small doses which produces the habit or addiction. Given a group of persons in health, or sick with some disease who take small doses of these drugs for three or four weeks continuously, and the majority will be unable to cease taking them should they desire to break off. The deprivation from their accustomed dose will produce such physical suffering and nervous distress that the great majority cannot go through it and cease using their drug. Probably a greater number of those who were using the drug because of disease will succeed in breaking away from it, than of those who began using it for causes other than disease or pain.

Alcohol, cocaine and heroin are the drugs, therefore, which attract mankind in the years of his youth and excessive indulgence is based on the desire to feel and enjoy life and its sensations more intensely and more abundantly. They are taken because of their power to inflate personality. In the years of youth, narcotism and forgetfulness are not sought, but the relief of strain, the soothing of hurt feelings and disappointments, the relief from the bitterness of being misunderstood. They are used to sustain personality in crises which, without them, there is dread of failure. They are used by the inadequate personality to lean upon for strength and encouragement when situations arise with which, unaided, the inadequate personality cannot cope.

One of the most frequent reactions to failure and disappointment in personalities lacking courage and fighting vigor, is a growing sense of inferiority. This, in the past, has been a common cause for over-indulgence in alcohol, for by artificial inflation and an increased sense of swollen ego, relief was obtained. Cocaine and heroin supply the same relief, and many instances of addiction are due to this often unsuspected cause.

Bad associates and evil environment are probably today the chief causes producing heroin addiction among the youthful habitues. The large majority of those addicted to this drug are below 25 years of age and certainly under 30. As many small boys take to tobacco smoking because it appeals to them as a manly or grown-up thing to do, so do many youths, under evil environment, take to alcohol or to heroin. Moreover, an addiction to heroin could be hidden, while alcoholic indulgence could not, and the over-indulgence in heroin would seem more like physical fatigue and be less suspected.

Alcohol has had, from time immemorial, certain customs connected with its use which not only sanctioned its use, but defended and forgave its excessive indulgence. These same customs covered over the real reasons why many men turned from moderation to the excessive use of it. The narcotic drugs have no such customs connected with their use in our civilization and the addiction to their excessive use has always carried with it a moral stigma. This stigma of moral degeneration, often undeserved and unjustly placed on the unhappy victim to the habit, has only in recent years begun to be removed. This more charitable point of view has extended more to the victim of morphine addiction than to the other narcotic drugs, because morphine was more often taken to relieve physical suffering. Few realize that nearly 80% of the morphine addicts have acquired the habit from legitimate medication, often wrongly used, but often, it is true, correctly and rightly given to relieve suffering. These unfortunate takers of morphine should not be classed as addicts; they usually have fallen unconsciously into a habit from which they cannot escape. If they have an incurable disease with suffering from pain, they should be given their morphine in doses sufficient to relieve it. But the giving of the drug should be carefully supervised, as all morphinists are prone to take more than they need through fear lest they may suffer.

These patients should be franked by the Health authorities, that they may obtain their drug in any State, without being imposed and preyed upon by unscrupulous persons.

The motives in life change after youth has passed and in the early thirties social customs or early weariness of life are the most common causes of alcoholic excess and the underlying causes begin to be those of a desire for narcotic forgetfulness and less those of a desire for inflation of personality. The use of narcotics after thirty is in the majority of cases based on the inability to break off a previously acquired habit, or is a habit acquired because of disease or suffering from some injury. The usual drug is therefore morphine, though heroin may be used to allay pain.

As the age of the narcotic addict increases, so do we find an increase in the number of those who use the drugs to ease the weariness of life, to forget sorrow and ruined hopes and lost opportunities. Alcohol in excess after forty, is usually used for its narcotic effect of blotting out some remembrance. Morphine is the usual addiction, though often in the rural districts one finds laudanum and crude opium the predominating form of the drug.

Through the kindness of Dr. S. Dana Hubbard of the New York Department of Health, the statistics of 2,723 narcotic addicts, applicants to the Drug Clinic of the New York Health Department, are given below.

These statistics bear out the deductions of our previous experience. As one would expect in such a clinic, the group contains mainly the youthful addict of short duration of habit who has drifted into the habit as a vice through evil association, using the drug characteristic of that type—i. e., heroin. Of the 2,723 addicts, 2,216 were men and 507 women. 89.5% of these were under 30 years of age, nearly one-third of the entire number being between 20 and 25 years of age, and about the same number of the total being native-born Americans. 65% of the addicts took heroin alone, and 14% added cocaine to the heroin. 18% took morphine. 19.5% were over 30 years of age, and only 12% had been addicted to their habit for more than 10 years.

The underlying causes of addiction, as given in their own statements, were bad associates in 71%; illness or relief of pain, 18%, and only 1% gave the reason for taking the drug as sorrow or other forms of trouble. In the article about to be published, from which these statistics are taken, Dr. Hubbard draws some further conclusions from his study of the situation in New York today. It is evident that the number of narcotic addicts has been enorm-

STATISTICAL STUDY, APRIL 10TH-JULY 1ST, 1919.

Total Number of Narcotic Applicants.....2,723

Borough Distribution:

Manhattan	Bronx	Brooklyn	Queens	Richmond	Total N. Y. C.	Out of Town
1,379	147	1,088	35	27	2,723	47

Racial Distribution.

Whites	2,338
Colored	385

Sex Distribution.

Males	2,216
Females	507

Nationality (Designated by stated place of birth.)

American	850	Brazilian	3	Canadian	60
English	8	Dutch	2	German	399
Hebrew*	511	Italian	64	Irish	210
Japan	11	Russian	117	Greek	93
Polish	312	China	39	Spanish	23
Swedish	7	Scotch	4	West Indian	5

*Subdivision by divisional class substracted from other nations.

Age Distribution.

15-19 yrs.	725	30 yrs. of 80% under age.
20-25 "	841	
26-30 "	626	
31-40 "	427	
41 plus "	104	

Drug Used.

Heroin	1,878
Morphia	493
Cocaine	4
Morphine and Heroin	36
Morphine and Cocaine	35
Heroin and Cocaine	277

Reason Assigned for Addiction.

Bad Associates	1,947
Relief of Pain	174
Illness	332
Excited by Curiosity	134
For Pleasure	11
Turned from Opium Smoking	75
Family Trouble	19
Financial Embarrassment	11
Over-work	10
To Try to do More Work	10

Length of Time Using Drugs.

1-2 yrs	196	7- 8 yrs	300
2-3 "	248	8-10 "	287
3-4 "	323	10-13 "	124
4-5 "	346	13-17 "	89
5-6 "	347	17-20 "	38
6-7 "	371	20 plus "	54

88% Ten years and under

Occupational Distribution: Skilled (Trade or Profession) 1,643**
Unskilled 1,080

**21% have to do with various means of transportation.

ously exaggerated, and instead, as claimed by some, comprising 1% or 2% of the population, it is probably not more than ¼ of 1%. The Harrison Law strictly applied in New York has produced but about 6,000 addicts, instead of the 100,000 or 200,000 as was claimed and expected. The exemption permitted under the law claimed by physicians for persons ill who must take their drug or suffer unduly, has only been 250. It is very noticeable also, that the physical condition of these addicts is usually not that of a narcotic morphinist—that of the thin, pale, cadaverous type of individual rather mentally dull, but the majority have been the younger, alert type which is seen in the stimulated class rather than the narcotic class. All these observations, therefore, confirm the domination of heroin in the addict of to-day.

Dr. Hubbard says that very many of these unfortunates are easily and quickly determined as showing feeble-mindedness which in young girls tends so strongly to prostitution.

The question is often asked whether or not the present prohibition of alcoholic beverages will increase the other narcotic addictions. It seems to me doubtful if it does to any appreciable extent. A good deal will depend on the ease with which various medicinal nostrums are available, containing various percentages of alcohol and of narcotic drugs. The success of the present prohibition will depend in much larger measures than is usually realized, on the freedom permitted the patent medicine vendors to sell their wares. Many of these nostrums contain alcohol in amounts sufficient to cause acute and chronic alcoholic poisoning when used as continuously as recommended by the manufacturers. One serious defect of the Harrison Law is that it permits the sale of mixtures containing less than two grains of opium to the ounce. This permits the unrestricted sale of paregoric and similar medicines. Public opinion will doubtless remedy these defects when their full effect for evil is appreciated and will soon place the legal control of the enforcement of the narcotic laws and the care of the addicts under the state or municipal health departments, where it rightly belongs. Other temporizing experiments will be tried, but in the end, the control and care of narcotic drugs and those addicted to their use, will be treated as public health measures.

The customs surrounding the use of alcoholic beverages have been so interwoven with our ideas of social intercourse, good-fellowship and hospitality, that the parallel ceases between alcohol and other narcotics as soon as you leave the pathologic side of their effects on the body and consider the social side of their use. The abuse of alcohol has long been condemned, but its ordinary use sanctioned. The use, even, of narcotic drugs, has always been condemned, except as medical means to relieve suffering, and their abuse still carries with it a stigma never possessed by over-indulgence in other substances. As already said, not only are there no social customs to sustain their use, but their use tends to anti-social rather than social results, since they are used to escape and forget the responsibilities and duties of life and are the means by which the necessity to face the realities of life may be avoided.

Over-indulgence in alcohol produces tissue changes in the various organs of the body, and if continued, these changes become permanent and progress until they themselves constitute disease processes. On the other hand, the excessive use of the narcotic drugs of opium does not produce tissue changes in the various organs nor cause changes which constitute disease processes. They do pervert the functions of various

organs, but when the poisons are removed, the functions of these organs can be restored. The problem of the underlying causes of narcotic addiction lies in the psychology and personality of the individual, and so does the solution of the problem. If you can solve the individual problem which lead to the addiction, you will solve the means by which the individual can be freed from his addiction. The feeble-minded and inferior personalities are a separate group which need institutional and special care, but the ordinary addict, relieved of his drug and physical suffering, and cared for until he can face his existence without artificial aid, can be relieved of his addiction; and if his problem is solved, will not go back to his narcotic.

Not infrequenty a habit is continued after the original cause has ceased to exist, and the habit must be continued because of the physical suffering which unaided deprivation brings. Many addicts loathe their habit, but physically cannot break from it. Most of them when free are anxious to remain so. Hubbard's experience with the addicts under the Health Department sustains this view. He writes that "Our experience seems clearly to indicate that the individual addict has only to be taken off his drug and made bodily comfortable and away from his old associates, and he will redeem himself. Off the drug and life's path made comfortable by suitable guidance, and the addict, like every normal individual, faces his daily problems and can do so; but to stand alone requires after-care until he can feel at home in his new surroundings. This may take several months, but with such help redemption is sure."

This is a more optimistic view than is held by many physicians; but even among the medical profession, the underlying causes of narcotic addiction are more understood. The underlying causes of narcotic addiction are more personal than social. It may be summed up by saying the causes lie in youth in the desire to live more intensely and to dream of his future greatness. After youth has passed, they lie in the desire to forget the weariness of living and to blot out the remembrance of lost opportunities. They begin and end in the realm of personality.

Hematuria is usually the first sign of a bladder cancer. The passage of bloody urine, even though it is not soon repeated, is sufficient indication, in an adult, for a cystoscopic examination.

ADDRESS OF THE THIRD VICE-PRESIDENT.

Delivered at the 153rd Annual Meeting of the Medical Society of New Jersey at Spring Lake, N. J., June 25, 1919.

OBSERVATIONS OF THE WORK OF THE PHYSICIANS IN THE SELECTIVE DRAFT OF THE STATE OF NEW JERSEY.

By Henry B. Costill, M. D.,
Trenton, N. J.

Since this Society held its last meeting the World War in which our country was then engaged, and in which the physician played a no inconspicuous part, has been brought to a victorious close. We are met today to celebrate that victory. The unusually large percentage of members who gave their services to the cause of humanity, entitles this society to celebrate with pardonable pride the victorious ending of this Great Struggle. And, I know full well you are all thinking the same thought that comes to me, that this meeting is not only a victory meeting, but in a higher, broader and holier sense, a thanksgiving meeting. Thankful that we as a nation, even though after much delay, finally took our place in the great struggle of the human race toward that higher plane of existence which comes only through the freedom alike of the individual and nation, to determine its destiny.

Thankful that out of the horror, the muck and the hell of it all, there has come the victory of right as opposed to might, and that forever we trust, has been banished from the earth that erroneous idea of the God-given right of any individual to control the lives of others.

Thankful that we as physicians were able to play our part in this great struggle, and that side by side with the men who fought was the physician, ever ready to minister to their needs, or relieve their suffering when ill or wounded.

When the events in which so many of our profession have played a part are fresh in our mind, it seems eminently fitting and proper that we visualize for a moment the field or fields of their activity.

To give you some correct idea of how whole heartedly the medical profession of our State responded to the call of humanity the following figures will show:

Total number of physicians in our State 3,153

Number of physicians in our State commissioned	814
Number of physicians who gave their services to the Government in the selection draft	1,164
Total number of physicians in our Society	1,721
Number of physicians in Society commissioned	500
Number of physicians in Society who gave their services to the Government in the selective draft	500

The physicians who were in service can be divided in two distinct groups: first, those who received commissions, and second, those who served in various positions in the selective draft work.

The services of those men who were commissioned will be recorded in the military history of the war, and a very brilliant and interesting record it will make, and it is not our purpose to atttempt to make any record of their work here.

But, of the second group of physicians, those who served their country in the selective draft in our State, and to whom very scant recognition has been given either by the Government or by the people, it is our desire to rapidly review the work done and the results obtained.

When our country entered the war in 1917, as you all well know, we possessed neither army, equipment, guns, nor ammunition, nor had we ships to transport an army if we had one. We not only had to provide men for an army, but all our factories, mills and shipbuilding plants must be kept running to their fullest capacity, and this capacity constantly increased. Likewise all our transportation facilities must be properlv manned and kept that way. The farm and garden must furnish an increased amount of food to supply the demand of our own army, and to feed those people of Europe to whom we had pledged assistance. Neither could our own people be neglected; wives, children and dependent parents must be provided for, and besides this an army of from two to four million men taken from the young men of our country, had to be raised and raised in a very short time. These were some of the conditions that confronted our Government when on that day in April, 1917, we decided to enter the great struggle.

To raise this army with as little interference as possible, with the various industries that were essential to the successful prosecution of the war, the selective draft was devised, which with all its faults and imperfections proved the nearest just and effective method of raising an army, protecting the people and all the important industries that had yet been proided.

The Draft Board, the Unit.

In the scheme of the selective draft the local board was the unit around which all of the machinery of the draft was built. The local board consisted of one physician and two laymen. This board with the district board, through the Government appeal agent, constituted the draft machinery in 1917, or the first draft. In December, 1917, the Medical Advisory Board and the Medical Aides were added.

Medical Advisory Board.

The draft of the summer of 1917 showed very clearly that the amount of work placed upon the local boards was more than they could be expected to stand; it also showed that there were continually arising cases in which the physical condition of the registrant required more time for careful investigation than could be given bv the physician of the local board. At the suggestion of the Medical Council of National Defense, the Provost Marshall General authorized the detail of an officer of the Medical Corps, to be assigned to the Governor of each state to be known as the Medical Aide to the Governor, whose duty it should be to select from among the older physicians, and particularly those who had developed some special line of work, at least ten men in each county, and in the large counties or cities, two boards, to be known as Medical Advisory Boards. These names were to be submitted to the Governor, and by him nominated to the President, and approved in a similar manner to those of the local boards. To these men, representing as they did, all the specialties in medicine, the local boards had a right to refer all cases in which they were in doubt, as to the physical condition of the registrant. This not only relieved very largely the work of the local board, but at the same time provided an additional safeguard to the registrants.

The co-operation of advisory and local boards in nearly every instance was very complete, and the combination proved an entirely satisfactory one.

It was, however, through the local board that all registrants were compelled to pass for classification. It was their duty to make the proper exemption for employment in necessary industries and farm work. To sit as a court in all claims for dependency, many of which required the personal in-

vestigation by the physician of the board, and it was here that the judgment and professional knowledge of the physician counted for so much, not only was it necessary that no fraud be practiced on the Government, but just as important that no hardships be done to a deserving dependent, and that all be given equally fair treatment.

That this result was obtained to a very high degree; the fact on one side was that the boards were always ready with their quotas when a Government call for men came, and, on the other that there were so few complaints either from registrants or dependents, and in the State of New Jersey no charge of attempt to defraud the Govermnent, or to take unfair advantage of a registrant was ever sustained, and remarkably few were ever made.

In view of the many dependency claims that required the finest kind of judgment in their adjustment, these results are certainly creditable.

Physical Examination.

No army was ever selected with greater care to obtaining men in perfect physical condition than that sent by the United States Government to Europe. This fact, together with the intensive training they received at the cantonments in this country, plus the high patriotic spirit and the determination to win, with which each and every one was thoroughly imbued, points very clearly the reason for the wonderful accounts they gave of themselves.

The selection of men physically qualified for the severe requirements of army service presented entirely new conditions to the civilian physician. The rules and regulations furnished by the Provost Marshal's office were not in all cases clear, nor well defined. They were frequently changed and re-changed, and as was at last admitted by the Provost Marshal General in his report to the Secretary of War, not at all in accord with the rules and instructions given to the examining boards at the various cantonments, which boards the registrants had to finally pass before being accepted as soldiers. And this, in a very great measure accounts for the differences in the results of the examinations by the two boards. Still, the perentage of rejection of registrants sent to the cantonments by the draft boards of New Jersey, was always well below the average of the other states, and in the period between January 15th and June 15th, 1918, our State earned the distinction of having the lowest percentages of rejections.

One very important fact I would like to call to your attention is the report of the Secretary of Labor, Mr. Wilson, in which he states that at no time was a single essential war industry handicapped by a shortage of labor. And to the report of the Provost Marshal General that the boards were always ready with their quota when called for. These reports, together with the fact that we furnished an army of four million men in a little over a year, is a very clear illustration of the value of the selective service draft, and the efficiency of its administration by the draft boards and for which they should be accorded all honor.

In the work of the board some interesting as well as amusing results occurred. The most curious to my mind was, that of all the rejections of registrants at cantonments, more than fifty per cent. were for defects so obvious as to be detected by anyone, such as deformed hand or feet, short limb, blind in one eye, or entire absence of eye. These things could only be explained on the ground that the civilian physician was not accustomed to making a quick and accurate inspection of an individual.

Of all the registrants examined, thirty per cent. showed some physical or mental defects, sufficient to prevent them being accepted for soldiers in Class A. This statement I believe, taken as it stands, is unfair, and should be modified by calling attention to the fact that many registrants amounting in the average to more than 30% and in some instances to more than those examined, were exempted as necessary employees in essential industries, and were not physically examined. These men belonged largely to the class known as "skilled labor." And, it is quite possible that defects would not run as high in this class as in those examined, consequently had all registrants been subjected to a physical examination, I do not believe the total result would have shown a percentage of defects running as high as that reported.

The defects most commonly found were in the order as here given: eye, heart, ear, feet, teeth, hernia, mental defects, including various forms of neuroses, of which there were many. Registrants of foreign birth, or of parents of foreign birth made a very much better physical showing than the native American of three or more generations.

Venereal Diseases.

Late in the summer of 1918, a report was received from the P. M. G. showing

that nearly ten per cent. of all registrants entering the cantonments were infected with some form of venereal disease, acute, chronic or latent. Through the Department of Public Health, the United States Government organized a very efficient campaign of education and prophalaytic control, draft boards were instructed to report to local health authorities all cases of venereal diseases coming before their board. Through co-operation of the State and local health boards, a quarantine was established in the area surrounding these cantonments. Pamphlets dealing very plainly with the danger involved in promiscuous intercourse were issued to all draft boards for distribution to registrants. This government crusade has done much toward arousing and educating the public to the danger of this vice, and I believe time is now ripe, as never before, for the physician to attach the social evil, and by pitiless exposure of reported cases, supported by a well directed campaign of education, assist our people to a better understanding of the danger, trusting that a full knowledge of this evil and its consequences will work its cure.

Deductions from Observed Conditions.

1st. That physical and mental defects to the extent approaching one-third of our young, adult male population points very clearly to error in our social and educational system. Had proper care been exercised by parents during the pre-school life of the child and careful medical inspection made during the school years, scarcely any of the defects above mentioned would have passed detection.

2nd. The markedly better physical development of the foreign born, or of parentage foreign born, should at once arouse us to the danger we Americans are facing, and bring forcibly to our attention the question whether we are not over-developing the minds of our children and very sadly neglecting their physical development.

3rd. The great number of heart lesions found among our high school and college graduates raises the question as to how carefully our athletes are developed, and as to whether many heart strains are not caused by the boy being pushed too rapidly into intensive training for the various teams of football, baseball, track and oar. And I cannot help feel that in the production of the irritable or nervous heart so frequently found among registrants, that the early and excessive use of tobacco, and particularly the cigarette, plus late hours to bed and an indoor life, played an important part.

4th. These observations would be incomplete should we fail to make a comparison of the registrant as he was entrained by the draft board and the same individual after three or six months of camp life and training.

The lean, lanky, round-shouldered anemic boy was transformed as by magic into an erect, hard muscle, brown face, red-blooded man, whose maker need not be ashamed to look in his face and say, he is made in my image.

Nothing could illustrate more clearly the desirability of at least compulsory physical training in our schools and colleges, or what to most of us would seem better, a period of military training in the life of each child, male or female.

And what of us physicians, particularly those of us who had an opportunity of studying at first hand large numbers of our young, adult male population, of observing their physical and mental defects and their frailties. What lesson have we brought away with us? Are we satisfied that as physicians we have measured up to the great responsibility resting upon us? Are we fully conscious of the fact that our position in the community, in the home, at the bed side, honored by the implicit confidence of the people, brings to us opportunities for directing the thoughts, moulding the character and shaping the lives of the children of our generation, as come to no other class or body of men? In a sense we are physicians, but in a broader sense we should also be educators.

For their direction and protection in all matters pertaining to health, hygiene or sanitation, the people look to us with absolute faith and confidence. They are willing to and do furnish enormous sums of money to build and maintain experimental laboratories that we may discover the cause of the diseases of the physical body. Is it not the right, the privilege, the duty of the physician who is familiar, as none other, with the blighting trail through the social fabric of that moral cancer the social evil, to attack it with the same vigor and with the same methods as he does the cancer of the physical body?

Sex education taught in our schools to this generation of children by conscientious, well-balanced physicians, both male and female, not in a haphazard way, but adopted by our State Board of Education as a part of the school curriculum, will yield in the succeeding generation parents with a better understanding of their responsibility and the dangers of transgressions. A well-

developed and efficiently-administered bureau of Child Hygiene under the direction of our State Department of Health, should watch the development of the child from birth to his entrance into school. Frequent, careful and a thorough medical inspection of the child during his school life under the control and by the direction of the same authorities, will largely eliminate from our young adults the many defects found by our draft boards.

And, now, in conclusion, I would like to say a few words of a purely personal nature to the members of the Selective Service Draft in the State of New Jersey. In the prosecution of the work assigned to me as Medical Aide, it was my good fortune to come in contact with by far the majority, if not all, the members of the various boards, and to observe your work at a close range. And, I take this occasion to say to you in all earnestness and sincereity that the results of my observations are that never were services more patriotically or faithfully rendered, nor a great responsibility more efficiently discharged, and whether the Government properly recognizes your services or not, you will have always with you a conscientiousness of a work well done.

I desire also to express to you my full appreciation of the kindness and courtesy I invariably received at your hands. Your willingness at all times to co-operate with me, made my position a very easy one. And the memories that come from my experiences as Medical Aide, will always remain the pleasantest of all my life's work.

THE SIGNIFICANCE OF CARDIAC PAIN.*

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Any organic cardiac lesion may be accompanied by pain as a symptom. Pain is a prominent symptom even in the condition known as Effort Syndrome,—the D. A. H. of the British Army Medical Service, or the Cardio-circulatory Neuro-asthenia of some of the American writers; all three terms connoting a condition in which there is no gross cardiac pathology definitely known.

Not all cardiac patients have pain. Many escape it throughout the entire course of their disease; but any patient with a cardiac lesion is liable, at some time or another, to have pain referred to the heart, although the conditions necessary to its presence may never arise.

What then is the mechanism of pain resulting from a heart lesion? We are familiar with the pain caused by renal and biliary calculus, and that associated with intestinal and uterine spasm. In each case the pain is a direct result of spasm in the smooth muscle fibres of the ureter, biliary duct, intestinal or uterine wall. It is not due to irritation of a painfully sensitive mucus membrane or peritoneal covering, or other part of the organ involved.

The heart is a hollow organ composed of involuntary muscle tissue, and when any undue strain comes upon it, either sudden or prolonged, causing it to work against resistance, it is incompetent for the time being readily to overcome, the sensation of pain that arises. In other words, pain of cardiac origin is always direct evidence of an overworked organ.

The peculiar distribution of pain to the precordium and left arm—(i-iv dorsa nerves), the neck—(vii-viii cervical nerves), or epigastrium—(vi dorsal nerve), is a matter of stimulation of the spinal cord centers in the upper dorsal and lower cervical regions, and its reflex determination thence to the sensory nerves; and its localization on the body is dependent upon the distribution of the nerve endings of those efferent fibres which happen to receive the reflex in the area of the cord involved by the afferent impulse from the heart.

This need not be dwelt upon further in this discussion

The lesions most commonly associated with cardiac pain may be mentioned briefly: namely, aortic disease, aneurism, aortic valvular disease, disease of the coronary arteries and increased blood pressure.

Bear in mind that the three factors in maintaining the circulation of the blood stream are: (1) the contraction of the ventricles; (2) the elastic recoil of the whole arterial system upon the volume of blood forced into the great vessels during cardiac systole; and (3) the resistance offered by the capillary network.

It will at once be clear that anything

*Read at the meeting of the Morris County Medical Society, held December 9, 1919.

which interferes with one or more of these element must throw an increased burden upon the heart muscle in order to overcome the defect in the mechanism and to maintain the circulation at a normal grade for that individual. It is equally obvious that with a defective circulatory machine, the normal reserve of the heart, which is intended to meet extraordinary demands or strain, is cut down, and under the new conditions of disease a new, but lessened physiological limit is established for what that heart can do under both the ordinary and etxraordinary demands of living.

Atheroma of the aorta and aneurism interfere at once with the contractility of the great vessels which ordinarily begin the elastic recoil of the arterial system as a whole upon the volume of blood poured into the circulation by cardiac systole: i. e., interferes directly with one of the three large factor in maintaining the circulation. This puts an extra strain upon the heart muscle, which strives to overcome this fault in a portion of the circulatory system, and if the patient's activity is not definitely limited, so as to keep within the newly established, and more circumscribed limits of his cardiac reserve, the heart muscle sooner or later becomes exhausted, and dilatation, or pain, or both ensue.

That dilatation usually precedes pain, or that the two are by any means always concomitant, I do not mean to imply. Often pain comes on without any dilatation, and there will be none unless the heart's work is pushed to an extreme; but the two do occasionally go hand in hand, and presumably their cause is the same.

In disease of the aortic valves there is a regurgitation backward into the auricle of blood which ought normally to be flowing onward into the pulmonary circulation, and so the heart has to work harder to keep the requisite amount of blood flowing through the pulmonary capillaries to be aerated, and thence on to the tissues at large. Overwork again cuts down the heart's reserve, and, when the heart muscle becomes exhausted thereby, pain follows.

Disease of the coronary arteries, by reducing their elasticity, interferes materially with the blood supply to the heart muscle itself; and when its nutrition is impaired it cannot do the work it is called upon to perform. Undernutrition, exhaustion, pain, is the sequence of events.

An increased blood pressure throws upon the ventricles more work than ordinary, and finally when too frequent trespass has been made upon the diminished reserve of the heart exhaustion and pain supervene.

Mitral stenosis also is occasionally a cause of cardiac pain in much the same manner as aortic valvular disease. The blood does not get through into the left ventricle so easily, nor in the required volume to furnish proper nourishment to the tissues. It is also dammed back against the right ventricle. The heart is thus doubly called upon to work harder, and may ultimately become exhausted unless the needs of the tissues are at the same time lowered by less bodily activity. Myocarditis in all its varieties and grades, from the acute and chronic infectious or rheumatic type, to the cardiosclerosis of old age, brings about the same exhaustion of the heart muscle working against handicap to supply the tissues of the body their proper quota of nutrition.

It will thus readily be seen that pain is always a late manifestation of cardiac disease, and as such a symptom to be carefully heeded.

One other point in this connection is worth emphasizing. Mackenzie and Lewis both point out that no diseased circulatory element,—such as a valve, an atheromatous coronary or other artery,—can be properly considered as an entity by itself. It may be the dominant lesion and the only one giving rise to definite symptoms or physical signs; but it has associated lesions in the heart muscle, capillaries, or other circulatory structures which must be considered in viewing the situation as a whole. No one spot in the cardiovascular system can be safely held as the sole seat of disease to the exclusion of all the rest.

Given a patient suffering from pain of cardiac origin, the first thing to do after relieving the immediate symptoms is to institute a careful inquiry for the cause of the pain. This may, on the one hand, be easily determined by finding direct evidence of aortic disease, mitral stenosis or myocarditis. Mitral insufficiency rarely shows this symptom; but may do so when the muscle has been considerably damaged along with the valve. It has already been pointed out that an inflammatory condition in the heart is not necssarily limited to the endocardium, but very often invades to a more or less extent the myocardium as well. So that, whenever one finds evidence of valvular disease, he should make careful study of the case to determine, if possible, how much actual damage has resulted to the heart muscle at the same time. Carditis is a broader and better term than endocarditis,

for its use implies the recognition that not only endocardium, but myocardium and pericardium as well, may have suffered by the infection; and it is most important from the standpoint of treatment to know as much as possible of the comptency of the heart muscle as well as the valves. Senile change in the heart muscle is to be considered always in its relation to similar change in the arteries and capillaries. If sclerosis be present in the arterial system, and we find evidence of diminution of the capillary area, there may be a compensatory high blood pressure, and this throws a gradually increasing strain on the heart muscle, always with the threat of dilatation. Especially is this so if the danger signal of pain be present.

On the other hand the casuse may be more difficult of determination; as in the effort syndrome, disease of the coronary arteries, and some of the cases in which the heart muscle is involved without valvular lesion and without giving rise to any of the ordinary symptoms of myocarditis.

I wish to emphasize this fact; that pain of any degree in the distribution of those nerves which commonly express the pain of heart disease is never to be regarded lightly. Pleuritis, intercostal neuritis, neuralgia and myalgia must be carefully ruled out. The situation is to be regarded seriously from the moment that suspicion connects such pain with the heart. Inquiry into the question of strain must be minute,—not only strain immediately preceding the attack of pain, but several hours or even days prior to it. And it must be remembered that prolonged mental or physical strain have an effect which is often more disastrous and stubborn than that of acute strain. Conversely such pain does not by any means always denote our usual conception of angina pectoris, or disease of the coronary arteries, and we must not make the mistake of giving a worse prognosis than circumstances actually warrant. As already pointed out, pain should attract our attention to the fact that this heart is working against a resistance it is unable easily to overcome, and the muscle is crying for rest.

Some of the terminology in common use should either be abandoned or employed only in a more exact sense than is at present the prevailing custom. Angina pectoris means cardiac pain. It should mean nothing more. Unfortunately it has come to be applied to that condition where the chief lesion is disease of the coronary arteries, and the diagnosis carries with it an absolutely bad prognosis in the mind of the practitioner, and a sword of Damocles for the layman, into whose heart the term always brings a chill of fear. As applied to this particular disease the term is bad because it is inexact: it is no better diagnosis than "convulsions" would be for epilepsy or eclampsa. We should keep the phrase in use amongst ourselves, but apply it always in its exact sense to the symptom and not to a disease. With the laity the term should never be employed. Their conception of what it means fills them at once with terror and despair, and we may be too apt to make use of it to avoid the difficulties of a more exact diagnosis.

"Pseudo-angina" is another term in common use, the employment of which I deprecate because I do not believe there is any such thing. Pain is a protective symptom, one of the most valuable and conservative with which nature has kindly endowed us; and wherever pain exists there is some cause for it, and if one hide behind such a word as this he is begging the question and not fulfilling his duty to his patient or to himself. Recent editions of such textbooks as Osler, Dieulafoy and Strumpel have given up featuring this condition as they did fifteen years ago, but still cling to it, hiding it away in the articles on neuraesthenia, where it remains, not so conspicuous, but, when found, as harmful as before.

Are there different types of cardiac pain? I should say rather differences in degree than in type. Its localization is in the distribution of the lower cervical and upper dorsal nerves: its character sharp with all varying degrees of severity. With the most severe pain, or in patients whose nervous sensibility is greatest, there may also be a sensation of a vise-like grip on the chest wall, due to the addition of a viscero-motor to the viscero-sensory reflex. The motor nerves supplying the muscles overlying the hollow viscera are closely associated with the sensory nerves supplying the skin over those muscles. So that where pain is present as a result of disease of a viscus, muscular rigidity usually accompanies it. This syasm of the voluntary muscles overlying a disease structure is a protective phenomenon, and when involving the intercostal muscles to sufficient extent is thought to be the cause of the gripping, constricting sensation complained of by patients suffering from angina pectoris.

As we are dealing with the significance of cardiac pain a word must be said about most difficult of all subjects in clinical medicine,—prognosis. The fact that a patient

suffers from cardiac pain may argue at once a very bad outlook if we become convinced that the disease is one affecting the coronary arteries, or if, in mitral stenosis, we find the lesion advanced so far that rest does not readily relieve the strain on the heart. On the other hand the pain in another patient may be associated with such lesions that a reasonable assurance is justified that rest and subsequent care may give that patient a long lease on a life of comparative comfort and activity.

Let me cite two cases which illustrate my meaning.

Case 1. A patient 65 years old, male, was brought into the accident ward of one of our large city hospitals some fourteen years ago, vomiting and complaining of severe pain high in the epigastrium. He had come from a banquet where he had been taken with this attack about a half hour previously. Gastric lavage and finally morphine served to quiet him somewhat. Physical examination save for slight rigidity and tenderness in the epigastrium was negative. Heart action was regular, not rapid; sounds clear, no murmurs; there was no increase in the area of cardiac dulness. Pulse was of good quality; radial and temporal arteries a little thickened; blood pressure not observed. Despite the lavage and morphine pain continued and the patient died about three hours after admission, death occurring suddenly and without preliminary signs of cardiac failure. Autopsy: showed a heart only slightly enlarged, with perfectly normal, competant valves, a fairly good muscle tissue; but coronary arteries like clay pipe stems, so narrowed that a fine probe would hardly enter their lumen. Evidence of arterio-sclerosis elsewhere only slight. Kidneys showed moderate chronic interstitial changes.

This is one extreme.

Case 2. A young woman with rheumatic history came to me 8 years ago complaining of precordial pain, and dyspnoea at night. Area of cardiac dulness was slightly enlarged, pulmonary second sound accentuated, no murmurs heard at that time. There was slight cyanosis of the lips and some oedema of the feet. This pain continued for the next five years, becoming less frequent, but always appearing as a direct result of overwork or mental strain. She kept at her work all this time. Occasionally a systolic murmur would be heard at the apex, but the condition always suggested more of a muscular involvement than valvular disease. About three years ago it became possible for her to make changes in her environment which made her work easier and reduced the factor of work and anxiety to a minimum. To-day she not only does her usual work, but takes light gymastic exercise several times a week without the development of any cardiac symptoms.

In sizing up a patient complaining of angina pectoris, the first and foremost consideration is that the mere factor pain gives us definite information that the heart is for the present overburdened,—is laboring against a handicap to which it is going to give in if relief is not promptly afforded.

The second consideration lies in the answer to the question as to how far you can relieve this overstrain. Can it be relieved entirely, partially, or not at all? Observation alone can answer this for you. If you are dealing with a case which, besides pain, has other symptoms of cardiac failure, and where the strain which brings on the attack is acute, and there have not been a long series of attacks, your prognosis should be good if, in the course of a few days of proper treatment, the symptoms subside and the heart steadies down again to its work. But until you have watched the effect of treatment in such a case prognosis must be guarded.

A more or less exact determination of the anatomical lesion is the next best index to the outcome. If you are convinced that you are dealing with disease of the coronary arteries, or with an aneurism, the outlook is of course, bad for the remote, and precarious for the immediate future. If there is good evidence that the condition is due largely to a valvular defect, without much muscle impariment, or to a myocardial degeneration which still admits of acquiring some reserve, your future prognosis, if the patient survives the immediate attack, should be fair, provided something can be done to remove the conditions of mental or physical strain which have brought on the trouble.

I am aware that this is broad generalisation; but there are no exact rules that I know of, and your judgment of the essential lesion, and the ability of the heart to regain its lost reserve, is the important thing.

Just as the proof of the pudding lies in the gustatory effect thereof, so, equally true, the proof of cardiac sufficiency lies in the determination of what that heart can do in response to strain. Just so far, and no farther can it go; and a knowledge of

the limit of this effort is the end to be sought by careful examination and inquiry into the patient's mode of life, both mental any physical.

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MODERN HEART METHODS—A VALUATION.*

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When requested by the president of our society to read a paper before you it had been my original intention to prepare one upon some particular cardiac condition but on second thought I decided to give what may seem to be a rather rambling talk on the subject with an account of more or less personal experiences in this line of work.

About six and a half years ago the remark was made in the staff room of the old hospital by one of the *surgeons* that "there was no one on the staff who knew anything about modern heart methods." I felt that this "meant me" and it needed but this extra little prod to start me off for London a few weeks later to learn what I could in a limited space of time. Armed with a letter from our mutual friend and eminent consultant, Dr. Walter B. James, I met by appointment, in his laboratory in the University of London, Dr. Thomas Lewis. I shortly found that his course was too advanced for me and at his suggestion went over to the London Hospital and commenced a course under Sir James Mackenzie and his assistant, John Parkinson.

My especial desire was to learn something on the subject of cardiac irregularities, my only knowledge on the subject having been derived from the reading of Lewis' book, entitled, "Clinical Disorders of the Heart Beat." A great deal of attention was paid to this subject and the polygraph was inconstant use. A tracing was made daily of each case and filed with the history. Parkinson at this time was working overtime at night installing an electrocardiograph, a Cambridge machine. He was an expert, having served for three years in Lewis' Laboratory. For several weeks I worked daily in the heart wards making tracings, clinical examinations, attending out-patient clinics, autopsies and studying in the evenings.

*Read before the Clinical Society of the Mountainside Hospital, Montclair, N. J.

On my return to this country, having purchased a polygraph, I endeavored to put into practice some of the things I had learned, with great satisfaction to myself and to the interest of most of the staff. Four years later we installed our electrocardiograph (to date the only one in this State, and we are justly proud.)

The continued use of the polygraph (and I made hundreds of tracings) resulted in the discovery of the fact that I was able to recognize and understand the mechanics of most of the arrhythmias and found, as did others, after this training that I could appreciate many of them *without* the use of instruments. However, I still believe that a thorough understanding of these mechanisms is impossible without such an apprenticeship.

From Mackenzie I learned of the intensive use of digitalis, that is to say, the exhibition of considerable doses given over a short period to produce an early accumulation. Also I learned the tremendous importance he lays upon myocardial efficiency and I believe he was the pioneer along this line. That the mere presence of a murmur or murmurs was not the whole story but that the ability of the heart to perform its work even if handicapped by a leaky valve or valves, is the great criterion. Also the fact that some murmurs can be lragely discounted or ignored. In fact he goes so far as to say that some murmurs heard over the mitral orifice suggesting a regurgitation, often merely indicate a safety device to prevent over-strain of the heart chambers.

I have seen him after a careful examination of a child, sent to the hospital for treatment with a diagnosis of endocarditis, make light of the murmur, ignore an apparent hypertrophy, knowing that the child's heart is normally placed higher and to the left than in the adult and that the irregularity that had caused anxiety was merely a "sinus arrhythmia" of no clinical significance, but rather a sign of good omen after an infection. Unfortunately, and I understand the situation thoroughly, in some of his writings he has *apparently* belittled the value of some of the modern methods and I have read the same criticism made by reviewers of some of his work.

Just remember that Mackenzie is the past master of the physical examination of the heart. That his judgments are based upon thousands of cases spread over a great many years of a very active professional life and that by his almost uncanny knowl-

edge he is enabled to make diagnoses and give prognosis impossible for the large majority of clinicians even when aided by instruments of precision. Do not forget that he is the inventor of the Mackenzie Ink Polygraph, an instrument that records synchronously the pulsations of the radial pulse and the jugular bulb representing, therefore, the action of the left ventricle and the right auricle,—a great advance over the sphygmograph; that for years he studied the use of the electrocardiograph in Lewis' Laboratory and as I said before, at the time of my visit, in 1913, was having one installed in his own hospital.

The instrument he seems to place the least value upon in heart work would seem to be the *x-ray*. Quoting from his article in the recently published Oxford Medicine, he says: "The inspection and palpation of the movements of the heart and the percussion of the heart's dullness give a far more valuable indication of the size of the different chambers of the heart than an *x-ray* examination. Indeed I am doubtful if an *x-ray* examination of the heart has ever thrown the slightest light on any cardiac condition. That the *x-rays* may reveal aneurysms and tumors, not perceptible to the unaided senses, is no doubt true, but so far as the heart itself is concerned, while it may give a more accurate conception of the size of the heart in bulk, it gives no idea of the particular parts that are increased in size. Like the modifications of the stethescope, the modifications of the *x-ray* methods by orthodiagraphy and teleroentgenography have been of little use.

I am not decrying the use of instruments of precision, what I wish to point out is that they have a limited sphere of usefulness in the examination of patients." Such statements, if not carefully and properly interpreted and without knowing the character of their source, might be misunderstood. It reminds me very much of a talk given to the physicians of this vicinity a few years ago by an eminent clinician from a neighboring city, who, I believe, wholly and unintentionally created a very erroneous view as to the value of certain clinical and laboratory methods and which could and did not fail to do harm.

Gentlemen: We are not Mackenzies, Lewis nor the gentleman referred to, and we need every possible aid to the correct diagnosis of our cardiac and cardiovascular cases. The cardiac laboratory will demonstrate to us conditions not even surmised. It bears the same relationship in its department as does the general pathological laboratory. Its findings must be looked upon as adjuncts as are other laboratory findings, —positive in some cases, negative in others, yet possible of demonstrating conditions to be found by no other means. That these instruments do not write down in ink or photographically a correct diagnosis, prognosis and outline of treatment in each and every case is undoubtedly a fact. However, that the electrocardiograph does record photographically hieroglyphics capable of correct interpretation in the vast majority of cases the presence and origin of all the various cardiac irregularities (with the exception of Pulsus Alternans) without the possibility of the technician's individual equation, is also a fact. That it also shows predominant hypertrophies, that it assists in the differentiation of certain valvular lesions, that it confirms or refutes diagnoses in some uncertain conditions and that it gives certain and sometimes otherwise unrecognizable indications of myocardial changes, is without possibility of contradiction.

These myocardial changes are principally indicated by signs of alteration from the normal in the conduction system along the Bundle of His extending down to its terminal branches in the Purkinje system ramifying in the walls of the ventricles. The pathology of this latter condition has been beautifully and uniquely worked up by Oppenheimer of the Mt. Sinai Hospital, New York City, and to which he has given the name of "Arborization Block."

Furthermore, we have in this instrument a means of studying the effect of heart drugs. It shows the effect of digitalis administration long before it is to be recognized clinically. For instance, in febrile conditions where the pulse does not show the usual effect of the drug, as in nonfebrile cases, digitalis action may well be checked up in this way. In such cases it was commonly thought that the drug was not acting simply because we were watching for a slowing of the heart rate.

Some of you may be interested to read an article in the November issue of the American Journal of the Medical Sciences, by T. Stuart Hart of the Presbyterian Hospital, New York City, on "The Heart in Broncho-pneumonia." In this article he refers to this very subject,—the use of digitalis in the cases of pneumonia in the recent epidemic of influenza. He gives the result of the use of digitalis in cases with

normal hearts and those with chronic valvular diseases.

In his summary he states among other conclusions:

"(a) That digitalis acts on the cardiac apparatus of these pneumonias in the same manner as in a similar series of hearts without complicating pneumonias.

"(b) That digitalis reduced the heart rate only in cases of auricular fibrillation and in these cases where it was administered in quantities sufficient to produce an actual auriculo-ventricular block.

"(c) That the administration of digitalis did *not* influence blood pressure."

His findings were checked up by electrocardiographic studies. I agree with him when he states that "It is wiser, unless the need is very urgent, to give digitalis in moderte amounts and to approach complete digitalization gradually, rather than by the use of the enormous initial doses that have been advised by some enthusiastic clinicians." * * * "Here, as in other fields of medicine, it is unwise to administer digitalis by arbitrary fixed rules, calculated on weight alone."

That the number of men in the profession who can by physical examination differentiate an "extrasystole" from a "dropped beat" due to partial heart block must be small indeed. I am told that Lewis has selected a case saying that it should show "arborization block" and then proved it by electrocardiography. It would be an easy matter to quote case after case where the man trained along these lines has been enabled to discover conditions entirely overlooked by the practitioner not versed in the mechanics of the heart beat.

I have seen cases in a dangerous condition from over digitalization where the signs present were supposed to be due to the disease not to the medication. I have seen cases where there was hesitation as to the use of digitalis for the lack of such knowledge. I have seen cases of auricular fibrillation with a pulse so almost regular to the average sense of touch that fibrillation would have been easily overlooked had it not been for instrumental assistance, and I do not refer to those cases where a complete heart-block permitted an idioventricular rhythm. The same might be said in regard to "auricular flutter" for although the ventricles may be beating regularly at the rate of one hundred to the minute, yet the auricles may be beating at three or more times that rate.

This condition is to be recognized *only* by the electrocardiograph. In these cases digitalis is indicated to the point of producing a fibrillation when on withdrawal of the drug the normal rhythm may be resumed,—a most interesting condition.

Another form of arrhythmia, the "Pulsus Alternans" is most important of recognition. This is done to perfection by the sphygmograph. The electrocardiograph cannot be relied upon for obvious reasons. In this condition alternate ventricular contractions throw larger and smaller quantities of blood into the arteries thus producing first a strong beat, then a weak one. However, as the difference in the measured height of these arterial excursions is seldom over a millimeter, it is easy to see that such pressure changes would be rarely, if ever, palpable over the radial artery and certainly not over the ventricle.

It is a condition most frequently seen in old cardiovascular cases. It is not a sign of good omen and if persistent is a decidedly unfavorable one. "It has been seen in pneumonia during the precritical stage, and also in patients under the influence of large doses of digitalis."....."Whenever it occurs, there is reason to believe, either that a tolerably healthy heart muscle is carrying an excessive burden or that a diseased or poisoned muscle is struggling to perform work of which it is hardly capable." (Lewis.) It may be found when the heart is beating at a regular and slow rate but is more liable to be found when the rate is accelerated or where there are premature contractions.

A few words as to this form of arrhythmia may not be amiss. Extrasystoles or premature contractions commonly noticed as "missed beats" are, of course, easy of recognition clinically but to differentiate the source of the abnormal point of stimulus is a different matter. This is possible in many cases by the polygraph, but most beautifully and accurately by the electrocardiograph. These conditions do not cause us any especial anxiety unless very frequent and persistent or when associated with other signs of cardiac failure.

As a rule digitalis is contraindicated, rather are sedatives indicated. Digitalis itself may produce extrasystoles, and, where they appear after every normal beat produces the "Pulsus Bigeminus." Clinically I had this presented to me very recently. The patient was an old man with a failing myocardium who had been away and out of my care for several months. On his return I found the pulse rate as noted by the

nurse was 44 per minute,—abradycardial rate, but only because every other normal beat was supplanted by a weak extrasystole which could have been easily overlooked. I realized that it was a case of over digitalis action and a few doses of atropine, hypodermatically, soon showed the actual pulse rate to be 88, just double. Clinically, the premature contractions may be missed or absent if there is not force enough to raise the aortic cusps. Instrumentally the condition makes a very pretty picture and thus explains the type of bradycardia.

I have always felt that extrasystoles of auricular origin were of more importance than ventricular though I cannot produce authorities to support me. My opinion is based upon the rather close relationship of auricular systoles, paroxysmal tachycardia and auricular fibrillation. They all indicate a condition of over excitability of points of stimulation removed from the normal site.

Within a few days I have been privileged to see a case whose only complaint was cardiac palpitation. The physical findings were practically negative, the patient being a fine specimen of manhood. His palpitation was due to what were apparently frequently recurring extrasystoles. However, the electrocardiograph showed the irregularity to be due to a continuous sin-arrhythmia with frequent standstill of the entire heart due to a sino-auricular block. These cases are not common, they may be due to a purely temporary and functional distubance of pneumogastric control or, of course, to actual damage at the site of the sino-auricular node. A differential diagnosis was thus easily made from 'suspected" extrasystoles and the case may be studied from an entirely different viewpoint. I wish it had been possible within the limits allowed me to have shown cuts in illustration of the conditions referred to in this paper.

I have frequently been asked as to the value of electrocardiographic examination in the diagnosis of valvular lesions. This is a difficult question and I shall quote indirectly from Lewis because as he says "The special sphere of this instrument is in relation to the condition of the *heart muscle* and we know that the relative balance of the muscle masses in these conditions is so variable and especially in aortic lesions that taken as a criterion alone, very little dependence can be placed upon the findings."

As to some of the individual lesions let us take first the most common *"Mitral Regurgitation."* Here the findings are far from constant but rather I believe, incline to a left sided predominance.

In *Mitral Stenosis,* we have perhaps the most constant findings and many times one can make a positive diagnosis of this lesion by this examination alone. There is a right sided predominance associated with an enlarged or bifurcated "p" wave indicating auricular over-action or hypertrophy. In this lesion when auricular fibrillation is present the picture is characteristic. Of course fibrillation is found in other conditions besides Mitral Stenosis.

In the aortic lesions though the tendency might be toward left sided predominance, yet this far from constant and even right sided predominance is found in some cases. A large excursion of the "r" wave in the second lead is quite common. In congenital conditions such as *Pulmonary Stenosis* there are generally signs of a right sided predominance with an exaggerted amplitude of excursion.

With the above statements we can see that in a case where a presystolic murmur at the apex may mean a mitral stenosis, or it may be the Flint murmur of aortic disease, the differentiation will be assisted by the finding of a right sided predominance suggesting the mitral lesion.

I remember the case of a young woman, desirous of entering a hospital to become a nurse who was found to have an indefinite murmur near the apex, and equally good men were divided as to their opinion as to whether a mitral stenosis was present or not. The electrocardiograph settled the question by the positive findings mentioned above. From another viewpoint, that of life insurance! I have had come to me for examination several persons who had been refused policies for alleged heart disease and were naturally much distrubed.

The presence of a soft blowing murmur at either the apex or base with an absence of hypertrophy, with a good exercise response and with a normal electrocardiogram would not have suggested much to me as to the presence of serious organic disease and especially if there had been no history of an infection.

Within a few days I examined a young man of excellent habits and with no history of infection. He had been told that on account of prominent vessels in his temples he was suspected of arteriorsclerosis and further that his heart was diseased. They told him that his blood pressure was 100—this latter, of course, meant nothing

to him. As a matter of fact his systolic pressure was 100 and his diastolic, 60. His heart showed no hypertrophy, he had a good exercise response, said he could run up and down any number of stairs and had done so in his office building, without undue shortness of breath or heart action.

I found the heart normal in size, being well within the normal limits on percussion, but what had evidently stampeded the insurance examiner was a "split first sound." Now a "split first sound" has no pathological significance as it merely suggests a slight asynchronism of the ventricular contractions or slight separation of two parts of the ventricular sound which are of different origin but ordinary fused.

On the other hand a slight widening of the auriculoventricular interval due to a partial block or block in its simplest form may lead to a *reduplication* of the first sound, not a *split* sound. A more pronounced widening of the auriculoventricular interval due to the same condition may result in a double second sound for the auricular systole may fall in early diastole. (Lewis.)

Now the young man just mentioned was unjustly rejected. A diagnosis of arteriosclerosis could not have been made upon these findings and had there been any question whatsoever as to the split first sound, the electrocardiograph would have settled the question.

You have probably noticed that several times in the course of this paper I have made use of the term "right" or "left" predominance." It is very necessary that you understand what we mean by these terms. In our interpretation of curves, we never say right or left hypertrophy. In the normal curve or where the balance of muscle masses is equal as to the two sides we get a balanced curve, one in which the "r" waves or "spikes" point upward in all three lads.

When there is a disturbance of this balance we speak of a right or left predominance for you see that even a tremendously enlarged heart may show a normal curve if the balance is perfect; or a predominance to right or left according to the location of the greater musce masses.

Without understanding the meaning of these terms and the limitations of the E. K. findings, the practitioner might very easily misinterpret them. Therefore, the electrocardiograph technician, if also a clinician, would vastly prefer to combine a physical examination with his instrumental findings. His work would certainly be much more valuable from the consultant standpoint.

To close, it is safe and proper to state that there is no case of cardiac or cardiovascular disease from which something may not be learned from laboratory examination. The thorough investigation of every case by any and all means at our disposal, insures accuracy of diagnosis and, therefore, better therapeusis.

I thank you for your attention to this rather rambling dissertation, but if it has been educational along the lines of the valuation of modern heart methods neither your time nor mine will have been wasted.

HEALTH INSURANCE FROM THE STANDPOINT OF THE PHYSICIAN.*

By CHAS. J. WHALEN, M.D., LL.B., Chicago, Ill.

Health insurance from the standpoint of the physician has a direct bearing upon public health because of the fact that wherever it has been tried it has stopped all medical progress, as shown by Dr. E. H. Ochsner, and has brought about the worst imaginable form of medical service. Poorly equipped doctors and inferior medical service are necessarily potent factors in keeping up the morbidity and mortality rate of the community. In Germany and Austria, where health insurance has been in vogue for thirty years or more, the quality of the German and Austrian medical men has so deteriorated and the people get such poor medical service that the lowering of mortality and morbidity in these countries has not kept pace with America and other countries not having health insurance laws.

Compulsory health insurance has crushed the independence and enthusiasm out of the German profession to such a degree that each year men of real ability are studying medicine in smaller and smaller numbers.

Thirty years ago Germany and Austria were leaders in the science of medicine. Today they take a place away down in the scale. It has been authoritatively demonstrated (Dr. E. H. Ochsner) that the medical men of the first magnitude in both Germany and Austria today, under forty years of age, can be counted on the fingers of one hand, and this in a population of one hundred and forty millions.

In countries not cursed by compulsory

*From the Illinois Medical Journal, November, 1919.

health insurance progress has been steadily upward. America, for instance, has taken the place previously occupied by Germany and Austria, before they established health insurance.

Because it has stopped scientific medical progress, as it has in Europe, by destroying the incentive for research and individual excellence, it is undesirable to the public, by whom the effects of insufficient service would be most keenly felt. In other words, where medical progress is retarded, the physical welfare of the community is jeopardized.

As illustrating the kind of medical service that is given under a compulsory health service, I call your attention to the working of the law in England. Brend in his book, 'Health and the State,' says that no one aside from the panel doctor is satisfied with the working of the English law. The German law was a practical failure. The English is worse. It fails to provide competent care for those needing it. Some investigation showed that for making diagnosis, writing prescriptions, making records, a panel doctor averaged three and one-quarter minutes per patient.

Health insurance laws, wherever tried, have demoralized the medical profession, and this necessarily reacts to the detriment of the public health. Friedensburg, formerly head of the German Insurance Office, in his work, Practical Results of Workingman's Insurance in Germany, says the demoralization of the medical profession is one of the most unfortunate by-products of the European social insurance system. The evidence shows there is constant strife between physicians and the carrier association. Evidence, too, shows there has been sudden prosperity of those physicians who have catered to the whims of the insured who practice malingering and the utter ruin of doctors who have held their professional standing above the demands of the masses for unearned benefits and pensions. The evidence, too, shows discontent and dissatisfaction among physicians, culminating in strikes, and again in the refusal of the best men to allow their names to go on the panels. As a result the insured get only inferior medical service. In other words, the least efficient doctors will make the most money, and from the standpoint of the people the services will become deteriorated.

"A physician who has the reputation of being 'generous' in his diagnoses is certain of a host of patients, and the courts of honor of the medical profession have repeatedly been forced to interfere, since this generosity has led to a suspicious disturbance of scientific knowledge. A melancholy counterpart is furnished by the numerous cases in which a physician of probity renders an expert opinion unfavorable to the pension claimant, begging that the claimant in question be kept in ignorance of this opinion, since otherwise the physician concerned would lose his practice, while his neighborhood would be made too hot to hold him."

Another phase of the medical problem is the fact that it would represent the first case in history of a compulsory trades union. No physician could serve, unless he joined a local panel, and received his credentials as a panel or union physician. His union, however, could not get a charter from the American Federation of Labor, because that organization makes its own laws and rules, and its subdivisions regulate their charges for service, while the panel physician could not say when or where he would work, or how much he would charge. The State Commission would fix his pay, the medical directors of the carrier associations would say when his patients were sick and when they had recovered, and the carrier associations would dispute his charges. His efforts to prevent fraud and malingering would gradually set up a boycott against him as an unfair physician. He would have to have under his care, and call upon daily, every day of the year, twelve patients, in order to make a bare living, and in order to do that he must be certified by the medical director, certified by the patient, audited and disputed by the carrier associations, and waste time arguing his appeals before the commission.

From a public health standpoint the justification of the expenditure of seventy million dollars annually in Illinois would not warrant the enactment of a compulsory health insurance law unless it can be shown that such a measure would materially lessen the morbidity and mortality.

I am able to show that the alleged improvement in health will not materialize. It will not remove the cause of illness, nor will it reduce the number of cases or the average length of disability, and I have but to refer to existing records or similar schemes in Europe to prove this assertion.

More Germans die or lose time by sickness, under health insurance, than Americans.

Not only do the wage-earners of Ger-

many and Austria lose more time through sickness under compulsory health insurance laws than in the United States without such laws, but it also is interesting to note that it has produced in the habits of German and Austrian workers a tendency to become sick, to imagine they are sick, or to make believe they are sick. The figures are illuminating. In Germany out of every 100 insured wage-earners, 36.7 were listed as sick in 1890, and 45.6 in 1913; in Austria the corresponding figures were 45.7 in 1890, and 51.8 in 1913. In Germany the average number of days of sickness for each sick member increased from 16.2 in 1890 to 17.4 in 1913. The average number of days of sickness per insured member, which was 5.9 in Germany in 1885, when the law had just gone into effect, increased to 6.19 in 1890, and 9.19 in 1913, while the Austrian statistics from 1890 to 1913 show an increase from 7.98 to 9.45 days. Not only did the duration of sickness per person increase, but more persons were reported sick in Germany and Austria in 1913 than in 1890, showing that compulsory health insurance laws did not prevent sickness nor minimize its duration, and, therefore, did not promote efficiency.

Lower Death Rate in the United States.

In 1912 the death rate in Germany was 15.6 per thousand population; in Austria, 20.5, and in Hungary, 23.3. Now compare these figures with the mortality rates in several countries which had not compulsory health insurance laws in effect. In the same year the death rate in Australia was 11.2; in New Zealand, 8.9; in Sweden, 14.2; in Switzerland, 14.1; in Belgium, 14.8; in Denmark, 13; in the Netherlands, 12.3, and in the United States, 13.9, which was further reduced in 1915 to 13.5.

This low rate was obtained in spite of the fact that the ordinary tendency to disease is aggravated by a great variety of climates in the United States, by the diversity of races represented in our population, and the fact that the United States has kept its doors open to millions of immigrants unused to our change of climate, many of them physically wasted by toil and privations in their homeland.

Will Not Decrease Poverty.

Under all the schemes for compulsory health insurance as yet proposed the persons most needing the insurance will not get it. Those who are out of work, except on account of illness, longer than the extension of one week for each four weeks of paid-up assessments; those who are unable to get into the voluntary insurance societies because they are unable to pass the medical examination, and those who are not insured because they are unable to get work on account of their age, alcoholism, shiftlessness, general incompetency, or any other disabling condition which prevents them from being employed in times of financial distress or panic—these unfortunate conditions will be greatly magnified.

Under the health insurance scheme the lot of the casual laborer would be grievously hard. It is axiomatic that the less a man earns per day the fewer days he works. Many cannot spare the amount necessary to pay the premiums continuously in order to receive the benefits. Therefore those who are unable on account of general incompetence, previous illness or any other disabling condition will be left outside the operation of this bill.

The proposed health insurance legislation does not make provision for the very poor, as such plans include the steady workers, a picked group, and not those who most need the insurance.

Moreover, the casual workers, the physical defective and the wage-earners above the insurable age who at present are able to provide for their own needs by at least part-time work, would by this bill be forced into involuntary idleness and consequent poverty.

Will Increase Poverty.

Finally, I wish to emphasize that health insurance will not decrease poverty, but on the contrary will increase it by creating what might be called a human scrapheap.

In addition to these who constitute the present charity list will be added the 250,000 who, through physical unfitness or old age, will be driven to involuntary idleness through the operation of this bill.

Age and physical condition would debar from steady employment and throw into the list of casuals, most of the workmen over fifty-five years of age, which, figured at only 2 per cent. of the covered wage-earners, would mean 48,000; add 10,000 mentally defective, 35,000 tuberculars, 100,000 venereals, and 60,000 chronics who are intermittently disabled, and you produce a scrapheap of over 250,000 for the State or community to support or provide with employment, because every employer would be justified in demanding rigid physical examination of workmen. Necessarily the employer in order to keep his assessments low will carefully choose his employees, excluding by medical examination

all who are not physically perfect, and the discard from these examinations will increase our already permanent pauper class.

Prevention is the antithesis of compulsory health insurance. It has often been claimed that a sickness insurance system creates an incentive for preventive work. The experience of the European countries does not support this contention. Indeed it is difficult to see any logical ground for the claim; a clear appreciation of the extent of sickness and disability and the heavy burden which they place upon society should be the sufficient and powerful incentive for prevention. Insurance is not the solution of the problem. If interest in prevention can be aroused through an insurance system it should be much more sharply stimulated by an organized program having prevention for its chief object.

Disability as contemplated under compulsory health insurance arises largely from carelessness, recklessness, intemperance, use of drugs and personal vice and immorality. Laxity in applying the laws governing communicable diseases, housing conditions, water supply, food inspection, drainage, streets, alleys and yards and smoke- and gas-polluted air.

Most dentists agree that 80 per cent. of adults would have comparatively good teeth, instead of 90 per cent. of them having bad teeth, if the teeth were looked after regularly from childhood. Sixty per cent. of all sickness is preventable. It would seem then that the logical and economic thing to do would be to strike at the root of this social evil by setting up a system of conservation.

All sickness and disability which can reasonably be prevented should be prevented instead of being allowed to remain unremedied until they impose a burden of misery and poverty on the individual and a burden of cost on society.

German Physicians Oppose Plan to Make Them State Employees — The Nederlandsch Tijdschrift states at the forty-first annual representative meeting of the medical profession in Germany, the Aertetag, to be held at Eisenach, the president of the Leipsiz League was to speak on contract practice; Mugdan, member of the National Assembly, on the "socialization of the practice of medicine; Schwalbe on reform in medical education, and others on measures to repress quackery and on social insurance. The cable has reported since that the delegates voted unanimously against the government's proposal that all physicians should be made state employees. The chief argument presented against the plan is the necessity for physicians to maintain confidential relations with their patients.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held December 12, 1919, at Hotel Chalfonte, Atlantic City.

The following interesting program was presented:

"Report of a Case of Carcinama of the Rectum," with lantern demonstration, "Dr. William E. Darnell, Atlantic City.

"A New Technique of Applying Radium Alone or in Conjunction with Other Methods in the treatment of Benign and Malignant Lesions," lantern demonstration, by Dr. William S. Clark, Philadelphia.

"Focal Infections," by Dr. Alfred Stengel, Philadelphia.

BERGEN COUNTY.

Raphael Gilady, M. D., Reporter.

The monthly meeting of the Bergen County Medical Society was held at the Union League Club, Hackensack, November 11, 1919. The entire session was devoted to the scientific program which consisted of a paper read by Dr. Charles G. Heyd of New York City, entitled, "The History in Disease of the Gall Bladder, Stomach and Appendix." Lantern slides accompanied the paper. Interesting discussions followed, all the members participating. Dr. Heyd was given a rising vote of thanks for his thorough paper in which he emphasized the fact that a complete history of the case will many a time save an erroneous diagnosis.

CAMDEN COUNTY.

Grafton E. Day, M. D., Reporter.

The December meeting of the Camden District Medical Society was held on the 9th inst. at the Camden Dispensary at 1.30 P. M., Dr. E. B. Rogers, president, in the chair. About twenty applications for membership were received and the program announced by the Committee of Program was carried out.

"Peptic Ulcer" was the subject, treated in a symposium, Drs. Joseph E. Roberts, Wm. M. Kain and Paul M. Mecray discussing the diagnosis, medical and surgical treatment respectively. It was agreed that fluoroscopic as well as x-ray examinations were essential in the diagnosis and that six months or more must elapse before a cure could be assured. The treatment as outlined by Drs. Kain and Mecray was a combination of wise conservatism with an understanding of the need at times of immediate and urgent surgical care.

The question of fees was discussed and the list as proposed at October meeting was adopted with slight modifications as follows: Office consultation, $1.00 up; vaccination, $1.00; writing of certificates, $1,00; telephone or letter consultation, $1.00; day home visits, $2.00; night home visits (10 P. M. to 6 A. M., $3.00; suburban town visits, $3.00 up; examination of lunacy cases, $10.00; examination of regular life insurance cases, $5.00; confinement cases, $20.00 up. It was resolved that said schedule shall become effective January 1, 1920.

The principal changes were in the office fees minimum, $1.00; visits, minimum, $2.00, with increased fees for night calls.

At the close of the business session the usual turkey dinner with "fixin's" was indulged in by those present.

It is proposed to magnify the scientific part of our sessions in the future, although the February meeting is scheduled as the Ladies' Night.

ESSEX COUNTY.

Eugene W. Murray, M. D., Reporter.

The regular meeting of the Essex County Medical Society was held in Newark on Dec. 18. Dr. George B. Philhower of Nutley, the president, being ill with pneumonia, Dr. Harrison S. Martland, vice-president, occupied the chair. There were twelve members elected.

Col. Thomas W. Salmon, medical director, National Committee for Mental Hygiene, gave a talk on "What Can Essex Do for Mental Hygiene?" He congratulated this city on having the first mental hygiene clinic connected with a health department in the nation. He urged that measures to prevent mental derangement should be taken in childhood when better results can be obtained. Also, that psychopathic hospitals be established in counties and States, to which all mental cases could be taken for treatment without having to wait and comply with the present red tape method of commitment.

Judge Harry V. Osborne of Newark said that the establishment of psychopatric hospitals would be of incalculable value to the courts in handling many of the cases that come before them.

Dr. John O'Reilly of Brooklyn, N. Y., spoke on Compulsory Health Insurance and its importance to the public and the profession in the impending legislation. He not only condemned health insurance as "an emanation of the brain of Bismarck," and described by him in 1884 as "a sop to the socialist," but also, as "Un-American, unsafe, uneconomic, unfair, unscientific and unscrupulous legislation."

Experiments in Germany, where he said, the system had originated and a part of the infamous kultur inaugurated by Bismarck, and carried to ruin by the "paranoiac Potsdam" and in England had proven this, he said, adding that the quality of service rendered by doctors, dentists, druggists, hospitals, and so forth, has steadily degenerated as their earning capacity has been reduced. The profession would accept and support an American voluntary type of health insurance, he said, such insurance would differ from the compulsory type in that instead, of being class legislation, will be for all the people who may wish to avail themselves of it.

Dr. Wells P. Eagleton epitomized the bill to be presented to the incoming legislation, and will have copies sent to every member of the society for study.

HUDSON COUNTY.

William Freile, M. D., Reporter.

The Carteret Club housed the Hudson County Medical Society on the 6th inst. at its second regular meeting, with Dr. Pollak presiding.

He mentioned that the committee on public health and legislation would be most important this year and that at the next meeting he would like to see a committee of six selected, comprising men of intelligence and integrity, to work in the proper spirit for the benefit of the public and the interest of the society.

The matter of employers designating the physician to take charge of injured cases, was brought up, and the president mentioned that a representative committee should have this in hand, as a bill would probably be introduced whereby the selection of a physician would be made optional, and thus many cases heretofore referred to New York would be kept in New Jersey and in Hudson County.

Drs. Woodruff, Jaffin and Curtis were designated as the membership committee; ten applications were turned over to the censors, and six were admitted to the society.

Dr. George H. Sexsmith described a "brainless man," the result of an auto accident, struck a little over the eye on the left side, the brain pouring out through the aperture. Operation and exploration revealed a complete cavity. Some oedema of the eyes followed, but no disturbance in vision, no paralysis, irrationality, or evidence of changed temperament.

Dr. B. S. Pollak spoke of the comparative rarity of T. B. ulcers of the tongue, and emphasized the necessity for differentiation from specific and malignant causes. He called attention to the frequency with which diabetes complicates T. B. and advised the recent classical treatment for the diabetic condition.

Dr. M. A. Swiney recited the cause of a pregnant woman who carried from two to five per cent. sugar and under a modified diet, went to a normal delivery. This topic was talked to by Drs. Bortone, Jaffin and Pyle, and the point made, that as many pregnant cases showed glycosuria, it behooved the attendant to be sure that he is really dealing with a case of true diabetes or not.

Dr. Henry Spence brought up the subject of Compulsory Insurance. He showed its importance to the profession and the people, and stated that Dr. John J. A. O'Reilly of Brooklyn was familiar with this law, and cognizant of what had taken place in this connection in Great Britain and Germany. The society then voted that Dr. O'Reilly be requested to address the next meeting on December 2nd, taking Compulsory Health Insurance as his topic.

Dr. Grant P. Curtis, Town of Union, late of Base Hospital No. 16, New Haven, read the paper of the evening, "Cardiac Sequelae of Influenza," which evoked a most interesting and helpful discussion. We hope to publish this paper with an abstract of the discussion, in an early issue.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Society was held Wednesday, December 17th, at the St. Peter's General Hospital, New Brunswick.

In addition to being one of the best attended meetings held by the society in many months it was notable in that two new members were accepted into the society in addition to five

applications received from practitioners in the county applying for membership. The names of the new applicants were referred to the committee on membership and ethics to be acted upon at the next regular meeting. It would seem from the renewed interest of members in the society and from the large number of applications for membership, that the efforts of the society to get all physician in the county into the organization is beginning to bear fruit. It is earnestly hoped by the officers that this awakened interest will be maintained, as too much emphasis cannot be laid on the importance of a united profession at this time.

The speaker of the afternoon was Adolphus Corwin on the subject, "How the County Medical Societies Can Aid the State Board of Medical Examiners." The discourse was highly interesting and instructive, the society going on record as being unanimous in indorsing the compulsory yearly registration of all physicians in the state, as advocated by the speaker. It was moved and seconded that the secretary express the will of the society in this matter to the secretary of the State Society in writing.

Following a vote of thanks to the speaker and an interesting discussion the meeting was adjourned on motion.

MORRIS COUNTY.

Britton D. Evans, M. D., Reporter.

The regular meeting of the Morris County Medical Society was held on the afternoon of December 9 at the Mansion House in Dover. Despite the disagreeable weather and the discouraging and treacherous road conditions the members were present in gratifying proportion. Among the guests were Lieut. Stallman, M. D., of the Picatinny Arsenal, and Lieut. John Daly, M. D., of the Naval Ammunition station situated in the northern part of the county.

A delicious dinner was served shortly after two o'clock which manifestly was enjoyed by all and came fully up to the high cuisine standard long since established by Host Horgan.

The meeting was called to order by the newly elected president, Marcus A. Curry, M. D. In a nicely balanced prologue the new president gave expression to his thanks to the members for his election, acknowledged the honor conferred upon him, and promised his best for the welfare of the society.

The more formal routine being disposed of Dr Flagge reported two cases of interest to the profession; one being a rare case of morbus maculosum neonatorum, and the other that of a man about seventy-five years of age who was emaciating rapidly and, evidently, had a malignant diseased growth in the abdomen, and in which the autopsy unexpectedly revealed a malignant disease at the pyloric end of the stomach.

President Curry then introduced George H. Lathrope, M. D., of Morristown, who read the paper of the day, the title of which was "The Significance of Cardiac Pains." He said that when confronted with this condition the physician is too apt to think of the pathology only to the exclusion of the physiology; by which was meant what the organ is able to do for the individual; he said that overwork cuts down the heart's reserve and undernutrition, pain and exhaustion are the results; he further stated that pain never is an early symptom but a late event in a diseased condition which has been going on for some time and wherever it exists there is some cause for it; and that it differs more in degree than in type. The paper has been promised for publication in the Journal whose readers will have opportunity to appreciate that it gripped the attention of its hearers and gained for the author much complimentary comment and a rising vote of thanks and appreciation. Those who entered into the discussion, which was made open to the guests by suggestion of President Curry, were Drs. Owens, Wigg, Farrow, Gordon, Lieut. Stallman, Flagge, Horn and Clark. President Curry expressed his particular appreciation of some of the points brought out in the paper. Dr. Lathrope closed the discussion by answering the questions asked and elucidating some collateral conditions which the discussion suggested.

It was decided to hold the next meeting in Morristown, the date and place to be fixed later by the committee.

WARREN COUNTY.

Charles B. Smith, M. D., Reporter.

The annual meeting of the Warren County Medical Society was held at Belvidere, N. J., Tuesday, October 27th, 1919, with an average attendance. We missed our State Counselor who was not present owing to a previous engagement.

Dr. Wm. J. Chandler, Recording Secretary of the State Society, was present and gave some fatherly advice to the county members, urging them to make an effort to get all the regular practitioners of the county as members of the Society. A membership committee, consisting of three, was appointed to invite every M. D. in county, not a member of the society, and report at our next meeting. A general discussion regarding the benefits of the society was engaged in by all present. The following officers were elected for the ensuing year:

President, George G. Mills, Hackettstown; vice-president, Chas. H. Lyon, Phillipsburg; secretary, Wm. Burd, Belvidere; treasurer, G. W. Cummins, Belvidere; reporter, Chas. B. Smith, Washington; censor, W. C. Allen, Blairstown (3 years); annual delegate to the State Society, F. A. Shimer, Phillipsburg.

Local Medical Societies.

Physicians 'Club of North Hudson.

C. V. Niemeyer, M.D., Union Hill, Secretary.

The club met Nov. 3rd and heard a paper on "Infant Feeding," by Prof. M. C. Pease, N. Y. Post-Graduate. He advocated using a caloric standard, as the most practical way to determine the amount of milk to be fed, and gave figures for children of different ages and in different states of nutrition. The paper was discussed by Dr. O'Gorman of Jersey City and others.

On Dec. 8th we were addressed by Dr. J. Levy of the State Department of Health, on the state's program for Child Hygiene and Pre-natal Care. Dr. Levy showed some strik-

ing differences between the vital statistics of Hudson County and those of other parts of the State. Dr. O'Gorman was with us again and discussed Dr. Levy's address.

Dr. N. B. Foster of New York, formerly of the Medical Department, University of Michigan, spoke on "Broncho-pneumonia and Its Surgical Complications." Many cases of broncho-pneumonia are passed over as bronchitis. Dr. Foster has used the x-ray extensively in diagnosis and finds it of great value. The subject was discussed by Drs. Curtis, Lang, Olpp and others.

A committee was appointed to confer with the North Hudson Hospital, regarding the extension of its laboratory service.

Summit Medical Society.

William J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, Dec. 26, at 8.30 P. M., Dr. Falvello entertaining and Dr. Krauss in the chair. Present: Drs. Bowles, Campbell, Dengler, Embury, English, Falvello, Jaquith, Kay, Keeney, Krauss, Lamson, Lawrence, Meigh, Moister, Reiter and Smalley (16 members), and Drs. Meeker and Noe of Summit and Dr. James of Bernardsville, as guests.

The amendment proposed at the last meeting, by which an honorary member may be elected by a majority vote of the society instead of a two-thirds vote, was unanimously carried. Dr. Raymond D. Baker, a member of the society from April 13, 1905, to Sept. 26, 1919, who has removed to New York City, was unanimously elected an honorary member.

The paper of the evening was read by Dr. T. H. McGoldick of Brooklyn, on the subject of "Diseases of the Pericardium." He went fully into the pathology, symptoms and treatment of the different forms of pericardial diseases, emphasizing the frequency with which they are overlooked, and discovered only at autopsy. The discussion was general and brought out many interesting points.

Academy of Medicine Home.

The three-story brick dwelling at 91 Lincoln Park has been acquired by the Academy of Medicine of Northern New Jersey for its future home and the academy will take title to the property about March 1. Alterations will then be made to the building to suit it for the purpose it is to serve.

It will be used by other medical and allied scientific associations, not only local but state and national. In the building will be housed a medical museum which is said to be one of the best and most complete of its kind in the country. This will be contributed by Dr. William S. Disbrow, who was president of the Board of Health when the city government was changed from the old aldermanic body to the present commission form. It contains all kinds of instruments, coins, medals, books, etc.

Already more than $25,000 have been subscribed toward the cost of the building. The academy will be maintained exclusively by its own members. It will establish a maintenance fund that will be increased from time to time by bequests and presentations .

Dr. John F. Hagerty is president for 1919-20. The other officers are: Vice-presidents, Dr. Oscar A. Mockridge and Dr. James H. Lowrey; recording secretary, Dr. Emanuel D. Newman; corresponding secretary, Dr. William Gauch; treasurer, Dr. Henry J. F. Wallhauser. Dr. Newman has held the office of recording secretary since 1912. The trustees are Dr. Widmer E. Doremus, Dr. Morrison, Dr. Harold A. Tarbell, Dr. E. J. Ill and Dr. Epstein. Dr. Edward W. Sprague is statistical secretary, Dr. Disbrow is executive librarian and Jacob L. Newman is counsel for the academy.

The academy is divided into three sections, one on eye, ear, nose and throat; another on medicine and pediatrics, and the third on gynecology and obstetrics and surgery under the auspices of the section on gynecology and obstetrics. The academy meets the third Wednesday of each month, the council and trustees the second Wednesday; medical section, the second Tuesday; surgical section, fourth Tuesday, alternate months; obstetrics and gynecology section, fourth Tuesday, alternate months, and section on eye, ear, nose and throat, second Monday.

National Societies.

National Anaesthesia Research Society.

Plans for the organization of this society were launched at a meeting held in Cleveland, Ohio, Dec. 18, 1919. The following officers were selected: President, Stephen Morris, Philadelphia; secretary-treasurer, B. J. Clark, Minneapolis.

The objects of the society are to promote the science of anaesthesia and to enable its members to submit to the dental and medical professions any views, findings or accomplishments they have attained. The society will co-operate with state authorities and other bodies in the preparation of suitable legislation which will safeguard those to whom an anaesthetic is to be administered and those called upon to administer it.

National Colored Medical Society Meeting.— The twenty-first annual meeting of the National Medical Association, an organization of negro physicians, dentists and pharmacists, was held in Newark, N. J., August 26 to 29. Atlanta, Ga., was selected as the next place of meeting, and Dr. John P. Turner, Philadelphia, was elected president.

American Association for the Advancement of Science.

At the 72nd annual meeting of this association held in St. Louis, Dec. 29th, Dr. Simon Flexner, director of the Rockefeller Institute for Medical Research, and president-elect of the association, said the idea that great epidemics like influenza, scarlet fever and the bubonic plague are gradually dying out is erroneous. "Just now the bubonic plague is ragging in the Far East," Dr. Flexner said. "There is always influenza somewhere. But one thing the public can be sure of and that is, it will have plenty of warning before there is another influenza epidemic such as we had last year. It is useless to make any predictions as to how soon we may have another outbreak. The same thing applies to scarlet fever. The popular belief that the disease is

dying out is incorrect. Nobody yet has found the germ of that disease, and until we find the cause, we cannot put an end to the disease. I believe the human race is growing healthier. In the last fifty years we have added ten years to our expectation of life. The war has increased the public interest in all scientific matters, and public health is one of these."

International Surgical Association.

Dr. William J. Mayo, Rochester, Minn., left for Argentina and other South American countries to promote an international organization for the advancement of surgery. Dr. Franklin Martin, Secretary of the American College of Surgeons will accompany him.

Pan-American Conference on Influenza.—The Uruguayan National Bureau of Hygiene is planning a Pan-American conference on influenza, to be held in May, 1920, in Montevideo. Other South American republics will be invited to send delegates.

Miscellaneous Items.

Hospital Installs Group Practice.—Dr. Otto V. Huffman. dean of the Long Island College Hospital, announces that a group of experts has been organized among the hospital and dispensary staff of the institution which will receive any cases referred to them by our alumnus of the hospital, and will give examinations diagnosis, and advice in regard to such cases. This service will be rendered to patients for an ordinary fee and in many cases without the payment of a fee. In each case the diagnosis will be made by a specialist and all cases will be passed upon by the medical and surgical staff. For the present these services will be extended to alumni of the hospital only.

The Frequency of Multiple Births.—For a rough approximation the order of frequency with which twins, triplets, etc., occur is, according to Knibbs, as follows; In a series of confinements 1 per cent. will present twins, 0.01 per cent. triplets, 0.0001 per cent. quadruplets and 0.00002 per cent. quintuplets.

Doctors Strike for Minimum Salary.—A cablegram from London to the New York Sun tells of a doctor's strike in Ireland. According to this report the doctors of Dundalk, Ireland, have gone on a strike to enforce demands for a minimum salary of seven guineas (bout $35) weekly for all public services. Their present salaries average $1,375 a year. The report states that many persons applying to the dispensaries for treatment have been refused.

Physicians Form Labor Union.—More than two hundred physicians in the Bronx, New York City, have organized a labor union, which is intended to take in eventually the entire city and to affiliate with the American Federation of Labor. The aims of the new union include bringing about union conditions for physicians in the employ of insurance companies and in hospitals and to fix union rates for physicians generally.

Physicians Form Association.—About fifty physicians in the Clinton Hill section of Newark recently organized the Newark Physicians' Association to abolish contract and lodge practice. Dr. Bernhardt H. Wolf was elected president of the association.

Sensible Shoe for Feminine Wear.—The kind of a shoe which American women should wear, but do not wear, has been decided upon in joint conferences of shoe manufacturers with members of the National Board of the Young Women's Christian Associations, and a publicity campaign has been instituted by the National Board among 400,000 members of the Association, to popularize sensible shoes for feminine wear.

Women Physicians Make Appeal for Serbia.—The American Women's Hospitals, which is affiliated with the Red Cross, began on June 1 a campaign to raise $250,000 to pay the expenses of equipping and transporting to various points in Serbia the hospitals, doctors, and nurses which the Government of that country has officially requested the organization to furnish for the purpose of fighting the epidemic of typhus fever which is now raging there. It is stated that only 140 physicians are left in Serbia, and that large areas of country are without medical service of any kind. While in this country there is one doctor to every 1,000 people, in Serbia there is one to every 21,000. The personnel of the unit which is to be sent has been selected and is headed by Dr. Mary M. Crawford of New York.

To Make New York Medical Capital.—An organization, to be known as the New York Association for the advancement of Medical Education and Medical Science, has adopted a constitution and by-laws and has filed an application for incorporation with the secretary of state at Albany. The project has as its aim the making of New York City a great medical center which shall fill the place formerly occupied by Vienna and Berlin. The constitution of the association names as the four prime objects to be obtained: (1) to improve and amplify the methods of graduate and undergraduate teaching; (2) to perfect plans for utilizing the vast clinical material of the city for teaching purposes and to make use of teaching talent now unemployed; (3) to bring about a working affiliation of the medical schools, hospitals and laboratories, as well as the public health facilities of the city to the end that the best interests of medical education may be conserved; (4) to initiate the establishment of a medical education foundation in New York City whereby funds may be secured to meet the financial requirements of all forms of medical education and investigation. There will be two classes of membership in the organization, one a general membership, including all physicians in good standing, teachers of auxiliary sciences, and investigators of problems related to medicine, the other a corporate membership of medical teachers and medical men with hospital appointments or affiliations. The corporate membership is limited by the constitution to not more than 150. A nation-wide campaign to raise $50,000,000 with which to finance the project will be started immediately.

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE—The transaction of business will be expedited, and prompt attention secured, if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

The Editor sends heartiest greetings to every reader of the Journal wishing him or her a very

Happy New Year

in personal, family, professional and civic life, as each of us shall to the utmost of our ability seek to protect and advance our profession and endeavor to promote the highest welfare of our patients and our communities and the world's peace and prosperity as we recall the words of the former great President—Abraham Lincoln: "With malice toward none, with charity for all, with firmness in the right, as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle, and for his widow and orphans; to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

VOLUME XVII.

The Journal this month begins volume XVII; the Editor will endeavor to do his best to make it more interesting and helpful and we ask, in order to do so, the co-operation of the members of our Society, especially the secretaries and reporters of our County Societies, as they recall the fact that our Journal is the organ of the County Societies as well as of the State Society; we want to know what the societies are doing, prompt information of the death of any of our members and any personal notes concerning them, deemed worthy of notice in the Journal. We shall have greater burdens to bear in conducting the Journal than ever because of the greatly increased price of labor and the consequent advance in our printer's charges.

ANNUAL DUES FOR 1920.

Do not forget that the dues for 1920 were payable January 1st and should be in State Society Treasurer Mercer's hands by the 15th. Do not forget to send on time. We do not wish any to be reported—Delinquent.

HOW TO OPPOSE HEALTH INSURANCE.

Communications frequently come to the office of the Secretary inquiring or suggesting different methods of ecective opposition to the so-called "Health Insurance."

Dr. Harvey, in his presidential address, touched upon this matter and a committee was appointed (see Journal, Sept., 1919, page 339), consisting of Drs. Harvey, Costill, English, McCoy, Eagleton, to consider the suggestions made by Dr. Harvey. The legislative committee also should be consulted and these two committees should devise some method of concerted action by which all component societies could unite in efficient opposition to any such dangerous legislation, which would be alike detrimental to the public and the medical profession. There is need of *prompt* action by these committees.—W. J. C.

There is the greatest need that all the county societies not only, but that all the members individually, shall wake up to the importance of decided opposition to this compulsory health insurance scheme. We call special attention to the paper of Dr. C. J. Whalen on page 17. The bill which will undoubtedly be presented to the legislature should be killed outright—the public's safety and the profession's scientific progress and efficiency alike demand it. Let us have another year to consider it and prepare a sane and safe law.

The proposed law, with comments, will be found on pages 28 to 31.

The late arrival of considerable matter concerning Health Insurance which our members should have promptly—before our Legislature meets this month—compels us to omit some editorials and other matter

which was prepared for this month's Journal. We have several valuable original articles which will appear as soon as we can give them space, among them one each by Drs. Alex. Lambert, Fred H. Albee, E. D. Newman, H. P. de Forest and G. P. Curtis. We expect to insert next month the address of our State Society's counselor, Albert C. Wall; also the memorial addresses on Drs. Gray, Strasser and Mitchell—too long deferred insertion.

We must wake up and pay much more attention to the physical and moral development of the youth of the country. We are losing a large portion of our men from a standpoint of military efficiency and are subjected to enormous wastage from the standpoint of economic and industrial efficiency. These are losses which the nation can ill afford in view of the coming contest for industrial supremacy.—Leonard Wood, M. D., Major General, U. S. Army.

N. J. SANITARY ASSOCIATION

The annual meeting of the State Sanitary Association at Lakewood last month, under the presidency of Hon. C. J. Fisk, was one of the best of the series. We insert on pages 1-5 Dr. Alexander Lambert's excellent paper on "The Underlying Causes of the Narcotic Habit." We will give in an early issue Dr. C. C. Beling's able paper on "Mental Hygiene and Public Health."

AMERICAN CITIZENSHIP—THE HIGHEST TYPE OF DEMOCRACY.

Dr. Curran Pope of Louisville, in welcoming home Kentucky's returning army medical men, spoke the following earnest and eloquent words which are worthy of a place in our columns and will be heartily endorsed by our members:

You have done your part nobly, suffered and sacrificed, until Winged Victory perched upon your banners. Victory is yours but not Peace. The smoke of battle has cleared away; you no longer hear the shrieking shell and gun fire rattle; you no longer see the terrible holocaust of field and hospital, for war has ceased; and the one thing for which the world has fought, and bled, and died, has been attained. You have lived to see the downfall of Autocracy and Militarism and the substitution in its place of the sublime right of peoples to be free. But you cannot rest from your labors, nor return like Cincinnatus to your plow. There is no peace to-day in this uneasy and restless world of ours. The same spirit that moved to deeds of heroism and untold sacrifice upon the blood stained and racked fields of Flanders, must inspire us again that we may still retain for ourselves and future generations the great heritage that was handed to us by our forebears.

Respect and reverence for freedom and all the glorious privileges given us under our noble Constitution, must be enforced. The freedom of to-day as we understand it, does not mean the Cave Man's right to seize and selfishly by force make what he wants his own. Freedom is but another name for the privilege of working out our own destiny, developing all the best that is in us and at the same time respecting the rights of others. We must be willing to sacrifice a portion of our unalienable individual rights so that the communal rights, in which we too will share, shall become the paramount objects of law and government. No man can really be free himself who does not wish to live under a reign of law and who does not consider the rights of his fellowman. Every human being wants to live and everyone seeks happiness, turning toward them as the flower turns the petals of its beauteous bloom toward the glorious sun. Under the laws of a free Republic there should be equal opportunity, a fair and generous chance. The child, soon to become a man or woman, must be trained and educated, must have inculcated into and made a part of its very soul life, a love of country, a reverence and devotion to its flag, a respect for and obedience to its laws, until in every fibre of the child soul and body there exists a loyalty to country, its republican institutions and a love for its laws. Then truly can it be said that each and every individual may without fear, without reproach, with pride and honor persue the even tenor of his way assured of safety and the protection of life, liberty and the pursuit of happiness. I would rather be an American citizen, live under the laws of my republic, throb and pulsate to its high ideals, to feel that no matter how big the question, Americans were able and capable of settling it; to feel that force and fraud, falsehood and injustice would never be tolerated in this broad land of ours; these rights I would rather have than to have been the "noblest Roman of them all."

And when my Country, my State and my City, has conferred upon me all these equal opportunities, all these rights and privileges, then it must cease to help and

do nothing to hamper. If then with all these advantages, I am unable with my brain and the brawn of my good right arm, to carve out my own destiny, then I must be content to find my own level for the fault lies not in the laws of my Country, or in liberty or in opportunity but in me. I must then bear the burden of my inefficiency and not try to seek in the Utopia of a paternal government, a panacea for my weakness and shortcomings. They that strive not, they that labor not, verily they should not partake but justly and truly suffer for their unwillingness to do rightly.

I believe that God Almighty has destined this country of ours to be a great example to the world. In this the hour of our triumph in arms upon sea and land, in the dark days of reconstruction that follow all great wars, let us once again seize the Torch of Liberty, hold it on high, showing the world that we can be as great in Peace as in War, because we have learned reverence and respect for the Law. When we shall have risen Phoenix-like and performed this, our solemn duty, actuated by the spirit of Bunker Hill, the endurance and patriotism marked by the bloody snows of Valley Forge, then the men in Blue and Grey who sleep beneath the sods of their native land; the Khaki clad lads whose heroism and supreme sacrifice made a world peace possible, will rest row by row beneath the poppies red and the lilies white, confident and satisfied that they died not in vain; but that the loyal Americans of this and future generations will always strive under law for the highest type of Democracy—that of American Citizenship. To you and me, loyal medical brethren of this Noble Commonwealth, will fall this duty. Will we shrink, will we hesitate, will be fail? Never.

A New Era in Medicine.

At the annual meeting of the A. M. A. at Atlantic City in June, the chairman of the House of Delegates said of physicians and nurses:

"Thoughtful men agree that we are entering on a new era in medicine, which will compel the closest interrelation between physicians, hospitals, nursing and the public. It is not probable that practice will again be followed as heretofore. The time is passing when the personality and skill of a single physician will satisfy his patrons, or command a fee measured only by the patient's ability to pay, for skill is no longer limited to a few. Teamwork of physicians and the evolution of the hospital, which provides for all domestic and medical service, has given the public an economic idea which will hereafter direct the practice of medicine. Cities and large towns already have their hospitals; rural communities soon will have, state aided no doubt, for it is a short step from state care of the insane to the state care of all sick.

"We should recognize that conditions confronting communities affecting physicians, apply equally to nurses. The average nurse is graduated with a feeling that her period of service has ended and her reign begun. This is an intolerable economic attitude. The average householder can not afford to employ servants for servants indefinitely, and he is already looking to the medical profession for relief in home care for his sick. The public needs practical nurses, trained in cleanliness and taught to do what is necessary to be done for the comfort of the household, including the sick.

"The general practitioner of medicine must come back, and a temporary substitute for the stricken mother must be trained and qualify for duties associated with the sick in the home. There are duties before the association, professional rather than scientific, which will call for exceptional devotion, patient service and skilful guidance. No body of men has keener insight, clearer vision, or higher motives, Weigh well your responsibilities."

Reconstruction of Medical Profession from Within.

"If the medical profession does not organize as a working body, the majority of doctors will ultimately be drafted into the service of the political state or will be employed by co-operative societies," writes Dr. J. P. Warbasse, of Brooklyn, N. Y., in an article on "Medical Reconstruction," which appears simultaneously in the Long Island Medical Journal, the Medical Review of Reviews, and the Western Medical Times.

He expresses the view that the whole population of every community must be served by the physicians through some plan of group practice, if not one, then another, He says in part: "A change in the organization of society is now in progress, and medicine like all other callings is destined to participate in the radical reorganization. The tendency is toward stateism. Stateism is not the ideal line for the best development of the medical profession.

"As an alternative the medical profession should organize itself compactly on syndicalistic lines, as a workers' movement. As so organized, it may compromise with the political state and develop the guild principle in conjunction with state ownership of medical institutions. Or as a syndicalistic organization of workers, it may aim to co-ordinate its functions with those of co-operative societies of consumers.

"The latter is the ideal plan. But in America it can not yet be consummated because of the still inadequate development of co-operative societies. The growth of co-operation, however, is rapid, and it is conceivable that by the time the medical profession can effect its own reorganization, the people will have developed their co-operative movement to a point at which the two can become co-ordinated. This is the goal toward which all should look. In the meantime the reconstruction of the medical profession should be set on foot as a problem purely of medical organization."

Medical Fees Under the Workmen's Compensation Laws.

At a recent meeting of the executive committee of the Physicians' Protective Association of New York a resolution was passed calling attention to Governor Smith's message demanding revision of the workmen's compensation law, to prevent direct settlement between injured employees and the insurance carriers, and stating that a similar condition exists relating to the payment of physicians' fees by the insurance companies, which has resulted in the denial of the best medical service to the injured workmen and working women of the state. This is owing to the failure of the medical provisions of the workmen's compensation law either to provide a proper fee for medical service or to compel the payment of the fee awarded by the commission against the insurance companies. The governor was asked to include in his proposed revision of the workmen's compensation law a measure to remedy this form of injustice to the medical profession.

The Saturday Evening Post on Health Insurance

The Saturday Evening Post for July 19 contains the following editorial, each paragraph of which is worthy of careful consideration. We physicians who receive so little encouragement in our efforts to advance preventive medicine should take courage when a publication of the character of the Saturday Evening Post, with a circulation of 2,000,000, emphasizes the need of "a vigorous educational campaign on sickness prevention." The editorial is as follows:

Compulsory state-managed health insurance on the German pattern does not go well here. Americans—wage-earners as much as others—dislike "compulsory"; they dislike being dry-nursed under the paternal hand of the state. The cost would be high. Many members of the medical profession object to it. Many workmen believe it would set up an oppressive discrimination against persons who though not in perfect health are able to do a very good day's work. Compulsory insurance was decisively defeated in the California plebiscite. It failed in New York.

A chief argument against it has been that a much less compulsion on the individual public health can be better conserved by a broad plan of hygienic and preventive measures under competent and liberally supported boards of health. It is pointed out that after thirty-five years of compulsory health insurance the German death rate is higher than ours.

Rejecting compulsory health insurance, then, we should turn energetically to the alternative of better health laws, stronger health boards. There ought to be a vigorous education campaign on sickness prevention. Rejecting compulsory insurance is merely negative. We ought to attack the positive side.

Of course we do attack it. Every state and probably every village has its health board or health officer. Yet there is no state and no village in which these agencies might not be profitably strengthened. Agitation for compulsory health insurance has had a good result in directing livelier attention to sickness prevention. Keep that up.

PROPOSED HEALTH INSURANCE ACT.

To Be Introduced in the New Jersey Legislature at the Coming Session, Jan, 1920.

An act to promote conservation of human life by creating a Bureau of Health Insurance in the Department of Labor to establish a system of mutual health insurance, to furnish benefits for employees in cases of sickness and accident (not covered by the Workmen's Compensation Act), and to define its duties and powers.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. A Bureau of Health Insurance is hereby created in the Department of Labor, of which the Commissioner of Labor shall be the head. The Bureau of Health Insurance shall consist of the Commissioner of Labor and such other deputies and assistants and Chiefs of Divisions as shall be necessary, who shall be appointed, subject to the Civil Service Law, by the Commissioner of Labor and whose duties and compensation shall be fixed by him. The word "Bureau" is used in this act to designate said Bureau of Health Insurance.

2. That on and after July 1, 1920, all persons who are employed, or operators in any newspaper plant, printeries, factories, workshops, mills, commercial laundries and all places where printing or the manufacturing of goods of any kind is carried on and any mines or quarries shall be insured against sickness and accident (which are not covered by the Workmen's Compensation Law or in which liability for damages, compensation or other benefits is imposed by act of Congress), in accordance with the provisions of this act, and shall be designated therein as insured.

3. The person or persons, association or corporation owning or controlling any newspaper plant, printeries, factries, workshop, mills, commercial laundries and all places where the manufacture of goods of any kind is carried on, and all mines or quarries shall be subject to the provisions of this act and shall be designated therein as employer.

4. The Bureau shall organize a system to carry out the provisions of this act by appointing such employees, agents, boards and committees and fixing their duties and powers; provided, however, that the Bureau shall have the power from time to time to discharge any employee, agent, board or committee and appoint new employees, agents, boards and committees, and fix their duties and powers as may be to the best interest of the Bureau.

5. The Bureau in its own name shall take such legal proceedings as shall be necessary to enforce the law, and may appoint a deputy or agent, who, in the name of the Bureau, shall proceed against or sue any person, corporation, association, society or fund, who shall fail to comply with the rules and regulations made by the Bureau.

6. The Bureau shall make such rules and regulations as may be necessary for the proper carrying out of the provisions of this act.

7. The Commissioner of Labor shall organize and manage the finances of the system of health insurance. A Reserve Fund shall be managed by the Commissioner of Labor and the State House Commission who shall be the trustees of said fund.

8. The Bureau shall secure a good and suffi-

cient bond, in an amount to be fixed by the Bureau, from all employees who handle the finances of the Bureau. The said bonds shall be approved by the Bureau as to form, sureties and conditions.

9. The Deputies, Assistants, Chiefs of Divisions and all other employees shall be under the classified Civil Service lists.

10. The Reserve Fund shall be invested and reinvested in such securities as savings banks are by law permitted to invest in.

11. The funds of the Bureau may be deposited in any bank, savings bank or trust company designated by the Bureau; provided, however, that the deposits shall not at any time exceed twenty-five per centum of the paid-up capital and surplus of the said bank or trust company.

12. No member of the Bureau of Health Insurance, nor any of its agents or employees shall have any interest, direct or indirect, in any of the contracts, investments or securities held by it, nor shall they borrow, directly or indirectly, any of its deposits or investments.

13. The object of this act being to conserve the health of those who come within its provisions by providing them with competent physicians and surgeons when sick and injured, and part wages while under treatment, the Bureau shall provide and administer a system of health insurance. The Bureau shall fix (1) the rate of premiums to be paid, which shall be fixed at a rate which will be sufficient to pay (a) the benefits; (b) the necessary expenses and disbursements incurred in cases of sickness of and accidents to the insured; (c) the necessary expenses and disbursements incurred in managing the system devised by the Bureau for carrying out the provisions of the act; and (d) a Reserve Fund; (e) provided, however, that the salaries and administration expenses of the Bureau of Health Insurance shall not be paid from the premium collected but from funds appropriated for that purpose by the state; (2) the benefits to be derived therefrom; (3) shall have power to change the premiums as the conditions of the fund or circumstances may warrant; (4) regulate the method of paying the premiums; (5) enforce the collection of the premiums; (6) arrange a system whereby those persons who come within section two of the act and are not exempted from its operation shall secure the benefits from said insurance.

14. The premiums shall be paid at such stated times as shall be fixed by the Bureau. The premiums shall be paid, on half by the insured and one-half by the employer; provided, however, that where the weekly rate of earnings is less than nine dollars the employer shall pay the premium.

15. The Bureau of Health Insurance may exempt an employer who comes within the provisions of section — of th's act, who, (a) pays all his employees full salary or wages when incapacitated from work through sickness or accident (not covered by Workmen's Compensation) or, (b) upon said employer submitting proofs and satisfying the Bureau that there is in force in said place of employment some system, fund or society or contracts entered into by said employer, the whole or at least sixty per cent. of which expense being paid for by said employer, and guaranteeing to the employees benefits, at least equal to the benefits they would receive if they were insured under this act.

16. Every employer shall, on the date on which he pays his employees, or at least monthly, pay to the Bureau the total contribution due from him and from his employees to such fund. If such contribution is paid at such time he may deduct from the earnings of any employee the share of that employee in the contribution, which shall be in proportion to his earnings, but must inform him, in a method to be approved by the Bureau of Health Insurance, of the amount so deducted.

17. Contributions due and unpaid shall have the same preference or lien, without limit of amount, against the assets of the employer as is now or may hereafter be allowed by law for a claim for unpaid wages of labor.

18. An employer shall not reduce the wages or salary of an employee on account of any contribution required to be borne by the employer, or make any agreement with the employee for the repayment of any part of such contribution. Any employer who violates this section shall be liable for a penalty of Ten Dollars for each offense. Every deduction or repayment in the case of each employee shall constitute a separate violation.

19. Contributions may be fixed at different amounts for different industries, according to the degree of sickness hazard in those industries, and shall be so fixed if the Bureau of Health Insurance finds a substantial difference in the degrees of sickness hazard.

20. A sickness benefit which shall not be more than two-thirds of the earnings of the insured person, shall be paid weekly beginning with the fourth day of disability on account of sickness or accident. Sickness benefit shall not be more than eight dollars a week, nor less than five dollars a week, provided that if at the time of disability the employee's earnings are less than five dollars a week, then he shall receive the full amount of such earnings per week. It shall be paid only during continuance of disability, and shall not be paid to the same person for more than twenty-six weeks in any consecutive twelve months, and shall not be paid for more than twenty-six weeks on account of the same case of disability. This benefit shall not be paid to an insured woman for two weeks before nor for six weeks after childbirth.

21. The Bureau shall furnish to insured persons all necessary attendance and treatment- by legally qualified physiceans and surgeons from the first day of sickness or the happing of an accident (not covered by Workmen's Compensation), such attendance and treatment shall be limited to twenty-six weeks of disability in any one year and shall not be furnished for more than twenty-six weeks on acount of the same case of disability. In case the Bureau is unable to furnish the whole or any part of the benefit provided in this section, it shall pay the cost of such service actually rendered by competent persons at a rate approved by the Bureau of Health Insurance.

22. The Bureau shall provide insured women and may provide the wives of insured men with such medical, surgical and obstretrical aid, (materials) and appliances as may be necessary for safe delivery. Funds shall pay weekly to insured women a cash maternity benefit, equal to the regular sickness benefit

of the insured, for a period of eight weeks, of which at least six shall be subsequent to delivery. It shall be paid upon a certificate of the attending physician that the beneficiary is abstaining from gainful employment during the period of payment. Benefits under this section shall be in addition to all other benefits under this act.

23. The right to sickness benefit shall begin when an insured person has paid at least four weeks' contributions during the preceding five weeks. The right to all other benefits provided for insured persons and their dependents, with the exception of maternity benefit, begin with the day the insured person becomes a member of a fund. The maternity benefit shall be payable if the woman confined has paid at least nine months' contributions during the twelve months preceding delvery. Right to all benefits shall cease upon termination of employment, provided, however, that where the insured has ceased to be employed he shall have the right to benefits for one week for each four weeks that he has paid premiums during the preceding six months.

24. Claims for benefits under this act shall not be assigned, released or commuted and shall be exempt from all claims of creditors and from levy, execution and attachment or other remedy for recovery or collection of a debt, which exemption may not be waived. Benefits shall be paid only to the person or persons entitled to receive the same, or to some person who is liable by law or in fact for the support of such person or persons.

25. In case the insured person, his heirs or assigns, are paid damages from another source on account of sickness or accident, the Bureau shall be entitled to be reimbursed, out of such damages when collected, for the reasonable cost of all benefits given the insured person on account of such sickness or accident.

26. If benefits in the form of cash are paid to any person by the Bureau under this act in any case in which liability for compensation exists under the workmen's compensation law, the Bureau shall, to the extent of such benefits, be entitled to reimbursement out of such compensation, and upon notice to the carrier under the workmen's compensation law the claim for reimbursement shall be a lien upon the compensation. If other benefits are furnished by the fund in such case, it shall, to the extent of the actual expense incurred in furnshing such benefits, be subrogated to the right of the employee or of their person furnishing such benefits to reimbursement therefor under the workmen's compensation law. When treatment in such case has been begun by or through a fund the care of the case shall not be a transferred to the carrier under the workmen's compensation law except upon the request of such carrier.

27. The Bureau may make appropriations for prevention of disease and the education of the employer and employee members in disease prevention and hygiene, and include the amount so appropriated among its expenses of administration.

28. The Bureau shall provide by regulation for the insurance of person employed within the meaning of this act who reside permanently or temporarily outside of the state.

29. Any employer, or insured, or employee, or any person, association, partnership or corporation coming within the provision of this act, who shall violate any of the provisions of this act, unless otherwise provided, shall be liable to a penalty of fifty dollars, each violation to be a separate offense.

30. All proceedings brought to collect penalties under the provisions of this shall be by action of debt, in the name of the Bureau to be instituted in any district court of a city, recorders' court of cities, or before any justice of the peace having due jurisdiction, and the first process shall be by summons returnable in not less than five nor more than ten days, which process shall be served on the employer or employee, owner or owners, person or persons or any of them, owning the place of operating the business wherein the alleged violation of law has taken place; if such employer or employee, owner or owners, person or persons, reside in the county wherein the offense was committed, or if the employer or employee, owner or owners, person or persons as aforesaid, do not so reside in the county where the offense was committed, then said process shall be served on the superintendent, foreman or person in charge of the business or place; service upon a corporation shall be made upon the president, vice-president, secretary or any directors, and if none of them reside in the county where the offense was committed, then service may be made upon the superintendent, foreman or person in charge of the business or place; in case the employer or employee, owner or owners of a building reside without the limits of the county, then service of the process may be made upon the agent in charge of said building, and if there be no such agent in charge of said building, then service of the process may be made by affixing a copy thereof to the main outer door of such building at least ten days before the return day thereof; all proceedings thereafter shall be the same as in an action of debt in said court; the finding of the court shall be that of the defendant has or has not, as the case may be, incurred the penalty claimed in the demand of the plaintiff, and judgment shall be given accordingly; in case an execution shall issue and be returned unsatisfied, the court, on application, after notice to the defendant, may award an execution to take the body of the defendant, if an individual, and in case such a defendant is committed under such an execution, he shall not be discharged under the insolvent laws of the state, but shall only be discharged by the court making the order for the body execution, or one of the justices of the supreme court, when such court or justice shall be satisfied that further confinement will not result in the payment of the judgment and costs; all moneys collected under the provision of this act shall be paid into the treasury of the State of New Jersey.

31. The salaries and administration expenses of the Bureau of Health Insurance shall be paid from the funds of the state appropriated for that purpose.

Statement.

The object of this act is to provide all workers in factories, etc., of the state with a cash

benefit and medical and surgical treatment in all cases of sickness and accident (not covered by workmen's compensation) so that the loss caused by sickness and accidents may be reduced to a reasonable minimum. It is the logical sequence to the workmen's compensation system. Governor Edge says, "in fact, health insurance would provide additional supports for our workmen's compensation system by conserving the physical vigor of our people against the constantly increasing demands of industry upon physical endurance. By automatically providing medical care and health instruction it is both curative and preventive and therefore must certainly operate to reduce the burden of any compensation or pension system, no matter what class of private or public employees are affected."

Comments on Health Insurance Act.

By Dr. Gordon K. Dickinson.

(In re tentative draft of act received from Hon. E. Colby).

Section 1. That commissioner of labor shall be the head. It is he who appoints all employees and is central authority. This opens up to politics.

Section 2. All persons who are employed in a number of specified occupations, broadly stated, shall be insured against sickness and accident. Disability not in any way dependent upon occupation.

Section 4. Bureau shall organize the system to carry out the provisions of this act by appointing employees, agents, boards and committees and fixing their duties and powers. This bureau, be it recollected, is appointed by commissioner of labor. No limit to number or powers of bureau employees. More politics and graft.

Sections 6 and 7. Bureau shall make rules and regulations necessary, and commissioner of labor shall organize and manage the finances of the system. In this, we have no evident responsibility except the political head, the commissioner of labor.

Section 13. Object of this act shall be conservation of the health of those who come within its provinces, by providing them with competent physicians and surgeons when sick or injured. No effort indicated to prove competency. As a rule, a man who will accept such a position is of the more incompetent class.

Premiums shall be fixed at a rate which will be sufficient to pay the benefits and necessary expenses and disbursements incurred in cases of sickness or accident; the necessary expenses and disbursements incurred in managing the system; for reserve fund, etc., etc.

No limit stated to the premiums or amount of money to be called for or used. It gives the **possibility** of marked increase in tax rate of the state.

Section 14. Premiums shall be paid at such stated times as shall be fixed by the bureau, half by insured and half by employer. Throws a heavy burden on employer.

Section 22. Bureau shall provide insured women, as well as wives of insured men, with such medical, surgical and obstetrical aid, **materials and appliances** as may be necessary for safe delivery. This is a broad statement. To be paid by taxes.

Section 27. Bureau may make appropriations for prevention of disease and education of employer and employees. This duplicates work already well established by U. S. Public Health Commission, state boards of health, etc., etc., out of public treasury.

A blundering philanthropy. Made in Germany. A bribe to labor under guise of altruism.

Meddles and muddles with medicine. Stimulates a trade union.

Lodge practice, producing lowest morale. By producing class consciousness. A venon. Will increase taxes.

Poverty but slight in N. J.—mostly idle and lazy. Majority well paid. Conditions in U. S. not what they are in Europe.

Those wanting it are labor, politicians and social busybodies.

Much danger in the proposition. Paternalism, destructive of individualism of of democracy.

Prevents the altruism of medical profession and invites commercialism. Health insurance will lower economic standard of the profession Cost of management leaves little for the doctor.

Doctor in health insurance cannot progress scientifically.

Will deter students. Will lower dignity of the profession. Quality in the medical profession is an asset.

No condition that boards of health, clinics, hospitals or physicians are not meeting.

Class legislation—unconstitutional.

Before deciding definitely we should have accurate data, obtained at considerable expense, as to number of poor people in N. J., their distribution; also amount of attention they receive from physicians, clinics and hospitals. Also, number of hospitals, clinics, etc., in state, as well as number of physicians, and their distribution.

Correspondenec.

Organization of the Medical Profession.

Editor Journal.

Dear Sir:—Your editorial comments in the December Journal upon the health insurance outlook are addressed to a profession that has always shown an utter incapacity for organizing for the protection of its own material welfare, a spineless indifference that is incomprehensible to the militantly organized world of to-day and to a body of men blind to everything outside of science.

According to your own opinion, and mine too, we are all about to become a toothsome morsel for the **poor starving laboring man** and his nest-feathering myrmidons.

Permit me to say that if the medical profession of America has fallen so low as to be satisfied to cringe and skulk for its daily bread (without butter) under the lash of labor; if it is complacent at the prospect of becoming a common beast of burden, and if it can muster less spirit and intelligence than a union of bricklayers it deserves to perish as a profession and few will mourn its passing.

Ralph S. Cone.

Westwood, N. J., December 10. 1919.

The Medical Profession's Welfare.

Editor New Jersey State Medical Journal.

Dear Sir:

The forward looking address of the retiring president, Dr. Harvey, at the last State meeting in June has impressed me very much and he is entitled, I think, to the thanks of the whole profession of the State, for so clearly and impressively enunciating the important issues with which we are confronted and the recommendation he made, for the creation of an active and aggressive committee, whose purpose shall be, the constant guarding of the welfare of the Regular Medical Profession in New Jersey. A very cursory review, of the standing of the profession, cannot fail to convince us, that the need to organize and strengthen our forces, is painfully apparent.

The predominant fact we are first met with, is, that our State Society only represents one-half of the regularly licensed practitioners within the State. Think what this means, to be reminded, by those who are interested in pushing legislation which is inimical to the regular profession, at Trenton, that our representatives, who are presenting the viewpoint of the members of the State Society, only represent 50 per cent. of the regular profession within the State, that the other half, inasmuch as they are not represented, may, or may not, acquiesce in the proposed inimical legislation. The effect of this unfortunate condition will be, plainly, to cut down the effectiveness of any plea made by our State Society before the Legislature, to one-half of what should be its actual weight. No one needs to be told that the number of irregular practitioners is increasing faster than neglected weeds and the report of the State Committee on Public Health and Legislation at the last annual meeting, indicated that largely through the indifference of the regulars, those irregulars, who numbers and influence is constantly growing, will most probably, in the near future, be able to obtain the recognition from the State, which they are organized and fight to gain. If this should be accomplished it will be the most lamentable and humiliating infliction which I think is possible to conceive.

The State of New Jersey requires an applicant for license to practice medicine that he shall first spend four years in a first-class medical school, preceded by a preparatory course and followed by one year as interne in a standard hospital and then pass an examination prescribed by the State before he obtains his license. And yet, the same State of New Jersey lets down the bars to your spinal carpenter, who, with a plumb-line nailed to the occiput and one hand used as a chisel and the other as a mallet and the back of his patient as a work bench, will undertake to cure the public of any and all diseases from cerebral meningitis, or a tuberculous spine, to cancer of the stomach, or housemaids knee. This privileged coterie advertise their ignorance by openly ridiculing, as piffle, the study of pathology or physiology, or the need of any examination of the blood, or sputum, or urine, in order to arrive at some understanding of what they are about to treat. The imposition of all this lies in the fact, that the major portion of the public are not aware of these alleged doctors' ignorance of what they are treating, but naturally assume, that they would not be permitted to do it, unless they had qualified as regular physicians are obliged to do.

Our need to organize for self-protection is again emphasized, in the fact, that we shall be confronted very shortly with a Health Insurance Law, with employers and employees' organizations seeking to exploit the physicians, in order, that the "cost" may be kept at the lowest level. Are we going to allow a repetition of the methods employed in fixing the fees for doctors which prevailed with the passing of the Workmen's Compensation Act? As the West Virginia Medical Journal says, as quoted in your editorials in the November issue: "Try to pass an act setting a price on the services rendered by bricklayers, machinists, or the Brotherhood of Railway Trainmen without consulting them and see what would happen." Those patient doctors who are making life insurance examinations must wish that we had a medical organization with the "punch" to it of a Bricklayers' Union. It is through the lack of it, that those life insurance companies who are doing an industrial business are still paying the munificient fee of 25 cents for inspection visits and 50 cents for examinations the same as were paid twenty or thirty years ago. These same companies, at the same time, are lauding the fact, that they spend hundreds of thousands of dollars yearly for "Welfare Work."

Are the doctors so obsessed with the idea that their mission is one of charity that they feel that helping to feed the treasury of a life insurance company is part of the day's work? We do need to organize and if I may be permitted to make a suggestion, it would be, that the Secretary of the State Society send a request to each county society, urging the formation of an organizing committee, whose purpose it shall be to increase and develop the membership of each county society. This committee should be changed frequently if it is found necessary to obtain results. It cannot be denied that "fiddling while Rome is burning" is just as unprofitable to-day at it was in Nero's time.

JOHN S. YATES.

Paterson, N. J.

Value of the Electrocardiograph.

By Henry Wallace, M. D., Glen Ridge.

To the Editor of the New Jersey State Medical Journal:

It gave the undersigned great pleasure to read the paper of Dr. Sailer of Philadelphia on the Electrocardiograph. It was a disappointment not to have been able to be present at the meeting when it was read and to have entered into the discussion. The paper is a timely one for the profession at large knows too little of the value of this instrument as an aid to more exact clinical diagnosis and treatment.

How many times has it been remarked that the polygraph and the electrocardiograph were very pretty scientific instruments or toys but of little value clinically. Such statements are merely due to the lack of education along these lines. These methods of investigation are not intended to supplant the usual methods of clin-

ical examination, in many cases the findings would be valueless without such clinical examination. On the other hand many a doubt may be cleared up and they explain to the student of these methods the source of all the cardiac irregularities, the tachycardias, the bradycardias, the various extrasystoles, the various blocks, the predominating hypertrophies, etc., etc.

Auricular fibrillation with its characteristic pulse, the totally irregular, may in some cases present a pulse which seems regular to the average sense of touch not to mention those cases of this condition where owing to a complete auriculo-ventricular block we get a perfectly regulee, though slow ventricular and pulse beat, due to its idio-ventricular origin. What might pass for a "missed beat" or to those more conversant with the arrhythmias and who would diagnose an extrasystole may in fact be shown to be due to a partial block a condition of much more clinical significance. A mitral stenosis suspected on physical examination may be made conclusive by electrocardiographic examination.

In febrile cases where the usual and expected slowing of the pulse as a result of digitalis medication is not found yet gives undoubted and conclusive evidence of the effects of this drug when studied by this laboratory method. In fact there is no case of cardiac or cardiovascular disease in which something may not be learned. Therefore the more exact the diagnosis, the better the therapy, the better the prognosis.

The writer is proud of the fact that the institution with which he is connected as attending physician and director of the cardiac department, The Mountainside Hospital of Montclair, is the proud possessor of the only electrocardiograph in the state. It is a Williams-Hindle and the expense of purchase and installation was covered by the subscriptions of friends of the hospital.

Very respectfully,

Henry Wallace.

A. M. A. Board of Trustees.

Williamstown, Dec. 17th, 1919.

Editor of the Journal.

A circular is being sent broadcast by the Medical Society of the District of Columbia claiming that one member of the Board of Trustees should reside in Washington largely for the purpose of watching legislation. This is hardly the province of the Board of Trustees. The circular further calls attention of the profession that the term of Dr. Philip Marvel expires next June, indicating that a man from the District of Columbia should take his place.

I trust the medical men of New Jersey will take a firm stand for the re-election of Dr. Marvel. He has been a very efficient member of the Board, attending its meetings regularly, and has been a strong factor in placing the association on the high plane it occupies today. I hope our delegation will work hard for the re-election of Dr. Marvel.

L. M. Halsey.

Dr. Marvel should be re-elected, not only for the reasons Dr. Halsey gives, but also because the New Jersey Society, being the oldest in the country, should have a representative on the Board.—Editor.

Special War Items.

Honorably Discharged, Medical Corps, U. S. Army.

Medical Society of New Jersey Members.
Campbell, Stephen, Woodbury.
Fisher, E. Moore, Greystone Park.
Graham, Archibald F., Paterson.
Schauffler, William G., Lakewood.
Vreeland, Clarence L., Pompton Lakes.

Dr. Irving E. Charlesworth, Bridgeton, major U. S. Army, arrived at his home from Honolulu, December 19, to remain until January 15th. For about two years Major Charlesworth has been stationed at the Department Hospital, Schofield Barracks, Honolulu, Hawaiian Territory. He left Honolulu November 29.

Service Medal Awarded.—The Distinguished Service Medal has been awarded to James M. Kennedy, Medical Corps, U. S. Army, "As port surgeon, Port of Embarkation, Hoboken, N. J., organized, provided and administered with conspicuous efficiency all hospitals required for accommodation of transports going overseas for that port, as well as for the large number of sick and wounded soldiers returning home."

War Cost in Man Power.—A new estimate of the total cost of the war to the United States in man power is officially announced as 116,492 dead and 205,590 wounded, a total of 332,182. These estimates include losses to army and marine units on all front to September 1, 1919. Those killed in action totaled 35,585, or 11 per cent. of the entire list; died of wounds, 14,742; died of disease, 58,073; died of accident and other causes, 8,092.

Therapeutic Notes.

Asthma.—In asthma there is a temporary emphysema of the air cells, and even violent expiratory efforts cannot expel the air through the contracted bronchi, but once the spasm is relaxed the normal function of the lungs is restored. In these cases there is always an excess of lime in the system, hence decalcifying agents should be used and the intake in the diet diminished.—(B. M. J.)

Bronchitis.—Bronchitis is usually the forerunner of emphysema, the vital capacity diminished, and the respiratory pump thrown out of gear. A dry atmosphere, to get rid of the moisture in the lungs, is essential, alkaline treatment is necessary, while decalcifying agents are only requisite in the dry spasmodic type. When the expectoration is profuse, lime, adrenalin, and atropine are beneficial.

Influenza.—Some of the most prominent features of the late epidemic of influenza, especially in those cases accompanied by broncho-pneumonia, were extreme nervous prostration, loss of the knee-jerk, and a paretic condition of the chest walls, so that the patients became very livid without much respiratory distress. The best results were attained

by respiratory stimulants, such as strychnine and atropine, and the lime salts.

Pneumonia Treated by Sodium Citrate.—The property of sodium citrate in preventing coagulation and reducing viscosity of the blood, Weaver says, makes it doubly valuable in the treatment of pneumonia. He gives sodium citrate, with plenty of water, at the rate of from 15 to 20 grains each hour, or 40 grains every two hours, sometimes more, to a full sized adult, and continued night and day until the result is attained. Occasionally, this dose will act as a purge, and the salt passes off through the bowels. This should be checked by a few doses of an opiate. The medicine should be continued into the second or third day, after the crisis, to assure complete resolution. If the blood pressure is low from cardiac disease, old age or other causes, and the pulse rapid, digitalis and strychnin should be given. All patients with lobar pneumonia of influenzal origin treated with sodium citrate recovered. Weaver is convinced that there is a scientific basis for the action of sodium citrate in pneumonia.

Medicinal Use of Alcohol.—The following regulations governing the sale of alcohol for medicinal purposes, issued by the Bureau of Internal Revenue, may be of interest to physicians:

"Physicians may prescribe wines and liquors for internal uses, or alcohol for external uses, but in every such case each prescription shall be in duplicate and both copies be signed in the physician's handwriting. The quantity prescribed for a single patient at a given time shall not exceed one quart. In no case shall a physician prescribe alcoholic liquors unless the patient is under his constant personal supervision.

"All prescriptions shall indicate clearly the name and address of the patient, including street and apartment number, if any, the date when written, the condition of illness for which prescribed, and the name of the pharmacist to whom the prescription is to be presented for filling."

Hospitals; Sanatoria.

Bridgeton Hospital.

The report for November is as follows: Number of patients admitted, 48; discharged, 51; operated upon, 28; died, 2; remaining November, 30, in hospital, 17. There were 2 births.

Newark Private Hospital Enlargement.

Having acquired the adjoining property at 9-11 Roseville avenue, the Newark Private Hospital has a plot with a frontage and depth of 100 feet. As soon as possession is obtained of the new holdings it is stated that the institution will make extensive improvements to the premises.

Salem County Memorial Hospital.

Dr. W. H. James reports for November as follows: Patients admitted during November, 33; number of operations, 22; deaths, 2; discharged, 32. Number of births, 4; remaining in hospital December 1st, 15.

St. Barnabas' Hospital, Newark.

A campaign is being carried on during the first ten days of December to raise $250,000 for this hospital. On the basis of gratitude, more than 100,000 patients have been treated in that institution during its fifty-three years; it has served all who sought its help, regardless of race, color, creed or nationality; 1,342 were Americans, and the balance represented 27 nationalities.

Since its establishment in 1867, its ward patients have numbered 36,500. Last year 1,767 patients were admitted and 1,873 cases were cared for in the dispensary, in which department 5,750 visits were made. Altogether the indoor and outside patients numbered 3,640.

State Hospital, Morris Plains.

The November report was as follows: In hospital Nov. 1st, 2,689; admitted during November, 46; discharged, 50; remaining in hospital November 30th, 2,685.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, reports for November: In the sanatorium November 1st, 197 patients; 109 male, 88 female; received during month, 29; classified as follows: Pre-tubercular, 6; moderately advanced, 5; far advanced, 18; incipient, 0. 19 were males, 10 females, five went to the preventorium ; three were readmissions. On Nov. 30, there were 201 remaining in the sanatorium.

Hospital Research.—One of the weaknesses in the practice of surgery is that men tend to become stationary, and call it standardizing their work. A surgical research department in a hospital would save the surgeons from becoming fossilized. The chief value of research work consists not in the number of new facts discovered, but in keeping all workers still students. The student type of mind, always groping for new light as it does, is a sine qua non if a surgeon is going to give his patients their due.—Jasper Halpenny in Canadian Med. Asso. Jour.

Deaths.

COOKE.—At New Brunswick, N. J., December 2, 1919, Dr. Henry G. Cooke, aged 86 years.

Dr. Cooke was born in Holindel, N. J., in 1833; was the son of an able physician; graduated from the College of Physicians and Surgeons, N. Y. City, in 1857; had an extensive practice in Monmouth County; removed to New Brunswick 22 years ago, where he practiced medicine until two years ago when failing health caused him to retire. He was universally esteemed. Action by the Middlesex County Society will appear in next month's Journal.

CUMMINS.—In Newark, N. J., December 4, 1919, Dr. James Hamilton Cummins, aged 57 years. He was born in Newton, N. J.; graduated from Bellevue Hospital Medical College in 1890; he practiced in Newark about 28 years.

Personal Notes.

Dr. W. Homer Axford and family have gone to Bayonne for the winter.

Dr. Harold D. Corbusier, Plainfield, has returned from military service and resumed practice—limited to treatment of orthopedic conditions—at 612 Park avenue.

Dr. Max Danzis, Newark, announces the engagement of his daughter to a son of Dr. Victor Parsonnet.

Dr. Henry A. Henriques, Morristown, and wife spent a few days in Philadelphia last month.

Dr. Edgar A. Ill, Newark, and family have moved into their new home in Parker street,

Dr. Isadore Topkins, Califon, met with an auto wreck recently by the overturn of his car twice and he was severely injured, but is recovering.

Dr. Jacob S. Wolfe, Bloomfield, entered a "string" of his silver spangled hamburg chickens at the Boston Poultry Show December 29. The date marked the seventieth anniversary of the first poultry show in America.

Dr. J. Ackerman Coles, Scotch Plains, has given to the Newark Museum Association about twenty paintings, a dozen bronzes, carved ivories, marbles, procelains and other art objects. Dr. Coles has taken a deep interest in the museum from its beginning, given to it from time to time and now adding this larger gift from his personal art possessions.

Dr. Z. Lawrence Griesmer, Roselle, who has been very ill for several months, is recovering. He was a major in the army and served almost two years in France. His illness was caused by overwork in the service.

Dr. Charles S. Heritage, Glassboro, who has been very ill, is slowly recovering.

Dr. Joseph M. Kitchen, East Orange, had a paper in the Medical Record of Nov. 8 on "Possible Dietary Causes of Rheumatism."

Dr. Leonidas L. Mial, Morristown, recently enjoyed a two weeks' shooting trip in his native state—North Carolina.

Dr. J. Harris Underwood, Woodbury, opened the addition to his private hospital last month when several medical men spent a pleasant evening there.

Dr. Elton S. Corson, Bridgeton, was recently elected post chaplain and Dr. M. F. Sewall member of the Executive Council of Shoemaker Post, No. 95, American Legion.

Dr. Joseph MacDonald Jr., East Orange, who suffered a paralytic stroke May 3, 1919, while riding in an elevated train in New York, has practically recovered. He recently spent ten days at Atlantic City before going to Florida for two or three months. Dr. MacDonald served as a major during the war and acted as head of the New Jersey Selective Service Examining Board.

Dr. Charles A. Rosewater, Newark, has resumed practice at 40 Milford avenue; practice limited to nervous and mental diseases.

Dr. Charles G. Boyer, Annandale, has recently recovered from a severe illness.

Dr. Florentine M. Hoffman, New Brunswick, was drawn as a member of the Middlesex County Grand Jury for the December term.

Dr. Alfred Cornwell, Bridgeton, enjoyed a gunning trip in the South last month.

Dr. Harry E. Lore, Cedarville, with others enjoyed a successful fishing trip in the South last month.

Dr. Lawrence A. Cahill, Newark, in a collision of his automobile with a trolley car recently, received a severe laceration over his left eye and was badly bruised. He went to St. James Hospital for treatment.

Dr. Cuthbert Wigg, Boonton, was a delegate to the layman's electorate session of the Newark conference of the Methodist Church last month.

Dr. Frank L. Field, Far Hills, who joined the Medical Corps of the Army at the outbreak of the war, has been promoted from the rank of captain to major, and is stationed at Mineola, L. I.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed	Failed.
Colorado, June	34	28	6
Florida, July	35	30	5
Maryland, June	109	103	6
Utah, July	11	11	0

Public Health Items.

Diphtheria in Bridgeton.—At the December meeting of the Bridgeton Board of Health 29 cases of diphtheria in epidemic form were reported as having occurred since October 10th.

Falling Birth Rate.—In the six months during March, 1919, the number of deaths in England and Wales exceeded the births by 126,000.—Medical Officer.

Morristown Health Report. — Dr. James Douglas, health physician, reported 309 cases to which he had been called as compared with 1,168 in 1918, when influenza prevailed. There were 283 deaths, the rate per 1,000 being 11.86; these were 339 births, the rate being 25.28 per 1,000.

Mental Hygiene, Newark Health Department.

October 1, 1919, a new work was introduced in the Bureau of Mental Hygiene, Mental Hygiene Social Service. The appointmen of a Psychiatric Social Worker to the Bureau now makes it possible to develop Mental Hygiene in a broader field. Mental Testing is a valuable and necessary asset, but with it must go a study of personality and environment. This can be done only outside of the clinic. Through the home visiting a closer contact is made between the patient, his family, friends, school, the clinic and physician. A better understanding by all interested in the child or adult mental defective, mentally retarded, epileptic, etc., or to group all types as a whole, the mentally mal-adjusted, is thus accomplished. The patient is helped to understand his own mal-adjustment and to find his place in the community.

Put briefly, the objects of the Bureau of Mental Hygiene are: 1. To aid in all possible ways the promotion of Mental Hygiene; 2. To give assistance through Social Service, to the mentally mal-adjusted, and those interested in them; 3. To maintain psychiatric clinics to

which all may come who suffer from mental disease or deficiency and for those who are not adjusting themselves to their environment and life problems; 4. To inform the public from time to time, of the facts as to the nature, cause and means of prevention of mental diseases and deficiencies and mal-adjustments; 5. To co-operate with all who deal with the mentally mal-adjusted.

The interest and co-operation of many public and private individuals, and divisions of the Department of Health had been very gratifying. During the month of October a total number of 42 cases were referred to the Bureau.

The Department reports 392 deaths during October; rate 10.7 per 1,000 population.

Influenza in Switzerland.—According to the Swiss Sanitary Department, the statistics of the influenza epidemic in 1918 showed that 22,689 persons died. More than 18,000 of the deaths occurred in cases where there were pulmonary complications.

Infant Mortality. — Indisputable statistics demonstrate an infant mortality rate of at least thirteen deaths under 1 year of age for every hundred living births, the world round, and the existence of appalling causative conditions of such a nature as urgently to call for ———remedial work on the part of all thinking men and women in this country. The same conditions which cause the death of thirteen out of every hundred babies born throughout the civilized world leave more or less permanent stamps on perhaps two or three times as many more babies who somehow manage to crawl over the infant dead line, many of whom will be the fathers and mothers of the next generation. The problem of infant mortality is far more than one of decreasing the number of infant deaths. Its scope is world-wide, and on its partial solution at least depends the welfare posterity.—E. B. Phelps.

Passage of Human Infections.—When the people generally and preachers editorial writers and other teachers understand that human diseases are spread almost entirely from one human victim to another, it will be possible to focus attention on the main avenues of passage and control them. Until they do, we shall continue to be ineffective in controlling infectious diseases. In looking to all possible trails and ignoring the main ones, we are about as efficient as a young, untrained hunting dog which tries to divide his attention on a dozen tracks at the same time. Like him, we shall continue to run our legs off and finally lie down, confused and entirely satisfied that the thing "just can't be done."—Milwaukee Health Bulletin.

Prescribing Alcoholic Liquors.

The new regulations issued on June 30 by the Bureau of Internal Revenue, state that "Physicians may prescribe wines and liquors for internal use or alcohol for external use, but in every such case each prescription shall be in duplicate and both copies be in the physician's hand writing." Not more than one quart shall be prescribed for one person for a given time, and only for patients under the physician's constant supervision. The prescription must give the patient's name, his address, the condition or illness for which the prescription is given and the name of the pharmacist to whom it is to be presented.

Medico-Legal Items.

Marriage of Diseased Persons.—The New Jersey Court of Chancery has decided that a marriage can be annulled where one of the parties concealed the fact that he or she had chronic tuberculosis at the time the marriage took place.

Pregnancy and Good Health.

(National Council of the Knights and Ladies of Security v. Glenn (Fla.), 80 So. R. 516).

The Supreme Court of Florida, in affirming a judgment in favor of plaintiff Glenn, on a beneficiary certificate issued by the defendant to his wife, holds that pregnancy is not a personal ailment or condition of bad or unsound health, so as to violate an agreement or stipulation that a member of a beneficiary society shall not be reinstated after suspension for nonpayment of dues, unless such member is in good health at the time of the reinstatement. The court holds further that a plea that the insured was "not in good health" at the time of her reinstatement was too vague and indefinite, and that the defendant might be required to set forth definitely and specifically in what respect the insured was not in good health, and the nature of her ill health.

The Liquor Law for Druggists and Physicians Explained.—William H. Edwards, Internal Revenue Collector for the Second District, in an attempt to make clear the rights of druggists under the war prohibition law in filling prescriptions for liquor says, "Under a new Treasury decision, any licensed pharmacist or druggist may fill a prescription for liquor if his name appears on the prescription in the physician's handwriting and if he has made application and received permit form 737, in accordance with the provisions of Treasury decision 2788, and, further, if he has qualified as a retail liquor dealer by the payment of a special tax. No such prescription may be refilled. Druggists filling these prescriptions shall preserve a copy of every prescription filled and once a month shall transmit to the office of the Collector of Internal Revenue a list showing the names of the physicians, the names of the patients, and the total quantity dispensed to each patient during the month. The regulations provide that the quantity prescribed for a single patient at a given time shall not exceed one quart. In no case shall a physician prescribe alcoholic liquors unless the patient is under his constant personal supervision. The physician shall keep a record in which a separate page or pages shall be allotted each patient for whom alcoholic liquors are prescribed, and shall enter therein, under the patient's name and address, the date of each prescription, amount and kind of liquor dispensed by each prescription, and the name of the pharmacist filling the same."

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THE APPLICATION OF REHABILITATION METHODS FROM WAR TO CIVIL LIFE.*

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New York.

The subject of my paper this evening seems especially appropriate to present at this time before the New Jersey Sanitary Association—the oldest organization of its kind in the state and one of the oldest in the country—more particularly since the State of New Jersey has reflected great honor upon its name by the passage of a comprehensive rehabilitation law, the first legislation of its kind to be enacted by any state, national government, or municipality, and which includes a substantial appropriation to carry forward this work.

The words, *reconstruction* and *rehabilitation,* have taken on a new meaning since the Great War, and perhaps there are no other words today that are more in the hearts of the people, the politicians, or the profession. This was especially impressed upon the mind of the speaker at the recent Congress of the Inter-Allied Nations on Rehabilitation, held at Rome from October 12th to 17th, at which he was privileged to be an official delegate of the Medical Corps of the U. S. Army. Here were assembled representatives from nearly all the allied nations who came to tell what had been done for the rehabilitation of those wounded in war. For the purpose of this congress was to serve as a clearing-house for such experiences, in the aim of learning and correlating the results in reconstruction obtained by the various nations of the world for the common benefit of all. Papers setting forth individual experiences were read; exhibits were held at which were accumulated all types of apparatus. orthopedic and otherwise, examples of the work done in curative workshops and vocational schools, and all varieties of products actually manufactured by the *blesses.* Another section of this vast assembly was devoted to reconstruction surgery.

At this congress the speaker met representatives from nearly every allied nation, men from China and Japan, from Montenegro, Servia, Greece, from Italy, from Great Britain and her colonies, from France and her colonies, as well as from our own country. All branches of rehabilitation work were presented by these delegates, nearly every country sending its own comprehensive exhibit of what had been done. From the representatives of China to those from Great Britain, one and all seemed fired with a single inspired purpose, namely, to learn what lessons for the good of mankind could be drawn from our common experiences in war rehabilitation methods, and to apply those same lessons to similar civil problems of each country. This purpose was discussed in formal papers and addresses at largely attended meetings; the same subject was debated informally on all sides by eager groups of surgeons, teachers, welfare workers, meeting by chance on the street, or in hotel lobbies. Future possibilities, and tentative programs of action were enthusiastically considered by the various representatives.

The President of the Congress, Colonel Galeazzi of Milan, seemed especially interested in the success of such future work, and visualized plans for the care of the Italian *mutilati* as well as for his civilian brother—but Italy, thus far, had taken no

*Presented before the meeting of the New Jersey Sanitary Association, at Lakewood, N. J., Dec. 5, 1919.

definite steps, had made no laws for the provision of such humanitarian work in civil life as that of which the President dreamed. Indeed, so far as the speaker was able to ascertain, in no foreign country had there as yet been set in motion any definite reconstructive measures for the care of crippled, or otherwise disabled, civilian workers. It remained for our country, and more particularly, for our own State of New Jersey, to set the example to all states and all nations. And it was with a unique sense of pleasure and a loyal pride that the speaker was able to tell men of other lands what his state had undertaken, and what not only were our plans, but plans already put into action and commencing to bear fruit!

The State of New Jersey seems especially well adapted, by existing facilities, to be the pioneer state in rehabilitation work of this kind. It has a large population extending over a relatively small area. It is covered by a veritable net-work of railways, affording easy transportation to a central point and permitting a close correlation of the work in the different sections of the state. In point of industry, it stands among the great manufacturing states of the union, with an infinite variety of products.

By the passage of her Rehabilitation Bill, New Jersey has begun preparations for the adequate medical care and ultimate return to usefulness of any of her thousands of workers who may receive accidental injury. To quote from the text of the law, "*physically handicapped* shall mean any person who, by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease, is, or may be expected to be totally or partially incapacitated for remunerative occupation." All persons over sixteen years of age who have been residents of the state for one year or more prior to injury are provided for by this law which defines rehabilitation to mean "the rendering of a person physically handicapped fit to engage in a remunerative occupation." For the definitive treatment of such cases a central institution is provided for by this law, which is to be called *The New Jersey Memorial School for Rehabilitation,* and is to be located in one of the cities designated as first-class in the state.

Particularly in the cases of the industrially injured—which, owing to the very marked industrial development of the state, we may expect will form a considerable proportion of such "physically handicapped" persons—if the work of rehabilitation is to be carried out from the inception of the crippled condition to its final treatment, it must be planned on a very broad and comprehensive basis. By necessity the initial treatment of accidents will usually be given by the individual's own physician, or at a hospital in the near vicinity of the place of accident. Provisions for major surgical operative work must be made in already existing hospitals in close proximity to industrial plants, distributed in appropriate places throughout the state. Finally, it would be ideal to have a central institution embodying a hospital and vocational school located in, or on the outskirts of, one of our large cities where the most difficult surgical reconstruction might be undertaken and likewise the care of all cases requiring lengthy convalescent treatment, consisting of various forms of physio-therapy, as well as metro-therapy, vocational therapy, et cetera. Here, also should be found shops for the manufacture of orthopedic appliances, artificial limbs; in short, such an institution should comprise all of the elaborately organized facilities for the highest degree of efficient service, such as have obtained in our best military reconstruction hospitals, as illustrated at Colonia, N. J., (U. S. Army General Hospital No. 3).

Owing to the complicated nature of the problem of rehabilitation, such resources, as touched upon above, seem absolutely essential; every facility should be provided for surgical reconstruction, for adequate physio-therapeutic care, for the maintenance of morale and for vocational re-education. In this connection, it should be emphasized that all such vocational re-education is primarily therapeutic in its purpose, and secondarily educative. For this reason, facilities must be sufficiently broad to permit always of a choice of therapeutic vocational work, of a varying degree educational, which shall be best suited to the individual.

The exact nature of the vocational work, to be carried out in the individual case, will be determined by a careful and exhaustive study of the physical needs and the future environment of the patient. If possible, when injury does not result in too serious physical handicap, he should return to his former occupation, or to one closely allied. The disposition of the case will depend entirely upon the physical demands of the former work. If it will be possible for him to later resume that occupation, it is almost invariably the case that a type of vocational

therapy can be chosen which, at the same time that it is effective from a therapeutic standpoint, will raise his efficiency to a higher degree. For instance, if a man has formerly been a house painter, the use of brush and paint may be employed to help work out adhesions in a stiffened elbow and wrist, bringing the arm back to maximum function at the same time that a workman may be raised to a higher plane of industrial efficiency by being taught sign painting, decorating and the like. Or, to use another illustration, likewise from the experience of the speaker, a young clerk during his convalescence may be given instruction in shorthand and the use of the typewriter, such exercise will not only help to restore function to the stiffened extremity, but the mental training will serve to make him a more competent *unit* when he does return to business. The foregoing illustrations are but two instances of many actual cases of re-training which occurred at U. S. Army General Hospital No. 3, Colonia, N. J., at which the speaker was chief surgeon.

This state work is, we believe, a most important one, and an undertaking comprising infinite details, and presenting many new human problems. In this work we shall come into close relationship with other agencies handling social problems, agencies already efficiently developed in the state, such as our state departments of Labor, Education, Institutions and Agencies, Public Health and the State Employment Bureau. Hospital organizations, the medical profession, the nursing corps are also closely allied, as are likewise all charitable agencies, and organized social welfare work. Of paramount importance in this connection will be the attitude of industry and of organized labor itself. The co-operation of each and every institution is urgently requested in this humanitarian work, for it is co-operation that will be mutually beneficial.

It is predicted that one of the greatest advantages accruing from the rehabilitation movement will be the correlation that it will bring about between these very agencies. Compensation, at present awarded by law to the injured individual, will yield far greater fruits to him, to the insurance carrier and ultimately to the state, under the rehabilitation program. By the careful supervision of the compensation paid out for his rehabilitation, under the joint auspices of the already highly efficient Department of Labor and the State Rehabilitation Commission, details of this complicated problem of reconstruction should be successfully worked out.

In an attempt to prophesy the advantages of such combined efforts, it is believed that no greater good can result than that following the sincere co-operation of the leaders of industry, in all its various forms and branches, whereby they shall make provision for the early return of their injured workers, under medical supervision, in a part of the plant specially set aside for such cases. Here they will not be expected to compete with normal, health workmen, but may perform the lighter tasks. They will be supervised in a kindly, intelligent manner, by trained men who are interested in helping them to ultimately return to the status of a fixed labor unit. Steps have already been taken by some of our far-sighted industrial organizations in the state for the after-care of men injured in their service, and it is believed that such practical and effective co-operation, the result of a broad, human sympathy, will yield far greater and more lasting benefits, than the results from actual state moneys expended. Such a relation between employer and employee may best be ilustrated by the following hypothetical case:

A man receives an injury while working in a factory; he is cared for in a first-aid station and is later given the surgical treatment his case requires. His surgical convalescence is good, but it is found that he has suffered a considerable degree of impairment of the upper extremity, so that an orthopedic brace is necessary. Medical advisors of the Rehabilitation Commission will see that the brace is properly designed and that he procures it at a place where it can be obtained at a reasonable price and is well made. The money which is granted him by the Compensation Law is sufficient to provide for this. The joints of his arm are, however, stiff and the muscles are weak. For the purpose of restoring as much function as possible to this member, at the same time that physiotherapeutic treatments are given during short periods of the day, his employer is stimulated to find some sort of job for him, as soon as he is able to do any work. This new work will be of a nature favorable to the restoration of function at the same time that this man, though partially disabled, is given a chance to earn a wage equal to or less than (usually the latter) his former pay.

The foregoing instance is in marked contrast to what may happen under the present system. A man with a similar injury may, or he may not, get the best surgical treatment; he may, or he may not, be fitted with an efficient brace; he may, or he may

not, be swindled by the firm from which he secures this brace; he may, or he may not, go back to work when he is able to do so. It seems that the tendency is to the latter. He is drawing his compensation money and on account of an undue apprehension, or lack of initiative to return to work, this event may be postponed, unfortunately, much to the detriment of the individual in some cases. In other words, the sooner an industrially injured man gets safely back to work, the better it is for his morale and for his physical infirmity. As to the latter much data has been accumulated during the Great War to prove that *active, voluntary joint-motion and muscle-exercises* are far more efficient in restoring function in such cases than is passive motion secured by the use of Zander apparatus and the like.

It is believed that the rehabilitation of cases of the industrially injured can best be brought about by the following agencies:

1. First-aid dressing station, located at the factory which shall permit of the simple sterilization of the wound and the application of dressing, immediately following the accident.

2. The requisite medical and surgical care of the patient by his family physician, or at the nearest hospital, as the severity of the case demands.

3. Post-operative treatment, including physiotherapy in various forms, either provided by the hospital, or by well-equipped state clinics which should be located in various industrial centers.

4. Provision by the patient's employer of suitable light work, or employment of some kind, as soon as possible, which shall enable him to assist in restoring lost function by *doing something* in vocational therapy. Such vocational work can best be furnished through the setting aside, by the employer, of a small portion of his factory space for the reception and care of these cases. Their work, under medical supervision, should be carefully superintended by competent, intelligent men, foremen who are interested and kindly-disposed, and at the same time on the alert to prevent the patient from overdoing in this work. It is believed that in no way equal to this can the morale be maintained and that there is better treatment for the physical infirmity. The influence of morale upon the progress of functional improvement can not be too strongly emphasized.

5. In case the injury is of too serious a nature to respond to the modes of treatment enumerated under *headings 2, 3, and 4*, a central institution should be provided in a suitable central portion of the state, which shall be equipped to carry on definitive treatment, whither the patient shall be transported, even though it be at a considerable distance. This institution should contain a highly organized surgical service, with a co-operating department of physiotherapy, an orthopedic appliance and artificial limb service, as well as the technic, which shall comprise a large variety of vocational branches in order that individual requirements may be fulfilled. Every facility should be afforded at this institution for complete surgical reconstruction, extending from the skillful plastic repair of the part disabled through all the phases of post-operative care in the aim of restoration of function. Not only should this central institution, *per se,* be the *last word* in the art of surgical reconstruction, but it should serve as an *educating center* for the whole state. Representing the best efforts in matters of rehabilitation, it should exert a leavening influence, a stimulus to other hospitals and institutions throughout the state.

Such an institution should also contain, as a part, a training school for reconstruction aides, or teachers of vocational and educational forms of work that are therapeutic in purpose, and which have proved of such value in the care and training of our convalescent soldiers. Up to the present time these reconstruction aides have never been standardized, although their profession has become as clear-defined as that of the school teacher, or the professional nurse. It goes without saying that in the immediate future a uniform educational standard should be required of the reconstruction aide precisely as the training of the graduate nurse is regulated.

Since the passage of our New Jersey law, other states have made similar legislation, among these being Illinois, Pennsylvanian and Rhode Island. Canada has sent delegates to this country for the purpose of making a survey of the work done here, in the aim of establishing, at some future time, rehabilitory methods for the treatment of the civilian injured of that country. The speaker, through his army hospital work and military experiences abroad, has been intensely interested in such endeavor all over the world and he ventures to predict that many, if not all, of the states of the union will pass similar laws in the near future. Certainly it would seem to be the particular province of the state to make

provision for the rehabilitation of its workers, since it is the state that makes the laws pertaining to the immediate care of other groups of individuals, such as the insane, the epileptic and the tuberculous. In the case of the industrially injured, however, we are dealing with normal individuals, most of whom are only temporarily disabled; they are being "helped to help themselves," and the period of their dependence will vary with the degree of assistance they are given. On account of the nature of such cases, it is believed that the state dollar will accomplish more by this work than by any other similar endeavor that has ever been attempted.

Internationally, this work has a broad appeal not only from the humanitarian standpoint, but more especially at this time, from the viewpoint of labor economics all over the world, in that industrial conditions have been so markedly changed due to the loss of millions of workers in the Great War and to the present tremendous demands upon labor in an attempt to restore the losses of production incurred during the period of war. Thus, the salvage or restoration of every injured workman has become today not only a humanitarian and a social problem, but an economic, a political one.

EPITHELIOMA OF TONGUE.*

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Incidence.—Jessett[1] collected records of forty-six hundred cases of carcinoma which included 400 cases of carcinoma of the tongue—from 8 to 8½%.

Bulkley[2] tabulated four hundred and seventeen cases of epithelioma of the skin and mucous membrane and of this number thirteen occurred on the tongue.

Andrews of Glasgow collected one hundred and eighteen cases of diseases of the tongue, such as abscess, haematoma, glossitis, leucoplakia, papilloma and tuberculous ulcer, of these ninety-eight were cancer. Eighty-eight occurred in men and ten in women. The average proportion in all cases reported is 85% in men and 15% in women.

*Read at a meeting of the Physicians' Club, December 12th, 1919.

Andrews further tabulated four hundred and sixty-nine cases of epithelioma and found the order of frequency as follows: tongue, lower lip, aesophagus, penis, cheek, larynx and tonsil—one hundred and eighteen or 20 8/10% of these cases were epithelioma of the tongue.

Position.—Any part of the tongue may be attacked by epithelioma, but the posterior part is not nearly as often affected as is the anterior half; the dorsum and the under surface of the tongue are not as frequently involved as are the edges; there is no difference as to the frequency of involvment of either side.

Precancerous conditions are much more common in the forepart of the tongue and at the borders than behind the circumvallate papillae; no doubt due to the greater liability of irritation or injury to that portion of the tongue free from papillae.

Age.—Children and young adults are nearly exempt from epithelioma of tongue, although a number of cases have been reported.

Variat[1] notes a case in a boy, age eleven; Chapple[1] in a man, twenty-four; Spencer[1] in a man, twenty-four; and one in a man, twenty-six; Harrison in a girl of twenty; Butlin in a married woman age twenty-four; Gorson[3] and Dupich in a woman of twenty-two. Lorsin[4] tabulated three hundred and forty-two cases of carcinoma of the tongue and found nine between the ages of 15 and 30. The greatest number of reported cases have occurred between the ages of 40 and 60. Riddell[5] reports 16 cases of epithelioma of tongue with the average age of the patient as 61, the ages running from 47 to 75. The probabilities are, that fewer are attacked after 60 years because of the fact that there are fewer people of advanced age and not because of lessened liability.

Rank in Life.—There does not seem to be any noticeable difference as to the occupation or social position of those affected. While clay pipes with jagged edges might be used by the workers, burns from cigars, cigarettes, ill-fitting plates or artificial dentures, highly-spiced foods, seem to equalize the occurrence in those in the better walks of life.

Causes.—Those theories applicable to the causation of cancer generally can be applied to cancer of tongue; but a pre-disposition to the latter can be explained by local conditions. Irritations and inflammation of the mucous membrane of the tongue, and the resultant white patches,

thickening, ulcers and scars are favorable sites for new growths.

Exciting Causes.—Smoking in all probability has a decided influence, not directly but rather by producing conditions on the surface of the tongue which pre-dispose to the development of carcinoma.

Syphilis being capable of producing ulcers and scars of the tongue, just so far is syphilis a predisposing cause of the carcinoma; the ulcers and scars are not more prone to become carcinomatous than the ulcer and scars produced by other causes.

Mechanical injuries by sharp or roughened teeth may be an exciting cause.

Development.—The first appearance may vary within very wide limits, commencing as a blister, an excoriation, ulcer, fissure, a tiny tubercle, a wart or warty growth, or a nodule in the substance of the tongue.

Varieties. — 1. The single epithelioma, the common form; 2. double epithelioma; 3. diffuse; 4. atrophic or fibrous; 5. hypertrophic.

2. Two epitheliomas may develop simultaneously upon the same tongue, having between them apparently healthy tissue.

3. Chronic glossitis due to syphilis, tobacco or other causes may cause epitheliomatous changes simultaneously over the whole of the anterior portion of the dorsum.

4. When the tongue appears smaller than natural, smooth, glazed and irregularly furrowed almost as hard and as unyielding as wood.

5. Occasionally so large that it projects from the mouth, dragging with it the tongue.

Symptoms.—In the earlier stage, subjective symptoms usually pain and salivation. Pain may be sharp, aching, gnawing and may radiate in surrounding tissue; but neither pain or salivation or both are pathognomomic of epithelioma as either or both may occur with benign growths.

Objectively, carcinoma is chronic and once established rarely recedes; it may be very slow in its growth, but never responds to such treatment as would be beneficial to benign growths; the continued growth is not so manifest by enlargement but more commonly by induration and ulceration. The induration is often very hard and can be best detected by pinching the growth between the finger and thumb.

When ulceration occurs, it is generally surrounded by a zone of induration, but this induration may be slight, due to the fact that the new growth is undergoing degeneration, leaving only a slight layer of cancer tissue between the floor of the ulcer and healthy tissue.

Course.—The course of an untreated epithelioma depends largely upon its situation in the tongue. If it occurs on the dorsum, it extends into the muscular substance and probably infiltrates a large part of the tongue before it reaches the adjacent structures.

If on the anterior portion of the border, it infiltrates the tongue and at the same time makes its way along the floor of the mouth to the gums and jaw; the bone may soften, the teeth loosen and drop out. If on the posterior portion, it spreads to the root of the tongue gradually makes its way to the epiglottis and larynx or extends to the palate, tonsils or burrows deeply into the tonsilar or carotid artery and causes death by haemorrhage.

The tongue and floor of the mouth being very rich in blood-vessels, and this combined with the muscular movements of the tongue produces an extension into the lymphatic glands; this extension occurs at a much earlier period than is obvious by clinical examination, and occurs sooner or later in every case.

Infection of the lymph nodes on the affected side may remain apparently dormant for a long time and even if the glands are not palpable, carcinoma is not necessarily excluded.

In the later stages of the disease the glands on both sides of the neck become involved. The probable cause of the extreme virulency in younger people is the presumed greater activity of the lymphatic circulation; and the general slowness in the very aged is the lessened activity of the lymphatic circulation.

Termination.—If not operated on, the large majority of patients die by slow exhaustion no doubt increased by the occurrence of small and repeated haemorrhages, excessive pain, profuse salivation, inability to injest sufficient food, sleeplessness, suppuration or sloughing. In a number of cases, septic pneumonia from the fetid discharges from the mouth causes death; asphyxia from infiltration of the epiglottis or by pressure upon the trachea of involved glands.

Non-operated patients usually die within eighteen months from the development of the lesion; the greater majority within one year.

Diagnosis.—The diseases most likely to be mistaken for epithelioma of the tongue are syphilitic growths or ulcers, tubercu-

lous ulcer, sarcoma, benign warty tumors, and benign ulcers and fissures. At times the similiarity of these conditions, with epithelioma is so marked that it is exceedingly difficult to differentiate, particularly when we consider that most of these conditions can be pre-cancerous and the changes to cancer are very gradual and by almost imperceptible gradations.

Primary syphilis of the tongue is comparatively rare and generally occurs at or near the tip of the tongue, while epithelioma frequently occurs farther back along the border; in syphilis, the neighboring glands are enlarged from the first or very early; and as a rule the secondaries will appear before an operation is determined upon. Dark field examination for the spirochetae would positively determine the diagnosis .

Secondary syphilis can scarcely be mistaken for epithelioma. In tertiary syphilis, the non-ulcerated or the ulcerated gumma presents a condition which requires careful study and observation, particularly when the non-ulcerated gumma begins as an undefined nodule upon the dorsum, firm and intimately associated with the tissues of the tongue, the neighboring glands show slight or no hypertrophy, the resemblance to epithelioma may be so striking that it may be absolutely impossible to differentiate.

We may obtain a history of syphilis, we may find old luetic scars upon the tongue or other parts of the body, we may discover a second gumma, a condition that is not uncommon, while a double epithelioma does occur, but very rarely .

An epithelioma as well as syphilis is frequently associated with a leucoplakia or a chronic superficial glossitis. The Wassermann, Noguchi and luetin tests, may be positive, the epithelioma may be developing from a syphilitic base, so that we may be compelled to give arsphenamine or mercury or both before we can positively differentiate. .

With ulcerated gumma the question of differentiation occurs with greater frequency, because of the fact that ulceration of the epithelioma is more common .

Gumma occurs more frequently in the central portion of the tongue, epithelioma chiefly on the borders; the edges of a gummatous ulcer are usualy underminded with the floor covered with a grayish or yellowish membrane and does not bleed readily; those of epithelioma are raised, hard and nodular. Gummatous ulcers are rarely so widely and deeply indurated as cancer. The glands in tertiary syphilis are rarely affected, while in epithelioma the involvement is fairly early.

Tuberculous ulcers of the tongue are always secondary to general tuberculosis or tuberculosis of the skin and usually occur in children or young adults. The Koch, Calamette or the Von Pirquet tests might be of some assistance.

Sarcoma of the tongue is a very rare disease, only 60 cases have been reported.[6] It may occur in any part of the tongue at any age, with or without ulceration, with or without glandular enlargement. To mistake a sarcoma for an epithelioma is not likely, nor very serious as both necessitate the same treatment.

It is extremely difficult to distinguish an epithelioma from a simple veruccous growth, because the latter often and imperceptibly changes into the former, the softer warts almost invariably ulcerate, the harder warts become more fixed upon the tongue, the base and surrounding parts become indurated and finally ulcerated and the development of malignancy. Frequently simple ulcers undergo this same evolution as is found with simple warts.

When we have a narrow indurated fissure, the differential diagnosis is difficult; the fissure may extend much deeper than appears at first sight, its edges should be separated, the overhanging borders raised, and the base thoroughly examined; exceptionally these fissures may be caused by actinomycosis, calculus or a foreign body.

Prognosis and Treatment.—There is but one prognosis in un-operated cases—death. There is but one method of treatment f epithelioma—operation, early and radical operation. Do not give the epithelioma a chance, but give the patient a chance.

If we hope to cure a fair proportion of cancers of the tongue it can be accomplished only when operations are undertaken at such time when a diagnosis from the clinical signs may still be a matter of doubt. Our greatest assistance in arriving at a correct diagnosis is microscopic examination of the suspected growth. While there is no doubt of the occasion of error due to intense infiltration of round cells that may partially destroy or obscure the epithelial cells; this can probably be avoided by repeated examinations of a number of sections. After careful study if there be the slightest element of doubt, it is far better to err on the safer side and remove the growth.

Pathology.—Only one variety of carcinoma attacks the tongue; the squamous-cell, although Blair[1] quotes Steiner as reporting an apparent carcinoma not of this variety, and reports one case of his own but acknowledges the possibility of error.

The microscopic findings of epithelioma of the tongue are the same as epithelioma of other parts of the body.

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81 New Street.

TROPICAL SPRUE SEEN IN NEW YORK.

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Of late years attention has been called to the existence of tropical sprue[1] or psilosis in the United States and cases reported in North Carolina,[2] Louisiana, New York, California and elsewhere. It is the object of the author in reporting two cases to bear testimony to the presence of the disease in New York and to mention a symptom occurring in one of these patients which is not mentioned in the previous literature of the disease.

Case 1. Mr. S. B., a married man, aged 57, a resident of New York, has been accustomed to spend from three to eight weeks in Florida every winter for the last eleven years. He has never been out of the United States. His family and past history have no bearing on the present illness. One year ago he had an attack similar to the present one just as he was about to leave Florida. This, however, disappeared without treatment after his return to New York. At that time he found that by living on milk alone or with, occasionally, a little meat, he rapidly got over his symptoms. Now for six weeks he has suffered from morning diarrhoea. This consists of two or three loose stools coming after breakfast and in mid-morning. The movements are very irritating and burn the rectum. They are light gray in color, of extremely foul odor, which has an irritating character to the nasal mucous membrane. His mouth has been sore along the lateral aspects and at the tip. He is weak and has difficulty in forcing himself to be about. On physical examination he is of a sallow earthy color, of poor nutrition. Heart and lungs show no abnormal signs. The pupils react normally; the knee-jerks are present and normal. Examination of the abdomen was negative. The urine was normal. The stool was soft and unformed, somewhat frothy, of a pale drab color, of a foul odor and strongly acid. The pancreatic ferments were normal. Occult blood was present by Weber's test. On microscopic examination the stool was largely composed of fat. There was an occasional bit of undigested starch. No vegetable remains, no pus cells were seen. A very few red blood cells were found. A very careful search for tubercle bacilli both from direct smear and by the antiformine method were made and none found. Exhaustive x-ray study of the gastro-intestinal canal revealed no etiological factors. This patient referred to his own physician for treatment has made an apparent recovery on milk and meat juice.

Case 2. Mr. J. E. B., married, 56 years old, has been ill for two and one-half years. The seventeen years previous to onset and two years following he had been a resident of Havana, Cuba. His trouble started with attacks of sore mouth and diarrhoea. The mouth was very sensitive to mechanical stimulation and to heat. His tongue was red as fire. The diarrhoea varied in attacks, consisting of from three or four to twenty movements, loose, foul, full of mucus but never containing blood. With his first attack his mouth became so sore that he could take nothing but milk and water. This he found seemed to help him and the attack promptly subsided. Later attacks also yielded to this diet but after a longer or shorter time would always come back. At present his mouth is somewhat sore. He has two or three loose movements in the morning and, with any indiscretion and sometimes without any discoverable indiscretion in diet his diarrhoea will become active and his mouth very sore. He suffers from intestinal gas. He feels cold most of the time and when exposed to even cool temperatures he suffers keenly. His top weight was 185 pounds three years ago. Six months ago he weighed 160. Present weight is 132. On physical examination the patient is of a curious gray

or clay color. He is poorly nourished. The heart, lungs and abdomen show no adventitious signs on examination. Pupils and knee-jerks show normal reaction. Proctoscopic examination showed a normal rectal and sigmoid mucous membrane. The urine was normal. The stool was of large size, pea-soup consistency, foamy, bubbling, color drab with a yellowish tinge, of a very foul odor, acid, consisting, under the microscope, mainly of fat. There was much mucus. Reaction for occult blood was negative. The patient looked to be profoundly anaemic. Blood examination was as follows: Red blood cells 4/660/000. Haemoglobin 75%. White blood cells 7/600. Polymorphonuclear leucocytes 52%, lymphocytes 48%. Gastric analysis showed the stomach empty after 12 hours fasting. An Ewald meal removed after fifty minutes yielded 12 mils, showing an apparent gastritis with considerable gastric mucus. The total acidity was 46; free HCl 30. Extensive x-ray study of the gastrointestinal tract was negative. This man returned to Havana where he started a milk treatment after the method of Thin[3]. He made splendid progress for a time but as he began to feel better the great appetite which he suffered was too much for him so that he experimented with foods other than milk with partial relapse. Treatment since has been this same experience over and over again with the curve upward. During eighteen months in Havana, New York, Montreal and London he has not received eight weeks of uninterrupted treatment. At one time on full milk diet, taking five and one-half quarts a day, he gained thirteen pounds in ten days and showed a daily improvement in strength and appearance which was remarkable. At another time when on a milk diet but also taking three and four pounds of raw strawberries a day, he did nearly as well. When first beginning his treatment he had great difficulty in taking milk. It gave him nausea to swallow a small mouthful and such was his distaste that he would spit out a small quantity which he was trying to swallow. In an attempt to make it palatable the milk was heated and salted and this found instant favor. When on full milk diet he would put into his twelve-ounce glass of hot milk four or five grams of sodium chloride. This salt he seemed to crave and this craving has not diminished. The salt is still taken with his milk and does not seem to interfere with the efficacy of the milk treatment.

Here then are two patients having symptoms of sore mouth and diarrhoea, coming in attacks. They had both lost weight. Both had a curious earthy color to their skin. Their stools were largely fat with normal pancreatic ferments. They responded in striking manner to milk diet. One of the cases showed characteristic improvement on strawberries.

It is desired to call attention to the fact that these cases were seen in New York, one having come from Havana, the other having been in Florida for a few weeks each winter. One patient found the addition of salt to his milk made the milk more palatable and developed a sort of salt hunger or craving so that he would take from forty to seventy or more grams of sodium chloride in twenty-four hours. No work was done on the chloride excretion in this case.

955 Park Avenue.

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THE CARDIAC SEQUELAE OF INFLUENZA*

Grant P. Curtis, M. D.,

Late of Base Hospital No. 16, New Haven, Conn.

Town of Union.

In considering the cardiac sequelae of influenza it will be my endeavor to present to the medical man who goes to the bedside, both in the home and in the hospital, such practical facts regarding these conditions as may tend to relieve his anxiety as well as to prevent some of the accidents that we have all known to follow in the path of this dread disease. I shall consequently abstain from the ultra-scientific and the use of statistics, in so far as is possible, for these are of most interest to the pathologist and the cardio-vascular investigator.

Now, the first thing that enters our minds is what are the most common cardiac sequelae? As we would think of them with

*Read before the Hudson County Medical Society.

the patient before us, they are, with regard to frequence of occurrence and not with regard to sequence, dilatation, principally of the right auricle and bradycardia, both the result directly or indirectly of myocarditis. Next endocarditis, pericarditis and coronary embolus. We will take up the least common of these first and dispose of them in inverse order that more stress may be laid upon that with which we have to contend most often and therefor causes in point of numbers at least, the most damage.

Coronary embolus, as a sequel of influenza, is so common that we can touch upon it but lightly. In the first place it is practically impossible of diagnosis clinically and in most instances the diagnosis is of no avail anyway for its usually results in death or causes no recognizable disturbance. It has been my fortune to observe this condition but once. Then an infarct was produced very near to the outer wall of the left ventricle, the base of the triangle having a width of about four centimeters. This infarct had apparently existed for some day or two previous to death and could hardly be attributed as a cause.

Pericarditis is not a common occurrence either as a complication or as a sequel of influenza and when it does occur it is usually as an extension from the pleura. In either case it is similar in its pathology and clinical course to the pericarditis following other infectious diseases. I may mention, however, that in nearly all autopsies following death from influenza there is noted a slight increase in the amount of pericardial fluid.

Endocarditis does not occur as frequently with this disease as was at one time supposed nor as frequently as in some of the other infectious diseases. Pfeiffer's bacillus has, however, been isolated from the valve leaflets by several investigators prior to our recent epidemic. Naturally, when it does occur its clinical course, treatment and results are the same as other forms of the acute type.

Bradycardia is a condition of more frequent occurrence than those previously mentioned and has manifested itself in my experience in twenty per cent. of all true influenza cases. Whether this percentage has been universally shown I am unable to say. This sequel is not to be "snap diagnosed" upon finding a slow pulse alone, but is to be checked by comparing the actual cardiac contraction with the pulse remembering that at times there are contractions the waves resulting from which do not reach the radial. It is furthermore not to be diagnosed until reasonable assurance is found that the patient is not one possessing a slow normal pulse or without eliminating the digitalis factor. The slow normal pulse error is not so likely to occur when we consider that the slowing of the heart after influenza usually occurs some days after a hitherto uncomplicated recovery has been in progress and at times follows upon an apparently uncomplicated case. The pulse in these cases may drop to thirty beats per minute and remain persistently slow in spite of the use of atropine. The etiology of this slow heart has been variously ascribed from pressure of glands upon the epigastric nerve to central and myocardial causes. It is now generally agreed to be of toxic origin and there is little doubt left that these post-infection bradycardias are the result of myocarditis.

The danger of permitting this condition to go unobserved is that upon exertion the heart is quickened unduly in an effort to meet sudden demands and permanent injury may result to an already weakened organ. I recall one case; that of an apparently uncomplicated case of influenza in a skilled laboratory man who was quite familiar with his normal self. His normal pulse rate was sixty-eight and five days after his temperature had returned to normal his morning pulse was noted to have dropped. A progressive drop within the next two days lowered the rate to thirty-eight per minute. This continued for several days in spite of the use of atropine and rest in bed. Having done a large amount of experimental work with the ductless glands, he one day presented an argument what that I deemed to be a sufficient logical foundation for the administration of thyroid. This was used for five days. Along side of him lay another case which had run a very similar course that was during this time treated with atropine. In another bed near him was a third case which received only rest and elimination in the way of treatment. The three all returned to the normal on practically the same day.

These cases together with others have led me to believe that quiet, together with elimination, will usually result favorably.

Since dilatation is the most common sequel, let us consider it from a time when the principle causal condition is a complication, remembering that no case of fully developed influenza is without the complication of myocarditis even though it may not be, in itself, of sufficient degree to pro-

duce particularly prominent symptoms. Just as true is it that no case of fully established broncho-pneumonia of influenzal origin is without its dilatation. Most natural sequences indeed these *must* be when we have a heart already over burdened and at the same time having its muscle fibers attacked by a virulent toxin producing degenerative changes in them. Now in addition to its already increased demands add the damning back of the pulmonary circulation due to pressure within the lungs, plus the oft-repeated thrust, I may say, of blood against the internal surface of the walls of the auricle caused by excessive cough. For as demonstrated by James Burney Guthrie and published in the J. A. M. A. of June third, 1914, the healthy heart dilates, on coughing. to a degree appreciable with the fluoroscope, and a weak heart will dilate to an extent readily appreciable to fine percussion of the right border after three coughs, this dilatation lasting from five to fifteen minutes.

Now let us picture a heart which has been subjected to these influences and has come to the autopsy table. The chest plate having been removed, the pericardium opened and the heart still remaining in situ the first thing noted is the increase in size of the right auricle, this varying in extent from two or three centimeters increase in the diameter to a degree sufficient to cover two-thirds of the exposed surface of the organ. In the latter instance the serated edges practically or entirely obliterated. The next most notable feature is the pallor of the organ, the result of the degenerative change heretofore mentioned. Then its apparent rotation to the left due to the dilatation of the right ventricle obscuring the small portion of the left ventricle normally seen in this position.

As the organ is grasped in the hand to sever the great vessels we note the remarkably soft feel, quite comparable to the sensation produced upon palpation of the degenerated calf muscles of a robust individual who has been long confined to bed with an acute toxic disease. When laid upon a flat surface it collapses and spreads similar to jelly instead of standing rounded and firm. The walls are noted to be thin and one heart I recall having, with ease, pushed a finger entirely through, much as one might do with a portion of retained placenta. Upon opening the right auricle we find that instead of having its normal capacity of about sixty centimeters it may readily hold more than the three other cavities together.

Now suppose we take a hypothetical case of a robust individual who has worried through his days of illness with influenza and broncho-pneumonia. His temperature has returned to normal. His pulse and respiration have dropped, resolution has progressed well in the lungs and the heart is pumping along regularly and apparently at ease. We feel that the battle is over and the fight is won. Our patient wants to sit up. He wants to get out of bed. He wants to walk to the bathroom. In fact he feels that he must get started. Bearing in mind the description given above we know what has happened to this heart. In addition we must not lose sight of the fact that though the other organs have figuratively been sent to the rear for a "rest period after the fight" this organ has had to "carry on" during the clean up though badly wounded. If we call upon any heart to suddenly increase its work we have to consider the following; a normal heart will increase its frequency gradually and increase its force of contractions. To quote from J. Strickland Goodall, "the slow superheart of the athlete can about double its rate suddenly," but "any impared myocardium will quicken out of all proportion to the work attempted and responds by dilatation." In our hypothetical case we have an organ impaired by degeneration and already dilated. He gets up and walks a short distance to the bath room. His degenerated heart muscle attempts to respond by further dilatation, it fails and perhaps his hypothetical friends send in flowers. If he has attempted the exercise with the doctor's consent the doctor has the family for a life-long enemy. If he doesn't die he does permanent injury to his heart so that he suffers from chronic dilatation and is handicapped for life.

I examined a case only last week of a robust young man of excellent habits who, during our recent epidemic, was thought to be doing so well that he was gotten out of bed against his will. He collapsed, nearly died and to-day has an area of cardiac dullness extending three centimeters to the right of the right sternal border and seven centimeters to the left of the left mid-clavicular line. Dyspnoea from exertion is sufficient to prevent him from keeping up with the procession.

Now I believe that I promised in a previous paragraph to present something which would tend to relieve the anxiety of the medical man regarding such sequelae. Thus far I have only added to it by dwelling upon the more serious phases of the question.

How, then, are we to know when our pa-

tient may safely place increased demands upon the heart? We must have some estimate of the myocardial efficiency. Every patient, or every doctor, does not have the advantage of the electro-cardiograph or even of the multigraph or the teleo-roentgenogram. However, every physician has or should have a reliable compact portable blood pressure apparatus which he should carry in all cases of influenza, bronchopneumonia and all other infectious diseases in which we know degenerative changes occur in the myocardium and this apparatus should be carried as faithfully as would a gun be carried into a den of thieves for with the aid of this instrument may he put himself upon a firm footing of understanding and guide his patient safely through this period of danger.

The modus operandi of obtaining this assurance of safety is simple and does not reuqire thorough training in the interpretations of the various phases of sphygmomanometry for, though such training is an advantage, one who can read a systolic pressure can gain satisfactory information. The first procedure is to determine the systolic pressure. It is, of course, well at the same time to determine the pulse rate. Then have the patient extend and flex the forearm upon the arm vigorously twenty or twenty-five times. This simple exercise can be done even while lying in bed with the armlet left on the other arm. Upon completion of the exercise selected observe the systolic pressure again. If the myocardium is not overtaxed by this we expect to find a slight rise above the first reading, then a slight fall below it and within two minutes a return to it. Should these be as stated we are safe in going a little farther, for example, letting him sit up in bed. Take the readings again and if still the same result we may go still farther and so on. Should we find, however, that there is first a fall in the pressure or that it rises out of all proportion to the slight effort exerted, or that there is a rise and then a fall without the return, eliminating, of course, any physical element, this patient has been given more than is well to be repeated and further rest is to be continued.

The same test may be applied to getting out of bed, to walking across a room, to lifting graduated weights, etc. I have selected the simplest and least severe as an example. It may be seen that these tests can be used in the treatment of these convalescing patients for we can at any time determine when a point of tolerance has been or is being reached. It is well, however, to keep the exercise well below the point of tolerance, thereby remaining within the limits of safety. In prescribing exercises for treatment it is advisable to use practical exercises when possible, such as walking to a certain room permitted a certain number of times, being always assured that plenty of rest will be obtained in the intervals. Practical exercises can be controlled as well by this method as can routine procedures approaching the form of calesthenics. They require, too, less effort for their accomplishment for the patient is doing something that he wants to and not simply because he is ordered to do it.

In conclusion: We have in our pathology a known entity. We have in its effects known results. We have in these simple tests a knowledge of the myocardial efficiency of inefficiency. Combine these and we have knowledge reduced to order.

AFTER DINNER ADDRESS.

Deliverd at the Banquet of The Medical Society of New Jersey, at the Annual Meeting, Spring Lake, June 25, 1919.

ADDRESS OF MR. ALBERT C. WALL,

Counselor of The Medical Society of New Jersey.

Jersey City and Orange, N. J.

Mr. Chairman and Ladies and Gentlemen: When I heard the passionate statements of this gifted gentleman in regard to certain facts, I wondered why, with all his wonderful grounding in statistics and his grasp of the situation, and the items, totals and analysis, that Dr. Hoffman should have made such a mistake, as it seems to me, in all humility, as to find fault with that clerk who fined the doctor for having given an overdose of cod liver oil. The man who gives an overdose of that confection is deserving of the deepest damnation.

Now, I have taken great pride in representing this association in defending the doctors who have been accused of negligence in the discharge of their duties; because the cases that arise in that fashion are different from the ordinary case. The ordinary case involves a question of property, and deals with whether the items shall go in the right or the left hand page of an account. It is easy to get excited about the rights of property; but it is far different when one is dealing with the reputation of a professional man, his standing in the community and what good people think of

him. We are all in the grip of the same great God of Etiquette. We do not know or care what the people in Patagonia or the East Side of New York think about us. But there is always some coterie of the elect to whom we are slaves, and before whose opinion we quake, if we have done wrong; to whose condemnation we are highly sensitized. In the professions, such as medicine and law, there are certain men who, if they say that we have done ill, that we have been false to our responsibilities, so weaken us that we have no defense at all. We simply go down. It strikes us to the heart.

So when a doctor is haled before a jury, and the question is whether some act of his was a negligent act or not, whether he should be mulcted for damages, as the cheap lawyers are so fond of saying, that is one thing; but when the question is whether he shall lose his reputation, as a man unfit or inexpert, that is a situation that gets rather near the nerve.

Now this Society has adopted (I am speaking from the lawyer's standpoint), a very wise way in dealing with that situation. As I understand it, you do not act the part of any insurance company. You do not say to a doctor, "If you get in trouble for some action that is called negligent, we will stand back of you and fight your battle and pay your damages." No, not at all. What you say is, "We will examine the situation; we will look into this thing; we will have a competent board of inquiry, made up by your own friends and the members of the society; and we will investigate the facts, to see whether we think that you are at fault or not. If you were at fault, we will not defend you; but if we think that you were not at fault, then we will stand back of you. We will do all we can to help you in your defense and rehabilitate your reputation, if it has suffered from this attack. In short, we will stand by you. But we are doing this for your reputation, for your standing; not for the money end of it. Consequently, you must agree that you will not compromise the case; in other words, that you will not translate this loyalty that we exert for you into some amount that you are willing to pay in order to get rid of the annoyance and bad reputation of being attacked in court."

Now that works out this way: As you never compromise a case, or turn back when you have once put your hand to the plough, you do not see the side that those who work in the law courts frequently see; for as soon as it should be known that you would compromise cases, cases would start up to be comopromised, and not tried. There is a danger in this, that loyalty may be carried too far. You know that the ordinary men, the persons that you call the laity, have certain indistinct feelings and divers prejudices about your profession, as they have about mine; and they do not formulate these things carefully. But there are a certain number of things that they hate, and one of the things that they hate is professional ethics. They hate it as the devil hates holy water. They think that it is the thing that makes the local man send for the consultant, and the consultant finds that the local man has made a mistake and conceals it from the family, because he has been sent for by the local man. Now your attitude towards patients is very different from the attitude that the public thinks you have. Many people have an idea that you are guarantors of immortality, while you consider yourselves the servants of nature. So the result is that when the feeling is growing on all sides, that if anyone suffers an injury, someone should pay for it, they reach out in an unthinking way and drag the doctor into the meshes of the law, to stand there and defend himself against something that may be one of the sequelæ or consequences of disease itself, with which the doctor has nothing to do. The result is that when you get into the court, you do not understand it. You feel a sense of wrong and injustice, and that you ought not to be dragged there; that it is an outrage. The real fact, however, is that in theory all men are equal before the law; and if a doctor makes a mistake he has to stand behind it, just as an engineer, a bricklayer or anyone else has to do. Then (when they do get into the courts, the doctors are not always wise about it. For instance, this idea of etiquette moves in certain minds, and they begin to talk about a doctor who testifies against a doctor; and they begin to use influence on the other doctor not to testify—although in no case that I have had anything to do with has this occurred.

There is a real danger that if you left your loyalty toward the man attacked carry you so far as to influence other doctors not to testify against the doctor and if you ostracize the doctor who does testify, instead of this fine bond of loyalty, you will have substituted a conspiracy to keep witnesses from the court room, which the law defines as a crime. If that should be

brought before the courts, you will lose much of the standing you now have. Courts in accident or negligence cases are dangerous things for both doctors and lawyers to go near. There is no temptation that comes into a lawyer's life with this class of cases that is so vivid and subtle, into which it is so easy to fall, as that which comes to the lawyer in talking to his witnesses before going to court. He has in mind certain primary things that he wants to prove, and here comes a cloud of witnesses, some very ignorant and not used to the accurate employment of words. The lawyer begins to ask questions, and can put nearly anything into their minds that he wants to. He wants to find a certain thing; and if he does not put a brake on himself, he will see that he is making them tell what he wants, and not the real facts.

The doctors also have a temptation, when they get into court; especially as experts. They do not realize the difference between themselves and a lawyer. A lawyer is trying a case, presenting a case for another. His own view has nothing to do with the case. In an ideal state, you would not need a lawyer; you would present your own case. So the lawyer has no responsibility, except not to go beyond the bounds of presentation. If a witness tells a lie, it is not the lawyer's part to get up and say that it is a lie. That would be improper. It is the jury that is to judge whether it is a lie or not. But the expert witness comes there with the full weight of his opinion and his standing as a man. He prepares the case with the lawyer. The lawyer is eager to win, and it is pretty hard for the doctor to pinch himself and say, "My duty is different from this lawyer's duty. All he does is to present the case."

So we each have our temptation, and we are each, judging from what has been said to-night, in a period of considerable danger, —you gentlemen, from this Health Insurance scheme. And it is a time when we cannot get any new word of guidance. We are not going to have anybody show us a new road. We have got to go by the old signs. We are professional men; and if we give way to these new and objectionable ideas, we shall become submerged in the socialistic waters. We want to remain as islands in a proletarian sea. We want to stand out for decency, for the old things that we all know are the best things.

My friend, Major Colby, mentioned Hippocrates. All lawyers do in speaking at doctors' dinners. There is a poem of Kipling's in which he mentions Hippocrates, and it is in line with what I am talking about. It is about our fathers of old and it recognizes their virtues and their weaknesses and the good hearts they had. It tells how they believed in herbs for disease and how all this science of the herbs was linked up with the stars and astrology; how most of their remedies "cured you dead," "but when the sickness was sore in the land and neither plant nor herb assuaged, they took their lives in their lancet hand and Oh, what a wonderful war they waged! Yes, when the crosses were calked on the door; yes, when the terrible dead cart rolled, excellent courage our fathers bore—excellent heart had our fathers of old, none too learned but nobly bold into the fight went our fathers of old."

And then the poem concludes:

"If it be certain, as Galen says,
And sage Hippocrates holds as much—
That those afflicted by doubts and dismays
Are mightily helped by a dead man's touch,
Then, be good to us, stars above,
Then be good to us, herbs below!
We are afflicted by what we can prove;
We are distracted by what we know—
So—ah so!
Down from your heaven or up from your mould
Send us the hearts of our fathers of old."

MEMORIAL ADDRESSES.

Delivered at the Annual Meeting of The Medical Society of New Jersey, Spring Lake, June 24, 1919. In Memory of the Three Officers of the Society who had Died During the Year.

AUGUST ADRIAN STRASSER, M. D.

Chairman of the Publication Committee.

By EDWARD J. ILL, M. D.

The president has directed that an obituary be written for Dr. A. A. Strasser. The writer knew Dr. Strasser intimately for sixteen years, during which time he was connected with the writer's department at the St. Michael's Hospital. He was a conscientious and pains-taking worker. He was ever ready to respond to calls and cheerfully so. His inclinations were to pediatrics, but surgery attracted him and he soon became so proficient that his work received our highest commendation. He was not only technically a good surgeon, but was interested in the pathology of what he removed, a rare trade in many surgeons of to-day. His energy and faithfulness no

doubt assisted in producing the illness which ended fatally. He died of apoplexy. on November 29th, 1918, in the house of my brother Charles, his friend for many years.

AUGUST ADRIAN STRASSER, M. D.

Doctor August Adrian Strasser was 44 yeras old and the son of John Strasser and Emma Binder. His parents were both born in Germany of good stock. Doctor Strasser was born January 11, 1874, in Jersey City, and graduated from the Jersey City grammer school in 1886, the Jersey City high school in 1891, and the New York University in 1893. He was a graduate of the College of Physicians and Surgeons, Columbia College, N. Y., 1896—was intern at St. John's Riverside Hospital, Yonkers, N. Y., 1896-1897, and practiced medicine in Arlington, N. J., from 1897 to the time of his death.

He was married October 11th, 1898, to Harriet Claus, and had two sons: August A. Strasser, Hans (John) A. Strasser. He was a member and ex-president of the Hudson County Society, a member and chairman of the Publication Committee of the New Jersey State Medical Society, an ex-president of the Academy of Medicine of Northern New Jersey and one of its trustees at the time of his death.

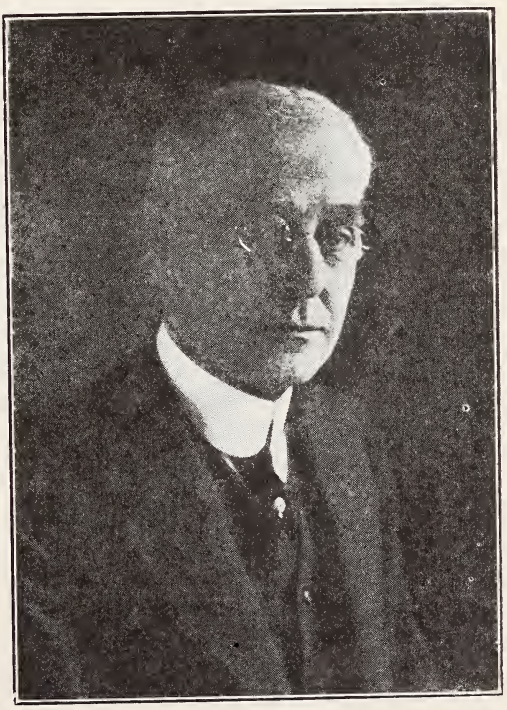
He was also an ex-president of the Pathological Society, and of the Physicians' Club and Trustee of the Society for the Relief of Widows and Orphans of the Medical Men of New Jersey. He was a Fellow of the American Medical Association, and a member of the Association of American Gynecologists and Obstetricians.

He was also a member of Deutche Medicinische Gesellschaft of New York, and an associate Fellow of the New York Academy of Medicine and Medical Director of the Stumpf Memorial Hospital, Arlington, N. J. He was a volunteer in the late war and First Lieut, M. R. C. He collopsed while in the service from physical strain.

THOMAS NEPTUNE GRAY, M. D.

Secretary of The Medical Society of New Jersey,

By Christopher C. Beling, M. D.



THOMAS N. GRAY, M. D.

Dr. Thomas Neptune Gray died on July 22nd, 1918. The Board of Trustees of the Medical Society of New Jersey met at the office of the President, Dr. Thomas W. Harvey in Orange, New Jersey, and took appropriate action by passing resolutions, which were published in the Journal.

Many appreciations of Dr. Gray and his work were spread upon the minutes of various medical societies and other organizations of which he was a member. All these posthumous recognitions set forth the high esteem and regard in which he was held

and the value of his service to the profession and the community.

Dr. Gray was born at Liberty Corner, New Jersey, on March 10th, 1854. His preliminary education was gained in the schools of Madison and Summit and in the Newark Academy. In 1879 he graduated in medicine from the College of Physicians and Surgeons, New York. He began practice in Orange and later associated himself with his father, Dr. William K. Gray, in East Orange, where he continued his work after the death of his father in 1896.

During the earlier years of his practice he served as editor of the East Orange Gazette, of which he was one of the founders. For some years he was the city physician of East Orange. Later he devoted himself specially to the study and treatment of diseases of childhood and contributed to its literature.

In 1914 he established himself in Newark as a consultant in pediatrics. In 1915 he was appointed director of the Division of Tuberculosis of the Health Department of Newark, and had complete charge of the Tuberculosis sanatorium at Verona until that institution passed into the control of the county. In 1916, in addition to his duties in connection with the Division of Tuberculosis, he was called upon to give his services to the Health Department as chief diagnostician during the epidemic of poliomyelitis. All through this trying period he personally saw most of the reported cases and never spared himself.

Dr. Gray was president of the Essex County Medical Society in 1912. In the same year he was elected Recording Secretary of the Medical Society of New Jersey, after having served as a Judicial Councilor for several years. He was a permanent delegate since 1909. He served as vice-president of the New Jersey Pediatric Society and was a member of the Practitioners' Club of Newark, the Practitioners' Society of Orange and several other societies. He was a member and trustee of the New Jersey Sanitary Association and one of the earliest members of the Society of Widows and Orphans of the Medical Men of New Jersey.

During the war he served on the Medical Advisory Board in Newark and was the secretary of the New Jersey State Committee, Medical Section, Council of National Defence.

Dr. Gray was a splendid type of physician, a rare combination of the old family practitioner and the modern specialist. His special work in pediatrics and tuberculosis showed the constant reflection of his wide general training and his broad sympathy. For him it was always the patient and not the case, not the fee to be gained but the service to be rendered. He was ever kindly in his manner, free and pleasant in his conversation and extremely fond of free association with his colleagues. Persistent and indefatigable in his work, he had very little time for any other interests.

The last few years of his life were ardently devoted to two main interests, the Medical Society of New Jersey and the cause of preventive medicine. The flourishing condition of the State Society is largely due to his faithful and efficient service. In the three years of his directorship of the Division of Tuberculosis of the Newark Health Department, he was unremitting in his efforts to educate as well as to safeguard the public against the disease.

Loyal to his ideals, firm in his convictions and outspoken in his views, he was always considerate of the opinions of others. In the words of his personal friend and colleague, our distinguished President, "future meetings of our Society will seem quite different without his presence and in his own county he is leaving a vacancy that cannot be easily filled. He has gone to receive the reward due one who has lived the life of a conscientious, hard-working Christian physician."

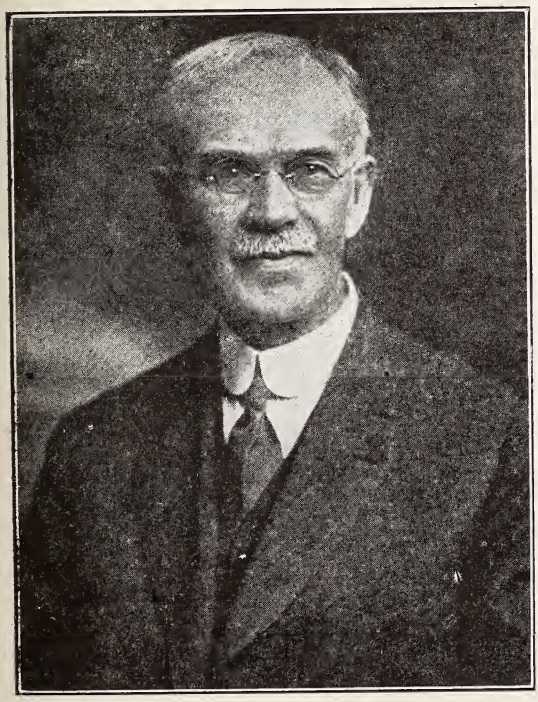
HENRY MITCHELL, M. D.,

Ex-President and Trustee of the Society,

By David C. English, M. D.

Dr. Henry Mitchell was born in Norwich, N. Y., August 6, 1845. He was the son of Dr. Henry and Mary Bellamy Mitchell. The father was for half a century the most prominent physician of Norwich and of Chenango County; he was also a member of the New York Assembly in 1828 and a member of Congress in 1832-1834. The son Henry was educated in the Catskill Academy and later in Phillips Exeter Academy; graduated from the Bellevue Hospital Medical College, N. Y., in 1866; married Elizabeth M. Roberts of New York, November 14, 1866; began practice in Norwich soon after graduation and while he was building up a good practice there, he decided to remove to Jersey City, in our State, and continued to practice there until 1879, when he removed to Asbury Park. In 1880 he was the prime mover in organizing the Asbury Park Board of

Health and served as its president from 1880 till 1894. Dr. Ezra M. Hunt, whom we all hold in grateful rememberance (the father of the State Board of Health and its most efficient organizer) said in his report of the State Board to the Governor in 1883, in speaking of the work in Asbury Park: "This city is an excellent example of what good administration can accomplish. The Board of Health there has for two or three years past had efficient organization and most intelligent oversight of health interests. Asbury Park has done and is doing very much to secure a thorough sanitary administration."



HENRY MITCHELL, M. D.,

Dr. Mitchell was instrumental in establishing a hospital for the care of cases of contagious diseases in Asbury Park. He was also a member of the Board of Commissioners of that city in 1886 and 1887, and was president of the Board of Trustees of the Public Library there.

Dr. Mitchell served as the executive officer of the New Jersey State Board of Health from 1894 until 1908 and his administration during those years was marked by the same thoroughness in organization and efficient administration. He was also one of the organizers and active workers in the New Jersey Sanitary Association; was its president in 1868. He was also president of the American Public Health Association in 1902.

Notwithstanding all his active work in public health matters, he never lost his interest in the medical societies with which he was connected; he took time to attend the meetings and to contribute toward their success, and this is especially true in relation to the The Medical Society of New Jersey. He was elected its third-vice president in 1900, delivering an address the following year on "What Administrative Measures are Practicable for the Prevention of Pulmonary Tuberculosis"; according to our rule he became president of the Society in 1903 and his presidential address at the next year's meeting was on "Preventive Medicine in New Jersey." Both of those addresses were able, scholarly and practical. After 1904 he was a Fellow and Trustee of the Society, he was regular in attendance even after he established his winter home in Daytona, Florida, he kept in touch with the work of our profession in New Jersey. He also labored earnestly to improve sanitary conditions in Daytona; a modern system of sewerage was established there, largerly due to his earnest advocacy and co-operation.

Truly an able physician; an eminent sanitarian, an active, practical citizen; a true christian gentleman, interested in the welfare of humanity, left us when Dr. Henry Mitchell departed on January 31, 1919.

The precious memories of his life and activities will abide with us and will be richly treasured, as will also be those of our departed members, Thomas N. Gray and August Adrian Strasser.

Clinical Reports.

Unusual Case of Gunshot Wound.—Dr. Fortunato Quesada, in La Cronica Medica, Lima, Peru, reports a case of a bullet in the anterior atlantoaxial ligament whose position was established by radiography, and which was impossible to remove by operation. It was left in situ, and the patient recovered.

Syphilis in Old Age.—Dr. Wile, in the Amer. Jour. of Syphilis, describes the case of a man seventy-nine years old, who exhibited a period of primary incubation of four months. Three months later his generalized eruption appeared. The features of interest in this case were the extreme age of the patient and the acquisition of the disease by coitus; the long period of primary and secondary incubation; the occurrence of glaucoma, due to specific iritis with rapid subsidence on treatment; the associated early nervous involvement without apparent clinical symptoms. A large percentage of syphilis in senile individuals belongs to the interesting group of accidental infections, and many of these cases for this reason are extragenital.

Multiple Chancres on Lips.

Dr. H. M. Robinson, Baltimore, reports the following case in the Med. Review of Reviews, as of interest because of the mode of entry of the invading micro-organism:

Case: M. J., aged 39. Widow. White. Born in Ireland; has been living in America thirty years. Occupation waitress.

History of Present Condition: About eight weeks ago, during coitus, patient was bitten on the lips, leaving two abrasions on the upper lip and one on the lower. These healed in about two days' time. Two weeks later patient noticed an itching on upper and lower lips, which she rubbed, causing a slight abrasion, which slowly enlarged and became hard. The top became moist and crusted, and when the patient was seen she had three lesions, each about the size of a dime.

Eruption: On the upper lip there are two lesions, one on either side of the mid line. On the lower lip to the mid line is one lesion. Edges are raised, infiltrated and round. The tops of the lesions are covered with a crust moderate in amount, brownish in color; on removal of crust a superficial ulceration was exposed with no exudate.

Spirochetes demonstrated.

Wassermann positive.

One dose of diarsenal 0.4 caused disappearance of lesion.

This lesion was of more than usual interest, because of another case about two months ago, of the same type, having only two chancres, one on the upper lip and one on the lower lip; the mode of entrance of the organism being the same, namely, that of a bite.

Gastric Syphilis.—Drs. Galliard and E. Mendelssohn of Paris, France, report the case of a man aged 55 years who had contracted syphilis at the age of 22. He began to complain of gastric pain at varying intervals after meals, with profuse diarrhea. The Wassermann test was repeatedly negative, and there were no tabetic symptoms. There was no hematemesis, melena, nor palpable tumor. X-ray examination showed the stomach free of adhesions but almost bilocular in shape, apparently through fibrous tissue contraction. Under eighteen intramuscular injections of 0.01 to 0.02 gram of mercury benzoate administered in the course of four weeks the bilocular appearance completely passed off, and with it the gastric symptoms and diarrhea. A series of intravenous injections of mercury cyanide was subsequently given in order to prevent recurrence.

Heteroplastic Nerve Grafts.

Dr. G. Roussy and Dr. A. Reverdin reported the use of heteroplastic nerve grafts according to the Societe de neurologie their results from to the method of Dr. Nageotte, i. e., using pieces of nerves removed from dead-born calves, the grafts having previously been fixed in alcohol. Roussy and Reverdin treated the following cases in this manner: (1) A case of paralysis of the internal popliteal nerve, the result of complete division of the nerve, in the middle portion of the thigh, with separation of the ends for a distance of 5 cm. (the external popliteal being intact). After freshening the two ends of the nerve, a nerve graft, measuring 20 cm. in length, taken from the sciatic nerve of a deadborn calf, was interposed. (2) A case of complete division of the ulnar nerve in the axilla, with a separation of several centimeters and a cicatricial neuroma on each end of the nerve. A 10 cm. long nerve graft, taken from a dead-born calf, was interposed. (3) A case of division of the ulnar nerve, associated with causalgia of the median, the result of a wound in the middle third of the arm. A graft, 5 cm. long, from a dead-born calf was interposed. (4) A case of neuroma of the ulnar from a wound in the forearm which would not permit of the conduction of impulses through the nerve. The neuroma was resected, the ends of the nerve were freshened, and a 5 cm. graft from a dead-born calf was interposed.

Mammary Carcinoma in Female of Thirty-four.

Reported by Dr. Stuart Graves, Louisville.

The following case emphasizes the necessity of physicians being on the lookout for carcinoma in young women. Two years ago I reported before this society a case of carcinoma of the cervix uteri in a woman twenty-one years old. In the present case the patient was not quite so young but considerably younger than the majority of women in whom carcinoma is supposed to occur, i.e., thirty-four.

I was called to St. Anthony's Hospital by Dr. G. A. Hendon to make a pathological examination of a section taken from a mammary tumor which he suspected was due to chronic mastitis or at least a benign adenoma; the tumor had a duration of about eight months. Dr. Hendon had seen the patient only a short time previously and had advised operation.

For the purpose of being certain about the diagnosis it was decided to make a section of the tumor before determining whether a radical operation should be performed. He first removed the tumor through a small incision and partially closed the wound while waiting for the pathological report. When I finished the examination and advised radical operation he seemed surprised because of the age of the patient and the lack of previous symptoms of carcinoma. Radical operation was then performed. Subsequent microscopic examination of the lymph nodes removed showed extensive metastasis in the axillary glands.

Irrespective of the older teachings, I would urge that every tumor in the female breast be removed regardless of the age of the patient. In the majority of instances the patient may be treated with more hope of complete recovery if the diagnosis is verified by the examination of frozen sections taken at the operating table, the character and extent of the operation being based upon the prognosis suggested by the microscopic examination.

Starvation in Pneumonia.

Dr. C. Joyce reports this interesting case in the Medical Jour. Australia, of a patient given only water for 13 days and making a good recovery.

J. M., aged 3½ years, a well-nourished boy, was first seen on March 20, 1918. The temperature was 39.7° C., the breathing labored and hurried. There was no sputum. The left lung was solid in the upper two-thirds. There were abundant fine, moist rales, and the breath sounds were tracheal in character, sug-

gestive of loud friction sounds. The bowels acted frequently. The motions were very offensive, green, with much mucus. The mother had given nothing but water for 24 hours. He gave calomel (60 mg.) and a mixture containing magnes, sulph. (one gramme), with extract of liquorice and peppermint water every two hours, until the motions became normal. Joyce saw the child again on the 22nd, and the temperature was 37.7° C., and the condition better in every way, though the motions were still offensive, but less frequent and watery. The patient was given the mixture every four hours, and, on improvement, to take barley water next day. This was done, and he had about 280 mils (½ pint), the only break in the water diet.

On the morning of the 25th Joyce was informed by telephone that the child was much worse, and he ordered the mother to bring him to the hospital. On admission the temperature was 40° C., the pulse 120 and the respirations 40. The child appeared to be desperately ill, quite apathetic, with pupils dilated and eyes kept closed, on account of photophobia. There was no rigidity of the neck, and the knee jerks were absent. On tickling the soles of the feet the whole limb was slowly drawn upwards. The left lung was not so dull, the breath sounds were lounder and harsher than normal, with scattered, moist rales. The right lung was now in the same condition as the left five days ago. No sputum appeared, it evidently being swallowed. The stools were brown, fluid and offensive. On March 27 the condition was the same. Calomel (60 mg.) was given, followed by magnesium sulphate (4 gm.) and a soap enema, which had to be administered daily henceforth, the first normal stool appearing on April 4, though the motions were not so offensive for some days before. Seeing that there was a condition of profound toxemia, water was the only drink given, while frequent spongings reduced the temperature and appeared to give relief. The temperature registered 40° C. daily, until March 30, and then fell by a rapid lysis, being normal on April 3. On April 4 milk and barley water were given. There was some rigidity of the neck muscles. A consultant agreed with Joyce that the child's condition was due to toxins from the lungs and bowels, and, while there was suspicion of a slight degree of meningitis, or at least meingeal irritation, that it was best to defer spinal puncture for the present. Recovery was slow, but complete.

Child Birth in a Well.

The Lancet (Feb. 22, 1919), reports a case of a child-birth in a well. The account was given by the mother of the infant, a girl aged 16 years, and is one of two documents supplied by the inspector of police in the district in which the occurrence took place.

This is the statement made by the mother:

I had left my husband's house and returned to my parents for my confinement. I began to have great pain and for seven days suffered agony. Fever was very bad in the village and most people had left it, so there was no dayee (nurse) or anyone to help me.

After I had suffered for seven days and nights I could stand the pain of existence no more, so without disturbing anyone I got up and went to a small well at the end of the compound and, holding the wall at the end of the well, let myself down and let go. I fell straight into the water and sank deep; then slowly rose to the surface and sank again. As I was sinking the second time my child was born, and I snatched it to my body and rose to the surface again. The walls were all within reach and I managed to catch hold of a projecting stone, and held myself up with the child pressed against me with my other hand. I did not call for help, but very shortly after this my father came and looked into the well and called, and I answered. Then he let down a basket and I put the child in and he pulled it up. Then he left the basket down again and I got in and he pulled me up. This all occurred at about 3 A. M.

The report from the inspector of the Deputy General of Police bears out the statement of the mother. The youthful mother and the child died about a week or ten days later, probably, from influenza.

Abstracts from Medical Journals.

Persistence of Gonococcus in Urethra.

Dr. V. Ribon, in Revista Medica de Bogota, warns of the danger of assuming that gonorrhea has been cured when the symptoms have subsided, as the gonococci may still lurk in the urethral glands and crevices. He describes how this can be detected and remedied by means of endoscopy, cauterization, copious permanganate irrigation, and massage with a stout catheter. He says that his remarks apply to both the male and female urethra.

Bone Grafts.

Dr. P. Mauclaire, in Presse Medicale, Paris, warns that a bone grafting operation should not be attempted until at least six months after the healing of a suppurating lesion. He found a small latent focus of osteitis in one case four months after apparently complete healing. The various technics that have been applied are reviewed and compared, and the results. In 128 cases of segmental grafts, complete success was realized in seventy-two. In his own twenty-four cases he has had eight successes, and explains that extraneous circumstances were responsible for some of the failures. If the graft is well nourished, it usually increases in size and the functional result is perfect. He prefers to introduce loosely the pointed ends of the graft into the marrow cavity of the long bone.

Tecnic for Lumbar Puncture.

Dr. Pontoppidan, in Ugeskrift fer Laeger, reports that lumbar puncture in a recent series of 100 cases was done alternately with the patient seated and reclining. Only 2.5 c. c. fluid were withdrawn, and none of the patients had any serious disturbances afterward. In 58 per cent. there was not a trace of headache or pain in the spine or other by-effects. This group included 35 seated and 23 reclining patients. In the others, presenting some by-effects, for from one to five days, the proportions between the seated and the reclining were about equal. In 6 cases the by-effects

were perceptible for from six to ten days in seated patients, and from six to eighteen days in 4 when reclining. These experiences show that the reclining posture has no advantage over the seated. They demonstrate further that it is not necessary to have the subject go to bed afterward. This was always advised, but the advice was seldom followed by out-patients.

Tracheotomy Without Loss of Blood.—Dr. Guthrie makes an incision in the midline of the neck from 1½ to 1¾ inches long. The incision must end one-half inch above the sternal notch to avoid the arcus of the anterior jugular veins. The skin and the superficial fascia are incised and the wound held open by a pair of catspaw retractors which should not be more than 1 inch in breadth. The parallel branches of the anterior jugular veins escape injury if the incision is made in the midline of the neck because they lie to either side of it. The sternohyoid and sternothyroid muscles are separated by blunt dissection. If care can be exercised during this step of the operation, the muscles can usually be separated without injury to the thyroid ima beneath. The retractors are reset. The left blade holds aside the skin, the fascia and the two muscles; the right blade holds the skin, fascia, the muscles and the thyroid ima vein. This exposes the trachea. It is incised, the head is straightened, and the tracheotomy tube inserted. This method has been employed successfully fourteen times in all types of cases.—Surgery, Gynecology and Obstetrics.

Influenza in Relation to Pregnancy and Labor.

In an article discussing influenza in relation to pregnancy and labor, Bland, P. B., in the Amer. Jour. of Obstet., gives a brief history of the past prevalence of influenza, the chief factors of the present epidemic, and tabular records of the results of the disease and pregnancy. His observations on the influence of influenza on pregnancy and labor and is effects upon the mother and child may be summaried as follows:

1. Epidemic influenza should be classified as the first and foremost acute infectious disease of our time.

2. No acute infection of the present day is associated with such a tremendous degree of morbidity of a high percentage of mortality.

3. No other acute infection of the present period is so prone to attack pregnant women as is this disease, and none more destructive.

4. Epidemic influenza, occurring in pregnant women, of a mild and moderate character, is not associated with grave danger to the mother or her gestation.

5. Influenza, when severe and associated with pulmonary complications, is an extremely serious affection and is associated with abortion or premature labor, in a large percentage of cases, frequently followed by death of both mother and child.

6. The disease in the mother is distinctly a contract infection.

7. Whatever is to be accomplished in view of our present knowledge of the disease, must be done by early and complete isolation.

Other conclusions upon the relation of influenza to gynecologic and obstetric conditions are presented by Lilian K. P. Farrar, in the Amer. Jour. of Obstet., as follows:

1. Mild attacks of influenza upon gynecologic or obstetric conditions.

2. Severe attacks of influenza produce menorrhagia or exacerbation of chronic gynecologic conditions, .

3. Severe attacks often cause abortion, premature delivery, or stillbirth.

4. Labor is prolonged and tedious.

5. Pregnancy has an unfavorable influence upon the course of a bronchitis or pneumonia in influenza.

6. Induction of labor has no beneficial effect upon the course of influenza.

7. The chances of general infection are greater if influenza occurs during the puerperium.—Boston Med. and Surg. Jour.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The annual meeting of the Atlantic County Medical Society was held January 9 at Hotel Chelsea, Atlantic City. The customary dinner following the business meeting was indefinitely postponed on account of the death of Dr. Emery Marvel, which occurred on January 7th.

Dr. William Edgar Darnall, chairman of the Library Committee reported that the library had increased in size and efficiency during the year. Dr. E. C. Chew for the Nurses' Committee reported that fees had been raised to $35 a week.

Dr. E. H. Harvey, for the Public Health Committee, suggested that meetings be held to explain the workings of the Municipal Laboratory, the Tubercular Clinic, and Baby Welfare Station, which have been established. He also suggested meetings for the discussion of the Workman's Compensation Law and State Health Insurance.

The Board of Censors recommended Dr. Royal E. Dunham for membership and he was unanimously elected.

The secretary-treasurer reported that nine meetings had been held, with an active membership increased from 97 to 111. The society purchased a Liberty Loan Bond of the third series.

Dr. W. Blair Stewart offered the following resolutions on the death of Dr. Emory Marvel:

"Dr. Emery Marvel, an honored and respected member of the Atlantic County Medical Society, died January 7, 1920. Always active in his profession and ready to respond to the call of a brother practitioner, Dr. Marvel was an untiring surgeon of unusual ability and success. He served with credit as president and in other official capacities in the Atlantic County Medical Society, and was a strong factor in promoting health activities in Atlantic City. His presence will be greatly missed in medical, civic and social circles.

"The Atlantic County Medical Society, in its annual session, January 9, 1920, adopted the following resolution:

"Resolved, That the society expresses its deepest regret at the loss of Dr. Emery Marvel and extends sympathy to Mrs. Marvel and the family.

"Resolved, That as a mark of respect to the memory of Dr. Emery Marvel, a full page of the book of records of the society shall be set aside as a record of this minute.

"Resolved, That a copy of this resolution shall be sent to the family and to the public press."

The society went on record as unalterably opposed to the Colby State Health Insurance Bill as proposed. But this did not carry with it opposition to the further consideration of the subject of health insurance.

A vote of thanks was extended to Hotel Chalfont and to Hotel Chelsea for their splendid hospitality to the society.

All the old officers—last years—were re-elected, and the chairmen of the standing committees were reappointed.

Drs. Allman, Ireland, Clark and Carrington were chosen delegates to the annual meeting of the State Society at Spring Lake this year. Drs. Senseman, Pollard, Salasin and Percy Joy were chosen alternates.

BURLINGTON COUNTY.

H. Eugenia Whitehead, M. D., Reporter.

The ninetieth annual meeting of the Burlington County Medical Society was held in the Parish Building of St. Andrew's Church, High street, Mount Holly, N. J., on Wednesday, January 14th, 1920.

The election of officers for the coming year are as follows:

President, H. Bartine Ulmer, Moorestown; vice-president, Daniel F. Remer, Mt. Holly; secretary and treasurer, George T. Tracy, Beverly; reporter, H. Eugenia Whitehead, Mt. Holly; Chairman of Sections: Medical Section, Elmer P. Darlington, New Lisbon; Surgical Section, H. L. Rogers, Mt. Holly; Diseases of Women and Children, A. P. Lore.

Delegates to State Society, A. L. Gorden, Burlington; G. H. Wilkinson, Moorestown. Alternates, H. G. Stroud, Moorestown; H. W. Bauer, Palmyra.

Delegates to county societies: Camden County, Joseph Stokes, Moorestown; Gloucester County, J. Boone Winterstein, Moorestown; Salem County, B. K. Brick, Marlton; Atlantic County, S. R. Maul, Riverside.

The Nominating Committee consisted of M. W. Newcomb, H. M. Bauer, J. B. Winterstein.

The new members elcted are H. D. Anderson, Burlington; Charles F. Voohis, Palmyra.

Three other new members were proposed.

The president, Dr. Stewart Maul of Riverside, made an address that was of special interest.

Marcus W. Newcomb of Brown's Mills, reported on the progress being made at the Fair View Sanatorium for tuberculosis, at New Lisbon, saying that several improvements have been made. New nurses are on duty, and there are eighteen patients at present.

A resolution opposing the proposed legislation for health insurance was unanimously adopted.

The dinner was served by St. Elizabeth's Guild, and the members present were well pleased. The ladies in charge were given a vote of thanks and it was decided to meet at the same place for the April meeting.

The Reporters of some County Societies have failed to send reports of meetings held.

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

The quarterly meeting of the Cumberland Medical Society was held at the Weatherby House, Millville, January 8th. The inclement weather prevented a full attendance. The principle speaker, Dr. E. J. Beardsley, who was to have discussed "Organic Heart Disease," was prevented from being present owing to the dense fog holding up the ferry boat in the Delaware pier. This caused especial disappointment on the part of the ex-army members, for they had been personally examined by Dr. Beardsley at Oglethorpe, Ga. Dr. Mary Bacon Leach, Bridgeton, and Dr. H. W. Baker, Vineland, were proposed for membership. Major I. E. Charlesworth, M. C., U. S. A., Honolulu, was present. Dr. H. G. Miller presented a case of hydrocephelus, in which the meninges protruded between the cranial bones and produced a huge meningocele in the occipital region.

Considerable discussion was occasioned by the "Insurance Bill." Dr. Winslow, Kauffmann and A. G. Sheppard were appointed a committee to attend the meeting of the Legislative Committee of the State Society in Newark, January 14. A delicious dinner was served in the Weatherby House during the evening.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Medical Society was held Wednesday afternoon, January 21st, 1920, at the Perth Amboy City Hospital, Perth Amboy.

The following new members, proposed at the previous meeting, were present, presented their diplomas, and were accepted to membership in the Middlesex County Medical Society. It was moved and seconded that the secretary cast a ballot for their election. Dr. Herbert L. Strandberg of 522 Amboy avenue, Perth Amboy, and Dr. Selden Talcott Kinney of 250 Main street, Perth Amboy.

A full report from Dr. B. M. Howley, chairman of the Legislative Committee, was received on the progress of the work being done by that committee, in this county, reference to the proposed "Health Insurance Act." Dr. Howley reported on the two meetings which had been held in Newark, of delegates from the various county societies and of the action taken at these meetings to secure a united effort, by all the societies, in opposition to the proposed legislation. It was regularly moved and seconded that a special meeting of this society be called at an early date, to which all the Assemblymen and the Senator from Middlesex County be invited, in order that this society might state directly to our representatives our opposition to the proposed legislation. Discussion by Drs. Silk, Sullivan and Tyrrell. Motion passed. The secretary reported that in reference to the resolution which was passed at the previous meeting, copies of which were sent to each representative of our county in the State Legislature, that the following members had sent answers: Assemblyman De Voe of New Brunswick, Assemblyman Raymond Lyons of New Brunswick and Senator Thomas Brown of Perth Amboy. No report was received from Assemblyman Appleby.

The paper of the afternoon was read by Dr.

Charles W. Naulty Jr. of Perth Amboy, N. J., Acting Assistant Surgeon United States Public Health Service at the Port of Perth Amboy, N. J. Subject, "Activities of United States Public Health Service in Middlesex County." His paper was a brief summary of the scope of the work as carried on and planned for in this section. The service was traced from its foundation in 1878 up until the present time.

MORRIS COUNTY.

Britton D. Evans, M. D., Reporter.

In Memoriam.

BRITTON D. EVANS, M. D.

One of the ablest, most faithful Reporters this Journal ever had. His departue is a great loss to us, to his County and State Societies and especially to the great State Institution which he served with conspicuous ability.

To him appointment to office meant the discharge of its duties to the best of his ability. —Editor.

UNION COUNTY.

Russell A. Shirrfes, M. D., Reporter.

A regular meeting of the Union County Medical Society was held at the Elizabeth General Hospital on the evening of January 14th, and was well attended. The legislative committee reported, commenting on the many undesirable features of the proposed compulsory health insurance bill, to be introduced at the present session of the legislature. After a free discussion, it was moved and carried that the committee be empowered to bring this subject to the attention of the public by holding meetings, procuring able speakers, and such other methods as they deemed expedient. An allowance of $150 was voted for this purpose. A committee appointed by the president offered the following resolution, which was adopted:

Whereas It has come to the knowledge of the Union County Medical Society that a bill to enforce compulsory health insurance will be introduced at the present session of the legislature, and

Whereas, We believe that this bill will be detrimental to the laboring man, and to the medical profession because it will provide inefficient medical service to the worker, and will seriously lower the standard of medical practice. As citizens and taxpayers we object to the proposed bill on the ground that it will require enormous expense in its organiaztion and administration, without giving in return, benefit to anyone commensurate with the expense involved; therefore be it

Resolved, That the Union County Medical Society express its unanimous disapproval of said bill, and that a copy of these resolutions be sent to the Senator and each Assemblyman representing Union County.

J. S. Green, S. T. Quinn, H. R. Livengood.

Dr. Prout spoke interestingly on the pressing need of additional accommodations for feeble minded children in this part of the State, and was appointed chariman of a committee to enlist the support and favorable action of the proper authorities on this subject

Dr. Frank Steinke addressed the society, reviewing his war experiences in France. A hearty round of applause marked the conclusion of his speech.

Several new members were elected, and other proposals for membership referred to the proper committee.

OTHER MEDICAL ORGANIZATIONS.

Medical Board of Jersey City Hospital.

At the last regular meeting Dr. Daniel T. Winter, visiting surgeon, reported a case of general septicemia with acute infectious arthritis obliterating and arteritis. The patient was admitted to the hospital October 11, 1919, and died November 1, 1919. She was thirty years of age and unmarried. Her blood count showed total red 4,240,000, total white 25,000. Wassermann, negative.

In her history, patient stated that her father died at the age of 67 of pneumonia; that her mother, three brothers and one sister are now living and well. One brother died in infancy; that during childhood she had measles and whooping cough; that she never had any venereal disease; that menstruation had not been painful until about one year ago, and that about the same time they stopped abruptly; that she had suffered from her present condition for about three and a half years; that the complaint started with an aching corn, then ankles, then knees, and finally every joint in her body pained her, including hips, elbow, shoulder, wrist, fingers, and jaws; that no joint after becoming infected ever cleared up; good appetite no abdominal pains, no vomiting, sore throat two or three days then clearing up only to reappear in two or three weeks, thirsty in the evenings, no cough, no cardiac discomfort. Previous to present illness feet and ankles would be swollen in the morning, but now they are swollen all the time.

Dr. Winters explained that he watched the case very carefully but was unable to make any progress against the disease.

Dr. Charles B. Kelly, assistant surgeon: Dr. Arthur P. Hasking, visiting physician in the psychopathic wards; Dr. Joseph A. Kopple and Dr. Leo. A. Kopple in charge of the genito-urinary department, and Dr. Margaret N. Sullivan, visiting in the gynecological department, each reported some very interesting cases.

778 cases treated during the month; 444 cases discharged during the month; average number of patients per day, 247; 3,839 cases treated in the clinics, of which 1919 were new cases; 225 brought to the emergency room; 328 ambulance calls; 3,933 patients treated in all departments.

Dr. John Nevin, the medical director of the hospital, is developing and adding new life and efficiency in this hospital's work. The nurses' department has 58 student nurses; five new courses were recently added: On infectious diseases, child hygiene, tuberculous disease, public health and industrial nursing. A large number of able lecturers and lectures on many important subjects have been provided.

SLOGAN.

Before formulating or enacting any legislation pertaining to the health of the Citizens of this State, the authorities should consult the doctors.

(Continued on page 68)

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Each member of the State Society is entitled to receive a copy of the Journal every month.
Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE—The transaction of business will be expedited, and prompt attention secured, if,—
All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to The Editor.
All communications relating to reprints, subscriptions, changes of address, extra copies of the Journal books for review, advertisements, or any matter pertaining to the business management of the Journal are sent direct to The Chairman of the Publication Committee.

Members who have failed to pay their annual dues, or the County Secretary or Treasurer who has failed to send them, when paid, to Treasurer Mercer of the State Society, will be blamable if the names of such members fail to appear in the Official List soon to be printed.

"I DON'T READ THE JOURNAL."

We are pleased to report that we have not lately heard that expression as often as we did a few years ago. Our members under the stress of war times were to a considerable extent wakened out of sleep and were compelled to notice what was going on in the medical world. We used to find on going into some doctors' offices two or three issues of our Journal and of one or two other medical journals, unopened on the shelves and we also found that those doctors were generally not buying any medical books—showing that they were not keeping abreast of recent years' marvellous advance in the profession, traveling in slipshod ways, and if attending society meetings, contributing little of value to them.

Today things seem somewhat changed, but even yet we are astonished to find how much ignorance there is in some quarters—for example—as to the iniquitous, disastrous health insurance law that the politicians and socialists are trying to force on the profession and the public. Evidently, a few are not yet doing much medical journal reading, and if that law passes they are the ones who will have to accept positions under it, at pay of six or eight cents per visit, with little time for rest and liability of legal prosecution for errors made in not obeying the dictator in charge.

But we turn from that class of practitioners—the exceptions that prove the rule—to the vast number of our members, the busiest, ablest and most progressive doctors who *take time* to read medical journals and attend medical societies' meetings and keep abreast of the times generally. We take this opportunity to thank many of them who have by word of mouth or by letter expressed their kind appreciation of our Journal, some assuring us that they read every page of it. A becoming modesty keeps us from quoting their expressions, as well as the words of commendation of the Manager of the A. M. A. Co-operative Advertising Bureau, Chicago, except to say that the latter expresses the judgment that our Journal is one of the best *advertising* journals that the Bureau receives. We commend that to the consideration of our present patrons and other advertisers, while we give credit to those who help us in our endeavors to make their Journal interesting and helpful, and urge them—especially secretaries and reporters of County and Local Medical Societies—to send us any and all matter that will tend to improve the Journal. We don't want any member to have a good, sensible, valid reason for saying—"I Don't Read the Journal."

OUR WORKINGMEN NOT PAUPERS OR CHARITY PATIENTS.

We query whether the proposed Compulsory Health Insurance Bill is an insult to the Workingmen of our State. The vast majority of them are hard-working, intelligent, thrifty, honorable workmen, good citizens, earning good wages and ready and willing to meet their just obligations. Why should they be placed in a cheap class, seeking to get "something for nothing," especially when the health and life interests of themselves and their families are involved? Why should they be deprived of the privilege of employing their own family physician—the ablest and best guardian of their families' health, the most competent guide and helper in family sickness?

Really the whole health insurance scheme is not an insurance provision; it is a vast charity scheme dishonoring to the working-

man and trifling with his health interests. We give the following extracts from an excellent paper by Dr. E. M. Stanton of Schenectady, N. Y., on "Some Fundamental Defects Inherent in Compulsory Health Insurance." See A. M. A. Jour., Jan. 24, 1920:

"The so-called compulsory health insurance is not health insurance at all, but only a thinly veiled scheme for forcing charity on a portion of the community which neither requires nor desires charity. At the same time the people who ordinarily need charity—those chronically ill, the unemployed, the aged, the widow, the orphans—are not provided for at all. In fact, they will be much worse off; for the available resources of the community will have been used up in forcing charity on the man with the job. I believe that history will fail to show a single example of a law forcing charity on employed working men which has not worked out to the detriment of the working man and served ultimately to enslave him. * * * *

"The fact should be emphasized that the moment we are forced to admit that the burden of compulsory health insurance cannot be borne by the insured, then the problem automatically becomes one more related to charity than to insurance. By no stretch of the imagination can the machinery proposed for compulsory health insurance be conceived of as an efficient method for the distribution of charity. The great political army of directors, secretaries, clerks, inspectors and others who would be called into being by compulsory health insurance is entirely too inefficient and expensive a proposition to be substituted for our present scientific development of state medicine and management of the charity problem."

THE WELFARE COMMITTEE.

The Welfare Committee has appointed Mr. Joseph H. Gunn of Newark, New Jersey, as the representative of the committee and of the State Society.

He will devote his time and efforts to completing the organization of the medical men of the State, and to protecting the interests of the profession in all matters that may come up before the State Legislature. He will visit each county in the State, and will ask the co-operation of the officers of the county society and of the "Committee of Five," recently appointed in many of the counties of the State, at the suggestion of President Dickinson.

The secretaries of the various societies and the chairmen of the local Welfare Committees, are urged to lend him every assistance in their power.

Now is the time for the doctors to get together and be united for one purpose. Already three measures, inimical to the welfare of the profession are prepared for introduction into the State Legislature. These bills are particularly vicious and threaten the welfare of the people as much as they do that of the profession. The Welfare Committee believe that this is the psychological moment, when the united weight of the profession may make itself felt in all matters of interest to the doctors. To bring success, however, requires the wholehearted assistance of every medical man in the State.

The Board of Trustees of the Medical Society of New Jersey met in the Board of Trade Rooms, Newark, January 14, 1920, Dr. O. H. Sproull, chairman, presiding. There was an unusually large attendance of the members. A communication was received from the Mercer County Medical Society concerning the Compulsory Health Insurance Bill, giving the action taken by that society.

Dr. T. W. Harvey, chairman of the committee on the Profession's Welfare, presented a report of the meetings and actions of the committee and recommended the adoption by the Board of Trustees of the resolutions approved by the committee, which were as follows:

1. That $1,000 be appropriated by the Board of Trustees for the use of this com-

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COMPULSORY HEALTH INSURANCE.

A PROPOSED LEGISLATIVE BILL THAT WOULD, IF ENACTED, PREVENT OR SERIOUSLY HINDER THE MEDICAL PROFESSION'S PROGRESS AND EFFICIENCY; THAT EXPERIMENTS WITH PUBLIC HEALTH ADMINISTRATION IN EFFORTS TO PREVENT DISEASE, SO THAT INCREASED MORBIDITY, MORTALITY AND POVERTY WOULD DOUBTLESS OCCUR, ESPECIALLY AMONG THE LABORING CLASSES, AND WHICH BILL, IF ENACTED WILL UNDOUBTEDLY LARGELY INCREASE THE TAXES OF THE CITIZENS OF THE STATE.

A POLITICO-SOCIALISTIC SCHEME, IMPORTED FROM AUTOCRATIC GERMANY, THAN IS UTTERLY UNSUITED TO THE SPIRIT OF AMERICAN DEMORACY, AND DAMAGING TO AMERICAN INSTITUTIONS.

mittee until the next annual meeting of the State Medical Society, to be used for the employment of a competent representative who shall operate under the direction of this committee, the object being the perfecting of the organization of the Profession and for placing them in a proper light before the public and to give publicity to such matters as may be of importance to the welfare of the Profession.

2. That this committee go before Governor-elect Edwards and present the resolution adopted by the Essex County Medical Society, that a medical man be appointed on the State Board of Institutions and Agencies, and that the Medical Society of New Jersey be consulted in making such an appointment.

3. We advise that the influence of the Medical Society be used to oppose the passage of the Compulsory Health Insurance Bill, through its regular committees or through special counsel and that $1,000 be appropriated for such purposes and such further sums as the Board of Trustees shall approve.

Dr. Harvey also reported that a conference was held by the committee with the members of Mr. Colby's commission to discuss the bill proposed to be introduced into the State Legislature this year.

He presented to the Trustees the following objections of the Welfare Committee to this bill:

1st. That the bill provides sickness benefits and medical care for "all persons who are employed or operate" in any of the various plants mentioned in the bill, making no distinction as to amount of pay that they may receive, or how capable they may be to pay their own bills; but does nothing for the many poor who are not employed in such plants, and are just as liable to need public care, and are more liable to be unable to pay for it.

2nd. This bill creates an autocratic bureau, responsible alone to the Commissioner of Labor, who is empowered to create such a bureau; to choose its personnel; to make all appointments; to have entire charge of its finances; to determine the premiums to be collected; to determine the benefits to be paid; to arrange for the medical care, appointing the doctors, determining the fees to be paid and the amount of service to be rendered. There is given to one man supreme power in establishing and administering a department of vital importance to the health of the citizens of this State and yet, no provision is made that this man should have any technical knowledge in such matters, nor is he required to consult others who have such technical knowledge.

3rd. This bill will add greatly to the burdens of taxation in this State, without yielding any benefits to its citizens at all commensurate with its costs.

4th. In all countries where legislation such as is proposed for in this bill has been adopted there has been as a certain result: A great depreciation in the scientific character of the average medical man's work; the creation of a tremendously burdensome medical bureau which inevitably tends to become autocratic and offensive both to patient and to doctor.

After a thorough discussion, the recommendations of the Welfare Committee were unanimously adopted.

Dr. Harvey also reported that on January 20th a hastily summoned meeting of members of the State called by the President met in the Newark Board of Trade Rooms with different sections of the State represented, and that at that meeting as well as at a meeting of the Essex County Society the Colby bill was well discussed and at both gatherings a unanimous vote was passed against the passage of the bill by the State Legislature.

At the Essex County Society meeting it was urged that the Welfare Committee appointed by the State Society should be supplemented by the selection of President Dickinson of five members from each county society to confer at an early day and whenever called by the committee.

The Board of Trustees unanimously approved of the President's action in response to the action of the Essex County Society.

Delegates were present from the New Jersey Pharmaceutical Association offering to support the State Medical Society in opposing the passage of the Health Insurance Bill.

After the adjournment of the Board of Trustees meeting, a largely attended conference of the Welfare Committee and the members of county societies selected by President Dickinson was held when the Health Bill was thoroughly discussed; many excellent suggestions were made as to methods of defeating the bill, which were referred to the Welfare Committee for final action, in which co-operation by the county societies' members was assured.

A report of the Mercer County Medical Society, and other matter, was received too late for insertion in this issue of the Jour-

nal; the former was sent to the Secretary, to South Orange, instead of to the Editor, New Brunswick.

Annual Conference on Medical Education and Licensure.

The next conference on medical education and licensure will be held at the Congress Hotel, Chicago, under the auspices of the Council on Medical Education of the American Medical Association, the Association of the American Medical Colleges and the Federation of State Medical Boards of the United States, on March 1, 2 and 3, 1920. Instead of the three separate disjointed programs as heretofore there will be a single program, thereby avoiding conflicts and duplications. Papers have been carefully selected and discussions will be more effectively directed. The program is outlined in the A. M. A. Journal, Jan. 17, page 196.

It is expected that the conference will be immediately followed by the annual meeting of the American Conference on Hospital Service.

Hudson County Legislative Committee.

Minutes of a meeting of the Legislative Committee of the Hudson County Medical Society held at the residence of Dr. John Nevin, Jersey City, Wednesday, December 24, 1919.

All of the members of the committee were present. A delegation representing the Essex County Medical Society, and the State Medical Society, having been invited to attend the meeting, were also present.

Dr. G. K. Dickinson opened the meeting and explained that the object of the meeting was to present to Mr. Albert C. Wall, Counsel of the State Society, the objections of the Medical profession to the passage of a bill to be presented to the New Jersey Legislature known as the Health Insurance bill. Dr. Dickinson requested Mr. Wall to give the members his opinion of the bill from a legal point of view.

Mr. Wall stated that the only proper way to explain the bill was to take it up section by section, and this he proceeded to do. He informed the gentlemen present that every bill presented to the legislature is accompanied by a statement which is supposed to give the meat and purpose of it. He then read the statement appended to the proposed bill, at the conclusion of which reading he stated that the bill has a very fascinating quality, just as the Compensation Act has, by putting a burden on the particular industry and letting them figure the cost of an accident like the depreciation of a machine, and then adding it to the cost of the commodity, instead of spreading the cost of taking care of people injured throughout the community, and adding it to the cost of the community, with the clumsy method of using the State and city facilities. This act provides for a system of insurance which shall be contributed to equally by the employer and the employee.

The title of the act was then read by Mr. Wall, at the conclusion of which reading he stated that the title of an act in New Jersey is quite important, because the scope of the act must be in the title, and if there is anything in the act which is outside of the title it is unconstitutional. There is a pretty broad system laid out under the title of the act under consideration.

The first section creates a Bureau of Health Insurance and sets up the power in the Department of Labor, with the Commissioner of Labor as the head of the Bureau, and provides for subordinates and chiefs of divisions when necessary, these appointments to be made by the Commissioner of Labor.

Section 2 provides that on and after July 1, 1920, all persons who are employed as operators in any newspaper plant, etc. (which are not covered by the Workmen's Compensation Act, or in which liability for damages, compensation or other benefits is imposed by act of Congress) shall be designated therein as insured. This section is wide in its application and applies to practically all of the industries where machinery is used to any extent, or where there is any hazard of employment.

Section 3 makes the owners and controllers of these factories, etc., subject to the provisions of the act. Mr. Wall also read Sections 4 and 5 of the act.

Section 6 provides that the Bureau may make such rules and regulations as may be necessary for the proper carrying out of the provisions of the act. That is a blanket provision which has come into vogue because of its extensive use in many of the Federal Acts during the recent war legislation. It is a departure from the way that these laws used to be drawn. The old idea was to actually provide a guide for all that was to be done under an act. This sort of method indicates what they intend to do, and then it says factory workers go ahead and make such regulations as seem fit under and within the law; we give the power. The experience of most people in their dealings with the federal government is that they are inching all the time. The power always wants more power. They never come to ask to have it limited. They are always inching their powers. The power to make rules and regulations, in matters of this kind, where they are dealing with health and physical welfare, is a power which you gentlemen should view with some alarm. It can be carried a great distance. If the act becomes a law, the courts will be unable to give you very much assistance. The courts do not pretend to know more about your business than you do, but when you go before them they will say you have a law, all we can do is to see that the provisions of the law are carried out.

In reply to a question by one of the gentlemen present, Mr. Wall stated that the Department of Labor was not the proper department to place a bureau of this kind under the control of; that it leaves it open to politics and also to the internal government of labor which is reaching out for power. The Board should be as far removed from Labor and Capital as possible.

Section 7 was then explained by Mr. Wall. He stated that the trustees will not amount to anything as they will be figureheads in the management of affairs, and that the real management will be in the hands of labor.

Sections 8, 9, 10, and 11 were explained by Mr. Wall and he stated that the criticism of Section 7 applied to these sections. Section 12 was read by Mr. Wall without any statement.

Section 13, Mr. Wall stated, invested the Bureau with great power. He called attention to

the fact that the regulations governing the operation of this section are not set forth in the bill, and will be adopted after its passage. They always provide for their salaries being paid. In this case the salaries will not be paid from the premiums, but from State appropriation.

Section 14, Mr. Wall stated, shows that the bill is quite close to the heart of labor.

Section 15. In discussing this section Mr. Wall stated that it provided a system similar to that in practice on the railroads and other industries, where a relief fund has been started. The men do not have to join but all of the employees are in favor of their joining.

Section 16. Now this section is one that puts in the edge of a wedge that labor has long been looking for. One of the things they have endeavored to accomplish is to make the employer collect the dues for the various labor organizations the employees belong to. Employers have resented that, but this accomplishes the same idea, because the employer must pay the money in both for himself and the employee. After such compensation is paid he may deduct the amount, and must inform the employee in a method to be determined. In other words the employer becomes the collector for the Bureau.

Section 17. It would seem as though that gave the Department of Labor a certain judicial right.

Section 18, 19. It would seem as though that gave the Bureau an unfair control over the industries, because they can make fish of one and flesh of another. Instead of a law applying to all firms alike he can so arrange matters as to permit him to say your hazard is so much greater than the other men that you will have to pay this much. That is a drastic power. A hazard can be classified, but it is another thing to say that that particular industry and employer shall pay such a percentage because you find his hazard greater. The penalty for violation of the section does not impress me as being fair inasmuch as we do not know the regulations of the Bureau as yet.

Section 20. It seems to me as though that part of the section relative to the twenty-six weeks is rather carefully put.

Section 21. That, of course, is rather important to you gentlemen. It permits the fixing of a rate of compensation for the doctor, and some physicians will do it at that rate, and the fact that they do will reflect upon the amounts charged for services entirely outside of the scheme. You are bound by these rates practically.

Sections 22-23. Mr. Wall stated were closely related to the preceding section, and the same criticism would apply.

Sections 24-25-26 were discussed by Mr. Wall, and he called attention to the fact that the policy of the State was involved in these sections. That if a person were to recover damages for injuries received, the bureau could recoup the amount expended by it out of the damages received. He also called attention to the provision relative to the operation of the law in connection with the operation of the Compensation act.

Section 27. It seems a curious thing for a bureau constituted as this to have such wide powers of making appropriations for prevention of disease and the education of the employer and employee in disease prevention, etc. There is no limit to that idea. It might be a foolish idea, but this Board should not have the power to say an appropriation shall be made. That this provision is unquestionably a scheme to increase the amount they can demand from the State.

Section 28 was not discussed.

Sections 29 and 30 Mr. Wall stated were unfair to say the least. That the rules and regulations of the Bureau have not been stated and the physicians do not know what they will be.

Mr. Wall concluded his remarks by stating that the whole act is right in line with the theory of collective bargaining.

Dr. Nevin stated that at a recent meeting of the Hudson County Society the consensus of opinion was that the bill should be defeated, and for that reason a committee was appointed to draft objections to the bill.

Dr. Quigley, chairman of the committee, at this time read the report of that committee, which report is as follows:

To the Legislative Committee
of the Hudson County Medical Society.

Your subcommittee met on the evening of December 20th, and carefully considered in detail the scheme of Health Insurance as embodied in the tentative draft of legislation to be presented to the Legislature of this State at its present session, furnished by Mr. Colby. We feel that while we are not prepared to gainsay the existence of conditions in the more poorly remunerated class of our population which deserve the utmost in the way of well-considered efforts looking toward their amelioration, the general scheme of compulsory health insurance as advocated variously in this country is not well considered, and that the present tentative draft is particularly open to most serious objection.

Coercion of any degree, of the individual is so distinctly un-American that it has never been invoked in this country except in the direct public emergencies; it will be noted that when the Federal Government offered to its men in service during the stress of war, what purported to be on paper, at least, the most advanced provision for the avoidance of widespread want and dependency ever up to that time enacted, that is, the War Risk Insurance privilege, it wisely left its provisions optional to the insured; further, the fact that even so excellent a system did not attain widespread popularity is evidenced by the overwhelming proportion of such insurance, since discontinued; co-operative medical service as represented in lodge practice has never been sufficiently popular in this country to warrant the belief that it proves satisfactory to its supposed beneficiaries; state co-operative medicine in Europe has proven so unsatisfactory after extensive trial both on the continent and in England to both the members of the medical profession and the subjects of its alleged benefits that in Germany not only the physicians, but even the advanced Socialists are repudiating it, and in England there is widespread discontent, and eager search for betterment of

the present existing legislation; to compulsorily foist on even a portion of the public so unsatisfactory a system constitutes a most objectionable form of coercive legislation.

Paternalism has always been stultifying to the individual; the German prototype of the present proposed legislation was confessedly devised to, and has in fact resulted in, the shackling of individual initiative among the workers, the results of which are seen in the terrible sinking of the individual in the mass exemplified in the German militaristic system, the reaction to which is apparent in the chaotic and revolutionary phase which that country is now experiencing; moreover, American experience with the operation of paternalistic activities as represented in the Government operation of transportation and other utilities, the War Risk Insurance Bureau, the Government allottment system, etc., has been invariably fraught with incompetence and scandal; and with undue expense for the service represented, to the individual; so the present proposition would open up a wide opportunity for State-wide graft, incompetence in administration, delay, red tape, and unduly high cost to the beneficiary of benefits available.

This scheme further introduces State-wide contract medical practise with all its attendant evils to both practitioner and patient; for the practitioner it means elimination of all the inventive to individual excellence which healthy competition represents, loss of morale due to the hopelessness of limited routine practise and hardship due to niggardly income possible under such a system—an income less than that of an ordinary artizan; without prohibitive premiums it means removing from his resources in treatment the aid of chemical, bacteriologic and x-ray diagnostics; it would stultify research; it would remove medicine from the desirable fields of endeavor for the prospective student; for the patient it would mean primarily the lack of choice of his own attendant and destroys absolutely that personal relation and strong feeling of confidence between doctor and patient which has always been recognized as so powerful a factor in the attainment of best results of treatment; it would limit him to the services of one whose mentality had been blighted by the stultifying influences outlined above, and whose interest in him as an individual would be subordinated to the resentment against a system which artificially forced that interest.

The present draft is as a whole entirely tentative, vague and indefinite, and yet shows by certain integral evidence that the framers in drafting it were aiming at legislation precisely on the lines of the vicious bill introduced in the New York Legislature; thus the last paragraph of Sec. 21 is a practically verbatum quotation from the New York bill, and in Sec. 9, terms are used which have no definition in the present draft but which represent portions of the scheme of organization definitely specified in the Davenport-Donohue Bill, which it is estimated would cast the people of New York State annually some $93,000,000 in increased taxes, and reduce the members of the medical profession there to drudges of the status of inexperienced bank-clerks.

It is vicious in that it proposed legislation purporting to broadly affect the health of the people without consultation with the medical profession which is best qualified to advise in such matters, upon whom the successful operation of the work would depend, and whose material welfare the legislation might vitally affect.

That it creates a new bureau under a department directly and narrowly concerned with the welfare of a portion only of the population to administer matters of the public health which should be dealt with on the basis of the welfare of the whole population by the same agency, the State Board of Health, whose function is to deal with all other phases of the public health.

It imposes on the employer a direct tax which yields him no direct benefit, in relation to conditions which it is not shown he is in any way responsible for; this tax must inevitably be passed on to the whole public of consumers.

It gives plenary powers to the Commissioner of Labor to create and operate a vast system involving enormous public expense and affecting the interests of a considerable portion of the people, without adequate preliminary investigation, estimation and limitation; the bestowal of such unlimited authority on one subordinate officer of the State government is unusual and dangerous, and should in any case be accompanied by the presentation of an intelligent and comprehensive outline of the organization of such a system, including cost of administration, expenses, salaries, etc.

It taxes for the operation of this system, in an amount not specified, but necessarily enormous by direct drain on the public treasury, the whole tax-paying population for the direct and exclusive benefit of a portion only of the population, which portion is not necessarily more greatly in need of such benefits than are other portions of the people so taxed.

Part of this tax for operation, moreover, is provided to be spent in educational propaganda, the need for which is not shown inasmuch as it will in large degree duplicate similar propaganda already in operation under the United States Public Health Service, State and municipal Boards of Health, private agencies of various kinds, etc.

Your subcommittee therefor strongly urges that your committee use its influence to the fullest to defeat the present passage of the legislation now pending, and to delay any legislation looking toward health insurance under State auspices until properly appointed and qualified commissions or other investigating bodies shall have had opportunity to study, with the fullest co-operation of our own profession, the entire field of the need of such legislation, and the practicability of meeting that need by any such system, and to devise if necessary such a system as shall be equitable on all classes, and efficient in its application.

Elks' Club, Jersey,
December 20th, 1919.

F. J. Quigley, B. J. Pollock, S. A. Cosgrove.

Dr. Dickinson at this time complimented the committee upon the completeness of the report. He asked Mr. Wall what the attitude of the lawyers would be if a similar bill were introduced to apply to the legal profession,

thereby preventing a man from choosing his own lawyer?

Mr. Wall replied that the lawyers would undoubtedly resist any such attempt to interfere with their business, but he did not believe that they could resist as effectively as the doctors can, and pointed out that in a great many instances the court appoints counsel to represent the defendant in a criminal prosecution. The lawyers would certainly feel insulted if such a thing came to pass. The relation of the doctor to his patient and the patient's confidence is one of the things that no man can set the limits of in the cause of disease.

Dr. J. J. Broderick said that assuming that this law is passed it could not operate without the assistance of the profession, and assuming that no one member of the profession would take office under the provisions, where would our friends be at.

Dr. D. C. English stated that in his opinion the members should not take the stand that their income will be affected, as that is not the all-important thing in the minds of the legislators of any state, or in our minds as physicians; but a statement to the effect that there will be no inducement to young men to take up the profession, and that in ten years' time we will not be producing the high-class physician and surgeon, would be a perfectly proper statement; that at the present time there is a dearth of physicians throughout the country. In our argument it can be brought out that it is going to destroy the profession's scientific standing and efficiency in the years to come.

Mr. Wall: Of course, when you oppose it, you want to oppose it with the arguments that will be most effective. I should think that one of the best plans would be to get Dr. O'Reilly or someone like him to supply the material. You should have many branches of attack. The doctor's argument about not placing too much stress upon the loss of revenue to the profession, and placing stress upon the disruption of the profesion in future years, is in my opinion a good argument. Your objections should be based on substantial grounds.

Dr. English called the attention of the Board to the fact that Andrews from New York is at the bottom of the New York law. He was at the conference in Harrisburg and made a strong speech all on the side and in favor of labor; that it was amusing to hear him address the Pennsylvania State Medical Society at its meeting on the next evening. He said on that occasion, "Of course we don't want any law that does not satisfy the medical profession."

I do not believe that there is a profession in the world so unselfish as the medical profession. The medical profession is and has been active in preventive medicine for years. There is not another profession that has done so much for the world. I think we should show that it is not only objectionable to us, but that it is going to be disastrous to labor itself. It means giving this or that labor man poor service. There is the great point. An investigation conducted in Germany showed that the doctors at that time received eight cents a visit under this system and gave three minutes of their time on the average to each patient. My main opposition is that it is striking down the standing of the medical profession scientifically. A physician will not have sufficient time for study and research for the development of the profession in the manner that we have conducted ourselves in the past. It is going to hurt us financially, but it is going to track down our profession, seriously lessening its efficiency. He said that Ex-Senator Colby represented that the physicians of England were satisfied with it. I stated that we preferred to wait until Mr. Hoffman got home from England to decide that point. My information is that they are not.

Dr. Cosgrove: I want to suggest that to deal with this matter properly we have to recognize something of the other fellows stand point. In the State of Pennsylvania they have a commission appointed to investigate the bill relative to this thing, and that commission as constituted has representatives of the medical profession and other interested parties. That commission has done a great amount of work and has gathered a great amount of material. Some of this appeared in a recent edition of our Medical Journal. In spite of their work and their results that commission has requested at least another year within which to complete their work before they will be in a position to make any recommendations. If their findings to date are correct, then the labor people and kindred organizations have some right to feel that conditions existed which should be investigated, and we should not overlook that fact.

There is an insistant demand for relief and that relief is going to work itself out in some form. Our operations will be to get a Board and try to shape that relief wisely. Don't let us clutter the other fellows point of view in our consideration of the matter.

Mr. Wall stated, in answer to a question, that if we can show that the work the people will receive will not be valuable the objection to the bill will get somewhere.

Dr. English stated that this bill was prepared with the idea of increasing the efficiency of the laboring man and returning him to his work promptly; in his opinion labor will not suffer as much in the future as it has in the past because of men being confined to their homes with sickness. Prohibition has already shown a marked decrease in the number of hospital patients. Many more cases of absence from work will be eliminated as time goes on, through efforts that are being made to improve housing conditions and the wiping out of epidemic diseases.

Dr. Nevin: I think that another good point to make in opposition to the bill is the question of the possible expense of carrying out its provisions. The bill should read "An Act to provide a system of benefits for the Commissioner of Labor and His Employees." I remember Dr. O'Reilly estimating that in New York State in carrying out the provisions of the law it would amount to $196,000,000 a year. If we can show the people of the State that we are going to have any expense such as this there will be a great deal of opposition. I have taken the matter up with the Governor-Elect and he was in a very receptive mood. I requested an interview from a committee of this Society. I don't know whether it is wise to have one appointed here or from the State

Society. I would also suggest that Mr. Wall give us some idea as to other points to be brought up from a legal point of view.

Dr. Dickinson asked Dr. English if the State Society would be willing to finance the question with Mr. Wall, stating that he understands the views of the members present who represent practically the three largest societies. Dr. English stated that of this he could not answer, but he would place the question before the committee and let the doctor have an answer as soon as possible.

Dr. Dickinson volunteered the information that pending the answer of the State Society to the question, the Hudson County Society would retain Mr. Wall, but he believes the matter should be a State Society matter.

It was suggested by Mr. Wall that a committee composed of representatives of each county society, and if possible of each municipality, present the matter to the Legislature. This plan he thought would carry a considerable weight.

Dr. Quigley stated that the bill not only affects the medical profession, but it also hits at the business men of the State, and that they should be aroused and interested.

Dr. Nevin stated that he had already taken this question up with the Chamber of Commerce of Jersey City and one or two other municipalities and he believed that the objection of those bodies would gain momentum.

"THE EVOLUTION OF MEDICAL PRACTICE OR WHAT AILS THE PROFESSION."

Dr. C. J. Whalen, Chicago, Editor of the Illinois Medical Journal, in a recent editorial with the above caption. gives the following pertinent paragraphs concerning physicians' achievements and present conditions:

"Let us study the signs of the times for a moment and see if there is any manifest reason for this dissatisfaction and unrest among physicians?

Diphtheria antitoxin has materially reduced sickness and mortality.

Typhoid fever, which was at one time a scourge, has reached the vanishing point.

Destruction of the mosquito has prevented malaria and yellow fever.

The control of plague is now an accomplished fact.

Improvement in the milk and water supply of cities has materially reduced morbidity from intestinal diseases.

By early recognition and hospitalization tuberculosis morbidity is being materially reduced due to the world-wide campaign of prevention.

Hookworm disease is now readily curable.

Puerperal fever is to-day as rare as it was formerly common.

Typhus fever no longer exists in America.

Scientific midwifery by dispensary physicians teaching dependency on state support.

Visiting nurses for ordinary sickness, thus helping families to self medication.

Tenement house inspection preventing diseases due to overcrowding.

The Pure Food and Drug Law.

School inspection helping to eliminate infection.

The regulation and suppression of alcohol consumption.

The fashion for fresh air and outdoor sleeping.

The disposition to work along lines of prevention, rather than cure.

The overcrowding of the profession caused by the lessening of morbidity.

The abuse of medical charity by hospitals and dispensaries is familiar to physicians and experience has cost them dearly.

The various forms of contract practice that are becoming firmly rooted and have reduced the fee for visits in the East to six and one-half cents.

Note the injustice heaped upon the profession by the Harrison Narcotic Law in placing a tax of $450,000 a year on the profession for protecting the public—said law being a public health measures for the benefit of the public and for which the public should pay and not the doctor.

Note the after-the-war program of the Red Cross that having the money they proceed to carry on the socialistic scheme of taking over all extra governmental health agencies and immediately proceed to the regulation of everything and everybody gratuitously.

Note the after-the-war program of the United States Public Health Service in their attempt to duplicate the socialistic dream of the Red Cross and go them one better if possible.

How many physicians have not experienced unfavorably the enveloping tenacles of the insurance octopus? We doubt if there is a physician who has not within a year had under his care a surgical case of some nature and for which he had charged only a reasonable fee, and upon recovery an insurance company steps in as the representative of the patient and informs him that his charges are exorbitant and threaten him in various ways; that finally he has to accept the small pittance they see fit to give, otherwise he gets nothing.

On the other hand note the persistent trend of sociology to make the care of the sick the function of the State. Our present experience with the narcotic law has taught us that it is unsafe to attempt to treat an addict in private practice.

The government deputies hounded physicians in an unbecoming manner, agents went so far as to lay bait and appeal to the humanitarian side of the physician and afterwards prosecute him because he was at least human. Some of the methods used by the government officials would be unbecoming even the worst shyster lawyer in the community.

To illustrate further the attempt at state control of medicine note the doctors' every day experience in the present day trend toward hospitalization of the contagious disease sick.

Note the free distribution and free (if requested) administration of antitoxin and serums.

Note the widely heralded campaign by the government and state for the free treatment of venereal disease.

Note the rapid growth and development of institutions like the Psychopathic, county and municipal hospitals for the care of the sick but not necessarily poor. These are all operating to bring about the state control of medicine.

We have mentioned but a few of the factors effecting the profession unfavorably. We could go on almost indefinitely enumerating conditions that are developing to such an extent that they interfere with the future welfare of the physician."

Editorials from the Lay Press.

Compulsory Health Insurance.

(From the Newark Evening News, Jan. 10.

"It's coming, anyway," declare the advocates of compulsory health insurance, implying that resistance is futile and that those who would oppose it are mere obstacles in the path of reform. These prophets have the right to their convictions, and they may assume the hazards of prophecy if they choose. But at least this may be said by the neutral observer—if compulsory health insurance does come it will depend for success upon certain human factors that may be ignored or brushed aside in the beginning, but cannot be eliminated in the end.

In outline, compulsory health insurance applies its compulsion not merely to employers, but to employees and to physicians as well. It requires employers to pay one-half the cost of the benefits and medical and surgical treatment; it requires employees to pay the other half; it compels physicians to sell their services as directed and for a fixed price; it compels employees to accept the services of the selected physicians. All this compulsion is advocated on the ground that those who most need medical and surgical care are the great body of working men and women in industry, and that there is no other way to satisfy that need. If this were wholly true, then compulsory health insurance would be desirable, with one proviso; it would be desirable if it would work.

But it is not wholly true that the sick of industry are not now able to obtain medical services. Not to speak at all of provisions voluntarily made by numbers of employers, there are few working men and women who cannot now obtain medical services from their own physician on terms they can afford to pay, who cannot now secure hospital treatment, who cannot now have necessary operations performed, either free or for a moderate fee. But voluntary assumption by employers of the burden of helping sick employees is now the rule rather than the exception in modern industry, and group insurance has developed largely as a part of this.

It is certainly a question whether the relation of patient to physician would be improved if the patient wer restricted to the services of the assigned physician. Sick people like to choose their own doctor, and the exercise of this choice, with the personal understanding that results, itself is a factor. People get well quicker when their physician takes a personal interest in them. The fact that sickness is an expense tends in general to conserve health.

More serious than any of the foregoing objections to compulsory health insurance is the reaction on the medical profession. Already we have district physicians, lodge and company physicians. Let us ask those who receive the services of these physicians, let us ask these physicians themselves, whether the patients obtain the best that the medical profession has to give, under a system that reduces service to a salary basis and destroys all relation of service to compensation in the individual case. Yet under compulsory health insurance the best that the system would provide would be no better than the average of the lodge practice.

Reputable physicians find in their profession a dual incentive—making a living and serving society. Those who succeed by their skill make more than a living, but at the same time a large part of their labor has always been given to ill-compensated service. Some of the greatest practitioners are also some of the greatest humanitarians. A good part of the services ordinarily rendered by physicians is rendered for a compensation altogether too small in proportion to its value.

The best physicians and surgeons, therefore—the best in the full sense, because they are successful in their profession and because they also discharge their duty of service to the less fortunate—already are doing as much as may fairly be expected of them in the way of underpaid service. And they are doing this of their own free will and as part of a self-assumed obligation. Men of this sort will not give the same quality of service under compulsion. That would be contrary to their temperament and habit. It ought not to be expected of them.

Who, then, will serve as physicians for small fees under compulsory health insurance? In the main, human nature tells us, it will be physicians of the inferior order, who have comparatively little skill and comparatively little sense of responsibility. And how would that help matters?

The political aspects of compulsory health insurance also must be considered. The administration will naturally be political. Will that be a gain?

On paper, compulsory health insurance makes a strong appeal, because it seeks to provide an ordered plan for the automatic care of the industrial sick and for their relief from monetary hardship when unable to work. But in practice compulsory health insurance predicates a somewhat different political and social order from ours. Where administrative government is pure and efficient, where the average compensation of physicians is comparatively meager, where the great body of the working people is more subservient and more accustomed to government care and regulation, the chances for success may be at least worth trying. In the United States neither the need for it, to the exclusion of other means of protection, nor the chances in favor of its practical success have been clearly established.

If compulsory health insurance is to come here, and to stay, common sense tells us first of all that it must be established and maintained, not merely with the tolerance, but with the active and cordial co-operation, of the rank and file of the great body of the medical profession.

Proof of High Regard.

From the Newark Evening News.

Of all the encomiums passed upon Dr. Britton D. Evans, dead, and they have been many, the one that would have been most pleasing to the medical director for more than twenty-seven years of the State Hospital for the Insane at Morris Plains, is: "He knew what he was talking about." He certainly did when it came to a question of conditions at the Morris Plains institution, and he did not mince his words, but year followed year without legislative and budget action sufficient to relieve the viciously crowded conditions at the hospital of which he feelingly complained.

Like a voice from the dead comes the posthumous publication of his annual report to Commissioner Burdette G. Lewis of the Department of Institutions and Agencies. In it the distinguished alienist complains that conditions do not permit the separation of noisy, even violently inclined patients from those suffering from depression and an exaggerated timidity; that 500 patients have to sleep in cots in poorly ventilated corridors, and that there is no suitable place for airing the cots, mattresses and bedding; that in the male wards the number of attendants is one to more than fourteen patients, when the maximum number should be ten patients, and that in the female wards there are almost twenty-five patients to each attendant.

It ought not to require the opinion of an alienist to prove to the most casual legislator how harrowing must be the experience by garish day, and worse by night, of a preternaturally timid soul in Bedlam; how downright wicked it is for the state to countenance such a barrier to possible mental convalescence; how impossible it must be to induce a mental improvement in patients subjected to an environment that vitiates the bodily health.

Better believe the doctor. If the Legislature in its wisdom thinks it fit to memoralize the long and distinguished service of Dr. Evans, the best proof of its high regard will be to set to work as speedily as may be to ameliorate the conditions he is complaining of for the last time, and not to pass the obligation on another year.

MEDICAL SOCIETY MEETINGS.

(Continued from page 58)

N. J. Mosquito Extermination Association.

The seventh annual meeting of the New Jersey Mosquito Extermination Association will be held in Atlantic City, at Hotel Chalfonte, on Thursday and Friday, February 5th and 6th. The first session will begin at 8.00 P. M., on February 5th and on February 6th the second session at 9.30 A. M., the third session at 2.00 P. M., and the fourth session at 8.00 P. M.

National Anaesthesia Society.

This new national society will be launched soon, with the avowed purpose of collecting data and prosecuting original research in this field of medicine. A lengthy account of its objects has been sent out—too long for insertion, but it gives no information as to when or where it is to be organized. Any one desiring to know can address the Executive Secretary, T. T. Frankenberg, 16 East Broad street, Columbus, Ohio.

Society of Surgeons of New Jersey.

The annual meeting and dinner of this society was held in the Robert Treat Hotel, Newark, on January 8th, when the principal addresses were made by Dr. Philander A. Harris, the retiring president, and D. C. B. Moulinier, regent of the Marquette Medical School, Milwaukee and president of the Catholic Hospital Association of the United State and Canada.

Dr. Harris after briefly reviewing the history of the New Jersey Society which was organized in Trenton in November, 1912, adverted to the correlative aims of the American College of Surgeons, formed a year later, chief among which is the betterment of surgical practice through standardization. Because of the slowness of the machinery for the admission of candidates to fellowship in the American College. Some 13,000 are on the waiting, yet he felt it desirable to have every surgeon join who may be eligible to fellowship in the college, and he expressed the hope that those of the New Jersey society who are not yet in line for admission would take steps at once to affiliate with that organization. At Dr. Harris's instance, the meeting voted to adopt the fellowship pledge of the American College of Surgeons, with the substitution of the name of the society for that of the college wherever it occurs, as an amendment to the society's constitution and by-laws.

The society elected these officers: President, Dr. Stephen T. Quinn of Elizabeth; vice-presidents, Dr. G. K. Dickinson of Jersey City, Dr. W. P. Conaway of Atlantic City and George N. J. Sommer, Trenton; treasurer, Dr. Henry Spence, Jersey City.

Society of Medical Jurisprudence Opposes Health Insurance.—At the 306th regular meeting the New York Society of Medical Jurisprudence the subject of compulsory health insurance was discussed from the legal and medical standpoints by the outgoing and incoming presidents of the society. The society went on record as opposing compulsory health insurance.

Hospitals

Gifts to Hospitals.

St. Barnabas Hospital, Newark, will receive $3.000 under the will of Miss A. A. Westervelt of Los Angeles, Cal., formerly of Newark. The Home for Crippled Children and the Hospital for Women and Children will receive smaller sums.

Hospitals Receive County Funds.

A resolution adopted by the Union County Board of Freeholders recently provides for the distribution of $75,000 among six hospitals in the county, as follows: Elizabeth General Hospital, $27.886.34; Elizabeth Hospital, $21,-515.71; Alexian Brothers' Hospital, $11,280.42; Muhlenberg Hospital, Plainfield, $11,379.06; Overlook Hospital, Summit, $2,365.06, and the Rahway Hospital, $573.06.

Perth Amboy City Hospital.

This hospital announces the equipment of a new laboratory, in charge of Miss Adams, Technician, which is now open to the medical profession. It is prepared to make chemical and microscopical urinalysis, blood counts, bacteriological smears, cultures, sputum examinations and autogenous vaccines. It will soon be equipped to make Wassermann tests and other laboratory examinations. Until March 1st, there will be no fee for any examinations.

Salem County Memorial Hospital.

The secretary of this hospital reports for the month of December as follows:

In the hospital December 1st, 15; admitted during the month, 39; discharged, 41; remaining December 21st, 13. Operations, 23; deaths, 4; births, 3.

State Hospital, Morris Plains.

Orlando M. Bowen, for ten years warden of the Morris Plains State Hospital, was made chief executive officer and also appointed approval officer at a meeting of the board of managers at the hospital held on Jan. 17. At the same meeting Dr. Marcus A. Curry of the hospital medical staff was appointed physician in chief and medical superintendent. These appointments are tentative, awaiting the election of a permanent superintendent in place of the late Dr. Britton D. Evans.

State Hospital, Trenton.

Dr. H. A. Cotton, Medical Director, reports the past year as one more successful than was expected. He makes a strong plea that a proper campaign of education be conducted so that the profession, as well as the public, be awakened to the necessity of more careful dental work. Infected teeth, the report shows, have been attributable for much of the insanity that has come under the hospital's observation. Infections and toxemia, as Dr. Cotton has previously pointed out, are shown to have been the most important contributing factors in producing mental disease. The education, as proposed by Dr. Cotton, should be along lines of endeavoring to have dentists extract infected teeth rather than through mechanical dentistry seek to save them. To the extraction of infected teeth as well as to operations on the tonsils and other organs of the body, Dr. Cotton has attributed his success in being able to discharge 274 patients of 410 cases that had been admitted.

An Experiment in Hospital Administration.—A few days ago the authorities of the London Hospital, the largest voluntary hospital in the metropolis, decided to fill the vacancies on the honorary medical staff of the institution created by the retirement of Dr. Frederick J. Smith and Dr. Henry Head, by the appointment of whole-time paid medical officers, consisting in each case of a director, three clinical assistants, and a laboratory and clerical staff. This of course is a tremendous revolution in connection with the English system of voluntary hospitals, under which the duties of the medical staff are and have been always rendered gratuitously, the reward for their services being supposed to emerge indirectly from the following two things: first, the unrivalled clinical experience must elevate them in the eyes of the public to the position of distinguished medical men; and, secondly, in their role of consultant they would be supported by their pupils from the medical school affiliated to their hospital. No one can say that so simple a plan of obtaining the best medical service for a charity at no expense to the charity has not much to commend it; as a matter of fact it has so much to be said in its favor that it may be a long time before the example given by the London Hospital is followed by any other large metropolitan hospital having schools attached. On the other hand there is no doubt that the cause of medical education may be found to be better served under the new plan. It must be remembered that the medical school of the British pattern was not invented as a whole but is the result of reconstruction, time, change of public thought and public standards of education, and a crowd of other circumstances. At the present moment, as has been lately said in these letters, medical education has become a very expensive affair in this country. Students concerned in the instruction for a medical career are not drawn from the wealthy class by any means, and are often hard set to find the necessary fees and living expenses of a curriculum extended nominally over five years and really over six. There is extraordinarily little margin left with these lads to pay their teachers, and in the meantime the work of teaching, given cheerfully by the medical staff when it was infinitely briefer and to some extent paid, is now very onerous, with the risk that many of those to whom it falls to deliver the lectures and organize the demonstrations are by temperament unfitted to discharge the task. Moreover many of them can ill afford the time in which to carry on the systematic work of medical education if much of their day is already occupied by their purely clinical and unpaid services. It is true, as I have said, that these services are supposed indirectly to command a professional income outside the walls of the hospital, but it is not much good to a physician or surgeon to say that he can take unlimited patients in private practice, if he has no leisure to see such patients in either his consulting room or house. Again medical education has become a highly specialized affair, particularly as regards the preliminary scientific training. It may be no trouble, and on the contrary it may be a very useful pleasure, to a young physician, a young surgeon to review for a discriminating class of his juniors the cause, treatment, diagnosis, incidence, and so on of a disease with which he is in professional touch. That is bringing the theory and practice of medicine together in the most valuable manner for teacher and taught. But it is a totally different thing if the same young practitioner is asked to lecture on the biology and physics which underlie his rational attitude toward his patients. To ask such a man to keep in touch with the developments of pure science when his daily work is to keep track of pathological variations from these scientific phenomena is to ask too much. When anatomy meant osteology, and not comparative morphology; when physiology meant the mechanism

of cardiac motion and respiration with no regard to general biology, and when physics meant the mechanism of the common pump, the ancillary sciences could be imparted by any clear headed young man three years ahead in his studies of the classes which he was addressing. But to-day the teaching role becomes at the same time a sacrifice on the part of the honorary staff, possibly a distasteful occupation, and certainly one for which proper emolument should be forthcoming. The move of the London Hospital is therefore progressive; it is toward the institution of a medical staff whose duties, while ministering to their patients, would also be to instruct the students on scientific lines, fitting them for future research work. But it is not easy to see where adequate salaries can be found to recompense such whole-time officers unless the public comes to the rescue. Medical education cannot be paid for out of money given directly for the needs of patients. The action of the London Hospital must, therefore, be regarded as an experiment, but it is a particularly valuable one, as shaping the education of medical students upon a university pattern. The metropolitan medical schools are already integral institutions in the University of London. These new medical officers will really be university teachers of medicine along lines analogous to those pursued in other faculties. The medical officer directing medical studies will be in intimate touch with the purely scientific education of his students, with their clinical training in the wards, and with their further work in the laboratories. A medical school conducted on those lines would be a proper part of the university faculty, and those interested in medical education will view this experiment with anxious attention.—London Letter, Medical Record Correspondent.

Deaths.

EVANS.—At Greystone Park, N. J., January 14, 1920, Dr. Britton Duroc Evans, Medical Director of the New Jersey State Hospital, Morris Plains, aged 61 years.

Further notice will appear next month.

HERITAGE.—At Glassboro, N. J., January 4, 1920, Dr. Charles S. Heritage, of uraemia, aged 48 years.

Further notice will appear next month.

MARVEL.—In Lankenau Hospital, Philadelphia, Pa., January 7, 1920. Dr. Emery Marvel, of Atlantic City.

Dr. Marvel was born on a farm in Kent County, Del.; followed the life of a farmer until he was seventeen years old; attended school at Dover, at seventeen became a teacher in a rural school and kept up his own studies during spare moments; obtained a scholarship in the Delaware State College, graduating from there he entered the University of Pennsylvania Medical Department, from which he graduated in 1895.

After his graduation he became one of the internes at the Howard Hospital in Philadelphia, and later was interne at one of the other hospitals in that city. When he was through at the latter hospital he was made one of the staff of the Cooper Hospital in Camden.

After having had about three years' of hospital experience, Dr. Marvel went to Atlantic City and was associated for a year with his elder brother, Dr. Philip Marvel, and then branched out for himself. He was for a number of years located at 811 Pacific avenue and then moved his private residence to South Carolina avenue. He had not been in the best of health for the past four years. He performed an operation a few years ago, in which he made a slight cut on one of his own fingers. The cut became infected and he had a serious time. Some time ago he realized that he was suffering from trouble with his kidneys and he went quietly to the Lankenau Hospital and placed himself under the care of eminent physicians and surgeons, including Dr. Deaver, for the purpose of determining the extent of his troubles. As a result of this period of observation he was advised that an operation would be necessary. He knew that would be a serious operation and fully realized from his own knowledge of his condition and from what had been told him by the doctors and surgeons that it might be fatal. But he calmly and courageously faced the ordeal with that quiet, determined courage which was one of his strong characteristics. He told his family that he would undergo an operation, but made light of it, for he did not wish to alarm either his wife or his brothers.

The operation was performed by Dr. Deaver. It was hoped that his strong and vigorous constitution would stand him in good stead, and it did for a time. He made a strong, brave fight, but the trouble had been permitted to go too long, and his strength had been sapped by fever even before the operation had been performed.

The deceased was devoted to his profession and for that reason never attempted to seek public office. Although he never aspired to office, nevertheless he was deeply interested in all public affairs and had the affairs of his city, his State and his Country at heart. He will be greatly missed, especially among the many of the indigent poor of the city, both white and black, for there were many of them who for years he had treated gratuitously.

Dr. Marvel was vice-president of the Amerıcn Medical Association, a member of the American College of Surgeons, member of the New Jersey State Medical Society, the Atlantic County Medical Society, the University Club of Philadelphia. For several years he was head of the surgical staff of the Atlantic City Hospital.

IN MEMORIAM.

Henry G. Cooke, M. D.,

Died in New Brunswick, N. J., Dec. 2, 1919.

The following minute was adopted by the Middlesex County Medical Society, December 17, 1919:

The Middlesex County Medical Society has heard with profound regret of the death of Dr. Henry G. Cooke, who was elected in 1898 an Honorary Member of the Society, having, with our Society hearty concurrance, desired to continue his regular membership in the Monmouth County Society, because of tender associations with that society for a third of a

century. We have for nearly a quarter of a century esteemed him very highly for his personal worth, his unassuming cordial manners, his kindliness of heart, his thoroughly ethical spirit, which endeared him to us and to all who were priviliged to come into personal touch with him. His long life of devotion in all the relations of life—family, professional, civic and religious, ending in a prolonged season of physical infirmity will cause us ever to hold in grateful remembrance our association with him. ,

We tender our sincerest and deepest sympathy to the family of our deceased brother.

This minute was ordered to be entered in full on our records and a copy was directed to be sent to the bereaved family, and a copy also to the State Society Journal.

D. C. English, A. L. Smith, J. W. Rice, Com.

Personal Notes.

Dr. Duncan Campbell, Woodbury, entertained the Physicians' Protective Association at the County Club, January 20th. Dinner was served and all had a pleasant and instructive time.

Dr. Wells P. Eagleton, Newark, and wife spent a week last month at Highland Pines Inn, Southern Pines, N. C.

Dr: Morgan D. Hughes; Bloomfield, is recovering from a severe attack of grippe.

Dr. John B. Cassady, Burlington, was elected last month president of the City Board of Health.

Dr. Walter B. Johnson, Paterson, is recovering from a rather severe attack of pneumonia.

Dr. Madeleine A. Hallowell, Vineland, has received from the Department of Institutions and Agencies resolutions expressive of high appreciation of her services as chief executive officer and medical director of the State Institution for Feeble-minded Women at Vineland, when her resignation because of continued ill health was accepted.

Dr. Charles H. Mayhew, Millville, has recovered from an illness that confined him to his home several days.

Dr. William Buerman, Newark, has been elected head of the Clinton Hill Improvement Association.

Dr. Philip Embury, Basking Ridge, had a narrow escape from death recently when his automobile was struck and demolished by contact with a train on Lackawanna Railroad. He was badly cut and bruised and taken to Overlook Hospital, Summit. He is recovering.

Dr. Horace M. Fooder, Williamstown, Assemblyman. from Gloucester County, has been elected chairman of the committee on Railroads and Canals; he is also a member of the Assembly Committee on Labor and Industries and on Municipal Corporations.

Dr. O. H. Sproul, Flemington, was recently re-elected a trustee of the Hunterdon County Historical Society.

Dr. Matthew K. Elmer, Bridgeton, was recently re-elected a director of the Cumberland National Bank of Bridgeton.

Drs. David H. Oliver and Stacy M. Wilson, Bridgeton, were elected directors of the Cumberland Trust Company.

Dr. William Gray Schauffler returned from service overseas on October 28th, 1919, and was honorably discharged on October 31, 1919, as Colonel Medical Corps. After residing and practicing in Lakewood since 1896, Dr. Schauffler has moved to Princeton, New Jersey, where he has resumed the practice of medicine on February 1st, 1920. He had been for a month in charge of Dr. Stewart Lewis's practice at Lakehurst, while the latter was recovering from the effects of last year's influenza. He has returned to Pine Tree Inn and resumed his work.

Dr. Wellington Campbell, Short Hills, was appointed last month chairman of the roads' committee and also of the committee on sewers of the Millburn Township committee.

Dr. Blaise Cole, Newton, was elected a director of the Merchants' National Bank, Newton, last month.

Dr. John W. Clarke, Lyndhurst, who has been quite ill for several weeks, is recovering.

Dr. Alfred M. Elwell, Camden, and wife are receiving congratulations on the arrival of a baby boy in their home.

Dr. Alexander Marcy Jr., Riverton, is spending a few weeks at Pas-a-Grille, Florida.

Dr. L. Cook Osmun, Hackettstown, was elected president of the Hackettstown Club recently.

Dr. Clarence M. Slack, St. Petersburg, Fla., a member of the Middlesex County Society, this state, was recently elected mayor of St. Petersburg.

Dr. Harry A. Stout, Wenonah, was last month seated as a member of the Wenonah Borough Council.

Dr. John R. C. Thompson, Bridgeton, has recently been re-elected physician of Cumberland County. The Bridgeton News speaks highly of his efficient work.

Dr. George B. Verbeck, Caldwell, has been appointed physician for the United States Public Health Service for the West Essex district. He will have special care of sick or wounded service men. Dr. Verbeck served in the Medical Corps during the war and was mustered out of service with the rank of major.

Dr. William J. Chandler, South Orange, and wife are enjoying a few weeks' trip in the Southland. They expect to return Feb. 19th.

Dr. A. Schuyler Clark has removed his office to No. 10 East 61st street, New York City.

Dr. Harvey M. Ewing, Newark, has installed a electrocardiograph in his new office in the Aldine Building, Newark.

Dr. William Martin, Atlantic City, read a paper on "Treatment of Splanchnic Relaxation by Electrical Currents" at the meeting of the Medical Department of George Washington University, District of Columbia, Jan. 14, 1920.

Dr. Benj. F. Slobodein, Perth Amboy, has moved his office to 143 Smith street.

Dr. Austin H. Coleman, Clinton, who has been ill at his home, has gone to Jacksonville, Fla., for a few weeks.

Dr. Floyd A. Thomas, Flemington, is spending a few days in Florida.

Dr. Charles B. Smith, Washington, was toastmaster at the Father and Son banquet given by the Y. M. C. A. of that city last month.

Dr. Jacob S. Wolfe, Bloomfield, entered a "string" of four silver spangled hamburg chickens at the New York Poultry Show last month. He won four prizes.

Public Health Items.

Dover Health Report.

The death rate of Dover for 1919 was 8.58 of actual residents and is said to be the lowest of any in the state. In 1918 it was 17.2. The number of cases of communicable diseases reported was 688 with 37 deaths resulting.

Kearny Health Report.—The Health Officer reports that during the past year there were 1,034 cases of communicable diseases, of which 423 were cases of influenza, eleven proving fatal; 125 cases of pneumonia, 52 fatal; 125 of chickenpox, 50 of diphtheria, 3 fatal; 93 of scarlet fever, 2 fatal; 65 of measles, 1 fatal; 74 of tuberculosis, 12 fatal, and 55 cases of whooping cough.

Newark Health Department.

The department reports the death rate for the month of November as 10.9 per 1,000 of population. There were 300 deaths as against 849 in November, 1918. Total diseases reported, 1,082 cases as against 3,523 in November, 1918.

Child Welfare.—The distinct need for standardizing child-welfare laws is shown by the diversity among the states in child legislation. This variation in standards evidences a lack of clear thinking. A board of children's guardians is needed in every state. Minnesota has adopted a children's code which is a model for all other states in the methods used and the results obtained in legislation.

Is Your Community Fit?—Are your schools provided with medical supervision to control the spread of communicable diseases among the children and to limit the number of sources of contagious diseases which often spread rapidly when carried to susceptible persons? Do your children have the advantage of regular physical examination by a physician? Is there a clinic for the treatment of all the physical defects discovered as a result of this examination? The after-war development of your community will depend largely on the physical fitness of your present school population.—Pub. Health Rep.

Fight Against Yellow Fever Apparently Won.—Major-General William C. Gorgas, on his arrival in Panama, on October 4, reports that yellow fever has been practically eradicated from Guayaquil, Ecuador, and that with this achievement yellow fever may be considered to be banished from the earth, as Guayaquil was the last large centre where yellow fever was endemic. No cases of yellow fever have occurred at Guayaquil for several months, and if there is no outbreak during the coming rainy season the sanitary measures instituted may be considered effective.

The Right to Marry.—A careful student of the literature and of the facts of eugenics realizes the complexity of the problem and the reason why we should be cautious about pushing everything to the point of legislative regulation. It is in the interest of civilization to provide principles and customs rather than laws, and to give the plain sense of the individual a chance to develop and to become effective. Give the people the facts and some help to think and the right sources of advice, and there will surely be results.—A. Meyer, Canadian J. Mental Hygiene.

Venereal Disease and Marriage.

When some of us began to suggest that it would not be a bad idea if people—men particularly—about to be married made sure that they were free from venereal disease and were obliged to bring a medical certificate to that effect, we were considered impractical dreamers, or hare-brained reformers. That would never be—never. There are thirteen states now that demand a certificate of freedom from syphilis or gonorrhea before a marriage license is granted. Those states are: Alabama, Indiana, Michigan, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington and Wisconsin. The first step is always the hardest. It will take much less time for the other thirty-five states to adopt venereal disease laws than it has taken the first thirteen.

And the law demanding a certificate of freedom from venereal disease is a good one. I am a staunch, uncompromising believer in personal freedom, but this law is for the benefit of the husband, the wife, the children, and the race in general. And there are no moral or humane objections to it. No man or woman capable of transmitting syphilis or gonorrhea to her or his partner or to the children would want to marry. If, however, they are morally so obtuse that they would, then the state has the right—nay, not only the right but the duty—to interfere and not permit them to commit such a crime—Critic and Guide.

The Ravages of Smallpox.—In the eighteenth century, smallpox was more common than is measles to-day. In 1802 a speaker in the British Parliament declared that "it is proved that in this United Kingdom alone 45,000 persons died annually of the smallpox, but throughout the world what is it? Not a second is struck by the hand of time but a victim is sacrificed on the altar of that most horrible of disorders, the smallpox." A few years later Lord Macauley said of the disease: "Smallpox was always present, filling chruchyards with corpses, tormenting with constant fear all whom it had not yet stricken, leaving in those whose lives it spoiled the hidden traces of its power, turning the babe into a changeling, at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden badges of horror to the lover." The history of smallpox in our own country tells the same story. In 1702, 14.4 per cent. of the population died from the disease. Nineteen years later, 5,989 out of the 11,000 inhabitants of Boston contracted the disease, 840 fatally. In 1730, it again ran riot in Boston, claiming nearly 500 victims out of a sick roll of 4,000. It stalked among the colonies like the instrument of a remorseless avenger.

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SOME MEDICAL TENDENCIES AND RESPONSIBILITIES.*

By Alexander Lambert, M. D.,

President of American Medical Association.

New York City, N. Y.

When asked to deliver an address to you tonight the invitation was given with the remark that I might say something about the work the medical profession had done abroad during the war. I thought then, and I still think that the work we did has been talked about enough, and war stories and war talk are no longer interesting. The time has come when we should examine critically the value of the medical knowledge we possess and the value of what we have been able to do with it; and let us look at things from a general, rather than a concrete point of view.

Permit me, first of all, to express my appreciation to you that you should compliment me with the invitation to address you.

It often needs a war of some equally disturbing element in life, to make us realize the direction towards which, for many years, we have been drifting. This recent war is no exception, and has made the medical profession stop and take account of many of their ways. Contact in daily work with other nations is the best method for a comparison of our ordinary habits of thought with theirs.

An unusual opportunity was given many of us abroad to compare the American point of view in medicine and the basis on which it is founded, with that of the English and of the French. The Red Cross founded a medical society which met once a month in Paris and to which came the English and the French Medical Corps, meeting with the members of the American Medical Service. It started in a small way, with a mixture of the three nations, of a total of about 60 men. It grew rapidly, until at the end, the meetings had from 600 to 800 in attendance. It proved the most successful forum for the exchange of views. It welded together the three medical corps into one friendly group, eagerly exchanging ideas and mutually admiring many features of the point of view of the others.

To one sitting and listening, month after month, the impression grew in one's mind that the French, like ourselves, were dominated by pathology as a foundation with the experimental work of the laboratory as its expression, as a basis from which to approach their problems. The English, on the other hand, while not ignoring this point of view, were more dominated by a basis of physiology in medicine, and one could not but be struck by the brilliant clinical pictures drawn by the Englishmen in their speeches and discussions of diseased processes.

The meetings of this society had the further advantage that they gave to the American physicians and surgeons the English and French experience of three years of war and enabled us to start in 1917 on a level with the other armies in their medical knowledge. Without this interchange of ideas we would have started with the published literature which was then at least two years behind the actual facts, for in surgery, in 1917, they had worked out of disorganization into clean-cut organization and a knowledge of what was best in the management of the wounded; they had developed the treatment of infections beyond antiseptics and a reliance on their use, and had laid down rational, clear-cut principles of good surgery and the reliance on surgical technique of the individual, rather than on the extraneous help of chemical antiseptics. The brilliant result of war surgery of the last eighteen months of the war was due to

*Paper read before the Academy of Medicine of Northern New Jersey, Newark, N. J., November 19, 1919.

the conquering in many wounds of the infection which occurred in every wound, through improved knowledge and improved technique. Antiseptics still have their field of usefulness. Through the rearrangement and improvement of technique in their application, Carrel and Dakin had solved the problem of the best line of procedure when infection had broken through the lines of defense and over-spread a wound.

In medicine, sanitation and preventive inoculation had shown conclusively on a large scale, their value in the prevention of disease. The details of all this would be an interesting story; but they were proven facts and they are the logical consequence of work laid down and known before the war.

In listening to the medical discourses of our Allies, it made me realize that even after over thirty-five years of work and study, my medical education was still incomplete; and being placed in a medical executive position in which no clinical responsibilities entered, I had time to consider the situation from a more detached point of view than is usual.

Thinking over my own education, which is typically American, I saw that it had been dominated by the French and German points of view. The French have been dominated by Pasteur and the Institute foundel in his name, and the Germans by the ideas of Virchow and Koch, basing the scientific study of medicine on pathological processes and the study of disease from the point of view of pathologic anatomy and tissue changes produced by disease.

When one stops and considers, it is clear that when the English would not take up with Lord Lister's antiseptic surgery, and the Germans did take it up, the development of surgery and of scientific medicine which evolved from the study of the infections which were a direct consequence of Lister's conceptions were certain to dominate medicine in the generation and the period in which it took place. No wonder then our recent past has been so dominated by pathology and the study of medicine based on bacteriology. Again, however, physiology has forged forward, for within the last ten years, the work of Thomas Lewis and Sir James McKenzie in medicine, has shown that the progress in our knowledge of the diseases of the heart has come from the study of the physiology of that organ.

My contact with many brilliant and interesting English physicians and surgeons during the war impressed on me their physiologic point of view; and as I sought for an explanation, it became evident that ever since Harvey had discovered the circulation of the blood, physiology has held a most honorable position in medicine in England. Physiology alone, in medicine, holds a position in the Royal Societies of Science. Medicine is not yet otherwise represented. England, since Harvey's time, has always had great physiologists; and as one thinks today, one is surprised that among all the brilliant men of American medicine, there should be so few physiologists. And as a matter of fact, in most of our medical schools, physiology, the science of normal function, is taught in the early years of the study of medicine and then pushed aside instead of being practically applied to show that the early symptoms of most diseases are the deviations from the normal functions of various organs. Forgetting that the morbid processes of disease are most susceptible to treatment during the stage of functional disturbance before the pathologic change of tissue has occurred.

One brilliant English friend said to me, "We lack today the abundance of young men that you have trained in scientific laboratory procedure, capable and ready accurately to pose the problem to study disease as it exists." I told him "Yes, I think you do; but on the other hand, we lack young men who in clinical medicine appreciate that morbid processes of disease can exist in a patient even if their laboratory tests and experiments are negative. That is, the disturbance of function as evidenced in a sick patient are not appreciated sufficiently nor given sufficient weight by our young men today."

In clinical medicine, if one is too much influenced by the study of morbid anatomy one tends to fall into the habits of thought that as soon as a man shows sickness he must have change of tissue and fail to look on him as sick until the disease has made such advances in his body that his symptoms are no longer those of perverted function but are those of actual damage of tissue.

I have often thought as I have studied pathology that I was gazing on the burnt out shells of last night's fireworks, and I often felt how little the tissue changes correspond to the clinical picture that I had seen during the life of the patient. In several forms of acute diseases patients may die from sheer intensity of poisoning, before any change in tissue can occur.

The point of view today of many young medical men is that if a disease is present it must show all the changes that they have learned about it in the laboratory, and that unless it does show these changes, the disease is not present in that human body. There is a failure to appreciate that clinical manifestations of disease are but the expressions of the perversion of normal function or the result of cessation or excessive action of some normal function.

Originally, in the dim past, in the time of Hammurabi, King of Assyria, many centuries B. C., disease was supposed to be an entering of a demon into the human body and they gave all the revolting things they could think of, to make the demon so disgusted with his new abode that he would quickly depart and leave the sufferer to go on in peace. Then later it was believed that the humors in the body were perverted and they had to be eradicated. Within our own memory we have been dominated by the idea that certain minute bacterial germs entering the body are sufficient to explain many diseases, and we have endeavored by all available means to overcome the invaders without injuring the body of their host. It has gradually dawned on us, however, that it is the products of their life processes which in turn throws out of equilibrium the normal functions of their host.

While we cannot fail to recognize that the study of bacteriology and pathology has been productive of the most far-reaching results and of the greatest benefits to humanity, for on these sciences have been built up the sanitation and preventive medicine through which we hold in control many of the former scourges of mankind. We can today control, as never before, typhus and typhoid fevers, yellow fever, plague and cholera, which, in the wars of previous centuries have decimated the armies and populations alike. Still, in our every-day life we cannot fail equally to recognize that there exists the tendency today, to believe too much in the infallibility of laboratory tests and mechanical devices and to study too little the normal processes of the body, and to study clinically where those normal processes first begin to deviate from the normal and becoming abnormal to show the early beginnings of disease. Our responsibility as teachers and as physicians, therefore, is to turn more toward the development and appreciation of clinical physiology, and bring it more into practical usage in medicine in the routine of our daily practice.

A short time before this address was written, I was much struck to pick up a book by Sir James McKenzie, called "The Future of Medicine" and to see that that brilliant physician who had done so much to develop the pathologic physiology of the human heart, most energetically chides the profession for neglecting the physiologic point of view and depending too much on mechanical and laboratory tests and methods. This address has not been written because of that book, but it confirms my opinion that the situation must be more general than I had believed it to be. I cannot go the lengths that McKenzie does, in believing that nearly all mechanical devices for the study of clinical medicine must be discarded or that we study too much in the laboratory and too much in pathology. My belief is not that we have taught too much of these studies but that we have taught too little of physiology and not that we have over-weighted on the pathologic side the education we are giving our successors, but we have omitted to put sufficient stress on the physiologic side.

Sir James McKenzie vigorously insists in one paragraph that all mechanical devices should be discarded from the study of the circulation, but in the next paragraph shows conclusively that only by means of his polygraph was he able to recognize accurately the changes that were occurring in the heart and arteries. He believes that all men should be taught to recognize these changes without the polygraph, but he does not seem to realize that only by actual use of mechanical aids can we teach ourselves the meaning of many phenomena we see. Unfortunately the knowledge of medicine and the practical application of medical knowledge is not inherited and must be transmitted from one generation to another, by individual to individual. For the greater part the record has to be left and each individual has to pick it up and rapidly as possible acquire the knowledge for himself; but the fact that the knowledge and details have been acquired and worked out hastens enormously the time in which it is acquired and digested by each succeeding generation.

Another tendency of medicine that the war has accentuated is the advantage of medical men working in groups. Medical knowledge has become so broad that no one man can master it all in the time allotted him to live. McKenzie expresses the belief that the modern idea that medicine is more scientific today than it was forty years ago is false, and he claims that the men of

today lack in broad, general point of view the knowledge which the leaders of medicine forty years ago possessed, and he believes that only the general practitioners who see a broad view of disease in daily life from their constantly varying experiences are able to look at things broadly.

This is only half true. The specialist has sprung up and developed both because in all branches of medicine scientific knowledge has increased so enormously that no man can acquire full grasp of all its subjects, and also because the best results are obtained by men specializing in those branches which really interest them. Even in the special branch of cardiac diseases in which McKenzie has made such brilliant advances and in which he has added to the sum total of human knowledge, he would have added vastly more had he possessed a broad knowledge of pathology. His presentation of cardiac diseases always lacks the pathologic balance to perfect it.

Besides the necessity of the specialist in medicine or the advisability, if you choose, through the development of medicine itself, the public has had a great influence in producing the specialist, because each individual that is sick has demanded that someone who is specially trained in that patient's symptom, pain, ache or morbid processes, whatever it may be, should be found to care for him.

Men going from civil life into the army realized the advantage of working together. Many expressed their appreciation of finding a dentist, x-ray expert and surgeon all working over the same patient together. Medicine has always been a most individualistic profession and few have realized the advantages of grouping. No small part in the brilliancy of the Mayo Brothers has been their successful organization of group medicine. It seems to me that there is a tendency toward this same thing elsewhere in medical life today, and it is my personal belief which, of course, is fallible, that it will probably develop in the profession through the greater perfection of present dispensaries.

The dispensary is an institution in which group medicine is already afforded, and if it could be brought about that the outside general practitioners would send their patients who needed special care to the dispensaries and the dispensaries would take the trouble, after caring for them, to give a note to the patient, sending him (or her) back to the outside physician, you would soon have a system that would work to the mutual advantage of the general practitioner on the outside, the specialist on the inside, and above all, to the patient. Four-fifths of the treatment given in dispensaries today, is given in specialties that the general practitioner outside does not or cannot give. Even in the classes of general medicine, or general surgery, patients could be sent for either therapeutic suggestions or diagnosis which would result to their great advantage in the majority of cases, if a note could be sent back with them to their outside physician.

I believe this is a possible solution of the situation of today, which fails to give proper care to all the sick in the community, and which renders physicians on the outside of hospitals and dispensaries unable to continue their development in studies of post-graduate work, going along, at best holding their own, but not developing as they should in their profession. Today a great amount of medical care is given in charity and if there were institutions which could give this for small sums to those who could pay only a small amount, it would improve the economic situation in the life of the people and also of the medical profession. We are responsible, therefore, to think not only in terms of the few who have hospital and dispensary advantages, but to think in terms of the effect on the general profession and the result on the community.

There is a very strong tendency at present, which is rapidly developing, to consider the position of the hospital as an institution of more use than the mere housing and care of the sick in the community and to make it serve a far wider service than it does at present. To broaden and develop post-graduate medical teaching and at the same time to look more and more critically at the standards of medical and surgical service given in the hospitals, raising those standards. Further yet to look upon the sick in the hospitals as those in many instances for whom the environment of life has been too severe, and they have broken under its strain, rather than that they should be a mere exhibit of this or that disease.

The medical profession has the entire responsibility on its shoulders of the development and standardizing of the technical side of all hospitals and they alone are able to judge correctly, if that responsibility is fulfilled. There is, however, a lay-aside to the hospital situation in which there is a lay-responsibility of giving the greatest re-

sults from the funds in hand. There is responsibility on both sides, lay and professional, of more hearty co-operation between trustees and managers and their medical boards, and their nurses' training schools.

The development of industry in this country has brought about the passage of certain laws which have endeavored to give justice to those injured in industry by placing on the industry the burden for the human wastage that occurs. This has resulted in the passage of the "Workmen's Compensation Laws." These laws are but the application of insurance principles to readjust the cost of calamity. For instance: In fire insurance, few men will deny the wisdom of taking out fire insurance on a home, because everyone knows that the chances of house burning are very small, and a very small amount put in will enable a company organized for that purpose to pay back nearly the full value of the house if the calamity should fall on that particular structure. So in workmen's compensation. Accidents are liable to occur in any industry to any workman, and the industry, for a small amount, can apply the same principles and pay a small amount for that individual, so that if the accident falls upon him the cost in loss of wages, in medical, hospital and nursing care may be given him during his period of recuperation. It may cost but a few cents weekly to obtain this. The burden is transmitted by the industry to all those who purchase its products, so that in the end it is a general expense on the community, borne by those who purchase products of each industry.

These laws have affected the profession because only through the medical profession can care of the injured be brought about. The laws were passed in most states while the profession was asleep and the insurance companies were not. While, therefore, the insurance and business side of the redistribution of costs is good business, the insurance companies dodged as much of the responsibility for care of the sick either in the time the law forced them to care for them, or in the amount of surgical care they should give for a certain moderate medical fee in each accident as they could persuade the different state legislators to permit.

It has become more and more evident that the value of insurance given is more in ratio to the extent of care given for the real serious cases of protracted illness and caring for all of these cases than it is to care for a large number of the less seriously injured. And the tendency in the last few years, as evidenced by the changes of the law in the various states from year to year, has been toward a greater and greater acceptance of full responsibility of all the seriously injured.

The medical profession have, from time immemorial, given enormous amounts of service for charity and this willingness so to do has been taken advantage of in these compensation laws and the profession has been deprived of its just dues for work done. This has become so flagrant that there has been a growing sense of injustice and resentment throughout the states in which the social insurance laws have begun to be put in force.

When these laws went into effect in this and my own state, I confess my ignorance of them was so great that I did not know what they meant nor what "Workmen's Compensation" was, and that, contrary to the general belief, I had nothing to do with their framing. But soon it was evident that an endeavor was being made to add sickness insurance to compensation for injury. Then it became necessary for some of us to study the subject, and in studying it deeply my position in the American Medical Association further placed the responsibility on my shoulders to arouse my profession to what had been done in Europe concerning these laws and what seemed about to come in this country, that it might be prepared, should the laws be passed. The more one studied the foreign laws and the situation of the medical profession, the more one realized that the foreign laws covered the economic principle for which they were passed; that is, rearrangement of the cost of sickness; but in Germany they injured the profession because the profession was asleep when they were passed and so busy in the daily care of the sick that they did not rouse themselves to protect their economic existence. In England they permitted a wrong economic principle—that of payment by capitation to go into the laws and which, while it may have improved the economic condition of many practitioners, hurt their professional standards and the dignity of their standing in the community. It brought the level of their work on a plane of glorified lodge practice which, however, developed, injures those who practice it, because it suffers them to give poor and hurried service for inadequate fees and the injury to the profession is because of the inadequacy of service given. But in the instance of the English profession it in-

creased in the majority of cases, the economic returns from fees.

It seems to me whether or not the medical profession believes in the application of the economic principle for the readjustment of the cost of sickness to the wage-earners who have small incomes is of little consequence. This is a question that in the end must be settled by the wage-earners and the community at large. To the majority of people who study the subject it appeals as the one economic solution to the situation in which a family of small means suffering the individual calamity of sickness, goes down to a lower level of living, through the economic strain of this calamity.

If, as in fire insurance, this calamity of sickness is spread over a large group and by small premiums from each member of the group, a sufficient economic return is obtained to prevent the calamity from overwhelming the individual, then the insurance principle involved in sickness insurance has accomplished its object, but what is the effect of such a scheme on the medical profession?

The best organization through which the medical profession in an American community can work under sickness insurance has not yet been worked out. It seems to me that the profession must insist that there shall be a state-wide free choice of the physician by the patients; that there must be a human limit to the amount of work undertaken in order that good service shall be rendered and that the pro rata fee given to the physician must be in proportion to all professional standards and not the standard of commercial existence.

None but physicians can judge whether or not the medical anl surgical service as given is of proper standard. Therefore, there must be means devised by which the profession will take the responsibility of judging whether or not their fellow practitioners are rendering a fair return for fees received in service given. There is no question that the laity, both those who will be sick and those who will control the insurance funds desire and will demand the best medical services that they can obtain for the moneys they have to dispense. These questions have not yet been satisfactorily solved abroad. Foreign usage, as far as the medical service under insurance acts is concerned, is in the vast majority of instances but a warning of what we will not do and need not do. However the solution will come, it must be peculiar to this country. It must be a fair, straight, United States product, for only that way will it be supportel by public opinion. There is this advantage, however, of the care of sickness insurance over accident insurance—accident insurance is cared for by insurance companies over state-wide areas. Sickness insurance has always failed unless controlled and governed locally in small areas. It is necessary that it be applied in limited areas. This enables both the profession and the insured in small areas to work to their mutual advantage. And it places a new duty on the organized professions brought together and organized in county societies to develop and accept a new responsibility—that of willingness to stand up for the good and the honor of their profession and sit in judgment over the standards of medical work given.

I do not believe that any insurance scheme could be put through successfully for the care of the people unless the medical profession is willing to accept this responsibility, and until the communal sense of the profession develops sufficiently to overcome its individualistic aloofness. It is not improbable that the present tendency toward group medicine which we all recognize is deveoping in the profession, will further develop a great co-operative action in the profession than has been evident in the past. But however that may be, there is no question that there is developing in the communities in which we live, new social demands which will require of the profession new social responsibilities.

The tendencies to explore new regions in one direction or another in the development of medical research and knowledge is bound to vary as the allied sciences of physics, chemistry and biology offer the greatest promise of results through their growth and development. This is but the normal expansion of a rapid and healthy development in medical science.

Through the really great increases of knowledge in the diseases of the heart and circulation and also in the functions of the various endorcine glands there is a growing realization that only through accurate knowledge of the normal functions can we learn to judge of the abnormal which constitutes disease. There is also an increasing appreciation that studies of what may seem facts of pure science without immediate practical value or application may soon be used in the daily practice of medicine.

Many centuries ago the studies in mathematics of the Alexandrian School were

looked upon as pure science of only academic interest and of no practical value. Today these same mathematics form the foundations of practical surveying and navigation. So in human physiology, no studies no matter how seemingly abstract and impractical, are without value. For example the studies of Blix, a Swedish physiologist who measured the maximum energy set free by a contracting muscle at different lengths. This, with the work of Lovatt Evans, showing that the chemical energy of contracting muscle is transformed into mechanical energy has enabled us, as Starling phrases it, "to understand not only the marvelous power of adaptation of the heart to the varying strains of every-day life, but also the condition of this organ in disease, when from overstrain or morbid alterations in its muscles or its valves it fails to carry on its function with efficiency."

Our responsibilities in professional endeavors are therefore to turn from the intense study of the end effects of disease more to the first stages and symptoms of the beginnings of disease, and to study how to recognize more accurately the very beginnings of morbid processes that in their early stages of functional disorders we may more successfully treat them.

Another responsibility is for the profession to learn to mould their self-reliant individualism into a stronger team-work through which by a greater development of communal sense they will be more willing to accept the social responsibilities of their citizenship.

MENTAL HYGIENE AND PUBLIC HEALTH.*

By Christopher C. Beling, M. D.,
Director, Bureau of Mental Hygiene, Department of Public Health.
Newark, N. J.

Had the New Jersey Sanitary Association included a paper on Mental Hygiene in its annual program some years ago, probably the topic would have been accepted largely as a matter of theoretical interest. Today, however, the recognition of the benefits which would result from the conservation of the mental health of the nation is both widespread and whole-hearted, and the connection between mental hygiene and public health is quite firmly established, in the minds of those, at least, who are working in the field of human endeavor for the betterment of the race.

The accumulated knowledge regarding the underlying laws of mental phenomena and the recognition of the fact that mental abnormality lies at the root of delinquency, prostitution, pauperism, illegitimacy, unemployment and crime, have furnished the stimulus for education in mental hygiene. The need of widespread application of the principles of mental hygiene for the promotion of public health is now generally realized but initiative in this respect seems to be lacking. The experimental stage has been passed and now the endorsement of public opinion and the financial support from public funds is needed for advancement.

The scope of mental hygiene, in itself, is a wide one. The object of this paper is its presentation from the point of view of its relation to public health.

It is not much more than a decade ago since the modern mental hygiene movement was started, with the book of Clifford Beers entitled, "A Mind That Found Itself" as a spur.

The first state society for mental hygiene was organized in Connecticut in May, 1908, and the National Committee for Mental Hygiene, Inc., in February, 1909. Since that time societies and committees for mental hygiene have been organized in as many as eighteen states of the Union, and also in Canada. New Jersey is not in the group.

The National Committee for Mental Hygiene and its affiliated state societies and committees were organized "to work for the conservation of mental health; for the prevention of nervous and mental disorders and mental deficiency; and for improvement in the care and treatment of those suffering from any of these disorders."

Dr. Lewellys F. Barker, the President of the National Committee, has defined the campaign for mental hygiene as "a continuous effort directed towards conserving and improving the minds of the people ; * * * a systematic attempt to secure human brains so naturally endowed and so nurtured that people will feel better, think better and act better than they do now."

Reviewing the first ten years' work of the National Committee, he says,

*Read at the 45th annual meeting of the N. J. Sanitary Association at Lakewood, December 5, 1919.

"Among our objects we have laid stress on (1) the protection of the mental health of the general public; (2) the promotion of the study of mental disorders and mental defects in all their forms and relations, and the dissemination of knowledge concerning their causes, treatment and prevention; and (3) the amelioration of conditions among those already suffering from mental disease and mental deficiency. Our three main fields of work have been original inquiry as to the problems of mental hygiene, the education of the nation to use the knowledge that scientists already have accumulated, and the organizations of agencies for the carrying on of the campaign."

The civic progress and efficiency of a community depends upon its mental health. Mental hygiene has for its purposes: (1) The discovery of evidences indicative of the development of maladjustments, which endanger or prevent a social existence, together with their causes and treatment; (2) the application of knowledge so gained to treatment.

The problem of mental health is of the most vital importance for the welfare of society, and yet society is very poorly organized to meet it. In every state enormous expenditures of money are made annually for the maintenance of asylums, reformatories, jails, penetentiaries and institutions for the feebleminded, but no provision is made for early care and preventive work.

The United States Public Health Service has outlined a program of mental hygiene activities to be carried on as rapidly as funds become available for such purpose. "With the increasing recognition by health authorities of the significance of mental disease as a health program, there is a growing demand for assistance in the formulation of a program of practicable control and preventive measures which can be inaugurated by health administrators." The program takes into consideration: (A) The most effective means by which the several Government agencies can co-operate in studies and investigations of mental hygiene; (B) the problems of better care and treatment of the insane, mentality defective and epileptic; (C) measures for the prevention of mental disorders.

Studies and investigations already made along these lines by the Public Health Service indicate the desirability and practicability of the following activities:

(A) CO-OPERATION WITH OTHER GOVERNMENT AGENCIES.

1. Mental examination of aliens, already prescribed by law; establishment of a school for training of medical officers as mental hygienists; provision of facilities for training of nurses and assistants for duty in mental hygiene work; investigation of care and treatment of insane aliens confined under immigration laws in public and private institutions at the Government's expense, (Department of Labor).

2. Mental examination of coastwise pilots, locomotive engineers, and train dispatchers as a safeguard to the traveling public. (Other bureaus of Treasury Department).

3. Practical methods for the mental examination of civil employees of the Government as regards fitness for different occupations. (Other departments and bureaus).

4. Study and prevention of insanity and mental deficiency among the wards of the Government, e. g., Indians, Esquimaux, etc. (Department if Interior).

5. Revision of educational methods from standpoint of mental hygiene. (Bureau of Education).

6. Devising practical plans for establishment of special classes for the training of feeble-minded and delinquent children. (Bureau of Education).

7. Adoption of a model law providing for the early treatment of mental disorder; the enactment of a model commitment law; and the establishment of psychiatric pavilions in general hospitals. (State Department of Justice and other agencies).

8. Establishment of psychiatric clinics in connection with courts to determine the mental statue of criminals, dependents and delinquents appearing before the court. (Federal and State Departments of Justice.)

(B) PREVENTION.

1. Securing adoption of a law making certain types of mental disorders reportable to health authorities. (State and local agencies).

2. Reviewing and publishing State laws of commitment of the insane and feebleminded.

3. Determining the prevalence of the insane, feebleminded, alcoholic and epileptic. (State and other agencies).

4. Investigating the prevalence and the care and treatment of the insane, epileptic, feebleminded, criminal and dependent classes confined in institutions in Alaska and in the insular possessions.

5. Compiling a national reference index of the literature on mental hygiene.

6. Investigating mental status in relation to certain constitutional diseases and drug addiction.

7. Co-operation with industrial hygiene unit of the U. S. P. H. S. in the studies and investigations of the mental status of workmen as related to output, fitness for the job, protection from health and injury hazards and permanence of employment.

8. Co-operation with the child hygiene unit of the service in the study and investigation of insanity in children of the personality of the potentially insane.

9. Co-operation with division of venereal diseases in studies and investigations of the mental status of prostitutes and of the relation of venereal diseases to mental disorders.

During the last decade the mental hygiene movement has advanced with great rapidity. The Impetus given it by the World War will carry it forward with greater momentum. Already a large body of knowledge has been accumulated on the subject of mental hygiene, but the systematic application of this knowledge for practical purposes for the early treatment, care and prevention of mental disorders, is, unfortunately, lacking in a great degree.

In an excellent paper on "Mental Hygiene and Departments of Health" which came to our notice recently, Dr. C. M. Hincks, secretary of the Canadian National Committee for Mental Hygiene, writes as follows:

"We realize that departments of public health are rapidly becoming well organized and that mental hygiene will profit greatly by being incorporated as an integral part of their running machinery. The subject is too broad and too important to be entrusted solely to isolated enthusiasts, to organizations supported by voluntary contribution, to hospitals for the insane and feebleminded and to public school systems. I say great appreciation for the work that has been done in the past by such individuals and organizations."

How may such a development be brought about? A wide range of possibilities may be discussed, but the most promising outlook for carrying on and making effective the work of mental hygiene lies in its incorporation into Public Health Service as one of its integral parts.

In Newark the first real public interest in mental hygiene was taken in 1908 when the Board of Health established a neuropsychiatric clinic at the City Dispensary and psychiatric wards at the City Hospital. It recognized the necessity of abolishing the practice of incarcerating mentally-afflicted persons in police cells pending their examination and commitment to institutions, and appreciated the urgent need for their early care and treatment.

With the growth of the work and the increasing demands from various organizations for assistance in mental hygiene problems, we were led to the conclusion that the Department of Health was the logical center for the co-ordination of all activities pertaining to mental health of the community. With this belief a Bureau of Mental Hygiene was established in the Department of Health on June 1st, 1919. Thus mental hygiene entered the domain of health service in Newark, after a slow growth of a dozen years, by being fully recognized as a fundamental activity to be carried on alongside of child welfare and the prevention and control of tuberculosis and venereal diseases.

The present development of our mental hygiene work would not have been possible had it not been for the substantial assistance rendered by the National Committee of Mental Hygiene, which, through its Medical Director, Dr. Thomas W. Salmon, evinced a sympathetic interest and co-operation. Through Dr. Salmon the National Committee has provided us with funds to cover the employment for one year of a psychiatrist to examine the juvenile cases in the Essex County Parental Home, and a trained psychiatric social worker for rehabilitation work among discharged soldiers and sailors suffering from nervous and mental diseases. For the ensuing year we have asked for trained psychiatrists, psychologist, social workers, clinic physicians and nurses. The public school children are being cared for by a well organized psychological clinic under the Department of Education. There are, however, about 15,000 children belong-

ing to the parochial school system who are not having any such attention. It is planned by the Bureau of Mental Hygiene to make a beginning next year to take up this problem.

With us in Newark the growth of mental hygiene has been slow but encouragingly progressive. The fundamental difficulty of bringing mental hygiene before the public lies in the lack of education and the erroneous conceptions still generally entertained regarding mental disorders. William Burnham, Professor of Pedagogy and School Hygiene, states it clearly and simply, as follows: "When an individual feels the need of help for any nervous or mental disorder, one expects, like the ancient Assyrian warrior, some great thing, something spectacular,—electricity, hydrotherapy, a rest cure or the like. For the prevention of mental disorders, however, and the development of healthful habits of mental activity, very simple things are the essential things,—orderly association, healthful interests, normal attitudes towards life, attention to the present situation, a proper balance between stimulation and response between rest and work."

We are trying, in Newark, to be a central aid for the extension of co-operation to the juvenile and other courts, to be the home and the schools, to institutions for dependents and institutions for study of social relations, to correctional institutions, to institutions for organized relief and those teaching industrial efficiency. In our Mental Hygiene Bureau we are striving for the prevention of maladjustments of behavior which lead to anti-social conduct, and in our psychiatric clinic we are endeavoring to correct such conditions and to safeguard society. As Dr. Stewart Paton has said, "Preventive medicine has already accomplished a great deal in safeguarding us from the ravages of disease, but, unfortunately no well planned and co-ordinated effort has been made to prevent the maladjustments in the higher levels of activity, marked by disordered feeling, unco-ordinated thinking and irrational conduct. The psychiatric clinic and the department of mental hygiene are not actually separate institutions although recognized as such merely in order to facilitate organization."

Problems, both from within and without, have been brought for practical solution to the psychiatric service of the City Hospital and the neuropsychiatric clinic at the City Dispensary. It needed a comprehensive organization with a larger personnel for the attainment of the proper results. The personnel of the Mental Hygiene Bureau now consists of two trained psychiatrists as director and associate director, a clinic physician, a trained psychiatric social worker and assistant, and a stenographer.

Our psychiatric social worker has commented that people do not seem to realize just what types of cases are handled by the bureau. Exactly in the same manner as people are now wont to apply to general medical clinics or specialized departments, e. g., Child Hygiene, for treatment of bodily ailments, so should they apply for advice and assistance in matters pertaining to mental health. This suggests one of the activities which the bureau has already planned to take up,—viz.: the teaching of the community regarding the causes, nature, and early care and treatment of mental disorders, by publication of leaflets, lectures, exhibits, etc.

From October 1st to December 1st of this year, seventy-one patients were referred to the social service department. The bureau has been in touch with seventeen charitable and other organizations, including the Red Cross and the United States Public Health Service. It has offered to various interested institutions and agencies any assistance it could render in follow-up work in the community. We have only made a beginning and we need all the public interest and support we can get.

In conclusion, let us hope that all this co-ordinated public health work in prevention of disease will lead us to the distant goal as visualized by Tennyson:

"All diseases quenched by Science, no man halt, or lame or blind
Stronger ever born of weaker, lustier body, larger mind."

An American Surgeon for an East London Hospital.—Mr. Philip Franklin, F. R. C. S., has recently been appointed surgeon in charge of the throat and ear department of the East London Hospital for Children. Mr. Franklin, who is of American parentage, has been especially energetic in initiating and promoting the "Fellowship of Medicine" of which he is an honorary secretary. He is also organizing the new American Hospital and Club in London.

PUBLIC HEALTH SERVICE IN MIDDLESEX COUNTY.*

By Charles W. Naulty, Jr., M. D.,
A. A. Surgeon, U. S. Public Health Service.
Perth Amboy, N. J.

The title chosen for the paper today covers rather an ambitious and to elaborate the various activities of the Public Health Service in this county of a distinct and indirect nature would require an extensive paper which is entirely out of all proportion to the object named at this particular meeting. I will therefore confine myself to the direct activities of the Service and but briefly touch upon several of the indirect phases of activities with which some of you, no doubt, are already familar.

Historically, the Public Health Service is a product of evolution from the Marine Hospital Service established in 1798 for the care and relief of Merchant Seamen. For the next eighty years the Service was confined practically to the administration of marine hospitals and relief stations. The beginning of this program of health activity dates from 1878. From then on there has been a gradual and continual increase in the scope of its sanitary investigations, culminating in the act of 1912, when Congress authorized the Public Health Service to study and investigate the disease of man and conditions influencing the propogation and spreading thereof, including the sanitation and sewage and the pollution, either directly or indirectly, in the navigable streams and lakes of the United States.

I take it for granted that all of the members present realize that the activities of the Public Health Service, insofar as the work of a community is concerned, must be largely of a supervisory or advisory capacity and that the Public Health Service cannot of its own accord assume or take over the functions of the local health authorities unless an appeal has been made through the proper constituted local and state officials. With this limitation clearly in mind the Public Health Service at the present time has sufficient legislative warrant to carry out the extensive program that has been outlined by the Surgeon General and is hampered in this activity solely by lack of personnel and appropriation.

In the County of Middlesex the Marine Hospital Service first appeared during the epidemic of cholera in 1894 in Hamburg-Altona, Germany, when the state health officer of the Port of Perth Amboy received a temporary appointment from Dr. Wyman, the then Surgeon General of the Public Health Service. As a result of correspondence with Dr. Henry Mitchell of the New Jersey State Board of Health in 1904, the Collector of Customs at the Port of Perth Amboy was notified to refuse to accept clearances made by the New Jersey State Health Officer and a Medical Officer of the Public Health Service was detailed for duty at the Port of Perth Amboy and at the present time there is a dual inspection service.

For ten years after the establishment of the permanent station at Perth Amboy the activities were confined largely to inspection of arriving vessels and the medical care of sick and disabled merchant seamen. With the outbreak of the European War immediately the activities increased many fold. During the period of the war the medical officer in charge of the station acted as medical examining officer during various recruiting campaigns for the army, the navy and for the coast guard. So far these phases of service activity have had little direct value to the county at large and should be considered more in a line of historical statement.

In 1916 Congress passed an Act known as the Civilian Employees' Compensation Fund—a plan to provide medical care and treatment for civilian employees who were injured in the performance of their duties. When the large munition plants were erected in this county by the Ordnance Department of the U. S. Government with their thousands of civilian employees, the question of furnishing medical care because a serious problem and it was planned to appoint a medical officer of the Public Health Service in each plant at a nominal salary, the contractor to supply the balance of his pay. Owing to a ruling of the Comptroller of the Treasury this was decided to be illegal and the proposition fell by the wayside. The Relief Station in Perth Amboy being already in existence and having a contract with the Perth Amboy City Hospital for the care of Government patients, the medical

*Read before the Middlesex County Medical Society, January 21, 1920.

officer was notified to take up the question of medical relief with the various plants and accordingly all civilian employees in the T. A. Gillespie Shell Loading Co., Raritan Arsenal, and other Government controlled munition plants in this vicinity who were injured in the performance of their duty and whose injury was sufficient to require hospital care, were referred to the Perth Amboy City Hospital for admission and medical care.

The War Risk Insurance Act provided that after discharge from the army or navy any person who had served in the military forces of the United States during the period of the war with Germany, who was wounded or was sick while in service and who developed a reactivation or a sequela of the condition for which he was treated or with which he suffered while in service, was entitled to free medical care and treatment from the Public Health Service and, when necessary, to receive hospital care and the necessary orthopedic appliances to restore him or her to a wage earning status. This Act provided that wherever possible such beneficiaries of the War Risk Insurance Act should be treated in a Government hospital and by Government medical officials. Wherever the condition of the patient is such that it is impracticable to move him, or his condition is such that it requires immediate medical care that it is impossible to incur any delay, the Government will repay the medical bill for the care of such patients. It should, however, be understood by the members present here that the prices paid by the Government for the care of such cases is $1 for an office visit and $2 for a house visit and that where a patient is admitted to a local hospital by the attending physician and not by a medical officer of the Public Health Service under an annual contract the patient is expected to be admitted to the ward and the Government will pay only ward rates. I would suggest here, at this time, that should any cases arise in your practice where there is any question as to the eligibility of the man receiving hospital or medical care and the question of reimbursement for his expenses should arise that I will be very glad to advise, as far as possible, in each case and may possibly be of service in presenting matters in such fashion to the District Supervisor that you will experience a minimum degree of delay in the adjustment of the re-payment of your bills.

From a careful reading of the various service publications it is apparently the intention of the Public Health Service to give medical care and attention wherever possible to service beneficiaries of the War Risk Insurance Act as close to their home town as is possible with the facilities and equipment at the disposal of the local institutions for the car eof such cases and it is not proposed to force any man to accept Government hospitalization without his consent. Yet, it must be remembered that any man who refuses to accept reasonable hospital and medical care or to submit to a reasonable examination by the Government medical officers shall have his War Risk Insurance compensation stopped until he becomes less recalcitrant.

During the war there was a bill known as the Kahn Chamberlain Act which provided for the interdepartmental board by hygiene and the establishment of a Division of Venereal Diseases under the Public Health Service at Washington. There were several generous appropriations made for the maintenance of the venereal disease service. One of the provisoes was that no money should be spent in any state unless the state would provide an amount equal to the amount to be appropriated by the Government or proportioned in a definite manner based upon the population. The State of New Jersey, through its State Board of Health, applied to the Surgeon General to participate in the expenditure of this fund and a medical officer was detailed to Trenton to serve in connection with the State Board of Health and to assist in the outlining and inauguration of the campaign against venereal diseases. As far as the County of Middlesex goes at the present there are two venereal clinics established, one in New Brunswick and one in Perth Amboy. I have not heard of any specific report made as yet of the number of cases treated or of the results of such treatment and it is therefore impossible to furnish any statement of the value of the work done in these two communities. The figures published by the Provost Marshal General as the result of the draft examination show that venereal diseases were extremely prevalent among the men of this country and the well-known ravages lasting for several generations as the result of sy-

philitic infection clearly demonstrate the necessity for an active campaign for the eradication of the venereal diseases if we expect to improve the general health condition of the generations to come and reduce the taxes that are levied from year to year for the support of our insane asylums and other state institutions.

There is a phase of service activity which is present every day in the year at the disposal of the medical practitioners of this county and which has received very little recognition as such from the medical profession at large. This is the supervision by the Hygienic Laboratory of the U. S. Public Health Service of the production and manufacture of all biological products and vaccines and surums used in the treatment, prophylaxis and diagnosis of diseases. This laboratory was for many years under the control of Dr. Milton J. Rosenau, one of the faculty of Harvard University. He was succeeded by Dr. John F. Anderson, who is now director of the laboratory of the Squibb Drug Co. in New Brunswick and it will be an agreeable surprise to most of you to know that our distinguished fellow-member of this county medical society, Dr. Anderson, was a collaborator in establishing definitely the unit for determining the potency of diphtheria antitoxin.

The present Surgeon General,, Rupert Blue, has worked a complete reformation in the activities of the Public Health Service during his administration and his far-seeing policies, that have been outlined from time to time, were at first considered rather utopian in scope but time has vindicated his predictions and as noted in the opening of my paper, the activities of the Public Health Service are limited at the present time only by lack of personnel and appropriation and while, unfortunately, I have not been in a position to participate in all of the service activities and the work in this county has been somewhat limited compared to the investigations and studies that are work itself has not been recognized and fully understood by the membership at large in this society. I consider it a pleasure and honor to have the opportunity to present for your consideration and information this brief outline of work done in this county and bespeak your earnest co-operation and assistance in the carrying out of the future activities of the service as they will be developed in accordance with the needs of the community.

THE AFTER CARE OF SANATORIUM PATIENTS.

By M. James Fine, M. D.,
Chief of the Division of Tuberculosis of the Newark Department of Health.
Newark, N. J.

It has been a too widely accepted belief that a few months in a sanatorium will cure the average tuberculosis case, and that if cure does not result, no further hope of improvement can be looked for. No greater fallacy can exist than this for the reason that even in incipient cases improvement is slow and dependent entirely upon the conduct and resisting power of the patient.

It may further be said that no good results will come in the average treatment of the tuberculous in sanatoriums unless there is a sustained and intelligent follow-up system. Although the period spent in a sanatorium may be regarded, with good reason, as a schooling and re-education in hygiene, the final goal in view must be the fitting of the individual to eventually resume some useful occupation.

SANATORIUM CARE SHOULD BE SUPPLEMENTED BY PROPER CARE.

A few months spent undergoing treatment in a sanatorium without an adequate after care regimen is not sufficient to restore the tuberculous to health; nor is it sufficient to restore him to his avocation, or to make even an approximate approach to the ability to do a normal day's work. Both common sense and past experience point to the acceptance of these facts. It is therefore of vital importance that an intelligent vision be exercised in providing a safe and sane system of after care for the discharged sanatorium cases.

It is apparent that far advanced cases requiring continuous sanatorium treatment cannot be considered at all industrially; only such types as show permanent and reasonably rapid improvement should come in this category. The real problem with this latter class of patients, especially where previous modes of living and economic efficiency were below par, is the diffiiculty of exerting

a moral and stimulating influence, well regulated and without haste.

WHAT ARE THE ESSENTIALS OF AFTER CARE?

How can this end be measurably accomplished? Our first duty is to guard against a relapse; we must inculcate into the patient's mind a true appreciation of his condition, impressing upon him both the physical and, in a good many cases, mental limitations, ,consequent upon his disease. The patient must be protected from falling back into old habits or engaging in occupations that have an unfavorable influence upon him. We must direct him in finding, if not congenial, at least suitable employment.

The benefits of the time put in at a sanatorium must not be over-emphasized lest over-confidence will result; while good treatment may have put the patient in the running for a successful struggle against tuberculosis, it is well to remember that the race is not won by the swift, for the speed of recovery and the return to strength should be permanent. Time, nature and prudent after care must complete the cure begun in a sanatorium.

To this end the patient and his advisors must work together to make the apparently arrested case permantly so. We must use normal means to accomplish a normal end in the case of tuberculosis, and "wild-goose" experiments will never accomplish anything. There are no "quick cures" in tuberculosis.

The patient should refrain from all rash actions; he should not grow overambitious, should not be lured by the prospect of "big money." He should be made to realize that the policy governing his conduct must be for a number of years one of "watchful waiting." It may be hard for him to renounce ordinary activities and pursuits but a timely renunciation may be the means of saving life for fruitful service in later years.

On the other hand, skilful after care must also look after those patients in whom there is a tendency to let themselves go, or to become shiftless. This state can be counteracted by the salutary effort of well regulated, purposeful work.

NURSING SERVICE IMPORTANT.

Upon leaving the sanatorium all patients automatically come under the supervision of the Department of Health and are required to present themselves for periodic examinations and further treatment should it be necessary.

Patients are also visited in their homes by the department nurses, who will materially assist in the recovery by useful counsel and direction. The influence of the nurse for health extends not only to the patient, but to the family and the the public with whom contact is made. The health teaching thus disseminated by the nurse would be useless unless applied; therefore she insists upon practical application.

In this manner far-reaching results are obtained, not by harsh measure of enforcement, but through the propaganda of example, through object lessons. The well-disposed patient himself acts as an educative agent, his family and friends become interested in the eradication of this plague, and with the active co-operation of the public much will be done in the coming years towards its virtual elimination.

The department through the Tubercular Division, has already put into force an organized plan whereby patients who have returned from sanatoria may follow a regular employment during the daytime and at home enjoy the advantages of sanatorium care and treatment by living the outdoor life in tents provided by the department, together with all the necessary furniture and equipment. The home treatment has been further extended to include vocational training, suitable to the condition of each patient.

Milk is supplied free to patients in need of assistance as is also any necessary medical attention as well as such body-building preparations as cod-liver oil, etc. Sputum boxes are distributed gratis, and instruction given by both nurses and physicians as to personal conduct and habits. The methods of preventing the further spread of the disease to relatives and other members of the household are practically demonstrated.

Co-operation with the attending and family physician is gladly given and nursing service is provided irrespective as to whether the patient is wholly or partially under the supervision of the department.

Where indicated free x-ray examinations are made to determine the exact condition of either the progress or the

degree of improvement of tuberculous lesions.

The Bureau of Tuberculosis would at this time remind the physicians and patients of the advantages offered by the department, alike to the person who cannot afford medical treatment as well as to the private patient. All treatments and diagnoses are strictly confidential and no information in connection with the patient is divulged at any time for any reason.

It is hoped that the profession and the general public will not hesitate to avail themselves of the opportunities offered for the benefit of the individual patient and the community at large.

Let me say finally that a word of caution spoken in time to the person who is over-working, to the dissipater, to the neglectful, is often the "turn" in the road.

362 Clinton Avenue.

COLON BACILLUS IN THE VAGINA AS A CAUSE OF LEUCORRHEA AND STERILITY.*

By Samuel Barbash, M. D.,
Atlantic City, N. J.

Some time ago I noticed in treating various cases of leucorrhea or vaginal discharges of non-gonorrheal origin that my results were far from satisfactory in some cases, and the thought occurred to me that if I could get an autogenous vaccine and administer it to some of these cases, that I might get better results. One case in particular, suggested itself, owing to the fact that the woman stated that she had had a profuse vaginal discharge extending over a period of two years since her marriage, that she seemed unable to check, either with vaginal douches or with local treatments. She stated that she had received local treatments for over six months with slight effect, and when the treatments were discontinued, her discharge became as profuse as ever.

I suggested that we try an autogenous vaccine, as an experiment, with the hope that it would help. We used no local treatment whatever and after the fifth hypo. of the vaccine, the discharge had completely stopped. She was given fifteen injections with the result that I got an apparent complete cure.

After this I began to use autogenous vaccines in all cases with very gratifying results. In the subsequent cases we used local treatments consisting of tampons impregnated with a preparation containing ichthyol, iodine and phenol. While I think that the local treatment helped, I am convinced that the vaccines were the prime factor in clearing the discharge.

The vaccines invariable contained the **colon bacillus** together with one of the **staphylococci.** We all know that the colon bacillus can for anatomical reasons very easily find its way into the vagina and up into the bladder and even into the kidney, as has been demonstrated in cases of cystitis and pyelitis, which occurs much more frequently in the female than in the male.

Looking over various standard works on bacteriology of the genito-urinary tract. I find that they are all agreed that the colon bacillus is found in as high as 75 to 80 per cent. of these infections. Assuming this to be the case it appears to me that the logical way of treating these cases would be to direct our attention to the colon bacillus and render it harmless.

The colon bacillus is active only in an acid medium, and of itself produces an acid medium. What the nature of the acid produced by the colon bacillus is, or whether it is a combination of acids, is a matter of conjecture to me. I do know, however, that in treating cases of leucorrhea with irritating discharges and frequency of urination, that I got excellent results with hexamethylamine internally, and locally in the vagina, together with autogenous vaccines. Whether the urotropin was decomposed in the vagina and liberated formaldehyde, I cannot say, but in two cases I was able rapidly to render slightly acid within a few days, a cervix which at first gave an intense acid reaction to litmus paper.

This brings us a step further into the activity of the colon bacillus and its acid producing ability. We get from time to time women who come to us with the story that they have been married for a number of years and are unable to become pregnant. A gynecologic examination is negative, there is no history of venereal infection and microscopic smears reveal no gonorrheal infection.

*Read before the Atlantic County Medical Society in September, 1919.

We sometimes find retroversion. There is no apparent physiological reason for this sterility, but the fact remains that the woman **is** sterile. I had occasion to test out with litmus paper in the vagina cervix the reaction in one of these women, who was apparently in the best of health and still was unable to become pregnant. She had had inserted into her, as a matter of chance in the hope that she would become pregnant, one of those bifurcated uterine dilators which remained there for three months. I was absolutely astonished at the highly acid reaction to my litmus paper and I know as well as I am living that that young woman will not become pregnant until her vagina and cervix are rendered alkaline, or slightly acid, inasmuch as the spermatozoon could not live in such an acid medium.

How this is to be accomplished, I believe, is by internal administration of hexamethylamine, as well as local treatment directed against the acid-forming bacillus. In addition to this I expect to use vaccines, should she return to me. I might add, that the first case on which I used vaccines, that is, the woman with the vaginal discharge of two years' standing, became pregnant before I finished my course in vaccines.

To me, a further proof that certain cases of vaginitis with leucorrhea, and associated with cystitis, were of colon bacillus origin, is illustrated by the following case:

A young woman thirty-two years of age, in perfect health, developed shortly after marriage, ten years ago, a vaginal discharge for which she received local treatments. It was found at the time, that she had a retroversion of the uterus and was operated upon and the Baldy Webster Operation performed. Due to some error, the operation was unsuccessful and she was reoperated upon. She was curetted each time. There was no diminution in her vaginal discharge, which became worse as time progressed. About two years ago, her vaginal discharge became so irritating that vaginal ulcers appeared. The discharge was ineffectually treated and the ulcerations were touched up with silver nitrate to cause them to heal. She was ordered to abstain from various articles of food and drink and not permitted to indulge in various exercises, like horseback riding, tennis, etc. At the time of her first examination, her entire vaginal vault was red and inflamed and there were three ulcers near the external vaginal orifice. A digital examination with one finger, caused excruciating pain. Local treatments through a small vaginal speculum for four days caused the patient to cry out with pain. She told me that coitus during the past two years was almost unbearable and was finally discontinued four months ago. Urination was not painful but slightly more frequent during the day than it should be. At night there was no increased frequency of urination, the patient sleeping six or eight hours without discomfort.

She told me that the last vaginal examination had to be made under general anesthesia. A specimen of the vaginal discharge was sent to the laboratory of the Atlantic City Hospital and a vaccine prepared. The culture showed the colon bacillus and the staphylococcus albus. Treatment was immediately started locally by applying tampons containing phenol, iodine and ichthyol, to which I later added ten gr. of hexamethylamine. I also gave her hexamethylamine internally with sod. acid phosph. My attention, as you see, was directed against the colon bacillus.

The results were startling, and by the fifth day the ulcers were almost healed, the vaginal discharge almost completely checked, and the patient, for the first time in two years, was not conscious of her vagina. Her vaginal reaction to litmus paper was highly acid at first, and on the tenth day after her treatment was begun, showed a mild acid reaction. This later varied from alkaline to mildly acid. Vaccines are being administered to this case and she appeared to be perfectly well at the end of two weeks' treatment, although she was remarkably improved in five days. After one week of treatment I told her that diet had no bearing whatsoever on her case and neither had exercise. She has gone swimming, horsebackriding and has partaken of vinegars, oils, salads, lettuce and has even eaten lobster and drank beer without any harmful effect whatsoever. This convinces me that inasmuch as I consider such cases as distinct colon bacillus infections, the treatment of which is directed against the germ itself, and its acid producing proclivities, that, there is no relationship whatsoever between

cystitis and vaginitis of this type, and food. Dec. 25, this patient reported as being perfectly well.

Of course I realize that a few cases of leucorrhea treated in this manner does not give us conclusive proofs, nor does one case such as I previously described prove that sterility in women is sometimes caused by the acid producing colon bacillus in the vagina, but the results obtained by me were so satisfactory I cannot help but feel that, along with the other and various methods of treatment in cases of this type, the method here suggested should be given a fair trial.

To sum up my conclusions, I find that an active, virulent strain of the colon bacillus associated with one of the staphylococci is often found in the vaginal vault. These cause at times a profuse leucorrhea with highly acid reaction, which in turn may cause ulceration in the vagina.

Second: That the colon bacillus by reason of its acid producing ability renders the patient sterile.

Third: That these conditions can best be remedied by treatment against the offending germs. The treatment should be directed in as many ways as it is possible to direct it. Locally, by antiseptics which will destroy the colon bacillus and chief among these are iodine, phenol and formaldehyde, either in the shape of hexamethylamine or even a well diluted formalin swab. I might even suggest the lactic acid bacillus in solution, which is said to have an inhibitory action. Internally by the administration of hexamethylamine, and subcutaneously by autogenous vaccines. I furthermore believe that if we attack the problem of sterility in the female from this viewpoint, that several of the gynecologic operations, often done, and often without success, will be discontinued. I refer especially to the one wherein a bifurcated uterine dilator is put into the uterine canal with the intention of dilating it. This seems so absurd when the spermatozoon is so small as to be invisible to the naked eye, and the normal uterine canal is large enough to permit the free flow of visible blood.

Defective Children in England.—Of 533,400 children outside of London examined medically, according to the report of the chief medical officer of the Board of Education, 259,000, or 48.5 per cent., were found to be defective.

WASSERMANIA.

By C. L. DeMeritt, M. D.,
Hoboken, N. J.

I use this rather slangy term, the best I can invent, for a new and hitherto unnamed psychosis, having a close but undetermined relation to syphilis. Wassermannia is a mental state characterized by the delusion that the health, the happiness, in fact the whole existence of syphilitic patients hang entirely on the results of frequent Wassermann tests of their blood. Its etiology is obscure. The spirocheta pallida does not play any direct part, for the condition is often found in people with negative Wassermanns and with no history or clinical evidence of syphilis. Cases of this sort are especially common among medical men. Indeed, the psychosis often starts first in non-syphilitic doctors and is communicated, by them, to their syphilitic patients.

My theory is that it is spread by a miasma, emanating from the intellectual fog surrounding certain pseudo-scientific medical circles where physical examination and clinical experience are discounted in favor of supposed short-cuts to diagnosis and prognosis.

I am not trying to be funny with the laboratory man. I think he holds the highest position in our profession. His patient and poorly paid work is the basis of medical progress. The benefits dispensed by the clinician are mostly the practical application of laboratory discoveries. This very fact makes it the clinician's duty, to the laboratory man as well as to his patient, to read laboratory findings in the light of common sense. The careless worker in medicine ever looks for a scapegoat, and the blame for many a wrong diagnosis or treatment is shifted to some laboratory worker, whose correct report only needed co-ordination with equally good work by the medical attendant.

One of the worst things medical pioneers have to contend with is exaggeration of their work by enthusiasts. After the announcement of something really good, comes a flood of "reports" in which the cant term "miraculous results" is apt to figure. Now it is a sad and disquieting thing to hear a twentieth century M. D. talking about miracles or near-miracles. However, we swallow the stuff. Then, when the inevitable reaction comes, the discovery is underrated for a time, and so it may take years to teach the profession its

real use and value. Arsphenamine went through this rapidly. Today, we are pretty well agreed as to its real worth. The Wassermann test is taking much longer.

Prophylactic treatment of Wassermania is of first importance. On taking charge f a case of syphilis, I tell the patient, who generally has a hazy idea of the "blood test," as follows: "The Wassermann test is only one of a number of things to be considered. Its importance is overestimated. I shall use it or not, as I see fit. You are not to worry about it. No number of negative Wassermann's can be taken as proof of cure. I do not promise to eradicate the last syphilitic germ from your body. I shall work to arrest the disease. If you take my treatment it is reasonably certain that you will have no more signs of syphilis, that any children you may have will be healthy, and that you will die of some other disease than syphilis. No one can honestly offer you more."

A candid statement like this impresses a sensible man more than promises of forthcoming wonders. His confidence is gained. The knowledge that he has to make a long, hard fight, with some probable ups and downs, but with the odds in his favor, nerves him to practice control of mind, as well as of body, and he goes through his trial with calm determination. Even a positive Wassermann, for I do use the Wassermann test, does not upset him. What a contrast to the poor Wassermaniac, whose joy over a negative report quickly gives way to the haunting fear that the next one will be positive!

In some advanced cases of Wassermania, both blood tests and arsphenamine must be forbidden. For example: A lady, thirty-seven years old, came to me four years ago with syphilis of seven years' standing, during the last three of which she had been treated by a medical Wassermaniac. In spite of about a dozen arsphenamines and some, but not enough, mercury, her Wassermann would not stay negative. She had some squamous syphilids and, quite naturally, a trace of albumen and a few casts in her urine. She was thin, worried and hopeless, a psychic castaway a burden to herself and others.

She handed me a bundle of Wassermann reports ranging from negative to four plus. "It's no use," she said, "my blood will not stay right. I am incurable."

I said: "All right, think so if you like. But understand, if I take your case, you are done with 606 and blood tests. They are of no more use to you They only torment you. Forget them." After six intramuscular injections of metallic mercury, she had gained ten pounds, her skin and urine had cleared up, and she was taking an interest in life.

Later, I removed both ovaries and the corpus uteri for cystic ovaritis and fibroids, with hardly any psychic disturbance following. Today, she is living an active and useful life and has to be reminded, now and then, that it is time for another course of mercury.

A young male syphilitic came to me recently from a New York clinic noted for its shameless prostitution of charity, where, though quite able to pay, he had been treated gratis. He had had over twenty arsphenamines. He had a three plus Wassermann and nephritis, although, just before being infected, he had passed a life insurance examination. The infatuated "professor" at the clinic, who had not made one urine examination while all this arsenic was being pumped into him, was proposing another course of arsphenamine.

To the medical Wassermaniac, the general mental and physical condition of syphilitic patients is of no account and syphilis itself is merely an incidental feature of the Wassermann reaction. From his disordered point of view, the only thing that counts is a negative Wassermann.

Clinical Reports.

A Thermometer in the Intestine.—A case, perhaps unique, is reported in the Journal de medecine de Bordeaux. The patient was an old man with tuberculosis, who had also been under treatment for a severe case of grippe, during which, after rectal thermometry the instrument vanished. The rectum was explored to no purpose. Radiography showed the presence of the object in the sigmoid. To extract it it was necessary to do laparotomy and then make a button hole in the colon. Death having occurred from grippe, autopsy showed that the intervention had been a technical success. In other cases of lost thermometer the instrument has, as far as known, been recovered through the natural passages. In future in this clinic the rectal thermometer will be introduced, mounted with a cork, which will prevent its slipping into the rectal ampulla.

Large Vesical Calculi—Dr. E. C. Smith, Quebec, reports this case in Surgery, Gynecology and Obstetrics. The calculus weighed 38.5 ounces in the moist state. This did not include any of the flakes and fragments which were lost during the removal and which would have at least brought the total weight up to 40 ounces. It was ovoid, light brown in color, smooth and flaked easily. It measured 9.6 by 14.2 centimeters with a circumference of

36 centimeters. Its cut surface resembled the cross section of a tree, being built up of numerous, concentric, yellowish white lamellae about twenty in number. It was apparently of the same composition throughout, no distinct nucleus or foreign body being present. Chemical analysis showed urates, calcium oxalate and earthy phosphates. The urates were the predominating salts. Mucin was also present.

A Temperature of 108° with Recovery.

Temperatures above 106° are generally considered apocryphal, and whenever reported meet with skepticism on the part of the medical profession. The following report by Dr. P. W. Williams, in the U. S. Naval Bulletin, seems to be absolutely reliable:

The patient was admitted to the observation camp with a temperature of 103° and was immediately transferred to the isolation camp. He was given the routine pneumonia treatment, which consisted of camphorated oil to the chest and a pneumonia jacket. Magnesium sulphate, fl. oz. 1½, and aspirin and sodium bicarbonate aa gr. X. His temperature continued to rise until 21 hours after admission, when it reached 108°, where it remained for 45 minutes. This was verified with two thermometers. The patient did not lose consciousness at any time. His temperature returned to normal in 72 hours after the maximum was reached. His mentality was somewhat hazy and sluggish for several days after his temperature became normal.

He later developed a mild degree of bronchitis, and this was followed by a right sided pleurisy, which yielded to treatment very rapidly. Patient was discharged from the hospital 26 days after onset. Urinalysis showed no albumin or sugar. Blood culture showed Gram-negative diplococci. Sputum analysis showed pneumococcus and micrococcus catarrhalis.

Passing a Bullet from the Bladder.

Dr. F. H. Bokman, in the U. S. Naval Med. Bull., reports the following interesting case:

A private, wounded at Soissons, July 18, 1918, was admitted to the U. S. Naval Hospital, New York, on December 10, 1918. Two machine-gun bullets had entered the upper third of the anterior surface of the thigh about two inches apart. One of these fractured the femur and remained in the thigh, while the other traveled upward and lodged in the pelvis.

The fracture of the femur united in good position without any complications.

The bullet which entered the pelvis gave no symptoms until October (about three months later), when he first noticed a little pain on urinating, but only while standing. There was no discomfort whatever while voiding in a bed urinal. No blood appeared in the urine. He thought that he had "a little kidney trouble" and did not consider it of sufficient importance to be reported to a medical officer.

On the night of February 14, 1919, the patient returned to the hospital after 48 hours leave, during which time, as he stated, he passed no urine whatever, although he made several attempts. A few drops only would pass at a time, accompanied by very severe pain. For the first time he noticed a little blood after each attempt at urination. Remembering that he experienced much less pain in the recumbent position and feeling the need of some relief, he took a bed urinal and lying down in his bed, made several rather vigorous efforts to void. After a few efforts, he experienced more pain than usual, and a machine-gun bullet dropped out of the meatus into the urinal.

35 Years Defecating and Urinating, and 11 Years Menstruating by the Rectum.

Dr. W. W. Keen, Philadelphia, in a paper read at the annual meeting of the Amer. Surgical Ass'n, said: The case designated by this title is worthy of a final record as an evidence of the possibilities of surgery and especially of the conclusive evidence afforded that the rectum could be ultilized as a common cloaca for the urine and the menstrual flow as well as for the feces for an indefinte period. The case was one of extensive and incurable vesicovaginal and rectovaginal fistulae caused by sloughing as a complication of typhoid fever. Ultimately Dr. Keen entirely closed the vaginal outlet. He had first reported the case in his Toner lecture in 1876. Only one similar case had ever been published. This was by Baker Brown in 1864. Reuben Peterson had assembled (Surgery, Gynecology and Obstetrics, 1917) thirty-eight other similar cases in addition to two of his own. In 1851 Maisonneuve had performed this operation for the first time, but his was not published until 1889. Rose had operated on three cases, in 1872, 1883 and 1886; one case was published in 1878, the other two in 1903. Dr. Keen's case was the only one in which the condition was caused by typhoid fever. In thirty-three cases in which the cause was stated, twenty-five resulted from childbirth and four from operations for cancer. Closure of the vagina was successful, except at the internal end of the remnant of the urethra. After several minor but unsuccessful operations done here, he excised this small remnant with entirely successful results. Fistulae in the cicatrix broke out at intervals of two, nineteen, and eight years, but were easily remedied. Thirteen years after the vaginal closure there was escape of urine. Digital examination by the rectum showed contraction of the rectovaginal fistula and the presence of a calculus in the vagina. The calculus was crushed by curved hemostatic forceps introduced through the rectum. At death the patient, at the age of seventy-three, had remained dry and well, with the exceptions noted, for thirty-five years and five months after the closure of the vaginal outlet.

An Open Safety Pin Swallowed by an Eight Months Old Child; Passed Through Rectum Four Days Later.

Reported, with x-ray cuts, in the Medical Record, August 2, by Dr. Samuel Weiss, New York City.

The presentation of this case is of interest because of its favorable termination without operative interference, and also because of a hasty and erroneous diagnosis due to faulty interpretation of the x-ray evidence.

R. N., eight months of age, and the only child, swallowed a small safety pin which was open. The mother became alarmed and ran to a physician who advised her to have an

x-ray taken. Following this procedure the child was referred to a nose and throat institution, where after twenty-four hours time the mother was told that she must take the child to another hospital as the case could not be handled there.

Directly from the hospital she brought the child to my office, and after fluoroscoping the child and locating the pin with its point down, a little below and to the right of the xiphoid cartilage, the little patient was placed on her abdomen and an x-ray plate taken. Following this the child was given a small quantity of a barium-buttermilk mixture and this time x-rayed in the upright position. After developing the plates and examining them I concluded that the pin was in the region of the duodenum.

The patient was admitted to the Philanthropin Hospital, on Dr Cronson's service, who after viewing the x-ray plates decided to wait for further developments. Upon his advice twenty-four hours later the child was again x-rayed and this time the pin was located in the cecal region and most of the barium which was administered the previous day was in the rectal ampulla. As the child had no elevation of temperature and was nursing and sleeping without being peevish, the operation was deferred with the intention of x-raying the child again the following day. During the night the child was restless and cried but fell asleep again; another plate was to be taken and if the pin was in the same place the patient was to be operated on. However, before another x-ray was taken, the nurse reported that the child had passed the pin which was imbedded in a hard fecal mass.

Credit is due to Dr. Cronson for his judgment and conservation, which prevented unnecessary mutilation of the little patient.

Hernia Through the Foramen of Winslow.

Reported by Dr. J. E. Engstad, Grand Forks, N. D., in the A. M. A. Journal, February 8.

H. B. was referred to me by Dr. Knutson of Buxton and admitted to St. Michael's Hospital in this city, about midnight, August 3, suffering from intense pain in the epigastric region. The patient gave a history of sudden attack of pain while lifting a heavy object about twelve hours before admittance. The family physician was called, who immediately recognized the gravity of the case and ordered the patient sent to the nearest hospital. The journey of more than 20 miles was accomplished in an automobile improvised as an ambulance.

The abdomen was very rigid and sensitive to pressure, and a tense mass was felt in the right epigastric region. The pulse was about 36, heart beats 90, the organ being in a state of auricular fibrillation, and temperature, 103. The kidneys and lungs were normal. After a speedy preparation a long incision was made, and immediately there protruded large masses of dilated and congested intestine filled with fecal accumulation. The strangulated intestine was soon recognized as being a part of the upper portion of the jejunum, about 75 cm. from the fossa of Treitz, the strangulated portion being caught in the foramen of Winslow. Traction was first made to relieve the impacted intestine, but the strangulated loop had already become edematous, and it was found necessary to introduce the tip of the index finger into the tight opening, carefully severing first the peritoneal covering and gradually the connective tissue of the opening, extreme care being exercised not to injure the immediately overlying structures, the portal vein or the common duct. All the structures underlying these canals had to be cut before the impacted loop could be released, the latter being accomplished by application of moderate traction.

The loop was immediately covered with warm packs; the intestine was then opened and emptied of pancreatic fluid and bile, after which the opening was closed by the usual intestinal sutures, silk and catgut being used. The injured intestinal tract at once showed unmistakable signs of restored circulation. The operation was completed by the introduction of two small drains and the usual closure. No effort was made to close the large foraminal opening, this omission being based on, first, the supposition that an enlarged opening would not again implant any loop of the intestine that might be forced into the cavity; and secondly, the great danger of traumatizing the vein. The drains were removed the second day.

The patitnt rallied immediately, and the progress toward recovery was rapid and without any incident up to the tenth day, when, without any previous warning, there was a rise in the temperature, the wound opened up, and a profuse serous discharge appeared. This rapidly changed in character, at times to bile and pancreatic fluid. The fat underlying the skin rapidly sloughed away, and on the whole the case looked rather unfavorable. On the thirteenth day an orange seed appeared in the discharges, which immediately relieved our misgivings, for instead of a fistula of the common duct, we now knew that we had a small intestinal leakage from the drainage incision in the intestine, which was about 40 cm. from the duodenojejunal fossa, or 60 cm. from the ampulla of Vater. The secretions from the fistula appeared at times almost unchanged bile and pancreatic fluids. In due time the opening was packed, which controlled the discharge of the secretions, and the wound healed rapidly. The patient was discharged from the hospital five weeks after the operation, with good health, the wound being healed with the exception of a space about an inch square, filled with granulation tissue.

Traumatic Rupture of Spleen: Splenectomy and Recovery.

Fred S. Clinton, M. D., F. A. C. S., Oklahoma, reports this case in the Journal of the Oklahoma State Medical Society:

On the 26th of December, 1919, E. S., 5 years of age, was thrown to the pavement and run over by a very light car resulting in injury to his left chest and abdomen. He was seen shortly afterwards and immediately removed to the Oklahoma Hospital. The history of violent contusion of the left side, especially along the base of the thorax, hypochondrium and flank, together with evidences of serious internal hemorrhage and increasing left side, suggested the necessity for immediate adbominal section.

Operation: The median abdominal incision

was enlarged to obliquely to the left sufficiently to grasp the pedicle of the spleen and control the hemorrhage and expose and deliver the spleen and place a hot pack in the splenic fossa. After identification of splenic pedicle by palpation, avoiding injury to the stomach and pancreas, two clamps were applied to the pedicle and the extensively ruptured spleen was removed, the pedicle transfixed and ligated in sctions with No. 2 chromic catgut; abdomen freed of clots, inspected, gauze pack removed, wound closed and patient placed in a warm bed, hot proctocysis instituted and small doses of opium given when necessary to procure rest.

Technic: Where a ruptured spleen is suspected, the principal points emphasized by experience and such operators as LeJars, Balfour, and others are as follows:

(a) Early abdominal exploration through adequate incision.

(b) Delivery of the spleen.

(c) Use of hot gauze pack.

(d) Protection of stomach and pancreas from injury.

(e) Preliminary ligation of any adhesions.

(f) Careful ligation of splenic pedicle.

The recovery of this patient was due largely to prompt surgical intervention.

Abstracts from Medical Journals.

Von Pirquet Reaction in School Children.

Dr. M. N. Chaifet applied the Pirquet test to 149 boys from a public school and 127 girls from an orphan asylum. In 35 per cent. of the boys and 65 per cent. of the girls a negative reaction was noted. The predominance of positive tests among the boys, the author explains by the fact that they come from the lower middle class where the environment is not very favorable, while the girls in the asylum live under much better hygienic conditions. Classifying the subjects according to ages, the author found that up to twelve years 4.3 per cent. reacted; from twelve to twenty years, 55 per cent., showing that with advancing years the reaction is positive in larger proportion. Further grouping shows that in 23.5 per cent. there were clinical indications of tuberculous infection. In 20.5 per cent. no lesions could be discovered. In 7 per cent. the reaction was negative, but other indications of latent tuberculosis were present. The author regards the test as specific and urges its application to all school children.

Aberrant Wassermann.—A contributor to the Journal de medecine et de chirurgie pratiques for May 25 states that even the best technique may be vitiated by a faulty interpretation. Too great dependence on a negative reaction may result in vicious interpretation, and this is true of the entire course of the disease. Whatever the serodiagnosis, the Wassermann is not a safe guid to treatment, which must be pursued along the old lines—that is, the patient must get his three or four years of treatment, just as if no reaction had been taken; but the latter should, of course, be practised for statistical purposes. This doctrine is applicable only to the first years of the disease. In ancient syphilis diagnosis by the Wassermann may be the basis of treatment. To use the Wassermann on a syphilophobic as a means of convincing him of his freedom from the disease should not be tolerated, because of the possibility of swindling the patient. In regard to permitting marriage, Wassermann tests should be excluded and no marriage sanctioned until six years after infection and eighteen months after the latest symptoms. This is the general rule, but the period may be reduced to three years in certain cases kept at the start on intensive treatment with a series of negative reactions.

Relationship of Convulsions in Infancy and Childhood to Epilepsy.

Dr. John L. Morse draws the following conclusions:

1. Convulsions which are a manifestation of spasmophilia are not likely to eventuate in epilepsy.

2. Convulsions which occur in the course of whooping cough must always be regarded seriously, as they are quite likely to be followed by epilepsy later.

3. Single convulsions or a series of convulsions occurring at the onset of an acute disease or with an attack of acute indigestion are less likely to be followed by epilepsy than are repeated convulsions during a considerable period or repeated attacks suggesting petit mal.

4. Repeated attacks which would be classified as petit mal or which suggest it, are just as likely to eventuate in epilepsy as repeated attacks of general convulsions.

5. Nothing can be told from the nature of the early attacks as to the nature of the attacks when epilepsy developes later.

6. When an injury to the head has directly preceded the onset of the attacks or there is no apparent cause for the attacks, epilepsy is more probable than when there is an apparent cause, such as indigestion, for each attack.

7. The presence of an apparent cause for the attacks does not exclude epilepsy.

8. The longer the attacks have persisted, the more probable is the diagnosis of epilepsy.

9. General impressions, which cannot be explained, have a certain value in diagnosis.

10. There is no way to determine immediately when a baby or child has a convulsion or has had repeated convulsions or repeated attacks suggesting petit mal, whether it has epilepsy or whether it will develop it later.

Ileus in the Pregnant and in Parturients.—Dr. Tuxen has been able to find on record only 106 cases of ileus in pregnant and parturient women, but he has encountered three cases himself. In one, torsion of an ovarian tumor had compressed the bowel, inducing mechanical ileus. In his second case, four and a half hours after the woman of 41 had been safely delivered of her fourteenth child, she suddenly developed symptoms of ileus, and a ruptured dermoid cyst was found. The contents of the small cyst had set up irritation, with dynamic ileus as the result. In the third case the bowel had become incarcerated from pressure of the gravid uterus at the sixth month. Diligent search failed to reveal any other cause for the ileus. The uterus expelled its contents a few days later.—Hospitalslidende, Copenhagen.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The Atlantic County Medical Society held its monthly meeting in the Hotel Chalfonte, Atlantic City, February 13th.

Dr. Samuel Stern and Mr. Walter A. Rulon of Atlantic City exhibited a child with Congenital Dextrocardia without transposition of other Viscera. X-ray plates were also shown.

"Comparative Studies upon the Toxicity and Therapeutic Activity of Arsphenamine and Neo-Arsphenamine," was the subject of a paper by Dr. John A. Kolmer of Philadelphia. Experiments upon white rats show that the rate of tolerance for neo-arsphenamine is much larger than that for arsphenamine. Experiments to ascertain the relative efficiency show that neo-arsphenamine is about one-half as effective as arsphenamine. Neo-arsphenamine is the remedy of choice because it is more easily administered and is followed by less reaction. Reaction following intravenous injections often presents an alarming picture: the taste of ether; swelling of the lips; slow pulse; flushing of the face and loss of consciousness. Reaction is generally due to acid solution. The drug dissolved in water must be neutralized with a 15% solution of sodium hydroxide. This precipitates in the blood a mono-sodium salt. Some advise one-third excess to convert the precipitate into a di-sodium salt which is less toxic but hemolytic. One method advises 3 or 4 drops more than required to make a mono-sodium precipitate.

Reaction is due to a toxic substance in the drug which is not definitely known and which is indicated by X. An individual develops an intolerance, becoming anaphylactic. Hemolysis in vivo plays a part. Arsphenamin is strongly hemolytic, but when dissolved in salt solution is less so than when dissolved in water. A concentrated solution is more hemolytic. Hence arsphenamine should be given in a well diluted, proper salt solution and should be injected slowly. Neo-arsphenamine when given in concentrated solution does not need to be neutralized.

Treatment: Neural syphilis is given 4 intravenous and 4 intraspinal injections, covering a period of four weeks. These are given in conjunction with daily inunctions and a course of potassium iodide in 15 grain doses; then a period of rest with repetition as needed, watching for albuminuria.

"Hyperthyrodism" was the subject of a paper by Dr. M. Howard Fussell of Philadelphia. Treatment is not successful in many cases because the patients come with end results. The aids to differential diagnosis are: Low sugar tolerance; adrenalin test; increased reaction in metabolism rate. The adrenalin test consists in the hypodermic use of ½c.c. of adrenalin chloride; the pulse rate increases ten beats to a minute and the blood pressure ten per cent. This test is of relative value because present in other conditions. Also true of sugar test.

In thyroid feeding, the limit is 5 grain in one day. Metabolism rate represents 34.9 calories to a square meter of the body and great increase means increased metabolism. Metabolism over 10% is pathologic. Metabolism rate runs parallel with increase of hyperthyroidism. Feeding of thyroid and adrenalin is practicable in ordinary practice. The metabolic rate is the most satisfactory, but most difficult to be determined, requiring considerable equipment.

Hyperthyroidism must be differentiated from neurasthenia, effort syndrome, organic heart disease, tuberculosis, gastro-intestinal disease, arthritis and local condition of the eyes. Treatment is medical, surgical, by x-ray and by injections. All cases which cause pressure are surgical. Those occurring at menstruation should be let alone. Rest alone causes reduction of toxic symptoms, but in addition drugs are needed to effect a cure. If after 4 or 5 weeks of rest no improvement is noted, it is useless to continue this treatment.

HUDSON COUNTY.

William Freile. M. D., Reporter.

The third regular meeting was held at Carteret Club, Jersey City, Dec. 2nd, 1919, President Dr. B. S. Pollak in the chair.

Proposed new members: Drs. A. V. St. George, Jersey City; Louis E. Dreary, Bayonne, and W. I. Dillingham, West New York.

Elections of new members: Dr. Hans H. Johnston, Jersey City; Dr. Alfred A. Muller, Arlington; Dr. William K. Yeaton, Hoboken; Drs. Louis W. Klugman, T. N. Davey, Augustin J. Molloy, W. S. Williamson and J. Jay Hunt, Bayonne; Dr. Thos. McG. Brannock, Jersey City; Dr. Robert Stewart, Secaucus; Dr. Joseph Schapiro, Town of Union (received into H. C. M. S. from Bronx Medical Society).

Committee on Public Health Legislation—Dr. Samuel A. Cosgrove, Jersey City, Dr. Geo. H. Sexsmith, Bayonne; Dr. Fred Quigley, Town of Union; Dr. John J. Broderick, Jersey City; Dr. John Nevin, Jersey City, chairman; Dr. B. S. Pollack, Secaucus.

The speaker of the evening was Dr. John J. A. O'Reilly of Brooklyn, New York, on "Compulsory Health Insurance."

The fourth regular meeting was held January 6th, 1920, at Carteret Club, Jersey City, President B. S. Pollak presiding.

The Legislative Committee rendered report on C. H. Insurance (report published in February Journal). Unanimously adopted. The society recorded itself against Compulsory Health Insurance, introduced by Senator Colby.

Resolution: Be it resolved, That we, the Hudson County Medical Society express it as our firm conviction that immediate measures should be taken to protect our School System, and to that end we request the Board of Education, the Board of School Estimate, and the City Commission to grant such increase in the salaries of teachers of the schools of Jersey City as may be necessary to return the present competent staff, and to make such a schedule of salaries for the future as will attract to the teaching profession the very best men and women possible to obtain, and

Be it further resolved, That copies of this resolution be sent resectively to the Board of Education, the Board of School Estimate, and

the Mayor of Jersey City. B. S. Pollak, M. D. Unanimously carried.

Election of new members: Drs. St. George, Deary and Dillingham.

Paper of the evening: "The Foundation of Modern Cardiology," By Prof. Louis F. Bishop, New York. (This essay will be published in an early issue.—Editor).

The fifth regular meeting of the society, postponed from February, will be held on Tuesday, March 2nd, when Dr. Geo. H. Sexsmith of Bayonne will read a paper entitled "The Moral, Legal and Economic Responsibility of the Physician in the Treatment of Fractures."

MERCER COUNTY.

Wilbur Watts, M. D., Reporter.

At the regular monthly meeting of the Mercer County Medical Society, January 6, 1920, the members showed themselves thoroughly aroused to the dangers and injustice of the Colby Bill on Compulsory Health Insurance by the unprecedented attendance and the heated and emphatic opinions expressed against it, following the reading of the bill. Most of the members were still in a state of active hyperemia of the combatative center when the meeting adjourned at 12.30 P. M.

Dr. H. B. Costill, a member of the Legislative Committee of our State Society, who opened the discussion, clearly indicated his disapproval of both the bill and its sponsor when, in his introductory remarks he said, "Some men are always looking for notoriety and notoriety. Possibly his reason for introducing his bill is to advertise his relations with Lloyd George while on a recent visit to England." Dr. Costill said that the Colby Commission had promised to have a committee from the State Medical Society present at all meetings when the bill was discussed. That such a joint meeting was held in November, 1919, at which time each member was furnished with a copy of the bill. He called attention to the fact that no new commission had been created to handle the bill but that it had been placed absolutely in the hands of the Commissioner of Labor. "A health bill placed absolutely in the hands of a laborer." He described the bill as vicious and absolutely devoid of any merit whatsoever, a menace to both the medical profession and the laboring man. He said he could not conceive of the labor organizations supporting this bill because he believed they would be clearly able to see the club concealed behind such a transparent, hypocritical offering of good will. He laid great stress on the advisability of fighting the measure primarily as citizens and then, if necessary, as medical men, believing that to come out in the open as medical men would unnecessarily antagonize many laymen who seem always to feel that the doctor is directly descended from Jesse James or Captain Kidd.

Dr. Costill was ably supported in his remarks by other members of the society, the principal discussion arising as to the proper method for the society to pursue to combat the measure. The discussions finally resulted in the following actions by the society:

Whereas, It has come to the knowledge of the Mercer County Component Medical Society, that a bill to enforce Compulsory Health and Accident Insurance, will be introduced at the coming session of the New Jersey State Legislature, and

Whereas We believe such legislation to be inimical to the best interests of the Medical Profession and the working men and women to the State, therefore be it

Resolved, That the Mercer County Component Medical Society unanimously go on record as being unalterably opposed to such legislation, and be it further

Resolved, That we request, the President of the New Jersey State Medical Society, to call an extraordinary session of the New Jersey State Medical Society to consider this bill, and that this session of the State Medical Society, be held not later than January 15th, 1920, and be it further

Resolved, That a copy of this resolution, together with a copy of the above mentioned bill, be sent to the secretary of each Component Society in New Jersey, with a request, that a special meeting of each Society be held to endorse these resolutions select delegates to such session of the State Medical Society.

M. W. Reddan, D. B. Ackley, Horace, D. Bellis, Committee.

A resolution formulated by Drs. Reddan, Ackley and Bellis, introduced by Dr. Bellis: That a special meeting be called by the N. J. State Medical Society to be held not later than January 15th, 1920, to discuss, decide upon and put into effect some definite campaign against the measure. That a copy of the resolution and a copy of the Health Bill be sent to the secretaries of the several county societies. Resolution adopted.

Dr. Crane reported on a meeting of the Essex County Society held recently in Newark and moved that Dr. Davin of New York and Mr. Hoffman of the Prudential Life Insurance Co. speak on the subject of Health Insurance before the Society and that the labor leaders of the city be invited to be present. Motion carried.

Dr. McDonald moved that a special committee be appointed, independent of the Legislative Committee, composed of suitable members to confer with the legislators and prominent newspapers men, and to bring before the public the objectionable features of the bill. Motion carried.

The Mercer County Medical Society honored its returned service men by inviting them, as guests, to one of the most elaborate, best-attended and most enthusiastic banquets ever given by the society. The spirit of good fellowship that prevailed clearly indicated that no man felt that his service was more important or his sacrifice any greater than any other man's, whether he served in France, in one of our home cantonments or as a servant to the general public.

The banquet hall at the Trenton House was beautifully decorated with the national colors and at each plate a small American flag was placed to be used as a bouttonnaire. The speakers of the evening were former Gov. E. C. Stokes, Mr. James Kearney, editor of the Trenton Times and but recently returned from an important commission abroad, and the Hon. Frank S. Katzenbach, one of the leading corporation lawyers of the State.

During the speeches the profession, both in and out of the service, came in for a great deal of commendation and not a little good natured criticism.

An interesting feature of the evening was a page of the menu devoted exclusively to the names of the guests of the evening. After each name silver or gold chevrons were placed to indicate the length and nature of service each man gave.

The service men acknowledged the honor done them by standing at attention, while one of their number expressed their appreciation and thanks to the society.

OCEAN COUNTY.

Ralph R. Jones, M. D., Reporter.

The Ocean County Medical Society met in Lakewood, December 17, 1919.

The following officers were elected for the ensuing year:

President, E. G. Herbener, Lakewood; vice-president, E. S. Carrigan, Point Pleasant; secretary, H. B. Disbrow, Lakewood; treasurer, Irwin H. Hance, Lakewood; reporter, G. W. Lawrence, Lakewood.

Annual delegate to the State Society, V. M. Disbrow, Lakewood. Permanent delegate nominated, Ralph R. Jones, Toms River.

Dr. Koler Buermann, a graduate of the University and Bellevue Hospital College, N. Y. City in 1911, was elected to membership.

The society was requested to nominate six associate members to the staff of the Paul Kimball Hospital, Lakewood. Col. William G. Schauffler and Capt. H. B. Disbrow made interesting reports of their experiences in army medical service in France and Germany.

SALEM COUNTY.

Norman H. Bassett, M. D., Reporter.

The regular meeting of the Salem County Medical Society was held at the Nelson House, Salem, February 4, 1920. On account of the severe storm prevailing the attendance was very small. In the absence of President Fleming of Pennsgrove, Vice-President Bassett occupied the chair.

Drs. Hilliard, Davis, Sherron, Good, James Hires, Ewen, Smith and Bassett answered the roll call.

The essayist appointed for this meeting, Dr. R. C. Sutherland, did not appear. The regular routine business was carried out. The Compulsory Health Insurance Act was discussed and letters and notes were read by Secretary Smith. Dinner was served after adjournment.

Local Medical Societies.

Mountainside Hospital Clinical Society.

A. H. Richardson, M. D., Secretary.

The annual meeting of the Clinical Society of the Mountainside Hospital, Montclair, N. J., was held on December 1st, 1919. President Seidler in the chair. Sixteen members were present.

The following officers were elected for the ensuing year:

President, D. Clark Thompson, M. D., Bloomfield; secretary and treasurer, A. H. Richardson, M. D., Montclair.

The following cases and papers were presented:

Anuerism Subclavian, Herbert Foster, M.D., Montclair; congenital malformation of urethra; perforation of axilla and cellular tissues on neck, W. H. Areson, Upper Montclair; modern heart methods, Henry Wallace, M. D., Glen Ridge; a case of pyloric stenosis, V. B. Seidler, M. D., Montclair.

The regular monthly meeting of the Clinical Society of the Mountainside Hospital, Montclair, was held January 12th, 1920. President Thompson in the chair. Thirteen members present.

The following cases were presented:

Hemorrhagic perforating gastric ulcer, Fletcher F. Carman, M. D., Montclair; an interesting complication following pneumonia, D. Clark Thompson, M. D., Bloomfield; a retro-coecal appendix; recurrent ulcer of the stomach, James T. Hanan, M. D., Montclair; anaphylactic shock, William H. Van Gieson, Bloomfield.

Summit Medical Society.

William J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, Jan. 30, 1920, at 8.30 P. M., Dr. Philip Embury entertaining and occupying the chair.

Present: Drs. Bebout, Bowles, Campbell, Embury, English, Falvello, Jaquith, Keeney, Lamson, Meigh, Morris, Pollard, Prout, Tator and Wolfe, and Drs. Noe, Meeker and Tidaback of Summit, and Dr. Banker of Elizabeth as guests.

Dr. J. D. Tidaback of Summit was proposed for membership.

In introducing the speaker, Dr. Embury emphasized the importance to the physician of paying more attention than is usually done to medical economics. So many restrictions in the practice of medicine have recently been made, e. g., Harrison Act, State Narcotic, Volstead Act, Compulsory Health Insurance, etc., that it is time the profession took a firm stand against further encroachments on the free exercise of their medical rights. He then introduced Dr. Eden V. Delphey of New York, chairman of the Health Insurance and Workmen's Insurance Committee of the N. Y. County Medical Society, who explained thoroughly the evils of the proposed legislation along lines of Health Insurance in New York, New Jersey and elsewhere, and urged the members present to oppose on economic and other grounds any unwise laws which might be proposed.

The subject was discussed by Drs. Banker, Prout, Jaquith and Pollard, and it was the sense of those present that the legislation proposed in this state was uneconomic, unsound, and destructive to the best scientific medical progress.

THE JOURNAL

OF THE

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PUBLICATION COMMITTEE:

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE—The transaction of business will be expedited, and prompt attention secured, if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

WATCH LEGISLATION.

Our members should closely watch the politicians during the closing days of this year's legislative session, lest they steal a march on us again, in putting through bills detrimental to, if not destructive of the standing and efficiency of our profession, and the public welfare as well.

See item on the Chiropractic Bill on page 102.

KEEP ABREAST THE TIMES.

By reading the many new things in medicine which are offered for your approval.

The doctor who fails to read the advertisements in his medical journal is sure, sooner or later, to miss something of benefit.

The advertiser puts his money and reputation into his product and submits it for your consideration.

Read advertising pages i to xiv and xv to xxviii in this issue. Cut them out and keep them in an accessible place for reference.

Begin now—write our advertisers and watch our columns grow.

Have You Paid Your Dues?

"THIRD AND LAST CALL TO DINNER."

Owing to the fact that no reports, as to members who have paid dues, have been sent in from several of our county societies, it is deemed best to defer the publication of the membership lists until next month. The lists will then be published and no opportunity will be afforded to have the names inserted in the lists until next year, when the new lists will again be issued. The omission of any eligible name is a matter of regret and especially to the man who happens to be the possessor of that name, for he is not known to those who may consult the list to find the name of a competent physician living in his town, and he is also deprived of the benefits of medical defense during the time he fails to pay his dues.

Many years ago our present secretary recommended that all county societies hold their annual meetings in the autumn —preferably in October. A large majority of our county societies adopted the suggestion, but a few still adhere to their old habit of holding their annual meetings in January, February and May. It is urged that these societies take again the matter under consideration and change to some time in the early fall months. One great advantage of this is that, as the annual meeting is largely attended, the members can then easily pay their dues directly to the treasurer and they thus comply with the requirements of the by-laws which state that all dues must be paid on or before January 1st of each year in advance. If any members are absent from the annual meeting they can be notified and their dues paid before January 1st. They will thus be in "good standing" **all of the time** and there will be no interval during which their eligibility to medical defense will have lapsed. Will all county societies make one more effort and not only get all their delinquents in, but add a few more new members to their lists before the annual list is printed.—W. J. C.

WASTE OF PAPER.

The Milwaukee Journal, in a recent issue, says:

"Congress is horrified by the waste of paper; it would like the money to spend on a few more investigating junkets."

Possibly there may be some foundation

for such observations, but there certainly is reprehensible inconsistency in urging upon medical journals and lay periodicals and newspaper publishers the imperative necessity of greatly curtailing their use of paper, and then using hundreds of thousands of pounds of paper on the Congressional Record and numerous lengthy publications of the different government departments. We are well nigh flooded with long documents, with the request that they be inserted in our Journal. If we complied with these requests we would have little, if any, space left for other matter. The result is that much of such matter goes to the waste basket unread.

The reply might be made that we could cull out of the mass sent us such portions as we could profitably use, but when we have more than thirty State societies and other medical journals and other medical literature beside some newspaper exchanges to examine monthly—and some weekly or daily—the amount of time consumed and careful judgment used in selecting matter therefrom that will be interesting and helpful to our readers, we are compelled, by lack of time, to forego the sifting of the large amount of other matter that comes to us, valuable as much of it is. We appreciate the kindness of those who send such printed or typewritten matter to us, but we are obliged to lay most of it aside for our occasional leisure moments.

It would be a vast improvement if the government and all organizations—Red Cross, Cancer, Tuberculosis, Venereal Disease prevention organizations would give us short, concise information, suggestions and remedial methods of rendering practical, helpful service. We venture the assertion that three-quarters of the long congressional speeches go to the waste baskets of our readers unopened or unread. These wholesale wastes of paper add largely to the cost of publishing our Journals and should be abated.

PLEASE READ THIS.

Recently, while discussing medical matters, a drug was mentioned, and one of the members of this Society remarked that he had sometime previously received samples of this drug but had been unable to find any literature concerning it and did not know for what purpose it was used. He was immediately told that this drug had been prominently advertised in the Journal by three advertisers for at least two years and, when shown these advertisements, admitted that he had not read the advertising pages.

Yet this physician is a busy, active and successful man, far above the average in intelligence and ability, was himself a contributer to the columns of the Journal and he has deliberately ignored the suggestions so lavishly offered him.

To the writer's mind came the thought —Is this the way our advertisements are usually treated. Your committee spends much time and money in obtaining these advertisements and those business firms, in return, pay thousands of dollars annually for the privilege of offering you their goods. Neither side does this work for amusement. Is it fair for you, through your Committee of Publication, to solicit and obtain these contributions, if you are to pay no attention to them?

It has been our endeavor to make the advertising pages attractive, and to this end, reading matter has been run into these pages and articles carried over from one page to another and humorous matter introduced; in order that your eyes might, of necessity, fall upon the advertising statements. Yet they seem to be too often overlooked.

How many of you have written for samples, or literature or catalogues or desk pads or pencils or used the occasionally attached coupon? We fear, not many.

If the members of the New Jersey Medical Society want these business houses to advertise in their Journal, they simply **must** show some interest in the advertisements, and the best way to do this is to ask these advertisers for more information concerning their wares and at the same time, informing them where the advertisement was seen. The last clause is important, and the whole matter is far from being a trivial one.

We publish advertisements mainly for two reasons: First, that reliable information regarding medical and surgical supplies, including medical books and details regarding sanatoria, should be conveniently presented to the profession; secondly, that the expense of publishing the literary portion of the Journal may be lessened to the subscribers. But you, Mr. Medical Man, must let the advertiser

know that his investment in the Journal is producing dividends for him. Neither side is doing this for his own amusement. We have sometimes lost good advertisers because they doubted if any business came to them through this particular advertiser.

We believe that business does come from our advertisements, but it is up to **you** to prove it.

Therefore, please read the advertisements, communicate with the advertising firms, call for the literature, samples, etc., and always inform them where your attention was called to their product.

You will please the advertiser, you will gratify your committee, you will help your Journal, you will gain for yourself quantities of valuable information for small cost and little trouble, and you often spare yourself the unpleasantness of admitting your ignorance of widely known and valuable professional aids.—C. D. B.

THE EDITOR'S WORK.

We take the following from the Journal of the Tennessee Medical Society:

"We would like very much to have the fellow who thinks that the editor of a state medical journal has no troubles to come in and correct a few papers for us. How does 272 corrections in one paper strike you? Capital letters in the wrong places, small letters where nothing but capitals are permissible, commas and things where nobody on earth who ever heard of a comma would expect to find one, misspelled and misused words, sentences without subject, predicate or other part, sentences with at least seven subjects, thirteen predicates and numberless other parts and parts of parts—all these and some two hundred other things as bad or worse are part of the game that the editor has to play all by himself. If it were not for certain "safety valves," every editor would swell up and bust at least once each month."

We recognize the fact that editors sometimes make mistakes in editing papers and correcting errors in proof-reading, but what shall the editor do when he receives a faulty paper for insertion in the Journal with a note from its author saying: "Put this in the Journal without any corrections or changes by the editor?" What shall we do when in the midst of work that taxes to the utmost head, heart and hands—as during the past six weeks specially—we send proofs to authors of papers asking them to carefully examine and correct and they are returned and inserted in the Journal and it is then discovered that the author failed to correct one-half or more of the typographical errors?

We have had no such extensive experience in making proof-reading corrections. New Jersey authors are somewhat more careful; their chirography is generally much worse than their spelling or punctuation.

The editor is obliged to conduct an immense amount of correspondence, much of which he ought to be relieved of; e. g., writing to secretaries, reporters and others for reports and other information that ought to be sent to him without his solicitation. It is our desire to show that our profession is alive in New Jersey and is creditably doing its work, for our Journal goes into nearly every State in the Union and it is read, as many communications from distant sections show, and our articles are frequently referred to in other journals. We ask our members to help us in our efforts to make the Journal worthy of the oldest medical society in the country with a record of which we have a right to be proud.

A NEW DANGER TO THE PROFESSION AND PEOPLE.

We take the following editorial from the Kentucky Medical Journal, it applies to New Jersey also:

The medical profession of Kentucky and of the United States is on trial as never before in its history. The passage of the National Prohibition Law, as was true to a degree of the Narcotic Law, puts a burden of responsibility upon every individual physician which only can be properly met if each of them realizes and acts up to his obligations to himself, his profession, his community and to the law.

It must be clearly understood that under this new law whiskey and other alcoholic preparations can only be prescribed for patients seriously ill and under the personal attendance of a physician holding a license from the U. S. Collector of Internal Revenue of his district authorizing him to so prescribe, under practically the same restrictions as are required under the Harrison Law about prescribing narcotics. It will be remembered that at its New York meeting in 1917 the American Medical Association, by formal resolution in its House of Delegates, declared that alcohol is not indicated in any diseased condition where

some other remedy cannot be used to greater advantage, and that the consensus of opinion of the profession is that in the vast majority of cases where whiskey is used as a medicine it does nothing but harm. The burden is therefore always upon the physician who prescribes it to know that that particular case is an exception to the general rule.

As was its duty to do, the State Board of Health is sending out special notice to the profession in advance of this issue of the Journal that under the law it is made the duty of the Board to cite any physician before it who is convicted in the courts for a violation of the National Prohibition Law, the Narcotic Law or the Abortion Law or for any other crime involving moral turpitude, to show cause why his certificate to practice should not be revoked. It should be understood that the revokation of a certificate under such circumstances is not as a penalty for violation of such laws, but is simply an act upon the part of the State to protect its citizens from one who, by a solemn decision of the courts has shown himself to be unworthy of the great privilege granted by such certificate.

On account of the danger to the good name of amiable, thoughtless or weak physicians who might be imposed upon by unfortunate or designing people, and to the profession as a whole, as well as to the best interests of the people, county societies and referees are requested to consider the advisability promptly of calling a meeting of the entire profession, especially urging the attendance of non-members, who are most likely to get involved in the meshes of the law, in order to give opportunity for the wise, strong men in the profession to warn, advise and protect those who might otherwise yield to temptation.

Believing that our members generally would be pleased to have more accurate information concerning preparations that are not clearly understood as to the importance and proper indications for their use, we have been fortunate in securing the promise of a paper on "The Importance and Use of Biological Products in Public Health Work," by Dr. John F. Anderson, Director of the Squibb Laboratories at New Brunswick—formerly Director of the U. S. Public Health Service, Washington, D. C., and also a paper by Dr. Howard A. Kelly, Professor in Johns Hopkins University and head of the Howard A. Kelly Hospital, Baltimore, Md. The first mentioned paper will appear in the April issue, and the second one in the May issue of our Journal.

We again call our readers' attention to our advertising columns. They will find our advertisers worthy of their patronage. We are careful to accept only those that are first class—there are none better. We call attention to the full page new ad of Bauer and Black, makers of Surgical Dressings, Chicago. Their goods are unexcelled and it is to our Journal's and our members' advantage to patronize this and other firms when they show a practical interest in us—contributing to our expenses in publishing our Journal.

Do not forget the Annual Meeting of the American Medical Association in New Orleans—April 26-30, 1920. It will be one of the best of the series. Attend it if possible.

Miscellaneous Items.

American Medical Editors' Association.

The fifty-first annual meeting of the American Medical Editors' Association will be held at the Grunewald Hotel, New Orleans, La., on Monday and Tuesday, April 26th and 27th (during the week of the A. M. A. Convention) under the presidency of Dr. Seale Harris, editor of the Southern Medical Journal. A most interesting program has been arranged and every doctor, even remotely interested in medical journalism, will find it to his advantage to attend.

It is advisable to make early reservation of rooms to assure your accommodations.

Pharmacopoeial Convention.

The Tenth Decennial Pharmacopoeial Convention of the United States will be held beginning at 10 A. M., May 11, 1920, at the Willard Hotel, Washington, D. C. Prior to the meeting of the convention the Committee on Credentials will meet in Washington to consider all applications which are made. It is important, therefore, that all applications for membership should be in the hands of Dr. N. P. Parnes, Arlington Hotel, Washington, D. C., at least six weeks before the date of the meeting.

Special Proctological Journal.

The American Journal of Surgery for February will be composed exclusively of articles devoted to the surgery of the Rectum and Colon. The following well-known Proctologists will contribute:

Dr. Alfred J. Zobel, San Francisco, Cal., Diagnosis of Anorectal Diseases; Dr. Samuel T. Earle, Baltimore, Md., Fistula; Dr. G. Milton Linthicum, Baltimore, Md., Syphilis, Tuberculosis and Cancer of the Re tum; Dr. J. Dawson Reeder, Baltimore, Md., Stricture of the Rectum; Dr. Louis J. Hirschman, Detroit, Mich., A Successful Memorrhoid Operation Under Local Anesthesia; Dr. Martin L. Bodkin, Brooklyn, N. Y., Proctitis; Dr. Lewis H. Adler, Jr., Philadelphia, Pa., Fissure-in-Ano or Irritable Ulcer of the Anus; Dr. David A. Kraker, Newark, N. J., Perianal Infection; Dr. Charles J. Drueck, Chicago, Ills., Fecal Incontinence; Dr. John L. Jelks, Memphis, Tenn., The Medical and Surgical Treatment of Protozoan Infections; Dr. Jerome M. Lynch, New York, Cancer; Dr. E. Reissman, Newark, N. J., The x-Ray as an aid in diagnosing Ilio-Cecal Valve Insufficiency; Dr. Edwin Beer, New York, Aseptic Amputation of the Rectum; Dr. T. C. Hill, Boston, Mass., Methods of Examination in Diseases of the Rectum and Sigmoid Colon; Dr. W. H. Kiger, Los Angeles, Cal., Tubercular Fistula in Ano; Dr. Samuel G. Grant, New York, Papillitis, Hypertrophied Anal Papillae; Dr. Dwight H. Murray, Syracuse, N. Y., Vaccine Treatment for Pruritus Ani; Dr. Walter M. Brickner, New York, Notes on Surgery of the Rectum and Anus.

Government Needs Physicians.

The United States Civil Service Commission announces that a number of physicians are needed in the Indian Srvice, the United States Public Health Service, the Coast and Geodetic Survey and the Panama Canal Service. Both men and women are eligible, salaries of $200 a month are offered with prospective promotion and higher pay. Information and application blanks will be obtained from the commission at Washington, D. C., or the civil service board at any of the principal cities in the United States.

Doctors Needed.—The February Virginia Medical Journal publishes a list of 138 places in Virginia where a doctor is needed. In some counties there are from 3 to 7 localities needing a doctor.

Reciprocity Between French and American Universities.

L'Union Universitaire Americaine en Europe elected recently a new executive committee which will enter on its duties July 1, 1919. Prof. Henry A. Yeomans, dean of Harvard College and exchange professor at the Sorbonne last years, is the chairman. Since establishing its headquarters in the Royal-Palace Hotel, rue de Richelieu, Paris, the union has enrolled about 35,000 students from the various services of the army. This new association of students from the American army in France, composed, as it is, of groups of American students from the fourteen universities of France, has just succeeded in working out a plan whereby it will be possible to send a considerable number of French students for attendance at American universities at the opening of the new school year in September.

Oestopath Convicted. — Prosecuted by a Pennsylvania state board of medical education and licensure, Phillip Sheridan Daily, an osteopath, is said to have been convicted before Judge Martin in Quarter Session Court No. 2, Philadelphia, October 30, on a charge of prescribing medicine without a license.

COMPULSORY HEALTH INSURANCE.

Dr. Charles H. Chetwood, on assuming the duties of his office as president of the Medical Society of the County of New York, January 26, said, in speaking of compulsory health insurance:

In plain language I would say that the letter, spirit, and purposes of compulsory health insurance, in any form in which it had been presented for legislative action up to the present time, merited only unqualified disapproval. The false assumption that such a measure was necessary in order to provide proper medical attendance for the laboring classes was without logical reason to support or justify it. Many of those present had given the subject more study and were better able to handle it than he was, but he wished it understood that there was no lack of sincerity in his attitude. In approaching any matter, opinion must be supported by facts. The argument of the advocates of compulsory health insurance was that this measure was necessary in order to protect the workingmen from becoming objects of charity and that it could be made safe for the medical profession. This question had been discussed from many different standpoints, the opinions expressed being influenced by different mental attitudes. There were those trained in the current political thought, not of the highest character, who had the idea that all evils could be corrected by Legislative action, and another class trained under paternalistic forms of government thought it was a good thing. On the other hand, a referendum of the medical profession showed that the majority of physicians opposed it. However, it was not for the medical profession to decide whether this measure was for the public welfare. It was not the single interest of this or any other group of the medical profession to determine whether compulsory health insurance was good for society. In order to arrive at a correct conclusion the views of the different groups directly affected were of interest. These three groups were the corporations or employers, the employees, the medical profession, and the law-making group. After discussing the viewpoints of these groups and showing that none of them was in favor of the measures thus far presented, Dr. Chetwood stated that after all the law-making group was the one which was best fitted to consider what was best for the public in its widest sense. It was not surprising in view of the great mass of conflicting opinion that had been advanced on the subject that many were bewildered. Nevertheless a careful review of the evidence showed that compulsory health insurance was unacceptable to employers, employees, and the medical profession. It was also unacceptable to the law-makers as shown by the fact that no measure had thus far been passed. Dr. Chetwood then argued somewhat at length to show that the principle of compulsory health insurance was not

in conformity with American ideals because it separated the people into classes which was contrary to our principles of democracy. He also quoted from the report of the British Trade Union to show that the act in England had proved a failure in most ways. It was claimed by some that statistics in England showed that poverty had been diminished since compulsory health insurance had gone into effect. On closer study of the situation it seemed that the operation of the compulsory health insurance law happened to be coincident with a period of great national prosperity. It might happen that if a compulsory health insurance measure were enacted in this country at the present time when we were passing into a period of great prosperity, statistics could later be adduced, showing that poverty had diminished under the operation of such a measure, which would be entirely out of conformity with the truth. Health conditions in Germany had not improved under compulsory health insurance and were no better than they were in this country. It had been charged that our dispensary system was demoralizing, but even if one accepted that statement (which he did not) two wrongs would not make a right. The dispensary system had played an important part in the evolution and development of medical workers. In closing, Dr. Chetwood characterized compulsory health insurance as Bolshevistic, socialistic, and thoroughly out of accord with American ideals.

THE CHIROPRACTIC LEGISLATIVE BILL.

The Legislative Committee of the Medical Society of New Jersey issued recently the following statement:

"The medical fraternity of the State, as represented by the Medical Society of New Jersey, will make a determined fight against the passage in the House of Assembly of Senate Bill No. 2, known as the chiropractic bill. The bill, which is declared by its supporters to simply be a measure to license the chiropractors, is looked upon by the medical men as a serious menace to the health of the people of the State, in that it would tend to break down the barriers which it has taken more than 30 years to erect as safeguards in the practice of the art of healing.

"In the first place, the chiropractic bill would take from the State Medical Board all power of regulation by establishing a separate board composed of chiropractors. This is contrary to all State policies, as all classes of healers are under the State board supervision. Furthermore, the bill would lower all standards of qualifications by permitting persons with but six months or a year of college courses, and now practicing, to continue to do so.

"Still another thing which the medical men object to is the plan for preliminary educational qualifications proposed by the bill. All educational qualifications for licensing under the State laws now, no matter in what capacity, must be passed upon by the State Commissioner of Education, but under this law the chiropractic board which the law would create would be the body to pass on the preliminary educational qualifications of the chiropractic applicant.

"The physicians do not object to the licensing of the chiropractors, but contend that they should be subject to the same requirements as are others who practice healing. They contend that they should be under the supervision of the State Medical Board, educational qualifications subject to action of the State Commissioner of Education, and that their standard of training be such as to safeguard the public which may seek treatment at their hands."

ANNUAL REGISTRATION OF PHYSICIANS.

The betterment of the personnel of the medical profession has been one of the prime factors in medical education during recent years. Proprietary schools have been almost entirely eliminated, medical courses have been lengthened and marked progress has been made in the scheme to furnish the public with medical men who, by education and experience, are best adapted to practice the healing art. There are, however, easily discoverable phases which should be eliminated and this holds particularly good in the medical practice act of many of our states. There are in every commonwealth so-called physicians who have no legitimate right to practice medicine. We hear from time to time of men who are practicing on the certificates of dead men and who by other devious means have been enabled to pose as honest practitioners. To overcome this difficulty and to eradicate this class, the annual registration of physicians has been proposed and is being tried in at least two states.

Professor Francis W. Shepardson, late Dean of Men in the University of Chicago and the present Director of Registration and Education of Illinois, is putting forth strenuous efforts to have such a plan carried out in his state. He puts forth the arguments in a paper recently read before the Kankakee County Medical Society that annual registration would permit the Department to keep in touch with legal practitioners; aid in keeping a correct roster of addresses; discover cases of individuals using licenses of others who have died or have left the state, or from whom certificates may have been stolen or purchased, and further would enable the Department to better control those unethical practitioners whose actions bring discredit upon the profession. Prof. Shepardson makes a very strong plea for the adoption of such a plan by his state. We are generally agreed that the public must be protected from illegal, unethical and criminal practitioners, and it seems reasonable to believe that if Prof Shepardson's plan were carried out, the State Board would have much better opportunity to purge the profession of those people who have no place therein.

A small registration fee such as $2.00 a year would give the State Board money to prosecute offenders and, as physicians are compelled to register annually in order to vote, we cannot see why their dignity would be lowered if they were to register annually for the practice of their profession. The State of Virginia taxes all professional men and the little opposition to such a plan in the Old Dominion has long since disappeared.—Medical Times.

Our Journal will be glad to have opinions from interested subscribers on this subject.—Editor.

Therapeutic Notes.

Graves' Disease—Medical Treatment.

After curing several cases of Graves' disease of recent origin by the use of the old liq. iodi fort. alone, Henry Bazett found that he got better results with less irritation, by the use of a combination of Ung. Hydrarg. Co. with Ung. Iodi of the British Pharmacopœia. He cites a case of bilateral goiter, in a woman of 38, who had been operated on at the age of 32, when the thyroid gland of her right side was removed, the left gland not being touched. On July 6, 1918, upon finding a left-sided goiter of extraordinary hardness, accompanied by incessant distressing palpitation and other nervous disturbances, Bazett prescribed 15 minims daily of Donovan's solution internally, and the following ointment for constant application externally:

Glyc. belladonnæ, 1 part.
Ung. iodi, 2 parts.
Ung. hydrarg, co., 4 parts.
Ung. plumbi subacet, 6 parts.

By August 2 the goiter had practically disappeared. A year later the gland perfectly soft and natural, could just be felt. The "illness" of which the patient complained when the treatment was first instituted was attributed by Bazett to the excess of the disappearing glandular substances in the blood owing to its very rapid dispersion.—The Practitioner,

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Xylol in Dermatology.—The antiseptic and parasiticidal properties of xylol have been utilized by L. Bory in many dermatological conditions. As an ointment for herpes circinata, sycosis, impetigo, echthyma, folliculitis, eczema (after the acute stage), and for pediculosis pubis, the following ointment is recommended:

Iodine, 1 g.
Xylol, 15-20 c c.
Soft paraffin, to 100 g.

For wounds as a first dressing the following modification is used:

Iodine, 1 g.
Xylol, 20 c.c.
Liquid paraffin, 80 c.c.

For the treatment of soft sores and their complications:

Iodoform, 10 g.
Xylol, 20 g.
Soft paraffin, to 100 g.

A usful application for psoriasis is:

Coal-tar, 3 parts.
Xylol, 1 part.

—Jour. des Praticiens.

Common Colds and Grippe.—Dr. L. D. Bulkley, New York, in the Medical Record, says: "Yesterday I had about as severe a cold as possible, which had been coming on several days, and had been simply neglected, and I sneezed and coughed all day, using any number of handkerchiefs. In the afternoon I took one or two doses of soda, half a teaspoonful, and in the evening took five more at half hour intervals, in warm water. At midnight I took one of the grip powders I have so long prescribed, ten grains of phenacetin with twenty of soda, with hot water, and went to bed with two handkerchiefs under my pillow. I dropped to sleep very soon, and slept soundly until called at seven-thirty, when I took another of the phenacetin and soda powders and found the cold entirely gone; exactly the experience which I reported before and which I have had many times.

French Treatment of Influenza.—A dispatch to the Sun from Paris gives details of a remedy for influenza advised by Dr. de Gerin of that city. It consists of the injection into the gluteal muscles once a day for five or six days of a solution of guaiacol, 0.1, eucalyptol, 0.5, and camphor, 0.5, in 3 c.c. of sterilized olive oil. If pulmonary complications appear, he gives a tablespoonful every two hours day and night of a mixture of tincture of opium and tincture of belladonna, of each 35 drops, and ammonium chloride, 4 grams, in 250 c.c. of distilled water, flavored with simple syrup, 75 c.c., and syrup of orange flowers, 25 c.c.

Influenza Treatment.—Dr. Beverley Robinson in the Medical Record, says: I have found nothing better than the mixture I have previously recommended, consisting of ammonium salicylate, gr. lxxii; caffeine, gr. vi.; essence of pepsin, 3i; water, ℥vi. Of this I at present give a tablespoonful every hour for three or four hours, and thereafter a desertspoonful. For convenience sake in many cases I give the remedy in capsules instead of solution, and I then omit the pepsin. At bedtime I give aromatic spirit of ammonia and sweet spirit of nitre. I then stop the salicylate mixture. If there is cough and fever I start warm creosote inhalations from a croup kettl, with or without compound tincture of benzoin. I use the benzoin only when objection is made to the smell of creosote. There is no specific against influenzal pneumonia but what I hvae outlined will help prevent it in a measure and will greatly modify its seriousness many times. Good whiskey, black coffee, and strophanthus in small repeated doses will save life, if any treatment will. Fear of contagion is a bugbear which should not be tolerated. It is lack of knowledge which makes it prevail.

New Use for Chlorazene.—Dr. R. C. Faulds (Clin. Med., Oct., 1919), reports a case of diarrhea in a child three months old. The patient had been suffering so long and was so far gone that, when the doctor arrived, it was out of the question to give anything by mouth, as the little one could not swallow. The doctor decided to try chlorazene solution by rectal injection. Dissolving one tablet in two glasses of water, he injected this, with the buttock well elevated. In a few minutes this was passed out and fifteen minutes later he repeated the same strength injection, using the second time an extra long rectal nozzle on the syringe in order to deliver the fluid as far up the bowel as possible. A passage of the bowels soon followed and no further symptom of diarrhea was noted. The child hade a speedy recovery.

Treatment for Pins in the Gastro Intestinal Tract.—When a child has swallowed a fish hook, open safety pin, pins, pennies, or any material that is apt to lodge in the intestinal tract, I put it on a milk, brain and mucilaginous diet Twice daily, I give a large dose of olive oil followed with the official Seidlitz powder—the size of the dose in proportion to the size of the child. If the stool is watched carefully for a few days, one will see results. Most of the time, the foreign substance is incorporated within a soap ball; and in any event, I can imagine that the little soap balls are just the right shape to bear the foreign sutsbance on and out of the many folds of the mucosa of the intestinal tract. Let it be called a ball-bearing method. I have removed articles by this method that have had points protruding in such a way that it would not seem possible for them to pass along without their penetrating and lodging in the intestinal wall.—R. C. Faust, M. D., Deary, Idaho.

Diet and Health.—A lack of the knowledge of how to adjust income and food expenditures is holding many children back in normal development, and thereby decreasing the ability of future citizens. Oftentimes medicine can be of no lasting value until the diet is regulated, and quite frequently when the diet is regulated medicine is unnecessary; but in the majority of cases the doctor has not the time to sit down and plan this adjustment with the mother, and the problem of food economics is a work apart from nursing, just as nursing is apart from the practice of medicine. To meet just such a situation as this the nutrition specialist in social work has come into existence. —L. L. Gillett, The Commonwealth.

The Elizabeth General Hospital will receive $2,000 according to the will of William T. Day, who was a prominent Newark lawyer.

Memorial Hospital, Morristown.

Announcement has been made of the identity of the donor of the two plots of land. given recently to the Memorial Hospital. She is Mrs. Marcellus Hartley Dodge of Madison, daughter of William Rockefeller. The plots are at the corner of Morris and Spring streets, abutting the hospital property, and in the rear on the Whippany River. Their value is said to be between $20,000 and $25,000. The nurses' home will be built on the Morris and Spring street plot.

Somerset Hospital.

By the will of J. C. Kenyon, Somerset Hospital will receive a one-half interest in the homestead property in Raritan which was left in trust for the use of his widow during her lifetime. She having died, it will be sold and the proceeds divided equally between the hospital and the American Red Cross Society.

St. Peter's Hospital, New Brunswick.

The twelfth annual report of this hospital has recently been issued. It makes recognition of the great loss sustained in the deaths of Rev. Monsignor O'Grady, the founder of the hospital and Dr. F. M. Donohue for many years president of the medical staff.

The number of patients treated during 1919 was two thousand nine hundred and ten, an excess of two hundred and eighty-four patients over the number in the preceding year. Of these one thousand, one hundred and fifty-six were free patients; one thousand, seven hundred and fifty-four were pay patients; the rest were out-door patients who came to the hospital merely for treatment.

Of the patients admitted, 1,289 were males and 1,621 were females. Of these patients, 2,634 were discharged as cured; 32 discharged as improved; 16 discharged unimproved; 68 deaths and 72 deaths of persons who died within 24 hours after admission, while 88 patients were still in the hospital.

In the obstetrical department the report showed 255 births, and 8 reported in the Caesarian section.

State Hospital, Morris Plains.

The following is the report of the hospital for December, 1919: Remaining in the hospital Nov. 30th, 2,685; admitted during December, 43; discharged, 61; remaining Dec. 31st, 2,667. The highest number was 2,685 on the 1st.

Changes in Sanatorium Management.—Commissioner Burdette G. Lewis of the Department of Institutions and Agencies, has made the following recommendations to improve conditions at the New Jersey Sanatorium for Tuberculous Diseases, Glen Gardner: a roentgen-ray examination of every patient admitted to the institution; the purchase of strictly fresh eggs and more careful adherence to the dietaries suggested by this department and approved by the federal bureau of foods and drugs; the employment of a traind social worker; the enlargement of the institution to accommodate enough patients to reduce the per capita cost of medical, scientific and social work, and to provide homelike surroundings including sitting rooms and play rooms for children.

Deaths.

EVANS.—At Greystone Park, N. J., January 14, 1920, Dr. Britton Duroc Evans, aged 61 years.

Dr. Britton D. Evans was born in Caroline County, Maryland. October 1, 1858, son of Dr. Lewis W. and Lucinda (Boone) Evans: on his father's side he was a direct descendant of Christmas Evans, eminent Welsh divine, and on his mother's side of Daniel Boone, the celebrated Kentucky pioneer. His father was a graduate of two of the medical schools of Philadelphia and a practitioner for many years in that city, and his grandfather, Colonel Britton Evans, served under General Harrision in the war of 1812 with the rank of Lieutenant of Artillery. took part in the war with Mexico and in the Florida war, and at the time of his death was organizing a company to go to Greece to help her in her struggle for independence against Turkey.

Dr. Evans was reared to manhood in his

native state, acquiring an academic education which prepared him for the activities of life. Later he became a student in the College of Physicians and Surgeons of Baltimore, from which he graduated in 1885. He began practice in Millington, Kent County, Maryland, and continued there for many years. In 1889 he married Miss Addie E. Dill, a resident of Wilmington, Del. Dr. Evans was appointed upon the staff of surgeons of the Pennsylvania Railroad Company, and then was called to the position of Assistant Medical Superintendent of the Maryland Hospital for the Insane at Catonsville, where he served nearly five years, gaining a valuable experience. He resigned in order to accept the position of Medical Superintendent of the Maryland Institution for the Feeble-Minded, and in a very short period was offered the position of Medical Director of the New Jersey State Hospital at Morris Plains—this being tendered to him for his efficiency and ability in psychiatry and in the care and treatment of the insane. He entered upon his duties there on June 1, 1892, and early instituted a program of improvement, by which the old "Asylum" was changed to an up-to-date hospital for the care of the mentally diseased. Infirmaries and operating rooms were opened, and a training school for nurses was established. Throughout the period of more than twenty-seven years, during which Dr. Evans was first Medical Director and later Superintendent and Chief Officer of the New Jersey State Hospital at Morris Plains, and while the inmates were increasing in numbers from 939 to 2,700, his constant aim was to make the institution a place where all patients, irrespective of social and economic position, could receive the best of scientific care and treatment.

In connection with his psychiatric work, Dr. Evans was called as witness in many famous cases in New Jersey, New York and in the Federal courts. His contributions to the world's medical literature on nervous and mental diseases have been numerous and valuable. Among those published are: "The Inebriate as a Producer of Dependents," "State Care of the Insane," "The Nurse and Her Mission," "The Therapeutic and Economic Value of Diversional Occupation," "The Treatment of Paresis," "Court Testimony of Alienists," and "Court Testimony of Medical Experts in Mental Disease."

Dr. Evans was a member of the Medical and Chirurgical Faculty of the State of Maryland, the American Medical Association, the Medical Society of New Jersey, the Medico-Legal Society of New York, the American Medico-Psychological Association, the National Conference of Charities and Corrections, honorary member of the Temperance Reform League of Boston, a member of the staff of All Souls Hospital of Morristown, Councilor of the American Congress of Internal Mericine for the State of New Jersey, Fellow of the American College of Physicians, ex-President of the Morris County Medical Society, and ex-President of the Tri-County Medical Society. He belonged also to the Free and Accepted Masons, Benevolent and Protective Order of Elks, Improved Order of Red Men, and the Royal Arcanum, as well as to numerous other societies and clubs, and was a member of the Methodist Episcopal Church.

Dr. Evans was not only a physician of the highest type, but also an alienist and psychiatrist recognized throughout this country and abroad. His keen, logical mind, quick insight, and sure analysis rendered him a remarkable judge of humanity, whether dealing with those whose minds were warped and twisted by disease or with those who stood highest in medical and legal circles. Yet, with all his gifts of mind, it is for the unique quality of his personality that Dr. Evans is held in such affectionate remembrance. His unfailing courtesy and quiet assurance won liking and respect, even from those who opposed his views. His delightful wit and bubbling humor made him the most entertaining of companions, and coupled with his easy diction rendered him a favorite speaker, whether at informal gatherings or on the lecture platform. Through his sure sympathies he became confidant and adviser to a great group comprising all ages and all grades of society. No one in trouble ever went to him in vain. His interest in those entrusted to his care not only included the hospital as a whole, but was exteded to the individual patients, among whom the humblest knew him as their friend. Dr. Evans possessed in unusual degree the power of inspiring loyalty and devotion in those with whom he came in contact. He was a big man, kindly, generous, great-hearted, and of strong feeling. In his going the medical profession has lost a shining light, and we and many others have lost a much loved friend.

Resolutions of the Medical Staff of the State Hospital.

It is with a profound sense of sadness that we record the death of our late Chief Executive Officer and Medical Superintendent,

Dr. Britton D. Evans.

During the many years of our services under his leadership his influence always was inspiring, elevating and endearing, and his ministrations to afflicted humanity have left us a heritage of the highest order of precept and example in carrying on the work he so loved and to which he so long and ardently adhered.

Through his death the medical profession has lost an invaluable member and admirable exemplar and the hospital and community a consistently kind and sympathetic friend. Therefore, be it

Resolved, At this, the regular meeting of the Medical Staff, held at Greystone Park, New Jersey, on the seventeenth day of January, nineteen hundred and twenty, that we the Medical Staff of the New Jersey State Hospital at Morris Plains, accept in bowed humility and reverence the will of Almighty God in taking Dr. Britton D. Evans from our midst; and yet in the same spirit we wish to manifest our love, aflection and appreciation toward him: so be it

Resolved, That there has been taken from the hospital over which he presided for more than a quarter of a century, a lovable and noble personality, whose lofty ideals always were ready to serve the interests of right, justice and mercy; a man of wholsome heart and impulses, of unswerving devotion and attachment to his profession, his work and friends; and be it further

Resoved, That we convey to his family our sincerest sympathy in a loss so irreparable and immeasurable; and be it further

Resolved, That this memoriam and these resolutions be spread upon the minutes of the Medical Staff meeting, and a copy of them presented to the bereaved family.

Memorial resolutions were also adopted by the Board of Managers of the State Hospital on January 16, 1920, in which they deeply deplore the almost irreparable loss the institution sustained in the demise of Dr. Evans.

FREEMAN.—In Trenton, N. J., January 13, 1920, Dr. Samuel Freeman, from pneumonia, aged 44 years.

Dr. Freeman was born in Hungary, came to the U. S. and settled in Trenton; graduated from the University of Pennsylvania Medical School in 1899 and practiced in Trenton twenty-two years: for ten years he served as city physician; he was a specialist in tuberculosis work of the county and State; chairman of the Mercer County tuberculosis hospital committee; a member of the New Jersey Tuberculosis League. He had been in delicate health from the results of an automobile accident, was for a few months in a sanitarium; studied tuberculosis problems at the Trudean School, Saranac Lake, and participated in that school's clinics.

He was a member of the Mercer County and the State Medical Societies and a Fellow of the American Medical Association. Besides his professional duties, he was an active lodgeman. He was a past master of Fraternal Lodge No. 139, F. and A. M.; past master, charter member and treasurer of True Craftsman Lodge No. 202, F. and A. M., and a member of the Shrine. He was active in the Young Men's Hebrew Association and a member of Har Sinai Temple, and was also a member of the Progress Club.

HINCKLEY.—In St. Barnabas Hospital, Newark, on February 22, 1920, Dr. Livingston S. Hinckley of Newark, from pneumonia complicated with endocarditis, aged 65 years.

Dr. Hinckley was born in Albany, N. Y., the son of Dr. John Warren Hinckley, who was also the son of a physician. The family moved to Jersey City, where young Hinckley attended a private school and subsequently the public school, and after completing his studies there, he entered Bellevue Hospital Medical College, from which he graduated in 1878; he was then appointed assistant physician in the Blackwell's Island Asylum for the Insane, later its acting superintendent, when it had 1,400 inmates and 200 employees; he subsequently opened a private hospital for medical and surgical cases—the first of the kind in New York. Afterwards he moved to Avon, N. Y., where he practiced and established a sanatorium. When the Essex County Hospital was established Dr. Hinckley was elected its medical superintendent, entering upon his duties Nov. 19, 1884, and held that position for seventeen years when he entered upon general practice in Newark He frequently acted as an expert for the State in criminal cases involving the question of sanity and gained prominence as an alienist.

Dr. Hinckley was a life member of the American Medico-Psychological Association, a fellow of the American Medical Association, a member of the Essex County Medical Society and a permanent delegate of the New Jersey State Medical Society. He was also surgeon of the Essex County Park Commission, a member of St. John's Lodge No. 1, F. and A. M., and a charter member and first president of the West End Club. Surviving are his wife and a son, Dr. Livingston S. Hinckley Jr. of Newark.

HERITAGE.—At Glassboro, N. J., January 4, 1920, Dr. Charles S. Heritage, aged 48 years.

Doctor Heritage was born in Glassboro. He was the son of the widely-known Dr. John Down Heritage. At Glassboro, Dr. Charles Heritage got his early education. Later he entered the medical department of the University of Pennsylvania. From there he graduated in 1892..

He was a member of the Gloucester County and the State Medical Societies, and a Fellow of the American Medical Association. He was also a member of the St. Thomas' Episcopal Church; a member of the local lodges of I. O. O. F., Masons and Jr. O. U. A. M. Also he was a director of the First National Bank. He was president of the Glassboro Loan and Building Association. At one time Dr. Heritage was president of the Township Committee. In the absence of Dr. E. Mortimer Duffield, he was the medical inspector for the Glassboro Schools.

The doctor had been ailing for about 10 years, about three years of which he spent in Hot Springs, Arkansas, and Florida. He died of Bright's disease.

WIDMER.—In Newark, N. J., February 1, 1920, Dr. Henry Rudolph Widmer, from cerebral hemorrhage, aged 38 years.

Dr. Widmer graduated from the College of Physicians and Surgeons, N. Y. City, in 1903. He was a member of the Essex County Medical Society of New Jersey and the American Medical Association.

WILSON.—At Woodbury, N. J., February 21, 1920, Dr. Howard A. Wilson, aged 60 years.

Dr. Wilson graduated from the Jefferson Medical College, Philadelphia, in 1884. He was a member of the Gloucester County and the State Medical Society and of the American Medical Association. He was the reporter of his county society, and was a successful practitioner in Woodbury many years where he was highly respected.

He was found dead in his office by his wife, having died very suddenly.

Resolutions: At a special meeting of the Physicians' Association of Woodbury and vicinity, held at the residence of Dr. Duncan Campbell, on February 22, 1920, to take action relative to the death of Dr. Howard A. Wilson, which occurred Saturday, February 21, 1920, the following resolutions were passed:

Resolved, We learn with a profound sense of sorrow of the death of our late colleague, Dr. Howard A. Wilson, therefore be it resolved, that we extend to his bereaved family our deepest sympathy in their sorrow.

Further, that we share with the community the realization that in the death of Dr. Howard A. Wilson we have lost a skillful and sympathetic hysician, an upright and patriotic citizen, and a faithful and loyal colleague.

Further, that a copy of these resolutions be sent to the family and published in the local papers.

Dr. Gilbert J. Palen, President;
Dr. Oram R. Kline, Secretary.

IN MEMORIAM.

Charles S. Heritage, M. D.

Dr. Heritage was born in Glassboro August 9, 1871. His early education was received in the Glassboro schools. Afterwards at Pennington Seminary. He graduated from the University of Pennsylvania in 1892, and for a short time afterward was associated with Dr. Halsey. He then commenced practice in Glassboro, doing general work, until six years ago, when he specialized in the eye, ear, nose and throat. He was a very careful, painstaking general practitioner and di most excellent work. He filled many positions of merit in his town: Member of the Board of Directors of the Bank, member township committee, member of the school board, and medical examiner of schools. Eight or nine years ago his health began to fail and he spent some time in the South, remaining at Hot Springs, Arkansas, for a long time and was one of the assistant physicians there. He returned home and took up the specialty, doing most excellent work. In 1914 he married Miss Anna Whitney Nock. Dr. Heritage was a member of the Episcopal Church, a fellow of the A. M. A. and a member of his county and State medical societies. He was president of the county medical society a few years ago. He died Jan. 4th, 1920, leaving a host of friends and mourned by people as an examplary citizen and a reliable physician. Would that there were more like him to practice the healing art. He will be sadly missed.

L. M. Halsey.

Personal Notes.

Dr. John F. Anderson, New Brunswick, Director of the Squibb Laboratories, read a paper at the recent conference of the State and Local Health Officers on "The Use of Biological Products in Health Work." We expect to insert this paper in the next issue of our Journal.—Editor.

Dr. John S. Young, Rahway, and wife are spending a few weeks at Palm Beach, Florida.

Dr. Walter S. Bray, Camden, has been given a $40,000 verdict against the West Jersey and Seashore Co. for damages received when he drove his car into an excavation at Second and Main streets of that city.

Dr. Oscar D. Gary, Ringoes, was confined to his home by illness last month.

Dr. Robert H. Hamill, Summit, and wife were called to Hammond, Indiana, last month by the illness of their son.

Dr. Frederick J. LaRiew, Washington, was elected president of the local Board of Health recently.

Dr. Robert W. Moister, Summit, injured his leg by a fall on the ice last month.

Dr. Frederick W. Owen, Morristown, made an address there last month on Abraham Lincoln.

Dr. Arthur L. Smith, New Brunswick, and wife were summoned to Chicago last month on the serious illness of a relative.

Dr. Frederisk S. Bootay, Belleville, has been re-elected president of the city Board of Health.

Dr. Harris Day, Morris Plains, has sold his house and hall, known as Day's Hall.

Dr. George W. Davies, Bloomfield, has purchased the Simonson residence, that city, which he has been occupying several months.

Dr. Charles V. Craster, Newark, has a paper in the A. M. A. Jour., Jan. 31, on "Tuberculosis: A City Plan."

Dr. Walter L. Elliott, Collingswood, has been elected president of the new Memorial National Bank of that city.

Dr. Joseph Fewsmith, Newark, and daughter, Mrs. Lord, spent the month of February in St. Augustine, Florida.

Dr. Theodore B. Fulper, Hampton, was ill at his home last month.

Dr. B. Van Doren Hedges, Plainfield, has been elected secretary of the City Board of Education.

Dr. Arthur L. Smith, New Brunswick, was re-elected president of the Board of Education of that city last month.

Dr. Samuel A. Cosgrove, Jersey City, was on January 14, elected president of the Greenville Medical Society.

Dr. Gordon K. Dickinson, Jersey City, has a paper in the A. M. A. Jour., February 14, on "The Myenteric Nerve: A Discussion."

Dr. Matthew K. Elmer, Bridgeton, was recently elected a director of the Cumberland National Bank.

Dr. Louis Schneider, Newark, has been appointed a member of the Board of Managers of the Contagious Disease Hospital at Soho. He has been and will continue to be a member of the Board of Managers of the Essex County Hospital for Tuberculous Diseases.

Dr. John Miller, Netcong, was caught under his sleigh when it upset and was dragged some distance as his horse ran away. His right leg was fractured.

Dr. Oscar C. Frundt, Jersey City, captain M. C., U. S. Army, has been awarded a Distinguished Service Cross for extraordinary heroism in action while in charge of a hospital train in Eastern Siberia. The train made weekly trips between Vladivostok and the battle area, and was on its way to the former city with wounded soldiers when it was fired upon by Bolsheviki. For his skilful handling of the train on one of these trips in June, 1919, and his care of the wounded, Captain Frundt received the award. He is thirty-one years old, is a former member of the National Guard and a graduate of Cornell University. He was at the Mexican border, serving with the rank of first lieutenant. On the regiment's return he was promoted to be a captain. He accompanied the outfit to Anniston, Ala., where it was merged with the 114th Infantry, remaining in this country in the medical service until he started for Siberia, February 19, 1919.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed	Failed.
Arizonia, October ..	20	17	3
Arkansas, Eclec, May	34	34	0
Dist. Colum., July..	18	15	3
Illinois, June	226	201	25
Illinois, September...	78	53	25
Iowa, Sept.	12	11	1
Montana, April	15	12	3
New Hampshire, Sept	1	1	0
New Jersey, June...	36	36	0
Texas, June	82	80	2
Wisconsin, June ...	16	15	1
Wyoming, June-Oct.	19	11	8

Public Health Items.

Teeth and Their Care.—Brushing the teeth should become a regular part of the child's daily life, just as putting on his shoes in the morning and taking them off at night.—Minnesota Health Jour.

Newark Health Report.

The total deaths during December, 1919, numbered 466; the death rate being 12.6. 45 deaths were from tuberculosis; 32 cancer, 32 apoplexy, 58 organic heart disease, 48 pneumonia, Bright's disease and nephritis, 53. There were 1,508 cases of disease reported. The infant mortality rate for the year 1919 was 76.2 per 1,000 births, as compared with 104.7 for 1918, and is the lowest rate in the records.

Health Districts in New Jersey.—Dr. I. W. Knight, formerly assistant epidemiologist to the New Jersey State Department of Health, has been appointed district health officer of the district embracing the counties of Camden, Gloucester, and Salem, N. J., with the exception of the city of Camden. This is the first attempt on the part of the State Department of Health to put into effect a plan for dividing the State into separate health districts and assigning a trained sanitarian to each district. At present there are sufficient funds available for only the initial district.

Deaths in New Jersey.—According to a report of the Bureau of Vital Statistics, N. J. Health Department, issued in December, there were 2,863 deaths in the State during the month of October. Among the deaths were 402 of children under one year, 194 over one year and under five, and 1,078 of persons sixty years old or over. There were twenty deaths from influenza and twenty suicides.

New Regulations in Regard to Quarantine Periods.—At a recent meeting of the department of health, New York City, the following regulations governing the isolation of persons affected with an infectious disease and amending Section 89 of the Sanitary Code were adopted:

For the purpose of these regulations, the minimum period of quarantine shall be as follows:

a. Diphtheria: Twelve days from onset; b. Scarlet Fever: Thirty days after the onset of the first symptoms; c. Cerebrospinal meningitis: Fourteen days from the onset; d. Acute anterior poliomyelitis: Three weeks from the date of onset; e. Typhoid Fever: Until ten days after the patient's temperature reaches normal.

Kentucky Health Board After "Healers."—Chiropractors, natureopaths and various other "healing paths" are having troublous times in Kentucky. The State Board of Health is making war on them, and the Grand Jury, on information furnished by the board, has indicted six of these would-be practitioners on the charge of practising without licens.

Our Health Department or Board of Medical Examiners should drive these false "healing paths" out of New Jersey. Why should regular, qualified physicians be required to pass a rigid examination by he State and then give these quacks free chance to exploit the people?

The Nation's Health.—The following figures regarding the health of this nation were given recently at a meeting of the American Public Health Association as an argument in favor of a National Department of Public Health: Of the 110,000,000 citizens of this country, 45,000,000 are physically imperfect; 15,000,000 die annually; 3,000,000 are in bed all the time; 1,000,000 have tuberculosis, and from 2,000,000 to 3,000,000 have hookworm and malaria. Only 37,500,000 are fairly healthy and 19,500,000 in full vigor.

Death Rates in the United States.—In 1900 the general death rate from all causes in the United States was 17.8; in 1917, the latest figures available, it had been reduced to 14.2. Had the 1900 death rate prevailed in 1917 there would have been in the United States, with an estimated population of 110 million, 396,000 more deaths than actually occurred.

The record of other years leaves little room to doubt what may be done in saving life. In 1900 typhoid fever caused a death rate of 33.8 per 100,000 population. In 1917 the rate had been reduced to 13.4. Diphtheria was reduced from 35.4 to 16.5 in the same period. Tuberculosis declined from 190.5 deaths per 100,000 of population in 1900 to 146.4 in 1917. Had the 1900 rate prevailed in typhoid fever, diphtheria and tuberculosis, in 1917, these three diseases alone would have caused 91,740 more deaths than actually occurred.

Smallpox in France.

The report of Dr. A. Fasquelles, director of the Service Anti-variolique de l'Armee, which has been submitted recently to the French Academy of Medicine, states the results of his work in protecting the French Army from smallpox during the war. He has made the following announcement: During the war of 1870-1871 more than 120,000 French soldiers were infected with smallpox, and more than 25,000 died. During the recent war only 12 cases occurred in the metropolitan French Army with only one death. This is the first time that a war has not been accompanied by a smallpox epidemic.

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REMARKS ON COMMON DISEASES OF THE RECTUM.*

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While proctology has won for itself a position as a definite specialty it is still true that the bulk of the surgery of the rectum is done by the general surgeon. Indeed, unless the proctologist is willing to undergo an arduous and extensive preparation in abdominal surgery, the major surgery of this branch involving as it does in many cases the most difficult and exacting intra-abdominal procedures, should not be regarded as belonging to the specialty but to the abdominal surgeon. Per contra it is incumbent upon the latter to become familiar with the lesser affections of the rectum in order to exercise judgment in diagnosis and treatment. This is my reason today for invading a special domain.

The rectum proper begins at the recto-sigmoid junction at the level of the third sacral vertebra and extends to the apex of the prostate in the male or to the upper level of the perineal body in the female. It averages about 11 cm. in length. It is continued into the anal canal which is embraced by the internal and external sphincters of the anus. The size and distensibility of the rectum indicate its capabilities for storage but it is not normally designed for prolonged storage of fecal material. The recto-sigmoid juncture which is the narrowest part of the bowel and is endowed with a rudimentary sphincter is a mechanism adapted to retard the onward passage of the intestinal contents until they are ready for expulsion. In normal adults of correct habits the rectum is usually empty. The presence of feces in any quantity excites the desire for evacuation. If this desire is not gratified the rectum often succeeds in emptying itself backwards into the sigmoid. The sigmoid becoming overfilled with inspissated fecal masses fails to functionate normally and the result is one form of constipation.

It is well known that carelessness in responding to the normal stimulus to evacuation will in time establish a tolerance by the rectum for its contents so that overfilling of the rectum itself results, which is further complicated by backing up of fecal material into the sigmoid and irritative processes are set up in the mucous membrane of the terminal portion of the intestinal tract. The rational treatment of diseases of the rectum should begin with prevention of this condition, for it is unusual to find a patient suffering from rectal disease who has not previously been of constipated habit. In this connection it is proper to say that the use of laxatives and purgatives has been greatly overdone by the profession. There has been a furor for emptying the bowels on all occasions, much as bleeding was carried to excess in former days. It is with difficulty that the surgeon has prevailed upon the physician to withhold purgatives in acute abdominal conditions because of their immediate deadly effects in many instances, while in chronic ailments too few voices of protest are heard against the prevalent use of purgatives by the physician, or the still more common self-medication by the patient with commercial preparations. Mothers, influenced by the prevailing ideas of the noxious character of the intestinal contents, often ignorantly interfere with the establishment of normal evacuation by the child,

*Read before the Gloucester County Medical Society of N. J., January 15th, 1920.

through frequent and ill-advised purgation. Such children are candidates for chronic intestinal and rectal troubles. Sound advice as to diet and correct habits and the inadvisability of meddling with intestinal functions would yield a great reward to coming generations. The present generation of the constipated we have with us and while much can be done, much cannot be undone to remedy engrafted conditions.

The most common disease of the rectum is that of congestion and dilatation of the veins which drain its lower end, together with the upper portion of the anal canal giving rise to the well known condition of internal hemorrhoids. These vessels are the lowermost radicles of the portal system, being derived from the superior hemorrhoidal vein which in turn is the terminal branch of the inferior mesenteric vein. Lying in the submucosa covered by the loose delicate and elastic mucosa they derive little support from their surroundings. When the vessel walls lose their tonus, as a result of prolonged congestion or increased pressure within the lumen due to obstruction above by increased intra-abdominal tension, pregnancy, cirrhosis of the liver or other conditions not always apparent, they enter upon the vicious alterations common to varicose veins in any location. These veins, seven or eight in number, run in the longitudinal ridges of mucous membrane known as the columns of Morgagni. The maximum number of piles in any one case therefore is eight. Usually there are less than that number. Miles has stated that there are three primary piles located respectively in the right anterior quadrant, the right posterior quadrant and at the left point of the compass respectively. These represent the terminations of the main hemorrhoidal branches. The other four, or (occasionally) five, piles are smaller and are derived from secondary branches of the main vessels. The young pile being covered by delicate mucous membrane which is easily traumatized bleeds easily and profusely. It does not protrude not having attained sufficient size to pass out of the anal canal. The pile in a later or intermediate stage of development becomes more fibrous, withstands injury during defecation and bleeds less frequently and less copiously. It protrudes during defecation but is spontaneously reducible. In its final stage the pile has undergone marked fibrosis and bleeds rarely or not at all but it has enlarged to the point where it protrudes on the least occasion and must be replaced manually. If it is not replaced promptly congestion and œdema may prevent replacement with the result that strangulation occurs.

In many cases palliative treatment in the earlier stages will prevent further development. General hygienic measures, the correction of dietary faults and constipation are important. In addition the patient should be instructed to pass the well lubricated and protected finger through the anal canal after defecation to disengage any hemorrhoids from the grasp of the sphincter which tends to traumatize, congest and elongate it. In spite of care however certain cases advance to the subsequent stages.

Operation is indicated for persistent hemorrhage even if small in amount as the total blood loss and consequent anemia and debility may be seemingly entirely out of proportion to the condition. The small continuous losses of blood do not stimulate blood formation but are a steady drain. The spontaneously irreducible pile also should be removed to forestall strangulation and fibrosis of the sphincter area. As a rule secondary bleeding piles are present as a complication. The injection treatment of piles should be taboo. While often successful and ostensibly simple and safe it is in reality less satisfactory and more dangerous than operation by either the ligature or the clamp and cautery. The period of disability under the latter treatment is but a few days and there is scarcely any result of surgery so uniformly satisfactory.

Less common than hemorrhoids but still very frequent are abscesses in the neighborhood of the rectum. We distinguish according to their location; (1) the anal or marginal abscess commonly due to a skin infection near the mucocutaneous junction; (2) the submucous abscess which is in an infective collection situated beneath the mucous membrane of the rectum but not penetrating its outer coat; (3) the pelvi-rectal abscess situated in proximity to the rectum but above the plane of the levator ani muscle, and (4) the ischio-rectal abscess which is the term indiscriminately used for collections of pus in the soft adipose tissues of the ischio-rectal fossa.

In all these conditions the question of immediate concern is free drainage of the purulent process. In many, however, avoidance of complications and ultimate cure demand a knowledge of the pathogenesis of the condition. The anal and submucous abscess have a strong tendency toward spontaneous cure and rarely introduce serious complications. The pelvi-rectal abscess, however, is less commonly derived from infection of the rectum itself than from disease of organs in proximity to it, as the bladder, prostate, urethra, pelvic organs, appendix, etc. The treatment appropriate to this condition, fortunately rare, is therefore not only drainage but the treatment appropriate to the causative disease.

Ischiorectal abscess when due to infection from the rectum, in the majority of cases is readily amenable to cure by simple incision and drainage. Incision should be prompt as soon as the acute condition is recognized without waiting for fluctuation or spontaneous rupture. The most common form is due to ulceration of the crypts of Morgagni through which infection works its way into the ischiorectal fossa. The point of entrance frequently remains as a small opening but drainage cannot take place because the walls of the anal canal are held in apposition by the tonic contraction of the sphincters. Hence the infection spreads in the soft yielding tissues of the ischio-rectal space. Careful and gentle examination of the crypts in cases suffering from ischio-rectal abscess will sometimes reveal the minute opening of entrance from which a small amount of pus can be seen to exude. In this case the incision to open the abscess should begin at this point and traverse the abscess in a radial direction. By this means the whole tract is opened at once and the common sequel of fistula in ano avoided. To aid in this examination one should remember the following observation reported by Mayo as learned by him at the London Hospital for diseases of the rectum. If the rectum be bisected by a transverse plane, all fistulas (and therefore fistulous abscesses) which are situated posteriorly to the plane have their anal entrance in the midline posteriorly, while all fistulas which open anteriorly to that plane have their point of entrance directly opposite the external opening, that is to say on a line drawn radially to the long axis of the bowel. If the abscess cannot be fortunately opened in this manner a circular incision is best, to which an external limb may be added in large abscesses making a T-shaped incision.

The most common and troublesome sequel of perirectal abscess is fistula in ano. Most fistulas following true rectal infection are complete and are kept open by means of the failure of the opening in the bowel to close. The treatment of the unbranching, fistulous tract is simple, consisting only in transforming it into an ulcer by incision. If it is unusually chronic it may be curretted or its walls excised, but the prime essential is laying it open and maintaining it in this condition by packing until granulation closes it. The very simplicity of this treatment exposes us to the fault of carelessness and failure, as witnessed by a considerable percentage of cases that come to operation two or more times for the same condition. The causes of failure are usually: (1) branching fistula; (2) high internal opening undiscovered at operation; (3) retained foreign material, and (4) confusion with conditions other than fistula in ano, notably tuberculous luetic sinuses and post anal dermoid or sacrococcygeal sinus.

Branching fistula must be treated by thorough opening of all the fistulous branches or by excision of the fistula bearing tissue through a flap laying bare the ischio-rectal space. Previous injection of the fistula with methylene blue or a concentrated solution of potassium permanganate is in some cases requisite for success.

A high internal entrance of the fistula, undiscovered and hence unopened, is an invitation to re-formation of abscess. At times the opening is so high that it seems inadvisable to pursue the tract by free incision into the rectum on account of the danger of hemorrhage as well as the subsequent formation of a long linear and irritable scar. In such cases Elting's suggestion of excision of the lower segment of the rectum bringing healthy bowel down to the anal orifice is a rational procedure.

Retained foreign matter whether fecal or of drainage material is due to improper after treatment and should not occur.

Of the conditions that may simulate simple fistula a tuberculous sinus unconnected with the rectum is a snare. Such

sinuses usually originate from abscesses having their point of origin in the bones of the pelvis or lower spine. These abscesses burrowing their way downwards point in the ischio-rectal space and either spontaneously discharging or being opened leave a long torturous sinus connected with the carious bone. The characteristic appearance of the tissues about the opening of a tuberculous sinus will usually give the alert diagnostician a clue and a radiogram of the sinus which has been previously injected with bismuth paste will clear up the diagnosis and point the treatment.

Other confusing conditions are the post anal, sacrococcygeal or pilo-nidal sinus. These are embryonic structures probably due to anomalies of closure of the termination of the medullary groove. The particular pitfall from the standpoint of treatment lies in the fact that they have an epithelial lining which must be completely excised in order to effect a cure. If treated by simple incision and packing by analogy with fistula in ano recurrence is certain. They are to be recognized often by a history of having been present from birth, by their position in the exact midline one or more inches posterior to the anus and by the close relation to the coccyx or sacrum rather than to the rectum. When they are derived from antecedent cysts of the same character, sinus formation having occurred only secondarily by rupture or incision, the diagnosis may be more obscure. It is well to inject such sinuses and trace them carefully, excising all suspicious tissue.

Finally a word as to the most serious disease of the rectum, namely, carcinoma. Of the malignant growths of the gastro-intestinal canal rectal carcinoma is next in point of frequency to cancer of the stomach.

From a diagnostic standpoint the outstanding feature is the insidious character of the early symptoms. Unless the growth is at the recto-sigmoid junction obstruction does not occur until late in the disease owing to the calibre of the rectum. Pain is not a feature until infection of the ulcerated area has occurred or metastasis has reached surrounding nerve filaments or trunks. Bleeding not usually profuse and abnormal sensations of more or less discomfort in the rectum are the commonest early symptoms and the patient usually announces to his physician that he is troubled with piles, and experience teaches us that the latter too often accepts this diagnosis without serious examination and so directs his treatment for a considerable period of the most valuable time. Over one-half of the rectal carcinomas are situated in the neighborhood of the recto-sigmoid junction, but the examining finger can reach fully 80% of all rectal growths. The remainder can be discovered with the proctoscope or sigmoidoscope. Could reasonably early diagnosis be made, the outlook for cure in rectal carcinoma would far exceed the prospects in gastric cancer since the rich lymphatic supply of the stomach means early and irremediable metastasis, while the rectum is poorly supplied with lymphatics and metastasis takes place correspondingly more slowly. Still nearly one-half the patients who reach the surgeon with carcinoma of the rectum are already inoperable on account of the extent of the growth, while many others require the most difficult and radical surgery to give them their only chance for life. These late cases, moreover, nearly always require an artificial anus which is always objectionable, though I have never seen anyone who had one who preferred death to an opening of this kind. The earlier the treatment the less is the necessity of artificial anus and the lower the immediate and ultimate mortality. The odium of operation for rectal carcinoma can be lifted only by a determined attempt on the part of the profession to penetrate the camouflage under which this disease lurks until it can proclaim itself more boldly as master of the situation.

SOME EXPERIENCES IN CONSERVATIVE AND RECONSTRUCTIVE WAR SURGERY.*

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In this paper I beg to offer some experiences and observations derived from nearly two years' service in Conservative and Reconstructive Surgery in the Army Medical Corps. **Conservative** in that a

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portion of the first year was spent in Camp and Base Hospitals, principally at Camp Meade, where I was in charge of the Orthopedic Department of the 79th Division as well as of the camp work and the base hospital, in active preparation for overseas service. **Reconstructive** in that the last eight months was spent as Chief of the Surgical Service at General Hospital 41, Fox Hills, Staten Island, originally Debarkation Hospital No. 2, where some 20,000 sick and wounded from overseas were received and treated, of which 80% were surgical cases.

The first portion of my experience (that derived from camp and base hospitals) was largely dealing with cases that one practicing in bone and joint diseases and injuries would meet in civil practice. In camp the supervision and treatment of ambulatory cases of bone, joint and muscle injuries were dealt with through our Central Dispensary to which cases were referred from the various regimental infirmaries. In the various organizations there were instituted periodic surveys of the men to discover physical defects and deformities. The care of the soldiers' feet was entered into in detail. Instruction was arranged for officers and enlisted men as to the care of the feet, socks and shoes. I had twelve surgeons assigned to this work, which was no small undertaking in itself. In our surveys we used a cypher which no one but the surgeons understood so that the men could gather no information relative to their physical conditions. This worked out very well as it gave no chance to magnify a non-disabling defect. We had a shoe repair and alteration department with experienced cobblers who made the necessary orthopedic shoe adjustments under our direction.

In the Depot Brigade to which all incoming recruits were assigned for the routine examinations we had a station for the orthopedic examinations of bones, joints and physical defects. In this Depot Brigade was a Development Battalion to which men with physiques requiring special or more gradual training were sent and this battalion became one of the most important conserving factors of our men.

At the Base Hospital the Orthopedic Service consisted of an examining office, work shop, two acute wards and one semi-acute ward of 34 beds each, and a convalescent ward of 80 beds. One of the principal occupations of our orthopedic convalescent patients while I was there was the planting and caring for a 30-acre garden, the idea for which orginated in February, 1917, by my receiving a Burpee seed catalogue from home to forward the annual seed order for my home garden. The plan grew to such proportions that when spring plants, trees, shrubs, etc., from nurseries throughout the East came for the hospital gardens by the carloads so that it taxed the gardeners to the limit to get them into the ground as they arrived. I speak of this gardening more particularly as it had such a salutary effect upon the convalescents from the orthopedic wards who needed exercise for joints and muscles temporarily limited in function as a result of injuries. This gardening was made a part of the prescribed physiotherapeutic treatment for those cases. It was not a passive or indoor exercise at some minor occupation killing time rather than producing results. These men were very much interested in this part of their treatment and the more interested they became the faster was their recovery. It was amusing to observe the patients did not always know the difference between root and branch and I can hear their captain now getting after some of his squads for their stupidity.

My experience at Meade brought me in touch with large groups of cases where I could study types and conditions in a way impossible in civil practice. Our chief objective here was the foot problem and it was a big one. We did not wish to send men across who could not stand up under the strain of military duty and we could not reject men who might be made fit for some kind of service. The need for men was too pressing. I found a large percentage of naturally or congenitally weak and pronated feet, not flat in the specific acceptance of the term, but feet which without proper exercise and treatment would stray into ways of becoming painful and disabling. And too, there were feet which might appear flat or exhibit a low arch which were perfectly normal and strong to those persons and never would become troublesome so far as their usefulness was concerned.

Of interest also were the various types of sprains and sprain fractures frequently met with, which are often overlooked and when treated lightly lead on to per-

manent disability. I should here state it to be my practice to x-ray all sprains, experience having taught that so many apparently simple sprains are actually complicated with fracture. Take as an example an injury to the mid-tarsus. Many times the patient will make his own diagnosis of a sprained foot and furnish his own treatment before seeking medical advice. It is difficult to fracture a ligament but comparatively easy to fracture a bone at the attachment of a ligature and this is what takes place very often. I have many x-rays of such cases.

A sprain of the internal calcaneo-navicular ligament which is essential in the support of the head of the astragalus on the inner aspect of the foot at the dome of the long arch, a common type of sprain, can be complicated by a fracture at the attachment of this ligament to the inner projection of the navicular, which if inefficiently treated results in a pronated painful foot which is commonly designated flatfoot. I have instances of such cases which had progressed so far in disability that resort to operative measures was necessary to produce a serviceable result. The most satisfactory operative procedure which I have used for the past ten years is ankylosing the astragalus to the navicular, which corrects the painful disability and restores proper function.

Another type of sprain fracture is that of the tubercle of the astragalus which can be palpated just anterior to the tendo Achilles. This tubercle varies in prominence in different individuals. In a recent case pain and crepitus is elicited when the thumb and finger are pressed deeply together anterior to the tendo Achilles. The most reliable treatment is immediate immobilization of the foot and leg in plaster of Paris. Should this not avail and pain persist when walking, operative removal of the fragment is indicated.

Still another type is fracture of the tip of the external or internal malleolus accompanying a twisting sprain of the external or internal lateral ligaments of the ankle joint. Fixation is here indicated or pinning of the fragment to the malleolus by a bone pin to insure union. Yet another type of sprain fracture is that of fracture displacement of the sustantaculum tali. I have had instances where the fragment presented in the sole of the foot to the examining finger. Operative removal is the most rational procedure.

The bunion cases on which I operated by a modified Mayo technique I had the satisfaction of getting back on duty in six weeks.

There were also quite a number of hammer toe cases in which the operative results were satisfactory. I removed the articulating surfaces of the flexed joint and got an end to end ankylosis in full extension. Amputations in hammer toe are not advisable.

My last assignment was to Fox Hills, Staten Island, where the Government was building a hospital of 3,000 beds and capable of extending to 5,000. As Chief of the Surgical Service for eight months the problem of organizing the service in its various departments was of much interest. General Surgery, Orthopedic Surgery, Eye, Ear, Nose and Throat, Genito-Urinary, X-ray, Physio-Therapy, Mechano-Therapy and Dental Surgery, each with a rounded out group of specialties, having offices fitted out with all the equipment required in the modern practice of these various specialties. It was a well-organized form of group practice, advantageous to patient and physician. As I look back upon my service I am impelled to say that I doubt if there was a group of medical officers anywhere who were more in harmony, more enthusiastic or who exhibited a finer spirit of earnest service than this group at Fox Hills. There were about 80 medical officers and the running of the hospital required the services of a Medical Detachment and Quartermaster Corps of about 1,000 men, as well as a large nursing corps and special nursing aides. The location of the hospital could not be excelled, situated as it was upon the hills adjacent to the Golf Club, overlooking New York Bay and the Narrows.

At first we were a Debarkation Hospital, receiving patients direct from the transports in groups varying in number up to a thousand at a time, transferring those who could travel to hospitals nearest their homes and retaining those for treatment who were unable to go farther. As we had to deal with large numbers we grouped cases as much as possible, having wards specializing in particular types, thus materially facilitating treatment. There were wards for Dakin treatments fracture wards, wards for

clean operative cases and wards for convalescent and ambulatory patients. As 80% of the work to be done was of a reconstructive nature there was ample opportunity for a broad field of this work, but my time will permit me to refer to but a small portion of it.

It was gratifying to observe the satisfactory condition of the fracture cases upon arrival. It spoke well for the kind of service the Medical Department was giving to our soldiers, particularly in the splinting of fractures. I have great respect for the Thomas splint which was a material factor in the accomplishment of this result. Most of our fractures were compound and infected, but with the protection and fixation the Thomas splint gave, the difficulty of treatment while in transit was minimized. There were fractures of the shaft and fractures into joints, many with loss of bone substance and pseud-arthrosis. Many of the open and infected cases were of several months' standing, although we received cases as recent as six weeks after the receipt of the injury when the fighting was particularly active and the base hospitals had to be cleared to make room for fresh cases.

A point in connection with these infected bone cases which impressed me was the fact that the infection was not the extending osteomyelitis we usually have to consider but a localized osteitis which included only the immediate area of trauma. I saw very few instances of the fulminating osteomyelitis so that the clearing away of devitalized tissue and loose bone spicules and instituting Dakin treatment caused them to respond readily. Operative closures were few as would naturally be expected in this class of cases. The most satisfactory way of effecting closures in these excavated bone wounds was removal of devitalized tissue and selving bone areas, allowing the soft parts to fill into the excavation. This method might produce adherent scars in some instances which would limit function in a degree but would be remedied subsequently after suppuration had cleared up.

A most troublesome form of infection to control was that of streptococcus hemolyticus which was found in a large portion of the cases. Just here under the topic of infections it seems pertinent to speak of the attention that has been directed to a radical departure from the heretofore accepted treatment of purulent joints. A prominent Belgian surgeon has called attention to the value of active motion in the treatment of infected joints as an aid in freeing the joint rapidly of pus and producing excellent functional results. This treatment has been taken up enthusiastically by some American surgeons advocating the method without emphasizing sufficiently the necessity for a careful selection of cases for such treatment. It is true that active motion of a joint will facilitate the expulsion of pus and one will be agreeably surprised to find the wide range of motion a properly selected case will display. But this gratifying result will not follow if there is active bone disease producing the suppuration adjacent to the joint cavity. It would be courting disaster to attempt a mobilizing method of a tubercular joint with active bone disintegration taking place. I have in mind at this moment a case where, on the false assurances of a quack, a hip splint was removed from a convalescent tubercular hip with the result that in a week's time the patient was on his back in bed with an acute exacerbation of symptoms, abscess formation, and it was not long before the disease had extended to the knee, ankle and spine and the patient became a helpless cripple. Neither should this method be adopted in joints with a productive osteitis, such as a gonorrheal infection.

In plastic work such as freeing of extensive scars limiting function, muscle and tendon transplantations for compensatory function, mobilization of ankylosed joints and bone graft work of nerve suture, it was not advisable to attempt such procedures until permanent wound closures had been accomplished and continuous for two months at least, and then not until the parts had been tested out by thorough massage and exercise, both passive and active, to determine that a latent process would not be stirred up by operating. The British would wait six months, but in most instances this seemed an unnecessary delay and there was no cause to change this rule on my part.

In ununited fractures the inlay graft was used when the fracture was well away from a joint and when the break was too near a joint to permit of the inlay, I used the inlay in one fragment and mortized into the other fragment. When there was a loss of substance of the shaft

the graft was cut so as to hold the fragments apart and at the same time furnish a bone bridge to fill in the deficiency.

We had a large number of head injuries, particularly face and jaw, which with the aid of our efficient dental department we sent out of the hospital quite presentable both from a functional and cosmetic viewpoint. As an instance we furnish an artificial chin and lower lip so that the patient could articulate, eat, smoke a cigarette with a degree of comfort he had not known since the receipt of the injury, which was from a shell tearing away a large portion of the lower jaw as well as the soft parts of the lower lip and chin. Another was that of the loss of the nose with a portion of the superior maxilla. We reconstructed the face so that the man himself said he was better looking than before the injury, which was borne out by comparison with a previous photograph which he showed us.

In ununited fractures of the lower jaw attempts have been made to produce union by various means without result, bone grafts are applicable, but it is often difficult to apply inlay grafts to certain types of these fractures on account of the wide dissection necessary, the limited thickness of the jaw, the possibility of interference with the remaining teeth and most of all the possibility of infection and the non-union or absorption of the graft when implanted. Here I had the opportunity of applying a technic which I had employed in civil practice with satisfactory results. This technique consists of preliminary fixation of the anterior fragment to the upper jaw by dental splinting to assure a proper occlusion of the teeth. The skin incision, located in the folds below the jaw to hide the scar, the exposing of the fracture, the freshening of the fractured ends, the drawing into proper alignment of the posterior fragment and holding it in position while the motor driven drill bores horizontally along the ramus well within the lower border through both fragments. A bone peg is made from a bone section taken from the tibia, fashioned exactly equal in diameter to the drill used, the pin is then substituted for the drill. The fixation of the fragments is secured when the bone pin is in place without resort to retention sutures and the operation is very greatly simplified as compared with the inlay methods. One case I operated on in the service I had the privilege of observing for nearly eight months since I operated. He is able to masticate, has good range of motion, and the facial contour is very much improved. This was a case where about ¾ of an inch of bone substance of the ramus was lost as the result of a machine-gun bullet wound.

Joint fractures were met with in every conceivable form, from the simple closed fracture to the most extensive destructive type with loss of all control of the limb. In some flail joints usefulness was restored by anklylosing them at a suitable angle, while others which were ankylosed in a vicious position were improved by correcting position or reconstructing a joint. The mobilizing of ankylosed joints is a problem requiring judgment and should be considered from every angle. A stiff painless joint is preferable to one movable but painful. It is quite a different problem to produce a painless movable joint at the elbow for instance, which is non-weightbearing, than at the knee joint. Various substances as fat, fascia and chemical treated membrane have been interposed to prevent re-union. In all reconstructive surgery it is essential, as far as possible, to avoid introducing substances of a foreign nature. I have used fascia in my cases and resorted to moderate traction and careful active and passive movements at an early period after operation.

We did few amputations. Those that we received at Fox Hills were in most instances done before the case was sent back to the base or hospital of the interior, so that our work in these cases consisted principally of re-ampuation to produce a painless stump or one better adapted for applying an artificial limb. Most of the amputations we received were of the guillotine type, done under pressure for time and as a life-saving measure. Amputations have been done too freely in the past in the attempt to settle a troublesome situation, but such an advance has been made in reconstructive surgery that now a radical removal is seldom resorted to.

I have had some striking examples of the value of reconstructive work of the extremities. As an instance, take a hand that has been injured at the wrist so as to destroy the power of extension though the flexors have not been injured. The hand is held in flexion, the strength of

grip is weakened or lost entirely because of the inability of the flexor muscles to contract farther. Extension of the hand must be restored before the grasp can be improved. I have instances where I succeeded in this by bone graft, fixing the carpus to the radius with the hand in full extension, thus restoring the grasp of the fingers.

The treatment of fractures of the long bones has made a marked advance. The Balkan frame has added much to the efficiency of technique. It has made possible the successful treatment of such fractures, at the same time maintaining the mobility of the neighboring joints. The old Bucks extension has been thrown into the discard. In the hands of the surgeon with an understanding of the practical mechanics of traction and counter traction in restoring the balance of muscle action the Balkan frame is an able assistant. I look for great improvement in fracture work resulting from experiences gained during the war.

We had a great many nerve suture and repair cases. Although there has not been sufficient time to give us the full significance of results, the methods have been so simplified that we have arrived at end to end suture as the method of choice.

In reconstructive work the importance of adequate physio-therapy should be emphasized. In all cases of limited function as a result of injury competent massage, baking, active and passive movements and electricity are necessary to restore the injured part as far as possible before operative measures are undertaken, and following operation they should be resumed as the case indicates. Too much emphasis can not be laid upon the value of employing competent physiotherapeutic management of injuries of joints, ligaments, muscles and tendons, and at an early period, to rectify as far as possible disabling injuries that we are constantly encountering among industrial workers. Its value has been amply demonstrated in the reconstruction of our injured soldiers.

Rabies Dormant Two Years.—A negro in Alabama is alleged to have developed rabies two years after he was bitten by a pet dog. He was sent to a hospital in Montgomery where he attacked the nurses and other attendants. In attempts to subdue him he was shot and killed by officers.

THE IMPORTANCE AND USE OF BIOLOGICAL PRODUCTS IN PUBLIC HEALTH WORK.*

By John F. Anderson, M. D.,
New Brunswick, N. J.

When last I had the privilege of addressing you, it was as Director of the Hygienic Laboratory, U. S. Public Health Service, and I told you of the work we had been doing there on the etiology and method of spread of measles and typhus fever. Since then I have become a resident and citizen of the State of New Jersey, and am, therefore, intimately interested in the local as well as the state public health problems which concern the people of New Jersey.

I have chosen for my subject a discussion of the use of biologic products in public health work, as I have long felt that their importance as a factor in controlling the mortality and morbidity from certain infections was not well appreciated by many health officials.

There is no branch of therapeutics more abused than biologic products by reason of the wrong use of its representatives, and none of greater value to the public health administrator when intelligently used. They are of particular value because they not only cure people sick of certain diseases, and are therefore specifics, but they may be used for the prevention of disease with the assurance of success.

It is for the latter purpose that biologic products are of the most interest and greatest use to public health officials, for your profession is primarily concerned with the prevention rather than the cure of disease. The old adage that an ounce of prevention is worth a pound of cure is particularly applicable to public health work, but the ratio more properly would be a thousand to one rather than sixteen to one.

The first biologic product to be used in public health work was smallpox vaccine. We cannot even approximate the number of lives saved in the 125 years of its use by the protection it has given individuals vaccinated against smallpox. But in spite of its known value in protecting against smallpox, there are some who even at this time are urging our law-

*Read at the Annual Conference of State and Local Health Officers of New Jersey, February 27, 1920.

makers to take this protection from our people by repealing the State Vaccination Law.

I need dwell but briefly on the value of vaccine virus or smallpox vaccine in public health. The medical history of the world before general vaccination came into effect shows the wide prevalence of smallpox and the tremendous mortality; none escaped, rich or poor, high or low, all paid the toll in death or terrible disfigurement.

In the present day, owing solely to the almost universal employment of vaccination, smallpox is a minor factor in our mortality reports, but its infrequency is beginning to breed a sense of false security and we are not as insistent in enforcing vaccination and revaccination as the occasion demands. In considering the value of vaccination, it must ever be kept in mind that revaccination is just as important as the first vaccination; this is because the immunity given by vaccination gradually disappears, and in many individuals this immunity has passed in seven to ten years. A child should therefore be vaccinated at infancy, and about every seven years thereafter.

I shall not weary you with statistics as to the protection given by vaccination and will only refer to those from Sweden in which country smallpox has practically disappeared by reason of the strict enforcement of vaccination. Previous to the employment of vaccination the deaths in that country from smallpox were about 20 per million inhabitants. After the enforcement of vaccination the deaths were less than at the rate of 20 per 100 million inhabitants.

You, as public health officials, and as leaders in your community, interested in the welfare of the people of this State, should make your representatives at the State House, in the Senate and Assembly, understand in no uncertain way that you will not permit any tampering with the laws of this State regarding compulsory vaccination.

As smallpox vaccine was the first biologic product used for the prevention of disease, so was diphtheria antitoxin the first to be used for curative purposes, and its value has been so well proven that it seems hardly necessary to more than mention it. It matters not how we study the question, the conclusion is always the same, namely, that the average reduction of mortality from diphtheria by the use of antitoxin in the treatment of diphtheria has been not less than 50% and under the most favorable conditions a reduction has been had to one-quarter, or even less, of the previous death-rate. This has been the experience, not in one city at a particular time, but in many cities, different countries, and at all seasons of the year, and always in conjunction with the introduction of antitoxin and proportionate to the extent of its use.

In spite of the fact that the case mortality of diphtheria has been reduced, there has been no marked reduction in the number of cases, except where immunization has been made on a large scale, but we now have available means by which we may soon be able to effect a reduction in the actual number of cases of diphtheria and a still greater lowering of the mortality.

Before discussing these newer methods I wish to say just a few words as to the dosage of diphtheria antitoxin. The object to be arrived at in the administration of antitoxin is to neutralize immediately the toxins or poisons produced by the diphtheria bacilli and which are circulating in the blood. Manifestly, this can best be done by giving a sufficiently large dose of antitoxin and repeating when necessary. Not less than 10,000 units should be given as the initial dose and if the case is of the laryngeal type, or is seen after 48 hours from onset, the dose should be larger and repeated as indicated by the condition of the patient. The response is obtained more quickly when antitoxin is given intravenously.

One thousand units is the dose for prophylaxis or immunizing purposes, but it must be remembered that the immunity conferred by antitoxin is passive and only lasts about three weeks.

The newer methods to which I have referred are what are known as the Schick test for the determination of the individual's immunity to diphtheria and the use of toxin-antitoxin mixture for producing active immunization.

As stated in the U. S. Public Health Reports the increased use of these procedures, especially where diphtheria is at all prevalent would constitute a distinct advance over the present methods of controlling the disease. The Schick reaction depends upon the fact that if a minute amount of diphtheria toxin is injected into the skin, a local reaction re-

sults if the individual is susceptible to diphtheria, while no reaction occurs in a non-susceptible person.

It is not necessary to give you the details of the test other than to state that a fresh solution of diphtheria toxin is prepared so that 0.1 c.c. represents 1/50 of the minimum fatal dose for a 250 gram guinea pig. This amount is injected with a special needle into the skin on the flexor surface of the forearm. If positive the reaction appears in 12 to 24 hours and is distinct in 24 to 48 hours. It reaches its height on the third or fourth day. There may occur certain pseudo-reactions, but with experience these are differentiated without difficulty.

"The Schick test is of practical value in determining the immunity to diphtheria of the public in general, but especially of the child population in schools, hospitals, institutions, and in homes during an outbreak of diphtheria. It will save a considerable amount of antitoxin and avoid unnecessary sensitization of more than 65 per cent. of the exposed individuals. The test is also of distinct value in the active immunization of susceptible individuals against diphtheria with mixtures of toxin-antitoxin, and in the diagnosis of clinically doubtful cases of diphtheria." Text of a circular of information issued by the department of health, city of New York.

As supplied by most manufacturers, the Schick test outfit consists of a tube of diphtheria toxin and a vial containing a measured amount of sterile salt solution. By mixing the contents of the capillary tube with the saline a solution is obtained which is ready to be injected into the skin.

After discovering susceptible individuals by means of the Schick test, the question at once arises as to how best to immunize these individuals. The protection afforded by injections of diphtheria antitoxin is of a very short duration, three or four weeks being the usual period. Far more lasting is the protection afforded by active immunization. During the past three years Park and his co-workers have employed active immunization with toxin-antitoxin mixtures in the case of over 4,000 susceptibles (including 1,000 infants under 1 week old) without the subsequent occurrence of a single case of diphtheria. Park summarizes his observations as to the value of this active immunization as follows:

The procedure is absolutely harmless. No reaction develops in infants, while in other children and adults a moderate swelling of the arm may appear and last for from one to three days. One injection gives immunity to 80 per cent. of those previously susceptible; two injections give immunity to 90 per cent.; and three injections to 97 per cent. The immunity conferred lasts for at least three years and probably much longer. No diphtheria has occurred in those so far immunized.

In order to increase the use of active immunization by practising physicians, several establishments making biological products put up small vials containing a mixture of diphtheria toxin-antitoxin. This mixture is used undiluted. The dose is one c.c. injected subcutaneously in the arm at the insertion of the deltoid. The injection is repeated at weekly intervals until three injections have been given. For children under one year of age the dose is 0.5 c.c. In the younger children the local and constitutional symptoms following the injections of toxin-antitoxin are much less marked than in older children and adults. The difference is due to a greater susceptibility of the older children to the diphtheria bacillus protein which is present in the mixture of toxin-antitoxin.

The development of an active immunity is determined at the end of three months by means of the Schick test. It has been found that the development of antitoxin in many individuals is often a slow process requiring from 8 to 12 weeks before a sufficient amount is produced to inhibit the Schick reaction. The number of successfully immunized individuals who will show a negative Schick retest after three injections of toxin-antitoxin will be, in different groups, from 90 to 99 per cent.

Any discussion of the use of biologic products in public health work would be incomplete without reference to the wonderful results achieved in preventing typhoid fever by immunization with typhoid vaccine.

During the Franco-Prussian War sixty per cent. of the total German mortality was due to typhoid fever. In the Boer War, there were 31,000 cases of typhoid fever with 5,877 deaths in the British Army. During the Spanish-American

War, among 147,795 troops, there were 20,926 cases of typhoid fever with 2,192 deaths in about eight months.

Typhoid vaccination was begun by Pfeiffer and Kolle and simultaneously by Wright in 1896. The former inoculated two volunteers and the latter immunized 19 persons with heat-killed cultures. Vaccination against typhoid was begun in the United States by Colonel Russell in 1908. The results of these first inoculations were so striking that it was soon made compulsory in the army. During the Spanish-American War before the days of vaccination, practically one soldier out of seven had typhoid fever and one out of sixty-seven died. During the mobilization on the Mexican border in 1916, where a larger number of soldiers were stationed than during 1898, and in practically the same climate, but with compulsory vaccination, there were only 24 mild cases of typhoid with no deaths.

If the same prevalence of typhoid fever had existed as was found during the Spanish-American War, out of the four million troops we had mobilized in the great war, there would have been approximately 600,000 cases of typhoid with 60,000 deaths. Or in other words, practically twice as many would have died from typhoid as were killed in action. With typhoid vaccination, typhoid fever has been practically eradicated in the army.

During the mobilization on the Mexican border in 1916, after the troops had been immunized against typhoid by use of typhoid vaccine, there developed some small epidemics of paratyphoid fever. Typhoid and paratyphoid are very similar in their clinical manifestations, but can be definitely diagnosed in the laboratory by agglutination tests. While the organisms causing typhoid and paratyphoid are quite similar, one does not produce immunity against the other. Paratyphoid is not so common as typhoid, but cases do occur not infrequently. It has been found by experiments conducted at the Hygienic Laboratory and elsewhere that better protection is obtained for each of the three diseases, namely, typhoid, paratyphoid A and paratyphoid B by use of the combined triple vaccine than when each of them is injected separately. Each cubic centimeter of the triple vaccine contains 1,000 million typhoid, 500 million paratyphoid A and 500 million paratyphoid B bacilli. Three injections usually produce an immunity which lasts from one to three years or longer.

The pandemic of influenza which began early in 1918, and soon extended over the entire world, was the most appalling plague in the number of deaths and those attacked that has occurred in so short a time in the history of the world. It has been stated, and it appears that the statement is a conservative one, that more persons died as a result of the disease than lost their lives in the great war. The number has been estimated by some as over 10,000,000. According to the U. S. Public Health Reports of August 8, 1919, conservative estimates place the deaths from the influenza epidemic in the United States alone at not less than 550,000, a number approximately five times the number of American soldiers officially stated to have lost their lives from all causes in the war.

Since the beginning of the great epidemic of influenza in the late summer and fall of 1918, the thoughts of all have turned to the discovery and use of a vaccine or serum for the prevention and treatment of influenza and its complications. Researches of a most painstaking and elaborate nature have been made with the disease, and as a result we must conclude that the micro-organism causing the disease has not been identified. This is true, even though we have a so-called influenza bacillus which was formerly thought to be the specific organism. It is, therefore, not possible at present to prepare any specific vaccine or immunizing agent against influenza. But it has been demonstrated by numerous investigators that deaths from influenza itself are very small in number and the greater part of the mortality is due to the complications of the disease, and by far the most important is pneumonia. If pneumonia can be prevented, influenza will be robbed of the greater part of its importance as a factor in our mortality reports. According to the report of the special Committee of the American Public Health Association, the pneumonias accompanying influenza in the 1918 epidemic were due largely to infections caused by the influenza bacillus, different strains of the pneumococcus and different varieties of streptococci. The Public Health Committee of the New York Academy of Medicine in its report

on the use of vaccines in influenza stated that the use of suitable vaccines for preventing the secondary infections due to different organisms, such as streptococci and pneumococci, offer a probability of success, and that "the numerous favorable results at hand show that efforts in this direction should be encouraged."

The results reported from Camp Wheeler and Camp Upton with the use of a vaccine against pneumonia showed that protection could be given against the types of organisms used in the vaccine. Major Cecil stated that at Camp Wheeler the camp pneumonia rate for unvaccinated soldiers was twenty times that for vaccinated, and that civil life has important uses for such vaccination.

Pneumonia is the most important item in our mortality reports of infectious diseases, and if by the use of proper vaccines the number of cases, and consequently the number of deaths can be reduced, one of the most important achievements of preventive medicine will be had. It is my firm belief that we are on the eve of such a development and that in a very short time the use of vaccines against pneumonia will be as universal and as effective as is now typhoid vaccine against typhoid fever, and that it will be a recognized procedure of public health departments to make such a vaccine available to the public.

Time will not permit me to more than refer to the use of other biological products of importance in public health work. Among such are tetanus antitoxin for the prevention of tetanus or lock-jaw, the use of which saved so many lives in the great war; the use of rabies vaccine for the prevention of hydrophobia; the use of cholera vaccine for the prevention of cholera, and of plague vaccine against bubonic plague. All have proved their value in preventing diseases, thereby contributing to the health and happiness of mankind.

I do not think I should close this brief discussion of my subject without giving a few words of warning. Biologic products, to give their best results, should be properly prepared, free from harmful substances and fully potent. These factors are safeguarded to a certain degree by the laws and regulations of the U. S. Government, but there still remains much in addition that can only be present as a result of the conscientious efforts of the producer, and it is, therefore, important that only the product of a well-known and reliable manufacturer be used. Furthermore, it must always be remembered that biologic products are what is known as thermolabile, that is, they are adversely affected by higher temperature than 50° F. For example, smallpox vaccine soon loses in its ability to produce a satisfactory "take" when exposed, even for a few hours, to high summer temperatures, and also a very few days at ordinary room temperature. The same is true, but to a lesser extent, of the antitoxins, serums, bacterial vaccines, etc. Biologic products should always be kept in the ice box until immediately before use.

CLINICAL RESUME OF INFLUENZA AS SEEN IN RECENT EPIDEMIC.*

By Frederick C. Horsford, M. D.,
Newark, N. J.

When it was decided to devote a part of the program for this meeting to a consideration of the pathological aspects of influenza and its complications, and especially since we have just passed through an epidemic of influenza constituting a second phase of the epidemic of a year ago, it seemed proper to offer a brief resume of the subject from the clinical side. The following data from Division B of the medical service at the Newark City Hospital, comprising cases observed during the months of January and February, is submitted and classified as follows: Influenza with various complications and sequelae—65 cases; cases judged as "colds"—5; exacerbations of a chronic bronchitis—2; broncho-pneumonia—30; lobar pneumonia—55; empyaema—3; a total of 160 cases.

Influenza. The cases of uncomplicated influenza ran a course of a few days to a week. The temperatures ranged from 102 to 104, either dropping quickly to normal on the second or third day or returning by lysis in the course of a week. The patients complained of headache, backache, and more or less pain in other neuro-muscular locations. There was very little involvement of the respiratory mucous membrane, as compared with the cases observed last year; no conjunctivitis; very seldom coryza. 23 cases

*Read at a meeting of the Essex County Anatomical and Pathological Society.

showed the presence of sub-crepitant rales in the lungs; in the remaining 42, no definite physical signs of catarrhal inflammation could be made out. The toxic signs, headache, prostration and neuromuscular pain, were all proportionately small in accord with the mildness of the inflammation of the respiratory tract. One case with meningeal symptoms lasting two or three days was observed. A spinal tap in this case gave a clear fluid, not under pressure, and the patient's symptoms were set down as due to meningismus. It is worth while to note that in this case, the uncommon accident of breaking the puncture needle in situ occurred. This accident was due to the boy's sudden violent movement, after the fluid had been withdrawn and when the needle was about to be withdrawn. The distal end of the puncture needle was subsequently retrieved with no untoward result. One case of double otitis media appeared as a complication of influenza. Four women aborted while sick with influenza, without however, any serious consequence, in contradistinction to the serious and usually fatal complication of premature labor and abortion with pneumonia. Two cases which appeared to be uncomplicated influenza, were found later to have signs indicating a previously developed pulmonary tuberculosis. There were several cases of pulmonary tuberculosis admitted during this period, but where the diagnosis offered no difficulty, they were not included in this report. Exacerbations of chronic pulmonary tuberculosis often complicates influenza. Pleurisy as a complication of influenza is rare. One case was observed in a young woman whose chest on one side posteriorly over an area paralel with the lower one-half of the spine and extending out to the post-axillary line was flat with absent voice and breath sounds. X-ray plates showed a shadow roughly corresponding to area described and accompanying reports were confusing in that encapsulated fluid was suggested at one time and at another "no fluid." No fluid could be obtained by repeated thoracentesis. After about three weeks the patient got well, but without much change in the physical signs. I am of the opinion that we had to do with a fibrinous pleurisy, which was seen late, that is after friction rales had disappeared. The physical signs will perhaps be more or less permanent on account of thickened and adherent pleura. It may be tubercular. One case sent to the hospital as influenza was found to be suffering from a severe type of diabetes mellitus. One case, admitted as influenza, proved to be diphtheria and was transferred to the Isolation Hospital.

A patient with the history of influenza and with a palpable and tender spleen was the only one in this report with an abdominal complication. This patient's blood showed a leukopenia and we were mindful of a possible typhoid fever. The Widal, however, was negative and the patient got better within a week, the spleen disappearing. A patient said to have been sick with influenza for three weeks before admission to the hospital evidenced the symptom complex of a post-influenzal psychosis, a depressed state with agitation, delusions, etc. There was no history of mental disease in the patient's family. He had moderately advanced arterial changes with moderate cardiac hypertrophy and some signs of insufficiency which may have been factors in the psychosis. This patient was transferred to the Psychopathic Ward and later he committed suicide.

A case of Epidemic (Lethargic) Encephalitis is introduced here in connection with influenza as a possible sequel. This diagnosis was made prior to his admission and confirmed on the following grounds: A young man thirty years old complained of headache, pains in the back of neck, amblyopia and especially diplopia. He showed a slight elevation of temperature. When examined he was lying in bed, eyes nearly closed, muscles a little tense. He showed a moderate degree of mental and motor excitement, which was characterized by its subdued tone. He talked quietly to himself, was disconnected and wandering in speech, appeared to have hallucinations and to be delusional. His voluntary movements, initiated by these false perceptions and ideas, evidenced muscular weakness (paresis), gross tremors and ataxia. He was oblivious of his surroundings, except when one engaged his attention, then he partly opened his eyes (ptosis). He answered questions clearly but, following a brief or monosyllabic reply, attention was at once distracted and he returned to his muttering delirium. At all times he showed a remarkable sense of well-being, in lucid intervals, laughing pleasantly (euphoria). There were no

pupillary anomalies, nor optic neuritis. There was evident moderate ptosis, slight nystagmus and strabismus, apparently the result of oculo-motor paresis. There were no paralyses, reflexes were not markedly disturbed, and in other respects physical examination was negative. The spinal fluid showed a very moderate increase in globulin and cells (12 per c.mm.). Red cells were normal, leucocytes 7000 per c.m. with 58% P. N. blood and spinal Wassermann negative, urine negative. After three weeks this patient appears to be getting better, which result occurs in a moderate number of mild cases of this disease ("Bassoe had five deaths among twelve; Sachs had three fatalities in one group of thirty cases and five in a second group of fourteen cases, House four in thirteen cases").

Broncho-pneumonia. There were 30 patients afflicted with this type of pneumonia, of whom 6 died, 20%. One of these cases came to autopsy and, according to Dr. Martland, the post-mortem findings were characteristic of the broncho-pneumonias which have been observed complicating influenza. The broncho-pneumonia cases, with very few exceptions, were not so sick as those observed last year. There was a noticeable absence of cyanosis. Some of these cases of broncho-pneumonia gave a history suggestive of influenza, preceding the onset of cough and of other signs referable to inflammation of the bronchi. In general, the evidences of bronchial inflammation were slow in appearing, four to even six days after the onset of illness, before definite signs in the chest were observed. Most of the cases showed only signs of catarrhal inflammation of the bronchi, with patches of broncho-vesicular breathing, occasionally a small area of frank consolidation, as denoted by the bronchial quality of the respiratory murmur and voice.

In consonance with the mildness of the disease, no cases were observed with large confluent areas of consolidation, resembling lobar pneumonia. These confluent areas of lobular pneumonia forming consolidations comprising the area of an entire lobe, perhaps on both sides of the chest, were frequently observed in the epidemic of a year ago.

Two cases classed as influenza, which might perhaps properly have been classed with the broncho-pneumonias, showed a localized area with slight dullness, harsh breathing and rales heard over more or less of a lower lobe. These cases are not very infrequent. They suggest tubercular broncho-pneumonia but often clear up without leaving a trace. Two cases of localized bronchitis or broncho-pneumonia developed in patients sick in the hospital, one with aortitis and aortic regurgitation; the other in an obese woman, who had recovered from an exacerbation of chronic bronchitis.

Lobar Pneumonia. Of the 55 cases of lobar pneumonia observed on Division B, 20 died, about 36%. There was nothing about the onset of the disease or its course which served to differentiate it from the cases of lobar pneumonia that occur regularly, at this time of year. In two cases the physical signs in the chest consisted first, of a pleuritic friction sound heard over the base posteriorly, closely followed by dullness, increasing to flatness, with much diminished voice and breath sounds, which a little later, became bronchial in quality, and still later, that is after several days, much increased in intensity. In these cases the signs were translated into the picture of disease sometimes seen at autopsy, where the consolidated lung is separated from the chest by a more or less thick fibrinous exudate, with perhaps a little serum. One of these cases after defervescence and after the third week, showed the physical signs of empyema, was very weak, has been aspirated twice, is recovering.

Of the cases dying of lobar pneumonia, three were women who were pregnant; two were prematurely delivered; and one aborted. Pneumonia is always a serious complication of pregnancy. One woman with lobar pneumonia was delivered at term, had a serious collapse, but recovered. One case of pneumonia, during convalescence suffered from a dendritin ulcer of the cornea. One case of lobar pneumonia, shortly before death, suffered from a thrombo-phlebitis of the left axillary vein.

Two cases of empyema were not related to pneumonia or influenza; one is definitely a part of pulmonary tuberculosis and showed itself first as a pleurisy with exudation; the other case occurred in a man with asthma and chronic bronchitis who was in the hospital three weeks without temperature above the normal. With the onset of fever and

signs of fluid, his chest was aspirated and pus obtained. He is probably tubercular.

Of thirty-four cases of pneumonia in which a type determination was made, six were reported in type I, two in type II, three in type III and twenty-three in type IV. The slowness with which specimens were got to and reports returned from the laboratory made the type determinations of little or no value in the matter of treatment. Only one case was given anti-pneumococcus serum.

The total number of deaths from 85 cases of pneumonia in Division B during the period represented by this report was 26, about 30% of those afflicted. We still have 3 pneumonias which are delayed in resolution. Deaths due to pneumonia at the City Hospital last year were 36% of the number afflicted. This percentage would be somewhat increased, if deaths ascribed to influenza were properly classed with the pneumonias where most of them belong.

In sixty-two cases of pneumonia at the Post Hospital, Fort Screven, Georgia, last winter, there were twenty-three deaths, about 37%. These 62 cases represented the prevalence of pneumonia in a command of about 2,100 men. That is 33% were affected, about the average for military camps. No cases in this command were certified as dying from uncomplicated influenza.

During 47 days of the 1918 epidemic of influenza there were reported in Newark 26,235 cases (about 7% of the population), and 1,133 deaths from influenza. During a like period of the present epidemic there have been reported 8,372 cases of influenza and 145 deaths. The average number of deaths during the past four years from pneumonia in the month of January was 143. This year during January there were 119 deaths from pneumonia and 39 deaths reported as due to influenza. If the deaths reported as due to influenza were added to those due to pneumonia, it would total 158, that is only a very little above the average for this time of year.

The present epidemic of influenza has attacked a very much fewer number of people, roughly 1/3, and the disease has been very much less severe, perhaps ⅛ as severe in all its aspects, than was the case a year ago, and this is in line with the history of epidemic influenza which spends its force very largely in the first year, and recurs in the second in a much milder form. This is to be expected from our knowledge of the factors of virulence, attenuation, susceptibility and immunity in relation to infectious disease. It appears that influenza, observed in its severe form last year and very much milder type this year, is a disease of the respiratory tract, spread by infectious material delivered into the air by patients sick with the disease, and that the complications of influenza are such diseases as arise in the body prepared for secondary infection by the influenza. Reports of death set forth in the statistics of Boards of Health as due to influenza constitute, I believe, an incomplete diagnostic return. Death occurring in the course of influenza is due, mostly, to a complicating broncho-pneumonia, that is the type of broncho-pneumonia which belongs definitely to influenza. Pleurisy, empyema, pericarditis, endocarditis, meningitis, et cetera, are other complications of influenza which may cause death.

IS HE A MALINGERER?

By Andrew C. Ruoff, M. D.,
West Hoboken, N. J.

Shakespeare says: "All the world's a stage and all the men and women in it are merely actors." This is especially so with reference to one form of persons injured by an accident, arising out of and during a man's employment;—in other words, in the man who is the victim of the "Workmen's Compensation Law" of States having such laws. Add a little of the psychic element, and you have your hands full making a diagnosis of actual and supposed injury. To illustrate: a man has worked for one concern a numbered of years; he has always been industrious and zealous in his work, he suddenly meets with an accident, let us say he loses a finger; the law pays him a definite amount for his injury, let us say two-thirds pay, or a maximum of $15 per week for each week he is disabled. When his condition clears up, and he is able to go back to work, he finds that a law under whose operation he must go, gives him some small allotment for losing that particular finger. He becomes disgruntled. The world has abused him, the Insurance Company paying him (and few concerns, though able, self insure) is a robber. He spreads his dissatisfaction among his fellow employees. There-

after another man is injured. He is a good actor, and then the trouble commences.

This actor receives a contusion of his hand. Fluoroscopically and otherwise, there is no bony involvement, no neuritis is suspected or found, yet he claims to have excessive pain. The Insurance Company noting an unusually long period of disability, insists on an examination. Examination reveals nothing objectively. This man is discontent with the law, and is now bent on beating it,—of course, usually at his own expense, or else he thinks he deserves a vacation. The question now arising is—is this type of man malingering, or has he any basis for his claim? The Industrial Commission usually answers the question, and must endeavor to answer it satisfactorily.

During my connection with liability insurance companies, I find that all are anxious and willing to pay just claims, and to give the injured the benefit of the doubt, so far as the law will permit them to do so. However, all companies must guard against the malingerer, and this element represents no small proportion of cases amongst the men injured during their employment. In limb and finger injuries, the amount of deception can quite often be overcome. In head, back and joint injuries, the deception is practiced to a marked degree of success.

To illustrate: a man receives an injury to his head. Examination by the insurance company doctor reveals nothing, that is, eye reflexes, pulse and respiration are normal, knee jerk and all other neurological tests negative. From the history of the case, and all subsequent treatment, the examining doctor concludes the man never had a cerebral involvement, and he accordingly reports the man as being able to work. The man is informed of the result of the doctor's findings. Some other man in his plant may have collected money for a head injury. This man, however, had a depressed fracture of the skull—compensation might have been paid with reference to possible subsequent results (grand mal and petit mal, or insanity). The man with the concussion however likens his condition to the fractured skull case. He has a vivid imagination, and is bent on being remunerated. Dissatisfied with the insurance company's disposition of his claim, he appears before the Industrial Department of his State.

The time elapsing between the time of the insurance company's examination and his appearance before the Industrial Commission may be several weeks. Meanwhile, this man is idle. His case is heard, He complains of headaches, dizziness and loss of appetite. On questioning he will enumerate a thousand and one different symptoms, and only lack of time will prevent his enumerating more. He is sure his accident has left him a cripple. The industrial doctor examines him. He finds nothing objectively—he therefore orders a neurological examination. The neurologist, who is one of the Industrial Commission's selection, is competent. I have read hundreds of such reports on this type of case. He usually gives them a very complete examination, and he rightly should do so, for it is not at the man's expense, but at the expense of the insurance company, and they must pay the doctor's price, be that what it may. He details all that the insurance company's doctor had already found—nothing. He states that he notes no physical basis for the man's claim. Then after a most brilliant dissertation, the neurologist says, "this man is undoubtedly suffering from a marked neurasthenia, and a traumatic neurosis, which undoubtedly will clear up on the prompt settlement of his claim. Next the settlement is made—the man gets $500 to $1,000, or whatever amount he is wise enough to hold out for. His condition now clears up. Was the expression, traumatic neurosis, justifiable, or is it not merely a subterfuge such as idiopathic, covering up a multitude of sins—so much for one type of case.

Now, it occasionally happens that a man can "elect" as it is called, to settle his claim under the Admiralty Act, which act, supposedly, and also actually, enables the man to settle his claim higher than under the Compensation Laws. Two glowing examples of this follow:

Case No. 1: W. A., employed at ———. Injured Nov. 24, 1917. History: While guiding girder bar, front end stuck in blocks and rear end swung around, knocking him down. Diagnosis: Contusion of the back. Disposition: Taken to hospital. History while at hospital: Examination revealed flaccid paralysis of the right leg, with complete anesthesia thereof. Sacro-iliac joint profoundly sensative. Diagnosis: Possible fracture of one of the lumbar vertebra.

X-ray examination, December 5, 1917: at hospital; x-ray examination shows a fracture of the right ilium, near the sacro-iliac joint, right side. There is also a relaxation of the sacro-iliac joint. Probable length of disability three months. Patient remained at hospital up to January 10th, having in the meantime had a plaster of paris cast applied to his pelvis, including the right leg. During his stay at the hospital, patient never elicited any signs of "life" to his right leg, and nurses at frequent intervals on directions from the doctor would prick the skin on various parts of his leg, each time without results, but each time succeeding in one thing if nothing else—that is, impressing on the mind of the patient that his leg was useless. During the last week of his stay at the hospital, the cast had been removed and he was going about the ward on crutches, the right leg being flaccid and simply dragging along as he walked. Patient insisted on leaving the hospital, signed a release and went home. The doctor in charge ventured no diagnosis as to what was causing the paralysis, nor as to whether or not it would ever clear up. From January 10th on the patient remained home, going to his place of employment at different intervals, and appearing at the home office of the Liability Insurance Company, bent on disposing of his claim against them. On January 14th, 1918, an x-ray examination was ordered taken of this man's lower spine and pelvis. This examination was performed by a man skilled in x-ray work. His report was a follows: X-ray findings, January 14th, 1918. X-ray examination of the lumbar vertebrae fails to reveal any evidence of fracture, dislocation or disease. Examination of both right and left sacro-iliac joints shows a decided decrease in the distance from the posterior portion of the left crest to the vertebral column.

I believe there has been a relaxation of the left sacro-iliac joint with an inward rotation of the left ilium. There is also a decided foye shortening of the sacrum itself, due to an anterior rotation. On these sacro-iliac plates, there is now seen a change in the appearance of the fifth lumbar vertebra. The outline of the laminae is irregular, in fact, the right laminae is at a considerably higher level than the left. I believe that there has been a fracture through the laminae of the right side with union now completed.

On receiving this x-ray report, we sent the following communication to Mr. A., the injured man on February 20, 1919.

Dear Sir:

Our Medical Director reports that you hesitate to undergo an operation, unless we can guarantee you perfect health afterward—something that is obviously impossible. In discussing the case with our General Counsel, he suggested that you come over and see him in regard to some agreement that would be mutually satisfactory. We would esteem it a favor if you will do so, and will appreciate it if you can let us know when you can call.

Very truly yours,
Liability Insurance Company.

(This letter was sent the man only after he had invoked the sympathy of his employers, who insisted that we undertake radical procedures if need be to end this man's plight.)

The man appeared at the home office some short while after receiving this letter. He was examined by Dr. ——— and myself, and we both came to the conclusion that the man was nothing more than a malingerer, bent on getting as much as he could in settlement of his claim. I might here state that try what tests we may, we could never once get W. A. to alter his reaction to different tests. This being so, we had no way of proving our contention, other than the fact that the picture did not present any typical spinal nerve lesion. We therefore suggested that this man be examined by an expert on bone injuries and diseases, in other words, an orthopedic surgeon.

On March 20th, this man was examined by Dr. A. Examination by this doctor revealed such a complicated condition that he did not feel at liberty to pass judgment on the case until such time as he could examine new x-ray plates and re-examine the man. On March 22nd, I re-examined the man in the presence of this orthopedist, who at this time scrutinized the plates. As a result of this consultation, the expert on bone work suggested that more plates be taken by a roentgenologist with whose workings he was more familiar, and upon whose plates he could more fully rely. I therefore took W. A. to the office of Dr. B., a noted roentgenologist. This x-ray man had orders to take as many plates as he desired so as to come to definite conclusion and in all nine plates were taken.

On April 14th, 1918, orthopedist and roentgenologist confer, re-examining W. A. They now concluded that without a neurological report they could not be justified in giving an opinion. It was therefore suggested that a nerve specialist examine this man and keep him under observation at a reputable hospital for one week.

On April 23rd, W. A. entered the hospital for neurological examination. The nerve man tried his utmost as did both the x-ray and bone man, and I have no reason to doubt the conclusion reached by them as being their honest opinion. The following is the orthopedic surgeon's report:

Gentlemen:

I have carefully gone over Mr. W. A. of ———, both physically and numerous x-ray plates which were made previously and by Dr. B. (roentgenologist). I did not find any evidence of injury to the bony structures of his spine, sacrum or pelvis. His paralysis and anesthesia may be due to a blood clot in the spinal cord. His symptoms are not quite consistent, and I believe it would be wise to take him into the hospital and examine him under an anesthetic. Will you please instruct him as to whether you wish me to go further with this case. If I am to do anything further, I must do this within a week.

Gentlemen:

Pursuant to your request, I have made a careful study of Mr. W. A., including an etherization test. At my request and with your approval, Dr. C., a neurologist, and Dr. B., a radeologist, have also examined him. From these various examinations, it seems that Mr. W. A. is suffering from a functional paralysis and anesthesia of his right limb. No pathological lesion can be found as an etiology. I concur with Dr. C. (neurologist), that this man has a functional condition. I cannot suggest any surgical treatment. The treatment could be better indicated by Dr. C., who will send you his report.

The following is the neurologist's report:

May 3rd, 1918.

Gentlemen:

W. A. was requested by Dr. A., orthopedist, and Dr. Ruoff to examine W. A. in ——— Hospital. I examined this patient, and found rather an unusual condition present. The man is well nourished and shows no muscular atrophy anywhere. He has a complete anesthesia of the right leg extending upon the truck line to about level with the naval. The anesthesia extends to the middle line, anteriorly and posteriorly. It does not involve the sex organs.

He seems to have a complete motor paralysis of the right leg. This paralysis however is neither spastic or is it flaccid. The tendon reflexes (the patella and Achillis) of the leg respond normally. He has a plantar reflex on the right side with the ventral flexion of the toes, which is normal. There is no Babinsky or Oppenheim reflex present. He has a Cremasteyk reflex on the right side, which is much more difficult to elicit on the left, in spite of the fact that the skin is completely anesthetic on the right side. His left leg seems to be in a normal condition. He has no sensory disturbance or pathological reflex, although the tendon reflexes are slightly exaggerated. The skin reflexes on the left side are somewhat less active than on the right. This condition cannot be explained on the ground of a definite pathological condition of either the spinal cord or the peripheal nerves, for if he had a right-sided lesion of the spinal cord between the eleventh and twelfth dorsal segments, we would have to expect either a loss of the reflex on the right side, or a Babinsky reflex being present with spastic condition and increase tendon reflexes. The reflexes are normal. If he had had a half-sided lesion of the cord on the right side, he would have a sensory disturbance on the left side of the body, of pain and temperature sense, caused by the injury to Gowers tract, in the right side of the cord, which conveys pain and temperature sense to the brain from the intermediate gray matter in the left side of the cord. The tactile and deep muscular sense fibres pass up the cord on the same side at which they enter until they reach the nucleus of Goll and Burdack, and here they cross forming the upper sensory decessation. So that the tactile and deep muscular sense would not be involved on the left side, as the pain and temperature sense, but on the right side of the body. This is not the case. Therefore, this whole picture cannot be explained by an organic lesion of the cord involving the motor and sensory fibres, and it cannot be explained by a lesion of the peripheal sensory and motor nerves because the patient has no

muscular atrophy. Hence, I can only explain this picture by looking upon it as a case of paralysis, due to a traumatic neurosis.

However, I consider this a very serious situation at best. There is no telling when such a disturbance will get better. It makes no difference what treatment is given the patient; furthermore, he may have a return of this condition even after a partial recovery. **There is certainly no malingering in this case.** I do feel, however, that special treatment ought to be given this man. He ought not to be allowed to remain in a hospital surrounded by an atmosphere of illness, but he ought to be taken out and placed in the open air and with as much freedom of action as possible, but at the same time receiving special medical treatment.

On reviewing these reports, our Medical Director memoed as follows:

"After going over the reports of Dr. ——— and the doctors who were associated with him in the examination of W. A., it is my opinion that the only thing we can do is to make a settlement and close the case. They are of the opinion that this man is suffering from a condition which will eventually clear up; in how long, no one can possibly say. It seems to be one of those kind of cases wherein the patient recovers in a year, a month or a day after the money has been paid."

P. S. I would recommend that this man be given some work for some short time so as to enable him to collect both his compensation and money for services rendered. In this way, distracting his attention from the condition from which he is suffering.

On the strength of the above memorandum, the following communication was forwarded to the man's employer:

Mr. ———, R. D. Co.

As you probably know, this company has made every effort to relieve the condition of Mr. W. A. We have lately had an exhaustive examination and x-ray pictures taken of his injuries by three specialists of the first order. The opinion of these specialists is: that there is absolutely nothing wrong with W. A. at this time which would prevent his using his leg. They seem to think that while he is perfectly honest in his opinion as to his inability to use the leg, that he is suffering from a form o neurasthenia, which is not uncommon. In other words, if he could get his mind off his condition, his leg would come along alright in time.

Mr. W. A. has been in here to see me this morning and in talking the matter over with him I suggested that perhaps he could be given something to do in your yard, which would occupy his time and attention and put responsibility upon him of doing something for which you might pay him, in addition to the sum we are paying him for compensation in the hope that this might accelerate his recovery. I thought perhaps you might use him as a gatekeeper, for while he is on crutches he thinks he would prefer to have some job where he would not be compelled to sit all day, as it makes his head ache. My own opinion is—that this headache is caused by his concentration on his injury and when he sits down he has nothing to occupy his time and naturally his thoughts revert to his misfortune.

This company will continue to pay his compensation until such time as he has recovered regardless of any sum he might be able to gain from you. I have been personally very much interested in this man as he seems absolutely honest, straight-forward and clean-cut, and it would be far more advantageous to him to recover even a partial use of this leg than all the money this company or your company might be able to pay him. I have instructed Mr. W. A. to call on you and trust you might be able to do this from a humanitarian standpoint. Give him something to do even though he is unable to earn it. I might say that we would be willing to pay in addition to the compensation some small amount of wages in case you thought this man was of no monetary value to your company.

The concern complied with our request and the man would come to the Home Office of the Insurance Company for his check bi-monthly. I examined him at each visit, but his condition grew no better nor did it grow any worse.

On May 28th, he complained of his eyes troubling him,—that is to say, he complained of specks before his eyes. We sent him to an eye specialist, whose report reads as follows: "On May 28th, 1918, W. A. came to my office. He complained of specks before his eyes, and eye fatigue. These spots are normal voluntary fatigue. His vision is slightly reduced, easily corrected with weak lenses. I advised a boric acid solution for local

use, and if he desires I would suggest his using glasses for reading."

We thought W. A. was honest and did all we could for him. However, on June 10th, 1918, we received the following communication from his attorney:

Dear Sirs:

Mr. W. A., who was injured on November 24, 1917, while working for R. D. Company, has consulted me in reference to his visits to you in an endeavor to procure an adjustment of his claim for damages. He informs me that he told you that he was willing to adjust the matter on payment of the sum of $10,000, and after going over the entire matter with him, I advised him that if your company would pay him the sum of $6,000 in a lump sum, that this would be a fair and reasonable settlement of his claim for compensation. Will you kindly take this matter under consideration and advise me by the 14th instant whether or not this matter can be adjusted on this basis, and oblige,

Having received a letter such as the above, our only conclusion could be that this man was now bent on a settlement, and naturally from now on we could never even hope for any improvement whatsoever. His claim was accordingly settled on July 18th, 1918, for a sum of $2,107.74. W. A. took precaution to cash this check. Two days following this, he inquired for a position with his old employers, having fully recovered from his injury and having no form of disability whatsoever to this right leg.

Case No. 2. P. C., employed at R. D. Date of accident, Feb. 13, 1919. Nature of accident: (as described by fellow employee): "While I was in charge of the job on the W. S. S., three men were taking off man-hold covers. Two of them came up and were alright. P. C. came up on the deck and was just about to crawl into the hatch when I grabbed him. He was overcome by gas in the tanks."

Disposition of case: Removed to hospital. Diagnosis at hospital (by three consultants): First consultant: Hysteria or deliberate malingering. Second consultant: Chronic Heart Disease. Third consultant: No Surgical condition present.

Examination of this patient at the hospital revealed a spastic paralysis of the right arm and right leg. Marked tachycardia with occasional epileptiform seizures. This lad was examined by me under date of March 21st, 1919. From the history as related to me by this lad and from his physical examination, I reported his condition as follows: "This man was gassed while in the employ of the above concern. He now, above other things has a marked tachycardia. He will probably be on temporary for some weeks to come. It is difficult to state whether the outcome will be satisfactory as some of these cases have a fatal termination."

On the strength of the above report, the man was placed on so-called temporary compensation. On April 4th, I re-examined this man, and found his tachycardia to be markedly increased and during the course of my examination, he went into an epileptiform seizure, which lasted about five minutes. At this time, I ordered the man to our private sanitarium which he refused, insisting that he could go home by himself (from Jersey City to Brooklyn). He was informed that he would do this entirely at his own risk.

On April 11th, this man again reported at our Jersey City office, consenting now to go to our sanitarium. Our Medical Director reported as follows: "The above is under my care at the ————————. His condition is serious. He has epileptiform attacks daily, going into a semi-conscious state which lasts from two to six hours. During that period the body is rigid, froths at the mouth and suffers no pain from any handling, or pin pricks. It is impossible to state whether or not he will recover, and it will be impossible for me to notify you preceding death, as should death occur, it will come suddenly. Will let you know in the course of two or three days as to the progress of the case."

At the hospital this man was extremely abusive to the nurses. I visited him three times daily, and never once did I catch him twitching a muscle in his leg or arm. On careful study of this case, I diagnosed it one of traumatic neurasthenia and traumatic hysteria.

On May 4th, I entered the room of P. C., bent on using some psychic treatment on him. I informed him that I would clear up his condition within the next forty-eight hours. I sat at his bedside and conversed with him. Suddenly, I flexed the index finger of his left hand. Now patient held all other fingers markedly extended with the index finger

markedly flexed. Successfully, and with the same suddenness, I flexed all the other fingers. The patient now claimed that he was unable to extend these fingers. I now flexed the elbow, which previously was held rigid. Next, I succeeded in moving the wrist joint. Having proceeded so far, I finally commanded my patient rather suddenly to shake my hand, which he did, apparently rather reflexly. I proceeded with the same manoeuvers with reference to the left leg. Before manipulating his leg, I noted his pulse was 72. On attempting manipulation of his hip joint (leg always held markedly extended, laterally). Patient complained of much pain in hip and precordium. Examination of pulse reveals a marked tachycardia—152, and a tendency toward collapse. I paid no attention to same—whereupon the hip grew more mobile, knee flexed and on demanding that the patient walk, he did so. I now summoned one of the nurses, and had her witness the fact that the man was able to use both his arm and his leg. The man now realized that he no longer had any basis in fact for claiming disability. He therefore complained of something that he had never previously mentioned. He said, "Yes, doctor, I can use my hand and my leg, but how about my manpower?" Questioned as to how he knew he lacked this, he claimed that he was only human and had attempted to intercourse some days following the supposed accident, but that at that time he could not consummate the act. This was evidently an attempt on his part to divert my attention on something I could neither prove nor disprove. In this case, I have apparently had some psychic or hypnotic influence on the patient. I left my patient. He now grew more abusive to his nurses than before. His spastic paralysis returned. He demanded to leave the institution. His demand was respected, we being convinced of his being a malingerer. He left and went home, only to return in two or three weeks to the home office, bent on settling his claim. Our Claims Manager saw his supposed condition. I examined the man in his presence. I demanded that he shake my hand, which he did, with the spasticly extended hand. I demanded that he stand up, which he did, however, now suddenly collapsing. Without attempting to revive my patient, I left the room. Patient came to readily. His claim was disposed of for $1,100 on June 3rd, 1919. The man resumed his active duties approximately two weeks after the date of his signing the release.

These are but two of many similar cases that I might relate. All are interesting—extremely interesting. Every insurance company has similar experiences, and every doctor has similar cases—the only difference being that the practicing physician certifies as to what he finds and to what his patient tells him—and rests his cases there—the insurance doctor examines his man, gives an opinion, and then faces the music if his diagnosis be incorrect.

Hence is the patient a malingerer, and if he is, how can you prove it?

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The monthly meeting of the Atlantic County Medical Society was held Friday evening, March 12th, at the Hotel Chalfonte, Atlantic City.

After considerable discussion, a motion was passed instructing the Nurses' Committee of the society to confer with the committee from the Nurses' Registry, relative to the increased rates for nursing, effective March 10. The committee was given authority to express to the nurses the views and sentiments of the doctors, and to take any necessary action.

"Practical Points in the Treatment of Fractures," was the subject of a paper by Dr. A. Bruce Gill of Philadelphia.

In fractures, injuries to the soft parts may outweigh the injury to the bones. In fractures of the femur, when the parts are parallel in alignment, the restored function is good; also when there is overlapping. But with bowing the results are bad because of much shortening. The less material used, such as bone-plates, wires, etc. (and if used, the shorter the time), the better, because they cause necrosis. Results can be obtained by means of splints and frame. Sometimes plates can be avoided by carpentering; that is, a hollow can be formed in one end into which the other end of the fractured bone can be placed. Bone grafts are to be avoided in acute fractures, they are reserved for old cases.

In fracture in the joint of the femur, the cast should remain in place at least eight weeks, better ten or twelve, but crutches can be used in six weeks. If cast is removed in six weeks, some brace or supporting apparatus should be used. In Pott's fracture, the essential thing to secure is the proper relation of the foot to the leg. As soon as the astragalus is under the center of the tibia, a good result is obtained, otherwise there is pain and swelling which may persist for months and even years. In old fractures, the only thing to be done is to break the union. Fractures of the elbow include fractures of the condyles or

above. The arm should be dressed in position of acute flexion. If the elbow cannot be readily flexed, the fracture is not reduced, and if not reduced, Volkmann's contracture results, which is most serious as regards function; it occurs within the first 24 hours and it is said to be due to too tight a bandage, but this is not accepted by Dr. Gill. In dressing, change the angle in bandaging.

Colles' fracture with its deformity caused by lower fragment being displaced upward and backward, is, perhaps, never absolutely reduced, but good functional results are obtained. Marked swelling and inability of the hand to function indicate that the circulation has been interfered with. It is impossible to tell from an x-ray picture what the deformity is going to be. If swelling persists beyond a week, something is wrong at the seat of the fracture. What are you going to do? Give an anesthetic and attempt a more satisfactory reduction. In all work upon osseous structures, the most rigid asepsis is necessary.

"Present Conception of Surgical Treatment of Toxic Goitre," was the subject of a paper by Dr. Charles H. Frazier of Philadelphia. Diseases of glands are increasing, especially those of toxic type. Gain in weight is the most striking evidence of the regaining of function. Secretion of the gland supplies the body with energy. It is important to make a differential diagnosis and to estimate the degree of toxicity. Cases of nervous disease which are toxic but not as a result of thyroid enlargement, should not be recommended for operation.

There are certain tests which aid in making the differential diagnosis, one of which is the administration of adrenalin chloride. But the estimation of the basal metabolism is the most important. If the increase in metabolism is not above normal, the case is not of the toxic type. In severe cases, the increase is 65 to 95% above normal; these are grave forms. Increase from 45 to 65 of moderate gravity; lower, milder cases. Estimation of basal metabolism should be routine practice. Pathology in serious cases is hyperplastic, at times, simple adenoma.

Treatment includes absolute rest, x-ray, polar ligation and resection. Rest is the best method of dealing with toxic goitre. X-ray records are not satisfactory. Surgical procedure: There is no condition in which better results are obtained; patients differing from extreme invalidism make complete recovery.

Certain groups of cases should be eliminated. Neurasthenics, cases which have enlargement of the thymus, those in the terminal stage of the disease, and those of hyposecretion rather than of the hyper type. The remaining cases are divided into mild, moderate and severe. In mild cases, operation ought not to be urged. With hygienic measures, they can get along comparatively comfortably. The moderate cases are potentially grave. The risk of operation is less and they should not pass on to the stage where there is greater mortality. There is spontaneous recovery in some cases, but these are the exceptions. In grave cases, there is but little choice; left alone, they become invalided, and many die.

Operative treatment: Injections of boiling water have resulted in disappointment. In cases above 45% basal metabolism, polar ligation is the selected method. If the risk is great, single ligation at first, and in a week or two, a second ligation. Ligation of artery is not sufficient. Results of polar ligation in satisfactory and inside of two months, patients improve up to 35%; sometimes the improvement is later.

After ligation when should the final operation of resection be done, and is it always necessary to do it? Yes, improvement from ligation will not be maintained after four months. If the final operation is deferred until a year has elapsed, the gain from ligation is altogether lost. Therefore, from 2 to 4 months after ligation is the best time for the final operation.

Preparation for operations of this character should be according to the technique elaborated by Crile, known as the anoci-association method. All patients should be under observation for at least two weeks before operation. In these cases, a skilled anesthetist is absolutely necessary.

Hemostasis: Every point must be clamped and double clamped before incision is made because these cases stand loss of blood badly. How much tissue shall be resected? As a rule, too little is removed. Dr. Frazier never saw one in which too much was cut away; it is necessary to leave only a thin layer of tissue on each side, and two layers of capsule. If enough is removed, results are more satisfactory and there are no relapses; if one lobe is left behind, there is a return of symptoms.

End results: 80% are virtually recovered. Women put on 35 pounds; are not emotional; are not nervous. The pulse rate will continue moderately rapid—80 or 90.

ESSEX COUNTY.

Eugene W. Murray, M. D., Reporter.

The Essex County Medical Society met at the City Hospital, Newark, March 25, 1920, Acting President Martland in the chair.

After the transaction of ordinary business the following new members were elected:

Drs. A. J. Alexander, J. A. Blair, L. S. Blumburg, C. A. Braun, J. A. Casey, R. W. Chapman, D. H. Crawford, A. L. Ellis, J. L. Froelich, D. B. Gershenfeld, S. M. Goldstein, P. G. Hood, Samuel Husbands, Edmund W. Ill, G. G. Jackson, Harry Klein, Maurice I. Klein, F. J. McCauley, John Nydes, P. M. O'Reilly, Aaron Parsonnet, George Polaner, Abm. Reinfeld, Chas. Rich, Samuel Rottenberg, Sam. Schiffman, Eugenio Sturchio, Max Wegman, M. B. Weinstock, F. C. Weber, E. W. Wood, Arthur Wilkes, of Newark; Drs. C. T. Brown, W. L. Harrington, R. T. Potter, R. E. Titman and G. W. Vannata of East Orange; Drs. H. C. Cassini, H. B. Harris of Orange; Drs. H. I. Burnett, A. G. B. Cirico, V. B. Seidler and F. F. Thompson of Montclair; Drs. H. Cherashore and A. H. Van Riper of Nutley; Drs. E. W. Mieran and E. H. Moore of Irvington; Drs. A. G. Pilch and W. H. Van Gieson of Bloomfield; Dr. John E. Toye of Arlington.

Dr. H. S. Martland, acting president, addressed the society as follows:

Gentlemen of the Medical Society of Essex County:

The present session of the State Legislature at Trenton has had and still has before it a

number of bills which are of vital importance to the people of the State of New Jersey and to its medical profession as they vitally effect the health of the people, tend to destroy the sound principles upon which public health has been established and will let loose on the unprotected public a band of professional bolsheviks, who under this guise will include charlatans, fakers and unscrupulous mental defectives.

One of the most dangerous of these bills, namely, Senate No. 2, entitled "An act to regulate the practice of chiropractic," has passed the Senate and House and has recently been signed by the present Governor. The bill provides for the appointment of an examining board composed of five chiropractors, who are not licensed medical doctors or osteopaths (excluding as you will note, the osteopath sect, from which they really originate). It states that the applicant shall be a graduate of a legally chartered or incorporated school or college of chiropractic requiring a course of three years, of six months each or its equivalent (the equivalent being determined by the above named board). The chiropractic under the reading of this law, is authorized to issue such certificates and file such reports as are required by the state and municipal health authorities; this means that he can sign birth and death certificates, report or conceal cases of communicable disease, etc. The act takes effect immediately. The passage of this bill, practically means that he can practice any branch of medicine taught in chiropractic schools, which for instance, can easily introduce a three weeks' fake course in surgery and thus permit many unequipped, uneducated and absolutely dangerous persons to perform cutting operations. God help the people!

The bill presents all the characteristic earmarks of medieval charlatanism assembled and drawn up by clever tricksters. There are no logical arguments in the bill that are worth considering in detail before this society, and that warrant taking up your valuable time; I wish, however, to read to you the brilliant opening section of this wonderful masterpiece of junk and buffoonery, leaving to the opinion of any intelligent man to fathom its meaning.

The opening section states, in defining for the public what the practice of this cult is, as follows. (See Sec. 1 in the Resolutions adopted).

That sounds like the musical criticism of a new comic opera. Can such an accumulation of junk be swallowed by intelligent men. I cannot believe that the present legislature could not see through such charlatanism, but rather am inclined to attribute the real cause of the passing of this bill to the fact that the system of law-making now in vogue is so absolutely rotten, that important laws having vital importance in the preservation of public health can be railroaded through without many of the members actually knowing what they have voted for.

The bill states that one of the important branches of the chiropractic art (I can not dignfy such quackery as a science), is the study and application of the universal philosophy of theosophy. Theosophy according to the dictionary is a system of philosophy which professes to investigate the unexplained laws of nature, the powers of man over nature and the direct knowledge of God attained by extraordinary illumination. A cult which has so many wonderful attainments certainly compares favorably to the dictrines of Mmde. Blavatsky and Ann O'Delia Dis De Barr, whose most profitable occupation was the separation of cash from the wallets of senile gentlemen. The passag of such legislation, certainly places us back to the days of old Barber Surgeons, and it is quite possible that in the near future, your appendix may be removed by the barber. It would appear from this act that the educated physician always struggling for the prevention of disease and its scientific treatment should discard his armamentarium and possess himself of the great triune, the Ouiga board, the rabbits foot and a horse chestnut.

It is rumored, and seems to be well known in certain medical centers, that the passing of this bill was accomplished somewhat in the following manner: For several years there has been employed a professional lobby at Trenton, for the sole purpose of slipping a bill through. It is thought that the Senator who introduced this bill as one of his pet measures was employed as their counsel. The bill was well greased and railroaded through both houses by the employment of a well-known professional lobbyist. Many of the men voting for this had not the slightest conception of the bill or what the passage of such a bill means.

One unacquainted with the methods of lawmaking, need only spend a portion of the day at Trenton to see the faults of the system; gentlemen, when the expenditure of money and greasing of vicious bills, will settle and change in one day medical problems of vital interest to the public health, the courtesy of a hearing on this bill being denied to the medical profession for the only reason that the politician does not think the medical profession sufficiently organized to command votes, this being the only language he understands, it is high time that the people of the State of New Jersey realize that the legislature at Trenton is not a fit and safe body to entrust with the making of laws regarding the public health. The fair name of this state has been disgraced. The passage of this and similar impending legislation is a blot on the intelligence of the legislature and people of this State. From now on from a medical, public health and scientific standpoint we are a laughing stock.

The present regulator of foolish and dangerous legislation which may slide through and does slide through both houses is the power of the Governor to veto a given bill. In this case the present Governor signed the bill after telling certain members of the medical profession that he would veto it.

After discussion the following resolutions were offered and were unanimously adopted:

Whereas, The Legislature of New Jersey has passed the bill known as the "Chiropractic" Bill and the Governor by signing has made it law, the Essex County Medical Society, as constituted out of all doctors legalized by the State to practice healing of the sick by any means of treatment, hereby publishes its estimate of the incalculable harm which must follow such legislation.

1. The following is the lucid (?) definition of "Chiropractic" as stated in Article 1 Section 1 of this new law:

"The term chiropractic when used in this act shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationship between all attributes necessary to normal composite forms, to harmonious quantities and qualities by placing in juxt-aposition the abnormal concrete position of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have now assumed their normal size and capacity for conduction as they emanate intervertebral foramina—the expressions of which were formerly excessive or partially lacking—named disease."

Is this mock seriousness? Was it intended to be an insult to ordinary intelligence?

Sec. 2. Provides for the appointment of five "Chiropractors" as a Board with plenary powers of licensing and supervising the practice of its licentiates. None of the five can be a "Licensed Medical Doctor or Osteopath." Hence they are not amenable to the requirements of existing laws for qualifications and character, which the State has hitherto found necessary to protect the people from charlatans and quacks.

Sec. 7 compels the State to grant the license to any "Chiropractic" according to their own (not the State's) designation, who claims six prior months of practice. Nothing is stipulated as to preparatory education, general or medical.

Sec. 10 reads, "The Chiropractor is hereby authorized to issue such certificates and file such reports as required by the State and municipal health authorities." Hence granting full powers for the judgment, misjudgment, or chicanery of the "Chiropractor" to sign certificates. Report, mistakenly, or conceal, contagious diseases, like smallpox, and rank as fully qualified to handle any case of individual sickness, or epidemic, or public hygiene.

2. This opposition of scientific medicine is based, not on prejudice for or against any kind of treatment for disease, but on the welfare of the people at large and maintaining standards of qualification for license. The progress of medicine, indeed, is such that widest range of resources makes it broad and not exclusive. Anyone duly qualified has every privilege of license and practice.

The public trusts the State's license in the important matters of health. This "Chiropractic" bill destroys with one full stroke the structure of licensing so long and laborously upbuilt by the State. Do our representatives at Trenton want to stand sponsor for such legislation?

Therefore, be it resolved, (a) That we consider this "Chiropractic" bill a disgrace to the State; destructive of necessary safeguards to the people's welfare. We call attention to the fact that constituted Medical Boards and individuals requesting it were denied public hearing and utterly ignored.

Finally (b) we hereby respectfully request, in our own behalf and that of all similar medical organizations in New Jersey, a hearing on all future bills involving health matters and urge the utmost publicity concerning them before enactment. Be it further resolved (c) that a copy of this resolution be sent to the Governor and each Essex County Representative at Trenton.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Medical Society was held Wednesday afternoon, March 17th, 1920, at the Perth Amboy City Hospital, Perth Amboy.

Three new amendments were added to the constitution, nominating a Committee on Medical Ethics; a Business Committee; a Committee on the Profession's Welfare and a Committee of Legislation. A committee of three to be appointed to revise the constitution, adding the new amendments.

A letter was read by Dr. Sullivan from Assemblyman Lyons stating his reasons for the stand which he took and the vote which he cast on the Chiropractic Bill. Mr. Lyons pointed out that the medical men had made practically no show of opposition to the bill prior to its coming before them and that his actual vote on the bill had been swayed by the influence of the Hon. Horace M. Fooder, M. D., a member from Gloucester County, who himself voted for the bill, stating that since he had not succeeded in getting the amendment to it passed, that he would support the original. On commenting on Mr. Lyons' letter, Dr. Sullivan stated that the Middlesex County Legislative Committee knew nothing whatsoever about this bill until it was introduced for action in the Senate, and on the strength of Mr. Lyons' statement that no opposition was made by the medical men, placed the entire blame for the poor showing made at Trenton at the door of the State Legislative Committee, whose duty it should have been to have given notice to each component society that this legislation was being considered at Trenton.

Announcement was made that we had succeeded in obtaining a hearing before the Senate Committee on the Osteopathic Bill on Monday afternoon, March 22nd, 1920, at Trenton. About twenty members pledged themselves to attend that hearing.

Dr. Robert L. McKiernan of New Brunswick was elected a member of the Middlesex County Medical Society.

The paper of the afternoon was read by Dr. F. M. Hoffman of New Brunswick on the subject of "Esophagoscopy," which proved to be highly instructive and interesting, Dr. Hoffman presenting in a clear manner the technic of this branch of the specialists' work, citing a number of case records with radiographs taken and specimens removed at operation.

Following a vote of thanks to the speaker the meeting was adjourned on motion.

At the close of the meeting a bounteous repast was served by the management of the Perth Amboy Hospital, for which a unanimous vote of thanks was given.

Local Medical Societies.

Summit Medical Society.

William J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Saturday, February 28, 1920, at 8.30 P. M., Dr. Lawrence entertaining and Dr. Moister in the chair.

Present—Drs. Bebout, Campbell, Embury, English, Falvello, Keeney, Lamson, Lawrence, Meigh, Moister, Morris, Prout, Smalley, Wolfe and Bensley.

Dr. J. D. Tidaback of Summit was elected a member of the society.

Dr. Embury called the attention of the society to Senate Bill No. 6 of Vital Statistics, and pointed out several features which are unwise and opposed to the best interests of the profession. After discussing the bill, a committee, composed of Dr. Embury, Dr. Prout and Dr. Meigh, was appointed to draw up resolutions of protest against these objectionable features, to be presented to the State Society.

The paper of the evening was read by Dr. Lawrence on "Lumbo-Sacral Pain." He said that most of the persistent backaches would be found on careful examination to be orthopedic in nature, due to subluxation of the sacrum. The exciting causes are falls, blows and strains, and the essential symptom is pain. The condition is frequently mistaken for lumbago or sciatica. Treatment consists of reduction and immobilization by plaster casts and later leather jackets. Results of correct treatment are very satisfactory. He also called attention to certain cases of malformation of the transverse processes of the 5th lumbar vertebra, in which there was severe pain.

Dr. Moister reported two cases of encephalitis letharica; both patients died.

March Meeting.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, March 26, at 8.30 P. M., Dr. Morris entertaining and Dr. Hamill in the chair.

Present: Drs. Bensley, Bowles, Campbell, Embury, Falvello, Hamill, Jaquith, Keeney, Krauss, Lamson, Meigh, Moister, Morris, Pollard, Prout, Reiter, Tidaback and Wolfe, and Dr. Katzenbach of New York, Dr. James of Bernardsville, and Dr. Noe of Summit as guests.

The committee appointed at the last meeting to protest against Senate Bill No. 6 reported their resolutions, which were placed on file.

The paper of the evening was read by Dr. W. H. Holzapfel, of the Manhattan Eye and Ear Infirmary of New York, on "Ophthalmology as Applied to General Practice." He reviewed briefly the eye conditions met with by the practitioner, and outlined the treatment of such cases. He called attention to the importance of early correction of squint in infancy; the rarity of true trachoma; the importance of familiarity in the use of the ophthalmoscope, and many other practical points.

Throat, Nose and Ear Men to Meet.—The annual meeting of the American Laryngological, Rhinological and Otological Society will be held in Boston, June 2, 3 and 4, under the presidency of Dr. Harris P. Mosher, Boston.

Academy of Medicine of Northern New Jersey.

The March meeting of the Academy was held March 24. Dr. Royal S. Copeland, health commissioner of New York City, addressed the meeting. He told of the successful results of the crusade against tuberculosis and diphtheria, touched on the milk situation as it relates to the nourishment of children and condemned the traffic in narcotic drugs.

He said that during the year 1919 the death rate was the lowest in the history of the city —12 per 1,000. He spoke of the fact that a large number of children were undernourished and said "It's a crime and a disgrace to every American city to have undernourished children," and he condemned the high price of milk as one of the causes. He urged the importance of concerted action of physicians and citizens in combating the narcotic drug traffic. The speaker ended his address with an appeal to the physicians to engage in the present industrial controversies, where the aid of all men is needed to solve the problems of unrest.

The nominating committee—Drs. Connolly, Tarbell and Sutphen, reported the following which will be acted upon at the April meeting: President, Dr. John F. Hagerty; vice-president, Dr. John P. Reilly; member of board of trustees, Dr. Linn Emerson; member of committee on admissions, Dr. C. B. Griffiths; member of committee on library, Dr. A. B. Twitchell Jr.

April Meetings.

Stated meeting April 21 at 8.45 P. M. Regular business; election of officers and members. Paper by Prof. F. C. Holden, M. D., Cornell University Medical College on "The Relation of Gynecology to General Medicine."

Section on Eye, Ear, Nose and Throat, April 12, at 8.45 P. M. Regular business; election of officers. Symposium, "Influenza, Its Complications and Sequelae in Civil and Military Practice."

Section on Medicine and Pediatrics, April 13, at 8.30 P. M. Regular business; election of officers. Reports of cases. Paper on "Rickets, Scurvy and Tuberculosis in Children," by Robt. E. Soule, M. D.

Section on Gynecology and Obstetrics and Surgery, April 27, at 8.45 P. M. Regular business. Reports of cases. Paper on "Pelvic Infection": (a) Etiology, Dr. J. B. Morrison; (b) Pathology, Dr. C. B. Griffiths; Treatment, Dr. V. Parsonnet.

All meetings held in the Board of Health Auditorium, Plane and William streets, Newark.

International Surgical Congress.—The fifth meeting of the International Society of Surgery will be held July 19th to 23d, in Paris, under the presidency of Dr. W. W. Keen of Philadelphia. The following subjects will be discussed: Surgery of the heart and great vessels, treatment of tumors by x-rays and radium, analysis of the blood and biological reactions in surgical affections, treatment of fractures of the thigh, and prophylaxis and treatment of tetanus.

Radiologists to Meet.—The Radiological Society of North America will hold its annual meeting in New Orleans, April 23 and 24.

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.
Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE—The transaction of business will be expedited, and prompt attention secured, if,—
All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.
All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

154th ANNUAL MEETING
of the
Medical Society of New Jersey
will be held in the
NEW MONMOUTH HOTEL
SPRING LAKE
June 15, 16 and 17, 1920

Board of Trustees' Meeting in the Hotel, Monday evening, June 14th, at 8.30 o'clock.

First Meeting of the Society—House of Delegates—Tuesday morning at 10.30 o'clock. Closing meeting Thursday noon. Other meetings as announced on Program, which will be sent to members about June 1st.

DR. CHANDLER'S ACCIDENT.

We express our own profound regret and that of our readers generally we believe, that the faithful secretary of the State Society—Dr. William J. Chandler—met with a very serious accident recently on Broad street, Newark, but on the excellent care received at the Newark City Hospital, he was able to go to his home the following day and is convalescing.

He has been compelled because of this accident to delay issuing the Official List of our Society's members until May 1st. He again urges all members who are delinquent in their dues to immediately pay them, and he also urges county society treasurers to forward dues when paid **at once** to the State Society's Treasurer—Dr. Mercer, 31 Washington street, Newark. After April 15 it will be too late for this year's Official List. This List is a Directory of the New Jersey Physicians that goes into many States in our country and is of decided value often to those whose names are enrolled.

LEGISLATIVE MATTERS.

As is well known, the Legislature had been at work grinding out its grist of legislation for two weeks before this committee was assigned to the task of watching legislation.

When we did go down to Trenton we found that the absurd chiropractic bill had already passed the Senate, and that it had a strong support in the Assembly. It soon developed that practically all the Assemblymen from the northern part of the State were in favor of it, many of them pledged to its support before the opening session. Hearing on the bill was refused to the doctors, and this also had been pre-arranged. Hopes that the bill would be vetoed by the Governor were found to have been vain. The bill is now a law, and these irregulars have a board of examiners of their own choosing.

The osteopathic bill designed to allow the osteopaths full privileges in the field of the practice and surgery, without raising their educational qualifications to the level of those required of the medical men, and one of the anti-vaccination bills had already passed the Assembly.

These two bills and certain bills of interest to medical men that had been introduced in the Senate, had all been referred to the Senate Health Committee. It was at this point that we had our general pilgrimage to Trenton and discussed these bills before the committee.

The bills that we opposed were the osteopathic, the two anti-vaccination bills (which take out the compulsory feature of our present law); a bill that creates a Board of Examiners in drugless therapeutics and would take the control away from the State Board of Medical Examiners. Also the bill for the registration of all licensees of the State Board of Medical Examiners. The committee

urged that this measure should be considered at a meeting of the State Society before it should become a law. This bill was withdrawn.

The other bills introduced by the State Board of Medical Examiners were favored by the doctors, particularly 209, that provides that the Board should have the power to license all those who propose to practice any special system of healing.

The Colby bill for Compulsory Health Insurance is still in the committee. There are so many agencies at work against this legislation at present that it seems unlikely to come up for consideration at this season of the Legislature.

The policy of the Welfare Committee has been to keep the County Medical Societies working on their representatives in the Legislature, not only by personal interview but by letter and wire. These efforts together with the impressive pilgrimage to Trenton has seemed to have an influence in convincing the politicians that the doctors are getting together. It remains for us to keep the movement going.

At present writing the osteopathic bill has been so drastically amended, that even if it passes the Senate the law will be more stringent than the one now in force, however, unless there is some unexpected change of sentiment, it will not become a law.

The bill 209 will undoubtedly be actively opposed by the same influences that pushed the chiropractic bill through.

The anti-vaccination bills should be actively opposed, and the present outbreak at Belleville among unvaccinated school children should be a most convincing argument against them.

Thos. W. Harvey,
Chairman, Welfare Committee.

SMALLPOX IN NEW JERSEY.

We commend to our legislators at Trenton, who vote to let down or overthrow the safeguards to the health and lives of the citizens of New Jersey, the following statement without further comment

Of the eighteen cases of smallpox sent to the Essex County Hospital for Contagious Diseases from Belleville so far during the present epidemic, **not a single one had ever been vaccinated.**

Belleville did not have compulsory vaccination for school children and nearly all the cases are from the schools.

COUNTY SOCIETIES.

We take the following editorial from the Kentucky Journal. It applies with equal force to our New Jersey conditions. We had partially prepared an editorial of similar tenor but this suits us better:

During 1920, the County Medical Societies should resume an activity for greater than that preceding the war. Some of our societies have always existed in name only, although many have been really worthy of the reputation of being live and progressive medical organizations. Much of the progress of the medical society depends upon its officers, particularly, its secretary. An inactive secretary usually means an inactive society. It is to be remembered, however, that the officers, particularly the secretary, must have the support of the members in order to make the medical society worth while. Members should not wait to be prodded into activity by the secretary. They should pay their dues promptly because they owe them, and should attend the meetings and help to make them worth attending because it is their duty. In some medical societies, the secretary deserves sympathy. We must remember that the secretary is elected for the purpose of performing a special duty for all of us, and that that duty is of importance to the welfare of every individual in the society. It is an outrage that members frequently criticise the secretary because he efficiently tries to keep up the standard of his organization, and thus the welfare of the individual members, by urging the prompt payment of dues, regular attendance at meetings, and the furnishing of an interesting program at each and every meeting. There was very little excuse for laxity and indifference during the war. There should be none for such an attitude now.

The members of the various county societies must be notified that under the postal laws, the Journal cannot be mailed them after March 1st, unless there dues are paid, and that under the State law they cannot be defended for a malpractice suit, however unjust, unless they are in good standing both at the time the cause of action arose and at the time the suit of action is filed. Let us work together for better county medical societies in Kentucky for 1920.

Patriotism, local pride and just common selfishness all say "Buy War Savings and Thrift Stamps." They also all say:

"Sustain and exalt the Medical Profession by faithful attendance on and cooperation in the work of your County Medical Society."

Do not forget the annual meeting of the State Society—June 15-17.

Next month we expect to give our readers the following papers:

"The Treatment of Disease in the Aged," by Prof. W. Gilman Thompson, M. D., of New York; "Chronic Purulent Inflammation of the Middle Ear and Its Accessory Cavities," by Prof. Clarence F. Keeler of Philadelphia; "The Indication for and Use of Radium," by Prof. Howard A. Kelly, Baltimore; "Some Observations on Gall Bladder Disease," by Dr. J. W. Martindale of Camden. A paper just received will have early insertion, on "Removal of the Lower Extremity by Disarticulation of the Hip Joint and Removal of the Upper Extremity, Including Scapula and Outer Third of Clavicle," by Dr. Edward Staehlin of Newark.

Dr. Mayo says we're going to live on an average of fifteen years longer pretty soon. Why the delay? If it doesn't come along a little before pretty soon some of us are not going to be here.—Waterloo Times.

Granted that a doctor has found a way of adding fifteen years to a man's life, could a man really afford it?—The Detroit News.

One thing can never be learned in schools, but students of medicine must themselves bring it with them as their best endowment in their future calling. All knowledge attains its ethical value and its true significance only by the human sense in which it is employed. *Only a good man can be a great physician.* All your knowledge and ability receives the stamp of genuine nobility only by the spirit of true humanity in which it is employed. With the intellectual and the scientific education, the education of the feelings and the manners must run parallel. You know that it is not the duty of the clinic to teach the latter, but, as your future instructor, I hold it my duty at the commencement of our common labors to at least point out this question, which I look upon as one of the weightiest importance for all professional treatment. — *Hermann Nothnagel.*

REGISTRATION OF PHYSICIANS.

Newark, N. J., March 14, 1920.

To the Editor of the Journal:

Dear Doctor—My attention has been called to a statement in the Journal regarding "Annual Registration of Physicians," and inviting opinions concerning it.

I wish to state emphatically that I not only disapprove of it, but will do all in my power to keep such a bill from going to the legislature. It is high time that we physicians wake up before any more men such as Mr. Francis M. Shepardson, late dean, Chicago, pulls the wool over our eyes. Every day laymen are trying to throttle the good work of the scientific practitioner of medicine and surgery, who have attained their prominence after years of the hardest kind of preparation required by all the other professions put together. The laity are continuously trying to narrow the work of the regular scientific doctor of medicine and to make his work harder and his earnings less and less and at the same time always wishing him to maintain a high standard so as to be of value to his family when in time of dire need, and when not specially troubled consulting the chiropractor and osteopath and other fakirs, for minor ailments, who are now reaping a harvest from their dishonest and incompetent work, while we physicians are struggling hard, honestly and honorably trying to help suffering humanity, and being inadequately paid for our services, and often too chicken-hearted to charge what we should.

Why don't they have the chiropractors register? They are getting as thick as fleas now about the country and if they don't register them soon they won't even fit in a decent sized directory, for they breed like guinea pigs now over night. But, no, the poor physicians must register to suit some fanatics who think the physicians are slipping something over. The regular physicians now after passing through a rigid four years' college course; 1 or 2 years on a hospital staff and 3 to 5 years of hard gruelling in practice before they can even earn a decent living, are obliged to register: 1, with the county clerk of the county in which he practices; 2, once a year for narcotic drug license; 3, once a year for whiskey license; 4, once a year income tax; 5, once a year to vote for a lot of incompetent legislators, and now they want us to register once a year, so they can find us, presumably I suppose, to keep us from interfering with the chiropractors and osteopaths, who are feeding ravenously on the poor deluded public and upon the sympathies of the conscience stricken legislators. You may forward this to Mr. Shepardson if you care to do so, but put me down as absolutely opposed to the law requiring us to register once a year.

Yours respectfully,
William A. Tansey, M. D.

526 Sandford avenue.

Doctor (noticing scars of herniotomy and removal of varicocele).—"Have you ever had any operations?"

Dicharged Soldier.—"Yes, sir, I have had a herniectomy, varcosity and a mucous insurrection of the nose out in California.

Miscellaneous Items.

Dr. Thomas W. Harvey Sr. after thirty-eight years' service as attending surgeon at the Orange Memorial Hospital, has resigned and been appointed on the consulting staff. Dr. D. A. Carter of East Orange has been appointed attending surgeon. Lt. Col. R. H. Hunt of East Orange has been appointed attending physician.

Dr. Madeleine A. Hallowell, Atlantic City, has invited the Gloucester County Medical Society to hold its May meeting at her residence. She was until recently at the head of the State Home for Feeble-minded Children at Vineland.

Health Congress in Brussels. — The Royal Institute of Public Health will hold a Congress in Brussels from May 20 to 24, under the patronage of the King of the Belgians. An invitation has been extended to the universities, municipal corporations and public health associations of the United States.

World Congress of Physicians.

It is proposed to form a World's Congress of Physicians and Surgeons. Dr. F. F. Simpson is now in London with introductions from the chief representatives of medicine and surgery in the United States to consult with the leading men of the medical profession there as to the co-ordinating and standardizing of all branches of medicine so as to form a World Congress of Physicians and Surgeons, composed of the various international congresses and associations already established. The creation of international associations to deal with specialties which are not already thus provided for is also to be considered. A meeting was held February 13 at the House of the Royal Society of Medicine to discuss the matter and it is also hoped to hold conferences on the institution of the Congress in Paris, Brussels, and Rome in the near future.

Osteopaths Lose Test Case.—The first step in a test case brought to determine whether or not practitioners of osteopathy may prescribe and administer drugs to patients was lost by the osteopaths when Judge Martin in Quarter Session Court refused to grant a new trial to Philip S. Dailey and fined him $50 and the costs of prosecution.

Osteopaths Cannot Vaccinate in Pennsylvania.—Deputy Attorney General D. J. Myers of Pennsylvania, recently rendered the decision that "osteopaths have no right to vaccinate nor issue certificates therefor, nor have they the right to issue certificates setting forth that a child has been properly vaccinated or vaccinated in accordance with the regulations of the Department of Health."

Illegal Practitioners Fined.—During December, 1919, six illegal practitioners, including one physician and two osteopaths, are reported to have been arrested and fined $200 each for practicing medicine in New Jersey without a license. They are Vincenzo D'Amico, Elizabeth; Gustave H. Heckman, osteopath, Mt. Holly; Morris Katz, Newark; Gerald Richardson, osteopath, Jersey City; A. Sassaman, New Brunswick, and Chester I. Ulmer, Gibbstown.

Commission Recommended to Study Health Insurance.—The National Civic Federation, which has made a study of social insurance, has recommended to the state legislature the appointment of a state commission to study the relation between sickness and society. The cause and extent of sickness, prevention, treatment, and replacement of the wage loss are suggested as proper subjects for investigation. The federation's committee is opposed to compulsory health insurance in the forms in which it has been presented.

Physicians Needed in Orient.—The Interchurch World Movement (45 West Eighteenth Street, New York City) has issued an appeal for physicians for five years' service in the near and far eastern countries. The appeal is directed chiefly to recent graduates and to physicians discharged from military service who have not yet become re-established in practice. In addition to general practitioners, specialists in pathology, neurology and psychiatry are urgently needed for service in Turkey, Syria, Palestine, Persia, Siam, Indo-China, Malaysia, Philippine Islands, India, Africa, China and Japan. There are places for more than 600 physicians, men and women. Married physicians who enlist for five years will be provided with a home and an annual salary equivalent to $3,000 in United States currency. Single physicians will be allowed an annual salary of $2,000. All traveling expenses will be paid. A grant from the Rockefeller Foundation for a course in postgraduate work in America may be available to those who give five years' service in China.

Camden County Medical Society.—The report of the February meeting of this society was not received until the April Journal makeup was ready for the press. It will appear next month.

General Wood in Good Sound Health.

The medical profession is being honored in having one of its prominent members—General Leonard S. Wood—endorsed by so many of the states as their favorite for the presidency of the United States, but a report was circulated that his health is not what it should be to be elected to that position. Dr. Alexander Lambert, president of the A. M. A., hower, explained the report as found on the removal of a tumor from General Wood's brain at Johns Hopkins Hospital in 1910. He said: "When General Wood was administrator of Cuba he rose suddenly from his desk one day and hit his head against a chandelier. A stiffness of the left foot developed. Dr. Lambert then read a letter from Dr. Harvey Cushing of Boston, who performed the operation. The letter ran:

"The operation disclosed a cyst at the foot center of the right hemisphere of the brain. It was a benign (non-malignant) tumor. The stiffness and awkwardness of the left foot, which existed before the operation, will be permanent. His mentality is not affected in the slightest and is absolutely perfect. General Wood enjoys health such as is given to few men. He is the most vigorous and sound human being, mentally and physically, that II have ever seen."

Editorials from Medical Journas.

The Liquor Traffic and the Public Health.

From the Iowa State Medical Journal.

The London Lancet is commentating on the effect of restrictive legislation on the liquor traffic shows quite a remarkable improvement in conditions of health and crime in England and Wales. Taking the year 1913—(the year before the war) it appears from the official returns that in England and Wales 1831 deaths certified as due to or connected with alcoholism. In addition to these there were 388 deaths attributed to cirrhosis of the liver. There were 1226 infants under one year of age suffocated in bed, more than a quarter of the mortality occurred on Saturday nights (following half holidays)). In the Poor-law-infirmaries 786 patients were treated for delirium tremens. In the same year the number of convictions for drunkenness amounted to 188,877 or at the rate of 1 to 135 of the population over fifteen years of age. Taking now the year 1918, the deaths from alcoholism were 296, a reduction of over 84 per cent. on the 1913 level. Deaths from cirrhosis of the liver fell to 1671, a decline of nearly 60 per cent. Infants from suffocation 557 or 55 per cent. less than in 1913 with no Saturday night incident. In 1918 only thirty-two were treated for delirium tremens in Poor-law-infirmaries, a decrease of 95 per cent. in 1918. Convictions for drunkenness in 1918 were 29,019 or one-sixth for the year 1913.

That this decrease of drunkenness was not due in any considerable measure to so many men abroad in the army is shown by the deaths among women. In 1903 there were 719 deaths among women from alcoholism; in 1918 there were 74, a reduction of nearly 90 per cent. In 1913 there were 1665 deaths among women from cirrhosis of the liver; in 1918, 579, a reduction of nearly 50 per cent. Delirium tremens in women in 1913, 214, in 1918, 6. Convictions of women for drunkenness decreased from 35,765 in 1913, to 7,222 in 1918. A reduction of about 80 per cent.

Quoting from the editorial the Lancet says: "Those figures provide adequate proof that during the war there has been in this country a real and substantial decrease of alcoholism; and since the greater part of it followed immediately on the enforcement of the war-time regulations for the control of the liquor traffic, it is legitimate to conclude that regulations were the chief agents in bringing about the improvement in national sobriety."

"Alcoholism is, of course, a much bigger factor in the causation of disease and mortality than is shown in official statistics, which necessarily represent only its most extreme and obstructive results; and the improvement effected through the system of liquor control is correspondingly more important than is indicated by the evidence summarized above; but even if that evidence be taken merely at its face value, it will enable us to form some idea of the price measured in terms of health and efficiency, which the community would have to pay for the full restoration of pre-war conditions in the liquor trade."

Dangers of Travel.

From the N. Y. Medical Journal.

When the dangers of travel are mentioned—thoughts of accident, of collision of trains and sinking of steamers, are at once conjured. But there are other dangers, which probably total more in the long run, if there is as much mischief in the transfer of bacteria by certain means as the sanitarians would have us believe. We have spoken of the unspeakable vileness, and undoubted danger, in connection with the toilet rooms of railway stations. To these may be added the condition of the toilets in the cars. Where these are kept fairly well in appearance and odor, the doorknobs handled by all manner of folks, must be a fertile means of transfer of germs of all sorts from one passenger to another. Some attempt is made to provide means of washing the toilet inside and outside but usually neither water nor towel is available.

The arms of the seats are handled by a hundred hands within a few hours, and are smeared with as many contributions of bacteria. So, too, are the seats and the stair rails of stations. The water served in cars is often far from clean, the ice being thrown into the tank by hands which have not been washed for their task. The best protection against the diseases spread by travel would seem to be to wear gloves, and certainly this would be an excellent practice, especially for children. But the ventilation (if we can use the word) of cars is another danger, which gloves would increase, for cars are invariably superheated. Not only does the superheating forbid the wearing of gloves, but it renders the nose and throat especially good soil for the sowing of bacteria.

Cancer of the Rectum.

Rectal carcinoma does not extend early; it tends for a long time to remain localized. This fact would make its radical removal a very hopeful undertaking if the growth were discovered promptly. Unfortunately, however, as with other cancers in concealed portions of the body, carcinoma in the large bowel is usually not noted until it has advanced to ulceration or grown large enough to become obstructive.

We have come to recognize that extirpation of the rectum by the sacral route only often fails to cure, even in apparently well localized cancers, because metastases in the retroperitoneal lymph nodes or in the liver are not revealed to the surgeon. Only by abdominal exploration—whether or not the "combined operation" is performed—can the surgeon assure himself either of the operability of a rectal cancer, or of the extent of the procedure needed to effect radical treatment.

Gynecologists have suggested that women submit themselves to periodic examinations in order to discover uterine cancers in their incipiency. When the public has learned the advisability of routine physical examinations at stated intervals, digital exploration of the rectum as part of that examination will reveal neoplasms at a period in their development when surgery can give greater assurance of their cure.—Edit. Amer. Jour. Surgery.

Plans to attend the annual meeting of the State Society this year.

Therapeutic Notes.

Influenza—Prevention of.

Dr. A. Kahn, New York, recommends the following:

Creosote ¼ grain.
Ex. nur vomica, ⅛ grain.
Pepsin (1-3000) 1 grain.

He says: I should advise the use of such a tablet 3 or 4 times every day, after meals. The patient must not skip a day.

Intestinal Affections—Lactic Lemonade In.

Following the work of Giani Moruzzi and Zoja, with the use, clinically and experimentally, of a serum peptone, fermented by the lactic acid bacillus, in the treatment of intestinal affections. Gpeza employed a liquid diet composed entirely of a lactic lemonade according to the following formula:

Ox serum, 500.
Lactic acid, 14.
Sugar, 250.

In a large number of serious intestinal affections, including dysenteric enterocolitis and typhoid fever, good results were obtained.—Le Progres Medical.

Tickling Cough.

Dr. A. K. Morgan, in The Lancet, says he has found the following codein prescription of service in allaying the tickling cough which is so often an annoying after-effect of influenza:

Codeinæ, gr. iss.
Acid. citric, gr. ivss.
Syrup, tolut, ʒiv.
Syrup, prun. virgin, ʒiv.
Aquæ, ʒiv.

Glycerin Substitute in Cough Mixtures.—J. Lennox recommends the following substitute for glycerin in cough mixtures:

Irish moss, ½ ounce.
Water, 24 ounces.

Boil for 15 minutes, strain, make up to 19 ounces by the addition of boiling water, then add one ounce of glucose, mix, and strain. Where a mucilaginous, demulcent ingredient, agreeable to the taste, is desired, this will be found to meet the requirements. The liquid keeps for a reasonable length of time.—The Prescriber.

Enormous Doses of Tincture of Digitalis.

Our pharmacopeia gives the dose of tincture of digitalis as ½ c.c. (I detest the word mil) or 8 minims. And if a student at a pharmaceutical or medical examination was rash enough to give the dose as 1 or 2 c.c. or 15 to 30 minims, he would run the risk of being marked "wrong" and losing a certain number of credits.

I frequently criticized the doses as given by the Pharmacopeia, though I recognize that the pharmacopeia cannot give extreme doses but must limit itself to safe average doses. But our medical and pharmaceutical examiners would be horrified or flabbergasted if they knew what enormous doses of some drugs we administer to our patients now and then, and without any bad effects; on the contrary, with life saving effects. What examiner, particularly a College of Pharmacy or Board of Pharmacy examiner, knows that in certain cases of heart disease we administer as much as ½ oz. or even 6 drams of tincture of digitalis at a dose and with very remarkable effect on the patient? Those who do not know it would do well to read the paper by Dr. G. Canby Robinson of the Department of Internal Medicine, Washington University, St. Louis. Twenty-six cases of auricular fibrillation or flutter were studied, to which single doses of tincture of digitalis ranging from 15 to 25 c.c. (4 to 6½ fl. drams), were administered by mouth. The effect began to be noticed in about two to five hours, the maximum effect was usually in about twenty-four hours and generally continued to be in effect from four to fifteen days, or on an average of nearly ten days.

And strange to say, not one of the patients died from these enormous doses of standardized tincture or digitalis. As tincture of digitalis is a 10 per cent. tincture, it means that the patients got at one dose from 1.5 to 2.5 grams or 24 to 40 grains of digitalis!—Critic and Guide.

(We insert the above but would advise great care in the selection of cases in which such large doses are used.—Editor.)

Eczema Treated by Rectal Saline Injections.—Percy B. Spurgin cites a case of very severe generalized eczema treated by means of rectal injections of saline solution. A simple soap enema was first given, followed by a rectal saline containing sp. vini gallici i oz. This was retained. A slight improvement was noted the next day, the patient sleeping and taking food better than he did before. Two days later there was a noticeable improvement. Saline and brandy were given every other day, after clearing the bowel with soap enema. The patient was apparently past all hope when this form of treatment was commenced, and the really extraordinary change which took place in a few days was deeply interesting and gratifying.—British Medical Journal.

Persistent Hiccough. — Relaxation of the spasm of the diaphragm and prompt relief of persistent hiccough has been found by Venegas to follow compression of the diaphragm. This is brought about by having the patient assume the supine position, flexing the legs and then the thighs to the extreme on the abdomen, thus pushing up the contents of the abdomen. This position must be maintained for ten minutes, or until relaxation of the diaphragm has taken place, and may be repeated upon return of the hiccough.—Journal of the American Medical Association.

Treatment of Vaginal Discharge. — Dr. George F. Chandler of Kingston, N. Y., advocates the principle of treating ordinary discharges of the vagina by a so-called dry method. Six treatments were given. The first three treatments consisted of swabbing the cervical canal with pure carbolic acid and painting the entire vaginal mucous membrane with a weak solution of iodin, after which the vagina was packed with dry sterile gauze in sufficient quantities to straighten out all the folds. The last three treatments consisted of the application of a powder made of equal parts of stearate of zinc, starch, and boracic

acid, and packing the vagina with sterile gauze. The advantages claimed were that this treatment cured more quickly than any other method.

Gonorrheal Rheumatism Treated by Intravenous Injections of Antityphoid Vaccine.—Dr. Payenneville, in the Presse medicale, reports two cases of gonorrheal rheumatism treated and rapidly benefited by Harrison's method, viz., intravenous injections of triple antityphoid and antiparatyphoid vaccine. The results appear to be best in recent, acute cases. One patient, threatened with ankylosis of the wrist, was very quickly enabled to move the joint by this treatment.

Treatment of Whooping Cough.—Dr. Joseph Winters, New York, in a recent paper said: Adults supposed to have whooping cough are usually cured by purgation and the cough is shown to be a digestive reflex cough. The whooping cough patient should be kept indoors at a temperature of 65 degrees F., with fresh air but no draft. The bedroom must not be cooler than 65 degrees F. Variations in temperature induced repeated coughing attacks and complications, and it was the complications that were responsible for most of the fatalities of whooping cough. Codeine and bromides might be given. After whooping cough children were extremely susceptible to repeated attacks of bronchitis and were also predisposed to tuberculosis.

Posture in Defecation.—L. Duncan Bulkley (Medical Record, December 27, 1919) advises placing the feet on a stool ten or twelve inches high during defecation, in this way providing the compression of the abdomen by the thighs as is the case with aboriginal man. This procedure, in addition to proper care in diet and mastication, with mild intestinal stimulants, gives very great benefit to the constipated patient.

Hospitals; Sanatoria.

Congress has appropriated $10,000 each to the government hospitals located at Cape May and Hoboken, in this State.

Gifts to Paterson Hospitals.

The Paterson General Hospital, St. Joseph's Hospital and the Barnert Hospital each will receive $5,000 and the Paterson Orthopedic Association and the Paterson Eye and Ear Infirmary, each $4,000 under the will of William H. Heap, of that city; and the three hospitals named above will also each receive $5,000 under the will of the late Lewis Levi of that city.

Sussex Hospital Orders an X-ray Machine.

The directors of the Linn Memorial Hospital have ordered an x-ray machine for use in the hospital. The building will soon be ready to receive patients.

The Hospital in a Small Community.—As usual in a small community, the two general hospitals seem to be regarded as competitors. It might seem that the community has work enough for both hospitals to do but, of course, there is room for competition if each seeks to monopolize the profitable patronage of the well to do. What will be the outcome of such rivalry? Will each institution, like a hotel, bid for trade regardless of the actual needs of the community? Will costly equipment be duplicated and high salaried employees multiplied until the cost of good hospital service reaches a maximum limit in both institutions? Or will one hospital, by virtue of its wealth and reputation, attract patients who can pay for the standards of service it maintains, while the other lowers standards as much as it dares, making its bid for patronage on the score of cheapness? And, meanwhile, what will be the fate of that part of the community which makes no demand for hospital care, both because it cannot afford the price and because it has not learned the value?—M. K. Chapin, Modern Hospital.

Obstetric Teaching Hospitals in London.—By all means let the small hospitals which can do so enlarge their existing accommodation for maternity cases and at the same time take steps to improve their teaching, which at present is admittedly defective; but the total number of beds which these hospitals will be able to set aside for midwifery will be quite inadequate to the demand. It would be suicidal for all the medical schools of London to try to establish maternity wards with a sufficient number of beds; this should be attempted by not more than three or four schools and the students of the other schools should obtain their clinical instruction either at one of the schools furnished with a maternity ward, or, better, at one of the new and large midwifery institutions, of which at least half a dozen will be required in the different areas of London. —Lancet.

Standardization of Hospitals.

Dr. John G. Bowman, Chicago, at the meeting of the Clinical Congress of the American College of Surgeons, outlined the following minimum standard which the American College of Surgeons asked hospitals to put into effect: "(1) That membership upon the staff be restricted to physicians and surgeons who are (a) competent in their respective fields, and (b) worthy in character and matters of professional ethics. (2) That the staff hold meetings at least once each month to review and analyze the successes and failures in the treatment of patients. (3) That accurate and complete case records be written for all patients and filed in an accurate manner in the hospital. (4) That clinical laboratory facilities be available for study, diagnosis, and treatment of patients." Such a standard would not only assure proper care and treatment of patients but would put the board of trustees of hospitals in possession of essential information which many such boards did not now receive. Among the 617 general hospitals of more than 100 beds in the United States and Canada, a large number could not now present even a fairly complete analysis of their clinical work. It was urged that communities withhold their support, financial and otherwise from hospitals whose trustees could not inform the community as to the character of

treatment received by their patients, such as would be provided by the college's minimum standard. Matters of incompetence should be dealt with in no uncertain manner; if one is incompetent and his incompetence was brought to his notice at frequent intervals, he would either endeavor promptly to perfect his training or retire from membership on the staff. The same principle was true regarding character and professional ethics.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, sends the following report for February 1920:

On February 1st there were 188 patients present in the sanatorium, 108 males and 80 females. This number includes 26 males and 36 females in the preventorium. During the month 17 patients were admitted, 8 males and 9 females. Seven of these admissions went to the preventorium. Among these were three readmissions. The admissions are classified as follows: Pretubercular, 6; incipient, 2; moderately advanced, 1; far advanced, 8. The largest number of patients present at any time during the month was 194, smallest number 198.

Essex Mountain Sanatorium.

Plans are being perfected for the enlargement of this sanatorium at an estimated expense of $500,00. The additional work, which will bring the cost of the institution at Verona to about $1,125,000, is to include remodeling of the original hospital, built in 1910, and its conversion to administration purposes; construction of a nurses' and doctors' home, a building for employees' quarters with a basement storehouse, a garage, a laundry and a covered passageway connecting the various buildings now in construction and contemplated.

Marriages.

MORRISON-SHAW.—At Stanhope, N. J., March 24, 1920, Dr. Frederick H. Morrison, of Newton, to Miss Mary C. Shaw of Stanhope.

ROBERTS-BISGAARD.—At Holmdel, N. J., March 21, 1920, Dr. D. Edgar Roberts of Holmdel, to Miss Julie H. Bisgaard.

Deaths.

ARNOLD.—In East Orange, N. J., February 5, 1920, Dr. Edward A. Arnold, from influenza-pneumonia, aged 32 years. He graduated from Cornell University Medical College in 1909.

REED.—In Asbury Park, N. J., March 1, 1920, Dr. Edwin B. Reed. He graduated from Jefferson Medical College in 1884.

REED.—In Atlantic City, N. J., March 1, 1920, Dr. Talbot Reed, Health Officer, from Bright's disease, aged 47 years.

IN MEMORIAM.

Frank M. Donohue, M. D.

Died June 28, 1919.

A task which the writer thought never would fall to his lot is that of recording the death of his beloved preceptor. Given an opportunity on finishing his high school course to enter the office of this well-known physician, a friendship was formed which grew and developed during the past thirty-two years into a profound admiration for his ability as a physician and surgeon and a love for him as a man.

Dr. Frank M. Donohue was born at New Brunswick, N. J., August 17, 1859, of poor but respected parents. His early boyhood was marked by an attentiveness to school work and manliness of character which made him the model of boys of his time. His education included the course at Rutgers College Grammar School and at St. Francis Xavier's, New York. If there be a "divinity which shapes our end" it was providential that he should embark upon the study of medicine, because he seemed to have been born to be a physician, and it was the good fortune of both that he should become the pupil of Dr. Clifford Morrogh, whose reputation and clientele was then state wide.

After a special course in chemistry and physics at Rutgers College, he entered the University of New York Medical College, graduating in 1881, receiving the first prize for general excellence, the Knapp prize for examination in Diseases of the Eye and Ear, and was Grand Marshal of his class. Shortly after graduation he took a course in gynecology, then a new specialty, with Dr. Paul F. Munde, a close friendship afterwards existing between them, and later became associated with Dr. Morrogh, who died the following year. It is worthy of note that the Middlesex County Medical Society in resolutions of sympathy and respect for this truly wonderful man, referring to Dr. Donohue, say that by an exhibition of similar skill and efficiency he became the worthy successor of that distinguished surgeon.

The writer had the good fortune to become a student of the subject of this sketch in June, 1887, spent five years in his office, was associated with him in practice during 1892, and can, therefore, speak in terms of intimacy of his work, character and influence for good upon the profession and community. He was a handsome man, very courteous and dignified in manner, particular about dress and personal appearance, fond of good horses and fine carriages, and while outwardly formal was yet a very warm hearted, generous and hospitable man. Those who have been favored by an invitation to his home will gladly verify this. A certain aloofness which might be taken for pride was but his conception of the dignity of his calling. Within the circle of his family and friends he was very cordial.

The amount of work he did at that time was enormous and the character of the work excellent. It embraced all branches of medicine, because specialties were not then so common. Besides a very large office practice, which numbered daily people from many cities in the central part of the State, and a consulting practice necessitating visits to two or three

surrounding towns every day, he had a large obstetrical practice and a surprising amount of general surgery. Cataract extractions, lithotomies, ovariotomies and hysterectomies were all numbered among the operations frequently performed. Before receiving his degree he had successfully removed by the perineal route a very large stone from the bladder, and he performed the first successful Cesarean Section done in the State, the writer assisting him a year later in removing a large intra-ligamentous cyst which had caused the obstruction. Laparotomies for gunshot wounds and perforating intestinal wounds from various causes successfully closed give some idea of the kind of work done, and these operations were performed in the patients' houses, with poor light, untrained help and far from present-day aseptic hospital surroundings.

He was for many years the chief surgeon and president of the staff of the Wells' Memorial Hospital, the leading surgeon and president of the staff of St. Peter's Hospital from its inception, three times president of his county society, the last time as a special tribute during the jubilee year, and during the draft period of the recent war gave freely of his time and skill to the Medical Advisory Board.

Besides these many professional activities he was interested in the welfare of his city, and was counted an exceptionally able business man whose advice and counsel was appreciated, as is shown by his having been a director and vice-president of the Peoples National Bank, director of the New Brunswick Trust Company, Sinking Fund Commissioner and chairman of the Board of Managers of the Boys' Home, Jamesburg, N. J.

With it all he was modest, unassuming, deferential to the opinions of others, exceedingly reluctant to criticise his fellow practitioners, but ready and willing at all times to give freely of his knowledge and skill to them. Kindly and tactful in the sick room where his splendid manner and evident ability to help was of incalculable benefit to the patient and comfort to the friends. Charitable to the poor and devoted to his home and his family.

He was the writer's mentor and guide and warm friend. Greater men there have been in the various specialties of medicine, but few there are who combined a comprehensive knowledge of medicine and ability in surgery, together with such admirable qualities as a man.

J. F. Hagerty.

Personal Notes.

Dr. William C. Albertson, Belvidere, has been ill at his home during the past month.

Dr. Gustav A. Becker, Morristown, has been reappointed jail and almshouse physician at the annual salary of $1,000.

Dr. Austin H. Coleman, Clinton, has returned home from Florida, where he spent a month for the benefit of his health.

Dr. John W. Clark, Lyndhurst, is still confined to his home by illness.

Dr. Harry H. Bowles, Summit, chief surgeon of Overlook Hospital, has bought the properly at 52 De Forest avenue.

Dr. B. Onuf, Rutherford, has a paper in the N. Y. Med. Jour., March 6, on "The Problems of Eugenics in Connection with the Manic Depressive Temperament."

Dr. Walter B. Mount, Montclair, having been honorably discharged from the U. S. Army Medical Corps, announces that he has resumed practice in Montclair, limited to obstetrics.

Dr. Henry W. Kice, Wharton, and wife, recently spent two weeks with their son, Capt. Luther Kice, at Laredo, Texas.

Dr. Margaret Mace, Wildwood, went to California last month and returned recently with a patient who spent the winter there.

Dr. L. Cook Osmun, Hackettstown, entertained at his home recently the Board of Governors of the Hackettstown Club.

Dr. Charles B. Smith, Washington, and wife after a brief visit with Dr. Mutchler at Rockaway, spent two weeks at Atlantic City last month.

Dr. John D. Moore, Bloomfield, and wife will prolong their stay in California until May 1st. The doctor is specializing in the study of the eye at the University of California.

Dr. Frederick W. Owen, Morristown, and daughter spent a week at Atlantic City recently.

Dr. Runkle F. Hageman, Somerville, was recently elected a deacon of the First Reformed Church of that city.

Drs. Ira T. Spencer and wife, Woodbridge, and John S. Young and wife, Rahway, recently returned from a four weeks' stay at Palm Beach, Fla.

Dr. Henry A. Cotton, Trenton, medical director of the State Hospital, discussed the relation of focal infection to mental diseases at the annual meeting of the New York State Medical Society last month. Dr. Cotton said that as the result of research work the past few years at the State Hospital, the medical staff is prepared to show not only by clinical evidence that certain types of mental diseases are caused largely by toxemia resulting from focal infection, but by pathological evidence, as shown by failures, the cases which die and where complete bacteriological studies have been made.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed	Failed
Georgia, October	14	13	1
Kansas, June	35	32	3
Louisiana, July	71	68	3
Massachusetts, July ...	58	45	13
Maine, November	11	9	2
Nevada, November	6	5	1
New York, May & June	384	306	78

National Board of Medical Examiners Incorporated.—Senate Bill No. 3959 has been introduced by Senator Kellogg to incorporate the National Board of Medical Examiners of the United States of America. It provides that Rear Admiral William C. Braisted, U. S. Navy; Major-Gen. Merritte W. Ireland, U. S. Army; Surg.-Gen. Rupert Blue, U. S. P. H. S.; Admiral Edward R. Stitt, U. S. Navy; Col. Louis A. LaGarde, M. C., U. S. Army, retired; Asst. Surg.-Gen William Colby Rucker, U. S. P. H. S., and Drs. Herbert Harlan, Baltimore; Isadore Dyer, New Orleans; Victor C. Vaughan, Ann

Arbor, Mich.; Walter L. Bierring, Des Moines, Iowa, and such other persons as may be chosen who are members of the National Board of Medical Examiners, an unincorporated, non-profit association known as the National Board of Medical Examiners, and their successors, are hereby created and declared to be a body corporate.

Public Health Items.

The United States Public Health Service is now operating 43 hospitals for the care of discharged, disabled soldiers, sailors, marines and war nurses, who are beneficiaries of the War Risk Insurance Act.

Newark Health Report.

The Bulletin of the Health Department reports that the death rate for the year 1919 was 12.6 per 1,000 of population; the birth rate 25.7 and infant mortality 76.2 per thousand. During January, 1920, there were 616 deaths, of which 78 were from lobar and 41 broncho-pneumonia; 61 organic heart disease; 58 Bright's disease and nephritis; 55 tuberculosis; 42 congenital debility and malformation; 36 cancer; 39 influenza; 24 apoplexy; 7 diphtheria. There were 6,340 cases of disease reported; 3,542 of influenza; 891 pneumonia; 129 diphtheria; 208 tuberculosis; 84 gonorrhea; 52 syphilis; 2 chancroid. 4,089 babies were supervised with 19 deaths; prenatal care of 846 mothers, of whom 44 were delivered in January with no death of mothers, one death of child under one month.

State Department of Health.

During December, 1919, there were 3,191 deaths reported; 500 under one year of age; 168 over one and under five; 1,172 over 60 years of age. The death rate was 12.05. Died of following diseases: tuberculosis, 286; cancer, 237; diseases of nervous system, 335; of circulatory system, 543; of respiratory system, 226, plus 218 of pneumonia; Bright's disease, 280; diphtheria, 68; influenza, 14; infantile diarrhea, 93.

Reporting Communicable Diseases.—Whenever a physician fails to report a communicable disease, the entire community is unnecessarily exposed to the contagion. Such failure may be attributed to sheer negligence, to wilful disregard of the obligations imposed by statute, or a mistake in diagnosis.—Connecticut Health Bulletin.

Ten Thousand Defectives at Large in New Jersey.—The State Board of Institutions and Agencies of New Jersey has submitted a report to Governor Edwards and the joint legislative appropriations committee stating that there are approximate 10,000 feeble-minded, epileptic, insane, unstable, and "unadjusted" persons and incipient and advanced tuberculosis patients at large in the state and unprovided for. The board asks that $2,500,000 be provided for 1920 and $1,500,000 for each year thereafter until 1931, for a construction program giving adequate facilities for caring for such persons.

Principles of Hygiene.—One of the main principles of hygiene is to bring about a consistent common-sense observance by individuals and communities of cleanly methods of living to prevent the erupted matter from the bodies of infected persons from being conveyed to and becoming "dangerous dirt" in the bodies of other persons. Another important matter is the establishment and maintenance of conditions in respect to air, water, food, exercise, and sleep, which tend to fortify individuals with vigorous health and the power to overcome invasion of the body by "dangerous dirt."—L. L. Lumsden, "Rural Hygiene," Public Health Report.

Death and Blindness Caused by Wood Alcohol.—Owing to the heavy increase recently noted in the number of deaths and cases of blindness resulting from the drinking of wood alcohol by those ignorant of its dangers, the National Committee for the Prevention of Blindness, 130 East Twenty-Second street, New York, is sending broadcast special warnings of the tragic consequences which may follow the use of wood alcohol, denatured alcohol and medicated alcohol for beverage purposes. The harmful action of this poison comes not only from taking it internally, but may likewise be induced by breathing its fumes, and by absorption through the mucous membranes of the body. Its effect is usually noticeable very shortly after exposure. Within a few hours after drinking, acute headache is noted, usually accompanied by violent attacks of vomiting, body pains, extending over the region of the kidneys, and excessive dizziness. Vision may become impaired, total blindness occur, and death itself result.—Illinois Health News.

Prohibition and the Death Rate.

The large number of deaths recently caused by the drinking of wood alcohol should not lead the public to overlook the important drop in the death rate from certain causes that has followed the legal prohibition of alcoholic beverages. Recent statistics show that for July, August and September, 1919, the number of deaths in Boston from alcoholism amounted to only 7, as compared with 31, 46, 38 and 34 for the corresponding period of the four preceding years. Similarly, accidents diminished from 152 in 1915, 176 in 1916, 197 in 1917 and 151 in 1918 to 112 for the corresponding three months of 1919. Suicides also diminished to a very marked degree. On the other hand, homicides showed no material decrease, a fact that has been noticed in other cities. It seems probable, however, that certain unusual factors are at work to increase the number of murders. As is usual after a great war, familiarity with means of violence and readiness to resort to such means are circumstances that must be reckoned with during the slow return to law and order. The diminution in the deaths from alcoholism, accident and suicide that has occurred in Boston has been observed in many other large American cities, and the saving of life from these causes probably far exceeds the increased number of deaths from wood alcohol poisoning.—A. M. A. Journal.

Continued on page XXI.

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THE TREATMENT OF DISEASE IN THE AGED.*

By W. Gilman Thompson, M. D.,

Professor of Medicine Emeritus in the Cornell University Medical College, New York City.

New York City.

In a general review of medical literature the diseases of infancy and childhood are found to have received far more attention than those of the opposite extreme of life, which fact might lead to the assumption that after, say, 80 years of existence, one ought to be old enough to take care of himself! Nevertheless, there are certain disease conditions which develop among the aged that call for special study, more particularly as regards their treatment than their etiology. I shall not attempt to confine within exact years the term "aged," for a man may be old at 70 or young at ninety, but in general in this discussion I shall refer to experience based upon observation of patients in the last two decades of a century, that is, octogenarians and nonagenarians.

I have been interested also for several years in collecting data regarding centennarians and have gathered the autobiographies of nearly 100 persons who lived to be a century old, or possibly reached a year or two beyond. It is a striking fact that in addition to whatever influence heredity may possess in the matter, reaching a very old age appears to be largely a question of good digestion, a survival of the fittest stomach, so to speak. It is true that the old man often complains of "dyspepsia" and has many dietetic notions or fads, but a careful research will reveal the fact that he eats more between 80 and 90 or 90 and 95 than he did between 60 and 70 or earlier. As one grows older the activities and pleasures of life become more and more restricted, but the sense of taste may survive in keenness that of all the other special senses, and the dinner table remain within easy reach. I could cite many examples of overeating among the aged. For instance, I knew personally a New England gentleman who died of a lobster salad eaten at his centennial birthday supper, and I saw a woman of 96 years who met her death through intestinal obstruction from overeating which amounted to bulimia and which her family proved helpless to control. Two sisters, each of whom entered upon her 92nd year were so fond of what they termed "old-fashioned New England cooking," including sausage, mince pie, doughnuts, green corn and similar gastronomic joys, that frequently I was called upon to counteract the effects of such indulgences. An old gentleman past 90 who recently visited in my family fairly ate me out of house and home! In the cases of this type, while digestion remains active, nutrition may be well maintained, although as a rule one does not meet with stout octogenarians. By no means all the aged, however, habitually overeat, and there are those who possess an atrophic or almost marasmic physique who yet sustain life for a long period on astonishingly little food.

Another fact worthly of note is that the aged often may not have presented any predominating symptoms of disease to which their death is attributable, hence the permission by health authorities of the simple term "senility" as a cause of death. They may have a little chronic nephritis, a suspected myocarditis or a good deal of arteriosclerosis, but they are not necessarily anemic, edematous or dyspnoeic as they very likely would

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have been were such lesion present earlier in life. Particularly do they lack the distressing picture of general anasarca, profound cyanosis, etc. They die suddenly and peacefully, and one might say the clock had merely run down. In the last census simple "senility" was given as the final diagnosis among 26 per cent. of all the nonagenarians and 40 per cent. of all the centennarians who died during the decade of 1900 to 1910. However, the aged may be said to have outgrown the diseases of middle life, just as the middle-aged have outgrown those of childhood, and the child those of infancy. Thus tuberculosis, diabetes, lobar pneumonia become increasingly rare with advancing years and even carcinoma and apoplexy are uncommon after the 80th year. Only 2½ per cent. of all deaths between 80 and 90 are due to cancer and only about one per cent. is the figure for centennarians. Even pandemics, such as last year's influenza, may spare the aged, although this was less strikingly true in the pandemic of 1891-2.

Presumably, however, one must die of something, and there are left for causes of mortality among the aged, in addition to a large percentage of "senility," acute and chronic digestive disorders, circulatory diseases, notably aortic stenosis, and myocarditis, and several varieties of pneumonia, these ranking as the common fatalities. In addition to the treatment of these diseases when they appear, one is called upon to deal with a series of functional disturbances like nervous and cutaneous disorders, such, for example, as insomnia, pruritis, etc.

The **bronchopneumonia** of the aged is often overlooked. In a thorax characterized by senile emphysema and rigid ribs the resonance is such as to obscure the dulness which otherwise might be determined over the affected area, breathing at best is shallow in the aged and feeble, temperature elevation may be little or none and cough is slight and perhaps without expectoration. Moreover, the patient often is too feeble to afford any voluntary aid to determine physical signs. In such cases the condition is to be diagnosed more by general symptoms than local physical signs. The quickened respiration, cyanosis, feeble, rapid pulse and progressive weakness.—these are the symptoms which, appearing concurrently in a person of 75 to 80 years or more, justify the diagnosis of a bronchopneumonia even in the absence of definite physical signs. It was Virchow who said referring to post mortem findings, "Everyone at the end of a long life must show a little tuberculosis," and of very many it also may be said 'they have a little bronchopneumonia' as a terminal disease. " As soon as this condition is suspected, it is desirable to begin stimulation of the heart with digitalis and caffeine. It has long been my custom also to give these patients alcohol in some form, either as sherry in an egg-nogg, rum in a milk punch or as plain whiskey and water. A very little stimulant goes a long way and two or three teaspoonsful of whiskey at a dose, or its equivalent four or five times in the 24 hours may suffice. The tendency to pulmonary edema in these cases is to be combatted by atropine given hypodermically, increase in the cardiac stimulation, and such counter-irritation over the thorax as the patient may bear. In a patient with a very thin chest wall it may not be possible to apply cups, for they bridge across between the ribs and one cannot get a good vacuum. Turpentine and vaseline in equal parts may be used or a weak mustard paste of a strength not over one to eight. The integument in the aged is apt to be irritated easily, and often is poorly nourished, so that any form of counter-irritation should be applied cautiously both as to strength and duration. Formerly I put these patients in pneumonia jackets or used continuous poulticing, but I am convinced that such things accomplish very little and the disadvantage of having to disturb the patient to apply them offsets any benefit they might confer. What the patient needs, and practically all he needs is absolute rest and carefully regulated heart stimulation. In these cases cough is usually feeble and unproductive, but the contrary sometimes is observed and then it may be desirable to give ammonium chloride either alone or in the time-honored compound liquorice or Brown mixture. Heroin is a treacherous drug, often depressing the heart action. Efforts are being made to eliminate it from the pharmacopea altogether, and if a cough seditive be required for the aged, it is preferable to use codeine in small doses.

A fulminating type of pneumonia sometimes is met with in very old persons. The patient, who was in previous fair health, is quite suddenly seized with

severe intrathoracic pain, dyspnoea and distress. Almost immediately he begins to raise both typical pneumonic sputum and bronchorrheal exudate. In a receptacle the well aerated and deeply stained pneumonic sputum may be seen floating upon the clear white watery mucus. Crepitant rales are heard over a large area, but pneumonic dulness may be obscured by emphysema. The temperature remains low,—not above 101° F., and chill is absent, but cyanosis is intense. The pulse may be full and blood pressure may not fall, but coma usually appears and within 24 hours the patient may die.

A patient whom I saw with this disease was a man 89 years of age whose condition became alarming within 6 hours of the invasion. This may read like an influenza case, but it occurred some years ago when no influenza was being recorded. In treating these cases atropine should be given hypodermatically together with caffeine sodobenzoate and some preparation of digitalis, and mustard pastes should be applied. In other words they should be treated like pulmonary edema. The rigorous open-air treatment suitable enough for younger subjects with typical lobar pneumonia is not for patients of this class, and they should be kept warm, quiet and comfortable.

Among the **diseases of the circulation** to which the aged are most prone, cardiac sclerosis and progressive stenosis of the aortic valve predominate; but these patients are sometimes unexpectedly tolerant of the obstruction, after they have learned to readjust their mode of life and adopt a more or less vegetative existence. A compensatory hypertrophy of the heart also aids in maintaining equilibrium of the circulation, so that these patients may remain reasonably comfortable for a number of years without developing such symptoms as vertigo, fainting, dyspnoea, pulmonary congestion or dropsy. In fact, death frequently is due to causes not primarily connected with the heart lesion. When any symptoms of break in compensation do arise, the administration of digitalis, combined with laxatives and sedatives is indicated. Some patients, however, are less fortunate in maintaining compensation. A woman of 84 years at present under my care, has so great a degree of cardiac hypertrophy compensating an aortic stenosis that the chest wall is lifted visibly by the pulsations. Although living an extremely quiet existence, for four or five years she has been subject to recurrent attacks of pulmonary edema, with profound cyanosis and dyspnoea. Active dosage of digitalis, the mixed bromides and a dose or two of atropine have sufficed, thus far, to control the condition so that the symptoms pass off within a few hours. The interesting feature of this case is the illustration it affords of toleration in the aged through many years of recurrent attacks, each one of which at the moment seems to threaten imminent death.

Angina pectoris, contrary to usual supposition, is not often met with among very old persons, it being commoner in the 6th and 7th decades of life. The last census record, that of 1910, showed that among a year's list of 1,427 deaths occurring from the 95th to the 100th year of life, only 3 were due to angina, and one of these may have been a case which I saw as the man died in that census year. He was entering upon his 95th year and had suffered from increasingly frequent attacks, which however, did not seriously restrict his activities nor keep him confined to his bed until two days before he died. Among centennarians in this year no deaths were ascribed to angina pectoris. The treatment of this disease presents no peculiarities in the aged. The nitrites may be given, nitroglycerine, and the diffusable stimulants such as camphor, aromatic ammonia, and if the pain be very intense, small doses of morphine hypodermatically.

"Cardiac asthma" is a confusing term made to cover a multitude of different conditions resulting in pronounced dyspnoea. In its strict sense it should refer to those cases of more or less prolonged dyspnoea with cyanosis which appear in the course of a myocarditis and which may either be due to pulmonary congestion or edema, or may be due to an autotoxemia arising through the failure of an impaired circulation to aid in removing the waste products of the body. Its treatment therefore demands stimulation of the heart, sedatives such as bromides or codeine for the nerves and catharsis with diuretics. Counter-irritation for the chest is also desirable. As these cases differ radically from ordinary bronchial asthma in that they are not due to spasmodic, muscular contraction in the bronchi, belladonna, and the ordinary antispasmodic inhalations may only serve to

make the patient more uncomfortable.

The condition of **heart block** with the Stokes-Adams syndrome is occasionally met with in the aged, and although it may not prove fatal at once it is apt to become so ultimately, after a few years and the attacks of syncope with bradycardia always are alarming. A man whom I have known for a long time has had these attacks for the past half dozen years. He is now 84 years of age and fairly active. While sitting at the table or perhaps calling upon a friend he loses consciousness, shows complete muscular relaxtion and has a remarkably slow and intermittent pulse. In this case there are no convulsions but the attacks are becoming more and more frequent. No remedies are of definite aid, and digitalis is disappointing as a preventive. Nitroglycerine and caffeine seem to be of use in some of the attacks but not in others, and the diffusable stimulants such as camphor and aromatic spirits of ammonia may be tried. It is most important for patients of this group not to overeat or to eat rich food for attacks often are precipitated by errors in diet. The use of all stimulants also should be curtailed.

The progressive **arteriosclerosis** of the aged is closely allied with the poor general nutrition which they often possess, although, as previously stated, they may consume more food calories than they need. This poor nutrition is manifest in the integument and muscles and general loss of fat throughout the body. The increasing sclerosis, however, is not accompanied by proportionate increase in blood pressure, for owing to changes in the heart or other factors, a man of 80 or 90 may have a lower pressure than he had at 60 when he was leading a more strenuous life. Similarly, the liability to cerebral hemorrhage lessens after the 80th years. The arterial changes which predispose to it are, so to speak, outgrown. The census of 1910 reported deaths of 372 centennarians, not more than 6 per cent. of which were due to this cause. An equally serious complication, though it is fortunately even less common, is the senile gangrene of the extremities resulting from obliterating endarteritis or a thrombosis. One of my cases was that of a man 97 years old who was one of the few really obese nonagenarians I have ever seen. He acquired a very rapidly progressing gangrene of the left leg. Before this could terminate his life, however, he died of a septic type of pneumonia which may have been due to infarct. Even serious gangrene is not necessarily fatal. I recall a localized superficial gangrene of the toes in a man of 78 years with complete recovery, and I have reported elsewhere a case of gangrene of the foot in an old lady of 82 who lived for nearly two years after the spontaneous amputation which took place at the ankle joint. In these cases pain in the affected area and just above it at times is excruciating, and morphine may be required to relieve it. Some benefit is derivable, however, from the local use of a menthol, chloral and camphor liniment applied above the gangrene, but the greatest relief is experienced from the topical application of dry heat. I have used this method in a number of cases, converting a moist foul-smelling gangrenous slough within a few hours into a dry and an almost odorless area. The method of generating the hot air is simple: A Bunsen gas burner may be placed on a stool by the bedside and covered by a piece of small-sized stove pipe with a pipe which directs the rising stream of hot air heated to 200° F. or more, directly upon the gangrenous foot or leg. Where electricity is at hand, I have made use of an electric fan, an electric toaster and a sheet of asbestos rolled into a tube. The fan drives a current of air through the tube arcross the toaster which superheats it and the tube further directs the current to the gangrenous area. For a few moments, perhaps, the patient complains of pain, but as soon as the area begins to dry up, the relief of pain is extraordinary.

Of constitutional remedies for the arterial condition there is little to add beyond the fact that potassium iodide, so freely extolled by the earlier clinicians, serves only to disorder the stomach and had better be left alone. When gangrene appears, it is desirable to stimulate the heart action with digitalis, and strychnine may be given.

It is rather interesting that the aged do not often complain of the symptoms which are customarily attributed to high blood pressure, such as persistant headache, vertigo, dyspnoea, or any of the serious symptoms of nephritis. The arterial walls may be very rigid or even thickened by calcareous deposit without apparent functional embarrassment to

the circulation. But when any of these symptoms do arise, in connection with hypertension, the more vigorous measures used for younger patients may not be employed and vaso-dilators, owing to the rigidity of the vascular walls, are not of much service, although chloral in 5 grain doses, is a safe enough remedy, and the bromides and codeine may serve. Little if any benefit is derivable from nitroglycerine in these cases.

Elderly persons through carelessness, forgetfulness or feebleness often sadly neglect the care of the **mouth.** If their teeth remain they acquire pyorrhoea, while stomatitis, thrush, leucoplasia, pityriasis and various types of ulceration occasionally are met with within the buccal cavity. Pus from pyorrhoea or decayed old stumps of teeth, or from ulcers, may be swallowed and give rise to considerable disorder of digestion, and in some cases the absorption of toxins may cause tachycardia. A woman of 81 whom I treated not long ago, had frequent seizures of tachycardia accompanied by indigestion and great weakness. I found her mouth in a truly filthy condition. All ordinary remedies failing to relieve her symptoms, I had a dentist call daily for some weeks to treat the pyorrhoea, and this was soon followed by complete subsidence of all the cardiac and digestive disturbances.

Where a patient is too feeble to care for the mouth himself, a nurse should make use of mouth swabs soaked in boric acid solution with tincture of myrrh.

Chronic gastritis is often observed in the aged, although, as previously stated, the very old may retain good appetites and be hearty eaters. The causes of the gastritis are to be looked for in the imperfect mastication of the food, the eating of improper food, taking stimulants of various sorts too freely, and in the condition of the mouth as above described. The gastritis may be characterized by epigastric pain and tenderness, eructation of much gas, and of acrid stomach contents. There sometimes also is nausea or vomiting. At first a few grains of subcarbonate of bismuth may be given in a dessertspoonful of the common mistura cretae, and later tincture of nux vomica with dilute hydrochloric acid and some simple bittler, such as compound tincture of gentian, will be found useful. Usually these patients need laxatives and a tea of senna pods at night or phosphate of soda in the morning may be prescribed.

The intestinal flatulence with borborygmi which is often so annoying and persistent in the aged may be relieved in several ways. Bulgarian bacilli in many persons seem to improve this condition at least for a time, and so do buttermilk, koumyss and other fermented milk products, but many persons cannot take these things for more than a fortnight without doing more harm than good and it is desirable to check the situation by repeated examination of the stools to determine the type and degree of bacterial invasion of the intestine.

The influence claimed by Metschnikoff for the bacillus Bulgaricus as a substitute for the elixir of long life has not received as enthusiastic support as its original advocates gave to it, and Metschnikoff himself did not succeed in proving all his longevity theories, for he died prematurely. These ferments, including yeast and the like, need not be discarded but it should not be permitted to claim too much for them.

Constipation is well-nigh universal among the aged. In those who eat very little it may be due to lack of sufficient bulky residue to incite persistalsis. Such patients often are thin with relaxed, flabby abdominal walls through which an astonishing accumulation of scybalae may be palpated. In those who eat too much it may result from accumulated waste, which the long overdistended colon fails adequately to propel. The difficulty in either case usually is accentuated by a long standing custom of taking laxative pills and often the habits of the aged in regard to the bowels become careless, or a failing memory does not record their action. The rectum, too, may become atonic and greatly distended. One of my patients, a woman who lived to be 92 years of age and who, like the others, above referred to, was a persistent overeater, repeatedly had packed away in the rectum a mass of hardened fecal material which only could be removed with an elongated rectal scoop and after injections of oil. On one occasion this treatment was required on three successive days before the rectum could be relieved.

It is not easy to argue aged patients out of the use of their favorite "Lady Webster Dinner Pill," or similar laxa-

tive which they tell you they have taken every night for forty years. However, an attempt may be made either to reinforce or completely to change the type of laxative used. For this purpose the mineral oils are most valuable, and where cascara or other fluid preparation is employed it may be preferable to give it in divided dosage several times during the day, thereby keeping the colonic contents from ever becoming too firm and solid. The aged do not, as a rule, take kindly to enemata, for they resent what they consider as too intimate personal procedures. The addition to the dietary of a large proportion of fresh green vegetables and stewed fruits is desirable, and raw fruit such as apples, pears or oranges taken just before retiring may be recommended. In obstinate cases it is important not to omit examination of the abdomen, and to bear in mind the possibility of rectal impaction or of intestinal obstruction higher up. In the last completed census record for the year 1910, among 417 deaths of nonagenarians, no fewer than 25 were reported due to intestinal obstruction.

The opposite condition, that of **acute enteritis,** is also very common. It may indeed result from the irritation of chronic impaction or be due to the strong cathartics, upon which the aged are so fond of depending, or to the dietetic errors which they so readily commit. In still other cases it is due to exposure. The enteritis of the aged is apt to be of sudden development and rapid course, with watery exhausting discharges. In these cases the giving or not of castor oil or other evacuants should be determined by the degree of evacuation which already has taken place, for it is important not to weaken the patient further. Opium preferably in fluid form should at once be given. It is important to keep the patient warm with hot water bottles and blankets and to give stimulants in the form of camphor, brandy, etc. Many an aged patient dies from a gastroenteritis from failure to appreciate promptly the gravity of his symptoms and secure immediate and adequate treatment.

The **cutaneous diseases** of advanced life are too numerous even to enumerate in the present review, but a word may be said in regard to one or two of the more important ones.

Herpes zoster is quite a serious malady owing to the wearing effect of the constant pain which it produces and the consequent insomnia. The neuritis which remains long after the eruption subsides may continue severely painful for many months, in fact I have known it to last for a year. During the eruptive stage the herpetic vesicles should be kept covered with dense layers of flexible collodion, which procedure tends to lessen ulceration. If the eruption be facial, however, collodion cannot be used so freely and constant application of saturated solution of aluminum acetate should be made. Asperine and codeine are the best remedies for the relief of the acute pain. After the eruption subsides the prolonged irregular neuralgic pains are best treated by the violet ray or other form of electric application. The facial cases in elderly persons may result in disfiguring cicatrization following extensive ulceration—a condition very difficult to prevent or relieve.

Another obstinate skin lesion is not very common in the aged, but when it does appear is most intractable. This is psoriasis. The eruption usually affects a number of areas simultaneously in these patients and their poor nutrition and poor peripheral circulation make it very difficult to deal with, for no sooner do large plaques in the groin heal than others under the breasts or inside the thighs arise. The itching often is unbearable, particularly at night. A woman of 80 whom I am at present seeing, has had the eruption widely diffused for more than four years. She improves for a time with the use of arsenic plus eliminative treatment —intestinal irrigation, alkaline diuretics, water drinking, laxatives, etc. She has tried practically every known topical remedy and on the whole finds more relief from the more bland ones, such as a boric acid ointment and a wash of balsam of Peru, with weak chrysarobinic acid.

The very aged are often unmindful of **personal cleanliness** either through forgetfulness or enfeeblement, and in this regard the habits of earlier life may be entirely changed. The skin in the various folds of the body surface may thus become macerated in its own secretions, denuded of epithelium and even ulcerated. In old women erosions about the vulva are common from lack of cleanliness in urinating. I have several times seen in Bellevue Hospital feeble old patients whose skin here and there would peel off with their underclothing, so long had

they gone without change or washing! In such cases cleansing with tincture of green soap and protection of the surface with a simple dusting powder soon restores the normal condition of the skin, but aristol may be needed for the deeper excoriations which are not uncommon about the vulva and even extend into the vagina. I recall a delightful old lady of 92 years who held the superstition, having had very little illness in her life, that if a doctor ever saw her in bed, she never would get out of it again. Whenever I was summoned therefore to treat her for indigestion due to overeating or to an attack of bronchitis, she would keep me waiting outside while she got up and dressed, immediately returning to bed after I had left. When she finally became too feeble to do this and I was enabled to install a nurse, she was found to be in a very wretched condition as to bodily uncleanliness, although in earlier years she had been most fastidious. In other respects mentally she was exceptionally bright.

Insomnia is one of the commonest of functional disorders among the aged, although they often sleep much more than they think they do, if their sleep be checked up by some disinterested person. The usual type is a failure to go to sleep again after waking in the middle of the night. It is astonishing how often this may be controlled without drugs. For instance, it is well to prohibit drinking any fluids after six or seven o'clock, so that the rhythm of urinary excretion will not waken the patient to urinate. Tea and coffee drinking should be controlled. Often it is well to order the principal meal of the day at noon rather than in the evening, and a most efficacious procedure is to have a thermos bottle at the bedside containing a cupful of hot cocoa, malted milk or Imperial Granum. This is to be drunk on waking in the middle of the night and often the patient will drop off to sleep again immediately. I have many times found alcohol a good hypnotic for the aged, particularly if they always have been abstemious. The nightly glass of beer is no longer obtainable, but whiskey can be prescribed by the physician, and very little is required. An old lady of 86 whom I am at present caring for drops off to sleep beautifully on between one and two teaspoonfuls of whiskey. It is absurd to suggest that such a person will acquire alcoholism.

Furthermore one should see to it that the sleeping room is quiet, free from loud striking clocks, etc., or other disturbing sounds, and dark shades should keep out the early morning light. A hot water bottle or two is a useful adjunct; woolen bed-socks may be worn, and sometimes very light massage may be of benefit. When drugs are really necessary, adelin in a 5-grain tablet is one of the best and least depressing, especially where the heart is weak.

Veronal, gr. v. and the triple bromides or bromatol are also useful. Morphine and codeine should not be given. One of my octogenarian patients goes to sleep easily on 15 minims of aromatic spirit of ammonia in a wine glassful of hot water, and compound tincture of cardamom (ʒ i in hot water) is admirable where a purely psychic effect is needed. The inquisitive old lady who insists on knowing every prescription one orders and saying "she has had it before and therefore it is of no use," is certain not to have heard of the syrup of lactucarium as a hypnotic! Insomnia is sometimes caused by intestinal dyspepsia. A colon distended by fermentation products restricts the play of the diaphragm which in turn embarrasses the respiration, and hence the patient awakens with a sense of oppression in his breathing or of abdominal discomfort. Thus it is true that the rhubarb and soda mixture or some such digestant may really prove to be a hypnotic through removing the cause of insomnia.

The so-called **senile epilepsy** may occur quite late in life and even, as a rarity, among centennarians. In a case which I studied in a woman 92 years of age there had been convulsive seizures of increasing frequency for several years until they reached a maximum of sometimes as many as a dozen or fifteen in a day. In this instance the combined use of codeine and chlorotone proved more effective than any of a long list of other sedatives. Apart from the convulsions and in the intervals between them, the patient seemed in normal condition.

A common difficulty in dealing with disease in the aged consists in overcoming long standing habits and prejudices. Their weakness and restricted activities may render them irritable and petulant, and quite naturally their long life and experience confirms them in the belief that they know better than anyone else what

is best for them. They may resent the personal ministrations of a nurse and refuse to take this or that remedy. Moreover, they are relatively quite susceptible to the action of many drugs, particularly cathartics and hypnotics, so that it is a safe rule to prescribe only about two-thirds of the routine dosage of such remedies. Much tact and judgment is therefore required in dealing with them. Having survived their seniors in whose judgment they might have had confidence they often are skeptical regarding the wisdom of their juniors, particularly so where new ideas of the treatment of disease are involved.

The aged, too, when they become forgetful of recent events present further embarrassment in their treatment by failing to describe accurately their sensations and bodily functions and failing to carry out the directions given them, thus placing themselves more nearly in the category of children, although in other directions their minds may remain keen enough.

The problem of treating the aged thus becomes worthy of special study, and the foregoing sketch cannot pretend to do more than point out a few of the general principles which are inadequately dealt with in medical literature.

CHRONIC PURULENT INFLAMMATION OF THE MIDDLE EAR AND ITS ACCESSORY CAVITIES AS SEEN BY THE GENERAL PRACTITIONER.*

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Agreeable to the request of your chairman, Dr. Diverty, to read a paper before your county medical meeting, I have chosen as my theme, "Chronic Purulent Inflammation of the Middle Ear and Its Accessory Cavities, as Seen by the General Practitioner."

I respond, however, with considerable reluctance, because I feel that I cannot bring before the profession any new points in diagnosis or treatment. But I do believe that if by emphasizing the more salient facts and the dangers of complications, especially intracranial complications, we shall come to a better understanding of this subject, my purpose shall have been fulfilled.

As the time allowed for this paper must necessarily be limited, I shall be brief, speaking only in a general way of this, one of the important subjects, diseases of the ear. There is no doubt that you, physicians of extensive experience as general practitioners, have seen various phases of this affection, and I shall be very happy indeed to try to explain any query which I hope you will have no hesitancy in asking.

Although chronic purulent inflammation of the middle ear and its accessory cavities has prevailed for centuries, it can nevertheless be prevented in the vast majority of cases. This is especially true if the pathological condition be recognized during the initial stage, or before the chronicity becomes too thoroughly established.

Chronic inflammation is preceded by the acute form, with possibly few exceptions, in which case it appears to have been chronic almost from its inception And the exceptional cases are those in which the systemic conditions are associated in the very young, with tuberculosis, syphilis and marasmus. Nor is it alone the acute exanthematous diseases of childhood, but the general acute infectious diseases to which those of any age may become victims that I wish especially to direct your attention against the dangers and the frequency of middle ear infection. It is the failure to successfully treat those conditions that affords the most prolific source of chronic purulent inflammation.

In many cases, the patient is too ill to localize the earache. Hence it is as incumbent upon the family doctor to examine the ears, and to recognize and incise the inflamed bulging eardrum, at the earliest moment, as it is for him to interpret a quickened pulse or a sudden rise of temperature.

When we consider the appalling number of totally deaf people about us and, believing as we do that fully three-fourths of these cases might have been prevented, is it not obligatory upon the medical profession to have a clearer conception of the causes and the prevention of deafness? The duty surely rests upon those of us who have given our best efforts to the work, to impart the results of our experiences to those who have

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not had clinical advantages in caring for the diseases of the ear.

The history of patients suffering with chronic purulent inflammation of the middle ear dates, invariably, from childhood and the condition is, as a rule, a sequel of one of the acute infectious diseases. The otorrhea may have been continuous or it may have been intermittent for many years. I have known cases ranging from several months to sixty years without special symptoms or inconvenience, except the impaired hearing and the foul discharge, to finally terminate in brain abscess, in septic sinus thombosis or in otitic meningitis. And for otitic meningitis, there is no known remedy.

With some people there is a superstitious belief that a "running ear" should not be stopped lest the pus comes out as boils in some other part of the body, or it "go to the brain." It is with deep regret that I acknowledge this ill-advice has been given, not by the laity only, but by medical practitioners. As the following case is characteristic of many similar ones, I will quote the words of a young woman upon whom a radical mastoid had been performed thirteen years ago. At that time she was suffering with bilateral chronic purulent otitis media, the sequel of measles when but a child of two years. This patient said: "I had always been considered mentally deficient. I had not the power of concentration. I had no desire to study, nor could I recite a lesson which I had studied. The strain in trying to hear the teacher's voice, or the voice of my classmates in recitation, was so fatiguing that I invariably suffered with a terrible headache and complete exhaustion by bedtime. Owing to the offensive discharge from my ears, I was considered unclean and was the object of persecution by the children who should have been my playmates and friends." I wish to add, however, that this young woman had a successful operation in the one ear and the other ear having responded to treatment, she was enabled to make up, in part, the opportunities lost in girlhood. She is now married and takes an important part in the social life in her community.

How many children are there today throughout the world who are being deprived of the heritage of youth and are anguished by impaired or the loss of hearing, due in great part, to the fact that their ear complications had not been recognized and properly treated at the onset?

A vast majority of all cases of brain abscess is traceable to purulent inflammation of the middle ear. The abscess may be encapsulated and may remain dormant for years, only to become active after some apparently slight accident to the head. The following case illustrates that point: A lad of fourteen years had suffered with unilateral chronic otorrhea for eleven years. The otorrhea was obstinate and resisted all the usual methods of treatment. Operation was refused. While skating on the ice, the boy fell, striking his head. The following day he was brought to the hospital. His case was one of symptom complex from the fact that his temperature fluctuated between normal and 105 degrees. He sweated profusely. There was vomiting, terrific headache, rigidity of the neck, mental confusion and slow cerebration. Kernig's sign was present. The spinal fluid was turbid and under pressure.

At operation at this time found the mastoid to be very necrotic and filled with cholesteatoma. The lateral sinus had disintegrated and there was a large encapsulated extra cerebellar abscess. The blow undoubtedly was the direct cause of the diffused septic meningitis resulting in the patient's death.

I have been informed by prominent clinicians who being called to see, presumably, tubercular meningitis, pneumonia, brain fever, alcoholism, cerebral syphilis or diabetic coma, or where death had been the direct consequence of intracranial complications, all caused primarily, by a suppurative process within the middle ear which had not been recognized. Or, if perchance recognized, not regarded with significance in the present condition.

I readily recall several cases sent to the hospitals with which I am associated, as having been diagnosed as typhoid, malaria, pneumonia, cerebral syphilis, brain fever, uremia, diabetic coma, vertigo or stomach trouble, while the ear condition and the intracranial complications, the true causes, had been entirely overlooked. In nearly every instance, the patient was comatose and quite beyond surgical help.

The transition of acute suppuration of the middle ear into the chronic form is

caused, occasionally, by general and by constitutional diseases. In the very young, marasmus may be the cause; in older persons, chronic purulent diseases of the naso-pharynx and of the accessory sinuses may be the cause. The chronicity is also greatly influenced by the lack of nutrition and by the unsanitary surroundings of the poorer classes. And having observed the anatomical formation of the mastoid in many cases of chronic otorrhea that have come to operation, I am convinced that certain types of the mastoid cells, notably the deploic type, are a possible predisposing factor to chronicity.

I know of no pathological condition which undergoes such a variety of changes as that of chronic purulent inflammation of the tympanum, presuming, of course, that the labyrinth is not seriously involved. The power of hearing shows great fluctuations which may be due to the swollen mucous membrane, to cicatricial tissue, to the permeability of the Eustachian tube, to the quantity or quality of the secretion, to cholesteatoma, to polypoid growths, etc. Climatic changes exercise a decided influence on the power of hearing. Warm and dry weather has a favorable influence, while a cold and moist atmosphere has a decidedly injurious effect.

After the suppuration has run its course, the degree of hearing depends mainly upon the pathological changes which remain in the middle ear. Strange as it may seem, the patient usually suffers very little pain, unless there is an obstruction in the free flow of the pus. It has been noticed in those suffering with severe pains of the head, on the affected side, to a degree beyond the objective signs, that there invariably exists in the attic, the antrum or the mastoid, a considerable amount of cholesteatoma.

The best precautionary means to prevent a chronic purulent inflammation of the middle ear is the proper treatment during its acute stage. And this is best attained by an early recognition and an immediate free incision of the ear-drum. Delay is dangerous. Do not wait for spontaneous rupture as too frequently the delicate structures of the middle ear and the mastoid are irreparably damaged before the rupture takes place; the rupture being sometimes delayed because of its unusual resistance, and in that case, the edges of the perforation are irregular lacerations which soon become necrotic.

If the discharge persists beyond 3 or 8 weeks, or if the mastoid shows evidence of serious involvement, a posterior drainage through the mastoid should, at once, be instituted. In every case it is important to determine whether the necrosis is in the tympanum, the Eustachian tube, the attic, the antrum or the mastoid. And there are many methods of examination; but I know of no surer test of the active disintegration of the osseous structures than that of the roentgenogram.

Treatment of chronic purulent otitis media consists chiefly of two methods:

(1) Direct medication of tympanum.

(2) The approach through the mastoid.

The character of the treatment, of course, depends upon the complication. Generally speaking, however, the middle ear is treated by the so-called wet, or dry methods. The wet method consists of a warm non-irritant germicidal solution used as irrigation, once or twice a day according to the amount and the character of the discharge. This is usually done by the patient, or by some member of the family.

The second, or dry method, is best obtained by cleansing the auditory canal and the tympanum; mild astringent preparations being introduced into the tympanum by the physician.

The case complicated by insufficient drainage due to too small an opening in the tympanic membrane, or to cholesteatoma, polypi, exostosis or to hyperostosis should have the treatment directed according to the existing condition.

Autogenous and stock vaccines have been used by doctors with a varying degree of success. These may have their usefulness. Personally, I have not had the good results that others claim. I do strongly urge an otoneurological examination by which the condition of the static and the acoustic labyrinth and the intracranial complications may best be determined.

When all other methods have failed, a thorough removal of all the diseased tissue, both membranous and osseous by a mastoid operation is the only safeguard against intracranial dangers.

THE DIAGNOSTIC SIGNIFICANCE OF THE HISTORY IN DISEASE OF THE GALL BLADDER, STOMACH AND APPENDIX.*

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A correct clinical history is the citation of the symptoms of disease in the order of their occurrence. As a corollary to this definition one may regard diagnosis as largely a precise interpretation of the clinical history, aided and augmented by special tests and physical examination.

A knowledge of the embryology and physiology of the gut tube is of significant value in interpreting symptoms in the right upper quadrant. The pharynx to the ampulla of Vater is a derivative of the embryonic foregut and it is a noteworthy fact that every enzyme and digestive juice is liberated within this segment, and furthermore that within this segment the food is entirely prepared for assimilation. The observations of neurophysiologists have demonstrated the very intricate nervous and chemical association of the various portions of the digestive tube. Roentgenological studies have demonstrated the interrelationship of various portions of the gut tube with the stomach and particularly with the manifestation of pylorospasm. If we survey, briefly, the functions of the gastro-intestinal tube we find that there are two points of normal stasis, namely, the stomach and the cecum. At these points we find two great chemical and physical barriers—the pylorus and the ileocecal valve—and the chemical reaction of the intestinal contents changes with its passage through these barriers.

The stomach may be said to subserve two functions, namely, secretion and motion. Of these two, motor function is pre-eminently the most important. Digestion may be maintained for years with very little general disturbance of health so long as the motor function or evacuating power of the stomach remains intact. On the other hand, conditions associated with either loss of the normal evacuating power of the stomach or with a stenosis at the pylorus very quickly come to the physician for relief. A physiological observation that has not been given sufficient importance in diagnosis is that whenever we have an irritation of a gut tube, that portion of the tube above the point of irritation participates in an exaggeration of its normal function.

The review of a number of cases from any of the big clinics demonstrates that indigestion is the most common symptom of abdominal disease. Various men have analyzed the so-called "indigestions and dyspepsias" and have found that intrinsic disease of the stomach is an etiological factor of quite minor importance and relative infrequency. Of 100 cases presenting symptoms of indigestion, less than 20 per cent. will have organic disease of the stomach; 40 per cent. will show disease within the peritoneal cavity, but removed from the stomach, and 40 per cent. will have their indigestion explained by reflex disturbances outside of the peritoneal cavity. It is a sad commentary on surgical diagnosis to find that of 1,000 cases of locomotor ataxia approximately 10 per cent. have been operated upon and 60 per cent. of this 10 per cent. have been operated upon for supposed disease of the stomach, gall bladder or appendix. If we group the stomach, duodenum and its accessory digestive glands, with the appendix we have an anatomical system that is closely interrelated in function, in nervous organization and in symptomatology. In the right lower quadrant we have the appendix and cecum with five salient physiological facts that are worthy of consideration in the interpretation of a clinical history. The cecum represents (1) a point of normal stasis; (2) of changed chemical reaction; (3) predominance of lymphoid tissue; (4) maximum fluidity of intestinal contents; (5) maximum bacterial activity. It is interesting to note in this connection that lymphatic channels connecting the cecum and the right kidneys have been demonstrated. This may account for the known predominance of right sided pyelitis and bacilluri.

We may say that an acute appendicitis in adults manifests itself by a symptomatic evolution that is usually distinct and clear cut. In children, however, owing to the absence of the submucous layer of the appendix the symptomatology of appendicitis is not nearly so clear cut as in the adult.

One may summarize the diagnosis of acute appendicitis within the first 24

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hours by the onset of pain, following by nausea or vomiting, or both, generalized abdominal sensibility, fever and leucocytosis. The orderly and regular sequence of these symptoms rests upon the fact that in about 95 per cent. of cases the infection begins in the mucous layer with very rapid turgescence of the lymphoid structure with occlusion of the appendix at its narrowest portion—the juncture with the cecum and known as the valve of Gerlach. There results essentially an empyema in an organ with a single terminal blood supply. In the female there is an accessory artery (in about 16 per cent. of cases) connected with the right ovary.

The initial stage of acute appendicitis represents pathologically a point of irritation and as a result the entire small intestine participates in hyperactivity, hyperperistalsis. The pain, therefore, is colicky in character, of maximum intensity, intermittent and confined to the zone of the umbilicus. Hyperactivity of the small intestine is followed as a rule by a sensation of nausea, or vomiting, or both, and since the mechanical factor producing the pain is hyperperistalsis of the small intestine, we have generalized abdominal sensibility. Infection and its systematic reaction manifests itself in fever, leucocytosis and etc. During the second 24 hours one of three processes takes place: (1) drainage of the products of infection back into the cecum; (2) gangrene; (3) perforation. When either of the latter two eventuate the entire clinical picture is changed and we have the localization of the infection to the right lower quadrant from periappendiceal inflammation and exudation. At this stage the pain is not colicky but constant in character, with localized tenderness, spasm and rigidity; with paralysis of the intestines in the attempt to splint the inflammatory process. The entire picture then become one of localized intraperitoneal abscess.

The history of a chronically diseased appendix is peculiar and atypical, having none of the precision in its symptomatology that goes with the acute appendix or with disease of the gall bladder or with ulcer of the stomach. The outstanding feature of appendicular dyspepsia is the extreme variability and entire lack of periodicity in its onset. Articles of food that at one time are associated with indigestion may be eaten with zest and relish on other occasions. The essential features of chronic disease of the appendix are the variations in the reflex gastric disturbances. The mechanism in a large majority of cases is probably pylorospasm, with pain, vomiting, increased secretion, increased acidity, gaseous and sour eructations. Its diagnostic possibilities may be epitomized by the saying of Moynihan "that the most frequent site of ulcer of the stomach is in the right lower quadrant of the abdomen." The ordinary postmortem incidence of disease of the appendix is approximately 17 per cent. It is interesting to note that the appendix shows pathological changes in 69 per cent. of the cases of cholecystectomy, whereas 55 per cent. show disease of the appendix in cholecystostomy. It must not be forgotten that chronic disease of the appendix may occasion a rather severe hematemosis. Gastric ulcer is associated with disease of the appendix in 54 per cent. of cases, while duodenal ulcer is associated with disease of the appendix in 66 per cent. of cases and in 15 per cent. of all laparatomies there are two lesions sufficiently severe to warrant operation.

For a long time gall stones were considered the only pathological evidence of a diseased gall bladder and the finding of gall stones at operation was interpreted as the essential pathological process. With refinement of diagnosis and the development of the x-ray and other laboratory procedures there came a change in the pathological conceptions of the affections of the biliary system. We now know that it is the infective process in the gall bladder itself that gives the surgical indication rather than the late or incidental occurrence of stones. In the strawberry gall bladder of Moynihan, stones are absent, likewise in many other forms of cholecystitis where only atrophy and fibrosis of the gall bladder are present. With the widening of our pathological knowledge came an extension of the operative indication and likewise a change in the choice of operation as between a cholecystostomy and a cholecystectomy. Various theories have been advanced to account for the infection in the gall bladder. For a long time it was assumed that infection took place from the duodenum by way of the common duct. This idea of infection by continuity of tissue has not been found tenable

for Coffey has shown that rupture of the duodenum takes place upon the injection of fluid before there is any reflux to the ampulla of Vater, and Archibald has demonstrated a very essential valvular mechanism at the ampulla to prevent reflux. The role of the portal vein in infection of the gall bladder has long been asserted. The path of infection in this case would be the transportation of infectious material to the liver and then subsequently elimination in the bile. This route would seem to be unlikely for three factors are necessary for the production of gall stones, namely, (1) infection, (2) biliary stasis of some degree and (3) foreign material, whether that foreign material is clumped bacteria or mucin is relatively immaterial. It has been demonstrated that virulent streptococci may be injected into the gall bladder without producing cholecystitis providing there is no interference with biliary drainage. Long ago the association of gall stones and typhoid fever was observed and it was supposed that there was a peculiar affinity between the biliary tract and the bacillus typhosus. Typhoid fever represents one of the best examples of a bacteremia with bacteria constantly in the blood current. In view of recent bacteriological work it is supposed that there is a selective affinity between certain types of bacteria and certain body tissues. Rosenow demonstrated that upon cultivating the bacteria obtained from the base of a gastric ulcer and injecting them into animals there was a selective affinity for the gastric mucosa with production of ulcer in about 75 per cent. of cases. What is true of bacteria from ulcers is also true of cultures from the appendix and from the gall bladder. The path of infection in cholecystitis would seem to be by way of the blood stream with lodgement of infectious particles in the terminal blood vessels of the gall bladder with the production of changes in the walls and mucous membrane, and with secondary infection of the bile itself. If the bacteria possessed a certain degree of virulence the changes in the wall of the gall bladder would be of such severity as not to produce gall stones. If the bacteria were of less virulence they might produce minor changes with the production of stones. Most of the gall stones have their basic element in cholesterin and Payr has demonstrated that the cholesterin contained in pregnant women is about four to one in excess of the cholesterin contained in nonparous women. When this fact is correlated with the slight normal stasis of a bile from pressure of the gravid uterus it associates itself very readily with the clinical fact that gall stones exist about four or five times more frequently in women and that in the cases occurring in women about four out of five have borne children, and the great majority (60 per cent.) of these date their first attack from about the midterm of pregnancy.

As soon as infection becomes established within the gall bladder symptoms manifest themselves. It seems definitely established that aside from the extremely rare intrahepatic or hepatic stones gall stones are always formed within the gall bladder. The early symptoms of gall bladder disease are those of dyspepsia. This dyspepsia conforms to no rule. It is as a rule of mild type, with variations in the amount of acid and gaseous eructations. There is a sense of weight or fulness usually confined to the region of the epigastrium, together with occasional tenderness along the right costal margin. There is a characteristic chilly or gooseskin sensation after a large meal and sometimes a slight catch in the breath suggests a right-sided pleurisy. This gastric irritability is made worse by certain articles of food such as greases, fried foods, apples, cheese and to a less extent by carbohydrates in general. After a variable period of indigestion an entirely new symptom comes into the history. There is a sudden acute attack of agonizing pain which comes on without warning; is associated with extreme restlessness and with the desire to lean over a chair or lie across a pillow. Occasionally the pain is so severe as to require a hypodermic of morphine. The outstanding feature of this attack of pain is that it occurs spontaneously, like lightning and after a variable length of time tends to disappear with the same spontaneity, leaving, however, a residual soreness along the costal margin.

The third clinical picture is due to the common duct and introduces into the history, for the first time, the presence of jaundice. There may be and usually is a preceding history of gastric distress, interrupted by periods of colic. Following one of these attacks of pain there develops jaundice. This icterus reaches a

maximum intensity in twenty-four hours to forty-eight hours, and is associated with a febrile reaction usually so distinct as to suggest a malarial paroxysm with its chill, fever and sweat. This febrile reaction is short-lived and gives a characteristic intermittent fever variously described as "steeple-chart" temperature or the "angle of cholangitic infection" (Murphy.) When the history reveals a colic associated with jaundice and marked by fever, leukocytosis, etc., and **occurring in that order,** we are warranted in making the diagnosis of calculous disease of the common bile duct.

In cystic duct obstruction there is colic and fever and the symptoms occur in that order, but there is no jaundice. In calculous disease of the common duct one is impressed by the fact that at the time the patient presents himself jaundice is absent in about 25 per cent. of cases. Inquiry, however, will reveal that in the larger proportion of cases (85 to 90 per cent.) there is a history of a "colicky jaundice."

The first mechanical factor in calculous obstruction of the common duct is the production of acute biliary obstruction with acholic stools. After a variable period of cholangitis, distention of the duct behind the obstructive calculous occurs, the duct dilates, and the stone floats up into the more ample and dilated common duct and biliary delivery into the duodenum is resumed.

It must not be forgotten, however, that it is quite possible for a calculus to pass through the common duct and be extruded into the duodenum with no further trouble, because a stone which can pass the cystic duct can easily pass through the common duct. If a stone in the common duct is sufficiently large to grossly occlude the common duct, jaundice does not become intermittent but takes on a remittent type. Cases of remittent jaundice of twelve to fifteen years' duration are recorded in the surgical literature. The greatest tendency is for a stone to become lodged at the ampulla of Vater and by accretions of pigment to increase quite rapidly in size.

Between attacks of calculous obstruction of the common duct the patient may apparently be well but is practically never free from a subicteroidal tint or slight jaundice. The patient is designated as sallow when she is really suffering from a continuous and persistent low grade jaundice or a jaundice of remittent intensity. Many of these patients who are persistently sallow notice that the jaundice varies during the day, becoming deeper toward evening. With each attack of pain and jaundice there is a fever of a characteristic "steeple chart" type, while early in calculous obstruction the liver is enlarged and generally the spleen.

The resultant pathological condition is a dilated and infected common duct with a calculus floating up and down—"the ball-valve stone" of Fenger or Osler—and the mechanical factor is chronic intermittent intrinsic occlusion of the common duct with cholangitis. The pathological conditions are at the same time paralleled clinically by (1) pain; (2) ague-like paroxysms of chills, fever and sweating;—("intermittent hepatic fever of Charcot"); (3) jaundice of varying intensity.

Stone in the common duct is preponderantly the result of a previous infection of the gall bladder and predicates a chronic cholecystitis. In 187 cases of obstruction of the common duct reported by Courvoisier in 100 obstruction was due to causes other than stone and in 87 the obstruction was due to calculous impaction. Of the 100 cases in which obstruction was due to causes other than stone, in 92 there was a dilatation or distention of the gall bladder and in 8 cases there was a normal gall bladder or an atrophy of the gall bladder. Of the 87 cases in which obstruction was due to stone, in 70 cases the gall bladder was atrophied and in 17 cases the gall bladder was dilated. Courvoisier thus enunciated his law "in cases of chronic jaundice due to blocking of the common duct, a contraction of the gall bladder signifies that the obstruction is due to stone: a dilation of the gall bladder that the obstruction is due to other causes."

The clinical differentiation of acute pancreatitis is sometimes difficult and the description of Fitz is even today the best epitome upon its diagnosis. "Acute pancreatitis begins with intense pain, especially in the upper abdomen, soon followed by vomiting, that is likely to be more or less obstinate, and not infrequently slight epigastric swelling and tenderness, accompanied with obstinate constipation. A normal or subnormal temperature may be present and symptoms of collapse precede by a few hours death, which is most likely to occur between the second and fourth day."

The history of pancreatic or biliary carcinoma is distinct. The genesis of a tumor requires time and the history of the onset of jaundice in malignancy is succinct and characteristic. By slow growth a neoplasm initiates from day to day only minimal changes, whereas vascular or inflammatory processes produce extensive changes within a short time. Neoplasms of the biliary apparatus, the pancreas or the contiguous portion of the duodenum early invade or compress the termination of the bile and pancreatic ducts. Jaundice develops imperceptibly and without pain, so that from day to day it seems hardly to advance in intensity, but without pause or hesitation, without intermitting or remitting, it progressively deepens in intensity from mild to severe, from lemon to black, until it becomes the typical icterus melas. Its evolution is not associated with colic and in its earlier stages is usually devoid of pain. It is not associated with chills, fever or sweats nor leukocytosis. With such a history malignancy is the probable diagnosis, and when this history is associated with a palpable or distended gall bladder the diagnosis is almost positive.

In all true organic ulcers of the gastro-duodenal segment of the gut tube at the period in which they are producing symptoms, a given set of symptoms are present and are usually in distinct relationship to certain articles of food or to a certain time interval between the ingestion of food and the production of pain. The history of hematemosis will be absent in over 75 per cent. of cases, and in the diagnosis the history is the all important fact. Three facts stand out in the history of all regular cases of ulcer—(1) pain, (2) the constancy of the pain—food sequence, (3) periodicity of attacks. These symptoms are fairly constant and the interval or period is definite. If, in ulcer the pain is produced one hour after the ingestion of a certain article of diet that interval is usually constant for that type of food. In the beginning all ulcers manifest themselves by aberration in the function of the stomach and since disturbance of secretion is more easily induced by irritation than disturbance of motor function one expects that the most prominent symptom produced will be that of hyperchlorhydria with increased secretion.

We may therefore say that the patient with a gastro-duodenal ulcer presents in the main a history characterized by (1) pain, bearing some relation to the time of ingestion of food as well as to the quality of food; (2) by chronicity; (3) by periodicity or the repetition of symptoms day after day during the symptom-producing period of the ulcer. The complex of chronicity and the periodicity of attack with pain or distress, repeated uniformly day ater day during the attack and bearing a fairly definite relation to food intake and control is of primary importance in the diagnosis of 80 per cent. of cases of uncomplicated peptic ulcer. In the irregular or atypical 20 per cent. the roentgen-ray examination with a bariumized carbohydrate meal is of great value: (1) by deformities of luminal contour; (2) by the triad of hypers—hypertonus, hyperperistalsis and hypermotility and of lessened value the determination of aberrations in gastric chemistry.

If an ulcer is situated on the lesser curvature near the cardiac end the symptoms are different than when located at the pylorus or in the duodenum. The symptoms of ulcer near the cardiac end will be those of pain, shortly after eating, with periodicity in its production, with the vomiting of partly digested food, with blood in the vomitus, with a progressive emaciation because the patient does not retain his food. With ulcers involving the pylorus there is soon induced relative pyloric stenosis from spasm and secondary pyloric stenosis from inflammation, with the vomiting of large quantities of fermented gastric contents containing food remnants. In the pyloric type of ulcer there is, as a rule, a loss of weight from insufficient nourishment and secondarily a cachexia from absorption of fermented and putrefying gastric content. Quite distinct from these two types is that of the duodenal ulcer where the patient is, as a rule, well nourished and states that when he has food in his stomach he is free from pain. We are in full accord with Moynihan that "persistent recurrent hyperchlorhydria is duodenal ulcer." In gall bladder disease, pain and discomfort usually come on with eating, while in duodenal ulcer the pain is relieved by eating. The patient with duodenal ulcer, usually a man, is ordinarily a well-nourished individual, with marked appetency for food and who informs you that "if he could eat all of the time he never would have a bit of pain." Consider the average daily history: The pa-

tient starts out in the morning, eats a good breakfast and about ten o'clock begins to suffer pain, a pain that is usually described as "gnawing," persistent and rather severe, but one that is tolerated. He seldom requires anodynes. He eats a sandwich or drinks a glass of milk and the pain disappears. The pain usually comes on when his stomach is empty and at about the time that he is naturally hungry. For this reason it becomes known as "hunger" pain. At about four o'clock the pain recurs and he takes another light lunch with rapid cessation of pain. Returning home he eats a well-proportioned supper, and before going to bed has a few crackers and a glass of milk. Sometimes about twelve o'clock he is awakened by epigastric pain of the previous type, but rather more severe. Repeated experience with the night pain has shown the wisdom of having some crackers or a piece of chocolate at his bedside. Upon eating something or taking soda the pain disappears. This history is repeated day after day with unvarying precision and consistency. Its story is typical and the diagnosis might be made as Moynihan expresses it "by correspondence."

The history of cases showing cancer of the stomach is of three kinds: (1) the man who is perfectly well, who has an "athletic stomach" and who has never had any previous gastric distress. There comes into his history an abrupt sudden development of gastric signs. His symptoms suggest an acute ulcer of the stomach possibly with hemorrhage, but at the end of three or four weeks the man has lost physically beyond what would be expected of a simple ulcer. His anemia has become more pronounced. He has a distaste or aversion for food. Finally from the anemia, emaciation and beginning cachexia the diagnosis of rapidly growing carcinoma is made. This type constitutes about 30 per cent. of all cancer cases and has an average duration of life of eight to ten months. The second class, and by far, the largest proportion, about 60 per cent., is represented by the patient who has a perfectly clear history of chronic gastric ulcer extending over a period of years. He has a form of gastric distress characterized by periodic discomfort or pain usually bearing a distinct relationship to food ingestion with some vomiting. His previous gastric history covers a period of eight to ten years, with intermittent attacks of typical ulcer history. Finally, there comes an attack from which he does not respond to the medical treatment that has heretofore proved beneficial. The pain becomes constant, marked distaste for food intervenes with particular aversion to meat; blood is constantly present in the stool and vomitus and he has an average duration of cancer symptoms approximating six months. The third class, of about 10 per cent., is represented by the patient who has a typical history of gastric trouble from which he nearly but never quite recovers, and after a variable period progressively, but very slowly, becomes worse, with a distinct distaste for food and without any interruption progresses to a well-defined cachetic condition of malignancy.

A BRIEF REVIEW OF SOME OF THE PRESENT USES OF RADIUM IN MEDICINE.

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I believe if I were to contend that radium is the most remarkable single discovery in physics, in chemistry and in medicine, which has ever been made in the history of the world, it would be impossible to controvert my position. The new field for radium in medicine is indeed one of the extraordinary unforseeable advances in a generation remarkable for its discoveries and only serves to illustrate the utter impossibility of prophesying what lies in the womb of the future in the therapeutic realm.

Enough years have now elapsed to enable us to test out the efficiency of radium in certain medical and surgical ailments, and to make it safe at last to present a resume of its achievements, which I venture to recite briefly for the benefit of busy practitioners.

It is necessary to recall, to keep the matter clearly before us, that radium gives out three kinds of rays and that of these the alpha particles are gross matter ejected from the heavy radium action which are intercepted by any kind of a screen or container in which the radium happens to be enclosed, and while these alpha particles are of extreme importance to the physicist, we have nothing what-

ever to do with them in medicine, so forget them. The rays used in treating medical and surgical complaints are the beta and the gamma radiations. The general practitioner who wants to understand some of the rationale of radium therapy must keep in mind this fact, namely, that these rays are not direct emanations from the radium itself, but are given off by a very active gas, which is being formed continuously by radium and which continually accumulates in it at a certain definite measureable rate. The effectiveness of radium in reality depends upon the production and the rapid breaking down of this gas, as it further disintegrates into the next product below it in the scale. This radium produced gas is the so-called "emanation" (of Rutherford) of which we are destined to hear more and more in the future. This gas can easily be detached from the radium which is then left practically inert until its full quota of emanation reforms. To buy radium is therefore just like buying a cow solely for the milk she gives, after you have milked her she is of no use again until the milk reaccumulates. There are manifestly two ways of getting the milk from the cow to the patient, one is to drive the cow to the home of every consumer, who abstracts the milk directly from the cow on the spot, the other is to take the milk from the cow out at the farm, leaving the cow in the barn. This constitutes the difference between using the radium with the emanation, which is comparable to driving the cow to the door of the consumer, and using the emanation abstracted from the radium, which is equivalent to keeping the radium (the cow) in a vault and taking the milk to the buyer's house.

The emanation is far more convenient, because a gram of radium in the form of its salts—say the bromide or the sulphate (in which form alone it can be used), would nearly fill a teaspoon, while the equivalent amount of emanation occupies a space smaller than a common pin head; i. e., six-tenths of a cubic millimeter. It is at once evident that it is, therefore, possible by using the emanation to give a more concentrated treatment, and to introduce it into smaller cavities, as for example in the uterus, as well as to subdivide it to any required degree.

Let me speak now of two available rays given off by the emanation, whether used in the radium or separated from it. The beta rays are more irritating and less penetrating than the gamma. They are used for superficial lesions where there is a fungating area which it may be of an advantage to destroy, or strike hard blows, while promoting the absorption of the underlying disease. They are readily modified or cut off by interposing lead screens of from one to several millimetres in thickness. Where the neoplasm lies deep in the tissues under a sound surface, as for example in the neck, or in the chest, or in the abdomen, it is important to cut off many of these beta rays, and to use only harder and more penetrating beta and the gamma rays, which are much less in quantity but far more penetrating, and not so irritating.

The whole question of the influence of radium upon diseased tissues hinges upon the fact that they are more susceptible to rays than are the surrounding normal tissues. For example, while an unduly prolonged radium treatment will slough out every tissue, including skin, muscles and bone, a shorter treatment will leave the normal tissues uninjured, while causing the absorption of the disease. In treating diseases lying below the surface, the first difficulty we encounter is necessarily that the overlying sound tissues receive a proportionately much more intense treatment than the underlying disease. This disadvantage is however usually easy to overcome by radiating from different directions, utilizing a number of portals in the sound tissues. For example, if I have a tumor the size of a small orange I may throw a treatment into the diseased part through the skin over its most prominent surface, and another treatment through a fresh area of skin into the tumor from above, again from below and from the sides, so that I can fire eight or ten treatments into the tumor in this way, giving the tumor a maximum application, while the skin at any one point receives but little radiation. The most important safeguard as far as the skin is concerned is never to give more than what is called "an erythema dose," that is to say, not to go beyond the reddening of the overlying skin. For if the skin is seriously irritated all treatments through that portal must be suspended more or less indefinitely, and we may lose out where we might have scored a success, and to lose out may mean to lose a life.

Another way of getting at the dis-

eased tissues effectively is to put all the emanation in a minute glass point or spicule, in a hollow needle and to insert it into the heart of the disease, and leave it sticking in there for half an hour, or longer, and then to withdraw the needle with the emanation.

Still another way is to make up tiny spicules of capillary glass tubing, each containing from a fraction to several millecuries of emanation, and to insert these into the disease and push them out of the needle and leave them permanently in the tissues. Let me explain that a millecurie is the equivalent emanation strength of one millegram of radium, so named in honor of Madame Curie. The difficulty with these latter forms of treatment is that some central focal necrosis is apt to follow from the intensity of the treatment in the immediate neighborhood of the emanation points. In most instances, however, this is negligible.

It is obvious that experience alone can teach us what is the average dose the skin will stand, what kinds of lesions respond regularly and promptly to radiation, and which only respond occasionally, and again what groups are entirely unsusceptible. Experience too has had to teach us not only the amount to use but the duration of the application in each case, as well as how often it is wise and safe to repeat it. So many factors enter into the problems of the radium treatment of disease that it becomes the highest kind of expert work, and is really the province of a specialist. Failure to use the right amount in the right way either leaves the lesion uninfluenced, or, if too small quantities are used, stimulates its growth, or, in the case of an excessive dosage, does serious damage and causes severe pain through the subsequent protracted sloughing. Overtreated cases cannot be treated again for a long time. Our earlier experiments in this field ought not to be repeated by each successive generation. Also let me say here that it is often much more difficult to deal with those cases which have already received x-ray treatments before applying for radium.

Wherein does radium treatment differ from x-ray treatment? Enormously in its prompt action and effectiveness. The world at large certainly realizes that there is a vast difference judging by the enormous purchases of radium, an outlay of sums of money which would install thousands of x-ray outfits if equally effective. It is also evident from the fact that many of our patients who have x-ray cancers of the hands come to us for radium treatment, while further applications of x-rays would clearly only stimulate the disease. Also the gamma rays of radium will pass through ten and twelve inches of lead, and even influence electroscopes passing through two buildings and a hundred feet of space, which is not the case with radiations given off by an x-ray tube.

Let me now enumerate a few of the diseases which are susceptible to radium.

Of all in the entire category, by a blessed piece of good fortune, **lymphosarcoma,** that hitherto utterly distressing and hopeless malady from the standpoint of medicine and surgery, melts with startling rapidity under massive radiations from radium. All cases of lymphosarcoma therefore should repair at once to a competent radium therapeutist, and under no circumstances should lymphosarcoma ever be operated upon surgically as a therapeutic measure. If radium did nothing more than relieve this disease it would justify our labors in working out the possibilities.

Furthermore, by a piece of utmost good fortune, that other hopeless malady, **Hodgkin's disease,** is also often curable by radium when taken early. We have cases remaining well after a lapse of five years and more.

We now have also a number of cases of **leukaemia** apparently cured after several years with no recurrence, and the patient in normal health. Let me urge here, with reference to these, as well as to all other groups of cases, of which I hear speak, that the rule applies here which the general surgeon has sought to emphasize for so long—namely, that the **successful permanent results are directly proportionate to the early recognition of the disease and its prompt treatment with radium.** Let us dub this the fundamental rule.

Epitheliomata of the hands and face, when not too advanced, are relieved in some ninety-five to ninety-eight per cent. of the cases. The good results in all these groups, as well as in others, become more and more manifest with increasing experience in the handling the radium, in adjusting skilfully its dosage, the frequency of the applications, in recognizing and allowing for the individual susceptibility, etc.

In **cancer of the lip** radium will often wipe out the local lesion, but the enlarged glands in the neck should be taken care of surgically. This developes the important principle—namely, that in carcinoma radium treatment is intensive, like firing a gun to score a bull's eye, and such necessary intensive treatments cannot be given over an ill-defined area where the extent of the disease is uncertain. In all such cases where the presence and extent of metastases is uncertain, a radical operation is better than radiation.

This same rule applies to **cancer of the breast**—where a seeming paradox has developed, which is this, that in a good operable risk (I mean where the chance of non-recurrence is excellent), the surgical operation is wiser and safer than radiation, simply because of the uncertainty of the extent of the disease and the impossibility of radiating successfully a large doubtful area. In two classes of breast cases, however, radium therapy is of great value. First of all in a palliative way it is sometimes of the utmost benefit in melting down a massive disease of the breast which has gone far beyond the operative stage! It never, under these circumstances, reaches the extensive glandular metastases or affects the ultimate outcome but it does comfort and give relief. On the other hand, in the local recurrences of the lenticular type, or in a massive nodule on the cartilege or bone, and sometimes in nodules in the axilla, or sometimes in those above the clavicle, radium therapy brings about a happy result with the dissipation of the disease. In all these breast cancer cases it is important to take a preliminary radiogram of the chest, as insisted upon for many years now by Burnam, to make sure that there are no enlarged intrathoracic glands. Unfortunately, these latter cannot be reached any better by radium than by surgery.

In **fibroid tumors** of the uterus radium is the preferable treatment, either inserted in the uterus, giving say two gram hours of treatment (a gram for two hours, or two grams for one hour) shifting the applicator so as to affect different areas in the endeavor to avoid a slough in the uterine mucosa, as well as by radiating through several portals through the abdominal walls. In older women menstruation is stopped in this way, the tumors cease growing, or stop, or shrink, or disappear entirely. In the occasional case, where the patient is not relieved by radiation, it has simply proven to be a question of deferring the operation, which can equally well be done at a latter date. I repeat it—radium and not surgery is the preferential treatment for fibroids.

In **cancer of the cervix** radium is the treatment **par excellence,** and I believe is always better than surgery. Even in the good operable risk it seems to me that radium is the best treatment, **provided the patient can be watched after the operation** at fairly long intervals. In the cases in which the disease has invaded one or both broad ligaments, and in the massive cases, there is no other rational treatment but radium, which occasionally, even in these hopeless groups scores an apparent entire cure. Also in recurrence after operation radium sometimes dissipates all the disease. I can only pause here briefly to state that if radium never cured a single patient in any of these groups, its palliative results would make the purchase of the large amounts of radium being distributed over the country well worth while.

Cancer of the body of the uterus is best treated by radical surgical operation as heretofore—however, in some of the cases which we have seen, where operation was utterly out of the question on account of the serious ill health of the patient, or by reason of other complicating diseases, perhaps a well-defined diabetes, we have seen some happy results and a prolonged recovery over a considerable period, and some cases of apparent cure.

Primary cancer of the vagina, so awkward to treat surgically, if it has not gone through into the surrounding tissues melts down rapidly under radiation and stays well. I have also seen remarkable results in the cancerous efflorescence spreading superficially down over the vaginal walls from a cancerous cervix.

Sufficient has been said to demonstrate the large range of diseases appropriate to radium therapy. Further hope for the immediate future is that by the discovery of other methods of treatment, and with growing skill in the handling of the radium, we shall be able to secure more uniform results in these groups mentioned, and perhaps even to enlarge and include some fresh groups.

In conclusion let me repeat and em-

phasize two great fundamental principles in radium therapy: (1) Early recognition of disease and prompt treatment secures the best results; (2) the patients must be kept under a prolonged observation after treatment, even after the disease appears to have been destroyed completely, in order to discover the occasional recurrence at the earliest possible period. Local recurrences, not too large, are as a rule just as easily treated as the primary lesion.

Finally, and most important, let me caution prospective purchasers. I have a strong suspicion from the numerous firms springing up that are dealing with radium (one of the last ones sending me a prospectus from an impersonal firm stating that it secures its supplies from abroad)—that more or less mesothorium is being put on the market as radium. The radiations from mesothorium are not distinguishable from those from radium, but while the life period of radium is upwards of two thousand years, that of mesothorium is not over eight, and the value of mesothorium is naturally less. Before the war mesothorium was about $30,000 a gram, compared with $120,000 for radium. Even the United States Bureau of Standards can not distinguish between a tube of radium and a tube of mesothorium.

REMOVAL OF THE LOWER EXTREMITY BY DISARTICULATION OF THE HIP JOINT AND REMOVAL OF THE UPPER EXTREMITY INCLUDING SCAPULA AND OUTER THIRD OF CLAVICLE.

By Edward Staehlin, M. D.,
Newark, N. J.

Indications for these operations are twofold: (1) Mutilating injuries of the thigh or arm respectively, where the mutilation is so severe as to render the parts beyond the hope of repair or restoration, as the result of the mangling of bone, vessels and muscles; and (2), malignant involvement of the respective parts.

Injuries which carry in their wake a clean severance of the large vessels are usually beyond the avail of surgical intervention—"Dead on arrival," is the verdict. Injuries, the result of mangling, crushing, or grinding influences, may, by the very nature of the crushing action stop hemorrhage, and a selective operation may be done—either an excision of the joint or a high raquet flap operation.

The surgical procedure I am about to mention is very applicable to this class of injuries. It is pre-eminently applicable where malignancy exists and has a twofold advantage in hip joint excision. In the first place, it permits the operation to be done with a very minimum amount of loss of blood and, secondly, it allows a digital examination of the pelvis for involvement of glands following the course of the pelvic vessels and so in a general way deciding a priori the justifiability of an operation or not.

Hemorrhage, with its resulting shock, of course, is the bane of hip joint and shoulder joint excisions. With my hip joint excision there was scarcely a tablespoonful of blood lost and very little more with the shoulder joint excision. The only hemorrhage after securing the large vessels is from collateral circulation, the obturator vessels in the hip joint excision, and the subscapular in the shoulder joint excision—really negligible vessels if one is on the alert.

I would recommend this method of operation as the very best method and give it precedence to high amputation methods of every kind that have been devised. I personally condemn the use of Wyeth pins and consider them unsurgical—even brutal—and would never employ them. I believe this method reduces shock, which accompanies all sawing of bone, to a minimum, besides it is safe, comparatively simple, speedily eliminates loss of blood and allows a field for inspection (digitally) for glandular involvement, which no other method offers.

Hip joint excision.—The preliminary step is a two-inch abdominal incision. Its center is on a level with the anterior superior spine and an inch toward the median line. The incision is carried down to the peritoneum but the peritoneal cavity is not opened. This small opening gives ample room to thoroughly explore the abdominal vessels—the iliacs—common external and internal—for glandular involvement and then allows the finger or thumb easily to compress the external iliac against the brim of the pelvis and so control the vessel absolutely and without fatigue to the one who exerts compression. The raquet incision is then made (either internal or external handle),

the vessels are doubly ligated and severed, muscles severed, allowing for skin flap, disarticulation done and the operation is completed.

Case Histories.—P. S., male, 28, was admitted Feb. 10, 1908. Seven weeks ago he stopped a runaway horse and was injured in the upper part of the right tibia. After the injury he was uncomfortable for two weeks but kept at work, then pain became very severe and loss of function occurred. A large swelling appeared on upper third of right tibia. At the time his weight was 130 pounds. The swelling was curetted away, the hemorrhage was excessive and was controlled by packing, but with each change of dressing the hemorrhage was excessive, which led to the opinion that he was suffering from a gumma. A section, however, revealed a small round cell and large spindle celled sarcoma. He was greatly reduced in weight, now 91 pounds, and was markedly anemic. He was operated upon March 30, 1908, and made an uneventful recovery. Discharged April 26, 1908, and has stayed well up to date.

Miss E. H., 43, was referred to me by Dr. Hagar, suffering from a swelling in her left popliteal space, as large as a good sized egg. It had been previously punctured and incised, adding an inflammatory process to the one originally existing. This mass was removed early in June, 1919. It had the appearance of organized placental tissue and was very friable, and emanated from the sheath of tendons in the popliteal space and diagnosed microscopically as sarcoma of the sheath of the muscles by the house surgeon, Dr. Wambsganss, of the Memorial Hospital. It proved so by microscopic examination.

Pathologist's Report of Specimen: Tumor growth derived from mesoblast (fascia of muscle). The cells are of the vegetative type and infiltrate deeply. They are rich in chromatin and mitotic figures. Their shapes vary—some are small round, others large round and others spindle shape. (Signed, Dr. Casilli). The parts were thoroughly curetted and sewed up. The latter part of July there was a recurrence, very rapid, and early in August an excision was done. She too made an uneventful recovery.

The shoulder joint excision is a little more difficult. It is applicable to the same class of cases and under the same conditions. It does not permit a preliminary step to so closely and directly examine the gland involvement, but it allows a prognostic inspection in course of the progress of the operation and removes the axillary glands en masse, undisturbed by dissection or handling and further removes the entire extremity, including ⅓ of the clavicle, entire scapula without opening the joint. The first step is an exposure of the clavicle—its outer ⅓; this portion is resected (a gigli saw proves very efficacious). When the outer ⅓ is removed there is offered a fine view of the subclavian vessels and here glandular involvement may be looked for in particular. The examination (digitally) may be carried on the left side to the very heart along the innominate vessel, care of course being taken not to open the pericardium or pleura, analagous to the peritoneum in the preliminary abdominal incision for hip joint excision. Should there be involvement of glands, the progress of the operation is desisted and the patient is no worse off than one suffering with a fracture of the clavicle. When no involvement is found you are justified to go on—the vessels are doubly ligated and severed, the incision is then circumscribed about the shoulder joint—so removing the outer ⅓ of the clavicle and the whole of the scapula en masse.

M. W., 43, admitted July 17, 1918; 3 months ago she noticed a lump in the left axilla which began to pain her a week before. There were several depressions in skin and soft parts about the upper end of the humerus from old appearing sinuses. Along about the upper end of the humerus was a hard firm mass, globular, size of an egg. It was regarded an old osteomyelitis. A piece was removed for examination and reported lympho-sarcoma of humerus upper ⅓. Operated on August 21, 1918, discharged October 1, 1918. This patient has made a splendid recovery and gave promise of having an end result equal to those of my hip joint excisions, but she fell victim to influenza last winter and succumbed.

From the standpoint of diagnosis the microscope and x-ray should be greatly relied upon as valuable adjuncts in making a differentiation. It is difficult to differentiate between osteomyelitis and sarcoma as the following case citation will prove:

P. K., aged 12½ years, was admitted

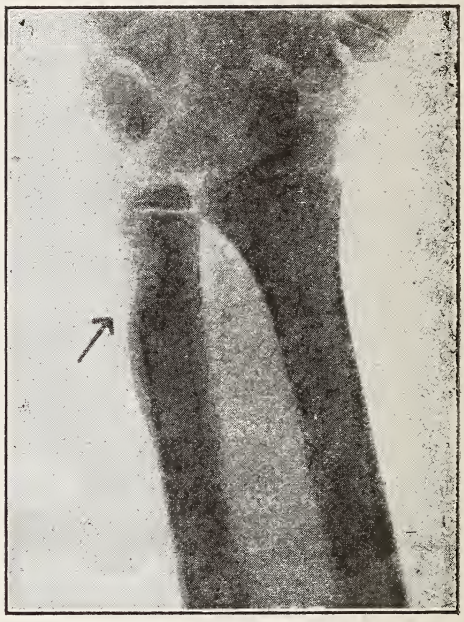
to the Newark Memorial Hospital December 24, 1918, with the following history: In August, 1918, he fell and hurt his left knee. Soon after, the leg became painful, especially at night, and swollen. This was diagnosed as acute osteomyelitis and the boy was removed to a New York hospital for operation. The leg

Case P. K., Periosteal Sarcoma of Femur.

above the knee was opened and drained. There was no improvement. Repeated radiographic examinations were always interpreted as osteomyelitis. He was removed from New York, and on admission to the Newark Memorial Hospital, the clinical examination showed an enlarged thigh, the swelling beginning at the knee joint and extending half way up along the extremity. It was not very painful when at rest, and had a nodular consistency. The right wrist joint was slightly swollen and had been incised and healed. Radiographic examination made by Dr. Reissman was reported as periosteal sarcoma with metastasis in the right ulna at the wrist. In consequence of the existing metastasis no operation for hip joint excision was done and the patient left January 12, 1919.

We have since learned that he returned to the same New York hospital where his leg was later amputated. He remained well for a short while and now has a metastatic recurrence in one of his shoulders. Outside of prolonging life for short periods, amputations in such cases, when metastasis has already occurred, proved useless.

I am very glad to avail myself of the excellent report of the roentgenologist,



Case P. K., Metastasis in Ulna at Wrist.

Dr. E. Reissman, on differential diagnosis, which I hereby attach:

"Pathological conditions of bone present two distinct manifestations to the x-ray, namely, bone destruction and bone production. Either one of these conditions is present no matter what the disease may be and only by a careful study are we able to classify and differentiate the lesion. The most important point of interest to the surgeon is, of course, whether the disease is benign or malignant. It being, however, expected of the roentgenologist that he make a more definite diagnosis, conclusions are generally drawn from the following four cardinal points: the origin of the tumor; bone production; the cortex; and invasion.

First: The point of origin; this will determine whether the growth originates in the medullary canal or from the cortex of periosteum.

Second: Bone production does not take place in carcinoma or giant cell sarcoma

and consequently helps to rule out certain growths.

Third: From the cortex we can determine whether it is destroyed or not and, if not, whether it is expanded. We can also see whether the growth originates from the cortex or periosteum.

Fourth: Invasion. If it is established that the growth infiltrates the bone and soft tissue we have certainly established malignancy. In the young, carcinoma of bone can usually be ruled out unless a primary growth is discoverable. Sarcoma, however, is not unusual.

"Periosteal sarcoma of the bone arises from the periosteum, produces new bone and extends perpendicular to the shaft into the soft tissues.

"A differential diagnosis between sarcoma and osteomyelitis in the latter stages is also based upon the evidence of destruction within the bone with sequestra, and destruction of the cortex in different individual spots, in the latter, with either very little or entire destruction occurring in malignant growths. There is also the fact that sarcoma rarely invades a joint. It is important to bear in mind that surgical interference, incising the growth for drainage, etc., makes an x-ray diagnosis very difficult since a mixed infection will mask the original cardinal points. This happened in the case described above which was for months treated as an osteomyelitis and so operated upon before coming under our observation.

The tendency to metastasis in periosteal sarcoma must be borne in mind and is an important factor in considering amputation of the extremity originally involved. The above briefly outlines some points in the differential x-ray diagnosis of bone lesions.

The case described above had all the earmarks of a periosteal sarcoma with an added osteomyelitic infection. The latter was due to surgical interference which masked the picture of sarcoma. There was also metastatic growth in the wrist joint which had also been unnecessarily incised."

15 Lincoln Park.

Thomas C. Kennedy and W. H. Kennedy, in the treatment of excessive hemorrhage from small fibroids, radium is the ideal treatment; it will not only stop the hemorrhage but will cause a retrogression of the tumor. Radium has not displaced surgery in the treatment of fibroids, but in selected cases it has proved of great value.

CAN ARSPHENAMINE BE KEPT IN A PERMANENT SOLUTION?*

A PRELIMINARY REPORT.

By Otto Lowy, M. D.,
Newark, N. J.

Arsphenamine is marketed in the form of a yellow powder which is sealed in an ampoule containing either inert gas or a vacuum. The object of this careful packaging is to prevent oxidation or chemical change. Ehrlich and all other investigators maintained that arsphenamine solutions must be used immediately after preparation, otherwise the toxicity would be increased and reactions were likely to occur. Gilbert T. Morgan in his monograph on Organic Arsenical Compounds, page 227, makes the following statement: "Although stable in dry condition when kept in closed vessels, salvarsan is very decomposable in aqueous, methylalcoholic and especially in alkaline solutions, even in the absence of air. The liquids become red, ultimately depositing intense reddish-brown precipitates which have completely new properties. It is important to realize that these changes represent the later phases of a decomposition process. The earliest stages are scarcely to be detected by physical and chemical means. Biological and toxicological tests, however, are capable of detecting the slightest alteration in salvarsan by a rise in the toxicity of the preparation. The toxic properties very considerably and unexpectedly. Colour is no criterion of safety, for when tested on rabbits samples of a clear yellow tint have sometimes proved so toxic that the experimental animals have succumbed during injection."

Several years ago we were led to believe that we could find a way to prepare a permanent non-toxic solution of arsphenamine. We conducted a long series of experiments, utilizing all the well-known reducing agents and other methods of preventing oxidation and chemical decomposition. Finally we evolved a simple method of preparing a stable solution of arsphenamine, which when tested in one government and two other laboratories appeared to have remained non-toxic. The solution tested varied in age from three weeks to five months. Re-

*Read before the Laboratory Section of the Amer. Public Health Association, at New Orleans, La., Oct. 27, 1919.

sults obtained in three independent laboratories were as follows:

Lab.	No. Rats Injected	Dose Per Kilo
No. 1	30	140
No. 1	20	140
No. 2	20	120
No. 3	40	120

Note.—The two that died were injected with a solution that had been boiled one-half hour before use. Eight of the ten lived.

The table shows that arsphenamine in solution can be prepared so that it is apparently not more toxic than the original arsphenamine and is definitely less toxic than solutions carelessly and improperly prepared.

Clinical Results—The solution has been used by Dr. D. D. Stetson, Acting Assistant Surgeon at New York Skin and Cancer Hospital, in 339 cases. Dr. Stetson can see no difference between our solution and solutions freshly prepared.

Dr. L. L. Davidson, Chief of the Department of Venereal Diseases, Newark Beth Israel Hospital has used the solution in 182 cases with favorable results.

Dr. W. J. Young of Louisville, Ky., has used the solution in 48 cases with favorable results.

The clinical results so far seem to indicate that the therapeutic value is the same as the freshly prepared solution.

Conclusion.

1. Solutions of arsphenamine as prepared by us have remained apparently unchanged for five months and passed toxicity tests of our own and two other laboratories. (The United States Public Health Service Hygienic Laboratory has tested preparations which have been in their possession since July 19, 1919.)

2. Clinical tests have shown that it is non-toxic and apparently does not give more reaction than those that occur with freshly prepared solutions.

3. The advantages of this form of arsphenamine requires little explanation. The average physician has neither the facilities nor the time to prepare arsphenamine.

4. Further experiments are being conducted in collaboration with the Hygienic Laboratory to determine the rate of deterioration, if any.

Since writing this report over 2,000 injections have been given at various clinics with comparatively few reactions. The solution has also received the approval of the United States Public Health Service and of the Council on Pharmacy and Chemistry of the American Medical Association.

Conc. Solution	Rats Lived	Rats Died
1.2 & 2%	30	0
"	18	2
2%	20	0
2%	40	0

THE IMPORTANCE OF RADIOGRAPHIC EXAMINATION OF THE THORAX.

By H. A. Knauss, M. D.,
Newark, N. J.

I am going to vary the monotony of the usual discussion by plunging directly into conclusions. These are founded on numbers of cases, the original films of which are on file in my records. It is impossible to accurately reproduce lung pictures. Therefore, the physician in charge should see that he receives the **original** films from the laboratory.

A good radiograph of the thorax should include the apices of the lungs, the heart and great vessels, and a part of the liver. That is. in an individual of average size, it is generally possible to get all these things on the customary 14x17 inch film. Generally speaking, two radiographs should be taken; I personally do not see any great advantage in taking them stereoscopically, although there is not a great deal of additional work connected with the stereoscopic method.

The first importance of radiographic examination of the thorax is that by this method and with expert observation and interpretation the clinician is many times aided in finding previously unsuspected conditions. To mention a few which even the most exacting physical examination will sometimes not disclose, there are the following: (1) Enlarged or persistent thymus; (2) aneurism; (3) marked dilitation of the heart; (4) mediastinal tumor; (5) early pulmonary tuberculosis; (6) empyema, and unresolved pneumonias; (7) foreign bodies; (8) lesions of the spine and bones.

It is impossible to go into details of the interpretation and description of the

various lesions. I have enumerated a few of the more important conditions to recall the extent of the subject.

Out of quite a few adults examined radiographically and clinically and proven to have pulmonary tuberculosis by both methods, it is surprising to find that a large number of these cases show definite lesions of the spine (usually the thoracic spine). It appears then that many times the disease is present in childhood in the intervertebral discs even before it extends to the glandular system.

It may even be possible that a large number of diseases, particularly of the lungs are nothing more or less than secondary infections, the entrance for which is paved by the presence of the tubercular toxins in about 90% of all of us.

Therefore, if you can find by the radiographic methods one early pulmonary tuberculosis, which has been overlooked by the clinical method out of even a hundred in which the findings are negative, you will have rendered humanity a service.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The Atlantic County Medical Society held its regular monthly meeting April 9th, 1920, at Hotel Chalfonte, Atlantic City.

The report of the Nurses' Committee, relative to the increased schedule of prices, elicited much animated discussion.

The following resolutions on the death of Dr. Talbot Reed were adopted:

Whereas, Almighty God, in His infinite wisdom has seen fit to remove from our midst Dr. Talbot C. Reed, a most useful and highly respected citizen of this community; and,

Whereas, The Atlantic County Medical Society feels deeply the loss of one of its most active and influential members; therefore be it

Resolved, That this society deplores the loss of the late Dr. Reed and that each member extends his sympathy to the bereaved widow; and be it further

Resolved, That a copy of this resolution be spread upon a special page of our minutes and that a copy be forwarded to the widow.

It was decided that in June the society tender the men who were in service a dinner at the Sea View Golf Club House.

"Diagnosis of Organic Heart Conditions," was the subject of a talk by Dr. E. J. G. Beardsley, Philadelphia. As nearly everybody sooner or later, comes to Atlantic City, there is here an unexcelled opportunity for the study of heart cases. The use of instruments of precision, such as the electrocardiograph, is causing many medical men to drift away from inspection and palpation. History is one of the most important factors. Dr. Osler said, "If I can take the history, I do not care who makes the examination."

Inspection and palpation are more important than auscultation. The patient should be undressed and in a good light. The average case can be easily diagnosed if you know where the apex is. If the apex beat is one inch out, something is definitely wrong; you have an organic heart case. Palpate for thrill. If there is a diastolic thrill, there is mitral stenosis, or aortic regurgitation, or a combination of the two. Blood pressure in heart cases is very important and should be taken routinely.

"Blood Chemistry in Its Relation to Nephritis," was the subject of a paper by Dr. Herman O. Mosenthal of New York. The normal percentages of non-protein nitrogen, urea nitrogen, glucose, amino acid, creatine, creatinine and carbon dioxide retention in the blood, were compared with pathological percentages. No disease is known in which amino acids increase in the blood. The test for these of no clinical value. Creatine and creatinine are closely related. They are found in muscular tissue. Their increase in the blood is due to faulty metabolism and not to renal insufficiency. The presence of glucose also is due to disturbances of metabolic processes.

The estimation of non-protein nitrogen is difficult. It takes time, the methods are not standardized, and it is not suited to routine work. The determination of urea and urea nitrogen is by simple, quick and accurate methods which given uniform results.

Urea nitrogen, uric acid, and creatinine are retained in the blood in the same order as they are insoluble in the urine. Uric acid is the least soluble and is retained first, urea nitrogen is retained next, and creatinine, being most soluble in the urine, is retained last. These three are estimated in relation to each other because, in doubtful cases, the order in which they are found in the blood is of diagnostic importance.

Deep breathing is characteristic of acidosis. Acidosis is not the same as in diabetes. When nephritic acidosis occurs, calcium and sodium bicarbonate are the remedies given. Bleeding in such cases is a common mistake: hemoglobin is diminished and the patient will succumb to secondary anemia.

BURLINGTON COUNTY.

H. Eugenia Whitehead, M. D., Reporter.

The regular spring meeting of the Burlington County Medical Society was held at the Fair View Sanatorium for tuberculosis at New Lisbon, Wednesday, April 14th. The board of managers, consisting of Drs. Elmer D. Prickett, Mount Holly; E. P. Darlington, New Lisbon; David A. Baird, Florence, and Mr. C. B. Joyce, Vincentown, invited the society to give the members an opportunity to visit the institution.

A special meeting of the Burlington County Medical Society was called at the office of Dr. E. D. Prickett, Mount Holly, March 18th, to meet, Senator Blanchard H. White. Senate Bill No. 269—introduced by Senator White, is an act to regulate the practice of drugless therapeutics and has the following preamble to the bill.

Whereas, The health of the citizens of the State of New Jersey is endangered by persons who attempt to practice drugless therapeutics without first obtaining proper qualifications and authority; and

Whereas, Due regard for the safety and protection of the citizens of this State demands that only authorized and qualified practitioners of drugless therapeutics be permitted to practice therein; and that

Whereas, At present there exists no authorized body or board of sufficient understanding, proper education or unprejudiced attitude to examine into the qualifications of the practitioners of drugless therapeutics to issue licenses to qualified persons;

Therefore, owing to the great and rapidly increasing number of our citizens who seek relief from dire maladies forsaking the heretofore dominant schools of medical treatment for a scientific drugless treatment, it is desirous to establish a State Board of Drugless Physicians to take entire charge of such practice and to carry out the provisions of this act.

This bill would include osteopaths, neuropaths, napropaths, Christian Science healers and possibly chiropodists, and has the appearance of vicious class legislation.

The Governor has signed a bill giving chiropractors a separate board and he may sign the compulsory health insurance bill also; Senator White agreed to meet with us that we might discuss the matter with him, and to help in any way to regulate and sustain the regular practice of medicine.

Dr. E. P. Darlington, chairman of the Section on Practice of Medicine, announced the fact he had received a telegram stating Dr. A. L. Morgan of Philadelphia, who was to read a paper on the "Post Influenzal Chest," was not able to be present. We were delighted, however, to have with us Major Phillips, Major Bethke, Captain Fisher and other members of the Base Hospital at Camp Dix, who entertained us with an account of their experiences with the tuberculosis patients under their care and observation while at the camp.

Captain Fisher brought a number of interesting diagnostic x-ray plates which he explained, and pointed out the portions of diseased lung tissue; the position of parts usually effected, showing many cases are accompanied with the "Dropped Heart" which diminishes the space of the tubercular lung. Plates also of the pneumonhydrothorax; explaining the difference with the presence of gas, air or liquid in the thoracic cavity. They used sodium iodide in these cases. Major Phillips and Major Bethke also gave interesting accounts also of of their experience along these lines.

Following a rising vote of thanks to the speakers the meeting was adjourned and a bounteous repast was served by the ladies of the Anti-Tuberculosis Society, representing Beverly, Burlington, Brown's Mills and Mount Holly for which a unanimous vote of thanks was given.

The society was delighted with the sanatorium and its management. It was a beautiful day and it gave us an opportunity of seeing the patients out on the porches enjoying the fresh air. The history and charts are kept daily showing noted improvement in many cases. The sanatorium has been the recipient of many gifts for the comfort and pleasure of the patients.

The fact that no other county has a better equipped sanatorium, nor one better cared for, is fully appreciated. There is a Victrola which renders great pleasure to all. The society will be glad of a donation of books or records from interested people who care to contribute.

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

There was a good attendance at the semi-annual meeting held April 6th at the Commercial Hotel, Bridgeton. President Hatch being absent, Vice-President Sharp presided. Drs. Mary Bacon Leach, Bridgeton, and Hugh Baker, Vineland, were elected members. The Committee on Public Health and Legislation reported on the Chiropractic Bill which recently became a law. The general discussion which followed elicited that no hearing was granted, which probably was due to lack of alertness on the part of the committees entrusted with such matters. The bill was obviously a lowering of the standard of medical education. The action of the Essex County Society was endorsed.

Dr. H. R. Loux of Jefferson Medical College, Philadelphia, delivered a most interesting illustrated address on "The Diagnosis of Renal Diseases." It was a rare treat for the general practitioner. A digest was requested for publication in the State Journal.

By way of constructive criticism it is hardly fair or courteous to invite a speaker to address the society and have the members arrive so late as to curtail the speaker's time. Why should not the hour for gathering be considered as important as an appointment for consultation or operation? The speaker arrived promptly at the hour appointed for meeting, 1.30 P. M., and yet there were not enough to form a quorum until 2 P. M. This has become a grave fault with our members. Members drive twenty miles and wait half an hour for members around the corner to arrive. It isn't fair. It destroys the morale of the society. No business man would stand for it.

There is a marked falling off of visiting delegates, and we miss them greatly. The next meeting will be held in Vineland. They are always good. You can't afford to miss it.

HUDSON COUNTY.

William Freile, M. D., Reporter.

The April 6th meeting of the society was held in the Elks' Club rooms, President B. S. Pollak in the chair.

After the transaction of regular routine business the following were elected members of the society: Drs. Francis G. Staples, William F. Hill, Alvin E. Kuhlmann, Samuel Barishow and Charles S. Hires.

President Pollack made a strong plea to the members that they show more interest in legislative matters pertaining to medicine in this State which is inimical to their interests. He said that out of a membership of 260, only 11 members went to Trenton to the hearing on the osteopathic bill, when Sussex County with about 20 members sent about 10 members.

Dr. G. K. Dickinson, president of the State Society, called upon Dr. A. A. Mutter of Arlington to state his case to the society. In brief Dr. Mutter said he had prescribed a pint of whiskey for a patient with pneumonia and five days later he was obliged to prescribe

another pint to be taken half an ounce every four hours; he was arrested under the National Prohibition Act, brought before Revenue Commission Matthews of Newark and later paroled in custody of his counsel. After discussion the case was, on motion, referred to the State Society's Judicial Council for Dr. Mutter's defense.

On motion the president appointed Drs. Quigley, Finke and Dickinson a committee to draft a resolution in relation to the use of alcohol in the treatment of disease.

Forty-nine physicians were nominated for membership in the sounty society.

The scientific program was as follows: Dr. Washburn of the Amer. Social Hygiene Asso'n, New York, spoke on "Public Health Aspect of Venereal Diseases," exhibiting two reels on modern diagnosis of syphilis. Dr. W. Frudenthal of New York addressed the society on a topic of special interest to physicians. Drs. J. A. Koppel and S. R. Woodruff discussed Dr. Washburn's paper. Dr. A. E. Jaffin presented cases of Lethargic Encephalitis.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Medical Society was held Wednesday, April 21st, 1920, at the Y. M. C. A. New Brunswick, N. J., at 4 P. M. This meeting was the best attended by the members in several months past.

The meeting was of special interest to the members. Its programme having been arranged by the New Jersey State Anti-Tuberculosis League as part of their campaign to eradicate tuberculosis and to bring before the society members a knowledge of the effort being made to accomplish this. Dr. Charles I. Silk, the Middlesex County representative of this organization gave a most instructive and interesting talk on this subject. An effort had been made by him to furnish and exhibit the United States Public Health Service films, but this proved to be impracticable at this time. A number of patients from the Amboy clinic were present and willingly consented to be examined by the members in demonstrating the various physical signs as described and explained by the speaker. Following the conclusion of the clinical demonstration of the cases, Dr. Silk explained the work of the League and the facilities at the disposal of the physicians of this State for the care of tuberculous patients in institutions maintained by the State.

The following were elected to membership on presentation of their credentials: Dr. M. H. Linden, 46 Livingston avenue, New Brunswick; Dr. Fagen, George street and Remsen avenue, New Brunswick; Dr. William London, 256 State street, Perth Amboy, and Dr. R. W. Renwick, 141 Market street, Perth Amboy.

Following Dr. Silk's address there was a lengthy and interesting discussion on the profession's welfare and the activities of the members of the recent legislature as it affected the medical profession. The stand taken by our own representatives both in the Assembly and the Senate was strongly condemned and the following resolution unanimously passed on motion: "That we, the members of the Middlesex County Medical Society, express our disapproval and condemnation of the secret propaganda that was carried on in this county in favor of breaking down the safeguards of the health of the State and its citizens and which propaganda succeeded in securing the aid of some of our prominent business men and our county representatives in the legislature to favor the legislation that we believe threatens the health and lives of our citizens."

Following the regular business meeting a delightful luncheon was served by the Y. M. C. A. Cafeteria, during which a social half hour was spent and voted by all the members most enjoyable.

UNION COUNTY.

Russell A. Shirrefs, M. D., Reporter.

A regular meeting of the Union County Medical Society was held at the Elks' Club in Elizabeth, April 14th, at 9 P. M. Dr. H. O. Mosenthal of New York was to have read a paper on "Renal Function and Its Relation to Nephritis," but on account of the railroad strike was unable to be present. In the absence of the president and vice-president and many others for the same reason, Dr. Cladek of Rahway presided over the 40 who were able to come. In addition to routine business, there was a free discussion on the subject of encephalitis. Two new members were elected and eighteen proposals for membership were received.

Other Medical Societies.

Summit Medical Society.

William J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, April 30, at 8.30 P. M., Dr. Smalley entertaining and Dr. Morris in the chair. Present: Drs. Bebout, Baker, Campbell, Embury, English, Falvello, Kay, Keeney, Lamson, Morris, Prout, Reiter, Smalley, Tator, Tidaback and Wolfe; and Drs. Lathrope, Douglass, Mills, Lewis and Larson of Morristown, and Drs. Noe and Meeker of Summit as guests.

The paper of the evening was read by Dr. George H. Lathrope of Morristown, on "Clinical Aspects of Fatigue."

Fatigue, like pain, is a conservative symptom, and may be physiological or pathological. The two main causes of physiological fatigue are an inadequate supply of muscle glycogen and an excess of sarco-lactic acid and other metabolic products in the muscles, nerve tissue being incapable of fatigue. Pathological fatigue is found in the prodromal malaise of acute infections, and may be one of the chief symptoms in such conditions as chronic infections (carious teeth, diseased tonsils, tuberculosis, etc.), in which it is an anaphylactic phenomenon. It occurs in endocrinopathies (Addison's disease, thyroid conditions, etc.), psychiatric states, cardio-vascular-renal diseases, and in other miscellaneous diseases such as diabetes, anemia, neoplasms, etc.

The paper was discussed by Drs. Prout, Lamson, English and Bowles. Adjourned after refreshments.

New Jersey Health Officers' Association.

This association met in Burlington, N. J., April 7th. Drs. J. B. Cassady, president of the Burlington Board of Health; M. W. Newcomb of Brown's Mills, president of the Anti-Tuberculosis League; W. F. Draper, surgeon in the U. S. Public Health Service, Washington, addressed the meeting on public health problems. Dr. Newcomb said that improvement of public health under prohibition will amaze the world; that the effect of absence of drink on the general health of the nation is hitting tuberculosis from two angles. In the first place, inability to get liquor, he said, will prove a blessing to the man who is especially susceptible to tuberculosis, the debilitating effect of alcohol having the tendency to decrease his power of resistance. By far the greater percentage of reduction in tuberculosis will result, however, the surgeon declared, from the fact that money spent heretofore over the bar in many cases now goes for more food and better clothing for the erstwhile drinking man's family.

Miss Margaret Haines, executive secretary of the Burlington County Anti-Tuberculosis League, gave a report on the organization's child welfare campaign. Miss Eugenia V. Dubs of Trenton told of the rapid development and practical benefits of the campaign to promote public health nursing in rural districts. Howard Eastwood of Burlington spoke on "Nuisances Affecting Public Health and Their Abatement."

Miscellaneous Items.

Special Commission to Study Health Insurance Recommended.—In a letter to the New York State Legislature Warren S. Stone, Chairman of the Social Insurance Committee of the National Civic Federation and Grand Chief of the International Brotherhood of Locomotive Engineers, recommended delay in legislation establishing a State system of health insurance until a special commission can make a study and devise a constructive plan. Similar letters were sent to the Legislatures of Massachusetts, Rhode Island, New Jersey and Virginia, in which States legislation of this character is contemplated.

Radium Therapy.—Dr. E. C. Samuel in the New Orleans Medical and Surgical Journal expresses an opinion in relation to radium therapy as follows:

"Radium offers greater hope in malignancy of the uterus than in any other part of the body. The most striking results are obtained in fibroid, but all fibroids are not amenable. Lymphosarcoma is markedly benefited. He does not find much benefit from radium treatment of malignant disease elsewhere in the body, with the exception of recurrent nodules after breast amputation."

Alcoholism Decreasing. — Frederick D. Greene, General Secretary of the United Hospital Fund, New York City, has announced that a survey of several hospitals shows a drop of from 70 to 90 per cent. in alcoholic cases, compared with last year. The City Board of Ambulance Service reports a large decrease in all cases, including intoxication. In January and February, 1919, the Board reported 412 and 364 alcoholic calls, respectively; this year the calls for the same months were 307 and 133, respectively. Bellevue Hospital figures showed 228 calls for intoxication during January and February, 1919, and a total of 31 for January and February of this year. Mr. Greene reports that 7,000 new patients a year can be accommodated at Bellevue in consequence of the reduction in the number of alcoholic patients.

Value of Vaccines and Antitoxins.—We have recently had the merits of vaccines and antitoxins set before us. With the exception of typhoid vaccines, tetanus and diphtheria antitoxin there may be a wide difference of opinion as to their value. The merits of E. R. Squibb and Sons laboratories are established. We have just finished reading an elaborate discussion by Professor Nolf of Paris in the La Presse Medical on Intravenus Injections of Peptone in Infectious Diseases with equal or better results than the use of mixed or so-called specific vaccines.

Medicine and the Laws of Moses.

Sir James Cantlie, the well-known authority on tropical diseases, speaking at St. Martin-in-the-Fields Church the other day, said that medicine rested on the law of Moses. He had never yet upset one of Moses's laws in regard to hygiene, sanitation or medical teaching. All that the scientists of today with their microscopes and textbooks did was to prove that the ancient law giver was right. There was not one page of the Bible that did not teach us a hygienic fact. A Ministry of Health had been started, and he hoped the minister in charge would see his way to take council with the church and see that they worked hand in hand, otherwise the department would come to grief. He had hitherto been trying to cure disease instead of preventing it as Moses did. Nowadays it was considered bad manners to speak of fleas or other disease carrying insects, but in ancient times every woman had the instinct to know the danger. Recently, we had been on the top of a volcano in regard to a possible plague epidemic, but it was being kept down, and every day rats caught at the docks were examined for the disease bacillus. Twenty-six years ago when he was a doctor at Hong Kong, there was an epidemic of bubonic plague, and he and others searched the Encyclopedia Britannica for information. Then a clergyman came to him and asked that he would read the fourth, fifth and sixth chapters of the Book of Samuel, where five forms of swellings and three golden images of rats were described as being offered to the God of Israel. "That's the cause of your plague, these rats," said the clergyman, and on that basis the medical authorities went to work. Tropical medicine came in only twenty years ago, but if we had read our Bible we would have known all about it before. Our wrong use of milk was the cause of indigestion and bad teeth. Moses laid down the salutary law that milk should not be drunk until at least two hours after eating fish, three after chicken, and four after meat, but we disregarded this and gave milk at meals.—N. Y. Med. Jour. London Letter.

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MAY, 1920

154th ANNUAL MEETING

of the

Medical Society of New Jersey

will be held in the

NEW MONMOUTH HOTEL

SPRING LAKE

June 15, 16 and 17, 1920

Board of Trustees' Meeting in the Hotel, Monday evening, June 14th, at 8.30 o'clock.

First Meeting of the Society—House of Delegates—Tuesday morning at 10.30 o'clock. Closing meeting Thursday noon. Other meetings as announced on Program, which will be sent to members about June 1st.

Dr. G. N. J. Sommer, Chairman of the Committee on Scientific Work, announces the following Orations, Addresses and Papers to be presented at the Annual Meeting:

Address of the President, Dr. Gordon K. Dickinson, Jersey City.

Address of the Third Vice-President, Dr. James Hunter Jr., Westville.

Oration in Surgery, Dr. William L. Estes, South Bethlehem, Pa.

Oration in Medicine, Dr. W. Blair Stewart, Atlantic City.

"Heart Irregularities; Their Clinical Recognition and Interpretation," Dr. Charles E. Teeter, Newark.

"Obesity," Dr. Fred C. Horsford, Newark.

"Co-operation of the Specialist and the Family Physician," Dr. Linn Emerson, Orange.

"Pulmonary Tuberculosis and Conditions Simulating the Same," Dr. Samuel B. English, Glen Gardner.

"Gastrospasm and Its Diagnostic Symptoms," Dr. Jacob Roemer, Paterson.

"Arthroplasty," with presentation of cases, Dr. George H. Sexsmith, Bayonne.

"Physical Diagnosis in Obstetrics," Dr. John F. Condon, Newark.

"Diverticulitis of the Colon with Special Reference to the Cecum," Dr. Martin W. Reddan, Trenton.

"Problems of Venereal Control," Dr. H. J. F. Wallhauser, Newark.

"Cerebro-Spinal Fluid; Its Changes in Various Diseases and the Symptoms," Dr. Ernest G. Hummell, Camden.

"The Causes of High Mortality in Intestinal Obstruction," Dr. Damon M. Pfeiffer, Philadelphia, Pa.

"Essential Uterine Hemorrhage," Dr. William A. Dwyer, Paterson.

"A Study of the Acute Infections of the Ear as Seen by the Physician," Dr. Clarence J. Keeler, Philadelphia, Pa.

"Etiology and Treatment of Mental Disease, with Special Reference to the General Practitioner's Duty in Prophylactic Work," Dr. Henry A. Cotton, Trenton.

"The Hospital, the Doctor and the Dentist," Dr. Fletcher F. Carman, Montclair.

"Focal Infections in Relation to Eye Diseases, Dr. William D. Olmstead, Trenton.

THE LEGISLATURE.

The New Jersey Legislature, we are thankful to say, has adjourned and may its like never again convene. We cannot fully report and characterize its proceedings as affecting the standards of the medical profession and the welfare of the public. We will spend the next few weeks—as we urge all our readers to do—in careful study of the actions, methods and motives of the men who brought discredit on the State and harm to the sacred health and life interests of the State and its citizens. After such caretors. The result was that the osteopathic

ful investigation we shall all come up to the annual meeting of our State Society in June prepared to discuss the situation and adopt some measures calculated to arouse the public to the dangers that threaten us by the conscienceless activities of scheming politicians and demagogues, who in order to secure position gain and power through vicious legislation, are willing to sacrifice measures that tend to safeguard the health and moral conditions of the public.

It passes comprehension how men who have been rated as honorable and conscientious citizens, when elected as legislators can descend to the questionable and often dishonorable practices of the low grade politician, yielding to secret propaganda that secures their pledge to vote for bad bills before they are considered by or even introduced in the legislative sessions and often without reading their contents; then log-rolling in voting on bills or absenting themselves from the session when the vote is to be taken because of cowardice or fear of their defeat at the next election. When health conditions are involved, as in the chiropractic, osteopathic and anti-vaccination bills, ought not such men to be held responsible morally, if not legally, for the sickness, suffering and deaths of the citizens of the State which the enactment of such laws would cause? The prominent business men who joined in the propaganda carried on by the chiropractors and others, by writing to legislators soliciting their votes for such bills, are partly responsible for the results and we believe the Governor of the State is not free from responsibility when he fails to veto such bills, as we had reason to believe he would in the case of the chiropractic bill. We should call the attention of careless, super-serviceable business men and others who thoughtlessly sign petitions in favor of medical laws of the contents of which they are ignorant and of the possible evil consequences of which they are not capable of judging, to the following facts:

Article 1, Sec. 1 of the Chiropractic Bill which was passed by the Legislature and signed by the Governor, says:

"The term Chiropractic when used in this act shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationship between all attributes necessary to normal composite forms to harmonious quantities and qualities by placing in juxta-position the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have now assumed their normal size and capacity for conduction as they emanate through intervertebral foramina—the expressions of which were formerly excessive or partially lacking—named disease."

The above description of "chiropractic" is perfect nonsense, and is, as the Essex County Bulletin says—"an insult to ordinary intelligence." The other provisions of the bill gives them a separate board of examiners with plenary powers of licensing and supervising the practice of its licentiates who are not held amenable to the requirements of existing laws for qualifications and character which the State has heretofore found necessary to protect the people from charlatans and quacks, and which licentiates are to rank as fully qualified to handle any problems of sickness or public hygiene.

As has often been well said, "The opposition of scientific medicine to this law is not based on prejudice for or against any kind of treatment of disease, and certainly not on the regular physician's financial interests, but on the welfare of the people at large, in maintaining standards of qualification for license. The progress of medicine, indeed, is such that widest range of resources makes it broad and not exclusive." Anyone duly qualified has every privilege of license and practice. The public trusts the State's license in the important matters of health. This chiropractic bill destroys with one fell stroke the structure of licensing so long and laboriously upbuilt by the State. During its consideration in the Legislature, the constituted medical boards and members of the medical profession requesting a public hearing were denied it and were utterly ignored.

When the medical men of the State were later granted a hearing by the Senate committee on the osteopathic bill, they had no trouble in convincing the committee that it was inimical to the public's welfare, though the osteopaths brought to that hearing their expert witnesses from Boston, Chicago and Philadelphia. The lack of educational qualification was the main objection in that

case, as it was in that of the chiropractic bill was never again considered by the Senate. The Anti-Vaccination bill met with a similar fate. The legislators evidently did not dare to pass, or even consider another bad bill—the imported German Compulsory Health Insurance Bill—which would drag down the scientific standing and efficiency of the medical profession and would prove inimical to the health interest of the State and to the laboring classes especially whom it falsely was claimed to benefit.

The large number of Original Articles recently received compels us to defer insertion of some to later issues of our Journal and also to omit other matter prepared for this issue. The Editor returns thanks to Prof. H. A. Kelly of Johns Hopkins University for prompt response to our request for a paper on Radium which, in the midst of exacting duties, he has **taken time** to prepare. We express our own, as we know we do our readers, appreciation of his valuable contribution to our knowledge on this important subject.

Next month we hope to give the splendid paper of Prof. H. P. DeForest of New York on "Raymond's Disease," illustrated, read at our last annual meeting.

LEGISLATIVE BULLETIN NO. 3.

Report of Mr. J. H. Gunn, to the Welfare Committee of the Medical Society of New Jersey, April 16, 1920.

"Chiros" Dominated the Legislators.

The "Chiro" group of legislators, backed up the "Chiro" lobby, reigned supreme as far as medical legislation was concerned in the New Jersey legislative session which practically came to a close yesterday. This group was not only able to pass the very vicious Chiropractic law, which was also signed by the Governor, but was able to defeat the efforts of the medical profession to restore the educational safeguards, which the "Chiro" bill broke down, and which were provided for in the Senate Bill 209. This latter means it would require all who practice the art of healing to obtain a license from the State Medical Board.

Defeat of Senate 209.—Senate Bill 209 came up for final consideration in the Senate Wednesday afternoon, April 14. Arguments for the measure were presented by Senator Haines of Camden, chairman of the Health Committee of the Senate, and sponsor of the bill and Senator Barber of Warren, a physician. Senator Mackay of Bergen, the leader of the "Chiro" group, endeavored to amend the bill by unanimous consent, so as to exclude the "Chiros" from its provisions, but Senator Haines upon the advice of the medical profession refused to accede to the request.

Senators Mackay, Simpson of Hudson and Heath of Mercer, attacked the bill. Mackay was especially critical of the physicians for what he termed their attack on the Chiropractors. Senator Simpson said his objection to the bill was that it would hamper the work of religious sects in practicing healing. Senator Heath declared that the "Chiro" and other drugless healers should be under a board of their own and not under the Medical Board. He said the "Chiro" law recently enacted was a step in the right direction, and hoped to see it prevail.

Vote on the Bill.—The vote on Senate 209 was seven for and three against. Eleven votes are necessary for passage.

The Physicians' Friends.—The Senators who voted for 209 and who should receive the thanks of the medical profession, are as follows: Haines, Camden; Barber, Warren; Pilgrim, Essex; Reeves, Cumberland; Runyon, Union; Sturgess, Gloucester; Charles D. White, Atlantic. Total, 7.

Opponents of the Physicians.—Mackay, Bergen, author of the "Chiro" bill, critic of medical profession on general principals. Chief advocate of "Chiros" in Legislature, and man who directed "Chiro" fight for new bill and against Senate 209.

Simpson, Hudson, has been friend of "Chiros" during his legislative career. Spoke and voted for "Chiro" bill when a member of the Assembly.

Heath, Mercer. New Senator, serving his first term. Firm believer in a separate board for "drugless" practitioners. Takes the stand that medical physicians should have nothing to say regarding the control of others who practice the healing art. Believes "Chiros" "should be given a chance. They treat only trifling ailments."

Senators who either refused to vote on 209, or who absented themselves from the Senate during discussion and vote on bill:

Allen, Salem, Republican leader. Absent from Senate during consideration of 209. Said he had given his promise not to vote for the bill. Voted for original "Chiro" measure. In original "Chiro" group.

Brown, Middlesex, Democratic leader. Absent from the Senate Chamber during consideration of 209. Voted for original "Chiro" bill. First promised to cast the eleventh vote for 209 if ten others were obtained. Later said he would think the matter over and listen to the debate. One of "Chiro" group.

Bright, Cape May. Voted for original "Chiro" bill. Always stood against Senate 209. One of "Chiro" group. Has seat alongside of Mackay in Senate.

Case, Somerset (President of Senate). Stood on the rostrum during two roll calls, didn't vote. Would never commit himself on 209.

Hagaman, Ocean. Said he had promised not to vote for 209, because he was under obligations to his opponents. Absented himself from Senate during consideration of bill. Voted for original "Chiro" bill. One of the "Chiro" group

Kays, Sussex. Sat in his seat and didn't vote. Said he saw nothing against the bill, and declared before hand, that "he would probably vote for 209." Voted for original "Chiro" bill. In "Chiro" group.

Martens, Hunterdon. Was against Senate

209 always. Would give no reasons. Voted for original "Chiro" bill. Sat in his seat and didn't vote on 209. In "Chiro" group.

Smith, Passaic, friend of the "Chiros." Voted for original "Chiro" Bill. Thinks "Chiros" "should have a chance." Sat in his seat and didn't vote on 209. In "Chiro" group.

Stevens, Monmouth. Originally thought to have been friend of physicians. When asked to support Senate 209, said he "would look up this bill and think the matter over." Canvassed several times, is said to have promised his support to bill. Voted for "Chiro" law.

White, H. Blanchard, Burlington. Promised to vote for Senate 209. Voted for original "Chiro" bill. Absented himself from Senate Chamber during consideration of 209. Considered in original "Chiro" group.

Whitney, Morris. Voted for original "Chiro" bill. Promised to vote for Senate 209. Sat in his seat and didn't vote on 209.

Warning.—Don't be deluded by the Senator who says, "I didn't vote either way." No vote is a vote against, as a majority of the whole is necessary for the passage of any bill.

Warning No. 2.—Absenting oneself from the Senate Chamber is an old ruse to escape voting on a measure.

New York Chamber of Commerce Opposes Compulsory Health Insurance.

The New York Chamber of Commerce at a regular meeting held April 1 unanimously adopted a report presented by its committee on insurance, opposing the bill introduced by Senator Davenport providing for compulsory state health insurance. The committee recommended, a year ago, that a commission be created to make a comprehensive study of health insurance on behalf of the state. This recommendation was not followed. Further study of the subject has convinced the committee that compulsory health insurance attacks the problems involved from the wrong point of view and is economically unsound and unwise. In support of this conclusion the committee submits nineteen general statements, from which we quote:

It is opposed to sound public policy in a democracy, in fostering objectionable class distinctions and a dangerous tendency toward a stratification of industrial society.

It is opposed to public policy in favoring a further encroachment on private rights and privileges, including the most personal concerns of the individual, and the supervision, control and direction of the person in matters of health and welfare.

It is a danger to democracy, in that the promises made are impossible of fulfilment, and on this ground will ultimately create an unwholesome industrial unrest.

It is a delusion in that the poorest poor, who are most urgently in need of sympathetic medical and financial support and assistance, are largely if not wholly outside the sphere of social insurance activities of any and every kind.

Such demand for compulsory health insurance as exists has been artificially created by a skilful propaganda.

It is at best a palliative, and does not reach the seat of the difficulty.

It does not promote the health of the individual, but rather fosters a tendency toward malingering and an undue prolongation of minor ailments for the purpose of wrongful gain.

Experience in other countries shows that medical treatment under its rules results in a standardized method of mediocre practice—the doctor who gives his whole time to the service reduces his profession to a mere trade; the doctor who gives only part of his time to the practice is bound to give it indifferent attention.

Experience abroad has also shown that medical practice under this system tends strongly toward a system of public medicine, opinion being divided as to whether under such a system private practice should be allowed at all, or whether the system should be universal; in other words, whether the doctor should become a state employee, leaving private practice and the work of the specialists to the few who are unwilling to submit themselves to state control.

All the estimates in England have been more or less at variance with actual experience. The state contribution has been very much greater than had been assumed would be necessary at the outset.

Compulsory health insurance is an elaborate bureaucratic scheme which controls wage-earners' lives and wage-earners' incomes. The hope held out that the institution to be created will be thoroughly democratic and, apart from the overhead charges, self-sustaining, never has been and probably never will be realized. Control of essentials soon passes into the hands of the state authorities, with a corresponding increase in the power of bureaucracy.

Adjourned.

From the Newark Evening News.

The best thing the Legislature did during its whole session was to adjourn and kill all of the pending bills except the appropriations and bridge and tunnel bond measures, which are to be acted upon next Wednesday. Not a single bit of constructive legislation has been made effective during the session unless one would so characterize the 3.50 beer bill and the ratification of the woman suffrage amendment. The trend has rather been reactionary—recklessly so.

Unless Governor Edwards vetoes the blanket election bill, with its vicious party column ballot provision, and the veto is not overridden, no one will know the complications that may result in the coming primaries and elections. The men who passed the bill were in ignorance of its provisions with the exception that they knew it was intended to prevent as much as possible independent voting and to give the party machines an undue advantage.

The jitney bill, which was an unfair measure, was lost only by a fluke at the last moment. The intention was to put the buses out of business rather than regulate them, but its failure does not relieve its sponsors and supporters of the responsibility they assumed. The bill for a special commission to value the property of the utility corporations was finally jammed through, but it is to be hoped that it will meet with the disapproval of the Governor, for it offers no safeguards for the public

interests in the making of rates. Highway legislation also failed, and as the last of the bills affecting this important branch of the state's business went down to defeat, it was revealed on the floor of the House that Governor Edwards and State Controller Bugbee had conferred for the purpose of reaching an agreement for the bi-partizan distribution of the spoils of the proposed new State Highway Commission.

"Deals" have been notorious during the session. Logrolling has been the prevailing method of pushing through measures that could not otherwise have had a ghost of a show with honest representatives of the people.

Three Bad Bills.

The New York Legislature has now under consideration three bills relating to the medical profession in this state, and three worse bills could hardly be conceived of. One of these is the revived Davenport bill for compulsory health insurance. It is unnecessary to review that, for the profession in this state is now familiar with its chief features and has condemned it with practical unanimity. It legalizes the worst features of the old lodge practice, and all that it insures is, in general, poorer treatment of the sick wage-earner than is now at his command with or without fee.

The second of these vicious bills is that known as the Gibbs bill, which purports to provide a greater degree of narcotic drug control than is now afforded by the national and state drug laws. An ordinary man's house is his castle and cannot be broken into without a warrant except in an emergency, to prevent crime or to capture a criminal, but under this bill a doctor's house can be entered at will by the commissioner of narcotic drug control who may, if he wishes, delegate this task to one of his deputies or inspectors. And when the house has been forcibly entered the inspector may pry into every bureau drawer or private desk on the bare suspicion that a morphine tablet may be lying around somewhere.

The third attempted invasion of the physician's rights is provided for in the Kenyon medical license bill, which calls for annual licensing after examination of the doctor's credentials, filing of his photograph, and payment of a $2 fee. Without all this verations and humiliating tomfoolery the practitioner of twenty or thirty years' standing will be put on an equality with the advertising venereal quack, or the unlicensed beauty doctor.

With the physician being forbidden to prescribe a necessary drug until he has done enough paper work to gladden the heart of an army surgeon, and broken the law by revealing professional secrets; being restricted to the dose of an ounce and a half of brandy a day in a case of prolonged sepsis or pneumonia; being liable to the invasion of his house by a drug commissioner's deputy who may without reason suspect him of hoarding morphine; and being forced to buy each year the privilege earned decades ago of practising his one-time honorable profession, the doctor's rights to life, liberty, and the pursuit of happiness seem to be not altogether unalienable.—Med. Rec.

"That life is long that answer life's great end."

Therapeutic Notes.

Basedow's Disease.

Dr. W. H. Foreman, in the Indianapolis Medical Journal, cites a case of early Basedow's disease in which the symptom of vomiting brought the patient to the hospital. Treatment was directed against the hyperthyroidism, but it should be remembered that this condition is often superimposed on an unstable nervous system, and, if the cardiospasm has persisted to the point of hyperplasia and hypertrophy of the cardia, frequent and complete dilatation of the cardia are necessary for the relief of the symptoms. Quiet and rest in bed, with plenty of fresh air and a nourishing diet of liquids and soft foods, with frequent feedings and small amounts at a time, are recommended. Bromides to quiet the nervous symptoms, with quinine and hydrobromide and ergotine for the effect upon the thyroid gland, were used with benefit in the case cited. Where the toxicosis affects the accelerators more than the vagus, as in the case reported, digitalis does little good.

The use of quinine and ergotine is empirical, but he has found from clinical experience that these agents are of value in reducing the goiter, and in reducing or modifying the secretion, modifying or relieving the symptoms. He has used to advantage the following thyrotoxic goiter tablets recommended by Crotti:

Sodium arsenate, 0.001 gram.
Sodium phosphate, 0.12 gram.
Salol, 0.10 gram.
Sodium bromide, 0.05 gram.
Calcium oxalate, 0.05 gram.

In conjunction with these tablets polyglandular tabulets are used to counterbalance disorders in the respective glands. These consist of the following:

Pituitary gland (desiccated), 0.05 gram.
Suprarenal gland (desiccated), 0.05 gram.
Pancreas (desiccated), 0.05 gram.
Corpora lutea (desiccated, 0.05 gram.

Influenza—Eliminative Treatment.

Dr. George L. Servoss, Reno, Nev., directed his efforts toward the prompt removal of the toxemia. He endeavored to increase skin, kidney, and bowel action, and to induce a higher vapory elimination from the air passages. He and his associates pushed stimulants of elimination to the utmost limit, and saw their patients recover promptly, none of them showing any complication whatsoever.

The treatment, which he considers the logical method of dealing with influenza, is as follows: After ordering a small dose of calomel, 1/6 grain every half hour or so, until a gram is taken, begin with

Potassium iodide, grs. 10
Liquor potass. cit. U.S.P., oz. 4.

M. Sig.: For the first 24 to 48 hours, one tablespoonful in a glass of water every hour. Thereafter,one teaspoonful in half a glass of water, every two hours on the odd hour.

After the bowels have been moved by the calomel, or the morning of the second day, the following is added to the treatment:

Corrosive sublimate, gr. 1.
Syrup wild cherry, oz. 4.

M. Sig.: One teaspoonful should be given in

half a glass of water every two hours on the even hour.

By pushing the first mentioned mixture to the utmost during the first 24 to 48 hours, that being based upon the sort of toxemia to be dealt with, the elimination becomes very thoroughly established. The calomel has stimulated the glandular action and this is further carried on by the second mixture. As a rule these are the only remedies which the writer employs in the average case of influenza, for he has found that, within 24 to 48 hours, there has been a marked change for the better, and at the end of four days the majority of his patients have expressed a desire to be up and about their business. If there is a high degree of toxemia it is sometimes well to raise the opsonic index through the use of some mixed infection vaccine.—Indianapolis Medical Journal.

Gonorrhea—Internal Medication.

Dr. Arthur H. Crosbie of Boston, in a discussion of the treatment of gonorrhea in the male, says, with reference to internal medication, that after trying out many things he has come down to two simple old remedies. He uses sandalwood oil capsules, three times a day after meals, and before meals a teaspoonful of a mixture of

Tincture hyoscyamus, ℥viss.
Potassium citrate, ℥v.
Water up to ℥iv.

The hyoscyamus, he says, is excellent to prevent chordee. If chordee is present he gives a fourth of a teaspoonful at bedtime. The potassium citrate helps to render the urine bland. He considers water under internal medication, because he feels that a large amount of water is more important than any other thing. Enough water should be taken so that the urine almost entirely loses its color. The patient should be instructed to drink at least a glass of water every hour during the day. This will render the urine bland and keep the discharge frequently washed out.—Boston Medical and Surgical Journal.

Ringworm of the Scalp.

Iodine, ʒi.
Rectified oil of tar, ʒj.

Mt. et ft. pasta. Sig.: Apply every six or seven days, washing the scalp with mixture of green soap before removing the application. —Coster.

Dysenteric Abscess of the Liver Cured by Emetine Without Operation.—About ten cases of this remarkable therapeutic success have now been recorded, which almost places emetine at the head of specific remedies. The latest case to go on record is that of Chauffard and Francon. Diagnosis was made by puncture and radiography and even after the first injection of emetine improvement was noted. About three weeks were required for a complete cure. Of interest was an aberrant Wassermann, not due to syphilis, but to the amebiasis and abscess. This became negative in about a fortnight. Five injections of emetine were required for a cure.—La Presse Medicale.

Hospitals; Sanatoria.

The Atlantic County Hospital has increased the Board for tubercular patients from $16.50 to $20.

Bridgeton Hospital.

The year 1919-20 was the busiest year in the hospital's history; there were 601 patients admitted, an excess of 74 over any previous year.

The number of medical cases admitted was 213. Of these, fifty-three were free, sixty-seven pay ward, and ninety-three private room cases. The number of surgical cases admitted was 388. Of these, fifty-three were free, 123 pay ward, and 212 private room cases. There were 366 operations during the past year. The total number of deaths was forty-five. Of these twenty-seven were medical and eighteen were surgical cases. There were thirty-four births and of these four were Cesarian section.

The total receipts from the patients for the year amounted to $17,116.45. Dr. W. P. Glendon, president of the staff, reports that the demands have far exceeded its capacity.

Elizabeth General Hospital.

The fortieth annual report of this hospital has recently been issued. It is for the year 1919. It shows the following facts: In the hospital Dec. 31, 1918, were 98 patients; admitted to wards in 1919, 2,375; admitted to private rooms, 1,001; total, 3,472 patients treated. Births, 273. Percentage of deaths, including all cases treated, 5½%. Average cost per day per patient, $1.37; average cost of maintenance per day per patient, $2.53; Discharged from the hospital: Cured, 2,267; improved, 904; died, 198.

Dr. Norton L. Wilson is president of the medical and surgical staff; Dr. J. S. Green, vice-president, and Dr. P. D. Bunting, secretary.

Muhlenberg Hospital, Plainfield.

The forty-first annual report—for the year 1918—has recently been issued. It shows the following: 2,521 patients were admitted during the year; 1,363 were operated on; there were 220 births. The cases treated in the wards and private rooms were: medical 524; surgical, 928; obstetrical, including babies, 558; eye, ear, nose and throat, 525; contagious 61. Patients discharged: recovered, 1,862; improved, 391; unimproved, 78; died, 175. Daily average cost per patient, $2.96. The hospital received no pay for 55 per cent. of in-patients treated. In the dispensary, 1,492 patients were treated.

Dr. William H. Murray is medical director; Dr. M. L. Clawson, secretary; Dr. B. V. D. Hedges, treasurer.

Mountainside Hospital Training School.

Ten young women graduated from this training school on the evening of April 29th. Rev. Warren Rogers of Jersey City delivered the address.

Monmouth Memorial Hospital Training School.

Seventeen nurses graduated from this school on the evening of April 10th. An address was

delivered by Uzal H. McCarter of Newark; Dr. Edwin Field of Red Bank gave the nurses their diplomas and Mrs. Scott, the superintendent, distributed the pins.

Bonnie Burn Sanatorium.

Dr. John H. Runnells, superintendent of the sanatorium, reports that on March 1st there were 196 patients present in the Sanatorium, 112 males and 84 females. This number includes 24 males and 37 females in the preventorium. During the month 35 patients have been admitted, 18 males and 17 females. Thirteen of these admissions went to the preventorium. Among these admissions there were four re-admissions. The admissions are classified as follows: Pretubercular, 13; incipient, 3; moderately advanced, 4; far advanced, 13; doubtful tuberculosis, 2. The largest number of patients present at any time during the month was 204, smallest number 194, present March 31, 204.

Hospital Ventilation.—A highly successful hospital superintendent attributes a great amount of his success to the fact that he has made a study of, and has been able to recommend and put into operation, a plan for the systematic ventilation of hospitals of which he has had charge, and this arrangement has been so satisfactory that doctors give his hospital preference wherever possible. He has found, he says, that the condition of the air has more to do with the health of the patients than most of us have any idea of, and that instead of mechanical equipment rightly installed proving an expensive proposition, it is in reality a most economical method.—C. A. Eddy: Hospital Management.

Marriage.

COLE-KERR.—In New York City, April 16, 1920, Dr. Blaise Cole of Newton, N. J., to Miss Betty V. Kerr of New York City.

Deaths.

CLARKE.—In Lyndhurst, N. J., April 12, 1920, Dr. John William Clarke, aged fifty-three years. Further notice hereafter.

REED.—In Atlantic City, March 20, 1920, Dr. Talbot C. Reed, aged 47 years.

Dr. Reed was the son of Dr. Edward Reed, the resort's first druggist. He was recently elected health officer of the city for a term of three years. He took an active part in matters pertaining to his profession. He was a member of the American Public Health Association, American Medical Association, New Jersey Medical Society, Atlantic County Medical Society, Hotel Men's Association, Chamber of Commerce, State Sanitary Association, a director of the Atlantic City Yacht Club, a director of the Visiting Nurses' Association, Atlantic City Boy Scout Council, U. of P. Alumni, secretary of the First Ward Union League, and various other organizations. See action of Atlantic County Society in report of that society's April meeting.

McWILLIAMS.—In New York City, April 11, 1920, Mrs. Annie V. McWilliams, wife of Dr. John F. McWilliams of Somerville, N. J.

Personal Notes.

Dr. William H. Axford, Bayonne, and wife have gone to their farm at Chester, N. J., for the summer.

Dr. Raymond D. Baker, Summit, who left there last year, has returned to Summit and occupies the Thomas house recently bought by Dr. Bowles.

Dr. Josiah Meigh, Bernardsville, and wife spent two weeks in Washington, D. C., last month.

Dr. Fred H. Morrison, Newton, formerly of the Paterson General Hospital, has opened the office formerly occupied by his father, Dr. Ephraim Morrison, who died last year.

Dr. Charles M. Williams, Washington, is convalescing from a severe illness.

Dr. Blaise Cole, Newton, spent a few days last month at Atlantic City.

Dr. James M. Reese, Phillipsburg, was presented with a Past Grand Tall Cedar's jewel at the 13th anniversary of the Tall Cedars of Lebanon.

Dr. Norton L. Wilson, Elizabeth, has resigned as a member of the board of governors of the Bonnie Burn Sanatorium.

Dr. Isaac Barber, Phillipsburg, brother of Senator Barber of Warren, has been appointed by the Governor and confirmed by the Senate as a member of the State Board of Taxes and Assessment.

Dr. Edward O. Cyphers, Belleville, spent two weeks last month in Washington, N. J.

Dr. Clarence A. Hofer, Metuchen, was operated on at a Philadelphia Hospital last month for appendicitis complicated with gall bladder disease. He is recovering.

Dr. Frederick W. Owen, Morristown, has been elected secretary of the Memorial Day association of that city.

Drs. Charles B. Smith and C. M. Williams, Washington, are recovering from severe illnesses. Their sickness has caused a serious scarcity of physicians in that section which includes Oxford with only one physician and Asbury which has not had a resident physician for several months.

Dr. Herschel Pettit, Ocean City, has been appointed surgeon of the general claim department of the Atlantic City Railroad Company.

Dr. Morgan D. Hughes, Bloomfield, and wife recently returned from a successful fishing trip through Sussex and Warren counties.

Dr. Enos E. B. Beatty, Newton, has purchased the house in which he has recently been living in Church street.

Dr. Walter H. Reiter, Summit, has moved into his recently purchased house, 50 DeForest avenue.

Dr. George B. Emory, Newark, and wife who have been residing in Morristown for some months have purchased a house in Franklin place.

Dr. Cadwell B. Keeney, Summit, has bought a house in Summit avenue and will take possession of it in the early fall.

Dr. Theodore E. Townsend, Westwood, spent two weeks in Bermuda in March.

Medico-Legal Items.

Proof of Cause of Hernia.—The Kentucky Court of Appeals holds that proof that the insured was suffering from a hernia about as large as an egg one day, and that on the following day it had developed to the size of a half-gallon cup, causing loss of time, was insufficient to show that the enlargement was caused by external, violent, and accidental means within an accident policy; although a case might arise where the character of the injury was such that it could not have been caused in any other way than by external, violent, and accidental means.—Transylvania Ins. Co. v. Allen (Ky.) 209 S. 44.

Husband's Liability for Medical Services to Wife.—The Georgia Court of Appeals holds that upon the trial of an action against a husband for medical services rendered by the plaintiff to the defendant's wife, evidence that before the date of the services by the plaintiff the defendant left the state as a fugitive from justice, taking his wife with him, and that she later returned to the former community and lived upon land belonging to her husband, the husband still remaining away, does not necessarily demand the inference that the parties were living in a state of separation as husband and wife under such circumstances that the husband would not be liable for necessaries, such as medical services furnished by the plaintiff to the wife.—Ward v. Johnson (Ga.), 8 S. E. 405.

Expert Testimony as to Cause of Condition.—The New York Appellate Division holds that it was improper, in a personal injury action, to permit the attending physician to testify that the plaintiff's condition of edema of the legs was not due to other cause than the accident; that question being for the jury. An objection to the question, on the ground that it was improper in form and called for incompetent testimony, was held sufficiently specific to call the court's action to the fact that it was the form of the question that was being objected to.—Broderick v. Brooklyn, Q. C. & S. R. Co., 174 N. Y. Supp. 571.

Violation of Law Voiding Accident Policy.—In an action on an accident policy payable on the insured's death from bodily injuries, directly and approximately the result of and caused solely by external, violent, and accidental means, it appeared that the deceased, having possession of a hypodermic needle in violation of New York Public Health Law, Art. 11A, directed his daughter to insert it in his arm, which resulted in blood poisoning, causing his death. The New York Appellate Division held that the complaint was properly dismissed, as the word "accidental" does not contemplate an insured's deliberate act constituting a crime. The suggestion that the insured did not know the law, and did not, therefore, intend to commit a crime, was held of no consequence.—Townsend v. Commercial Travelers, etc., Acc. Assn., 177 N. Y. Supp. 68.

Public Health Items.

Orange Health Board's Report.—Health Officer O'Brien reported for March an increase in number of cases of whooping cough, measles and diphtheria, the numbers being respectively 15, 13 and 32 cases.

Newark Health Board's Report.

Total number of deaths during February, 862; death rate, 23.5 per 1,000 of population. Death causes: Influenza, 159; tuberculosis, 51; pneumonia, lobar, 138, broncho, 98; Bright's disease, 50; cancer, 29; apoplexy, 38; diphtheria, 11; congenital debility and malformation, 38; accident, 31; diarrhoeal diseases (under 5 years), 17; all other causes, 196.

Cases of diseases reported: Diphtheria, 94; pneumonia, 1,194; tuberculosis, 150; measles, 799; influenza, 5,416; gonorrhea, 59; syphilis, 47.

Care of the Eyes.—To read or stury when tired or drowsy is to strain the eyes to a dangerous degree. Avoid evening study whenever possible. If you are using your eyes by artificial light, be sure the light does not shine directly into the eyes, and try to have it come from behind and to the left side so as to avoid the harmful glare. Never sit with the gas or electric light directly in front of you. If electric light is used, the bulbs should be wholly or partly frosted. The best form of artificial illumination for the eyes is the so-called indirect system, where the light is reflected from the ceiling and walls of the room in a soft glow and where all glare is entirely hidden by an opaque shield.—W. M. Carhart, Pub. Health, Michigan.

Vaccination a Sure Weapon Against Smallpox.

Vaccination is the one sure weapon against smallpox in the confirmed judgment of every member of the Essex County Health Officers' Association, which discussed the subject at a special meeting at the Health Department building in Newark, April 16th. The high degree of effectiveness of vaccination was illustrated by D. C. Bowen, state epidemiologist. With his staff he arrived in Millville recently, at the height of a smallpox outbreak. Within a few hours after reaching the scene, the state authorities announced they would have the epidemic in check within a fortnight, and, Mr. Bowen said, they made good. There were no new cases after two weeks passed. Vaccination did it, said Mr. Bowen. First, every school child was innoculated, followed by the employees of the two large industrial plants of the town Fourteen doctors, working incessantly, completed the task in three days by which time almost every inhabitant had been vaccinated. After that, Mr. Bowen said, he was able to fix the date of the end of the outbreak, and not only that, but he actually named in advance the persons who later were stricken with the disease—those who had failed to submit to vaccination.

(Continued on page XVI.)

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RAYNAUD'S DISEASE.

A CLINICAL STUDY OF 17 ORIGINAL CASES WITH 10 ILLUSTRATIONS.*

By Henry P. de Forest, Ph. B., M.S., M.D.

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New York City.

In the preparation of this article, an attempt was made to examine thoroughly all of the accessible articles that had been written upon Raynaud's Disease in French, German, English and Italian books and periodicals. More than one hundred such articles were collected and abstracted, but in not a single one of these did there appear a portrait of Maurice Raynaud. An effort was therefore made to secure, if possible, some likeness which would give us an idea of the man himself. A considerable correspondence was conducted with various libraries and medical schools here and abroad without avail. Then a personal friend, Mr. Charles Carrington, the well-known book dealer of Paris, was asked to co-operate in this attempt. Mr. Carrington has suffered severely as a result of the war. He is in feeble health and his eyesight has failed, but his determination to succeed was as strong as ever. He finally learned that Madame Raynaud was still living near Paris and to her residence he was taken under the guidance of his secretary. The result far exceeded his expectations, for not only did Madame Raynaud write an interesting biography of her husband, but sent to the writer, the photograph taken of Maurice Raynaud in the year 1880 shortly before his death. This, the first published photograph of this gifted man, she sends to her American medical friends with the hope that it will give an added personal interest to the article which the writer has prepared.

To Madame Raynaud and to our mutual friend, Mr. Charles Carrington, the writer takes this opportunity of expressing his thanks on behalf of himself and on behalf of the members of the Medical Society of New Jersey.

This correspondence continued over a period of some months before success was finally secured and will explain the delay in the publication of the manuscript.

Biography. — Auguste Maurice Raynaud, or Maurice as he is usually called, was born July 5, 1834, in Paris. He was the son of Jacques Auguste Raynaud, formerly Professor in the Lycée Bona parte at that time the Bourbon College and later the Lycée Condorcet, and at the close of his career the Rector of the Academy at Nevers. His father married Anne Felicité Marine Vernois, a sister of the famous French surgeon Vernois, who died in 1877. Maurice Raynaud from his early youth was distinguished by his intelligence, his diligence, his fine character and open and generous nature. His studies from year to year were crowned with success. He participated regularly in competitive tests and in 1852 in open competition was selected as one of the six successful appointees from all of the colleges and Lycées of France. In 1858 he wrote an interesting study upon the philosophical works of Flourens. At this time he had already begun the study of medicine and in 1862 was a candidate for the degree of Doctor of Medicine and also for the degree of Doctor of Literature. For the latter degree he prepared two theses. The first of these was in

*Read at the 153rd Annual Meeting of the Medical Society of New Jersey, at Spring Lake, N. J., on Wednesday, June 25, 1919.

Latin, "De Asclepiade Bithyno, Medico ac Philosopho"; the other represented a considerable amount of original investigation in the history of medicine and was entitled "Les Médecins au Temps de Molière."

Of much greater import to the members of our own profession was the thesis which he prepared for his Medical Degree, "De l'Asphyxie Locale et de la Gangrène Symétrique des Extrémitiés." This thesis was truly a classic. The subject was absolutely new and as the years have passed, it has served to link firmly the author's name to the disease which he so carefully described.

Raynaud at this time was less than thirty years of age, but the unusual excellence of these initial efforts was so great, that his continued and rapid progress in his profession was assured. He received a fellowship in 1863. In 1865 in a public competition he won the position of "Agrégé" or assistant professor in the university. From this time onward his activities were many and the various articles which he contributed to medical literature were of permanent value. He was one of the first to investigate the question of preventive and therapeutic serums by experiments with the blood of heifers inoculated for cow-pox. He was made an officer of the Legion of Honor in 1871 and was elected a member of the Academy of Medicine in 1879. His clinical teaching at the Hôtel Dieu added to his reputation and attracted many pupils. In 1881 he was elected to read a paper entitled "Skepticism in Medicine" at the International Medical Congress in London.

This paper he was destined not to read for on the 29th of June, 1881, while in his country home in apparently his usual good health, he was suddenly seized with violent pain about the heart and in three hours he was dead.

His funeral took place on the 2nd of July, 1881, and the published eulogies delivered on that occasion by representatives of the French Academy of Medicine, of the University of Paris, of his associates on the teaching staff and even of his hospital internes, show a universal appreciation of his many talents as a learned physician and a warm affection for Raynaud as a man.

It rarely happens in our profession that a young physician at the threshold of his career, makes such accurate observations as to the causes, the symptoms and the clinical history of a disease hitherto unobserved, that this original description, after a lapse of fifty years, still remains the best treatise upon the disease in question. Such an unusual distinction may be properly accorded to Auguste Maurice Raynaud, from whose thesis, written in 1862, we quote the following paragraph:

"Je me propose, de démontrer, qu'il existe une variété de gangrène seche, affectant les extrémités, qu'il est impossible, d'expliquer par une obliteration vasculaire; variété characterisée sur tout par une remarquable tendance a la symétrie, en sorte qu'ly affecte toujours des parties similiaires, lex deux membres supérieures ou inférieures ou les quatres à la fois, plus, dans certains cas, le nex et les oreilles et chercherai a prouver, que cette espéce de gangrène a sa cause dans un vice d'innervation des vaisseaux capillaires."*

*Translation.—"I propose to show that there exists a variety of dry gangrene affecting the extremities which is impossible to explain upon the basis of vascular obliteration; a variety characterized especially by a remarkable tendency to symmetry since it always affects similar portions of the body, the two upper extremities, the two lower extremities, or all four at the same time. In certain instances the nose and the ears are also affected. I shall seek to prove that this kind of gangrene has at its cause, a disturbance of the innervation of the capillary blood vessels."

Historical.—With this brief but suggestive outline of Maurice Raynaud, the man, let us still more briefly consider some of the earlier recorded facts relative to the disease which bears his name. Appendicitis and duodenal ulcer had occurred for centuries before McBurney and Moynihan described their symptoms and surgical treatment. In the same way, the disease which Raynaud described had been observed many years before. Monro narrates that Lachmond (1676) has preserved for us a narrative of a curious case met with by Bernhard Schrader when the latter, as a student of surgery, was travelling in 1629 with his brother John and a companion named Alexander Lax. The three put up at an inn in a place called Geest, and there they found that the daughter of their host, a girl of twenty-three, suffered every month from considerable pain in her fingers and toes

and in the tips of her ears and nose. There was also an edematous swelling of the hands, feet and face, whereupon there followed, shortly before and after full moon, mortification of the parts, so that the ends of these, having become white and dry, dropped off in little pieces, without feeling, pain, moisture or bad odour. That which survived of the affected parts retained its natural form and appearance. And when Schrader made further inquiries, the father showed him a box in which were stowed away a hundred or more pieces of dead tissue that had fallen off in the course of three years.

Hertius, of Nassau (1685), tells of a woman of that town, aged twenty-six, who, after being long tormented with heat and pain in her hands and feet, tried to ease her suffering by plunging them into very cold water. The consequence was that gangrene supervened, and she lost portions of all her toes and of many of her fingers.

It is probable that other isolated cases have been recorded in the medical literature of former centuries, but no attempt was made to explain the cause of such conditions and they were looked upon as

AUGUSTE MAURICE RAYNAUD, M. D.,
Paris, France
Born July 5, 1834. Died June 9, 1881.

isolated medical records of a curious rather than of a scientific value.

Definition.—A vascular disorder, dependent upon vaso-motor influences, characterized by three grades of intensity: (a), Local syncope; (b), local asphyxia; (c), local or symmetrical gangrene.

Before proceeding with a discussion of the various cases of Raynaud's Disease, which have come under the writer's personal observation, it may be well to outline the three characteristic stages of this disease. These are as follows:

Local Syncope.—The first of the three characteristic stages cannot of itself be regarded as a disease, so long as it amounts to nothing more than the familiar "dead fingers." The most characteristic feature of local syncope is the corpse-like pallor of the symmetrically affected parts. The color is usually like wax or tallow. Rarely it is snow white. Occasionally there is a yellow tinge somewhat suggestive of the co-existence of a mild type of jaundice.

Local Asphyxia.—This stage usually succeeds the first, but is sometimes the first manifestation of the disease which is noticed by the patient. The vaso-motor constriction of the arteries relaxes but that of the veins persists. The resulting accumulation of partially oxidized blood in the capillaries, produces an appearance of asphyxia which usually deepens in intensity toward the distal extremity of the affected parts. The actual tint in these cases differs widely. It may be bluish white, dusky blue, slate color, dark blue or quite black. Sometimes it is violet or bluish red or red with almost no admixture of blue. The violet color may become replaced by black if the attack continues or if gangrene supervenes.

Symmetrical Gangrene.—The parts are first deprived of blood by an arterial spasm. This arterial spasm relaxes, but the venous spasm persists. The blood which remains in the affected parts is partially oxidized at first but by reason of its inability to escape, becomes more and more incapable of supplying the tissues with the oxygen necessary to main tain their continued vitality. A true gangrene then ensues. As a rule, this is quite superficial in character and the sloughs which occasionally occur, as in the case observed in 1676, may retain the natural form and appearance of the fingers, toes or other parts affected. These gangrenous areas are usually quite symmetrical. The illustration of Case IX shows this condition very well and although at the time the sketch was made, it appeared as though definite and marked disfigurement would occur, there is, at the present time, not a trace of a scar or deformity on any of the fingers. Even the nails have been reproduced without tissue defects.

Should a deeper gangrene occur, the resulting slough is more extensive and a loss of portions of the body may take place.

Synonyms and Terminology.—Thus far there have been no synonyms suggested for this disease considered as a whole and including all three stages. Other writers, however, have used various names to describe the different morbid conditions. Thus, for **local syncope**—digitus mortuus, doigt mort. todter Finger, local anemia, regional ischaemia. For **local asphyxia**—local apnoea, local cyanosis, regional rubor, acro-neurosis, acro-cyanosis, acro-asphyxia, vasomotor ataxia, are terms which have been suggested.

The climax of the disease is symmetrical gangrene. Symmetry, was to its discoverer, one of its characteristic features. Moreover, in Raynaud's observations, it was so much an affection of early life, that he felt tempted to call it "juvenile gangrene." Acro-spacelus, acro-sclerias, nervous gangrene, idiopathic gangrene, spontaneous dry gangrene, anemic spacelus, insular necrosis, are descriptive phrases which have been used by various writers to describe the condition, so much better described by Raynaud under the name of **symmetrical gangrene.**

It is impossible within the space limits which may properly be accorded to a single article, to consider, in full detail, the history of the seventeen cases which have been observed by the writer. For the proper consideration of my own statistics relative to sex, age, nationality and occupation, an epitome of these cases is here presented.

Case I. Symmetrical Local Syncope of Both Cheeks and Both Knees: Gangrene of the Nose: Broncho-Pneumonia: Punctate Hemorrhage of the Tricuspid, Mitral and Pulmonary Valves: Patent Foramen Ovale: Cloudy Swelling of the Kidneys: Death: Autopsy.

B. N., a new born male child of German parentage, first seen in 1907. Family history negative. The symptoms began six hours after birth and progressively continued until the death of the child five days later. (Fig. 1.))

Fig. 1.—Symmetrical Local Syncope of both Cheeks and both Knees; Symmetrical Gangrene of the Nose and of both Little Fingers. Case I.

Case II. Gangrene of the Nose: Symmetrical Local Asphyxia of Both Cheeks, of Both Hands and of Both Feet: Epidemic Influenza: Death.

K. C., a male child born in 1917, first seen in 1919. Family history negative. Both parents were born in Hungary. (Figs. 2, 3, 4 and 5.)

Case III. Symmetrical Local Asphyxia of Both Hands and Forearms: Recovery.

Miss N. W. X., an American schoolgirl born in 1899; first seen in 1912. Family history negative. The symptoms developed co-incident with the excessive physical growth and psychic changes of puberty.

Case IV. Symmetrical Local Syncope, alternating with Asphyxia of all of the Toes of the Distal Half of Both Feet: Multiple Superficial Ulcers of the Anterior Tibial Regions: Recovery.

Miss F. D., an American woman born in 1879; first seen in 1901. Family history negative. Lived with her sister.

No definite occupation. Did a certain amount of painting with water colors and with oil.

Case V. Symmetrical Local Syncope of the Middle and Ring Fingers of Each Hand. Recovery.

Mrs. D. T. X., an American woman, housewife, born in 1869; first seen in 1895. Family history negative. These symptoms appeared during five successive pregnancies and persisted throughout lactation.

Case VI. Symmetrical Local Syncope of the Chin, of Both Hands and Forearms and of the Anterior Superior Spine of each Ilium; Anteflexion, Sterility and Vaginal Fissure: Recovery.

Mrs. H. T., born in Germany in 1879, housewife; first seen in 1905 (Fig. 6.)

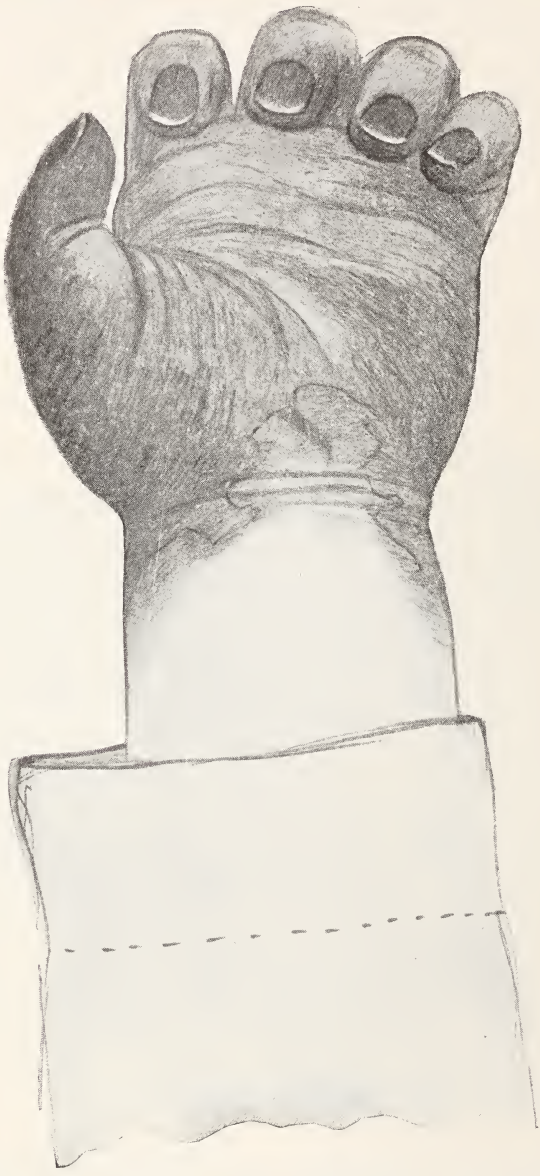

Fig. 2.—Symmetrical Local Asphyxia; Left Hand. Case II.

Case VII. Symmetrical Local Syncope of the entire Middle Fingers and of the Terminal Joints of Index, Ring and Little Fingers of each Hand: Myxedema, Exophthalmic Goitre: Pollenosis of Vernal and Autumnal Type: Chronic Asthma; Chronic Lichenified Eczema: Recovery.

Miss B. F. L., an American woman, born in 1890; first seen in 1919. Family history negative. Disturbance of various functions throughout her life. Hay fever

for five years. Spasmodic attacks of local syncope, worse during the months of August and September when her asthmatic attacks were continuous and severe.

great fatigue, accentuated by changes in climate and altitude necessitated by his work in railroad construction.

Case IX. Symmetrical Local Gangrene of the Tips of the Thumbs and of all of

Fig. 3.—Symmetrical Local Asphyxia; Right Hand Case II.

Case VIII. Symmetrical Local Asphyxia of Great Toes and of Second Toe of each Foot: Local Syncope of Ring and Little Fingers of each Hand: Perforating Ulcers of Left Foot: Onychogryposis: Recovery.

X. M. D., an American, an electrical engineer, born in 1878; first seen in 1912. Family history negative. Possible malarial attack in 1908. Vaso-motor spasms usually at the end of a day's work with

the Fingers of Each Hand: Slight Exophthalmic Goitre: Pollenosis of Vernal and Autumnal Type: Recovery.

Miss J. X. I., an American woman, trained nurse, born in 1884; first seen in 1919. (Figs. 7 and 8.)

Case X. Symmetrical Local Syncope alternating with Asphyxia of both Hands and both Feet, also Ears, Eye Brows and Tip of Nose: Irritable Fissures of both

Heels: Vaginitis: Irritable Fissure of the Hymen: Operation and Recovery.

Mrs. G. L. C., an American woman, practical electrician, born in 1867; first seen in 1904.

Case XI. Symmetrical Local Syncope alternating with Local Asphyxia of both Hands: Onychogryposis: Abdominal Spasms: Cerebral Spasms: Death.

Fig. 4.—Symmetrical Local Asphyxia; Left Foot.
Case II.

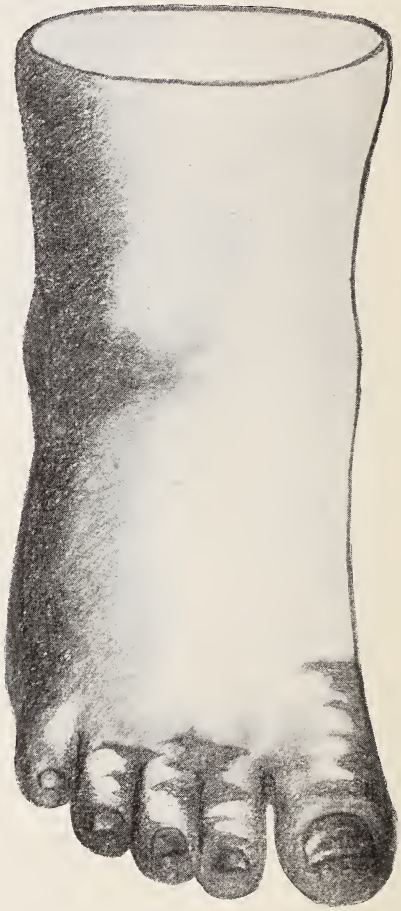

Fig. 5.—Symmetrical Local Asphyxia; Right Foot.
Case II.

K. C. X., an American, born in 1862; first seen in 1899. Superintendent of wall paper manufactory, bronze powders used extensively.

Case XII. Symmetrical Local Gangene of both Feet: Perforating Ulcers of both Feet, Double Amputation, ultimately developing as Thrombo-Angiitis Obliterans: Progressive Symmetrical Gangrene: Death: Autopsy.

M. I. T., born in Germany in 1855; first seen in 1900. Dealer in chromos and chromolithographs.

Case XIII. Symmetrical Local Syncope alternating with Asphyxia of both Ring Fingers: Retroversion of the Uterus: Membranous Enteritis: Recovery.

Mrs. K. U. M., an American Woman, born in 1858; first seen in 1907.

Case XIV. Symmetrical Local Syncope alternating with Asphyxia of Hands, Feet and Face: Symmetrical Gangrene of Toes and Feet: Onychogryposis: Perforating Ulcers: Spasmodic Hematuria: Circulatory Spasms: Cerebral Spasms: Vertigo; Amnesia: Aphasia: Pneumonia: Death.

Mrs. U. K. Q., an Englishwoman, born in 1838; first seen in 1906. Housewife. Family history negative. Hysteria as a child. Robust health. Numerous miscarriages.

Case XV. Symmetrical Local Syncope of both Feet: Purpura Hemorrahagica: Recovery.

K. K. T., a physician, born in 1838; first seen in 1904.

Case XVI. Symmetrical Local Syncope: Local Asphyxia: Symmetrical Gangrene

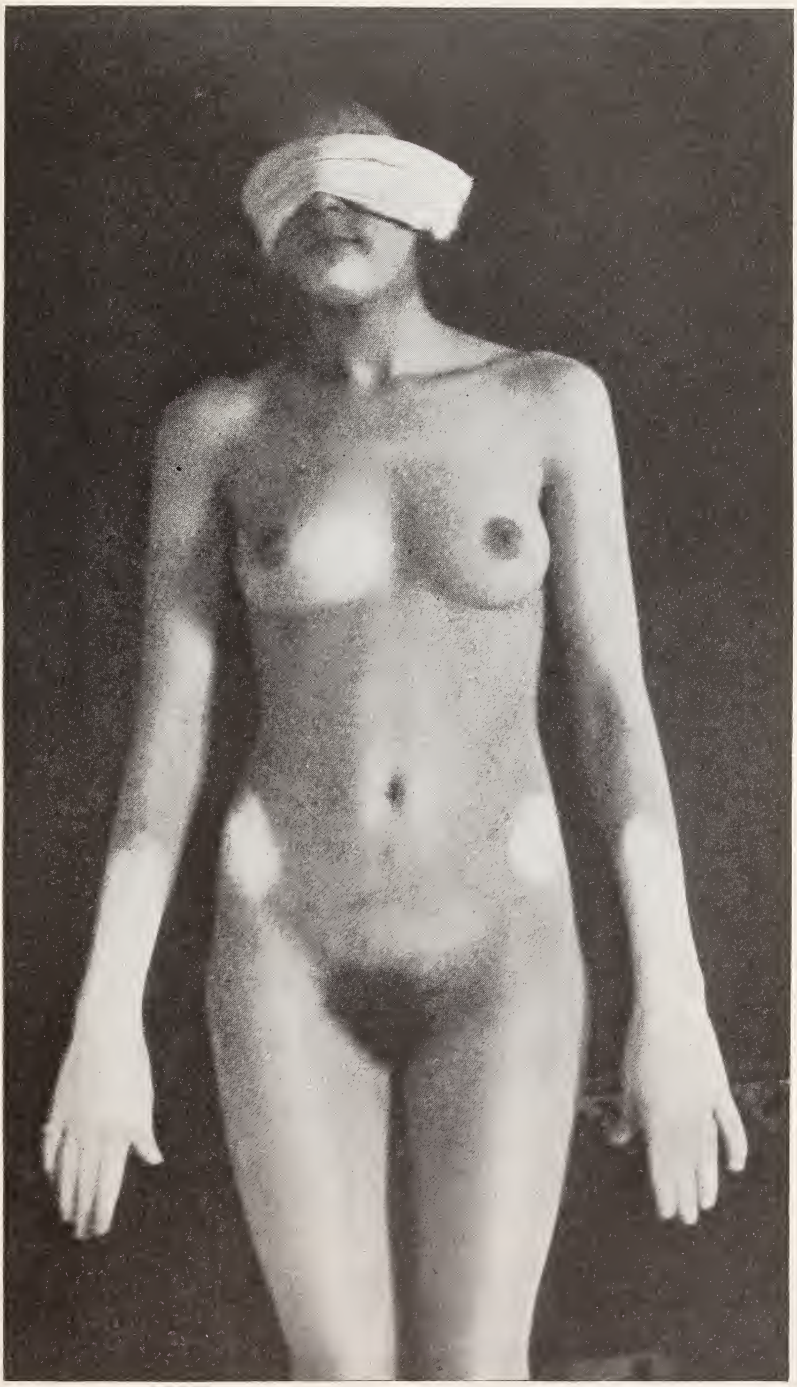

Fig. 6.—Symmetrical Local Syncope of the Chin, of both Hands and Forearms and of the Anterior Superior Spine of each Ilium.
Case VI.

of both Feet: Symmetrical Superficial Gangrene of both Buttocks and of Back: Perforating Ulcers: Cerebral Spasms: Death.

D. S. K., born in Germany in 1863; first seen in 1903. Manufacturer of pigments and bronze powders.

Case XVII. Symmetrical Local Syncope alternating with Local Asphyxia of both feet: Symmetrical Gangrene of the Tips of the First, Second and Third Toes: Perforating Ulcers of Feet: Recovery.

Miss F. T., an American, born in 1829; first seen in 1905; housekeeper. Family and personal history negative. Parents and grand-parents lived to be over 80 years of age. Diet, chiefly oatmeal and tea. No exercise for years.

Fig. 7.—Symmetrical Local Gangrene of the Tips of the Thumb and of all of the Fingers; Left Hand.
Case IX.

Age.—These cases are arranged in order of the age at which the patient was first seen. They range from an infant less than one day old to the last patient who was 76 years of age when she first came under observation. Practically every decade of life is represented in the series. Some authors have maintained that the disease is more common in childhood and in old age than in adult life. This statement is not substantiated by the cases here recorded.

Sex.—In this series there were 7 males and 10 females. This supports a statement made by authors that the disease is more frequent in the latter than in the former sex, though the difference is not a noticeable one.

Nationality.—Nearly half of the cases recorded (8) were either born in Germany

or of German parentage. Four (4) were of English descent, the others were Americans by birth or by descent for at least three generations. These were all of English descent originally. It would appear, therefore, that this disease is about equally divided in this series between the German and English nationalities. So far as could be ascertained, there was no admixture of the Scandinavian or Latin races in the ancestry of any of the cases observed.

Occupation.—At least five (5) of the individuals, including one woman, were engaged in occupations in which various metallic substances, particularly copper, were used more or less constantly. The possible influence of this material will be discussed more at length when the etiology of the disease is considered.

Before going further in the discussion of Raynaud's Disease, let us consider, in detail, a few instances which represent in a more or less typical way, the characteristic features of the disease as described by Raynaud himself.

Illustrations.—There are no illustrations at all in Raynaud's original thesis, nor in his subsequent work which appeared in 1874. Illustrations of the disease are also absent in all of the standard books of medicine which the writer has consulted. Here and there in more than one hundred articles can be found a very few illustrations. Most of these are photographs, barely a dozen in all, and this form of illustration is of little value in emphasizing the contrast in the color picture shown by the skin.

The illustrations in the present article

Fig. 8.—Symmetrical Local Gangrene of the Tips of the Thumb and of all of the Fingers; Right Hand.
Case IX.

have been made in a different way. Wherever practicable, a tracing or a photograph has first been made from life and from this as a guide, the artist, Miss Freda Steidal, has endeavored by a pencil sketch, to reproduce the contrasts which appears. It is hoped that the illustrations prepared in this manner, will be an aid to diagnosis and to differential diagnosis.

Cases VI, II and IX of these seventeen cases have been selected for a more detailed report of each stage of the disease.

Case VI. Symmetrical Local Syncope of the Chin of both Hands and Forearms and of the Anterior Superior Spine of each Ilium: Anteflexion, Sterility, and Vaginal Fissure: Recovery: (Fig. 6.)

Mrs. H. T., age 26, a native of Germany. Housewife.

Family History.—Negative. Both parents are living and are well.

Personal History.—As a child she was not robust. Had measles, scarlet fever, tonsilitis and typhoid fever before puberty. She came to this country when thirteen years of age and since then has been in better health.

Menstruation began at fourteen. It has always been regular, of the 28-3 day type with some pain at the onset. This pain usually started in each ovarian region and extended over the crest of the ilium and down the front of the thighs. She was married when twenty years of age. She became pregnant at once but miscarried at the end of three months. She was not curretted after the miscarriage. Her menstruation has been regular ever since. Her first husband died of an accident a year after their marriage. As a widow she supported herself as a milliner. When twenty-five years of age she married again. Since then her menstruation has been more profuse, but pregnancy did not occur.

Present Illness.—Since her first marriage and possibly in childhood, she had spasmodic attacks of vaso-motor disturbance which caused marked pallor of the fingers, hands and the forearms followed by numbness and pronounced anesthesia. She did not think that this was made worse by coitus. Similar white patches about 4 inches in diameter would also appear over and around the anterior superior spine of each ilium and at times two small patches would occur on either side of her chin meeting in the median line and in area and appearance not unlike a "butterfly" as she described it. While these attacks lasted, the areas involved had a corpse-like waxy pallor and were quite numb. Pricking any one of them with a pin caused neither bleeding nor pain.

Physical Examination.—Showed a slender, but well-developed woman of nervous temperament, with reddish brown hair and dark eyes. Her heart and lungs were normal and there was no abdominal tenderness.

The pelvic examination showed that the vulva, vagina and cervix were normal with the exception that at the posterior commissure of the vulva, there were two small vaginal fissures, both of which were quite painful upon slight manipulation and gave her much pain during intercourse. The cervix was long. There was a marked anteflexion of the uterus which probably accounted for the sterility, for the relief of which she sought medical advice. No history of syphilis could be elicited.

At the time when she was first seen, August 1, 1905, there were no areas of local syncope which would be observed. Her hands were somewhat large in proportion to the rest of her body, but the circulation in the extremities appeared to be normal.

For the relief of her sterility a dilatation and currettage was recommended, with the wearing of an Outerbridge stem pessary for a month. Preliminary to this operation, the vaginal fissures were cured by thorough stretching with the fingers and by the use of graduated glass vaginal dilators.

Soon after her next menstrual period which began a week later, a recurrence of local syncope occurred. The areas of this are well shown in the photograph (Fig. 6.) The tissues were totally blanched, quite anesthetic, did not bleed on scratching or pricking with a pin, and showed as clearly on the surface as if they had been painted. This condition lasted for several days and gradually faded away until the normal color of the skin was restored.

Progress and Treatment.—In this case the outcome of the treatment was most satisfactory. A tonic to correct the anemia and for the improvement of the circulation and of her general condition

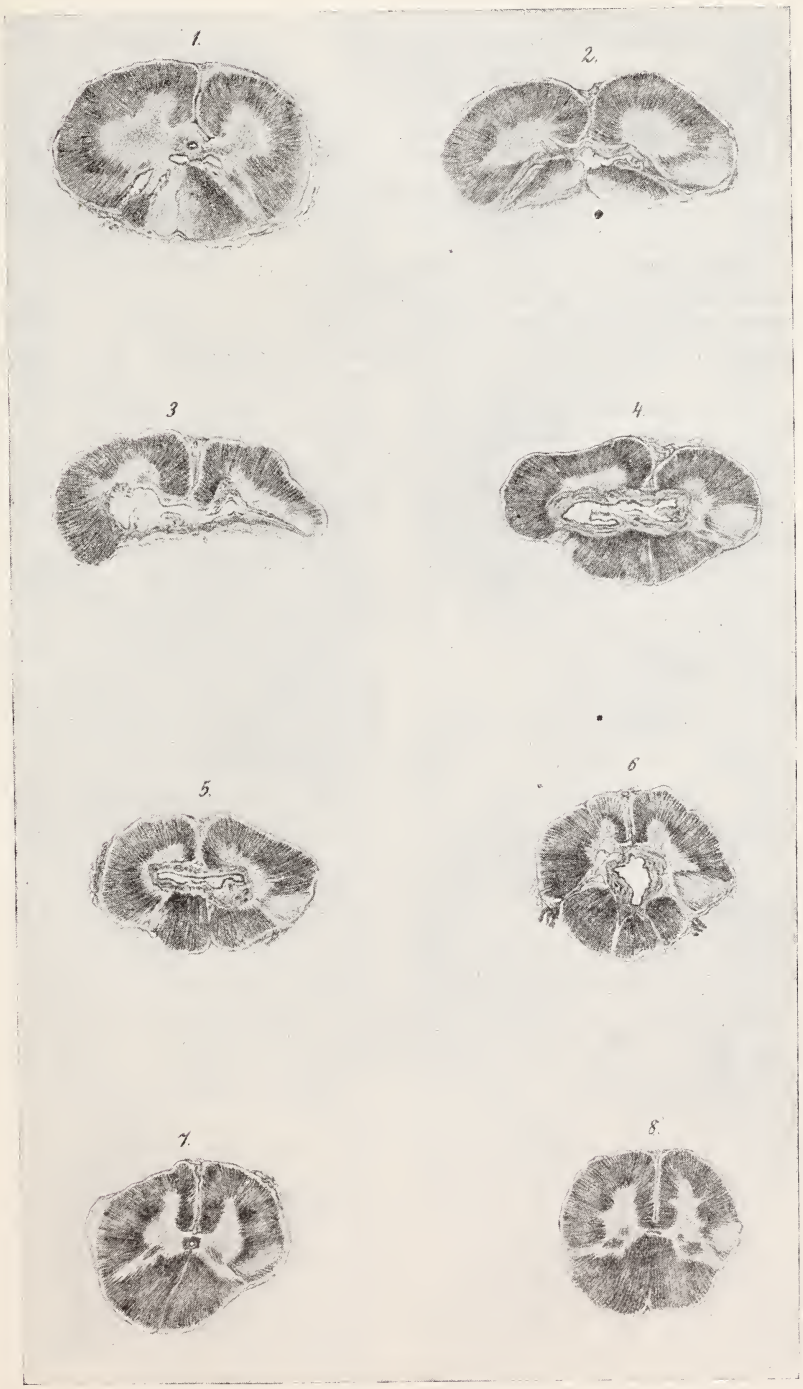

Fig. 9.—Serial Sections at Different Levels of the Spinal Cord in a Case of Raynaud's Disease.
(Microphotographs.)

was taken for several months. The operation was performed immediately after her menstrual period in September. The Outerbridge pessary was worn until the October menstrual period had past and it was then removed. She became pregnant a month or two later and has had two children, both of which are alive and well. A few minor attacks of local syncope occurred during 1906, but since that time the patient's health has been excellent and there have been no recurrences.

Case II. Gangrene of the Nose' Symmetrical Local Asphyxia of both Cheeks, of both Hands and of both Feet: Epidemic Influenza: Death. (Figs. 2, 3, 4 and 5.)

This patient, K. C., a male, two and one-half years old, an American, was first seen on February 10, 1919.

Family History.—Both father and mother were born in Hungary and had been in this country so short a time, that English was not spoken well. The details of the family history could not be elicited.

Personal History.—It would appear, that this child, a patient of Dr. A. S. Ambler of College Point, L. I., had a normal birth and was a healthy baby until the fifth of February of this year. He then contracted epidemic influenza with gastro-intestinal symptoms. As his home surroundings were poor, he was admitted to the Flushing Hospital in the service of Dr. Frederick B. Wood, through whose courtesy I was permitted to see the case.

Present Illness.—Two days after admission, it was noticed that the tip of the nose was black in color. This congestion continued until there was a well marked area of superficial gangrene on the tip of the nose. A few hours after the asphyxia of the nose began, a similar patch appeared upon each cheek. Close examination of these areas showed a few minute blisters. At this time the condition of the nose and cheeks, though less pronounced, closely resembled that of Case I and the illustration serves well to illustrate both cases. (Fig. 1.))

The congestion of asphyxia deepened on the cheeks, but did not become sufficient to cause necrosis of tissue from actual gangrene. This vaso-motor spasm relaxed in the course of an hour or two and by the 17th of the month the face was almost normal. Only a slight patch of skin on the tip of the nose became necrotic. On the 13th of February, it was noticed that the tips of the fingers of each hand and of the toes on each foot were becoming more and more asphyxiated. The asphyxia progressively extended until on the 20th of the month, it involved the areas shown by the sketches here reproduced. The front and back of both hands were involved nearly to the wrists. The fingers of the right hand remained extended but those of the left became more and more flexed, swollen and congested. Attempts to straighten these fingers evidently caused much pain to the child. The asphyxia deepened and finally the nails and adjacent portion of the finfiers of each terminal phalanx became quite gangrenous in appearance. The finger nails being deprived of their normal blood supply, were pearly white in appearance. This is shown very well by the artist in the illustrations. (Figs. 2 and 3.)

The feet became involved in a similar way. The pearly white appearance of the nails, particularly on the left foot, were well marked. The most definite areas of actual gangrene were on the under surfaces of the toes on the terminal joints. (Figs. 4 and 5.)

The child was evidently suffering from a severe attack of epidemic influenza with cough and slight expectoration. Numerous moist rales were heard from both lungs, both front and back. No definite lobar pneumonia could be detected, but the characteristic breathing of a "patchy" pneumonia so common in therecen t epidemic, could easily be detected. The patient's condition was one of progressive apathy and from his entrance into the hospital, it was apparent that the two co-existing diseases would probably prove fatal.

Little could be done on the way of treatment. The child became progressively weaker, the gangrene steadily extended nearly to the wrist of each hand, swallowing became more and more difficulty, and death finally occurred on the 23rd of February, 1919.

No autopsy could be secured.

Fig. 1, illustrating Case I, shows the exact condition observed in the face of this little patient also, except that the lesions on the forehead and over the temples did not exist. Gangrene of the tip of the nose and the two small patches of minute coalescent blisters on the cheeks were the same in both children.

The intense violet blue asphyxia of the hands and feet were drawn from life and show accurately the conditions that existed just before the death of the child.

Symmetrical Local Gangrene.

Case IX. Symmetrical Gangrene of the Tip of the Thumb and all of the Fingers of each Hand: Associated with Slight Exophthalmic Goitre and Pollenosis of Vernal and Autumnal Type: Recovery. (Figs. 7 and 8.)

Miss J. K. I., an American woman, 35 years of age, was first seen in March, 1919.

Family History.—Her father died of old age. Her mother, now 70 years of age, has had "numb fingers" all her life.

Personal History.—Her general health has always been good, although from time to time she herself has been troubled with "dead fingers" for years.

For many years she suffered from pollenosis of a combined vernal and autumnal type. Under a systematic course of Pollen Antigen begun five years ago, she has been free from attacks of hay fever for the past three years. She has a slight goitre, slight exophthalmos, and at times has some form of spasmodic heart attack, rapid pulse, precardial pain, and mental apprehension.

Present Illness.—She accompanied the American Expeditionary Force to France as a trained nurse in one of the Base Hospitals. Soon after her arrival in September, 1917, she went to the Field Operating Hospital stationed just back of the firing line, where she remained through the greater part of the early winter. Her fingers were habitually "numb" no matter what the temperature was. They were white in color, and appeared to be bloodless to the base of the fingers. She wore bed-socks habitually, but the trench life and the inability to get properly warm, exaggerated her trouble. Her finger tips then became blue and finally quite gangrenous. All the ten finger nails were lost and a portion of the skin on the ball of the fingers separated with the nails. The condition is well shown in the illustrations. (Figs. 7 and 8.)

She continued with her work, although her fingers were all bandaged and she wore woolen gloves habitually, night and day when not in the operating room. A thin slough including the nail separated like the end of a glove from each finger tip. Throughout this painful illness she remained on duty under the most trying conditions, recovered from her attack and finally returned to the base hospital in the spring of 1918. She had a severe attack of what was called rheumatism; the exact nature of this is not known. She still continued her work with the sick and wounded soldiers and in the spring of 1919 after over eighteen months of service, she returned to her home station with her hospital unit.

At the present time there is not even the slightest scar on any finger to indicate the loss of substance nor is there any onychogryposis of any of the fingers. She lost twenty pounds in weight during her overseas work, but this has been regained and her general health at present is excellent.

Etiology.—Raynaud's Disease is due to a vaso-motor disturbance. The trophic nerves regulate the contraction and dilation of the blood vessels and capillaries and thus exercise direct control over the supply of blood to various parts of the body and indirectly controls nutrition. Since the disturbances of circulation and of nutrition are symmetrical in character, it is evident that the irritation or possible destruction of the nerves must take place either in the brain or in the spinal cord. The exact nature of this irritation has never been definitely explained, though many theories have been advanced to account for it. That it must be due to a toxemia of some kind, is evident when the symptoms and progress of the disease is considered.

Copper as a toxic and etiologic factor.—It is a well-known fact that certain substances taken in minute but continued quantities into the human organism give rise ultimately to definite nerve lesions. Certain nerves appear to be especially susceptible to certain of these poisons. Lead for example, is well known to have a selective action upon certain nerves of the forearm and leg and certain other nerves of the abdominal viscera, particularly those of the intestines. "Lead colic" and "Drop Wrist" are well known results of this form of poisoning. Certain forms of mercury affect certain glands and cause salivation. Phosphorus for some reason affects the teeth and mandible. Arsenic causes edema. This list might be lengthened but the facts

which I have cited are sufficient to show that certain of the metals produce definite and characteristic toxic lesions under certain circumstances.

When the occupation of the persons cited by the writer is considered, it is a noteworthy fact that five at least of the number of cases (VIII, X, XI, XII and XVI) were more or less actively engaged in pursuits in which finely powdered particles of metallic copper or bronze powder were inhaled from the air, constantly and for long periods of time. Little is known concerning the poisonous action of copper as a metal. Metallic copper is not infrequently swallowed in the form of copper coins. These, as a rule, pass through the intestinal canal without doing damage. Even when they remain in the body for a considerable time, merely mechanical disturbances are to be expected unless, as it exceptionally happens, subacute symptoms arise. Michous reported the case of a dog which carried a large copper coin in its stomach for ten years with no apparent discomfort. On the other hand, Senfft reported the case of a child who accidently swallowed a copper penny and developed chronic toxic symptoms which lasted for five months.

Tschirch has shown that copper oxide is not free from poisonous affects. All the soluble salts of copper are poisonous, but those which most frequently cause poisoning are blue vitriol (sulphate of copper) and verdigris (acetate of copper).

Copper is combined with tin to form bronze: combined with zinc to form brass, combined with zinc and nickel it forms German silver. All three of these are practically separate metals, so far as their use in the arts is concerned. It is a well-known fact that relatively large pieces of lead, of mercury or of silver can be left in the tissues for a considerable time without doing harm, while on the other hand, the same amount of the same elements in a finely divided form, would produce definite poisonous symptoms.

Is it not possible that finely divided copper either in the form of the powdered metal or as an ingredient of bronze powder or brass or German silver dust, inhaled in small quantities for a considerable length of time, may be a factor in causing a peripheral neuritis of the vasomotor or trophic nerves in a manner quite analogous to the poisonous effects of lead under similar circumstances?

If this should prove to be the case, further investigation might well show that Raynaud's Disease is a more frequent occurrence in copper workers than has hitherto been recognized.

It is quite evident that even if this hypothesis were true, it would fail to explain the occurrence of the disease in a large number of instances. On the other hand, it is quite evident that the disease is primarily due to some form of toxemia. Epidemic influenza and a resultant broncho-pneumonia certainly existed in Cases I an II and possibly in some other of the series. So many cases have been reported in which an undoubted malarial infection existed, prior to the development of Raynaud's Disease, that by some writers, malaria is regarded as the definite causative factor in a considerable number of cases. Auto-toxemia, from intestinal disorders, seems to play an important rôle in certain instances. Syphilis is a common co-existent condition. Its presence was definitely excluded in all of the patients of the present series, but on the other hand, many cases have been reported in which the spirochaeta pallida was believed to be the exciting cause of the vaso-motor disturbance. A neuropathic heredity and conditions which impoverish the blood, are predisposing causes. Grief, fright, fatigue, and in recent years the combination of all of these, incident to war, may be considered as factors in the production of the disease.

Exposure to cold is the most common exciting cause. This is particularly true with the attacks of local syncope which usually precede local asphyxia and symmetrical gangrene.

Pathology.—Little is known of the pathology of Raynaud's Disease. Few autopsies have been recorded, and the autopsy findings thus far reported have shown no pathognomonic lesions. The illustration herewith reproduced Fig. 9, was prepared from a series of sections taken from the spinal cord of my former chief, Prof. Paltauf, and were obtained from the spinal cord of a case of Raynaud's Disease reported by Julius Hochenegg in Vienna in 1886. These sections closely resemble those of the spinal cord in cases of syringomyelia and there is a variable destruction of different columns of the cord at irregular intervals. So far as the writer is aware, this is the only illustration of the lesions in the spinal

cord in cases of Raynaud's Disease which has ever been published.

Symtomatology.—"Local syncope, local asphyxia and local gangrene, all symmetrical in location and primarily affecting the fingers and toes and sometimes the nose and ears, rarely other parts of the body:" these are the classical symptoms originally described by Raynaud himself. Each group has been so thoroughly described in the text and exemplified by the illustrations that further discussion is unnecessary.

Hemoglobinuria, spasmodic in character, may occur. Intestinal crises and cerebral spasms also occur with various symptoms dependent upon the blood supply and the contraction of the arteries involved.

Diagnosis.—If the clinical picture of the three classical symptoms, be kept in mind and the illustrations consulted in cases of need, the diagnosis of Raynaud's Disease should present no especial difficulty unless the case is a complicated one.

Differential Diagnosis.— While the diagnosis of an uncomplicated case of Raynaud Disease is easy, a consideration of the cases reported by the writer and of the numerous other cases which can be found in medical literature, emphasizes the fact that this disease frequently precedes some other disease by which it may be overshadowed in the importance of its symptoms as they develop. In other cases the symmetrical symptoms may appear coincident with those of some other malady and not infrequently they may develop in the course and progress of some disease, the nature of which is already clearly established. It is important, therefore, that the differential diagnosis be clearly made since the treatment for the two or more co-incident conditions, may have to be carefully separated.

Syphilis.—If it exists, can now be readily recognized with the aid of the Wassermann test.

Malaria can usually be definitely shown to exist by carefully made blood smears and the demonstration of the malarial organisms in the blood.

The use of arsenobenzol or salvarsan for either or both of these diseases, is in no way contra-indicated.

Erythromelalgia closely resembles Raynaud's Disease, but differs from it in the absence of a stage of syncope, the non-occurrence of gangrene, the presence of tenderness and the relief of the symptoms, instead of their aggravation by the use of cold applications.

Thrombo-angiitis obliterans (Buerger's Disease) is now being recognized with increased frequency. In Case XII of the present series, the patient at first suffered from a simple and uncomplicated form of Raynaud's Disease. In the terminal stages of his illness, the lumen of the blood vessels throughout the lower extremities, became more and more occluded and finally, at the time of his death, the diagnosis of Buerger's Disease, rather than Raynaud's Disease, could properly have been made, since the symptoms of the former completely overshadowed the early and milder symptoms of the malady from which the patient at first suffered.

The early symptoms of Buerger's Disease are: pains in the calf of the leg on walking (intermittent claudication) and spontaneous and uncontrollable pains in the toes, feet and legs, ordinarily occurring during the night while the patient is lying in a horizontal posture. The lumen of both arteries and veins progressively becomes more and more occluded and spontaneous gangrene develops. The upper extremities may become affected, but this is much less apt to be the case than in Raynaud's Disease. Practically all patients, thus far reported, have been males, and the poorer classes of Jews from Russia, Poland, Galicia or Roumania, where the population is known to be especially subject to disturbances of sugar metabolism.

Diabetes often gives rise to gangrene in its terminal stages. The history of the cases of the persons with sugar in the urine and the lack of symmetry in the affected parts, should serve to differentiate these diseases.

Treatment.—It is obvious that the primary requirement in the treatment of Raynaud's Disease or of any other diseased condition that human flesh is heir to, is to be sure that the diagnosis is a correct one. From what has been said, it would appear that in most instances a definite diagnosis is not difficult. As a rule, unless the disease is far advanced and extensive gangrene be present, the treatment is entirely medical in character. In the more advanced cases, surgical interference may be demanded.

Hygiene.—Inasmuch as exposure to

cold in cases of Raynaud's Disease is by far the most exciting cause of an attack, the affected parts must be well protected against sudden changes in temperature. Fur-lined gloves or double stockings with a thick layer of cotton between the outer and inner stocking can easily be improvised and the maintenance of a reasonable equable temperature should be secured.

Medical Treatment.—Many theories have been advanced to explain the occurrence of Raynaud's Disease. The most probable explanation is that the disease is due to some form of auto-intoxication. Whether this toxic principle is due to errors of metabolism which give rise to some form of toxin or whether it is due to some definite organic poison introduced into the body from without or whether, in a certain number of cases, there is a true inorganic poison, such as copper which has been mentioned, the principles underlying the medical treatment of the disease remain the same. Elimination must first be secured. A brisk cathartic with frequent examinations of the urine to determine the amount of uric acid and the amount of indican which are present, is the basis of all treatment and if the patient shows signs of improvement, it will be found that the percentage of indican and the degree of acidity steadily decrease. The elimination of nitrogenous foods and particularly of tea, coffee, alcohol and tobacco should be insisted upon. There is no doubt, whatever, that the development of the allied condition of thromboangiitis obliterans is dependent in a great measure upon the character of the diet. It is also certain that the use of alcohol, even in small quantities, particularly in women, is a predisposing and sometimes active cause of certain forms of peripheral neuritis. Tea, coffee and tobacco also are nerve stimuli when used, even in small amounts, for long periods of time.

Next in the line of more active medical treatment, positive rather than negative, in character, is the use of a reliable nerve tonic. The standard U. S. P. Elixir of iron, quinine and strychnine is the one most frequently used by the writer in teaspoonful doses given in a wine-glass full of water fifteen minutes before each meal. In children the elixir of nux vomica and calumba may be used. To either of these bitter tonics, it will be found advantageous in many cases to add nitroglycerin in the proportion of 1/100 of the grain to each dose. This acts as a vaso-motor dilator. Nitrite of soda in three or five grain capsules can also be used for the same purpose if it be desirable to separate the two groups of medicines.

Most patients are definitely anemic, and the degree of anemia can now readily be determined by any number of simple and accurate methods of hemanolysis. The administration of iron in some form must, therefore, be begun and the peptonate of iron and manganese with 1/40 of a grain of arsenic added to each ounce of the preparation, has proved in the writer's experience the most satisfactory. For little children, the preparations of iron with either sugar or chocolate are somes of help on account of their palatability.

A definite amount of food, nutritious in character and easy to digest must be specifically prescribed and with the aid of a simple calorie list such as the one compiled by Franklin W. White, M. D., of Boston, entitled "Food Values in Household Measures," is of much practical assistance in placing the estimate of calories in a simple and practicable form. For an adult at least 3,000 calories a day should be taken. Milk and eggs are, of course, the most important articles in such a high calorie diet. If the patient can be shown how to record, with the aid of Dr. White's card, each item of each meal of the day, and its calorie value, it is soon possible, with the aid of a notebook for reference, to compare the daily records and see how the diet can be varied and the calories increased until the re-
in a kimona and a pair of stockings if a quisite amount is secured. Once a week the weight should be taken with the patient nude, if a man and attired merely woman. A definite increase of from one to two pounds a week is desirable.

The use of electricity has been advised by some writers. It has been tried extensively but the results do not seem to be as satisfactory as the treatment based upon diet, good regimen and the medical treatment which has already been indicated.

The use of the Farradic current is not contra-indicated and may have a certain psychic value in some instances. The

treatment of syphilis and malaria or of any other disease which may co-exist, should, of course, be followed co-incident with the treatment of Raynaud's Disease itself. The sequence of the occurrence of the two diseases is unimportant.

71 Central Park West, N. Y. City.

RADICAL CURE OF INGUINAL HERNIA*

By John F. Hagerty, M. D.,
Medical Director of St. Michael's Hospital.
Newark, N. J.

I think it may be safely said that there are few ailments having for their operative relief and cure a plan so generally well understood as that of hernia, and yet because this deformity is so common —it is said that one-tenth of the population are subjects of the same, and from the writer's experience this proportion might be increased rather than diminished—and because of the resultant loss of efficiency and decrease in working capacity leading often to total incapacity and often to great suffering and death, we may be excused for presenting such a trite subject. It is true, too, that while the general principles of the operation are well understood, there are many details on which its complete success depends, and we shall speak more particularly of these.

To better understand the operative measures a brief study of the anatomy of the inguinal region will be made.

The inguinal region is that portion of the abdomen situated immediately above Poupart's ligament. This ligament, which is the lower free border of the aponeurosis of the internal oblique muscle strengthed by connective tissue, extends from the anterior superior spine of the ilium to the spine of the pubis. The external abdominal ring, at which point hernia appears externally, marks the lower orifice of the inguinal canal and is formed by the semi-circular edge of the external oblique muscle. In the male it can be plainly felt by invaginating the skin of the scrotum. The inguinal canal, oblique in direction 1 to 1½ inches in length, gives passage to the round ligament in the female, and in the male is filled up by the spermatic cord, which is surrounded by loose connective tissue and fibers of the internal oblique muscle and transversalis, known as the Cremaster muscle, and which is brought down by the testis in its descent. The inguinal canal is not an actual but a potential canal. When open it is pathological.

The peritoneum of the anterior abdominal wall is lifted up into folds by several cords which are situated between it and the fascia, and these folds divide the surface into various fossae. Three of these folds are well marked, and pass from the sides and apex of the bladder to the umbilicus. They are the urachus and the obliterated hypogastric arteries. External to the latter is another fold caused by the deep epigastric artery, and to the outer side of that is the external inguinal fossa through which with the spermatic cord the hernial protrusion enters the inguinal fossa—that between the deep epigastric and obliterated hypogastric artery—does not pass through a previously formed canal. It passes directly forward through the abdominal wall, and is known as internal or direct inguinal hernia. The deep epigastric artery is on the outer side.

The testicle, as you remember, develops within the abdomen, behind the peritoneum, beginning to descend about the sixth or seventh month of foetal life, and by the ninth month, as a rule, is in the bottom of the scrotum. At this time the process of peritoneum, which has been drawn down, is still in communication with the abdominal cavity, and this canal like process is called the processes vaginalis. Before birth the walls of the vaginal process become adherent, so that on one side we have smooth peritoneum and on the other the closed serous sac is adherent to the testicle. When this adhesion does not occur there is a congenital hernial sac, and this may become a hernia either at birth or in later life.

The causes for nonclosure of the vaginal process are sometimes found in disturbances of descent of the testicle, and such hernias are found in combination with cryptorchidism.

The processus vaginalis may not close completely throughout, and hydrocele may develop within the tunica vaginalis or along the cord, and combinations of hernia and hydrocele may be observed.

*Read at the meeting of the Surgical Section of the Academy of Medicine of Northern New Jersey.

The same malformation, though less common, may occur in the female.

The canal is bounded in front by the aponeurosis of external oblique, and on the inner side by the conjoined tendon representing the internal oblique and transversalis muscle which have arched over from the outer half of the Poupart's, and are inserted into the pectineal line and public crest.

Diagnosis of Hernia.—Ordinarily the diagnosis of inguinal hernia is easily made, and yet in our work at the hospital a certain number of cases are seen in which a mistake in diagnosis has been made. There may be no hernia, or other ailments may be designated as hernia. Those of us who did draft board work will recall how frequently the claim of hernia was made and not established, and how hard it was at times to dispute such claims. The confounding of hydrocele, varicocle, inguinal adenitis, psoas abscess, hydrocele of cord, lipomata, tumors of testicle, and epididymitis with or without fluid in the tunica, with hernia is often made, and the differential diagnosis may be brought out in the discussion, if time will allow. Two important elements enter into the question of diagnosis. Is there a hernia requiring operation and how long has the hernia existed? Depending on the individual—that is whether he is honest or seeking to establish a claim for damages, some patients who complain of pain on straining, or at work, in whom no protrusion can be found, and but very slight impulse obtained by coughing, but where the external ring is large and canal is lax, I think will be benefited by operative means—that is tightening up the canal. Great caution must be exercised with these cases and I am more inclined not to operate unless there be protrusion and impulse to the finger within the canal. The question of how long a hernia has existed is of great importance because of the not infrequent claims for damages against employers. As to strain—that is a strain or injury or fall causing hernia, the writer believes that in all hernias that must have been a congenital defect—imperfect closure of the processus vaginalis which thus forms a weakness in the abdominal wall—that it requires considerable force and length of time to push or develop a peritoneal process into or out of the canal so as to be recognized and which will cause enough suffering to call the individual's attention to it, and that all hernias felt at the external ring or below or in whom a sac is found of any size cannot be regarded as having been caused by recent strain.

Operations for the cure of hernia have been performed since the earliest times. Celsus about the 1st century employed many of the principles in use today. He did not operate on strangulated hernia nor umbilical hernia in children, nor for inguinal hernia in children under six years and advised strongly against castration. Other operators later advised removal of the testicle during operation and this was practiced for several centuries. About the 10th century attention was fixed upon the mechanical treatment and many appliances were introduced. For a long time after, operations were rarely resorted to. In 1831 Stromeyer discovered and introduced what was known as "subcutaneous" surgery, viz.: the introduction of various fluids into and around the sac, designed to close the canal. With the exception of quacks and fakirs this method has been abandoned. In 1876 after the introduction of antiseptic surgery, real advances were made by returning to ancient methods with modifications, and Czerny in 1876 described his method of obliteration of the sac and closure of the canal. Various modifications were now introduced in the effort to secure more perfect and permanent closure of the canal.—Infolding of the sac (McEwen), torsion of the sac (Ball), torsion of the sac with suture of the same external to the aponeurosis of the external oblique (Kocher), high ligation of the sac and closure of canal by cicatricial plug (McBurney), high ligation of sac and transplanting of cord after suture of the canal (Bassini) which was modified by Halstead, who removed all the veins of the cord and transplanted it above the aponeurosis of the external oblique muscle rather than below, as in the Bassini method. Besides all these methods, most of which were being introduced while many of us were students, further attempts to seal up the canal or place some impassable barrier therein were made. The introduction of woven wire mattress (Phelps), of bone plates as portion of scapula of dog, etc. (Wier), were made but quickly discarded. Infolding of the conjoined tendon by a second line of sutures, or overlapping of the aponeurosis have been tried. McBurney's

method was soonest of all discarded, and all have given way to Bassini's, which was first done in 1890; and which with slight changes, is the operation of choice today. Andrews introduced a method of inserting the deep sutures which we used for some time. Poupart's ligament is dissected free externally and internally. Mattress sutures are introduced from without through Poupart's, taking up a bite of the conjoined tendon, then back through the ligament and tied on the outer side. It is a very good and safe way of placing the suture. A good bite of muscle can be snugged up to a broad surface of the ligament, but it is harder to get the reflected edge and the bottom of canal, and not infrequently in dissecting the loose areolar tissue outside of Poupart's, oozing and sometimes infection occurs.

There still exists among different operators varying methods of skin disinfection, question as to the kind of suture material to be used and the length of time patients should remain in bed. Infection, I think, is prone to occur in this region, and so especial pains should be taken to render the field sterile. The parts should be thoroughly and carefully shaved. Washing with benzine or ether should be made. Then painting with iolin, followed after the application is dry by washing with alcohol. This is hardly the place to discuss methods of skin disinfection, and yet if with the above method the majority of wounds heal primarily, when failure occurs it can safely be charged to some other cause.

As to suture material—it is urged because the tissues encountered in the inguinal canal are tendinous in structure that healing here will be much delayed and that slowly absorbable suture material should be used. We have not used in several years kangaroo tendon or chromicized gut, relying upon plain catgut No. 2 for the deep sutures, and No. 1 for the rest, and in the large majority of our cases feel certain of our results. Given a clean wound and the parts in apposition, healing begins at once, and union firm enough to last until complete healing takes place will be secured with plain catgut. The use of nonabsorbable suture material is not to be considered at all. Torek (Annals of Surg., July, 1919), says the presence of foreign bodies encourages the formation of plastic material.

Recovery is so prompt and satisfactory after operations nowadays that it is difficult to keep patients long in bed. There is a very great strain placed upon wounds in the lower abdomen, and while several weeks, as was formerly the rule, may be too long, two weeks at least should be spent in bed and two weeks more elapse before laborious work is undertaken.

The question of removal of the testicle will occasionally present itself. In hernia with undescended and, as is often the case, atrophied testicle with the other testicle well developed, in order to secure perfect closure of the internal ring, the testicle may be sacrificed. In very large scrotal hernias in men past middle life, with large varicose veins of cord and the sac intimately adherent to cord or in combined direct-indirect hernia seen in this type of patients, where better closure of the ring can be secured, the testicle may be removed. The occasion for doing this will not often arise and one must have good reason for doing so.

When to Operate and When Not.—Bull and Coley as a result of their large experience at the Hospital for the Ruptured and Crippled established the rule that children under four years should not be operated on. My own experience is that in children under one year, with an intelligent mother who will keep a truss in place, practically all hernias will spontaneously close, but that after one year this is less likely to happen, and where the hernia is large or causing discomfort operations should be done. Our experience with infants and small children is that they bear operation well and repair is very satisfactory.

There will be met men about middle life or older with very large scrotal hernias, not infrequently direct and often double, in whom it will be hard to decide whether to operate or not. These hernias cannot be reduced completely or will immediately reappear, showing them to be direct or having adhesions which are sometimes extensive, of the contents in the sac. The canal will be very large, muscles lax, and one's individual experience and judgment must be his guide. It is better not to promise too much in these cases though they are often able after operation to wear a truss with comfort and possibly to resume their work. Strangulated hernia, no matter what the size, requires operation.

In strangulated hernia one's judgment

will often be taxed to know how best to deal with the strangulated gut. Whether to replace, or to excise, or to leave in the wound, walling off with gauze to form a foecal fistula and perhaps lead to secondary operation, must depend on one's good judgment, the ability of the patient to withstand a prolonged operation and the skill and ability of the operator. Strangulated omentum or long strings of twisted omentum should be removed, but as a rule omentum should be spared when possible.

I shall now review the method we have found most satisfactory, and if I go into detail there is no intention of being elementary or didactic. This description applies to the cure of indirect inguinal hernia in men, which constitutes about 93% of all hernias.

The field of operation is prepared as described. With skin clips and sterile towels an area about 3 inches by 6 inches is exposed. Incision is made not in direction of Poupart's ligament but almost vertical with the lower end slightly below the orifice of the external ring. The towels have been so placed as to entirely cover the genitals. Incision is carried down to the fascia and with a wipe all loose tissue is brushed away exposing clearly the fascia and below the external ring. Two sets of veins will be encountered crossing the wound, and a perforating artery (superficial external pudic). When the incision is carried very low free bleeding is sometimes met with. All these vessels are clamped and tied. With the finger i nthe external ring the fascia is lifted up and incised well toward the mid line. Clamps are applied and as the fascia is lifted up, thus avoiding injuring the ilio-hypogastric nerve, the fascia is divided with Mayo scissors the full length of the canal. The outer half is now laid back with wipe until the reflected edge of Poupart's is exposed the entire length and the inner half dissected up until the tendinous edge of the conjoined tendon is exposed down to and over the fascia of the rectus to the pubis. Incising the fascia towards the mid line gives more material to work with and makes it easier to cover the roof of the canal after the deep sutures have been placed. Where the nerve is in danger of being injured it is dissected free, if necessary, and carried to one or the other side. Fibers of the cremaster and loose connective tissue covering the contents of the canal may now be picked up between forceps and divided, exposing the sac and cord. The contents of the canal are now lifted out and separation of the sac begun. The sac can often be more readily recognized above than below, though by stretching the contents on the fingers and using a wipe its edges may soon be seen and it can be dissected away from the cord. Where it is difficult to recognize the sac, the vas may be dissected free, then the veins, leaving only the sac. Should much fat, as is often found in children, and loose tissue surround the cord it can be removed and when the veins are very large they can be excised. The sac is now freed of all loose tissue and dissected out to the internal ring. A small lump of fat here will often mark the high point of the sac. When the lower end of the sac is intimately adherent to the tunica it can be ligated and the distal end ignored. Lusk makes a good point of having the sac free from muscle fiber or connective tissue before ligation. After satisfying oneself that the sac is empty it may be ligated by transfixing and tying, or, as in the later Kocher modification, the transversalis and internal oblique may be lifted up, an artery clamp introduced about one inch above and then underneath and the sac grasped and drawn through. This has the effect of angulating the sac at its point of exit from the abdomen, and helps to prevent recurrences. The sac is then drawn forcibly out through the muscle and ligated and sutured into the muscle and the distal part cut away. Two curved clamps are now placed under the cord and grasping the inner edge of aponeurosis will throw the cord and the nerve out of the field and expose the inguinal canal. With No. 2 plain catgut, sutures are placed about ½ inch apart, grasping the conjoined tendon, not the free edges of the muscle but the tendinous and suturing it to the everted edges of Poupart's ligament. One suture is placed above the exit of the cord, one immediately below, being careful not to constrict the cord, and three or four or five sutures below, closing the canal completely. These sutures must be accurately placed so as to have even apposition, and below when necessary to include the fascia of the rectus, down to the pubis. Before tying, the canal must be dry and no fat or other tissue must come between the conjoined tendon and Poupart's. The sutures must

not be tied too tightly, and should there be gaping extra sutures may be placed. When this is finished the operation is practically completed. The cord is now dropped back in place, the aponeurosis sutured by continuous suture as far down as possible, being sure to secure the upper angle, and two silk wormgut sutures are passed through the skin and subcutaneous tissue picking up the fascia, where sutured, then the skin incision is closed by a continuous suture of fine catgut. A bolster is laid over the wound and tied in place with the two silk wormgut sutures. This keeps the wound protected even though the dressings become displaced, as they are apt to here, and also by binding the skin down to the fascia, obliterates dead space and helps to stop oozing. Gauze dressing is now applied and held in place by adhesive strips.

In children a starch bandage or Plaster of Paris spica is often of advantage, but no bandages are applied in adults.

Where the sac has been adherent to the testicle, and in most scrotal hernias there will often be considerable swelling and ecchymosis of scrotum following operation. Support either by pad or bridge of adhesive will be found helpful.

Retention of urine postoperative, is a not infrequent and annoying complication. Allowing patients to turn on either side or even to get up is often preferable to catheterizing. Have tried pituitrin without success.

In hernias in the female we have at times attempted to transplant the round ligament, but feel that it is wiser as a rule not to do so. Dissection of the sac is often difficult in these cases because of intimate adherence to ligament.

There are varieties of inguinal hernia so unusual that they need only be mentioned—such as properitoneal and interparietal hernias. These are usually direct hernias which have dissected up the different layers of the abdominal wall.

Just a word as to direct hernia. The protrusion not having come through a preformed canal, but pushed its way through the abdominal wall, no sac will be found as in inguinal hernia, that is, no prolonged sac. As a rule, the sac and contents are replaced and the canal closed as in indirect hernia, only greater pains must be taken to secure perfect closure of the canal. It must not be forgotten that the bladder may be found in these hernias, and great care must be exercised in dealing with the bladder. It is well to remember the position of the deep epigastric artery and its liability to injury in these hernias.

Anaesthesia—Except in a few cases of cardiac or renal diseases and in strangulated femoral hernias we have used general anaesthesia. The risk or discomfort afterwards is not very great—one is free to do the operation as he likes and should complications be met, they can be more readily dealt with. It is easier to maintain strict asepsis and the relief from pain has not been satisfactory with local anaesthesia though these objections might be overcome with greater experience.

In conclusion, success in these operations depends on high ligation of the sac which has been emptied of its contents and freed from muscular or connective tissue, on complete obliteration of the inguinal canal by accurate suturing of the tendinous insertion of the conjoined tendon and fascia of the rectus, when necessary, to Poupart's ligament, transplantation of the cord, and as an essential condition primary union, which depends on thorough asepsis, complete hemostasis and gentleness in handling the tissues.

No one method is perfect and increasing experience teaches new lessons. Failures will occur, but when they have occurred, in our experience, they could be attributed to wound infection.

Literature.

Woolsey's Surgical Anatomy.
Sultan—Abdominal Hernias.

Clinical Reports.

Splenic Anemia in Children.—A case of Banti's disease is reported by Dr. J. W. Amesse of Denver in Colorado Medicine, occuring in a boy of 6 years. A splenectomy was done and the boy recovered. He has gained 20 pounds in weight, eats and sleeps well, and gives every promise of living out the natural span of life. An interesting feature in the case was the fact that the boy's mother, who was only 16 years of age when he was born, gave a clear history of an obscure disease, accompanied by pronounced anemia from her birth to her twelfth year.

Diverticulitis and Intestinal Obstruction.

Dr. H. L. Rocher, in Journal de medicine de Bordeaux, reports the case of a boy of thirteen years who while at supper was suddenly stricken with sharp pain in the epigastrium and in the left iliac fossa. Ten minutes later food was vomited. From that time on complete retention of feces and gas was noted, with continuous vomiting. Nine days later the child was taken to a hospital and subjected to operation. A persistent Meckel's di-

verticulum, seven centimetres long, was found to have become inflamed and adherent to the mesentery gripping tightly two loops of bowel. The diverticulum was removed and the patient recovered. The specimen was one centimetre thick at its distal extremity but perforation had not occurred.

Gonococcus Otitis in Infants.—Dr. H. Putzig in Deutsche med. woch., Berlin, reports a case of purulent otitis media in a 14 month old child which occurred nearly two months after the child had been successfully treated for a typical gonorrhea. He thinks that it was due to a second infection transmitted from the mother who was still suffering from a specific gonorrheal discharge. He emphasizes the need of bacteriologic examination of the discharge in all cases of persistent suppuration of the ear in infants, especially those who have had gonococcus infection, as knowledge of the gonorrheal origin makes possible specific treatment, such as with 1 per cent. protargol solution and, if necessary, potassium permanganate lavages, which usually bring about a cure in a few days. If a bacteriologic examination is not made, the child may be seriously injured by a protracted otitis, and through lack of knowledge of the danger, other members of the family may become infected.

Malignant Sarcomas.—Dr. M. Emmert, in the Nebraska State Med. Jour., reports a case of tumor on the posterior surface of the right thigh midway between the trochanter and the popliteal space, about the size of a large orange in which a clinical diagnosis of sarcoma was made and operation advised. The tumor was removed. The pathologic diagnosis was simple fibroma with large connective tissue cells. Six weeks after leaving the hospital a streptococcus infection started in the scar and spread over the entire leg and thigh. This subsided in two weeks. One week later there developed rapidly on the median surface of the left ankle a tender inflammatory mass which was thought to result from the recent infection. This persisted for several weeks and then the inflammatory condition subsided, leaving a firm mass which was recognized as a sarcoma. The mass was removed five months after the first one. The pathologic diagnosis was fibromyxosarcoma, spindle and round cells. The second patient was only 2 months old. At the time of birth, a mass the size of a pigeon's egg was noticed on the thoracic wall. The mass was excised later. The microscopic diagnosis was fibromyxosarcoma.

Rupture of the Abdominal Aorta.

Drs. Devic and Lamy, in Presse Medicale, record the case of a man aged fifty-three who was admitted to a hospital with violent attacks of lumbar and abdominal pain, radiating to the inguinal regions. There was no evidence of syphilitic infection, the vascular system seemed normal, and there were no signs of incipient tabes. Lumbar puncture revealed marked cerebrospinal hypertension and lymphocytosis. The attacks of pain recurred frequently during three weeks, and one night the patient died suddenly without making any outcry that might attract attention. At the autopsy an extensive recent clot, occupying all the subperitoneal cellular tissue was found. On the posterior aspect of the aorta, midway between the celiac axis and the bifurcation was a transverse rent in the vessel at the site of an atheromatous plaque. Rupture had occurred in two stages, a false aneurysm of the size of a mandarin orange, with incipient fibrous deposits, having first formed, and secondary rupture followed, causing immediate death. Many atheromatous plaques were found at other points in the aorta. Examination of the other abdominal structures was negative. An unquestionable syphilitic origin of the atheroma was shown by microscopic study, in spite of the absence of all history of the disease. The severe pains experienced were due to irritation of the solar plexus.

Case of Bullet Embolus.—In the London Lancet for January 3, 1920, Dr. H. J. B. Fry records the following remarkable case of bullet migration. Of all the strange and bizarre wounds which occurred in the great war it seems one of the most unusual.

A soldier while standing by his battery was wounded on April 2nd, 1918. He suddenly experienced a sharp stinging pain in his left foot. Examination of the foot showed no wound, but a small circular wound was found just below the left anterior superior spine of the ilium. Marked ecchymosis of the upper thigh and groin region soon appeared, and clinical signs consistent with arterio-venous aneurysm of the iliac vessels developed. The foot became cold and blue and no pulsation of the leg vessels could be made out. X-ray examination showed no sign of foreign body from the imbilicus to the knee. Gangrene developed and the leg was amputated below the knee. The patient succumbed one month after the original injury.

It was found at autopsy that the bullet had entered the left external iliac artery and penetrated into the lumen of the left internal iliac vein causing an arterio-venous aneurysm of these vessels. From here the bullet was carried by the blood stream up the common iliac vein and the interior vena cava. It passed through the chambers of the right side of the heart, through the pulmonary valve, into the left branch of the pulmonary artery where it impacted as an embolus in one of the branches supplying the lower lobe of the left lung, and causing two infarcts in this lobe.

Dr. Fry goes on to say that such a tortuous course of the bullet's migration was in itself remarkable, but even more than this, examination showed no injury in any of the veins along which the bullet passed. The tricuspid and pulmonary valves were also uninjured. All through the illness there was no pain or discomfort referred to the heart or lung.

Bladder Tumors.—Dr. Howard A. Kelly, Baltimore, says: Malignancy in bladder tumors is not always to be determined from the microscopic standpoint. Some tumors which are classified as malignant by the pathologist are clinically benign and vice versa. An ulcerated and infiltrated base is the clinical test of malignancy. The treatment is occasionally by excision, but, as a rule, by fulguration and radium. Many patients have apparently been cured, even those who have tumors which are malignant and infiltrative.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held Friday evening, May 14th, at Hotel Chalfonte, Atlantic City.

"Progress in Surgery of Thoracic Diseases with Special Reference to Tuberculosis, Abscess and Tumors," was the subject of a paper by Dr. George P. Muller, Philadelphia.

In gunshot wounds and wounds from stabs, the psychic shock should have subsided before operation, but any prolonged waiting is not permissible. It is true that many cases get well without operation, but by comparison, it is found that the percentage of recovery from cases operated upon is much higher than from those not so treated.

Empyema: The treatment by suction drainage is very old. It was abandoned but has come into favor again. Excision of rib and drainage is attended by an average mortality between 20 and 25%, which is high. If these cases are traced, it is found that a large percentage develop a chromic cavity. Aspirate for dyspnoa, and then as soon as localization occurrs, use the trocar. The cavity should be washed out continuously. The mortality should be reduced to 5% if the operation is done in sections.

Abscess is serious from a surgical standpoint If it does not empty early into a bronchial tube, it should be evacuated. It is not necessary to make a differential diagnosis between abscess and gangrene, because the gradations between the two are difficult to distinguish.

Bronchiectasis: This is not a common condition. It is characterized by foul breath and paroxysms of coughing which expel a quantity of fetid mucus; these paroxysms occurring at intervals of six to eight hours. The treatment is to get rid of the cavity. Two methods are used, the less dangerous of which is ligating the pulmonary artery; in addition, the phenic nerve in the neck is sometimes cut. The second method is to remove a lobe or a whole lung. A cavity is left and infection finally results in empyema.

Tuberculosis: This being a granulomatous condition, compression will help. Nitrogen injections into the pleural cavity are given.

Tumors: Carcinoma and sarcoma are almost always secondary and nothing can be done. Dyspnoa, cough and loss of weight hold the diagnosis so long that the condition becomes too advanced for surgical relief.

Exploratory Operations: The technique of thoracic surgery has been perfected to such a degree that such operations are a safe procedure.

Carcinoma of the œsophagus has eluded us.

Nothing need be said of surgery of the heart except that drainage in suppurative pericarditis is resorted to.

"The Treatment of Epilepsy by Luminal—the Necessary Method of Administration for the Control of the Seizures," was the subject of a paper by Dr. Francis H. Dercum, Philadelphia.

Heredity, alcohol and syphilis are important factors in etiology. Arrested and deviate development are noticeable in the skeleton, in the teeth, the digits and hard palate. A study of twelve brains presented gross anomalies in convolutions and fissures. Epilepsy occurs from toxins, from infections of childhood, and from gastrointestinal disturbances.

Treatment: The patient should live close to nature; he should not be allowed to labor too vigorously; he should be subjected to as little strain as possible. Elimination should be free, by the skin as well as by the other excretory organs. Drugs: Sodium bromide, at the same time withdrawing salt from the diet.

Luminal in nocturnal doses of 1 gr. 1½ grs. will control the seizures. No ill effects result. The method of administration is as follows: Sodium bromide, in 10 or 15 grain doses, is given three times a day, after meals, and at night time 1 grain of luminal. The sodium bromide is gradually decreased until, at the end of six weeks it is entirely withdrawn, the patient getting along with luminal alone. The results are amazing, physically, mentally and psychologically. If hypothyroidism is suspected, try small doses of thyroid extract. Epileptics who have an attack of fever or are ill in any way, do not have an attack of epilepsy. Increased metabolism is, probably, the explanation.

Luminal belongs to the series of medinal and veronal. It is made from veronol. It is a strong motor sedative. In chronic insomnia, an hypodermic injection of luminal sodium, which is as soluble in water as common salt, produces an effect in twenty minutes.

An interesting discussion followed. A number of physicians reported successful results from the use of luminal.

CAPE MAY.

Eugene Way, M. D., Reporter.

The semi-annual meeting of the Cape May County Medical Society was held in the rooms of the American Legion at Cape May Court House on Tuesday, April 6th, with the following members in attendance: Drs. Douglass, Washburn, Hughes, J. Way, C. W. Way, E. Way, Corson and Marcy. Professor Stevens, County Superintendent Hand, and A. A. Surgeon, A. J. Casselman of Trenton, were present as guests.

Dr. Hughes presided and an interesting and timely address on the control of venereal disease was delivered by Dr. Casselman, who was voted the thanks of the society. The question of fees was taken up for discussion, and on motion it was voted that the minimum fee for office consultation be $1 and that a graduated increase according to locality be made for house visits; confinement cases to be $25 and double fees for night visits. It was decided that the next meeting be held at Cape May Court House.

HUDSON COUNTY.

William Freile, M. D., Reporter.

The eighth and last regular meeting of the society of the season was held Tuesday evening, May 4th, 1920, at the Elks' Club, Jersey City. The usual order of business was pursued, including election of delegates to the New Jersey State Medical Society, and in addition fifty-one new members were received.

Dr. W. F. Faison, Jersey City, gave his experience with radium.

The paper of the evening, "Practical Infant Feeding," was presented by Prof. Marshall C. Pease, Assistant Professor of Pediatrics at the Post Graduate Medical School, and attending on the babies' wards of the Post Graduate Hospital, also assistant attending at the Willard Parker Hospital.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Medical Society was held Wednesday, May 19th, 1920, at the Perth Amboy City Hospital, Perth Amboy, at 4 P. M. In the absence of the president, Dr. Laurence F. Runyon, the vice-president, Dr. George W. Fithian, presided.

Inasmuch as the regular date for the next meeting of the society would coincide with the date set for the State Society meeting at Spring Lake, it was regularly moved, seconded and carried that the next regular meeting be postponed one week, that is to June 24th, and at the invitation of Dr. Alfred L. Ellis it is to be held at his home in Metuchen.

It was voted that as many members as possible, of the Middlesex County Medical Society, attend the 154th annual meeting of the Medical Society of New Jersey at the New Monmouth Hotel, Spring Lake, June 15, 16 and 17th.

Following the conclusion of the regular business a paper by Frank C. Henry, M. D., of Perth Amboy, on "Some Errors in Treatment of Labor," was received by the members present with a great deal of interest. Following the conclusion of the paper an animated discussion was entered into by several members of the society. A unanimous vote of thanks was extended by the society to Dr. Henry for his instructive and interesting paper.

The meeting adjourned on motion following which a delightful luncheon was served by the matron of the Perth Amboy Hospital.

PASSAIC COUNTY.

Peter Brancato, M. D., Reporter.

The regular meeting of the county society was held May 11, 1920.

After the transaction of routine business, it was resolved to elect three new permanent delegates from the Passaic County Society to fill vacancies created by death or resignation of former delegates. Should this procedure be considered irregular, it was decided to nominate the following members as permanent delegates: Drs. G. E. Tuers and William Neer of Paterson and Dr. A. W. Van Riper of Passaic.

The following members were elected delegates to the annual meeting of the State Society: Drs. T. A. Dingman, O. R. Hagen, J. P. Morrill, W. A. Dwyer, T. A. Clay and W. W. MacAlister

Dr. Elias J. Marsh demonstrated a most interesting and unusual case: A subluxation of a cataractous lens of the eye. There was no history of trauma, still the lens was hanging loose by a mere point of its upper periphery and could be seen to sway backward and forward as the patient's head was correspondingly tilted.

In the discussion that followed Dr James W. Atkinson gave a clear and concise exposition of this type of case, indicating that the patient lie face down when operated upon, using a speculum which would obviate pressure on the eyeball, and hinting at the concomitant danger of loss of vitreous humor. Dr. E. L. Henion considered it safer to let it alone unless the operation were performed by a very competent man.

The papers to be read on the subject of fractures were postponed, at the suggestion of Dr. John C. McCoy, till a special meeting to be called at the discretion of President Francis Todd.

SUMMIT MEDICAL SOCIETY.

William J. Lamson, M. D., Secretary.

The regular monthly meeting of the Summit Medical Society was held at the Highland Club on Friday, May 28, 1920, at 8.30 P. M., Dr. Pollard entertaining and Dr. Jaquith in the chair.

Present—Drs. Bebout, Campbell, Embury, English, Falvello, Kay, Keeney, Lamson, Lawrence, Meigh, Pollard, Prout, Reiter, Smalley, Wolfe and Bensley.

The paper was read by Dr. Edgar A. Ill of Newark on "Tuberculosis of the Kidney." He called attention to the fact that this condition occurs as frequently as any other surgical condition of the kidney, and should be suspected in any case of prolonged acid pyuria, accompanied with frequency of urination. Painstaking care is necessary to demonstrate the presence of tubercle bacilli, but they can be found, sooner or later, in every case. He reviewed the pathology, symptoms and treatment, and a free discussion followed the paper.

AMERICAN MEDICAL ASSOCIATION.

The House of Delegates of the American Medical Association, on Thursday of convention week, decided upon Boston, Mass., as the convention city for 1921, and elected the following officers: President, Dr. Hubert Work, Pueblo, Col.; first vice-president, Dr. Isadore Dyer, New Orleans, La.; secretary, Dr. Alex. R. Craig, Chicago; treasurer, Dr. W. A. Pusey, Chicago; speaker of the House of Delegates, Dr. Dwight H. Murray, Syracuse, N. Y., and trustees, Drs. Chas. W. Richardson, Washington, D. C., Wilbur T. Sarles, Sparta, Wis., and Walter T. Williamson, Portland, Oregon. There were 3,650 registrations, a very large proportion of these being Southern doctors. A number of attractive and handsome entertainments were given for the doctors and the ladies accompanying them.

Prohibit Sale of Fake Remedies.—The village of Athens, N. Y., has incorporated into its sanitary code a regulation providing that no corporation, association, firm or individual other than licensed pharmacists and physicians shall sell or offer for sale in the village of Athens any medicine or so-called remedies, or any so-called medical appliances, unless before offering their commodities for sale they shall receive a permit from the local health officer.

Do not fail to attend the annual meeting of the State Society this month at Spring Lake.

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

154th ANNUAL MEETING

of the

Medical Society of New Jersey

will be held in the

NEW MONMOUTH HOTEL

SPRING LAKE

June 15, 16 and 17, 1920

Board of Trustees' Meeting in the Hotel, Monday evening, June 14th, at 8.30 o'clock.

First Meeting of the Society—House of Delegates—Tuesday morning at 10 o'clock. Closing meeting Thursday noon. Other meetings as announced on Program, which has been sent to members.

As the full program has been sent to all members, and a list of the papers was given in last month's Journal, we omit insertion again. We remind those who expect to attend of the importance of having their rooms at the hotel engaged as early as possible, as we expect a large attendance, and the hotel authorities wish to comfortably accommodate all who attend.

Annual Delegates must present to the Committee on Credentials their certificates of election, signed by the president and secretary of their respective county societies. Permanent Delegates must present their identification card bearing their own and the Recording Secretary's signature and the seal of the State Society.—W. J. C.

OUR ANNUAL MEETING.

This year's annual meeting should have an unusually large attendance, every trustee, officer, permanent and annual delegate and many other members of our county societies should endeavor to be present. The Scientific Program is fuller than usual and is of general excellence. That should favor a large attendance, but in addition we have business to transact of vast importance to the profession that needs careful consideration to protect the Society's interests and the profession's efficiency.

In these years of world war and world unrest the most valuable and most sacred institutions and organizations are suffering from the evil and destructive attacks of fakirs, demagogues, political grafters and money grabbers generally. The family, the church and the Sabbath—three institutions to which America—largely owes its greatness—have been undermined, and now our great profession, with its marvelous development and blessing to humanity, is seriously and infernally attacked; its scientific progress halted; its efficiency crippled and its very existence threatened. It needs no prophet to foretell that with the dragging down of these institutions America's greatness and glory will go.

For the first time in its grand history of 154 years, the Medical Society of New Jersey was compelled last year to stop in the midst of its great altruistic work to conserve and advance the health interests of our State and its citizens, to consider the profession's material interests, when it appointed a committee to consider and guard the profession's welfare. And we emphasize the fact that that action was taken **not to increase the financial income of its members, but to enable the profession to continue its progress in the science and art of medicine for the good of humanity.**

The committee has done its duty as well as novices in this line of work knew how. Several meetings have been held at considerable expense of time and study, at no charge for its members' personal expenses, but at considerable cost to the Society, as authorized by the Board of Trustees and the committees of five of

the county societies that met with them. They did not, however, reach the allowance granted them by some hundreds of dollars. The committee will present its report at the annual meeting with some recommendations that will aid in future work. It is evident that the time alloted for the annual meeting will be fully occupied; that the sessions should begin on time and that all discussions should be brief, concise and practical, avoiding all unnecessary repetitions.

RAYNAUD'S DISEASE.

We offer no apology for the large amount of space we have given to this issue of our Journal to Dr. DeForest's paper on Raynaud's Disease; nor have we any hesitation in expressing the conviction that it is one of the ablest and most important papers that has ever appeared in our columns. It has been said that this disease is of rare occurrence and therefore consideration of it is not of so much importance as that of some other diseases that are far more common and need to be studied for their more efficient treatment; but the truth is that Raynaud's Disease is far more common than is generally believed, and the fact is that it is a disease that is so little known that medical practitioners generally have failed to recognize and correctly diagnose it.

Dr DeForest has, therefore, rendered a most valuable service to the profession by giving us by far the ablest and most practical paper that has ever appeared in the English or any other language on this subject. The doctor has given the subject an immense amount of time in its study in this country and abroad and has mastered it theoretically and practically, as is shown in the 17 cases which he reports in his paper.

We feel highly honored in having the Medical Society of New Jersey and its Journal chosen as the medium through which Dr. DeForest gives the profession at large the results of his study and makes this most valuable contribution to medical literature. The doctor has not only furnished us with the paper, but has also provided the cuts which so clearly and fully illustrate it. The sketch which he gives on page 181 of his efforts to secure the picture of Dr. Raynaud, is remarkable and is one of the evidences that neither time, trouble or expense were considered in the preparation of this paper. We believe this picture of Dr. Raynaud is the only one in existence. The Medical Society of New Jersey does express its appreciation of Mr. Carrington's efforts in securing the photograph; of Madame Raynaud's generosity in its presentation, as well as of Dr. DeForest's honoring us and serving the profession by providing the paper.

MEDICAL LEGISLATION.

We call our readers' attention to the following editorial which appeared in the May issue of the Kentucky Medical Journal. New Jersey greatly needs medical men in our Legislature of the same ability and character as Kentucky has recently had:

"The recently adjourned meeting of the General Assembly of the Commonwealth of Kentucky was peculiarly fortunate in that it was able to secure advice along matters of public health and medical education from the thirteen physicians who were amongst its leading members. In order that the profession of the State may show some recognition of the appreciation they feel for the sacrifice these gentlemen made in spending sixty days away from their active practices, we are publishing photographs of each of them in this number.

"For many years the electorate of the State has shown an appreciation of the character of the service that can be rendered by physicians in the General Assembly. It is especially gratifying that it has been the rule to elect men whose attainments as physicians have been of the highest grade. Several members of the 1920 Legislature are veterans in legislative work. These men developed a leadership that showed itself not only in medical and health legislation but in all of the great constructive work done at Frankfort this year. They were particularly active in the laws remodeling the State Board of Charities and Corrections, and making out of this hitherto political organization a great non-political business-like body which will enable Kentucky to resume its position of leadership in the treatment of its unfortunates. No other class of members were better able to appreciate the necessity for good roads and many of the best provisions of the new good roads law, were introduced by the medical members. They were also active in the school legislation, which has revised Kentucky's educational system, so that it is now possi-

ble for us to develop a system whereby the school children of the State will receive an equal opportunity for education with our sister states.

"The medical profession has a right to feel very proud of its representatives at Frankfort, and the citizens of the State generally have reason to congratulate themselves on their selection. It is of special moment that the profession realize that the term of all four of the Senators who are physicians expired with this session, and it is of especial importance that the leading physicians in the nineteen districts which will elect Senators in 1921, arrange that there shall be at least as many of our profession in the next General Assembly as there were in this.

"It is of interest to know that there was not a meeting or caucus of the medical members of this General Assembly during the entire session. All that they did in regard to medical and health legislation was done at the meetings of Committees and in the open before all those who were interested in each particular bill. There has never been any idea of improper influence on legislation by members of our profession, and no previous session has been freer of any organized effort on its part to use or influence its members in favor of or against particular bills."

PROFESSIONAL ETHICS.

From an Essay by Dr. Ezra M. Hunt, delivered at the annual meeting of our State Society at Mt. Holly, May 27, 1873. We give only his first section; the other sections are: 2. What is our duty in reference to practitioners of different faith and practice from us? 3. What are our privileges as to advertising, or in general as to the management of our profession as a business; 4. What is our right relation to patent medicines or instruments and to dealers in or venders of the same? The whole essay is worthy of our careful reading and study and also of adoption in practice. Limiting the insertion, for lack of space, we call special attention to his first division of the subject, as follows: "We believe first, then, that it is due from all members of the regular profession, that they should be members of the regular profession, that they should be members of some District or County Society, and have thereby relation to the medical men of the section in which they reside. This kind of consideration seems due from one physician to another, because experience has shown that association has a tendency to maintain the morale and courtesy of members of any profession. Just so soon as you see the standard of any science elevating itself, or of any art, we see a tendency in its votaries to segregate, not only for discussion and comparison of investigation and experiences, but for acquaintance; and we maintain that in all healthful medical advance the same feeling is apparent. That graduate of regular medicine, who is willing to stand aloof from societies in which his brethren are mingling, in almost all cases is not only withholding his influence from an approved method of advancing our callings, but is lowering his own standard, is encouraging personal exclusiveness, and fostering a spirit inimical to the welfare of the body of medicine and its ethical rules.

We are aware that local causes may exist why some particular neighborhood society may not seem promotive of good feeling or awaken scientific interest, but more frequently we have found jealousies and petty rivalries to diminish with such association; and now and then a virulent exception by no means nullifies the statement. We would give to practitioners such liberty of choice as that they may belong to the County Society of their own county or of any adjacent county, but we do believe that the ethics of our profession is greatly conserved by such association; that those standing aloof are not as ethical as they should be; and that we should all encourage a full membership of these societies in all parts of our State. When questions of difference arise, they are to be met with that courtesy of debate and forbearance of feeling which belong to us as gentlemen and as physicians, and when the misunderstanding seems flagrant, it should calmly be referred, as suggested in the code of the American Medical Association to a kind of jury of our peers without the arena of excitement, and their conclusion should not only have the force of an opinion, but of an ethical decision."

Dr. Hunt closed his essay with the following words:

"Ethics is not a dress-parade question, but has integral relations both to the welfare of the profession and the common interests of the public whom we serve. We are ethical because we are on duty and on the march after disease, and need the drill and decorum of a well-equipped corps, and need that stragglers and deserters be kept

outside the line in order that we may do good effective service for the public weal."

We regret the delay in inserting some able papers in the Journal. It is owing to the unusual number received which is rarely the cause of delay. We shall be obliged to give more space than usual in the next two months' issues to Original Articles, because of the annual meeting orations, addresses and papers that will require several months for their insertion.

Resolution adopted March 10, 1920, at Newark by the Welfare Committee of The Medical Society of New Jersey:

Resolved, that the action of the Legislature in passing, and the Governor in signing the Chiropractic bill have made a serious attack upon the protective medical legislation, that the State has taken forty years to erect. This has been done by sacrificing the interest of the citizens of the State of New Jersey for the purpose of securing the support of interests sinister in their purposes and for political results.

INTEREST ON LIBERTY BONDS.

Uncle Sam is distributing $43,454,162 as interest to holders of Fourth Liberty Bonds in the Second Federal Reserve District.

The total amount of subscriptions for the Fourth Liberty Bond issue in this district was $2,044,901,750; there were 3,604,101 individual subscriptions; the rate of interest on these bonds is 4¼%. It is expected that as has been the custom in previous payments of interest money due on Liberty Bonds and Victory Notes that thousands of patriotic men, women and children of New York, New Jersey and Connecticut will re-invest their Liberty Bond intesests money in Government Savings Stamps. In order to facilitate the re-investment of coupon money in Government Savings Stamps arrangements have been made for their acceptance at post offices and banks, as direct payment in lieu of currency for these minature Government discount bonds.

Clip your coupons and re-invest the interest money in Government Savings Stamps or Treasury Savings Certificates.

The public has no way of telling a good physician from an ignorant one.

Public judgment is based on the kind of car he drives, the church he attends, the social position of his wife, his whiskers or the protuberance of his abdomen. To the public a 48-inch waist measure signifies a 48-calibre brain.

A man may be a good Elk, a first-rate Shriner, an excellent grand sachem of the Red Men, own his own magnificent home and be looked up to as a famous doctor, and not be able to tell a mitral leak from a gastric ulcer.—A. M. A. J.

IS HE WORTH WHILE?

Is the non-attending member in our county society worth while? The distant living member is not included in this consideration. Is the non-attending member worth defending when he gets a malpractice suit on hand? Is it worth while for the active members of the society who kept things going and who would be compelled to lose their good time attending court to help the fellow in trouble when that particular individual never bothered attending any of the meetings nor bringing anything good to the fellows? One courtesy deserves another. The sick or unfortunate are excepted. Twenty years ago, such actions "went." To-day it is ver different. The Medical Defense Fund, any other means of progress have put an entirely different construction upon the membership. If the non-attendant does not thing it worth while, why should the active members make it worth while to defend him? Pay his dues? Surely, that is not the only good thing in this world. Good-fellowship is often valued above price. A physician without any joint interest or fraternal feeling is not worth a shuck, for by his own action, he makes himself a poor member. He is hardly worth while.—Bucks Co., Pa., Medical Monthly.

MULTIPLE BOARD AND CONFUSION IN LICENSURE.

The chief difficulty in medical licensure at present is the confusion caused in several states by the multiplicity of the medical and sectarian boards which have to do with the licensing of those who are to treat the sick. This condition should be corrected. Whether or not the practitioner is to make use of medicinal substances, whether he is to apply massage, electricity, cold compresses or to perform a surgical operation is not so material. The matter of first importance is whether he who holds himself out to treat the sick

has had training sufficient to familiarize himself not only with the normal conditions and functions of the human body, but also with the various forms of disease so that he may tell whether or not a paitent is sick, and if so, what the trouble is. The practitioner should also be familiar with the many procedures and materials used in the treatment of human disordres so that he can select and apply the right treatment to each particular patient. These statements apply to all practitioners of the healing art regardless of the particular system or method of treatment they advocate. To claim that one form of treatment is applicable to all human disorders is as illogical as to state that the slide-trombone constitutes an entire orchestra. Before one specializes in the playing of any particular musical instrument in an orchestra he must first have secured a training in the fundamentals of music, so that he may know not only when to play but—fully as important—when he should not play. In fact, a note from an instrument in the wrong place may produce more disastrous results than if the player fails to respond at the time his part is indicated. So in the practice of the healing art. Every one who treats human disorders by any special method or system of treatment should first have a thorough training in the fundamental medical sciences, so that he will understand not only when his particular method should be used, but, even more important, when it should not be used. Here again, the use of the wrong method of treatment may produce results fully as disastrous, if not more so, than if such treatment is not used in cases in which it is indicated. In fairness to all who practice the healing art, therefore, there should be in every state: (a) one board of registration; (b) one standard of educational qualifications, and (c) one examination, including written, practical, laboratory and clinical tests. In other words, let all practitioners alike be required to possess reasonably high educational qualifications, and then let them practice as their educated common sense may dictate. Such a provision would not only end the confusion which exists in many states, but also insure better care for the public when sick or injured.—A. M. A. Journal.

Remember date of Annual Meeting. Make your plans to attend it.

Miscellaneous Items.

We heard a young doctor just out of his hospital service say the other day that he had had four years in a medical school, Class A, too, and that he had spent nearly two years in a good hospital, but that he had never had one word said to him about the ideals of medicine, the ethics of medicine, nor the history of medicine. No wonder we have so many dollar grabbers, if this young man's experience is the common experience of students and internes.—Tenn. Med. Jour.

Making a Skilled Physician. — Hippocrates named six conditions necessary to become a skilled physician: Natural talent, instruction by a competent master, a place favorable to study, education begun in youth, love of work and long application. The first of these conditions is the most important, for where there is not a natural disposition it is useless to attempt to force Nature. Theory should be combined with practice. Want of experience begets either timidity or rashness. Timidity discloses impotence and rashness ignorance.—Tweedy, Bri[4]. M. J.

Unnecessary Things.—I am not so sure that all the x-rays that are being taken really have to be taken. No more than I am sure that all the teeth that are extracted, or all the tonsils, ovaries and appendices that are removed have to be extracted or removed. However, the unnecessary taking of an x-ray does not injure the patient, does not jeopardize his life and does not make him an invalid for a time. It only injures him in his pocketbook—which, however, in the case of people working for a wage or a moderate salary is sometimes a serious matter.—Critic and Guide.

Probabilities as to When the First Birth Will Occur.—According to Knibbs, statistician for Australia, the probability of a nuptial first birth occurring in less than one year after marriage is 0.4946 for age 15 of the wife; 0.7770 for age 18; 0.9176 for age 21; the maximum, or 0.9771, for age 25; 0.9075 for age 30; 0.6748 for age 35; 0.3245 for age 40, and 0.0622 for age 45. The foregoing statistics are based on the supposition that the husband is approximately the same age as the wife. If he is younger or older than the wife, the probability will be affected accordingly.

The Return to Barbarism.—The war has an after-math characterized as a return to barbarism through regression and inversion of social values. A laboring man earns more than a physician, a chauffeur than a professor in the Sorbonne, while the mopmen are the best paid of any of the university personnel. It is an era of bad taste, egoism, and brutality, and materialism overrides intelligence—a logical demonstration of the outcome of Marxism had the latter ever been successfully introduced. The arm is now more powerful than the brain, for with complete equality conceded one of the two must go under.—Journal des praticiens.

Gov. Smith Urged to Veto Chiropractic Bill.

A communication was sent to Governor Smith of New York State last month by the board of managers of the State Charities Aid Association asking him to veto a bill passed by the Legislature urging public recognition of the practice of chiropractic. The bill authorizes the licensing by the state of persons not necessarily possessing medical degrees who claim to be able "to locate and adjust by hand misplaced or displaced vertebræ of the human spine, to relieve the nerve pressure caused thereby."

The memorandum submits that "no persons trained in anatomy and the treatment of disease recognize that there is any such thing as "misplaced or displaced vertebræ," in the sense referred to. If a man is hanged his vertebræ are very likely displaced, but aside from some such casualty the words "misplaced or displaced vertebræ" do not correspond to anything recognized as existing in medical and surgical practice. The whole structure of chiropractic is built on an assumption which, according to the best information we can get, has no basis in known fact that is contrary to all accepted scientific teaching."

Resolutions adopted by the board of managers say approval of the bill would constitute a real and serious danger to the health of the people of the state.

The Doctor's Dilemma.

(From The Milwaukee Journal.)

The doctor, like his brother professional men, finds himself in a tight place in these days where income and outgo make such close connections. But the doctor has an additional grievance. The salaried man gets his pay, such as it is, on time. The doctor frequently has to wait for his and sometimes waits in vain. All the other bills apparently take precedence over the doctor's. Not, surely, because his services are less valued or because he is less in need, but more because he has the feeling that in his profession service should rank above profit. Were he to emulate the tradesman, he would run the risk of lowering the splendid tradition of his brotherhood. A minister almost never sues for his salary. A doctor must look at it in somewhat the same way. If the ethics of a profession stand in such wise, an obligation of honor surely lies upon those whom the profession serves to accept the same high standard and live up to it. * * *

Medical Science.

From the Green Bay, Wis., Press-Gazette.

The victories which medical science has won over disease have in very few instances if ever, been decided by a lucky chance. Only by utilizing the accumulated knowledge of centuries and all the information available from his contemporaries, has the investigator been enabled to make significant discoveries leading to the cure or prevention of disease.

Contributions to the medical science of today come from the most diverse sources. The physical chemist determines one fact, the pathologist another, the zoologist, the bedside physician, the sanitary engineer, the economist and many other specialists make and record their observations and the interpretations which they place upon them. These discoveries must stand trial at the hands of contemporary workers along the same lines. If they stand the test, they become incorporated into a working hypothesis to be applied practically until new discoveries show it to be false or in interpretation, or place it in a new light, where its application may be different.

The literature in which observations bearing on medical subjects are reported and thrashed out is of such enormous volume that no one mind can compass it. Even with the aid of periodicals which attempt to collect and classify this literature in the form of abstracts, the worker in one single little branch of a medical specialty is pressed to keep abreast of his subject. It is like a fusillade of bullets directed against our common enemy—disease. If many a bullett misses the mark it is nevertheless true that now and then some do hit it squarely. Disease is slowly but surely being pushed back from trench to trench, and ultimate victory is only a matter of time, perseverance and concerted action.

In Fixing Your Fee—Think.

In a recent issue of "The Bulletin," published by the Academy of Medicine of Toledo, an anonymous correspondent calls attention to a subject that is worthy of more consideration in our medical societies:

"There is a story that is told about a certain mill in which there was trouble with the machinery. Several men of limited experience had attempted to correct the difficulty and had failed. It was important that the mill be kept running and finally there was summoned a man known to be well trained for the kind of repair needed. He came and in thirty minutes had accomplished what was desired. When asked for his bill he replied, $25.50, and in explanation said that the 50c was for his time and labor and the $25.00 was for 'knowing how' to do the work.

"There is another story that is also well worth telling. In the city of Toledo there is a certain human mill called Mr. Blanck, in which there was trouble with the machinery. Several men of limited experience, called friends and druggists and osteopaths, had tried to remedy the trouble and had failed. It was important that this human machine be kept running and finally there was summoned a man known to well trained for the kind of repair needed. He is a physician and a member of cur Academy. He came as requested and recognizing the real cause of the trouble prescribed and outlined a plan that relieved it. When asked for his bill it was $2.00, the price of one visit and based upon the value of time and labor. To him a visit was just so much work and they all looked alike. The 'knowing how' that he had obtained by years of preparatory study and expense was considered to be so simple and easy that it was thrown in for good measure and good fellowship.

"In these stories we should find a lesson. Day after day the physicians of this community go about their work understimating the value of their services. A thing is always mighty easy to do when one knows how and it is the 'knowing how' for which we are employed. It naturally follows from this that we should

be paid for 'knowing how' and for its value to the purchaser, instead of on the basis of mere time and labor. In the matter of charges many physicians are just drifting, usually under 'a charge per visit system,' when they should apply 'a charge per value received system.'

"Every medical visit should constitute a separate and independent engagement in the matter of charge. In Toledo the minimum for a residence call should be $2.00, and the blue sky the limit, if the 'know how' is worth it to the other fellow. What the physicians' service is worth to the patient, is a topic that should soon appear on the program of the Academy of Medicine."

Therapeutic Notes.

Bronchial Asthma.

Dr. Schnirer recommends the following:

Tincture of lobelia, 5 grams.
Wine of antimony, 5 grams.
Anisated solution of ammonia, 1 gram.

S.: During the attack 10 drops may be given every fifteen minutes.

Cough in Children.

Tinct. Belladonna, 10 minims.
or
Tinct. Byronia, 10 minims
Tinct. Lobelia, 10 minims.
Fluid Extract of Anise, 20 minims.
Syrup q. s. ft., 4 ozs.

Sig. From a half to a teaspoonful according to age every two hours. If the cough is tight and distressing apply some anticongestive ointment over the throat and upper part of the chest.

Gastric Ulcer—Treatment.

Dr. H. Laveson, in the Indianapolis Journal, gives the following method which he considers the best for gastric ulcer: The patient is kept in bed for three weeks. Nothing is allowed by mouth for three days, fluid being furnished by the Murphy drip method. One half quart (1,500 c.c.) is given in twenty-four hours, thirty drops a minute. This relieves the distressing thirst so often present in this disease. The addition of forty-five grains of strontium bromide to the drip helps to keep the patient quiet and comfortable. Feeding is begun on the fourth day, consisting of two ounces of fully peptonized milk every hour or two from 7 a. m. to 7 p. m. Half way between the feedings a powder, consisting of ten grains of bismuth and twenty grains of bicarbonate of sodium, is used. If the bowels are not constipated, and if pain and acidity have been permanent symptoms we may rely on the following prescription:

Extracti hyoscyami, } aa, gr. ss.
Argenti nitratis, }
Misce et fiat pilula, No. 1.
Mitte No. xxiv.

Signa.: One pill three times a day.

Each day the milk is increased one ounce until four ounces are taken every hour, or eight ounces every two hours, depending on the need of the individual patient, i. e., some do best on hourly feedings, some on nourishment every two hours. After eight days of feeding a tablespoonful of well cooked farina is allowed, at first twice a day with the milk feedings which are kept up continuously. On the tenth day farina and cream of wheat are allowed with three of the milk feedings. On the twelfth day the cereal is increased to two tablespoonfuls, and a small sprinkling of powdered sugar is allowed. On the fifteenth day four soft feedings are allowed, evenly spaced throughout the day, milk toast being used once. On the seventeenth day a soft boiled egg is allowed or custard. In the fourth week the patient is allowed to be up, but can do no real work for a period of seven or eight weeks. His diet consists of two soft boiled eggs, cream soups, vegetable purees and soft foods, such as jellies, custards and creams, may be added. Farina, cream of wheat and rice cooked to a pulp are best. The bismuth is continued for six to eight weeks and for a year or more only soft unirritating foods should be taken.

Prostatitis—Chronic.

Argenti nitratis, gr. i (0.06 gram).
Cocainæ hydrochloridi, gr. ii (0.12 gram).
Olei theobromatis, ℥iss (6 grams).

Fiat suppositoria No. vi.
Sig.: One to be inserted before retiring.

Pyorrhea.

Sodii bicarb, ℥ss.
Glyceriti acidi tannici, f℥j.
Acidi carbolici, gtt. xv.
Aq. chloroformi, f℥vj.
Aqu. dest, q. s. ad f℥vj.

M. Sig.: f℥i in aq. as a mouthwash b. i. d. For pyorrhea and receding gums.

Warts.

Among the escharotics suggested for the removal of warts is painting with glacial acid. Stronger caustics should be used with great caution. The surrounding skin should always be protected. Burning with the thermocautery followed by application of mild corrosive preparations, radium, treatment with Roentgen rays, are efficient methods. A good preparation is:

Chloral hydrate, 10 grams.
Salicylic acid, 2 grams.
Collodion, 30 grams.

Also the following is suggested:

Calomel, 1 gram.
Salicylic acid, 2 grams.
Wool fat, 20 grams.

Apply to a wart two or three times a day.

Antangonism of Adrenalin and Quinine.—Drs. Clerc and Pezzi speak of the subtotal antagonism between these substances. Thus adrenalin excites the center of the vagus in the bulb while quinine paralyzes it. One drug therefore excites the heart and the other slows it. Similar antagonism is seen in the province of the blood pressure, but here the activities are complex: adrenalin raises the tension by combined cardiac and vascular action, and quinine makes for hypotension by a mechanism which is not altogether obvious. Both drugs are technically vasoconstrictors.—Le Progres Medical.

Insomnia of the Aged.—People of advancing years are apt to be wakeful in the latter part of the night. This tendency can be generally relieved by giving a combination of hyoscyamus and passiflora in the following form:

Tinct. hyoscyamus, 1 oz.
Tinct. passiflora, 1 oz.

Mix and give five drops in water every half hour for two or three hours before bedtime.

Myalgia.—Pain in general, neuralgia, rheumatism, stiff neck, pain from an injury, sprain, etc. Apply a flannel cloth wrung out in hot water, cover this with a dry towel, and over it pass slowly and lightly a hot sad-iron; constantly moving it, as the patient winces from the heat; this controls the pain.

Pertussis.—Dr. Audrin claims to have cured, rapidly, cases of whooping cough by the injection of sulphuric ether, pure, given every second day in doses of 15 minims up to the age of 10 months and after this period 30 minims. The injection should be intramuscular, given in the thigh and at the same point for succeeding injections. The stage of the disease is not given. Rarely is a fourth injection necessary.

Hospitals; Sanatorium.

Bequests to Hospitals.—Under the will of Henry C. Kelsey, former Secretary of State, the following Trenton hospitals will receive legacies: St. Frances Hospital, $80,000; McKinley Memorial Hospital, $80,000; Mercer Hospital, $60,000.

The Hackensack Hospital.

The Hackensack Hospital building fund campaign for $500,000, which was started May 24, has now reached a total of $325,000. Much enthusiasm has been manifested in the campaign. The plan for a new hospital provides for a five story fireproof building, with every modern improvement, which will be erected on the present site of the institution.

Bridgeton Hospital Training School.

Three nurses graduated from this school on the evening of May 12th. Major Millard F. Sewall, M. D., made the address to the graduates and President Powell of the Directors' Board presented the diplomas and made a plea for more students to enter the training school.

City Hospital, Newark, Training School.

Twelve nurses graduated from this school last month. Dr. Carl E. Sutphen, president of the medical board, presided and made the principal address. Mayor Gillen presented the diplomas.

Training Schools.—Eleven nurses graduated from the Muhlenberg Hospital School, Plainfield, on May 20. The president of the board of governors presided and addressed the graduates.

Thirteen nurses graduated from the Overlook Hospital, Summit, on May 20th. Dr. R. H. Hamill presided. Dr. F. I. Krauss, Chatham, addressed the graduates. The Janeway prize of $20 was won by Miss Grace Hopkins of Summit.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, reports that on April 1st there were 215 patients present in the sanatorium, 119 males and 96 females. This number included 29 males and 30 males in the preventorium. During the month 51 patients were admitted, 20 males and 31 females, twenty-five of these went to the preventorium. Five were readmissions. The admissions were classified as follows: Pretubercular, 25; incipient, 1; moderately advanced, 5; far advanced, 20. The largest number of patients present at any time during the month was 225; smallest number 214; the present number is 224. The daily average for the month was 219.8.

Report of the School for April:

Total possible days—boys 449, girls 681½; total days present—boys 437, girls 643½; total days absent—boys 12, girls 38; days lost by personal illness—boys 9, girls 0; pupils neither absent nor tardy—boys 10½, girls 12; times tardy—boys 0, girls 0; total enrollment—boys 57, girls 75; total on roll—boys 30, girls 45; per cent. of attendance, .956. The difference between days absent (50) and days lost by personal illness (9) is (41) due to the pupils being at home.

Marriage.

RODGER-HORNER.—In Camden, N. J., May 22, 1920, Rev. Dr. J. C. Rodger, late of Shanghai, China, to Dr. Clara L. Horner of Camden.

Deaths.

MILLER.—At Netcong, N. J., May 7, 1920, Dr. John Miller, aged fifty-eight years.

Dr. Miller graduated from the New York University Medical College in 1886. He practiced at Netcong about thirty years.

MOORE.—At Sussex, N. J., April 30, 1920, Dr. John Moore, aged 76 years. He graduated from the College of Physicians and Surgeons, New York City, in 1866, and had practiced in Sussex over 50 years.

SEALY.—In Newark, N. J., May —, 1920, Dr. Edward Sealy, from apoplexy, in his 71st year.

Dr. Sealy was born in Newark January 3, 1850; graduated from Rutgers College and in 1884 graduated from the Bellevue Hospital Medical College. He was head physician and surgeon in the Hospital for Women and Children, Newark.

SMITH.—In Salem N. J., May 13, 1920, Dr. Ellen Bradway Smith, suddenly, aged 55 years.

Dr. Smith graduated from the Woman's Medical College of Philadelphia in 1892 and has practiced in Salem many years. She was a member of the Salem County Medical Society, the Medical Society of New Jersey and

the American Medical Association. Death resulted from an automobile accident, having received a fracture of the skull.

The following resolutions in memory of Dr. Ellen B. Smith were adoted by the Salem County Medical Society:

Whereas, The Salem County Medical Society wishing to give expression to the loss it has sustained by the death of Doctor Ellen B. Smith,

Would Resolve, That in preparing an appropriate tribute to her memory we cannot overestimate the value of the service that were rendered by her to this society, and the community in which she has for so many years practiced her profession.

This splendid service in the cause of relieving suffering humanity was best exhibited in her untiring, self-sacrificing devotion to their needs and reached its highest attainment in conscientious duty well performed. Her genial manner made her a more than welcome visitor to the sick and depressed; to many of whom the dispensing of cheer and encouragement, rather than drugs, made the path easier for their convalescence and return to health.

It is Further Resolved, That a copy of these resolutions be entered upon the minute book of this society, a copy forwarded to the family, also published in the Salem paper and the Journal of the New Jersey State Medical Society.

R. M. A. Davis, David W. Green, Wm. H. James, Committee.

Personal Notes.

Dr. A. Schuyler Clark, New York City, has removed his office to 10 East 61st street.

Dr. Clarence A. Hofer, Metuchen, was reported last month as having been operated on in a Philadelphia hospital. It was an error; he was operated on in the Mayo Hospital, Rochester, Minn. and is recovering.

Dr. Samuel L. Salasin, Atlantic City, has been elected health officer of that city in place of Dr. Talbot Reed, recently deceased.

Dr. Archangelo Liva, Lyndhurst, was chairman of the Italian loan drive for South Bergen County.

Dr. John C. McCoy, Paterson, Lieut. Colonel M. C., U. S. A., was decorated on April 30 with the Distinguished Service Cross at Governor's Island by Lieutenant General Bullard, commander of the Department of the East. Colonel McCoy was cited for exceptional bravery under fire at a hospital at Joug-sur-Nurin and at Chateau-Thierry, where he commanded Red Cross hospitals.

Dr. F. Irwin Krauss, Chatham, has been selected to make the address to the graduates of the Overlook Hospital Training School on May 20th.

Dr. Henry E. Ricketts, Belleville, reported last month to the Freeholders that there were eight cases of smallpox in the Isolation Hospital. The highest number was thirty-three in the preceding month.

Dr. Fred E. Riva, Milltown, had a narrow escape from serious injury in a bad automobile accident last month.

Dr. William G. Schauffler, Princeton, delivered an able address on "Hygiene" in the Emmanuel Methodist Church at Pennsgrove recently.

Dr. Charles B. Smith, Washington, who had been ill from blood poisoning underwent an operation last month, performed by Drs. Babcock and Morgan of Philadelphia, and is convalescing.

Dr. Ernest McDede, Lyndhurst, returned recently from a four days' hunting trip in Sussex County.

Dr. Henry H. Bowles, Summit, was operated on recently for an abscess in the head by Dr. E. B. Sutphen of Morristown.

Dr. George B. Philhower, Nutley, and wife have returned from Richmond, Va.

Dr. Norman H. Probasco, Plainfield, underwent an operation recently in St. Luke's Hospital for intestinal disease.

Dr. Robert R. Sinclair, Westfield, was quite ill last month.

Dr. Norman N. Forney, Milltown, has recovered recently from a severe attack of blood poisoning, the result of a wound received in operating on a patient.

Dr. Archangelo Liva, Lyndhurst, was reappointed school physician by the local Board of Education last month.

Dr. Josiah Meigh, Bernardsville, and wife recently return from an automobile trip to Washington and Virginia.

Dr. George B. Philhower, Nutley, and wife spent a few days in Richwood, W. Va. The doctor has recovered from his severe illness recently.

Dr. George S. Laird, Westfield, spent a few days in the Pocono Mountains recently.

Dr. Richard G. Savoye, Westfield, is spending his vacation in Florida.

Dr. Ellery N. Peck, Boonton, has been appointed local representative of the U. S. Public Health Service at Boonton.

Dr. D. C. English, New Brunswick, represented his 191-year-old Presbyterian Church last month at the Centennial Anniversary of the First Presbyterian Church of Lambertville. He expresses thanks to Dr. and Mrs. E. W. Closson for their generous hospitality on that occasion.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed.	Failed.
Alabama, January...	6	6	0
Arizona, January....	16	11	5
Dist. Colum., Jan....	8	8	0
Florida, March	6	3	3
Hawaii, January....	11	5	6
Missouri, January...	21	18	3
No. Dakota, Jan.....	8	6	2
Pennsylvania, Jan...	95	81	14
So Dakota, Jan	23	22	1
Vermont, February..	2	2	0
W. Virginia, Jan.....	12	7	5
Wyoming, February..	2	2	0

The New York Board licensed 8 by endorsement of their credentials on January 19th.

The Iowa Board licensed 15 by reciprocity in January.

Public Health Items.

The Newark March health record showed a death rate of 14 per 1,000. That of March, 1919, was 17.8.

Health and Education.—A very significant trend in education during the past few years is shown in the recognition that health is fundamental to sound intellectual development and that the rigid regulation of all things pertaining to the hygiene of students is indispensable. Generally speaking, there is serious economic and academic loss year after year in our schools, colleges, and universities, due to lassitude, indisposition, illness, and epidemics among students, all more or less preventable. —John Sundwall, Pub. Health Rep.

Factors Essential to Recovery from Tuberculosis.—Two things more frequently than any others work against the recovery of persons who have tuberculosis. One is that in so many cases of tuberculosis the true nature of the disease is not recognized while it is in the early stage, when it is much more easily cured than it would be later. The other is that many persons refuse to believe that they have tuberculosis until the evidence is so plain that the diagnosis of the physician is no longer needed. —Bull. Maine State Dept. of Health.

Loss of Health.—The transition from vigor to health, from health to impairment, and from impairment to disease is gradual, almost imperceptible. The loss of vitality does not take place abruptly, suddenly, in ways that stagger and arrest one's attention, but our vital losses, like our financial losses, are in driblets, in pennies, nickels and dimes, and occasionally quarters. And in the one case, as in the other, we do not become alarmed until our surplus is dangerously drawn on.—W. S. Rankin, Tr. Ass'n, Life Ins. Presidents.

Dr. Worl on Smallpox and Vaccination.

Dr. Edward E. Worl of Newark, in a communication in the Newark Evening News, recently, after commending an editorial in the News, gives his convictions in favor of vaccination, founded on an experience of over 2,000 cases of smallpox, as follows:

It needs medical experience with smallpox properly to judge its value. No one who has seen the miseries of this disease (smallpox) would hesitate to do anything to mitigate its horrors. We must not forget that once smallpox was as common as the measles, and, like the measles, essentially a disease of young children Only lately I saw in Soho Hospital nineteen cases of smallpox, none of which had ever been vaccinated. Six of these cases came from one class in a Belleville school.

Personal liberty does not include the right to endanger the health of another, for the courts indorse this position. When a person gets smallpox the expense comes on the public tax rate; therefore, we have a right to say what shall be done to avoid this expense. Vaccination is not a belief, nor is it to be considered on grounds of sentiment or prejudice. Vaccination is a medical treatment to destroy a destructive disease. Vaccination and revaccination, properly performed, and kept cleanly, are a complete protection against smallpox. Unvaccinated people are a potential danger in any community.

No reasonable citizen will object to a measure practiced for 125 years and with the authority of all civilized countries for it—the armies and navies of the great nations are vaccinated. At this time it is not necessary to debate a settled question purely medical in character.

We have in Newark fortunately been able to keep our people fairly well vaccinated, but as time passes on this immunity has to be renewed to maintain its protective value. Some years ago I analyzed 404 cases of Newark smallpox, taking the cases as they appeared on our records, with the following results:

	Cases	Deaths	Per cent
Totally unvaccinated	195	56	28 7-10
Vaccinated when exposed to smallpox in their homes	70	4	5 5-7
Vaccination mark more than 5 years old.....	131	12	9 1-10
Vaccination marks said to be less than 5 years old	7	0	0
Secondary smallpox	1	0	0

First attack at 3 yrs. old.
Second attack at 52 yrs. old.

This table shows the fallacy of waiting until smallpox appears before vaccination is performed. We have, then, to run a race with the smallpox to see which takes first. Seventy-five per cent. of people can be revaccinated at some time in their lives, for immunity varies with the individual.

I do not think it is generally known that even smallpox does not always protect against itself. I have seen three well-authenticated cases of secondary smallpox, and I have been able to vaccinate a well-pockmarked individual who considered himself immune to vaccine by virtue of his attack of smallpox in early life. Fortunately the vast majority of our people are very sensible on the question of vaccination and have the good judgment to aid their physicians in destroying this disease.

Health Conditions in the Panama Canal Zone.—The annual report of Lieutenant Commander Arthur T. McCormack, M. R. C., U. S. A., chief health officer of the Panama Canal, for the calendar year 1918, shows what tremendous improvements in health conditions have taken place in what was once one of the most unhealthy sections of the world, as a result of the administration of the medical branch of the U. S. Army. Colonel McCormack says: "The Health Department of the Panama Canal is a model of its kind, entirely devoid of politics. One hundred per cent. of the time of all its employees is given to health work. As a result, the Canal Zone is probably the healthiest section of the world today. In the cities of Panama and Colon violations of the sanitary regulations are punished by a fine or imprisonment by the health officer. The certainty of punishment makes resort to this power rarely necessary."

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THE DOCTOR.

By Gordon K. Dickinson, M.D., F.A.C.S.,
Jersey City, N. J.

Where the grass was ever green and the soil always fertile, where the roots were always moist and the sun never failed to warm the foliage, and where frost was unknown, there civilization made its first appearance and progressed without interruption. These Gardens of Eden were found in Peru, along the banks of the Nile and in the Valley of the Euphrates.

In Babylon some sixty centuries ago, man had already developed to an advanced state, and from inscriptions found on the rocks there, it is learned that a physician named A-su was in great repute. He was one who knew water and its value. It was his cure-all, and he was greatly exalted. From his teaching we have today that which concerns man's longings as well as his being, evidenced in immersion, baptism, holy water, cleanliness, and the stimulating and beneficent therapeutic effects so valuable and yet so often neglected.

About the same time pyramids were built on the banks of the Nile, one constructed by Im-hotep, an architect, philosopher, physician, and most wise. The Greeks, being travelers, as were all great men in those days, came down to Egypt, were inspired by the pyramid and the renown of its builder, and returned to Greece so impressed that a deity was made of Im-hotep and he was called in their language, Aesculapius.

Temples were erected to this god and into them were brought the sick and the ailing. They were attended by the disciples of the cult, and, as travelers passed by, the sick were exhibited. Perchance, some one would know of a similar case in some other country which had been benefited, and would advise as he thought best. The attendants at these temples soon became proficient themselves.

The knowledge of nature being slight, disease conditions in man were thought due to mystical influences, possession of the devil, bewitchment, or the result of strange natural phenomena, and in these temples, the treatment as it has been at all times, was according to the suspicion or superstition of the day.

The intellect developed greatest in Greece, a climate of frost and sunshine, a climate which tends to evolve man's maximum mental capacity. The mind in the childhood of our race, as well as in the child of life, begins with inquiry and speculation. The Greeks, by fortune wonderfully blest, were greatly given to philosophical studies and evolved a mentality, the product of which has influenced mankind to the present day.

Stoicism was first developed by them, which showed a single side of nature. Their minds became narrow and their views contracted. Stoics were stern, upright, self-controlled and courageous, activated by a true sense of duty. Stoicism soon became tiresome to the Greeks and there developed under Epicurius men of easy tempers, agreeable, gentle, benevolent, pliant, cordial to friends and forgiving to enemies, but selfish at heart. This shortly degenerated into a readiness to gratify the senses.

These philosophies, however, helped to prominence two wondrous minds. One,

Hippocrates, a great man because he lived in a time when the greatest superstition and ignorance prevailed. He had no knowledge of the causation of disease, but he studied symptoms, and separated medicine from mysticism and the then accepted methods of treatment.

Another product of this age was Aristotle, who began life in a drugstore and before its completion was the author of many books. He was an accurate observer, competent biologist, and bequeathed to the world observations, even in embryology, which have stood the test of time.

The philosophies led to dialectical discussions and hair-splitting arguments, until one Socrates, a man of small stature, ugly face and verminous garments, discovered reason and gave it to the world.

The people tiring of philosophy warmed to that which might be termed humanism, and by the time Christ appeared, philosophies had had their day and His preachments could have their full effect.

Stoicism passed over to Italy and Rome, where there was a military government, fitting in so well that there soon developed an autocracy which lasted for a thousand years.

The Christian religion centered in Rome and in it also developed autocracy. These thousand years were spent in discussions and disputations on canonical matters. No time or energy was spent to any other purpose. Though called the Dark Ages, nevertheless out of it came the Brotherhood of Man.

But medicine was forced to the background here, and went over to Arabia, where it was fostered by the Arabs and the Jews; then traveled to Egypt, where in Alexandria was erected the largest and best equipped school that perhaps the world has ever known. It then journeyed further along and into Spain. The clear-cut, clever mind of the Moor and the Hebrew found plentiful opportunity and much was done to their credit for the advancement of medicine, so that before the fifteenth century it found its way into France.

At this time we have the Reformation, the art of printing and the discovery of America. Autocracy ceased and individual endeavor soon conquered.

Galen who wrote voluminously in the beginning of the dark period was still an authority. Versalius was the first to break the spell, showing Galen to be wrong in anatomy.

Individual minds saw clearly and gradually broke through the fog, adding a bit here and there to the science of medicine, but it being very largely in the hands of the unlearned, treatment was Galenical and unimproved. Devils were still being driven out; bad humors purged; unexplainable natural phenomena considered the cause of plagues, and the priest and his processions more highly respected than the art of the practice of medicine.

But some discoveries in chemistry substituted it for alchemy, and important discoveries in physiology planted that which later became the foundation of the true science of medicine. With each discovery in the allied sciences medicine shifted. As in the olden days philosophies and religion had their effect and mysticism as well, so as the sciences developed they also controlled.

Man's mind is but a composite of just these several elements. We are all religiously inclined; we are all given to metaphysical thoughts; we can all be moved by the mysterious; but we can all be reached by reason.

There is another parallel. In early ages we had the stage of inquiry without knowledge, then came one of faith (because faith was greatest where knowledge was least), and with increased knowledge came the age of reason. This is also seen in the development of each individual mind. Early life is given to inquiry; later, faith is strongest; but before life is half over it changes from faith to a temporary agnosticism, and then to reason. So the development of medicine is but a recapitulation of the mental attributes of each individual man.

Reason in medicine began when phenomena were observed scientifically. Aristotle was the father of scientific medicine. The Hebrew and the Moor added materially. Central Europe added nothing. In the sixteenth century science began to demonstrate accuracy of observation, increased animal dissection and autopsies added to greater enlightenment and established a firm foundation for the truth.

With the death of the Galenics, which was not completed until the end of the eighteenth century, the practice of medicine being freed from autocracy, men

like Boerhaave who took his students to the bedside in the hospitals, and Sydenham who was another Hippocrates in his study of symptoms, and many others which would be pedantic to mention, had their influences. But medicine was a matter of opinion largely, and not built on solid ground until we could determine the true cause of disease conditions.

This was not accomplished until Pasteur proved that belief in spontaneous generation was an error and that microbes existed, and if we could but hunt for the germ the cause of the disease could be generally found. Frascator in the sixteenth century was of the opinion that little seeds passed from one person to another, disseminating disease, but he gave no proof. Pasteur supplied the proof. He is the founder of modern scientific medicine. Back of Pasteur we have no medicine as a science, but from his time we have medicine as we know it today, and believe it to be approaching, a true science. However, without the discoveries and discussions of the martyrs of medicine of the previous centuries we would be in no position to make use of this wonderful man's discoveries.

The science of medicine is as true and certain and substantial in its foundations as any other science, but the practice of medicine is still an art and ever will be. No man's mind is so capable that he can comprehend all that is now known in the science of medicine. He grasps what he can and according to his mentality, but at the bedside he finds there is still a third element, that is, the patient's reactions to him and to what knowledge he possesses. Science is inflexible. Man is always flexible. We cannot live by science alone, and the practitioner and the patient meet on the common ground of mysticism, religion and philosophy. Failure to recognize this trinity and the unity of this trinity, is the reason for so many lapses, the reason that the public fail to comprehend medicine and the medical practitioner. In evidence, we have the terror which sometimes takes hold of the public when general vaccination is ordered.

When people were being given nauseous medicines to drive out the devil or were being purged to get rid of him, Hahnemann substituted a new thought. He gave that which was tasteless and agreeable. The public and the profession soon found that they could recover just as quickly and with less disgust without disagreeable compounds, and the doctor further discovered how diseases would act when not disturbed.

Each practitioner though full of the science of medicine, imbued with great knowledge of physiology from its foundation, biology and its outgrowths, has but a small armamentarium he can justly rely upon. But he can study symptoms. He can cross-examine, and delve deeply into the recollections of past conditions. He can make perfect diagnoses from this and from this alone, then treat by diet and regulated life.

Some hundred years ago the stethoscope was invented, and after that an instrument for the study of the pulse. Nowadays we have the x-ray and elaborate laboratories. It is becoming almost an iniquity, for the doctor employs the laboratory and obtains an opinion and diagnosis from the x-ray man, rather than work his brain at the beside. In place of experience, reading, detailing a history, and coming to a logical deduction, he takes the easier path and gets another man's opinion. May it not be that this will lead to an ultimate degeneration of the physician's mind? Cornell students won every boat race until cars were put in the streets of Ithaca. They then rode up the hill to the college and lost their wind. So the physician who asks but few questions by the bedside, makes only superficial examinations, does not hypnotize himself in deep thought, but sends for the plate and report, will ultimately become a failure. Osler never Oslerized himself in that fashion.

A few years ago our medical colleges recognized their moral responsibility to the public as well as to the student and, where previously it was a simple matter for the young man to obtain his diploma (often on a basis of cash only), they decided to produce a man of culture and a man educated in his profession. To properly accomplish this, an academic course is required and the period in the medical college prolonged, with not only didactic lectures, but a personal touch. Now, instead of sending out into the world to confine women, men who never had seen a confinement (thereby perpetuating the infamy which lasted so long, characterized by infection and death), they require a thorough obstetrical experience. So in other departments experience is given that irregularities

may be observed to offset the stereotyped descriptions of the lecture room and text book. If not, the practitioner becomes more incompetent than a clever nurse or even than a medical orderly.

But, in this country in particular, the public now realize that instead of sending out for **"a"** doctor, they may send out for **"the"** doctor; instead of medicine and diagnosis being a matter of opinion it is a matter of education and training, and that there exists a marked difference between the professional value of different physicians.

Where medicine is slack and slow, public opinion and politics are determined to regulate our problems. Over a hundred years ago the legislature of New Jersey attempted certain interference in medical affairs, but it was uncommon in legislative circles to dictate until within recent years.

The object of this paper is to show that the "affairs of man pass forward in a determinate way, expanding and unfolding themselves, hence, we see that the matters of which we have spoken as though they were matters of choice were in reality forced upon them by the necessity of the times. They should be considered as presentations of a certain phase of life which nations in their onward course sooner or later assume."

We today are very much given to the material. The numerous wonderful inventions and great changes in architecture, the prodigious exploitation of natural resources and the accumulation of wealth, and, in this country particularly, the free and general education where in our public schools we see the child of the laborer associated with the child of his employer, all have tended to produce a material type of mind.

But the pond has turned and the bottom is coming to the top. The water is murky and has not settled. The war occurred and aggravated conditions. Sociologists and men of the Epicurean type favor the so-called "lower classes," calling them the poorer. Their minds have been pauperized. Conceits and ambitions have been stimulated. Legislatures have been influenced, with the result, that the weak points in the practice of medicine have been exploited with exaggeration and radical methods instituted.

Some one has said that there are three herd instincts of mankind. Some can be compared to the bee that works from early till late, thriftily putting aside its food. Others, to the sheep with his head down to the ground, grazing and indifferent. Others, to the wolf, prowling around for destruction. We have these types in our profession, the sheep type more abundantly, because medicine being a "calling" developing the sympathies with a kindly touch leads the doctor away from the harsh and uncomfortable surroundings of the politician.

The time has come when the profession must wake up. His self regard, his high esteem for his calling and the future of the young doctor yet to come, all depend upon how the doctor today acts and reacts to his surroundings. For the inevitable is with us as it was with the men of the past. If we keep our heads to the ground grazing, forgetful of what might come, there will be disaster and our profession will be taken over by an unwise and harsh government.

The medical profession cannot manage its own economic and business matters, but it needs to state this fact correctly and with the formality that the worm will turn and will not tolerate the taking over of its affairs to the disadvantage of the profession and the people at large.

The symbol of medicine is a serpent with its tail in its mouth. Conditions ever changing, often come back to where they started. May there not be a reversion in medical matters to some early historical condition where authority, blind to the best interests of the profession, prevails? May it not go back forty-one centuries to the time of Hammurabi, who left a code in which the physicians' fees and penalties were laid down by law?

Every man, whether he be a physician or not, should be a citizen and the best citizen possible, and there is no reason why each physician should not also be a politician. If we are to face politics, if we are to protect the people against the ever-present irregular pathies, if we are to obtain and keep control of the confidence of the people, we must stop idling and worshipping in medicine idolatry.

Let us be physicians forever in altruism, giving a life of devotion to our patients. Let us study, obtain experience, sit by the bedside and fight for our patient, but let us also be citizens, let us unite as a body of strong influential people that the truth may prevail and our profession be honored.

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THE STATE JOURNAL.*

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I am discussing this subject from a personal standpoint. I have referred to no data whatsoever, and have but a dim recollection of events of the past several years, during which state medical journals have seen their inception and successful growth to their present status. I have no present idea of the date the first **bona fide** state medical journal was established, and neither do I know when the last one was established. I recall something of a controversy between a few state journals and certain independent journals, both so-called, but took little or no stock in the discussion at that time and have no particular concern with the controversial side of the subject at the present time if, indeed, there is such a side. I make this statement in order that it may be clear that my discussion is purely speculative and is based entirely on my own conception of the subject, and in order that I may not be criticized for misquoting or misrepresenting. Neither do I desire to precipitate a controversy at the present time; and I certainly have no intention of offending. What I shall have to say may fail of approval by both state journal editors and editors of privately owned publications.

Being both an art and a science, medicine has offered a most fertile field for discussion from the earliest days, and its connection with the occult and with religion has been an added interest. Medical journalism, therefore, early took its place in professional circles, and we may justly feel proud of the record. Indeed, the final chapters in the history of scientific medicine could hardly have been achieved except for the medical journal; and except for the medical journal further advances would be sporadic, local and extremely slow of co-ordination. It would be a matter of extreme interest to have traced for us the record of medical achievement through the pages of medical periodicals, noting the development of scientific issues and their incorporation eventually in standard text-books. This has been done from time to time and in relation to some given subject, but the whole story, so far as I know, has never thus been told. We owe much to these pioneer publications, some of the earliest of which are still being published, and speaking for the state journal, I desire to yield tribute to them accordingly.

It would be equally as interesting to trace the development of organized medicine, from the early stages when religion, occultism and individualism held sway to the present time when science controls, with art second in command. In the earliest days, the monastery, the alchemist, the astrologer or the individual, held the secrets of medicine and either buried them in their libraries or handed them down from father to son or master to apprentice, as the case

*Read at the annual meeting of the American Medical Editors' Association, New Orleans, April, 1920.

might be. Eventually the barber intervened and assumed the prerogatives of the surgeon. From so many angles the subject of medicine was necessarily a controversial one, and through this fact, perhaps, eventually came to us the medical, which has, in this late day, reached such a perfect state of organization. But for the existence of the medical society and its medium of expression, the medical journal, the science and art of medicine would today be rather the art and science thereof, sporadically developed and rich in superstition and erroneous concepts. It would be of great interest to trace the development of medical organization along with the development of medical journalism and the advancement of medical journalism and the advancement of medical science. Perhaps from our ranks will eventually arise some genius with sufficient means and the inclination, who will favor us with such a work. Such a work would, indeed, be an enviable monument to the memory of its author.

Medical organizations for many years had for their sole object the interchange of views on medical subjects at stated intervals. It early seemed necessary to preserve these views and make them available to those who were not able to participate in their discussion, including posterity. For this purpose, existing medical journals were utilized and the volume of transactions had its origin. In the early days when there was more art than science, perhaps little of either, ideas were often strange and sometimes ridiculous. It was the custom in those days to decide by vote whether an essay should be dignified by discussion, and even now the custom persists in many organizations of receiving a paper and opening it for discussion. It was necessary to be somewhat autocratic in such matters, which fact early gave rise to a spirit of intolerance which doubtless had an inhibitive influence in the development of newer ideas. The better class of medical journals would not accept for publication articles which did not track closely established authorities, and medical organizations made short shift of them when presented for discussion. While this policy was dictated by necessity, and while the results in the main have been beneficial, it was doubtless through or as the result of such dogmatism that the sects had their origin. There are in medicine as in all other walks of life, the extremes of personal inclination. We have autocrats on the one hand and anarchists on the other, with the usual large and preponderating middle class in between. And while we see outcroppings here and there of both extremes, it is the great middle class that today has control of organized medicine, and which is indirectly assuming control of medical journalism.

So long as it was merely a matter of securing priority for a distinct advance in medicine, or of preserving for posterity the worthy productions in medical science and art, the existing medical journal on the one hand and the annual transactions on the other, was quite sufficient to meet the purposes of organized medicine. With the development of civilization in all of its complexities, the enormous expansion of medicine, in its broadest term, and the intricate ramifications of both in the social and economic problems of the day, a medium for propaganda became essential. Existing medical journals could accommodate only so much of this material as would be of interest to the great bulk of their readers, and the volume of transactions was entirely too cumbersome. Hence the state journal.

The entry of state journals into medical journalism was not by accident, nor was it the result of a preconceived and concerted policy. Journalism is a profession and a business combined, and only those engaged in it are familiar with the problems involved. The primary objections offered by medical societies to the adoption of the periodical plan of publishing transactions, in contra-distinction to the annual volume thereof, was the prohibitive cost of a publication designed for a limited circulation. It was not thought that advertising could be easily secured for a publication of this sort, and altogether the technical difficulties to be encountered acted as a powerful deterring influence. Here and there efforts were made to utilize existing private publications, with more or less unsatisfactory results, but comparatively few societies persisted in that practice for any considerable length of time. In some instances the results were so unsatisfactory that the volume form of publication was resumed. An occasional society, whether as the result of a more powerful organization or a better analysis of the

possibilities of the case, early established its own publication, eventually proving the successfulness of the project. Examples set by such publications have been an encouragement to other organizations to follow in their footsteps until state journals have become an important factor in medical journalism and must be reckoned with.

In the early days of state journalism, there were numerous publications of national and even international circulation, in this country, and a still greater number which circulated in a limited territory, fairly comparative to the field to be covered by state journals. They were enjoying subscription and advertising patronage in proportion to purpose and merit. As a rule, at least in the larger publications, the reading pages were controlled by medical editors, while the business end of the publication, including the advertising, was in the hands of the business management, probably not medical. In the smaller publications the two were combined in a single office, in a sort of Dr. Jekyl and Mr. Hyde management. This resulted in an advertising policy which eventually aroused criticism, from which arose a controversy coincident with the development of state medical journalism, which, while in many respects unfortunate and disagreeable, had its good points. It had an important bearing on the investigation of the proprietaries at that time in progress. In this free country of ours no one will relinquish what is considered a vested interest without a struggle, and the proprietaries very naturally resented the interference of the medical profession. The connection between the manufacturers of these proprietaries and existing medical journals was of such nature that sympathy was easily aroused and prejudice engendered. This was true of all classes of medical journals, and is still true with many of them, including some state journals, both privately owned and association owned. The effort to regulate proprietary remedies did not begin with state journals and, as a matter of fact and in common with other medical journals, state journals were inclined to favor their advertisers, to whom they recognized an important obligation. The reform was fostered by far-seeing members of the medical profession who had no occasion for prejudice either way. Eventually, following the lead of the Journal of the American Medical Association, which, with all due deference to my hearers, I consider to be the leading medical publication of the world, the great majority of state journals adopted the policy of applying the same ethical standard to their advertising pages as was applied to the reading pages. Privately owned publications have been loath to adopt this policy. I do not care to discuss this phase of the situation, but I may be permitted to hope that eventually those privately owned publications which have a place in the sun will adopt the same standards.

There are all sorts of medical journals in the world, some of them occupying well-chosen fields, while others are floundering about in shallow water, all dressed up and nowhere to go. In an attempt to classify medical journals, I have made the following divisions, under one or more of which they should fall:

(1) The strictly scientific and technical publication would concern itself in detail with the advancement of the science of medicine, rather along theoretical than practical lines.

(2) The purely scientific publication would concern itself less in detail with the technical and more in detail with the practical side of medicine.

(3) Publications which deal with one or more of the so-called specialties in medicine, such as the eye, ear, nose and throat, or the laboratory. The field of this class of publications being more limited, both the technical and the practical side of the subjects handled may well be considered.

(4) Publications which concern themselves primarily with the circulation of such items of interest to medicine as abstracts of scientific articles appearing in other publications, and miscellaneous items otherwise.

(5) Publications for the exchange of views on problems connecting the medical profession with various phases of modern life, such as medico-legal, social, industrial and other problems of like nature.

(6) Publications for legitimate propaganda, under which classification would come such publications as: (a) those of organized medicine, including state journals;(b) industrial medicine and, (d) reforms of various types, more or less related to medicine.

Of these, I shall concern myself only, and briefly, with sub-paragraph (a) of paragraph 6.

Organized medicine has its problems aside and apart from scientific medicine. Likewise, it has its problems in connection with scientific medicine. It would be fruitless to discuss these problems here, but it may be well to refer briefly to some of them. In the first place, the machinery of the organization must be properly constructed, frequently repaired and always kept well oiled and in good running order. The county society itself must keep constantly after its members to keep them interested in matters of their profession and even in inducing them to continue their membership. For our purposes the county society has jurisdiction over the medical profession in the county and it should know the professional and ethical status of each physician, and secure for membership those who are worthy and well qualified. It must consider the welfare of the profession and take such steps as will better the professional, moral and financial status of its members; it should maintain and insist upon having an advisory supervision over public health matters, and it should by suitable measures teach people to depend upon them for advice in all matters pertaining to health; it should see to it that those who are elected to make the laws are informed on medical subjects and that they are in sympathy with the principles underlying the practice of medicine and the protection of the public health; it should likewise see to it that those elected to enforce the law appreciate the importance of enforcing public health laws along with those against crapshooting, bootlegging and the like, and that all of these things are done not by threat or political chicanery but by public education. It is not the right of might that should be insisted upon but the might of truth, which must prevail. The county society must arrange its programs so that they will both interest and instruct its members. Its burden is no less to educate its own members than to educate the public. It should understandingly elect its own officers, and these officers should conscientiously perform their several duties.

These are some of the few things the county society should do, and if the county has any considerable population, it will be necessary for the society to have some means of spreading its propaganda. There is no agency better for that than the county society bulletin, and every county society in this broad land in a position to do so, should support such an institution. But when the purposes of propaganda have been served, the bulletin has met its mission. It is not, and must not be, a medcal journal. As soon as it becomes a medical journal it ceases to be a bulletin, and the society is without a means of spreading its propaganda. It is conceivable, of course, that a county society might have contributors in sufficient numbers and of such quality that their contributions will appeal to a wider clientele, in which instance it might become a medical journal in fact. I exclude from consideration such publications. If the papers read before a county society are published in its bulletin, and this bulletin has a circulation among other publications and other organizations elsewhere, it can readily be seen that no other publication or organization will want to accept such contributions as original. If they are worthy of notice they will have been abstracted and credited to the bulletin and the publication subsequently accepting them will gain the reputation of taking second-hand material and palming it off as new. If the articles are not worth while, it is obvious that they will not be wanted. In any instance, the bulletin has served but a few with an article that is not worthy of consideration by the few, or else it is worthy of much wider circulation. If the bulletin is publishing original articles in order to induce members of the society to contribute to medical literature, and to give them an opportunity to develop, it is meeting its purposes admirably and serving its sole function, so far as the publication of original articles is concerned. Its principal function is propaganda among its own members and to serve as a connecting link between its own and other organizations dealing with similar problems.

The district society has no legislative, judicial or executive function. It is a sort of post-graduate school—a medium for the further development of contributors and their contributions. It serves as a stepping stone from county to state organization. It requires no medium of propaganda, preferably utilizing the county society bulletin or the state journal for its purposes. The contributions

to its scientific program should either be passed on to the state organization or should revert to the county society, in the one place to appear in the state journal, in the other to appear in the county society bulletin.

The state organization has the supreme problem of co-ordinating the activities of all of its constituent (county) societies, and it must have an attractive medium for propaganda purposes. The problems of a county society are in some instances magnified immensely by the time they reach the state office, and sometimes they dwindle into insignificance. In any instance, they should be received by the central office, carefully scrutinized, estimated and eventually handled in the most satisfactory manner possible. Each county society should know what each other county society is doing, the problems being considered and the medical subjects being discussed. Each county society must be informed of the problems of the medical profession as a whole, warned of the effects of these problems on the profession locally and advised as to the steps necessary to make the most of the situation. More often than otherwise, grave problems present themselves in the simplest guises and their solution along the most expeditious lines appear to be wise, whereas such procedure might be playing into the hands of those who would undo the medical profession and discount its accomplishments one hundred per cent. The state organization must strike at principle and settle all such problems with due regard for the honor and integrity of the great profession it represents. It must construct scientific programs for its sessions calculated to inspire and instruct its members and should in every way possible endeavor to place in the hands of its members such information as may be needed, not only for the successful plying of their vocation but for the elevation of the standards of the practice of medicine from both the scientific and the ethical standpoint.

These are only some of the functions of a state medical organization and it must be clear that some efficient and attractive medium of propaganda is absolutely essential. For this purpose no better agency could be found than the present state medical journal, so-called, which is essentially a bulletin, much as the county society publication except on a larger scale with a larger circulation and problems of a more intricate nature. It suffers many of the limitations of the county society bulletin, but of many of them it is free. Its clientele is sufficiently large to warrant the publication of original articles and abstracts of original articles appearing elsewhere, and medical and news items of various types, of more or less interest to its readers. As a medical journal, it is handicapped by the necessity of including in its pages a large amount of material pertaining to its own peculiar affairs which is of but secondary if any interest to a wider range of readers. If it should not appeal to a large proportion of its readers, no publication can afford to carry it. Its nature as a publication catering to local interests, no matter if the locality is large and prospering, is an inhibition difficult to overcome, both from the standpoint of the subscriber and the advertiser. Such a publication might attain some degree of eminence in the broader fields of medical journalism by virtue of an exceptional group of contributors, but such is hardly to be expected. As the county society bulletin must yield to the broader interests of the state journal, so the state journal must yield to the broader interests of the profession of the nation, and when a contribution of exceptional merit and one requiring national circulation without delay is produced, it should not be buried between the covers of a state journal but be passed on to an ethical publication with the wider distribution. If this is done there can be little or no criticism launched at the well-conducted state journal. The great mass of its literature is paralleled in other state journals and in other publications, and the loss of such contributions to the profession outside of its own territory will not matter.

Finally, it is my personal opinion that any medical publication that has not made for itself a place in the estimation of its readers, is doomed to failure and will be perpetuated only at a loss to its managers, as an imposition on its friends and an injury to the ethics of medicine. If two state journals are growing where one ought to grow; if two privately owned medical journals are circulating in a territory where one ought to circulate; if a county society bulletin is aspiring to state journalism in a field already amply and properly covered, or if

any of them are failing to serve the legitimate purposes of ethical medicine, there is certain to be slow music and grief somewhere, albeit joy may serve as the proverbial silver lining to the cloud. The medical profession is long suffering and frequently does not know just what it wants, but along with the mills of the Gods it grinds slowly and none the less surely. I know that I am bending every energy to the end that it will not be the Texas State Journal that thus misses its goal.

SOME OBSERVATIONS ON GALL BLADDER DISEASE.

By J. Watson Martindale, M. D.,
Camden, N. J.

The most common disease of the abdominal cavity is appendicitis. Bacteria easily gain entrance into the appendix and give rise to disturbance there. Probably next in order of frequency is gall bladder disease. There are several conditions necessary for the production of gall stones. There is a large amount of cholesterin present in all gall stones, no matter what the variety. Calcium is the most important mineral constituent of the bile, and also is present in all gall stones. There must be an infective process first in gall stone formation. This sets up inflammation of the bile passages and the desquamation and degeneration of the epithelium of the mucous membrane of the biliary passages produces chloesterin. The cholesterin unites with the calcium salts present in normal bile, and thus we have the nucleus of the gall stone formed. The gall stone itself is an irritant, and its presence gives rise to the formation of more cholesterin, which unites with more calcium, and thus the original stone becomes larger or there are more stones formed. Typhoid fever plays an important part in the pathogenesis of cholelithiasis. The most common organisms found in gall stones are the typhoid bacillus, bacillus coli commune, streptococcus, and stayphylococcus. Thus gall bladder disease is prone to follow typhoid or appendicitis, in which the last three named organisms play an important part.

Women are more frequently affected than men in the ratio of 7 to 2. Pregnancy and tight lacing may interfere with the flow of bile and thus favor the production of stone. Want of exercise and overeating, particularly starchy foods, appears to favor cholelithiasis. People who drink little fluid are susceptible to this condition, and lastly, it has been said that the drinking of artesian water, which in many cases is impregnated with lime salts is an etiological factor. The use of artesian water for domestic purposes has increased to a large extent during the last twenty years, and with this increase there has been a corresponding increase in nephro and cholelithiasis.

Diagnosis.—The diagnosis of gall stones is by no means easy, as the symptoms are very variable, and in many cases there are no symptoms whatever. In doing a hysterectomy recently on a woman for fibroid tumor, the writer discovered a gall bladder full of gall stones. As the operation had been difficult on account of a stormy anesthesia and a large number of adhesions, it was decided not to interfere with the gall bladder. There have been no symptoms since the operation, five years ago, and the supposition is that the patient still has the gall stones. In doing a post mortem on a woman who had died of pneumonia, it was discovered that the woman had a fibroid tumor and also a gall bladder full of stones. In her case neither the tumor nor the gall stones had been productive of any discomfort, and the woman had lived and died oblivious of the fact that she harbored such an interesting pathologic collection in her abdomen. So long as the stones remain in the gall bladder probably they give rise to little or no trouble. When they emerge from the gall bladder and get caught in the cystic duct they give rise to the characteristic biliary colic. If the stone is caught in the common duct it will produce jaundice if it is large enough to obstruct the lumen of the duct and prevent the bile from finding its way into the duodenum. On the other hand, a stone may be in the common duct and still allow the passage of bile between it and the side of the duct. Chronic obstruction of the duct with infection generally gives rise to the so-called Charcot's fever, which comprises, jaundice, irregular chills and fever and profuse sweating. Before the protozoa of Laveran were discovered as the cause of malaria, these cases were often looked upon as malaria, and were dosed with quinine with very indifferent success.

Where the stone is in the common duct

and the obstruction is nearly or quite complete, the gall bladder becomes enormously distended with fluid and attains an enormous size. This fluid is probably first bile, but it may become infected and produce pus. Then we have an empyema of the gall bladder. On the other hand in some cases the fluid is merely a collection of mucus, possibly caused by the irritation of the stone in the common duct. The fluid thus formed works its way back through the cystic duct into the gall bladder. In some of these cases there is no jaundice, and the enlarged gall bladder may be mistaken for a loose kidney. The shape is exactly the same in some cases, and it is enough to puzzle the elect to tell whether one is dealing with a movable kidney or a distended gall bladder. The fact that the kidney can be replaced in the loin and the sickening pain felt on pressure of the kidney are the main points which prove the swelling to be a displaced kidney, but in some cases an abdominal section alone discloses which is the offending organ.

The x-ray has proved to be very unsatisfactory in the diagnosis of gall stones. For this reason it is generally possible to differentiate between the gall stone and the renal stone, as in the latter cases the stone is easily discernable in the majority of instances.

Given a case in which there is pain in the right hypochondrium, radiating to the right shoulder and severe enough to cause severe shock, one would be inclined to think of a stone in the gall bladder trying to pass through the cystic duct. Should the patient develop jaundice with the above symptoms the attendant would be justified in attributing the symptoms to a probable obstruction in the common duct. Should these symptoms continue and the patient's life appear to be in danger as a result of the condition, the surgeon would do right in opening up the abdomen with the expectation of finding disease of the biliary apparatus which required surgical interference.

Two women died recently who had suffered from repeated attacks of abdominal pain. In both cases death had occurred suddenly, and the diagnosis of the physician in charge had been acute indigestion. Autopsy in both cases revealed a ruptured gall bladder with an outpouring of pus and infected bile and the tell-tale gall stone lying in the abdominal cavity. The gall stone in both cases had ulcerated through the wall of the gall bladder, and the escape of the infectious material had caused a fulminating peritonitis, resulting in death.

Treatment.—An old boiler-maker had a stone in his kidney. It bothered him greatly. He had the stone removed. Another formed and he had that taken out. He remembered that when scale formed on the inside of a boiler he used distilled water to get rid of the scale. He thought what was good for a boiler was good for his kidneys. He began to drink distilled water and has had no trouble since. It has been proved beyond the shadow of doubt that distilled water will prevent the formation of stone in the kidney, and it is equally as efficacious in stone in the biliary passages. Here we have an excess of calcium just as in renal stone, and distilled water is a fluid which is hungry for salts. The ingestion of large quantities of distilled water will absorb a considerable amount of the calcium salts, while urotropin is an antiseptic which will tend to disinfect in a measure the bile ducts. This treatment has been found very efficacious in individuals who have had the first, second or third attack, also after operation to prevent the re-formation of stone.

There is a prevalent opinion among the laity that the ingestion of olive oil in large quantities will dissolve gall stones or cause them to become so coated with oil that they will easily be passed through the biliary passages into the intestine. This belief is so prevalent that importers of olive oil have done a thriving business. They have published numerous articles in the lay press where individuals have passed gall stones in large quantities as the result of the olive oil treatment. These men have been honest in their belief, as small masses looking like gall stones have been expelled after the olive oil had been taken, and when the oil was discontinued there was a cessation of the so-called passage of the gall stones. Olive oil is often of distinct value, inasmuch as it is a useful article of diet. It has some caloric value and exerts considerable influence on the stomach, by producing an excessive secretion of hydrochloric acid and it increases the motility of that organ.

There are few now who believe that the olive oil given by the mouth can dis-

solve gall stones in the biliary tract, and that such an idea ever gained credence is probably due to the discovery of the stools of concretions having a resemblance to biliary calculi after its administration. These usually consist of large white lumps, varying in diameter from 0.5 to 2 centimeters, and of the consistency of hard tallow. They are now known to consist of thick emulsions or masses of combined fatty acids (soap), formed by the action of the intestinal secretions and bacteria upon the oil given by the mouth.

To illustrate the fallacy of giving olive oil for the purpose of dissolving gall stones it might be of interest to describe a case coming under the observation of the writer. A woman of fifty years had suffered pain in the right hypochondrium for some years. X-ray exposures had thrown no light on the subject, and while the symptoms pointed to gall stones there was not evidence sufficient to make a diagnosis. An exploratory incision was made and disclosed a gall bladder filled by one immense stone, the size of a large potato, and resembling that vegetable in shape. Since her childhood this patient had taken large quantities of olive oil. She had always been thin and she had been told that the olive oil would fatten her. Later on she acquired a taste for the oil, and when she developed pain in the gall bladder region she kept on taking the oil in the belief that it would either dissolve the stones or so lubricate the biliary ducts that the stone would pass easily. In this case the mucous membrane of the gall bladder was so badly diseased by the presence of the stone that it was deemed advisable to remove the organ.

It is good judgment to remove all appendices which are the seat of chronic inflammation, and there are many of them throughout the land treated for indigestion, gastritis and other abdominal conditions. A chronically sore appendix harbors enough bacteria to set up a secondary inflammation in the bile ducts, and it should be removed, at the same time making an examination of the gall bladder at the time of the appendectomy. If there are stones in the gall bladder they should be removed.

If there is evidence of stone formation in the bile ducts or gall bladder and the patient is not relieved by medical means, he should have the stones removed and the gall bladder drained. There are too many gall bladders removed at the present time. Cholecystectomy should be reserved for those cases in which the gall bladder is badly diseased. Cholecystostomy has been abandoned to a large extent, and the removal of the gall bladder substituted. By doing the latter operation we miss the beneficent effect of drainage of infected bile. Many hundreds of patients have been made comfortable by the drainage operation, and Mayo Robson, who has done many operations of that character, says the recurrences are rare. Some surgeons are now turning the gall bladder into the duodenum, doing a cholecyst-duodenostomy. In health the pylorus contracts after digestion is complete and allows the regurgitation of bile into the stomach, thus neutralizing the acidity of the stomach contents. After the removal of the gall bladder this physiological function is more or less interfered with, while in cholecystostomy the functions of the stomach are in no way disturbed. In quite a number of instances there has been a leakage from the stump of the gall bladder after a cholecsystectomy. This has caused a localized peritonitis, with adhesions to the stomach and has necessitated a second operation to relieve distressing symptoms. In a number of cases gall stones have formed in the common duct after the gall bladder has been removed.

Summary.—Gall stones follow appendicitis and typhoid fever. They must have first the irritant action of bacteria, which causes injury to the mucosa of the biliary passages. This produces cholesterin which unites with the calcium of the bile to form gall stones.

Distilled water is a fluid hungry for salts, and will take up considerable quantities of calcium salts. Hexamethylenamin is decidedly germicidal, and will act as an antiseptic in the biliary ducts and gall bladder.

The removal of the gall bladder should be a last resort, and should not be done unless that organ is irremediably diseased. Cholecystostomy or turning the gall bladder into the duodenum provides for the drainage of infected bile, and by leaving the gall bladder in place we have a reservoir which holds considerable quantities of bile to be emptied into the stomach after digestion is completed, thus neutralizing the acidity of the stomach and preventing hyperchlorhydria.

ERRORS IN GYNECOLOGY DIAGNOSIS AND PRACTICE.*

By Frederick C. Holden, M. D.,
New York City.

It is my intention to bring forward for discussion this evening, not difficult points in differential diagnosis, nor matters upon which we differ as to treatment. I desire to emphasize some common conditions often overlooked and to draw our attention to useless methods of treatment, still commonly in vogue.

Gynecology is of necessity a branch of medicine handled primarily by the general practitioner. Most women consult their family physician first, as to their backaches and their menstrual irregularities. A large part of gynecological conditions is the result of parturition and naturally the patient consults the man who confined her, in seeking to remedy these ills. Therefore it is upon the family physician that the burden of proper primary diagnosis and management of gynecological conditions rests in the large majority of cases. Why do we have common errors in gynecological practice? Errors in diagnosis and practice, of course, occur in every man's endeavor. These errors, however, should not be common, and it is my opinion that when we have diminished the errors in diagnosis, the errors in practice will have reached the vanishing point.

How shall we attack the problem of diagnostic errors? First by the realization that in every case a definite and complete working diagnosis is necessary. In far the largest portion of all gynecological cases, a correct diagnosis is not difficult. Two requirements are necessary, first-time, and second, a moderate amount of experience. Time is perhaps the large factor. The time must be spent, first, in a careful and complete history, and second, in a thorough physical examination. A moderate amount of experience is necessary to interpret the story presented by the history and physical findings.

Let us first consider what is known in many clinics as the "usual" gynecological case: namely, a woman with a lacerated pelvic floor, lacerated cervix, retroversion and adnexal disease. How is this patient treated as a rule? I say treated for certainly in the large majority of cases no effort is made to arrive at a working diagnosis. The error in practice of necessity follows the errors in, or omission of, a working diagnosis. The type of case referred to, complains as a rule of pain in both lower quadrants of the abdomen, sacral backache, and a leucorrhoel discharge. A working diagnosis is always essential to a rational outline of treatment. Commonly, this patient is subjected to one or two lines of treatment. First, meddlesome medical gynecology; second, incomplete surgery.

What does the meddlesome medical man do with a case of this type? He subjects his victim to a long line of interference known as tampon treatment; this is usually associated with douches, and possibly the ill-advised insertion of a pessary. This treatment continues over a period of time dependent upon the patient's original confidence in her medical adviser, but sooner or later she seeks relief elsewhere.

What does the surgeon whose work is incomplete, do with such a case? As a rule, a laparotomy with removal of the diseased adnexa of one side and a ventral suspension. This is incomplete surgery, for the lacerated pelvic floor and lacerated cervix are definite points of pathology producing definite symptoms. Let us consider this so-called "usual" case from the standpoint of the history, diagnosis and treatment. The lacerated cervix especially when associated with adnexal disease, gives in the large majority of cases a definite history. There is the story of a previous delivery, frequently instrumental. The leucorrhoeal discharge is an indicator of the endocervicitis which, if present before her first labor, is probably gonorrhoeal; if subsequent to delivery, it may be dependent upon a low grade infection introduced after the laceration. The lacerated pelvic floor with its attendant cystocele and proctocele is but an aggravator of the backache and other pelvic symptoms in most cases. The abdominal pain usually presents a characteristic history. It has lasted over quite a period of time. It is dull and almost continuous, worse when up and working. This is due to the adhesion produced in and about the affected adnexa and to the continued presence of a chronic focus of infection in the pelvis. The uterine displacement in this case is of only secondary importance as the ever-

*Read before the Academy of Medicine of Northern New Jersey, April 21, 1920.

present infection is the chief offender. Physical examination of such a case, as it relates to the field of gynecology, is by no means difficult; obviously a lacerated pelvic floor with moderate cystocele and proctocele; a lacerated cervix that is easily palpable, and presents a typical picture on inspection.

Bimanual examination will reveal an adherent retroversion with at least tenderness in both fornices and usually palpable inflammatory masses. The diagnosis is obvious when following a careful study of the history associated with even a routine physical examination. Thus we see in what is styled the "usual" gynecological case a characteristic history, a physical examination which presents no difficulty and therefore a simple diagnosis. Yet to what is this patient as a rule subjected? Meddlesome medical gynecology or incomplete surgery. What are the principal instruments in the armamentarium of the medical gynecologist? Tampons, pessaries, douches, tinct. of iodine, bladder irrigations, etc. I cannot conceive of a man, in the light of today's knowledge of cervical infection and the lymphangitis secondary to it using a tampon in the treatment of a lacerated and infected cervix, no matter what so-called medicament it is saturated in. Of what use is a pessary in an old laceration of the pelvic floor and adherent retroversion? Douches produce a physical cleanly state but, by the greatest stretch of imagination, surely no one actually believes that they markedly reduce a chronic focus of infection in the pelvis, when due to tubo-ovarian disease.

The next most common case of treatment is incomplete surgery. The patient, as I have stated, has frequently a laparotomy, which may be well done but the lacerated pelvic floor and infected cervix are entirely overlooked, and the patient continues with her backache and leucorrhoea, much to the surprise of the surgeon. The hypothetical case in question requires an amputation of the cervix, a repair of the pelvic floor and a laparatomy. The extent of the work necessary after opening the abdomen can be stated only at the operating table.

A method of treatment frequently useless, about which volumes have been written as to its uselessness, is so-called dilatation and currettage. If I were asked to tabulate the etiological factors usually present in the production of gynecological cases in their order of frequency, I would say: First, conditions following parturition; second, activities of the gonococcus; and third, uses of the uterine dilator and curet. The question of the injudicious use of the curet after incomplete abortion has been covered so thoroughly of late that I hesitate to mention it. There are, however, very few cases of post-abortal sepsis admitted at Bellevue that do not present the history of a curettage shortly before admission. The dilator or uterine sound is, in some ways, as vicious an instrument as the curet, for its introduction into an infected cervix will just as surely carry the infection beyond the internal os. The following conditions are to my mind those, frequently erroneously curetted: abortion, incomplete, endocervitis acute and chronic, myoma uteri, ectopic gestation and salpingitis acute. Why are these conditions commonly curetted? Because they produce menorrhagia or metrorrhagia, both of these states are however symptoms and not diagnosis. These conditions are not only commonly subjected to a needless operation, but the needless operation frequently is followed at last by a long period of morbidity. An aseptic incomplete abortion, combating the septicaemia and with a hope of recovery, is frequently denied its only chance by an injudicious curettage. Endocervicitis acute and chronic are frequently not permitted to remain as a local infection by the indiscriminate introduction of a uterine sound or applicator. A uterine myoma or an extra uterine gestation needlessly curetted is unfortunately not an unusual sight. An acute salpingitis, which should be treated expectantly and subjected to proper medical gynecology, is often transformed into a case of acute pelvic peritonitis of a serious type by needless intra-uterine interference.

In drawing a few conclusions, if I may, from this rather rambling talk, I wish to state that errors in gynecological diagnosis and practice would be greatly reduced, not by extended courses in cystoscopy as it relates to gynecology or in gynecological diagnosis and surgical technic but in:

1. Careful history taking.
2. Thorough physical examination. This of course includes abdominal examination as well as vaginal. I regret to state that at some gynecological clinics, patients are not examined abdominally,

a vaginal examination only being performed. There is no reason why the gynecologist should have his entire vision limited to that area below the ileopectoneal line.

3. A proper appreciation of the pathological state represented by our diagnosis. This will do away with an enormous amount of unnecessary office treatment in gynecology, as well as unnecessary operative interference.

4. Should surgery be found indicated in a gynecological case, let it be complete surgery, not a laparotomy only, leaving important surgical work undone. This error is frequently committed by two types of men—the occasional surgeon and the surgeon who occasionally intrudes upon the field of gynecology. The gynecologist frequently leaves his work incompletely done by having his vision limited to the pelvis.

5. Gynecological diagnosis is, as a rule, not difficult, as in most cases it does not require unusual skill. It does require a careful and time-consuming consideration of the case, a knowledge of gynecological pathology, and an ability to apply both medical and surgical procedures to the remedy of those conditions.

DIAGNOSING INCIPIENT PULMONARY TUBERCULOSIS.*

By Charles I. Silk, M. D.,

Visiting Physician to the Perth Amboy City Hospital, Medical Division; Chief of Perth Amboy Tuberculosis Clinic.

Perth Amboy. N. J.

I did not expect to speak on this subject myself, and the only reason why I was selected to represent the State Anti-Tuberculosis Association in this demonstration is because the more prominent men are attending the annual meeting of the national organization at St. Louis, Mo. So I will ask you to bear with me if I do not come up to your expectations.

This is not so much of an address to be read or delivered, as the post card would seem to indicate, but rather, what we are pleased to call a demonstration, consultation clinic. It is the purpose of this clinic to demonstrate the most approved and practical methods of diagnosing incipient pulmonary tuberculosis and to consult with you on any cases which you may see fit to bring to our attention at this meeting.

The necessity for these clinics was brought out at a meeting of the executive committee of the State Anti-Tuberculosis Association, of which I have the honor to be a member. These clinics were decided upon as an effective means for stimulating the medical profession at large and the general practitioner in particular, in the taking of greater pains in diagnosing incipient pulmonary tuberculosis, in the reporting of all cases of tuberculosis to the respective boards of health and in focusing their attention on the subject of tuberculosis as a whole.

When we consider that tuberculosis heads the mortality column, that about every tenth death is due to tuberculosis, that about 150,000 to 200,000 persons die of tuberculosis annually in the U. S., and that it costs this country about three-fourths to one billion dollars, a very conservative estimate, if based on present-day valuation, in the loss of man power and maintenance of the sick and their families, that it is a preventable disease and curable in its early stages, then we must all agree that the subject of tuberculosis is of paramount importance.

That the medical profession does not measure up to the requirements of this all important and vast problem can be learned from the following facts:

1st. The great majority of cases of pulmonary tuberculosis admitted to the different sanatoria are in the advanced stages of the disease, indicating that the incipient stages are overlooked, or not diagnosed, or else the patients are not made to realize the importance of applying for early sanatorium treatment, or all of these.

2nd. The number of cases reported to the health authorities by the medical profession as compared to the number of active tuberculous individuals, that can be reasonably estimated living in a community, is entirely out of proportion. In some instances a lesser number of living cases is reported than the number of deaths certified to, as being by tuberculosis. Whereas the lowest and most conservative estimates, by the highest authorities on the subject, prove that there exist at least from five to ten living persons with active pulmonary tuberculosis for every death caused by this disease. In the Framingham Demonstration they

*Read at the February monthly meeting of the Middlesex County Medical Society.

have found 20 living cases for every death.

There is no one single sign or symptom or laboratory test that is pathognomonic of pulmonary tuberculosis, with the exception of finding the tubercle bacillus in the sputum and even this is subject to error, as I will endeavor to bring out in some cases that will be demonstrated after these remarks.

In arriving at a diagnosis all factors bearing upon any given case must be taken into consideration. Beginning with the history which should be taken carefully and be always written, paying particular attention to the most important points, such as: cough, catching of colds and other acute diseases, loss of weight, haemoptysis, night sweats, etc. History taking is a very simple matter, but taking it properly requires good judgment and tact on the part of the one doing so. To illustrate family history: A patient, a short time ago, being asked if there was any tuberculosis in his family, answered, no. Any consumption in the family? No. Father living? Yes. Age? 45 years. Mother living? No. Age at death? About 40 years. Cause of death? Bleeding from the lungs. This is only one example of many instances that may be cited to prove what can be done by proper questioning. The patient is not always able to describe his symptoms so as to lead one to suspect pulmonary disease. Very often, he will give such vague symptoms as pain in the shoulders or back, even suggesting the diagnosis of rheumatism, where on careful examination we find that it is pleuritic involvement which gave rise to these symptoms.

Temperature and pulse should never be omitted, as these are some of our most important indicators of activity. In all doubtful and difficult cases, temperature and pulse should be taken and charted at least three times daily, on rising in the morning, at 4 P. M., and at 8 P. M., the patient being kept at rest, preferably in bed, for a period of say, two weeks, or a month or more, if necessary, until a diagnose is established.

Physical Examination. — The usual classic text-book examination should be followed as a matter of routine, with the patient in a sitting posture facing a good light, fully relaxed and at ease, skin bare to the waist line. Slipshod methods cannot be expected to be productive of good results.

Weighing and measuring is an essential part of the procedure. Without scales, one is really not in a position to deal with tuberculosis patients.

Sputum.—In every case, that is at all suspicious, the sputum should be examined. It should be collected with care, so as to prevent contamination and spread. The writer prefers to collect the sputum personally during the examination while making the cough test, which is to be demonstrated after this paper, whenever this is possible. If sputum is unobtainable at this time, then a specimen jar is given to the patient with proper instructions for collecting same. Which are to the effect: that it be done the first thing in the morning, after cleansing of the oral cavity and before breakfast is taken. The examination of the sputum as described above, as a routine procedure, will surprise you how frequently you will find tubercle bacilli in the sputum when you least expected. As a practical point, the writer would suggest, that where the patient is to collect the sputum, that he be told that a nurse or some other messenger will call for the same at an appointed time. This is necessary in order to impress the patient with the importance of the examination and to make sure that a specimen is obtained or else you will frequently find that the patient has failed to comply with your request.

X-ray.—The roentgen examination of the chest, both radiographic as well as fluoroscopic, is a very valuable, but not indispensable aid in diagnosing incipient pulmonary tuberculosis. It should be made use of in all doubtful and difficult cases for the purpose of verification or contrary wise. A positive finding is of more importance than a negative. Roentgen examination can be of value only if made by one experienced in roentgen analysis.

After all is said and done, it does not depend so much upon the expertness of the examiner, whether he will make a correct diagnosis as upon the pains he will take in arriving at such a diagnosis. Any one of ordinary diagnostic ability, who will write out a careful history and follow the routine as outlined in this paper, I am sure, can make a diagnosis of incipient pulmonary tuberculosis in the majority of instances.

AN ESSAY ON GOOD FELLOWSHIP.*

By Joseph M. Rector, M. D.,
Jersey City, N. J.

Were I to define good fellowship in the language of one's every-day life, I would begin by describing the actions of a broad-minded man, tempered and guided by judgment, stability, tolerance and fairmindedness. One's life in its daily dealing with his fellowmen, is always indicative of character, and that disposition is the outward evidence of its human instincts. Character is centrality, the impossibility of being displaced or overset, while society is frivolous and shreds its day into scraps, its conversation into ceremonies and escapes.

One should not always be guided by his environment, per contra, it is often better to so temper his surroundings as to bring out all that is good and noble.. The curse of congeniality is narrow-mindedness. The man of one book, of one thought, cannot see beyond the end of his nose, finds all the evil in his neighbor and sees none of his redeeming qualities. Restricted is the vision which shuts out the light of happiness, casts aside the many principles of fellowship, and with the dimmed light of a hackneyed conscience, fears the gaze of the broadened mind. One can plainly see the decrepit fortitude of selfishness, as he lives in the little corner of his own detested threshhold, shunning the open gaze of his generous brother, or with lowered head grovels along through life just as the domestic swine satisfies himself to wallow in his own filth and uncleanliness.

The inter-association of men will aid in the determination of character. The failure of united intercourse will develop a rut in life, which controls its being, which dooms its possessor and changes a useful soul into a lifeless automaton. He who fails to advance with the world, who does not realize the rights of another, is the man who allows the pangs of jealousy and deceit to warp his better judgment and curtail his mortal usefulness.

Distrust breeds hatred and misgivings. Unwarranted suspicion attempts to cast the drag-net of greed upon a less suspecting brother, robs one's self of his own individuality and often distorts a weaker mind. Ambition, in the possession of an honorable man, is a quality begun in good will, fostered in generous temperament and advanced by dogged perseverance. It extends an open hand to progress, it promotes originality, it arouses healthy competition and challenges all good fellows to test the lance of friendship. There is no ban to the generosity of thought and principle of others. The attainment of one's coveted desires is not interfered with or is there any cause for distemper or enstrangement.

So often do men condemn each other for no other reason than suspicion and fear of success. How often is jealousy the lone cause and beginning of enmity. It is always found among a class of men whose indolent habits and inherent inactivity give them food for idle thoughts, juggles their biased, sleepy brain into inflamed action, until they believe, in truth, an injury is knocking at their door and they must awaken or suffer the penalty of oblivion. Malice and envy require constant thought and skillful planning to succeed. Its reward is continued distrust and unrest; but, above all, the piercing eye of charity and kindness will readily fathom the shallowness of universal disbelief, whose imaginary safety is but a hollow shell or fantasy, in which the unfortunate mortal works his own destruction. Individuality and self-reliance are the weapons at every man's door to be used as best he may. The fact that one's temperament is often of his own making and that his actions will follow his own inclination, is there scant wonder why such diversity exists and yet, there is one way to live in this world and enjoy its blessings,—that of peace and harmony with all mankind.

"For what does it profit a man if he gains the whole world and suffers the loss of his soul"—and so, what possesses a man, should he own the world but not the friendship, confidence and good-will of his fellow men?

One should learn to detect and watch that gleam of light which flashes across his mind from within and not dismiss, without notice, his thought because it is his own creation. It does not necessitate a genius to win the confidence of one's neighbor. Remember that the work of genius is but our own rejected thoughts. Universal brotherhood looks forward to

*Read by request before the Medical Board of the Jersey City Hospital.

a unity of interests which will guide all men to a common good-will, whereby life in the aggregate will work an existence worthy of a civilized community. The power of causing appreciation is a magnetism in the possession of every man; it is an attribute belonging to us all. "There is a time in every man's education when he arrives at the conviction that envy is ignorance, that he must take himself for better, for worse, and though the wide universe is full of good, no kernal of nourishing corn can come to him but through his toil bestowed on that plot of ground which is given to him to fill." We but half express ourselves and are ashamed of that divine idea which each of us represents.

It is easy for the firm man who knows the world, to reject the sneers of the cynic, to turn the scoffs of the disgruntled into praises of admiration. It is not necessary that one should ramble far away into the realm of possibilities to show a fellow-man the daily life of catholic unity. No man can violate his nature, but he can so tune his actions and motives, as to teach an acceptable existence to all mankind. If one is unmindful of his worth, or is ignorant of his own power, mark whereof he errs and lead him into the assemblage of men. Your genuine action will explain itself and put to shame the false disposition of an ill-fated brother. He will measure you and all men and all merits; he will awaken to the falsity of his being and will shortly grasp the hand he would have spurned and save the life he would have destroyed.

Let there be an agreement in whatever variety of actions that may exist, one tendency should unite them all. "The voyage of the best ship is a zigzag line of many tacks. Watch the line from a sufficient distance and you will see it straighten to the average length."

PRIMARY SARCOMA OF THE APPENDIX.*

By Dr. Hyman I. Goldstein,

Camden, N. J.

A brief review of the literature of carcinoma and sarcoma of the appendix vermiformis. Mention is made by the author of fifteen (15) cases of primary sarcoma of the appendix found recorded in the medical literature of the world and adds the report of his own case. There are now on record about three hundred and twenty-five (325) cases of primary carcinoma of the appendix. Sarcoma of the appendix is a very great rarity. The first authentic case was reported by Hastings Guilford in England, before the Reading Pathological Society in 1893. The first case in America was reported by J. C. Warren in 1898.

Author's case—Miss Lena G., 25 years old; white girl; F. H. negative—except "mother has gallstones" for the past 20 years. Patient worked in pen factory for eight years. Had several attacks of appendicitis. Operation, September 30, 1919, by Dr. A. C. Wood. Found intestinal obstruction by hand, and tumor of appendix. Examination by Prof. Allen J. Smith, of the University of Pennsylvania, who reported lympho-sarcoma of appendix. Eight months after operation (June 1, 1920), patient is working, and well; although she has not regained her best weight and complains of constipation.

Conclusions: 1. While carcinomata of the appendix have been more frequently reported during the past fifteen years, they are still comparatively rare.

2. Sarcoma (primary) of the appendix, of any type, is a very great rarity.

3. That the following are the only authentic and accepted cases of primary sarcoma of the appendix found recorded in the entire medical literature of the world. Those of Guilford, Warren, Patterson, T. Carwardine (two cases), de Jong, T. G. Davis, Powers, Wohl, Smit, White, Steward, Jones, Bernays, Wright and the author's case—a total of 16 cases, if we accept all these cases, and exclude Glazebrook's case, of sarcoma of the appendix, in the entire literature of the world.

4. All the cases showed symptoms resembling attacks of acute or recurrent appendicitis. It is impossible to make a correct diagnosis before operation.

5. All appendices removed at operation and at autopsy should be carefully examined; there may be more malignant appendices found which at present escape, because of failure to examine them carefully in the laboratory.

*Abstract of paper read before the Pathological Society of Philadelphia; College of Physicians, June 10, 1920.

In spite of the similiarity in sound, an ingrate lacks much of being great.

Clinical Reports.

Wandering Appendix.

Drs. McLain Rogers and V. M. Gore of Clinton, Oklahoma, report this case in the June Oklahoma State Journal:

Mr. R. B. A., age 45, farmer, living in Washita County, was admitted to our service February 12, 1920. He was suffering with an acute bowel obstruction. He gave a history of an abdominal operation in 1911. The record of that operation as furnished us by the El Reno Sanitarium shows that the appendix and caecum were involved in one mass under which was pus. The walls of the caecum were thickened. The abscess was drained and diagnosed as of appendiceal origin. The patient made an uneventful recovery and was discharged from hospital June 14, 1911. Operative findings February 12, 1920: A loop of bowel, ileum, was bridged across by a heavy band. Through this opening a number of loops of bowel had herniaed and become strangulated. This band proved to be the appendix which was not attached to the caecum at all. The appendix was two inches in length. It was attached by its base to the ileum some fourteen inches from the ileo-caecal valve, was patent from base to tip, admitting a large pen stock throughout its lumen. The tip of the appendix was attached in the mesentery of the ilieum about eight inches from the caecum. Appendix was removed and stump inverted. The caecum was examined and scar of appendix original attachment recognized. Patient recovered and was discharged from hospital March 4, 1920.

Irritable Bladder in Women.

Dr. C. A. L. Reed, Cincinnati, at the meeting of the Southern Surgical Association, said that irritable bladder was characterized by frequent desire to urinate, pain in the bladder often extending to the rectum and perineum, sleeplessness, and nervousness, all in a history of long duration and obstinate resistance to all treatment. The causes of irritable bladder were found outside of the bladder and inside of it. Those that were outside of it embraced pregnancy, uterine displacements, infections of the uterine appendages, ovarian tumors, displacement of the intestines and adhesions. Those that were inside of the bladder were gonorrheal and other infections, tumors, calculi and ulcers. Among the avrious forms of ulcers the one which was described as punctate was the most important as being probably responsible for the majority of all intractable cases of irritable bladder. It was a small round ulcer about 2 to 3 mm. in diameter, a few being somewhat elongated. It formed in myriad numbers over an area of from 2 to 6 cm. long and from 1 to 4 cm. broad on the front wall and vertex of the bladder. The underlying pathology was that of chronic interstitial cystitis with static edema, causing macular necrosis of the epithelium. The pathology of the condition and the function of the bladder combined to make the condition incurable by so-called conservative means, as demonstrated by ample experience. The diagnosis could be made only by careful consideration of the history, the presence of occult blood in the urine and cystoscopic examination which should be made in all cases of chronic irritable bladder. The only rational treatment was by excision of the ulcer-bearing area. These successful cases were reported. Thirty-eight of these cases now on record proved that it was a surgically safe procedure and one by which many, probably the majority, of these sufferers could be permanently cured. The conclusions reached were: "(1) The punctate ulcer of the bladder with its associated pathology is a demonstrated clinical entity. (2) The condition, by virtue of the pathology, is not only chronic, but incurable by so-called conservative methods. (3) The usual limitation of the ulcerative process to the anterior wall and vertex of the bladder make it surgically accessible. (4) The treatment by excision of the ulcer-bearing area is justified by its demonstrated practicability and by its equally demonstrated results."

"Blue Cornea"; Inherited Syphilis; Motor-Oculi Paralysis.

The Kentucky Medical Journal cites the following cases, reported by Dr. Samuel G. Dabney, Louisville:

Case 1. The first case may interest those of you who practice obstetrics. It is the first baby I have ever seen born with blue cornea. Both cornea were blue, one more so than the other. The usual explanation given for this phenomenon is contusion of the cornea during delivery. In this instance I asked whether the child had been delivered with forceps and received a negative reply. I gave a favorable prognosis.

It has now been two months since the child came under my observation and the blueness has entirely disappeared in one eye not so completely in the other. The cornea of the worse eye appears slightly staphylomatous the other has the normal curve. The only explanation given by text books is corneal contusion caused by forceps delivery. In this case however, the child was born with blue cornea and was not delivered with forceps. Such cases must be very rare.

Case 2. The second case is also of interest to the general physician. A baby was brought to me when five weeks old. The mother was a buxom healthy looking woman about thirty years of age, who stated that the baby had considerable difficulty in breathing which interfered with nursing. Examination showed some small sores about the corners of the mouth, lips and anus. The child did not, however, otherwise have the appearance of inherited syphilis. It looked rosy and the mother said it had gained in weight. We know that most children with inherited syphilis present a peculiar old and weakened appearance. I asked the mother how many children she had, and she replied this was the first one to live although she had borne six!

I generally prescribe some simple local measures in cases of this kind; a few drops of an essential oil, such as peppermint or eucalyptol in oil of vaseline will keep the nose open and facilitate nursing. Of course the

treatment is essentially specific and I leave that to the family physician. I telephoned him I thought this was unquestionably a case of inherited syphilis. He did not seem to have thought of that before although I believe he attended the woman in all her miscarriages. He gave the child mercurial inunctions and rapid improvement has occurred.

Two or three questions present themselves in case of this kind. What will a Wassermann test show in the mother? I believe it will be positive. The family physician will have this test made and if positive the mother will be treated accordingly. I thought the case of interest because of the slight evidence of inherited syphilis presented. In the absence of the so-called snuffles no one would have paid much attention to the small sores about the mouth, lips and anal region.

Case 3. The third patient is a male of forty-two apparently in perfect health, who came to see me a week ago with a dropped lid, and when the lid was raised he saw double in that eye. The pupil was not dilated, there was no paralysis of accommodation, he could still read fine print. In other words, the paralysis involved only certain fibers of the motor-oculi nerve. The statement has been made that over sixty per cent. of such cases are syphilitic.

An interesting part of the history is that on two ohter occasions this patient has had dropped lid and double vision which disappeared within a week or two without any special treatment. The history is typical of so-called recurring ophthalmoplegic migraine without the migraine. Such cases are rare but are occasionally observed, i. e., paralysis of the motor-oculi nerve with violent pain recurring over a long period of time. This patient has had motor-oculi paralysis recurring the third time; he has a negative blood Wassermann, and is apparently in perfect health. He says the symptoms have disappeared on two previous occasions without treatment. Recurring motor-oculi paralysis without assignable cause must be rather rare.

Prostatic Operations; Report of Cases.

Dr. J. Hunter Peak, Louisville, reported these cases at the Jefferson County Medical Society, Kentucky, as given in the Kentucky State Journal.

Case 1. Mr. K., aged seventy-seven, height six feet, weight one hundred and forty-five pounds. There was an early "gonorrheal" history; otherwise the patient was an unusually well preserved man both physically and mentally. When seventy-four years of age he noticed difficulty in voiding his urine; the stream became smaller gradually and the residual urine larger in amount until he reached the age of seventy-six. During the next year his bladder was never empty, and he had what might be termed a constant dribbling or overflow. On January 3rd, 1918, he had complete retention of urine with prostate so large and urethra so tortuous that a catheter could not be inserted.

The patient was taken to the Sts. Mary and Elizabeth Hospital where an immediate prostatectomy was performed. The median and right lobes were about the size of English walnuts; the left lateral lobe was as large as a hen's egg and acted as a valve which prevent emptying of the bladder and also the insertio of a catheter. The period of recovery wa rather protracted but uneventful; the patier now past seventy-eight, is in perfect healt and weighs over two hundred pounds.

The foregoing is the type of case some oper ators think should have had the double opera tion; that is, first draining the bladder supra pubically, and when the patient was in bette physical health enlarging the suprapubi wound and removing the prostate. I believ in many cases where the kidneys are badl crippled from back pressure this might be th best method of procedure, but am inclined t the opinion that the prostate can be so quickl removed that the risk is not much increase by the one-stage operation.

Case 2. Mr. F. C., aged fifty-five, heigh five feet and ten inches, weight two hundre and twenty-five pounds. This patient had acute urinary retention; the catheter could be introduced, but the cystoscope revealed an enlarged middle lobe with a pedicle acting as a ball valve.

The perineal route was chosen in this case and Young's technique employed the enlarged middle lobe being removed. The other two lobes being normal were not disturbed. There was practically no hemorrhage, and all drainage excepting the retained catheter was removed within forty-eight hours. The patient was discharged well at the end of ten days.

Case 3. Judge C., aged seventy, height six feet, weight one hundred and fifty pounds. Normal urination had been impossible, there being simply an overflow, but the catheter could not be used. Examination disclosed the bladder filled with pus and urine. Dr. A. W. Nickell kept this patient in the hospital four weeks irrigating the bladder and giving special attention to the crippled kidneys and existing cystitis until he was much improved in health. This could be done because he could be catheterized.

This man's prostate was nearly as large as a goose egg, that is the three lobes combined. The middle and right lobes were removed, enucleation being easy; the left lobe was nothing more than an abscess. The patient remained in the hospital four weeks after the operation and made an uninterrupted recovery.

Dr. A. W. Nickell, in discussing the paper, said: There is an important and distinct medical side to the majority of cases of prostatic disease. When the Judge, aged seventy, mentioned by Dr. Peak, came to me he gave the history that he had been catheterizing himself for about three years. Examination revealed a badly infected urinary bladder, which was a veritable manufacturing plant for the bacteria of mixed infection, especially the staphylococcus and colon bacillus; there was evidence of serious interference with kidney function; the patient was septic; the urine contained albumin probably due to the pus which was present; his appetite was meager; he had a low hemoglobin percentage and blood cell count. I kept him in the hospital for four weeks, and under vesical irrigations, supportive, eliminative and restorative treatment with autogenous vaccine his appetite and digestion improved, he gained several pounds in weight, and finally his condition was such that I thought he could be

ccessfully operated upon. Dr. Peak performed a brilliant operation, and the patient ade an uneventful recovery.

bstracts from Medical Journals.

Excision of a Fistula in Ano.

The operation of excision of a fistula with nmediate closure of the wound by sutures hus obtaining union by first intention is not ery popular because of the large percentage of ailures. The operation can be tried only here the sinus is straight, superficial and not ver 2½ inches long and the sinus must not e surrounded by dense induration. It the inus is otherwise it will be found impossible o accurately coaptate the edges without ten- ion on the sutures, and there is always danger f the stitches becoming infected.—Charles J. Drueck in the Mississippi Valley Medical Journal.

What Is Diabetes?—Dr. J. F. Wilkinson, in he Australia Med. Jour., says: All our pres ent knowledge and particularly the recent experimental work of Allen show that the underlying deficiency is a failure of the internal secretion of the pancreas, with consequent inability to convert sugar from the crystalline to the colloid form, in which form it must be present before it can be utilized by the body cell. Such failure on the part of the internal secretion of the pancreas may or may not be related to gross disease; it seems reasonably certain that nervous disturbance may disturb the equilibrium normally maintained between the organs of the endocrine system, and undoubtedly nervous disorder frequently upsets the balance of a diabetic. There is reason to believe that the white races generally are overtaxing the pancreatic function; the present-day enormous consumption of carbohydrate, and particularly of sugar, is a new thing for the race. In America the consumption of sugar per head has risen from 4,900 grams per head in 1810 to 40,700 grams per head in 1916; perhaps a sugar famine would not be an unmixed evil.

Radium Therapy of Cancer of the Uterus.—Degrais in his brief article considers primary epithelioma of the cervix and postoperative recurrences. The former he divides into operable and inoperable. In the former the surgeon believes that his cases which escape operative death and ordinary recurrence will survive from 6 to 8 years and radium can hardly better such a result. It is true that we have but few cases to serve as a basis of study—cases in which the knife has been point blank refused. The author has cases of primary epithelioma in which radium alone was used which are living 5 or 6 years after the application of radium, and one case in which survival is now 8 years. This was a papillary growth in which not even a preliminary curettage was used. As a rule the author makes use of the curette under the circumstances. The results in the author's series of cases have been typical throughout, the appearance of the servix depending on the amount of tissue originally involved. Thus in certain cases the cervix was almost as if amputated. In the use of radium in recurrence the author does not speak of cure but has invariably secured benefit and prolonged life, often over long periods. The curette is always used as accessory. In the third type of case, the postoperative recurrence, radium has its peculiar usefulness. He cites one case of precocious recurrence in which radium stepped in and gave the patient at least 6 years more of life.

Cause of Death in Grippe.—Dr. Rennaud, in La Presse Medicale, reports that he has treated over 600 cases of influenza during the epidemic and that he saw as the essential cause of death pneumopathies with multiple foci of hepatization. The mechanism is either asphyxia or cardiac collapse. There is essentially a pneumococcus sepsis of epidemic character so that the entire picture does not differ essentially from the epidemics of malignant pneumonia which occasionally appear in cold weather. He had 27 cases of severe type and did not lose one, his management being early repose and digitalis as a background, with adrenalin and pneumococcus serum in more desperate cases, the use of hydrotherapy—in short, the usual treatment for pneumonia.

Damage Caused by Gonorrheal Injections.

It has long been recognized by genito-urinary surgeons that the treatment of gonorrhea by injections is contrary to the rules of a true surgical technic. We remember Prof. Lassar saying many times that gonorrhea is the only disease in which we drive the germs in instead of driving them out. And we believe it is a great mistake to give posterior injections or bladder irrigations so long as the gonorrheal process is limited to the anterior portion of the urethral canal. It is wrong to force open the cut-off muscle which serves as a wall between the anterior and posterior urethra so long as we are sure that the posterior segment is not affected. We have seen numerous cases in which we believe that the extension of the gonorrheal process from the anterior to the posterior urethra was caused directly by the injections. Of course we can never be sure of such a thing. There is always a possibility of believing that the extension of the process would have taken place anyway, but cases that have come under our notice seem to leave little doubt of the fact that the mischief was caused directly by the injections.

One case was that of a drummer, a young man of twenty-four, who became infected with a typical first gonorrhea. All the symptoms pointed to the fact that the process was limited to the anterior portion. I treated him by internal antiblennorhagics and by protargol injections, using about two drams of ½ per cent. solution with each injection. At the end of four weeks this man was practically cured. The discharge was very scanty. There were no shreds in the urine and gonococci were practically absent. The man at that time had to leave New York. I told him that while he was practically cured, he was not quite cured and advised him that it would be best for him to be under a physician's care for a week or two, until the cure was quite complete. A physician whom he saw in Buffalo gave him a sil-

ver nitrate injection and immediattly following tht injection all the symptoms of the case became aggravated, the discharge increased and urination became painful. He had symptoms of acute prostatitis and in another week he was laid up with an epididymitis. When he came back to New York six weeks later the case was a very bad one and it took three months of very careful and anxious treatment before he was brought to the stage in which he was when he had left nearly five months previously. There can be no doubt that in this cases the extension of the disease was caused directly by the silver nitrate injection which gave the gonococci favorable (inflamed) soil for development.

I will state here in passing that while silver nitrate in proper strength, used in chronic cases of posterior urethritis is of great, sometimes of remarkable benefit, this drug is responsible for many damaged urethras. It is unfortunately only too often used unscientifically and in acute conditions where it only adds fuel to the fire.

County Medical Societies' Reports

BURLINGTON COUNTY.

H. Eugenia Whitehead, M. D., Reporter.

The regular summer meeting of the Burlington County Medical Society was held at Coles Hotel, Moorestown, on Wednesday, June 9th, at one P. M. After the transaction of ordinary business, the following new members were elected:

Drs. Robert E. Sievers (U. S. Army service), Bodentown; Charles Street Mills, Riverton; Fred C. Wittee, Riverton; Fred C. Clark, Roebling; Charles F. Voorhis, Palmyra. This was a banner month. Three of the new members were homeopaths.

Dr. Harry L. Rogers, chairman of Section on Surgery, announced the following program:

"Fractures of the Femur," by Dr. Emlen Stokes, son of Joseph Stokes of Moorestown, and a recent graduate of the University of Pennsylvania, at present finishing his internship at Pennsylvania Hospital. It was a very concise and instructive paper on the most recent treatment, appliances, etc. The technic of bone grafting, time to operate, preparation of patient, extent of injury to soft parts, physical examination and roentgenographic pictures to determine location, extension of bone injury and plan for operation in respect to bone grafting before cutting or opening, one should make sure the graft will be covered without undue tension by healthy skin and soft parts, contact should be with good tissue. The graft inlay type is best whenever possible—fixation should be secured by the graft itself and not by metal plates. The limb should be firmly immobilized for a period of eight to ten weeks following operation. We consider this a very valuable and instructive paper.

Dr. Richard D. Anderson, U. S. Navy, Burlington, read a paper on "Salpingitis," which included all inflammation of the oriduct, eustachian tubes and surrounding parts. He handled his subject cleverly and the paper was much appreciated.

Twenty-four members were present and all seemed to enjoy the meeting at Moorestown A vote of thanks was tendered the young mer for their most interesting papers. The meet ing was adjourned. An elaborate dinner wa ready, waiting for us which was enjoyed thor oughly.

MORRIS COUNTY.

The Morris County Medical Society met o the evening of June 8 at the Mansion House i Morristown, with President Dr. Marcus A Curry presiding. There was a goodly attend ance of members and the guests were Dr. An nie E. Freese of the staff of the State Hospita at Morris Plains and Dr. Gustave Rosania o Morristown Memorial Hospital. This was the first meeting since December 9, owing to deterrent elements and conditions which obtained throughout the winter and spring.

Dr. Julia Mutchler of Dover and Dr. Harvey Arbuckle of Boonton unanimously were admitted to membership in the society. Two other applicants were recommended favorably for admittance but final action was compelled to be deferred pending the reaching of the end of the "red tape" incident to local registration technicalities.

The loss to the society by the death of Dr. Britton D. Evans on January 14 was considered a matter for official recognition even at this late date and it was the unanimous sentiment of the members that a blank page in the minute book be suitably inscribed by Secretary Kice.

In an impersonal form Dr. F. W. Owen brought before the society the unfortunate circumstances arising out of the physical incapacity of a member who entered the late war as first lieutenant, then rose to captain and being stationed on the exposed lake front near Chicago had contracted laryngeal if not pulmonary trouble which necessitated his going to Albuquerque, New Mexico, in an effort to overcome his physical incapacity which resulted in hardship to his family. The members generously arranged voluntarily to meet the exigencies of the situation.

President Curry introduced Dr. Christopher C. Beling of Newark, who delivered the discourse of the evening. His subject was "Epidemic Encephalitis Lethargica." Preceding his discourse with extenuating remarks for the absence of Dr. Harrison S. Martland, who planned to be present to enter more fully into the pathology of the subject, Dr. Beling reviewed about twenty cases of the disease coming under his personal notice and attention in Newark and surrounding towns in northern New Jersey. The point was quickly patented that encephalitis lethargica occurs from November to May, in contra-distinction to poliomyelitis which comes into prominence from May to October; and that encephalitis lethargica attacks chiefly the adult as opposed to poliomyelitis which finds most of its victims among children. The chief characteristics of epidemic encephalitis lethargica seemed to be high temperature, mental confusion, somnolence, from which it gained the name of "sleeping sickness" in some parts of the country; sleepiness in an agitated form was sometimes found with intervals of delirium mostly of a professional nature; marked and unusual jerk-

ng of the muscles of the face, abdomen and imbs and impairment of the mid-brain. An inusual case was cited where the temperature ose to 104, but the patient also was suffering from broncho-pneumonia which makes he cause of the high temperature uncertain. Dr. Beling stated that differential diagnosis was a very delicate problem and that cerebrospinal syphilis, tumor of the cerebrum and cerebellum, hysteria and gumma of the pons, have to be eliminated before the diagnosis of encephaltis lethargica definitely can be made. The treatment of the disease was not entered into but it was stated that there were no wholly reliable signs which would permit the attending physician to make any kind of a prognosis.

Dr. Beling was roundly applauded for his infinitely painstaking discourse on the interesting subject of rising importance.

Dr. John V. Donnet, pathologist at the State Hospital at Morris Plains, upon invitation of the president, led the discussion. He said that "sleeping sickness" was a misnomer for the disease, as it already had been appropriated for another disease where the symptoms seemed to be similar but which is indigenous to the tropics. Dr. Donnet said that the pathogenic micro-organism of sleeping sickness is the protozoan known as trypanozoma and has no relation whatever to epidemic encephalitis lethargica of this part of the world. He said that the main anatomical lesions in encephalitis lethargica are found in the motor-nuclei of the cranial nerve; that these lesions are characterized by exudation of the lymphoid cells in the lymph sheave surrounding the blood vessels, the origin and psysiological properties of which are doubtful; that the epidyme also shows signs of infiltration; that the floor of the fourth ventrical and the lateral ventrical usually is covered with small granulations similar to that found in general paralysis and is due to amyloid degeneration of the lymphal cells; and that a slight degree of meningitis always is present and the cord shows a few degenerative processes—the main one being infiltration of the neuroglial septum. In a general way the lesions are similar to those due to toxin agents. The spinal fluid is negative and the blood rarely shows an increase of lymphocytes; while in poliomyelitis the increase of lymphocytes is quite prominent. Dr. Donnet said that in all cases a thorough examination of the blood and spinal fluid should be made in order to eliminate the other acute or chronic disease which may be mistaken for encephalitis lethargica.

Dr. Abell (nee Dean) described her personal experience with a case where were found, interference of speech, marked ptosis, irregular type of temperature, rising to 101 or 102 and going down to 98 or 99 for a few days and going up again. The patient gradually recovered. Drs. Lathrope and Knowles took part in the discussing and questions were asked by several of the members which were answered by Dr. Beling, who received a rising manifestation of appreciation of his worthy discourse.

It was decided to hold the annual meeting at the State Hospital at Morris Plains, which privilege was offered by President Curry.

After adjournment refreshments were served by Proprietor John Sweeney in a prompt and appetizing manner.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

A monthly meeting of the Middlesex County Society was held on June 23rd at the residence of Dr. L. P. Ellis in Metuchen, the president Dr. L. P. Runyon in the chair, with an unusually large attendance. Dr. Hoffman acted as secretary in the absence of Dr. Nafey.

Dr. English reported on the revision of the constitution and by-laws. There was an anunated discussion on the Legislators' and Governor's actions on the medical legislation, after which Dr. Alfred L. Ellis read a very interesting paper on "The Practical Management and Care of Children and Their Diseases," which was discussed by several members.

Dr. Ellis and his good wife subsequently served those present with a bountiful and excellent luncheon for which they received the thanks of the society.

SUSSEX COUNTY.

H. D. Van Gaasbeek, M. D., Reporter.

The Medical Society of the County of Sussex was invited by the directors of the Alexander Linn Hospital Association to hold their spring meeting at the hospital and to inspect the same. Accordingly the society met at the hospital on Tuesday, June 8. After being shown through the hospital, inspecting its rooms and wards, the president, Dr. Jacobs, called the society to order and proceeded with the regular order of business. Two new members were elected: Dr. Joseph Morrison of Newton and Dr. B. W. Roy of Sussex.

The members of the society and their guests were then informed that "dinner was served," and on proceeding to the dining-room of the hospital they found awaiting them a very bountiful and excellent repast furnished by the Ladies' Auxiliary of the hospital. They were waited on by a committee of the ladies, who performed the duties of waitresses in a very excellent and artistic manner, in fact as if to the "manor born." After dinner was finished the society was again called to order by the president.

A telegram was read by the secretary from Dr. Casselman (who was expected to be present and address us), saying that he had missed his train connection and would be unable to be present. Dr. Casselman was to have spoken on "The Diagnosis and Prevention of Venereal Diseases," to be illustrated by two (2) reels of films, entitled the "Modern Diagnosis of Syphilis." In his place Mr. Shelby, the film operator, who is connected with the Social Hygiene work of this state, gave the reels, prefacing it by saying that he was very sorry that Dr. Casselman was not present, but that the reels would speak to the medical men. They were very interesting and instructive.

E. D. Easton, secretary of the Anti-tuberculosis League, read a paper on the "Importance of an Early Diagnosis of Tuberculosis." This paper was written by Dr. English of the Glen Gardner Sanatorium, the doctor was unable to be present on account of illness. The paper was a very interesting one, calling the attention of the general practitioner to the great importance of the diagnosis of this disease in the early stages and laying especial

stress on the early general symptoms, as well as the early physical signs, which being taken together would enable one to make an early diagnosis. This paper was very generally discussed by nearly every member. This meeting was probably the largest meeting of the county society which has been held in many years. All present expressed their appreciation of the ladies' committee's hospitality and as very much pleased with the hospital and its furnishings.

The Alexander Linn Hospital was purchased and fitted out with modern hospital requirements from a legacy left by the late William A. Linn of Hackensack, N. J. He was a son of Alexander Linn, M. D., who practiced his profession for many years in Deckertown, now Sussex, N. J. The hospital is very complete and beautiful in all its details. It has six private rooms and room in wards for 20 patients. A large and completely furnished operating room and a small operating room, complete in all details for minor operations. It is a fitting and lasting monument to the memory of an able and distinguished general practitioner. It fills a long-felt need in this community and is a source of great pride to the board of directors and the residents of this community.

Local Medical Societies.

Associated Physicians of Montclair and Vicinity

From the Montclair Times, June 12.

The Associated Physicians of Montclair and vicinity was organized in 1909 by a group of doctors in Montclair and the surrounding towns of Glen Ridge, Bloomfield, Verona and Caldwell. The membership now numbers sixty and includes most of the physicians in active practice in these communities. Dr. Herbert W. Foster of Montclair was the first president. Eight regular meetings are held each season, from October to May, at which prominent physicians from New York and other cities read papers on medical subjects. After each meeting refreshments are served and a social half-hour is enjoyed. The meetings have always been held at the Montclair Club on Church street.

At the annual meeting on May 24, the following officers of the association were elected for the coming season: President, Dr. William H. Areson of Montclair; vice-president, Dr. Martin J. Synnott of Montclair; secretary, Dr. Archer C. Bush of Verona; treasurer, Dr. Harvey M. Ewing of Montclair; historian, Dr. Henry Wallace of Glen Ridge.

The affairs of the association are managed by an executive committee, to which President Areson has appointed the following members: Dr. Synnott, chairman; Dr. Bush, Dr. Ewing, Dr. Philip E. Krichbaum of Montclair; Dr. Leslie C. Love of Montclair, the retiring president; Dr. John D. Moore of Bloomfield, Dr. Walter B. Mount of Montclair; Dr. Victor B. Seidler of Montclair; Dr. David C. Thompson of Bloomfield and Dr. Wallace.

The executive committee held its first meeting on Friday, June 4, 1920, and made tentative plans for the coming season. It is expected that very well-known men can be procured as spreakers, and that a series of interesting and instructive papers will be heard. It is planned to throw these meetings open to the general medical profession.

Morristown Memorial Hospital Clinical Society.

George B. Landers, M. D., Secretary.

The regular semi-annual open meeting of the Morristown Memorial Hospital Clinical Society was held at St. Peter's Parish House, Friday evening, June 4.

Dr. Wilbur Ward, chief surgeon of the Sloan Maternity Hospital, read a paper entitled "Some Problems of Present Day Obstetrics." After liberal discussion of the paper by the various members of the society and their guests a social hour and refreshments were enjoyed. Among those present were Dr. Mefford Runyon of South Orange, Dr. A. R. Chamberlain of Maplewood, Dr. James S. Green of Elizabeth and Dr. B. B. Ranson of Maplewood.

Medical Section Rutgers Club.

The Medical Section of this club held its annual outing at DeLisle's, Allaire, N. J., on June 30th. Twenty physicians of New Brunswick and vicinity were present and enjoyed a sumptuous dinner. Dr. D. C. English is chairman and Dr. C. F. Merrill is secretary and treasurer of the organization; Dr. F. M. Hoffman was in charge of the outing. Dr. C. J. Sullivan gave two fine solo selections during the musical entertainment.

New Jersey Sanitary Association.

The Executive Council of this association met in the Robert Treat Hotel, Newark, June 30th with Chairman T. Frank Appleby in the chair and a large attendance of members. After luncheon suggestions were made as to the subjects of papers to be presented at the annual meeting which will be held in Lakewood, December 3rd and 4th next. A committee consisting of the president of the association, Dr. A. C. Hunt; secretary, Dr. Edward Guion and Chairman Appleby, was appointed to secure papers and make full arrangements for the meeting.

TUBERCULOSIS RESEARCH FELLOWSHIP
University of Minnesota.

To encourage study of the means for the prevention and cure of tuberculosis, the Hennepin County Tuberculosis Association of Minneapolis, Minn., announces that it has set aside a fund for the support of a tuberculosis research fellowship in the Graduate School of the University of Minnesota. The candidate for the fellowship must be a graduate of a Class A medical college. He will be expected to devote himself to research in some problem concerned with the causes, prevention, or cure of tuberculosis. No teaching or other service will be required. The fellowship yields $750 the first year and progressively increasing amounts to be appropriated for the second and third years as conditions warrant. Inquiries and requests for application blanks should be addressed to the Dean of the Graduate College, University of Minnesota, Minneapolis, Minn.

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Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

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PLEASE TAKE NOTICE.

Mistakes are frequently made and failures to correct them are caused by failure of members to observe the directions at the head of this column. We, therefore, emphasize the following points:

The Secretary of every county medical society should send notice at once of the election of every new member to Dr. W. J. Chandler, State Society Secretary, South Orange, N. J., and the treasurer of every society should collect promptly the dues and send them **immediately** to Dr. A. Mercer, State Society Treasurer, 31 Washington street, Newark. No Journal will be sent and no medical defense will take effect until the State Society's dues are in Dr. Mercer's hands.

All communications relating to reprints, subscriptions, changes of address, extra copies of the Journal, failures to receive the Journal, books for review, advertisements, or any matter pertaining to the business management of the Journal are to be sent direct to the Chairman of the Publication Committee, Dr. C. D. Bennett, 167 Clinton avenue, Newark, N. J.

All original articles, reports of county, local or other medical societies, news items, personal notes, marriage and death notices, all exchanges of medical journals or newspapers, and any other matters of medical or scientific interest for insertion in the Journal, should be sent direct to the Editor, Dr. D. C. English, P. O. Box 83, New Brunswick, N. J.

OUR ANNUAL MEETING.

The 154th annual meeting of the Medical Society of New Jersey at Spring Lake last month was the largest, except the sesqui-centennial in 1916, and one of the best the Society has ever held. The scientific program was much fuller than usual; so much so that it was feared that the time alloted for the meeting would require the reading of some papers by title only and that the discussions of several would have to be omitted, but all papers were presented though the discussions were somewhat curtailed. The addresses by Drs. G. K. Dickinson, the President, and James Hunter, the Third Vice-President, and also the Orations in Surgery and Medicine by Drs. W. L. Estes and W. B. Stewart were of a high order of excellence and, indeed, all the papers showed careful preparation and were deeply interesting and instructive.

The Business Sessions were well attended and were more than ordinarily interesting because of the awakening of the members to a realization of the fact that we are compelled to stop and consider, in the midst of our abounding altruism, the future scientific standing and efficiency of our profession, so endangered by the propaganda of false cults, fakirs and politicians who have in a measure succeeded in their endeavors to enact laws that are inimical to the best interests alike of the profession, the laboring classes and the public generally. There were present at the Board of Trustees' meetings 19 of the 23 members, an unusually large number. The absence of Dr. Sproul, the chairman, was deeply regretted as it was owing to sickness. The Board's preparatory work with the prompt despatch of business by President Dickinson, helped greatly the House of Delegates to promptly and successfully transact a large amount of business in a manner which we believe will conserve the material interests of the profession and enable it to maintain its scientific and altruistic work. We note at present the following facts:

Our membership has been largely increased, the net gain, over deaths and removals, having been about 200. Our Treasurer, Dr. Mercer, reported a bal-

ance on hand January 1st last of $1,619.22, with one railroad bond and three Liberty Bonds on hand. (It has been considerably reduced by recent large expenditures). Our Journal has shown a balance on hand of $211, notwithstanding the greatly increased cost of paper and printer's wages Dr. Bennett, chairman, referred to the fact that the old method of printing the now $3,000—far more than the net cost of the Journal, with its far greater advantages; he also referred to the subscriptions to it from far distant points. The Committee on the Profession's Welfare has done good work and plans were adopted for a much more thorough work still. The Banquet was an occasion that will not be forgotten by those who attended. The addresses of Dr. John J. O'Reilly of Brooklyn, N. Y.; Rev. Dr. Everitt and Judge Robert Carey of Jersey City, were exceedingly earnest and eloquent and they ought to call forth earnestness, loyalty and devotion to our profession and give us courage and well-directed effort in maintaining its standing and honor.

We insert in this issue of the Journal the report of the Welfare Committee. and of the Committee on Publication. The full Official Transactions will be published in the September Journal. Dr. Philander A. Harris, the President of the Society, is enjoying his needed vacation and will not return until September 1st. The First Vice-President, Dr. Henry B. Costill of Trenton, will respond to calls requiring presidential action. We congratulate Dr. Wells P. Eagleton of Newark on his election as Third Vice-President—a proper recognition of his worth and his services in the work of this Society.

WELFARE COMMITTEE.

The State Society's Welfare Committee held a very important meeting in the rooms of The Essex Club, Newark, on June 30th. Dr. Wells P. Eagleton was elected chairman for the present year, Dr. Harvey, who has served so faithfully and efficiently the past year, asked to be relieved, but was assigned important work. Plans were tentatively outlined for an aggressive work in the fall, and in the meantime future methods of work will be more fully considered. A preliminary work, however, will be done to awaken fuller co-operation of the county societies' committees of five on Welfare Work. Their hearty co-operation is most easnestly solicited. If any society has not yet appointed such a committee its president is requested to name—i only temporarily—five members to serve and send their names to Dr. Harvey, Orange, N. J.

DOES PROHIBITION PAY FROM A HEALTH STANDPOINT?

With the beginning of prohibition alarmists—there are always such—predicted dire calamities: increase in crime, resort to habit-forming drugs and other vicious practices. The time has been brief for the compilation of accurate statistics on the subject, but some actual evidence has accumulated: In New York City, the Board of Ambulance Service has reported a large decrease in cases of alcoholism and intoxication. In 1919, during January and February, there were 412 and 364 alcoholic calls, respectively. This year, during the same months, these calls numbered 307 and 133. Bellevue Hospital's figures show 228 calls for intoxication during the first two months of 1919 and thirty-one calls for January and February of 1920. As a result, it is estimated that there will be room for seven thousand new patients a year in Bellevue Hospital, owing to the reduction in the number of alcoholic patients. These figures are for New York. What of other cities?—A. M. A. Journal.

THE NEW QUACKERY.

There are fashions in quackery. The 1919 Model is that which commercializes the trend of the public toward the so-called drugless methods of healing. A mail-order course on "How to Cure What Ails You, Without Drugs: in Six Easy Lessons," by Dr. Quack or Professor Fake, is the lure. It proves a veritable gold mine for those who promote the scheme and for the magazines whose advertising pages furnish the point of contact between seller and purchaser—the spider and the fly. The theories so solemnly propounded by the exponents of the new quackery are usually made up of about 5 per cent. banalities of elementary science and 95 per cent. of pseudo-scientific flapdoodle. The occasional rational, if obvious, things that quacks of this type say mislead intelligent people into accepting the ridiculous theories that are thus commercialized. Because the product sold is not put up in a bottle, the public assumes that it is free from quackery; therein it is mistaken.—A. M. A. Jour.

The State Medical Society is not accomplishing its maximum of good without a full and complete membership which includes every eligible and desirable physician in New Jersey. It is impossible for your state secretary or your county secretary to approach every man who should be within the fold. If you have as your neighbor a non-member qualified for membership, it is your plain duty to call on him, inviting him to your next meeting and urging him to join.

NEW MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY.

Entered on the Roll since the Official List was issued in May. The only ones entered and recognized as in good and regular standing and entitled to Medical Defense in malpractice suits are those whose dues are paid and have been received by Dr. Mercer, Treasurer of the State Society.

Atlantic County.

Davidson, Harold S., Atlantic City
Ewens, Arthur E., Atlantic City
Frank, Myrtle G., Egg Harbor City
Silvers, Homer I., Atlantic City

Camden County.

Casselman, Arthur J., Camden

Essex County.

Charbonneau, Eugene G., 2 Lombardy, Newark
Ellis, Arthur J., 261 Clinton av., Newark
Failing, Brayton E., 15 Lombardy st., Newark
Madden, Russell F., Brooklyn, N. Y.
Polaner, George, 133 Elm st., Newark
Runyan, Wm. J., 145 Franklin st., Bloomfield
Silverstein, Wm. A., 17 Fairmount av., Newark
Sobin, Julius, 77 13th av., Newark
Stickles, Lloyd C., 49 Parkhurst st., Newark.
Stokes, Earl B., 1 Whittlesey av., E. Orange

Gloucester County.

Ulmer, Chester I., Gibbstown .....

Hudson County.

Ackene, Abraham, 495 Palisade av., W. Hob'k'n
Allen, Isaac L., 521 Paliside av., W. Hoboken
Audi, Angelo, 221 Central av., W. Hoboken
Auriemma, Michael, 419 Adams st., Hoboken
Barishow, Samuel, 630 Ocean av., Jersey City
Benson, James J., 433 15th st., West N. Y.
Cinnotti, Walter C., 171 Palisade av., W. H'b'ken
Clark, Charles C., 461 Clinton av., W. Hoboken
Cobham, James, 2 Madison av., Jersey City
Comoro, Herman, 433 15th st., West N. Y.
Connelly, Thos. W., 228 Bidwell av., Jersey City
Connolly, John R., 276 Ave C, Bayonne
Daly, Edmund F., 151 Ave. C, Bayonne
Delahunt, Jos. H., 433 16th st., West N. Y.
Dodson, Louis W., 509 Highpoint, W. Hoboken
Drasel, Chas. 509 Highpoint av., W. Hoboken
Drasel, Wm. A., 246 Clinton av., W. Hoboken
Edgar, Joseph A., 343 Webster av., Jersey City
Fauquier, Leonard B., 149 Bostwick av., J. City
Ferguson, C. C., 913 Bergen av., Jersey City
Frank, Morris, 920 Ave. C, Bayonne
Friedman, Aaron, 1003 Garden av., Hoboken
Gallati, Chas., 404 Monastery av., W. Hoboken
Goldstein, William H., 116 Johnson av., Kearny
Granella, H. A., 213 Garden st., Hoboken
Haggerty, Leidy S., 529 Elm st, Arlington
Hill, William F., 299 York st., Jersey City
Koppel, Joseph A., 114 Summit av., Jersey City
Kresch, Philip, 580 Boulevard, Bayonne
Kuhlman, Alvin E., 527 Union pl., Union
Magnetti, Jules, 859 Kearny av., Arlington
Markofsky, Davis M., 307 Varick st., Jer. City
Markowitz, Irwin, 234 Bergen av., Jersey City
Merten, Hainz, 656 Summit av., Union
Mount, James B., Soldiers' Home, Kearny
Mulligan, A. A., 331 Cleveland av., Harrison
Murphy, Edward A., 324 York st., Jersey City
Nattras, R. B., 934 Bloomfield st., Hoboken
Neves, Chas. S., 1206 Bloomfield st., Hoboken
Newman, Abraham J., 42 Sherman pl. J., City
Nichols, Louis G., 720 Washington st., Hoboken
Nicholson, Frank P., 113 Bowers st., Jer. City
Norton, James F., 299 Varick st., Jersey City
Owens, Rich. C., 675 Bergen av., Jersey City
Pflug, Fordman J., 1106 Bloomfield st., Hoboken
Poulin, Wm. J., 243 Palisade av., W. Hoboken
Robbins, Henry B., 317 Varick st., Jersey City
Rudolph, John J., 636 Garden st., Hoboken
Russell, David L., 7 Kensington av., Jersey City
Salmon, Edward H., 235 Fulton av., Jersey City
Schlein, August, 707 Park av., Hoboken
Shapiro, Nath. J., 192 Palisade av., W. Hoboken
Sherwood, Frank D., 30 Crescent av., Jer. City
Shipman, Frank C., 3663 Boulevard, Jersey City
Snyder, J. E. C., 1023 Garden st., Hoboken
Staples, Francis G., 142 Magnolia av., Jer. City
Stanley, Percy, 12 Beach st., Arlington
Stockfisch, Robt. H., 48 Prospect st., Jer. City
Wallace, Clifton R., 930 Ave. C, Bayonne

Hunterdon County.

Boyer, Charles G., Annandale
Topkins, Isadore, Califon

Mercer County.

Treiber, Benjamin A., Trenton

Somerset County.

Borow, Benjamin, Manville
Brittain, E. G., Bound Brook
McConaughy, Francis, Somerville
Zuck, Arthur C., Skillman

Some other county societies report the election of new members but their dues have not been received by Dr. Mercer up to July 1st. Another list will be given in the September Journal.

OSTEOPATHS vs. CHIROPRACTORS.

An osteopath, signing his communication C. E. Binck, M. D., D. C., says:

"Chiropractic, to a certain extent is founded upon scientific truth—Osteopathy. However, Chiropractic is fake Osteopathy and a medical humbug, claiming that a subluxated (displaced) vertebrae is the physical and perpetuating cause of 95 per cent. of all cases of disease; the remaining 5 per cent. being due to subluxations of other skeletal segments. Human nature favors economic adventure along the line of remedial measures for human ills, and history is replete with instances of shrewd men taking advantage of this fact and turning it successfully into money-making endeavor, through false and misleading statements. The general Director of a School of Chiropractic, in New York City, says: "seventy-five per cent. of the Chiropractors cannot read and write properly."

The Chiropractor may be all right. God Almighty may have been very shortsighted when He constructed the foramina through which the spinal nerves pass from the cord to the mechanism of existence, and some wise

man (D. D. Palmer) discovered that frequent correcting adjustments—very frequent—are required to make good the divine omission and to restore conditions of health. What possible fault can I find with such human wisdom? Is it possible for the bony parts to impinge upon the spinal nerves? Research work shows that this does not take place except in rare cases, and then only from caries or severe external injury.

Christian Science—the Religio-Medical Masquerade, unscientific, devoid, alike of truth and healing power.

REPORT OF COMMITTEE ON PRESIDENT'S ADDRESS; LATER KNOWN AS THE WELFARE COMMITTEE.

The committee appointed to report on the recommendation of the President's address at the last annual meeting of the Medical Society, respectfully submit the following report:

The recommendation was the appointment of a new standing committee whose function should be the furthering of the welfare of the profession.

The resolution appointing this committee was as follows:

Resolved, That a committee of five be appointed by the chair, of which Dr. Harvey will be chairman, to consider the recommendations contained in the President's address, and that the committee shall have full power to adopt and carry out any measures which they deem proper, at such expense as the Board of Trustees shall approve.

In accordance with this resolution the following committee was appointed: H. B. Costill, D. C. English, J. C. McCoy, W. P. Eagleton, T. W. Harvey.

To this committee was also referred Dr. L. M. Halsey's set of resolutions of similar import.

This committee was organized immediately. The first problem that presented itself was the Compulsory Health Insurance bill. This committee met with Mr. Colby's Commission on Old Age Insurance, and heard his exposition of the bill. The committee decided that the bill was a very bad one and that we should oppose it, although we believe that it is possible to have Health Insurance that will neither be an imposition upon the people at large nor upon the medical profession, which the Colby bill certainly is.

President Dickinson early in January called a mass-meeting of the members of the State Society in Newark, to take action in reference to this bill. This meeting was well attended and at this meeting Dr. McCoy of the committee moved that each county society should be asked to appoint a committee of five to cooperate with the State Society committee and to use their personal influence with their representatives in the legislature. On January 14th, President Dickinson called these county committees to a meeting in Newark, where a program of action was discussed. About one-half of the county medical societies were represented.

Just before this meeting of January 14th, the Board of Trustees voted the welfare committee a substantial credit. Two resolutions were adopted and the committee was directed to push the campaign against Health Insurance.

These resolutions were as follows:

1. That $1,000 be appropriated by the Board of Trustees for use of the welfare committee until the next annual meeting of the State Medical Society, to be used for the employment of a competent representative who shall operate under the direction of the committee, the object being to perfect the organization of the profession, to place them in a proper light before the public, and to give publicity to such matters as may be of importance to the welfare of the profession.

2. We advise that the influence of the Medical Society be used to oppose the passage of the Compulsory Health Insurance Bill, through its regular committees, or through special counsel and that $1,000 be appropriated for such purposes and such further sums as the Board of Trustees shall approve.

Consultations with other interests opposed to this bill such as the New Jersey Pharmaceutical Association, the Manufacturer's Association, and the insurance companies developed the fact, that the opposition to this bill was going to be so strong that it was not at all probable that it would pass the legislature.

Moreover, the opposition was in the hands of men who had very great familiarity with legislative procedures, and hence were much better able to conduct a campaign against the bill than was our committee. However, the committee deemed it wise to carry out the proposed program and to be prepared; we therefore engaged a representative and publicity agent, Mr. Joseph H. Gunn of Newark.

Mr. Gunn was appointed after it was apparent that there would not be much work for us to do in connection with the insurance bill, and that therefore a medical man was not needed, but that we would have to take up the work of the Legislative Committee. We were led to appoint him because of his familiarity with legislative work.

Before his appointment was completed the legislature had convened, and it became known that the regular Legislative Committee of the State Society has ceased to function. Our committee had already tried to have a meeting with the chairman of this committee, and had told him that we would co-operate in every way.

It became evident that the Welfare Committee must take over the ordinary legislative work, but it was February 9th before we could get down to Trenton, and in the meantime the Chiros had pulled off their bill in the Senate. The story of our vain endeavors to get a hearing on this bill before the Assemblymen and the Governor has been told in the State Journal. However, as a result of our appeals to the officers of the county societies, a very active movement was started and we are sure that it has been many years since so much interest has been exhibited in organization work among the doctors.

The Hudson County Medical Society held a meeting on December 2nd, 1919, to which representatives of Bergen and Essex counties were invited. Dr. J. O'Reilly of Brooklyn made the chief address, the subject being "Compulsory Health Insurance." Essex held a similar meeting in December, 1919.

These meetings were the starting point of a State-wide discussion of this subject.

The plan of action instituted by the committee has been to establish and keep up continuous communication with the officers of the county societies, by means of personal letters asking for their support and assistance in interviewing their own Assemblymen and Senators; by legislative bulletins that have been sent to large numbers of the doctors; by press stories that have been published in various papers every week, and also by work in Trenton, which varied from having a large delegation before the Health Committee of the Senate, through much negotiation, preparation of and pushing certain amendments, down to policing the corridors to see that a wavering Senator did not go out to lunch just as a critical vote was pending.

Copies of the proposed Health Insurance bill were mailed to the secretary of each county society for distribution.

The committee has taken this position on all questions before the legislature:

1st. That before formulating or enacting any legislation pertaining to the health of the citizens of this state, the authorities should consult the doctors.

2nd. That all those who ask for a license to heal the sick in New Jersey should be required to have the same preliminary education and equivalent training in fundamental principles of the healing art and be under the control of one licensing board.

Review of Our Legislative Activities.

The bills that we opposed and that failed to come to final action, or were defeated, were:

The Compulsory Health Insurance Bill.

The Osteopathic Bill.

The Two Anti-vaccination Bills.

The Registration Bill.

The Bill creating a Board of Drugless Physicians' Examiners.

The only bill that the committee particularly urged the legislature to pass was one sponsored by the Board of Medical Examiners, that would place all drugless healers under the control of the Board of Medical Examiners. This bill held out some chance of counteracting the Chiro bill. The bill was opposed by the Chiro lobby. An offer was made that if an amendment should be accepted, excepting the Chiros from the provisions of the law, all opposition would be withdrawn. Even the board was willing to accept the compromise, but the committee declined to allow any such amendment to be added. Our only interest in the bill was the possibility that it offered of controlling the Chiro board. The bill was beaten on the Senate floor by a vote, seven affirmative to three negative, eleven Senators not voting.

Those who refrained from voting were as efficient factors in defeating the bill as were those who voted against it. "We have them on the list."

There were a number of other bills introduced by the Board of Medical Examiners and the Department of Health which were examined by the committee and marked for approval or disapproval, and our representative was instructed as to our stand regarding them.

Few of these bills managed to get very far. Two of them, the two eugenic marriage bills, calling for certificates of freedom from venereal disease, that were introduced by the Chamber of Commerce, were supported by this committee and were passed by the legislature. They were however killed by the Governor. The Registration bill we asked to have withdrawn, in order that the society might consider it at this session. The objections to it are: 1st, that it is a special tax on the doctors of two dollars a year; 2nd, it is proposed to use this money for the purpose of financing the prosecution of illegal practitioners, which we hold is a police function of the State, the expense of which should be borne by the people at large and not by the doctors.

The only advantage is that it will provide a census of the licensees of the Board of Medical Examiners.

The legislative work of next year will probably include a new Osteopathic bill which will be more skilfully drawn, and consequently more difficult to defeat.

Some constructive action will be necessary looking to the placing the Chiropractic Board under the supervision of the Board of Medical Examiners.

The legislature should be urged to provide that medical men should be appointed on all administrative boards having to do with health matters in this State.

Greater opportunity for the nomination of medical men as State officers should be given to the State Medical Society.

Legislative Committees should be compelled by rule to hold public hearings on all bills referred to them that have to do with technical matters, and should also be required to summon experts.

Compulsory Health Insurance.

The Compulsory Health Insurance scheme will come on again. This should be attacked with a well thought-out constructive plan by which medical relief can be provided for that will not involve injustice to any of the parties interested.

So many of the features of such legislation are present in the various schemes of welfare work being carried on, by the great industries, that it ought not to be difficult to formulate a law that would be satisfactory. Here again, however, we have to call attention to the fact that too little consultation has been held with the doctors by these great industries and there are many of their plans already in operation that are open to criticism as unfair to the medical profession.

The German plan which was most unjust to the doctors grew out of the various trade or shop benevolent societies.

At the January meeting of the Board of Trustees this committee presented the following objections to the Colby bill:

1st. That the bill provides sickness benefits and medical care for "all persons who are employed or operate" in any of the various plants mentioned in the bill, making no distinction as to amount of pay that they may receive, or how capable they may be to pay their own bills; but does nothing for the many poor who are not employed in such plants, and are just as liable to need public care, and are more liable to be unable to pay for it.

2nd. This bill creates an autocratic bureau, responsible alone to the Commissioner of Labor, who is empowered to create such a bu-

reau; to choose its personnel; to make all appointments; to have entire charge of its finances; to determine the premiums to be collected; to determine the benefits to be paid; to arrange for the medical care, appointing the doctors determining the fees to be paid and the amount of service to be rendered. There is given to one man supreme power in establishing and administering a department of vital importance to the health of the citizens of this State and yet, no provision is made that this man should have any technical knowledge in such matters, nor is he required to consult others who have this technical knowledge.

3rd. This bill will add greatly to the burdens of taxation in this State, without yielding any benefits to its citizens at all commensurate with its cost.

4th. In all countries where legislation such as is proposed in this bill has been adopted there has been as a certain result: A great depreciation in the scientific character of the average medical man's work and the creation of a tremendously burdensome medical bureau which inevitably tends to become autocratic and offensive both to patient and doctor.

The committee makes the following suggestions as to the essential provisions of such a law:

1st. From the medical point of view such a law should not be compulsory. Voluntary insurance against sickness has been successful in many forms; by insurance companies, by fraternal orders, by organized trades, and by the State as in Denmark.

2nd. When compulsory it should be plainly stated, that only those receiving an income below a certain amount should come under the provisions of the law.

3rd. The law should also apply to those who are not regularly employed in any one industry all of the time.

4th. All of the expenses of the bureau of administration, sick benefits, medical aid and supplies, nursing and hospital service, reserve fund, etc., should be paid out of the premiums. In other words the public at large should not be expected to bear any of the expense. If the State or the people at large are to bear any expense for sickness insurance, such provision should be for the indigent, and for those unable to pay any premium.

5th. There should be free choice of physicians without regard to membership of any panel or group.

6th. Rates of remuneration for medical services should be a matter to be determined by mutual agreement, between the representatives of the State or county societies, and the Bureau of Health Insurance.

A very important piece of constructive legislation proposed by Dr. Hermann Biggs, president of the New York State Board of Health, was introduced in the New York Legislature this past winter, in the form of Senate bill No. 1533, that amends the Public Health Law by providing for an act "to amend the public health law, so as to provide for residents of rural districts, for industrial workers, and for all others who cannot otherwise secure such benefits, adequate and scientific medical and surgical treatment, hospital and dispensary facilities and nursing care, to assist local medical practitioners, and in general to improve th health of the inhabitants of the State, by au thorizing a county, city or health district t create and maintain one or more health cen ters, to provide State aid for same, and mak ing an appropriation therefor."

These health centers would act as boards o health, would support hospitals and dispen saries, would establish diagnostic clinics, an arrange all their activities in the form o groups of physicians and health officers, tak over public health nursing, medical inspectio of the schools, periodical medical examinations and establish headquarters for all publi health, nursing and other public welfar agencies.

As a result of our experiences, we are prepared to make the following recommendations:

If the State Medical Society desires to be o use to the profession and to really look after the welfare of its members, there should be a reorganization of its work.

In the first place a fund must be provided, and this should be raised by a special assessment for this specific work, of at least two dollars a member. It is not right to expect any committee or individual member of the Society to give the time, the expense of traveling, or the telephone and telegram bills incident to this work.

At present there are three committees whose work more or less overlap, the Judicial Council, the Legislative Committee and the Welfare Committee, the last one being only a temporary one.

The work of the Judicial Council can very well be left as it is, but your committee believe, that the work of the other two committees should be concentrated in the hands of one man, a member of the Society, who would receive a salary and whose work should cover legislation, organization, hospital standardization, and the origination of new and constructive work in improving the condition, and protecting the interests of the medical profession. He should represent the profession in all conferences with other associations, seeking changes in the health laws of the State.

He should be the executive officer of a "Standing Committee on Professional Welfare." It will be very important for him to establish an active alliance with the chairmen of the County Welfare Committees, and each county society should be urged to continue the committees that were established last winter.

Our experience with the county societies has led us to feel, that their officers do not realize that many opportunities for usefulness are allowed to slip away unimproved, because of lack of promptness in correspondence.

Our State Society officials have found it very difficult to arouse some of the county officers to pay attention to their duties. We mailed copies of the Colby bill to twenty of the county society secretaries; not more than two were acknowledged.

We sent a letter to everyone of the twenty-one secretaries introducing Mr. Gunn, and nearly every week other communications were sent to the county societies by the committee through Mr. Gunn. Certain counties did not answer at all; others contented themselves with one reply promising co-operating; six

unties were really very active and efficient. owever, there was a very general representa- n of the Society at the hearing before the nate Committee.

Essex County under Vice-President Mart- nd and Secretary Pinneo has kept up a very ely campaign; they printed and distributed ur hundred copies of the Colby bill; they ıve issued four bulletins dealing with the ogress of events in Trenton; they are now anning the organization of a professional ague that shall unite the pharmacists, the octors and the dentists in one militant body.

Furthermore, this official should be empow- ed to employ an agent or representative who ıould be personally at the Capitol during the ntire session of the legislature.

A very important work for these represen- atives would begin with the primaries. It hould be their duty to know what the candi- ates for the State's legislature stand for as egards any legislation which the doctors are ikely to be interested, either from a scien- ific or material point of view.

There is, unfortunately, little reliance to be laced upon the pre-election promises of a andidate for the legislature, but if we know omething about them, and are pretty sure hat they are liable to vote for any evil meas- ıre, if they can make a good trade, it should e possible for the united profession to throw heir influence against such candidates at the oles.

Of the various methods of influencing poli- ticians probably the weakest is the much vaunted influence of the family physician upon his neighbor and patient. Outside of personal medical matters he has none. This was ex- emplified early in our efforts to hold up the Chiro bill.

The demonstration of a large delegation be- fore the Health Committee of the Senate on the Osteopathic bill undoubtedly was more productive of results than any other method.

The third method of working through the agency of a professional lobbyist presents sev- eral problems. The Society needs an agent in the lobby, in order to keep in touch with the situation, but there are many varieties of lob- byists and many of us believe that it would be better to be beaten in all our efforts before the legislature than to descend to some of the present-day methods of influencing legis- lative action.

A fourth method that ought to be success- ful is for the county societies, through their sub-committees, to go into politics and at the primaries, and by legitimate political propa- ganda let it be known, that the doctors must have some attention paid to them.

For instance, no medical man should ever vote for any of the men who refused them rec- ognition at the recent session of the legisla- ture. The list of names of these men should be in the hands of every doctor in the State before the next election.

The Welfare Committee of each county should take an active part in local political affairs, for the purpose of seeing that only those men should be nominated or elected to the legislature who will be just to the doctors. This can only be done through the district party leaders, because it is a lamentable fact that our representatives, at Trenton, are, as a rule, automatons who move and speak and vote as they are directed by the invisible pow- ers.

It would also be of some help to elect a few more doctors to the Assembly: a solitary doctor, unless he is particularly forceful, has very little chance in the presence of the num- erous deals and trades that make up the nor- mal process of law-making.

This has been a rather expensive experience for the State Society, but the only expenses charged to the Society have been those incurr- ed by our professional assistants. The total has amounted to $1,618.23.

In closing this report the Welfare Commit- tee wishes to express their appreciation of the work of Mr. Gunn, and of the counsel of the State Society, Mr. Wall, and also of the sup- port and co-operation that they received from President Dickinson and the Board of Trus- tees, and from the officers and committees of the county societies.

Mr. Gunn's work was particularly import- ant and satisfactory and the experience he has gained of the aims of the Society and the knowledge acquired of the needs of the doc- tors, will make him a valuable assistant in any future work.

Respectfully submitted,

H. B. Costill,
D. C. English,
J. C. McCoy,
W. P. Eagleton,
T. W. Harvey,
Committee.

REPORT OF THE COMMITTEE ON PUBLICATION.

Presented at the 154th Annual Meeting of the Medical Society of New Jersey, Spring Lake, June 15, 1920.

To the Medical Society of New Jersey.

Mr. President and Gentlemen:

Herewith is submitted the Business and Comparative Statements of the Committee on Publication for the year 1919.

It will be noted that while the net gain is a little less than for the year 1918, it is still on the right side of the ledger and we are well pleased for even this.

Conditions of publication have been very hard, with continuing increases in cost and per- sistent retrenchments on the part of adver- tisers.

During the year, the advertising rates were slightly increased although not sufficiently to meet the added expenditures, but the full benefit of this will not be apparent before January, 1921, as we extended to old advertis- ers the privilege of renewing their old con- tracts on the old basis; but with 1921 the new rates will be in force for everyone.

It seems desirable here to call attention to our reprint system. We give to writers 100 reprints free and the Journal pays the printer for this. For additional reprints a charge is made, and many may have supposed that this was a source of income to the Journal. This, however, is not correct, as the charge for these reprints goes directly to the printer, and the Journal receives none of it. Reprints are al- ways an expense and not an income for the Journal.

Your committee continues to receive frequent complaints from members that they are not receiving the Journal and investigation usually shows that this is because of the failure of the county treasurers to collect and remit the dues of these members to the State Treasurer, who then has no reason but to consider them in arrears and delinquent. Only members in good standing are kept on the mailing list and probably many have been so deprived of the Journal and also of the benefit of the Society's Medical Defense. The list has just been revised with a net gain in names of about 200, some of which should probably have been added months ago. Will the county treasurers kindly note this matter and promptly make return of collections?

Committee on Publication in its effort to make a favorable showing becomes a bit discouraged at times, and it is hard to see how we can show any profit at all for the coming year, even with the new rates; this, not because of any lack of advertisements, but because of the ever swelling tide of expenses. However, your Editor and committee are loyally doing all they can to make your Journal as much of a success financially as it seems to be from the literary standpoint, concerning which the Chairman is often in receipt of complimentary notes from exchange editors, referring to its value as a distributor of medical information.

Respectfully submitted,
Charles D. Bennett, Chairman.

Business Statement.

From January 1st, 1919 to December 31st, 1919

Accounts	Gains	Losses
Journal	$ 10.00	
Advertising	3,354.05	
Extra Subscription Account	63.55	
Printing and Mailing		$2,983.12
Reprint Account		26.65
Stationery & Supplies		5.00
Editorial Salary & Expense		1,400.00
Expense Account		82.85
Cuts and Plates		9.54
Commissions		415.62
Discounts		79.04
Subscription Account	1,750.00	
Gains and Loss Account	36.12	
Net Gain		211.90
Total	$5,177.60	$5,177.60

Business Statement.

Accounts Showing Income or "Receipts."

Advertising	$3,354.05	
Subscriptions (Regular)	1,750.00	
Subscriptions (Extra)	63.55	
Sales of Journals	10.00	
Dividends	56.42	
		$5,234.02

Accounts Showing Expense or "Disbursements"

Printing and Mailing—		
Journal	$2,763.37	
Official List	219.75	2,983.12
Reprints		26.65
Editorial Salary & Expenses		1,400.00
Commissions on Advertising		415.62
Discounts		79.04
Expenses		103.15
Stationery and Supplies		5.00
Cuts and Plates		9.54
		$5,022.12
Net Gain		$211.90

Comparative Statements.

	1918	191
Advertising	$3,655.30	$3,354
Subscriptions (Regular)	1,760.00	1,750
Subscriptions (Extra)	55.00	63
Sales of Journal	6.63	10
Dividends Received		56
Printing and Mailing	2,821.89	2,983
Cuts and Plates	1.50	9
Editorial Salary	1,321.00	1,400
Reprints	29.40	26
Commission on Advertising	457.38	415
Discounts	74.59	79
Stationery and Supplies	28.75	5
Miscellaneous Expenses	230.52	103

Miscellaneous Items.

Some of us find so much fault with oth people simply because we find so little fa with ourselves.

Courtesy is the eye which overlooks yo friend's broken gateway, but sees the ro which blooms in his garden.

"The man who loses his temper often thin he is doing something rather fine and majest On the contrary, so far is this from being t fact, he is merely making an ass of himself —Bennett.

"When a man, by means of the efficiency his brain, has put his reason in definite cor mand over his instincts, he at once sees thin in a truer perspective than was before po sible, and therefore he is able to set a ju value upon the various parts which go make up his environment."—Bennett.

"To fear that you can't hold out" in ar right course, to shirk just responsibility be cause you have no respect for your own judg ment, to avoid duties and decisions that righ ly belong to you because you dread to grapp with them—that is a greater insult fro within than anyone can offer you from withou

"Walking Doctors" Becoming Extinct Species

According to a recent investigation by th National Chamber of Commerce, it has bee estimated that two-thirds of the doctors o the United States own automobiles. Mor than ninety per cent. of country doctors ar said to own passenger cars.

Business Manager Needed in Washington.

"A business manager in Washington coul reduce the Government's pay roll in that cit alone by 25,000 employees simply by puttin the eight-hour day into effect in place of th seven-hour day. The Government clerks ge a full month's holiday each year, fifteen day' sick leave without showing a doctor's certi ficate and another fifteen days on showin such a certificate—all on full pay. And the work seven hours a day. Yet they go about Washington mourning like Rachel for he children.

"Secretary Baker lopped 500 of them of the pay roll one Saturday recently, and by Monday morning he had letters of protest from 167 senators and representatives.

Yes, I am convinced that a business man- a r with some authority would be a useful r mber of the Government."—Thomas R. N rshall, Collier's Weekly.

Limit Liquor Prescription Issue.—In an ef- t to defeat the indiscriminate sale of liq- r on physicians' prescriptions, Commissioner lliams of the Bureau of Internal Revenue, ued a ruling, May 28, limiting the number prescriptions for physicians to 100 for each ee months, excepting with "good cause."

Cause of Death—Accident Hastening Dis- se.—A night watchman at a foundry went to rk as usual on April 18, 1917. The follow- g morning he was discovered at the foundry a state of collapse. He developed pneu- nia and peritonitis, and after a few days d. His dependent claimed, under the ine Workmen's Compensation Act, that his eumonia was traumatic, and that the injury using it was due to an accident sustained the deceased while alone at the foundry the night of the 18th. When he was dis- vered, on the morning of the 19th, he said, got hurt," and then or afterward indicated here he was hurt. The employer claimed hat the death was not due to injury, that hen deceased began work on the 18th he was coming down" with pneumonia. The court eld that this, if true, was not decisive. Evi- ence that an existing disorder reaches the gent. It was his procedure, therefore, when he infiltrating character of the growth had een determined and when the tumor was suffi- iently localized to permit of complete re- noval, to carry out a radical resection. Fol- owing the removal of an infiltrating papillary arcinoma, cystoscopy should be done at an arly date as the not infrequent recurrences ield promptly in many instances to radium, notwithstanding the resistance of the primary umor. It was of interest to note that the se of radium had not diminished the tend- ncy of bladder tumors to recur, recurrences eing observed in about thirty per cent. of the ases treated. The recurrence, however, re- sponded to radiation in most instances, al- though in three cases it did not yield. Radium had certainly proved to be a valuable aid in the treatment of bladder tumors and while the results obtained in the infiltrating types were far from satisfactory, improved technic whereby more intensive radiation might be safely accomplished might offer a more en- couraging outlook in the future handling of these cases.

Clinical Experiences in Treating Children with Tuberculin.

Dr. Richard C. Newton, Montclair, in a paper read at the A. M. A. meeting in 1919, advocated the use of tuberculin as a routine diagnostic measure for the detection of tuberculosis in weak and anemic children. If a positive response to tuberculin was elicited treatment with tuberculin should follow. He reported in detail seven cases of tuberculosis in children which had shown surprising improvement under treatment with small doses of tuberculin. In summarizing he emphasized the point that there was no average dose of tuberculin, but that the dosage must be determined in each individual case. He did not agree with those who said tuberculin should not be used in the treatment of tuberculous children on account of its psychological effect. Tuberculous children should be treated not only with tuberculin, but by all hygienic measures, since the elimination of tuberculosis among the adult population depended upon its early recognition and elimination among children. The general practitioner had not learned to use tuberculin. In his experience it had worked well in every incipient case of tuberculosis in which he had used it.

Dr. Fritz B. Talbot of Boston expressed the opinion that the trend of this discussion was rather dangerous. His experience did not uphold any absolute evidence of the beneficial effects of tuberculin treatment in children. All children susceptible to tuberculosis might be treated by other means—fresh air, good food, rest, and sunlight—and it seemed to him that some of the cures attributed to tuberculin might be due to these hygienic measures. There was a dangerous element in giving tuberculin because every one admitted that the dosage was a very important factor in determining infection or disease, and the younger the child the more easily would a tuberculous infection become a tuberculous disease. Personally, he thought there was danger that the tuberculin might awaken an infection into an active tuberculosis. If the claims that were being made for sunlight were substantiated, he thought it would be just as effective and much safer than tuberculin.

Dr. Abraham Levinson of Chicago emphasized the danger of tuberculin in pulmonary tuberculosis, and said that even if tuberculin were beneficial in glandular tuberculosis in children one could not be sure that there was not a primary focus in the lung and a secondary glandular involvement. He had seen one or two cases in which he believed tuberculin was responsible for a miliary tuberculosis. It was well not to be carried away by enthusiasm for tuberculin, and to remember that even though tuberculosis in a child was glandular there might be a latent pulmonary focus that could be lighted up by tuberculin.

WOULD BAR NURSES AS ANESTHETISTS.

The restriction of the administration of anesthetics to licensed physicians and the exclusion of nurses from doing such work during surgical operations was urged yesterday by James Taylor Lewis, counsel for the State Medical Society. On the ground that the law prohibits any one without a doctor's license from giving ether or chloroform or other poisonous gas to a patient, except when directly and continuously supervised by a physician, Mr. Lewis held that criminal action should be brought to prevent the continuation of this practice in certain hospitals, as not only was the law being violated, but lives were continually being placed in danger. If it could be shown that nurses, after special training, were competent to administer anesthetics, then, he contended, the law would have to be changed so as to give the nurse the right to do the work under the proper restrictions. Mr. Lewis recently read a paper on this subject before the Society of Anesthetists.

After paying tribute to the importance of the

nurse in the treatment of disease, Mr. Lewis showed that nevertheless there were elements concerned in the giving of anesthetics that made it a phase of the practice of medicine as defined by the law. He then quoted the section of the public health law (Article 8, Sec. 160, subdiv. 7:) "A person who practices medicine within the meaning of this article, except as hereinafter stated, who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, or physical condition."

Mr. Lewis then pointed out how, in his opinion, the nurse, in administering an anesthetic, did something more than place the cone over the patient's mouth, and that she had other duties which came within the definition of practicing medicine. "The nurse who gives the anesthetic and sits with the cone over the face of the unconscious patient is required to go much further. It is her duty to keep the tongue up, to watch the pulse, to pass upon the strength of the pulse, its quality, the color of the lips, the color of the skin, the condition of the skin; indeed, many other symptoms which indicate the then present physical condition of the patient to whom she is administering the anesthetic. If that is not diagnosing the physical condition, if that is not even diagnosing the presence or absence of a disease, perhaps, then, the definition as described in our own statute means nothing.

"The operating surgeon can give no attention to the effects of the anesthetic, and if the nurse notices symptoms which seem to indicate that the patient is 'going bad' the responsibility of taking action is hers, and she must prescribe. Because some great surgeon has a woman nurse who has given an anesthetic to an enormous number of patients, and is now course of which the serosa had been contaminated with septic material. He keeps the patient in the semiseated position and gives 4 liters of saline by the drop method of proctoclysis, but places his main reliance on ether with which the contaminated region is disinfected after it has been cleaned out. He has never had peritonitis develop in patients treated with this combination, even when the peritoneum was much soiled with the contents of stomach or bowel or with septic products. Because a few nurses, through large experience, have acquired skill furnishes a poor reason for saying that all nurses, however qualified, may calmly walk into a hospital, even as a nurse on probation, or a pupil nurse, and proceed with administering an anesthetic, putting in danger the life of the patient. I am convinced that any hospital sued under such circumstances might be mulcted in damages for negligence in not furnishing qualified employees and agents in the administration of their affairs."

Mr. Lewis cited the statutes and court decisions in a number of other States, and especially that of Judge Kirby in Kentucky, in which the court said: "Dr. Frank and other physicians employing trained nurses say that in so doing they assume the responsibility. Where the trained nurse is known to them to be competent they may take the responsibility, but it is a responsibility, the extent of whic they probably have not duly considered. In suit growing out of the death of a patie where the surgeon had voluntarily employe an anesthetist who was not licensed, he woul in the event of his brother physicians testify ing in this case certainly be held responsible.

"If a doctor," continued Mr. Lewis, "operat ing in a hospital in the City of New York o elsewhere, allows a nurse to administer an an esthetic, of whose knowledge he knows noth ing, and of whose ability as an anesthetist h is uninformed, he must expect to be held re sponsible for any untoward result which ensue by reason of the giving of the anesthetic. Th hospital, in turn, must be held responsible i it permits unsupervised and inexperience women to give anesthetics, whether they b graduate or pupil nurses, because the em ployment of such inexperienced persons can not be pleaded by them as a bar to an actio against such institution where damage o death ensues."—From the N. Y. Times.

Hospitals; Sanatorium, etc.

The Morristown Memorial Hospital has received a bequest of $500 from the estate of Mrs. Elizabeth Proudfit, who died in Geneva, Switzerland, April 30th.

Bridgeton Hospital.

The report for the month of May shows: In hospital, May 1, 26; admitted during month, 49; operated upon, 34; discharged, 52; died 6; remaining May 31st, 17; births during month, 7.

Salem County Memorial Hospital.

Dr. W. H. James sends the following from the report of Dr. C. M. Sherron, president of the Hospital Medical and Surgical Staff: From its opening Sept. 1, 1919, to May 31, 1920: Patients admitted, 347; patients discharged, 274; improved, 35; not improved, 8; died, 22; remaining in the hospital, 8. Surgical cases treated, 179; medical cases, 45; maternity cases, 45; births, 42; infants still-born, 3; Cesarian operations, 3; unclassified cases, 13.

The Floating Hospital.

Probably familiar to many who know nothing of the extent of its service is the Floating Hospital, which may be seen plying its course up and down New York Harbor during the summer months, bearing its burden of tiny sufferers and affording weary and over strained mothers brief respites from heated, sordid tenements and crowded city streets.

For nearly forty-five years this hospital, the first floating one for babies in the world, has been ministering to the children of the poor of New York and during that time has had under its care about 1,713,130 babies, children and mothers.

The steamer's first trip as a hospital was made on July 19, 1875.

The hospital is an enterprise of St. John's Guild of the City of New York, which aims to afford relief to sick children of the poor of the metropolis without regard to race or creed.

Beth Israel Hospital Training School.

Five nurses graduated from this Newark hospital on June 16th. Dr. N. G. Price presented the diplomas.

Morristown Hospital Training School.

Seven nurses graduated from that school on the evening of June 3rd. Prof. Howard A. Kelly of Johns Hopkins University Medical Department, Baltimore, Md., delivered the address to the graduates, using the story of Florence Nightingale as an example for the nurses.

Perth Amboy Hospital Training School.

Ten nurses graduated from the Perth Amboy City Hospital Training School May 25.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, reports that on May 1st there were 228 patients in the Sanatorium, 118 males and 109 females. This number included 31 males and 49 females in the Preventorium. During the month 43 patients have been admitted, 16 males and 27 females. Ten of these admissions went to the Preventorium. Among these admissions there were ten re-admissions.

The admissions are classified as follows: Pretubercular, 8; incipient, 4; moderately advanced, 5; far advanced, 26. The largest number of patients at any time during the month has been 239; smallest number, 228; present May, 1920, 237.

Marriages.

BANGERT-PARKER.—In the Central Presbyterian Church, East Orange, June 22, 1920, Dr. George S. Bangert to Miss Elizabeth Hartshorne Parker, both of East Orange. They are residing at 479 Park avenue, that city.

BENSLEY-NICOL.—In Summit, N. J., June 19, 1920, Dr. Maynard Gilmore Bensley to Miss Muriel Nicol, both of Summit.

Deaths.

JONES.—In Camden, N. J., June 8, 1920, Dr. William S. Jones, aged 62 years.

Dr. Jones graduated from the Jefferson Medical College in 1878; was a member of the Camden County Medical Society and the Medical Society of New Jersey, and a Fellow of the American Medical Association; he was for fourteen years a member of the faculty of his alma mater; superintendent of the Old Soldiers' Home, Vineland, N. J., and State Medical Examiner of Institutions. He died from heart disease.

McGIVERIN.—While en route for Los Angeles, Cal., June 7, 1920, Dr. Edward D. McGiverin of Jersey City, aged 34 years.

ROBINSON.—At East Orange, N. J., April 13, 1920, Dr. William Dawson Robinson, aged 77 years.

Dr. Robinson graduated from the Bellevue Hospital Medical College in 1879. He was a member of the Essex County Medical Society. The Medical Society of New Jersey and the American Medical Association.

Personal Notes.

Dr. Augustus L. L. Baker, Dover, attended the convention of Railroad Physicians at Scranton, Pa., last month.

Dr. Raymond D. Baker, Summit, has moved to 52 DeForest avenue.

Dr. Runkle F. Hegeman, Somerville, has purchased a fine property on West High street and has moved there.

Dr. Henry A. Henriques, Morristown, and family, have gone to Winter Harbor, Maine, for the summer.

Dr. James M. Maghee, West Orange, has bought the property at 7 Main street, that city, and has moved there his residence and office.

Dr. Wells P. Eagleton, Newark, at the annual meeting of the American Otological Society, June 1, 1920, was elected president of that Society for the ensuing year.

Dr. Anderson A. Lawton, Somerville, spent ten days in Minneapolis in June.

Dr. Fred J. LaRiew, Washington, and wife recently entertained in their home Dr. and Mrs. Stites of Williamstown, Pa.

Dr. George L. Orton, Rahway, and wife are receiving congratulations on the arrival of a baby daughter in their home.

Dr. William Wolfe, Chatham, recently returned from a visit in Aberdeen, Md.

Dr. John G. Wilson, Perth Amboy, recently returned from a two weeks sojourn in Canada.

Dr. Henry B. Orton, Newark, attended the Triological Convention at Boston in June.

Dr. Harry H. Bowles, Summit, who had pneumonia, is still in Overlook Hospital, convalescing from empyema which followed the pneumonia.

Dr. Roger W. Moister, Summit, is spending the summer at New London, Conn., with his family.

Dr. Hugh D. Jamison of East Orange, expects to move to Summit in the fall, and open an office. He will specialize in disease of the eye.

Dr. Irving E. Charlesworth, Bridgeton, has recently been honorably discharged from the Medical Corps, U. S. Army.

Dr. Charles D. Bennett, Newark, is spending the month of July with his family at Christmas Cove, Maine.

Dr. Henry H. Rich and wife, Newark, took a trip to the coast last month, returning early in July.

Dr. William R. Ward, Newark, expects to visit the battlefields of France and Belgium next month.

Dr. George H. Foster, Rockaway, and wife recently took an automobile trip through New Jersey and Pennsylvania.

Dr. Henry H. Janeway, New York, a member of the Middlesex County Society, read an able paper at the annual meeting of the Amer.

Association for Thoracic Surgery, on The Treatment of Malignant Tumors of the Thymus by Radium.

Dr. Henry C. Pierson, Roselle, enjoyed a fishing trip to Barnegat last month.

Dr. Watson B. Morris, Springfield, and wife entertained the Springfield and Millburn Bridge Club at their summer home, Cedar Lake, recently.

Dr. Charles B. Smith, Washington, and wife, left home last month by automobile for Chapman's Beach, Conn., for the summer, where the doctor hopes to recuperate from a long illness. Dr. Paul Correll of Easton, Pa., will accompany them.

Dr. Charles B. Smith, Washington, is recovering from a severe illness from blood poisoning and is resting a few weeks at Chapman's Beach, Conn.

Dr. Charles E. Saulsberry, New Brunswick, attended the golf tournament at Shawnee-on-the Delaware last month.

Dr. Frederick W. Scott, New Brunswick, has been appointed local surgeon for the Pennsylvania Railroad.

Dr. A. E. Olpp, West Hoboken, has been mentioned as a candidate for Congress in the Eleventh District.

Dr. Robert H. Woodruff, Hackettstown, is chairman of the committee on organization of the Hackettstown Golf Club.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.,	Passed.	Failed
Colorado, January ..	13	6	7
Connecticut, March .	28	21	7
Maine, March	3	2	1
Massachusetts, Mar..	29	20	9
Minnesota, January .	6	5	1
New Hampshire, Mar.	1	1	0
Oklahoma, January.	9	9	0
Rhode Island, Jan...	2	2	0
Utah, Jan. & April..	4	3	1
Wisconsin, January..	14	13	1

National Board of Medical Examiners.

The results of the eighth examination of the National Board of which was held in Chicago and St. Louis, Feb. 18-25, 1920, has recently been published. The written examinations were held simultaneously in the two places from 9 A. M. to 1 P. M., and the laboratory and clinical examinations in the afternoons from 2 to 5. The subjects of the examination and the relative value of each were: anatomy, 100; physiology, 75; chemistry, 75; pathology, 75; bacteriology, 50; materia medica, pharmacology, and therapeutics, 75; medicine, 200; surgery, 200; obstetrics and gynecology, 75; hygiene and sanitation, 50; medical jurisprudence, 25. A percentage of 75 was required to pass. Falling below 65 per cent. in two subjects, or below 50 in one subject, constituted a failure.

There were sixty-two applicants who applied for examination. Sixty were found to have the essential preliminary and medical qualifications. Forty-eight appeared for examination, of whom thirty-six passed and twelve failed.

Public Health Items.

Newark Health Department Report.—The death rate for the month of April was 12.6 per thousand of population. The death rate for March was 14.00. As compared with the rate for April, 1919, which was 13.00 per thousand, it is apparent that we are going to have in 1920 a considerably lower mortality than in the previous year.

The deaths from whooping cough were less than the previous month, being 5 to 11. The deaths from influenza were also materially decreased, 4 reported for April as compared with 17 for March. There was an increase in the deaths from tuberculosis, 44 to 34 in March. The mortality from pneumonia, both forms, remains very nearly the same as for the previous month. The reportable diseases recorded during the month totalled 3,034 against 3,071 for March, and 1,550 for the same period last year. The principal increase in contagious disease during the month was in measles, there being 1,618 cases as compared to 1,282 for the previous month.

Vaccinations in Passaic.—About 5,000 pupils of five of the public schools of Passaic were vaccinated in May as a precautionary means against smallpox, under the supervision of Dr. John N. Ryan, city health officer. The vaccinations were ordered by Dr. Ryan following the removal of Ernest A. Blood, physical director of the Passaic schools, to the Isolation Hospital, suffering from a mild case of smallpox.

Smallpox in New Jersey.—Dr. J. C. Price, State Director of Health, has recently urged the need of general vaccination in consequence of the prevalence of smallpox in various places in New Jersey. During the past six months the disease has appeared in fifteen municipalities.

The Ideal of Preventive Medicine.—Preventive medicine can never be satisfied until it has attained Isaiah's ideal (Isaiah lxv, 20: "There shall be no more thence an infant of days, nor an old man that hath not filled his days; for the child shall die an hundred years old." — Arthur Newsholme, Commonhealth, Nov.-Dec., 1919.

Every Physician a Health Officer.—Hasty conditions of work, failure to employ laboratory means of diagnosis or to utilize available consultation facilities (especially in tuberculosis), and lack of training of medical practitioners in preventive medicine, are among the obstacles to further control of disease. There will not be complete success until means are discovered for enlisting every medical practitioner as a medical officer of health in the circle of his private or public practice, and for securing his services not only in the early and prompt detection of disease, but also in the systematic supervision during health of the families under his care, and in advising them as to habits or methods of life which are inimical to health.—Arthur Newsholme, Commonhealth.

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MODERN CARDIAC METHODS.*

By Harvey M. Ewing, M. D.,

Assistant Attending Physician and Associate in Cardio-Vascular Diseases, Mountainside Hospital, Montclair, N. J.

Newark, N. J.

The patron saint of the cardio-vascular section of internal medicine, no doubt, is Harvey, and yet when he attempted to have his ideas of the action of the heart published in 1628, he met the rebuff so many men have met when they sought to change the current of majority of opinion. His publication failed to pass censorship in England and was finally brought out in Frankfort.

His work was one of the radical advances in the process of lifting medicine out of the occult, mysterious and indefinite and placing it upon the foundation of accurate knowledge. Previous to Harvey's discovery, the conception of the function of the heart was ludicrous. It was thought to be the reservoir of vital spirits which it manufactured from the thinnest portions of the air drawn from the finer tubules of the lungs.

Laènnec published his work on Mediate Auscultation in 1819—one hundred years ago—and the medical world was bidden to step up and actually hear what was going on within the chest. This was not altogether an unmixed blessing in the case of cardio-vascular diseases, for men began to hear murmurs and a great variety of sounds, concentrating their attention on these audible manifestations of cardiac activity and it was only natural, as the study of pathologic anatomy spread, for men to try to correlate all unusual sounds with some anatomical change which they found, post mortem.

Heart failure came to be considered purely a mechanical process depending upon a weakening and stretching of the muscle due to the strain occasioned by incompetent or stenosed valves, and indeed such was largely the teaching until quite recently. Ten years ago the conception of heart disease in the minds of even the more prominent clinicians, especially concerning the irregularities, fibrillation and conduction abnormalities, was quite imperfect in the light of modern development.

Mackenzie was responsible for perhaps the greatest advance in the study of cardio-vascular diseases since the discovery of Harvey, when in 1908 he published his first volume of Diseases of the Heart. In one place he says: "Human nature is so constituted that evil is associated with what is mysterious. This applies particularly to sounds whose cause is unknown, to murmurs and associated sounds; and many healthy persons have been looked upon as diseased, and their usefulness needlessly restricted, as a result of a murmur, a queer sound or an irregularity which owing to an imperfect knowledge of the real nature of the sign," and I would add, an impelling desire to associate every unusual sound or irregularity with a pathologic anatomical change, or as Mackenzie puts it, "a confused conception of what constituted heart failure has misled the physician in estimating its significance."

This fact was brought out quite strikingly in both the American and British armies. Many times I have seen a man up for cardio-vascular examination, thoroughly frightened and unnerved because he thought (and I believe honestly so) that he had serious heart trouble and would break down under the strain of army life—all this because of a murmur

*Read before the Clinical Society of the Oranges.

or an unimportant irregularity which some well-meaning but incompletely informed physician had detected and pronounced as evidence of serious, or potentially serious heart disease. In the examination of a portion of one Division, U. S. A., just to mention one group of cases, out of 15,423 drafted men examined for diseases of the heart and lungs, 243 were referred for special cardio-vascular examination because of a murmur, noise or irregularity. Of these 243 suspects I found, on careful examination, that only 43 showed sufficient evidence of heart disease to unfit them for military service. Some of the men accepted for full service undoubtedly had mitral insufficiency but the functional capacity of the heart was not impaired and they were, in the vast majority of cases, not only not harmed but actually benefited by the hard work they encountered.

MacKenzie's conclusion based upon a keen observation of the physiology of the heart, both normal and pathological, compelled attention to the fact that no matter what the morbid anatomical state of the heart, the all-important consideration is its functional capacity,—and there is the keynote of modern medicine —physiology. His adaptation of the old kymograph to clinical needs resulted in the ink polygraph and with its aid he cleared up much of the mystery that surrounded the irregularities and gave us our first clear conception of these phenomena and others hitherto unknown.

Then Lewis, Cohn and other workers both here and abroad further developed this work by means of the electrocardiograph which is the instrument of greatest value yet devised for the accurate study of physiological changes in the heart. The electrocardiograph is simply an extremely sensitive string galvanometer so adapted as to be responsive to the differences in electrical potential currents created by the contractions of the heart muscle. The contracting portion of a muscle is electrically negative to the inactive portions of the same muscle, and in a simple muscle strip this negativity flows across the strip with the contraction wave. This changing electrical relationship of various sections of the muscle strip produces, if collected and measured by an appropriate instrument, a diphasic flow of current.

Now this same phenomena occurs when the heart muscle contracts but necessarily in a more complex manner. The resulting electric currents, when conducted through the galvanometer of the electrocardiograph, cause corresponding movements of the string which are photographed on a moving film. Therefore the electrocardiogram is the visible representation of physiological activity in the heart muscle. And by thus being able to know the points of origin and direction of flow of contraction waves and the time between contractions of the various parts of the heart, we get very direct information as to the activities of the various essential structures in the heart.

Valvular lesions of themselves do not affect the electrocardiogram, but where there is associated change in the muscle or conduction apparatus, we do get definite electrocardiographic curves. Mitral stenosis does, however, give a pretty typical picture, showing a notched "P" wave and right-sided hypertrophy. The question of whether ventricular hypertrophy exists or not and which ventrical is affected, is one that is constantly arising in the consideration of heart disease and is of some importance. It is impossible to accurately percuss the cardiac outline and to gain any real knowledge of the size of the heart or of any portion of the heart by this method of investigation. In fact, percussion in general has fallen somewhat into disrepute in certain quarters.

Neuhof[1] states that "the left border of the heart may be several centimeters beyond the percussed outline and the lower point of the heart usually two to five centimeters below the position determined by percussion and palpation, especially in tall lean individuals." Examination of any number of x-ray plates of the heart will furnish striking evidence of the great variability in the position of the heart with respect to the chest wall, and, therefore, the fallibility of percussion. Orthodiagraphic x-ray will show the total size of the heart and a teleroengenogram will give an accurate picture of the flat measurements of the heart, but neither will show whether the muscle is dilated or hypertrophied. Now the electrocardiograph, since its action depends upon the activity of the heart muscle, does show definitely whether the muscle mass is increased to one side or the other.

The conduction apparatus is essential

to normal cardiac activity and impairments of its function furnish some of the most serious forms of heart disease. They are obscure or impossible of diagnosis by ordinary methods but become an open book when translated by the electrocardiograph. The best-known form of disturbed conduction is diminished or total loss of the capacity of conducting impulses through the main stem of the Bundle of His—heart block, in other words. Various degrees of imperfect conduction can be clearly shown by the electrocardiograph, ranging from a mere lengthening of the auriculo-ventricular conduction time as shown by the increasing of the "P.-R." interval to more than the normal 0.2 sec. on through various combinations as **two to one, three to one** block to complete block where the auricles and ventricles beat independently of each other, but each at a regular and rythmic rate of its own.

Imperfect conduction is associated as a rule with myocardial disease of various sorts and herein lies a great deal of its significance. It may be transitory or permanent and when permanent is very apt to be progressive. So it is important to diagnose it and when diagnosed to follow the patient over a long period in order to know whether it is of the transitory type and is disappearing, or of the permanent type and is becoming more complete. The transitory type not infrequently is associated with the severe, acute, infectious diseases and is missed unless the heart has been checked by the electrocardiograph. The permanent type is better known clinically and appears in its most disturbing form as Adams-Stokes syndrome. From the standpoint of treatment it is good to know that impaired conduction does or does not exist in any form, for digitalis will increase the difficulty and perhaps prove dangerous.

A very interesting diagnosis which the electrocardiograph has made possible is that of Bundle-branch block. In this condition the main auriculo-ventricular bundle conducts impulses normally, but one of its two main branches does not, and so the impulse will reach the walls of the right ventricle sooner when the block is in the left branch and vice versa. Thus, that ventricle first receiving the impulse will contract first and the other ventricle will contract later, so making the whole process of longer duration and of abnormal sequence. A very typical electrocardiogram is obtained in these cases.

Of course such a lesion must be associated with some myocardial degeneration. Of this condition Lewis[2] in his monograph "Clinical Electrocardiography," says: "As a permanent feature the right branch is more frequently defective than the left, occurring more commonly with aortic disease, and the death amongst patients exhibiting this sign is extraordinarily high." Oppenheim[3] of Mount Sinai has gone still further, ascribing a certain definite form of the electrocardiogram to lesions involving the finer branches of the bundle in the ventricular muscle and has found in these cases, post-mortem, disseminated sclerosis in the sub-endocardial layer. These cases, he says, "fall into the atherosclerotic group. One case was aged twenty and had no known etiology except a recent grippe with associated cardiac disturbance."

Sino-auricular block is another conduction difficulty where the impulse apparently never leaves the sinus node and there is, therefore, a complete pause of both auricle and ventricle—a real dropped beat. This may or may not be associated with myocardial disease. Tobacco may cause it and it is conceivably due sometimes to vagus influence.

Nodal rhythm is a peculiar phenomena where the auriculo-ventricular node takes on the function of impulse formation and the contraction spreads upward into the auricles and downward into the ventricles, simultaneously. Interference with the orderly formation and transmission of the impulses causing the normal beating of the heart is apt to be of extreme gravity and as it occurs in a considerable variety of forms, difficult and often impossible to diagnose clinically and, furthermore, since digitalis given promiscuously may increase the mischief, this class of cases is one in which the electrocardiograph has one of the most useful fields,—making possible an accurate diagnosis.

Fibrillation and flutter are two arrythmias of considerable importance which are diagnosible clinically in most cases and are shown with unmistakable clearness on the electrocardiographic film. In fibrillation the auricle beats in a rapid and totally irregular fashion while the ventricle responds more slowly, but, likewise, irregularly and with beats of varying strength, thus markedly impair-

ing the heart's efficiency as a pump. A fibrillation may be slow and rather difficult to diagnose from multiple extra-systoles, without instrumental means. Flutter is a rapid regular rhythm varying between two hundred and fifty and three hundred and fifty beats per minute. Usually the ventricle responds to only every other impulse or every fourth impulse. Cases which would be difficult to understand clinically are those that show a rapid change back and forth from flutter to fibrillation and back to flutter, or where there is a changing ratio between the number of auricular and ventricular beats making the pulse apparently irregular.

These two irregularities are rather satisfactory to treat because it is in them that digitalis is pre-eminently of benefit and its effect has been shown to be due largely to the production of partial auriculo-ventricular block, so protecting the ventricles from the bombardment of rapid and irregular stimulae to which they cannot properly respond.

Premature contractions, commonly known as extra-systoles, are frequently met both in health and in disease and often prove puzzling to the physician as well as being a source of much worry and discomfort to the patient. They are of divers forms and are usually complained of as a stopping of the heart or a missed beat. Indeed many physicians so diagnose them and failing to understand properly what is actually occurring are apt to inform the patient that he has heart trouble with often disastrous results to his morale.

In truth these striking interruptions in the orderly rhythm of the heart usually have no serious significance as far as we know at the present time. They are frequent in young men and are often induced by tobacco and a variety of other conditions. Of course, occurring in association with myocardial changes they take on a more serious significance. Many extra-systoles or an increasing number of multiple extra-systoles arising in different foci take on a different aspect and must be considered as evidence of myocardial disease. They arise in a focus of heightened irritability somewhere in the heart muscle and the location of this focus can be determined pretty definitely by means of the electrocardiograph. They must be viewed in connection with other findings in most cases, for while they are perhaps associated with most forms of serious heart disease at sometime in their course, yet the importance of the diagnosis lies usually in being able to disabuse the patient's mind of the fear of serious heart disease, which really is justified in a sense by the spectacular impression they make upon his mind.

These four groups of cases, namely: 1, changes in the relative muscle mass of the two ventricles; 2, impaired conductivity; 3, fibrillation and flutter; 4, extra-systolic arrythmias, comprise the most frequent and most important conditions in which the electrocardiograph is either a great aid or an essential to diagnosis, and they include the most serious conditions met with in the cardio-vascular system.

There are many other conditions which the electrocardiograph has brought to light or clarified, such as sinus arrythmia, effect of vagus influence, dislocation of pace-maker, escape of the ventricles in slow rhythms, the tachycardias, and so on. Some of these are apparently of little clinical importance and the real significance of others is not yet determined, for this is a new method of investigation.

Much has been learned concerning digitalis action on the heart by means of the electrocardiograph, furnishing, as it does, unmistakable evidence of digitalis action on the musculature and conduction systems even when it is not evident clinically. As a check to digitalis therapy it is quite valuable.

I have merely mentioned the ink polygraph for the reason that it does not give any information that is not obtainable with the electrocardiograph, with one exception, and it is much more difficult to operate. The obstacles to be overcome in adjustment of the tambours and the mechanical errors introduced in the operation of the apparatus make the tracing much more difficult of interpretation than the electrocardiogram. It does show pulsus alternans more constantly and more clearly than does the electrocardiograph. This and its portability are its only advantages. Historically, we owe much to it.

With the application of the mercury manometer to the estimation of intra-arterial pressure most of us are familiar, although it may astonish you to know that I have recently heard of a physician, not forty miles from New York City, who insisted that in a certain case the dias-

tolic pressure was higher than the systolic. Many do not yet appreciate that the auscultatory method gives the most accurate readings. One young man who was with me in the cardio-vascular work in the army admitted that he knew nothing whatever about blood pressure and had no idea of how to use the instrument.

X-ray is another of the modern methods in the study of cardio-vascular disease and has a distinct value. Its use either in the orthodiagraphic or the teleroentgenographic method gives a very accurate picture of the size, shape and position of the heart and the aorta, giving aid in determining effusion, adhesions, patent ductus arteriosis and abnormal positions, such as dextro cardia. In the study of the aorta the x-ray is of great value.

Careful history and physical examination and close clinical observation are old methods which have lost none of their value in modern diagnosis, but are apt to be neglected in favor of instrumental means. No greater mistake could be made! If we had to choose we would better discard all of our instrumental methods and rely upon the development of the keenness of perception, analytical ability and the balanced appreciation of values that have made some of the world's greatest clinicians.

However, most of us are not destined to be great clinicians and all these mechanical and electrical devices have widened our horizon, giving us a fuller and more exact appreciation of what we see clinically in our cases and their use is a real aid in accurate diagnosis and upon accurate diagnosis is dependent intelligent prognosis and rational treatment.

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Theodore N. Vail, builder of the American telephone system and one of the greatest captains of industry that America has produced, who died recently, spent two years studying medicine, with the idea of becoming a physician, but, like Alexander Hamilton, changed his mind. As in the case of Hamilton, what medicine lost, business gained and the country was the richer in the end thereby.

SCARLATINA.*

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Scarlet fever, scarlatina or scharlach (febris rubra) scarlatina is the scientific name for scarlet fever, and refers to any case of scarlet fever whether it is mild or severe. Sydenham—in 1670—first assigned this condition as a distinct disease among the acute exanthemata. Scarlet fever is almost constantly present in the larger cities in North America. Outbreaks of scarlet fever in epidemic form are rare in India, Japan, Ceylon, Asia, Australia and Africa.

Etiology. Klein's streptococcus, Edington and Jamieson's bacillus scarlatinae, and Mallory's protozoon body were each thought to be the cause. Virulent streptococci are **always** associated with the special organisms of the disease itself—these streptococci are known to be the cause of many of the severe complications that arise in the course of this disease. Jochmann found streptococci as the most common and dangerous cause of the secondary infections of scarlatina, but is **not** the **cause** of the disease. However, while we do not know the cause of scarlatina, it has been definitely proven that the streptococcus is the main etiological factor in the tonsilar and pharyngeal pseudomembranous conditions of scarlatina. It has been definitely established that the Klebs-Loeffler bacillus is **absent** in the great majority of cases in the early scarlatinal angina.

G. H. Memoine, in 117 cases of scarlatinal angina found streptococcus pyogenes alone in 93, while Klebs-Loeffler was found in addition, in 5, and the bacillus coli communis in 9 cases. "Inclusion bodies" have been found by Bernhardt, Dohle, Kretschmer, Hofer and others. These "inclusion bodies" are present in the polymorphonuclear cells of the blood in scarlatina cases. Klimenko's fusiform bacillus and Schultze's "micrococcus S" are not the causes of the scarlatina. At present it may be stated that the specific germ of scarlatina has not yet been discovered. Mallory and Medlar thought scarlatina may be due to a strongly gram-positive bacillus (B. scarlatinae); however, this is not proven.

General Symptomatology. — The dis-

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ease is commonly **ushered** in by **sore throat,** headache, vomiting, together with a **very rapid pulse,** sharp rise of temperature and by the appearance of an erythematous rash, seen usually by the second day upon the upper thorax and neck, and then spreads rapidly over the entire surface of the body. The tongue becomes reddened at the tip and margins with swollen papillae projecting, giving rise to the "strawberry tongue." The uvula is injected and the buccal mucous membrane is of a bright-red tint. There is tenderness about the neck, pain over the submaxillary, inguinal and axillary glands, especially the last two groups, are nearly always enlarged. Tonsils become very red and swollen and may show whitish patches. Some cases may show early marked involvement of the pharynx and with a poorly defined, irregular, transient, or **wholly absent** rash. Some cases may show a very faint rash for a few hours and slight redness of the pharynx and tongue—often attributed to "stomach upset"—these are the cases that may cause ill feeling, and dissatisfaction between the patient's family and the attending physician, because of the question as to diagnosis.

The trouble is, that many of our mild, atypical cases of scarlatina resemble other possible minor ailments. It is, therefore, advisable to withhold, in all **doubtful** cases, the expression of a positive opinion for 24 to 48 hours, at least until positive evidences of disease have appeared. The **prodromal** symptoms are of short duration, usually a few hours, and may be entirely overlooked. The first thing noticed may be an erythematous blush appearing first over the upper part of the chest, cheeks and neck (a bright fiery red blush). The period of **incubation** varies from 3 to 7 or 8 days. This period may be shortened or prolonged. The more severe the epidemic the shorter is the incubation period.

Signs and Symptoms.—During the first twenty-four hours the characteristic early symptoms are the **sudden**. and abrupt onset, vomiting (often early and persistent) headache, intense congestion of the faucial mucous membrane, sore throat, rapid rise of temperature, and rapid increase in pulse rate, sometimes convulsions. These suddenly appearing symptoms and onset are suggestive of scarlatinal infection.

(1) Von Leube attributes great significance to **early vomiting** and considers this an initial symptom of the greatest diagnostic value—occurring more often in scarlatina in childhood than in any other disease, with the possible exception of pneumonia.

(2) Throat. Early sore throat is almost as constant as the eruption. There is present usually from the first, a diffuse, mottled, congested appearance of the uvula, soft palate, and tonsils, and the tonsils are swollen and crypts filled with exudate. The eruption in the throat makes it **sore.**

(3) Skin. The early rash develops as a rule within the first 24 to 36 hours and appears as a widely scattered punctate blush and differing from the sharply defined, pin head, slightly elevated rash of **measles** and the areas of pale white skin between the measles rash are absent in scarlatina.

At the end of the first 48 hours, the real scarlatinal rash has made its appearance first upon the upper thorax and then spreading quickly over the neck, chest, extremities, etc., and only slightly upon the face. The rash is a diffuse, scarlet blush made up of minute brightly red injected puncta, very slightly elevated and closely studded together, forming a uniform or finely mottled surface. The region about the mouth is comparatively free from rash. The rash develops more rapidly in blonde, healthy, full-blooded children than in darker skin or pale children. The rash is more pronounced over areas exposed to irritation or pressure as the buttocks, back, bends of elbows, groins; upon streaking or pressing the skin the red blush of the eruption momentarily pales. This paling is **not** characteristic of scarlatina in any way.

As stated previously and now emphasized again, the earliest places where the rash appears are upon the upper thorax and neck, especially down over the subclavicular regions, and far less commonly upon the small of the back. In a few hours the rash spreads all over and at the end of 10 or 12 hours reaches the legs and entire trunk. Again emphasizing the fact, that upon the face (differing thus from measles and smallpox) true scarlatina rash is much less marked, and occurs only upon the cheeks and forehead, usually the lips and nose being free giving a peculiar white ring, which is quite striking. The dorsal surfaces of

the hands and feet show a marked eruption, while the plantar and palmar surfaces do not appear so injected. The rash remains at its maximum for from one to three days. The remittent intensity of the rash has been emphasized by Henoch.

(4) **Pulse rate.**—The pulse is markedly increased out of all proportion to the fever. From the second to the third day the rash begins to fade and the temperature comes down slowly (in measles there is an abrupt fall in temperature very often), but the pulse continues quite rapid.

(5) **Tongue.** — The appearance of the tongue and throat are almost pathognomonic of the disease in some cases. The eruption makes the tongue "sore" at times, and results in the well-known "strawberry tongue," as mentioned above. The tongue loses its heavy coating after the second day, and becomes deeply injected, the papillae at the tip and along the margins becoming more prominent, giving rise to the "katzenzunge."

(6) **Enlarged Glands.**—Von Jurgensen emphasizes the diagnostic value of early enlargement of the inguinal glands in scarlatina. Schamberg also has emphasized the great frequency of enlargement of the inguinal, axillary, and maxillary glands. He found the inguinal glands enlarged in all cases, the axillary in 96%, the maxillary in 95% and the posterior cervical glands were enlarged in 77% of the cases. The study of these 100 cases by Schamberg showed that the maxillary glands commonly attained the largest size, and also most frequently underwent suppuration. In all of the 100 cases studied, on the second or third day of the disease, the enlargement of the lymphatic glands was well marked.

(7) **Polymorphonuclear leucocytosis** is present. In measles there is a leukopenia. Dohle (in 30 scarlatina cases) "found inclusion bodies" in the polymorphonuclear leucocytes—he did not find them after the sixth day of the disease. Kretschmer, and Nicoll and Williams also found these bodies in the blood smears in 45 out of 51 cases. Isenshmid and Schemensky have found them in practically all the cases of scarlatina in early stage. They are not found in German measles, measles, diphtheria or whooping cough. The most characteristic "inclusion bodies" are those of a triangular form with a long tail-like end. They may be found in pneumonia.

(8) Rumpel (1909), Leede and Jampolis have reported and recommended as a suggestive diagnostic sign, the appearance of petechiae in the skin on the inner surface of the elbow joint, when the skin is stretched until it becomes anemic, after a broad constricting band above the elbow joint has been previously applied for ten or fifteen minutes and then loosened. A negative reaction is perhaps a greater indication that scarlatina is not present than is a positive reaction that it is present. Jampolis found it in 199 out of 200 cases. Bennecke confirmed the diagnostic significance of the Rumpel-Leede phenomenon. A venous stasis only being produced in the arm, the arteries being left alone, the hemorrhages appear at the elbow in from 5 to 20 minutes—punctate or larger, in some cases becoming confluent. He found them in nearly 100% of cases.

(9) **Desquamation.** — The eruption is due to an inflammation of the skin and to very minute vesicles which form in the deeper layers of the epithelium and loosen the cells. This loosened epithelium peels off, and gives rise to the characteristic desquamation. Desquamation usually begins in from ten to twenty days after the onset of the disease. It begins around the roots of nails, palms, and soles and extends over the whole body. Schumacher states that desquamation is not a positive sign of recent scarlet fever, as scarlet fever can exist without any subsequent desquamation, and that desquamation may be the result of a number of constitutional diseases of long duration, as pneumonia and tuberculosis, or some local inflammatory condition of lengthy duration, as sunburn or poison ivy poisoning; or the internal ingestion of some drugs as arsenic; or the external application of strong antiseptics, as phenol, or formaldehyde gas. Desquamation begins first where the rash was first seen, and from where it first disappears, namely, the upper thorax and neck.

(10) P. Teissier and R. Benard found a **positive Wassermann reaction** in 84% of the cases of scarlatina in the Hospital Claude-Bernard. The **Babinski sign** in scarlatina and diphtheria has been reported to have occurred in a rather large percentage of cases, 19-25% of all cases.

(11) **Transient Albuminuria.**—Early in the course, is seen in 75 to 90% of all cases according to Eichhorst.

Age.—The greatest number of cases occurs between the ages of one and five or six years. McCollom at Boston City Hospital reported 75% of patients were between 2 and 10 years of age.

Immunity.—As a rule one attack protects against a subsequent infection. Second attacks have been reported. Others have reported even third attacks. One must **not** make a positive diagnosis of a second attack of scarlatina without first excluding all other possible conditions, and without a careful study of all the presenting symptoms and signs, and thorough study of the history of the case. Henoch has seen but one authentic case of a second attack of scarlatina. According to Korner when a second attack occurs, it usually follows from two to six years after the first (which first attack usually occurs before the age of 10 years). Murchison has reported a third and Stiebel a fourth attack of scarlatina. The various erythemas must, of course, be excluded, such as drugerythema, measles, and rubella; also antitoxin erythemas; toxic or simple erythemas, erythema scarlatinforme, erythema scarlatiniforme desquamativum, etc. Jacobsen in April, 1914, reported a family of four children had scarlatina in 1908 and 1911. Over a year later the children had scarlatina anew, each one of the children having a typical attack. The second attack was more serious than the first in all, and one girl, 8 years old, died from it, from myocarditis.

Types and Varieties.—Numerous varieties or types of scarlatina cases have been described, such as: 1, scarlatina anginosa; 2, scarlatina maligna (toxic); 3, scarlatina modificata: (a) scarlatina miliaris, (b) scarlatina laevigata, (c) scarlatina laevis, (d) scarlatina sine exanthemata, (e) scarlatina hemorrhagica, (f) scarlatina variegata, (g) scarlatina sine angina, (h) scarlatina sine febre.

A simple classification is this one:

1. Well developed and severe cases of scarlatina; 2. mild ones—in which there is sore throat, and a slight (evanescent) rash, with subsequent desquamation or peeling; 3. still milder cases—not sufficiently concentrated infection to cause a rash, but which produces a sore throat, and possibly exfoliation of the tongue ("strawberry")—these "subcases" are of the greatest importance from a public health standpoint. The eruption may at times be abortive, or not seen at all, or the rash fails to appear (scarlatina sine eruptione)—it is possible the rash appears, but is so faint and evanescent as to go unnoticed.

Mortality.—In a study of 1,153 cases of scarlatina by L. I. Dublin, there were 90 deaths or a mortality rate of 7.8%. McCollom found an average of 8.4% mortality rate in 37,810 cases in Boston in 28 years. In 32,317 cases of scarlatina during a 12 year period in Philadelphia (1898-1910), 1,759 deaths occurred or a mortality rate of slightly over 5%. Dublin found 82% of all cases (1,153 in the series) were among children between 2 and 10 years. The greatest disposition to the disease is found among children 3 to 7 years of age according to Dublin. According to Osler 90% of all scarlatina deaths are of children under 10 years. Dublin's figure was 92%.

Sequelae and Complications.

Otitis.—According to Carter **otitis** is perhaps the commonest complication of scarlatina. According to Holt, perhaps 75% of the severe cases show otitis. In 4,015 cases analyzed by Caiger, 11.05% showed otitis media. Bader and Guinon found 33% of all the cases of scarlatina showed mild or catarrhal otitis media and the purulent form in 4.5 %. Ten per cent. of acquired deafness has its origin in scarlatina. Barasch found among 1,438 cases, 13.8% otitis. Fisher reported middle ear trouble in 20% of cases. Richardson of Providence, in a letter to me, states that about 12% of the cases show acute otitis media with less than one-half to one per cent. developing mastoiditis. Finlayson, of 4,397 cases studied, found otitis in 10%.

Nephritis.—Osler records the presence of nephritis in from 10 to 20% of his cases. M. Barasch reports 16.1% of 1,438 cases developed nephritis, at the Urban Hospital, Berlin. No case, however mild, is wholly free from the danger of a subsequent severe renal inflammation. The occurrence of nephritis during the course of scarlatina is due to the circulation in the blood of the specific virus or toxin, and which acts as a direct irritant. Nephritis appears less common in young adults than in childhood. Scarlatinal nephritis develops late in first or early in second week—from the tenth to the twentieth day of the disease.

We may have (1) early or initial mild nephritis, (2) septic nephritis and (3) post-scarlatinal nephritis. Out of 1,200

cases, Richardson found, two or three years ago in a study of records of the Providence City Hospital, about 1% nephritis with no deaths. However, since that time he found the incidence in nephritis was very much greater in that **one** year than in all the cases he had previously, put together. Wilson, of the Bureau of Hospitals, New York City, states in a communication to me that the frequency of complications in the order of their occurrence are endocarditis, angina, arthritis, **nephritis,** mastoiditis. Complications are very much more frequent where the cases are permitted to get out of bed too soon after the fall of temperature. Barasch reports among the 1,438 cases above mentioned the following complications: nephritis, 16.1%; otitis, 13.8%; rheumatism, 5.9% sepsis, 9.1%; endocarditis, 1.3%; late involvement of glands in the neck in 33.4%, and in 16.4% of the total there was complicating diphtheria.

Heart.—The heart is very susceptible to the scarlatina poison (shown by the marked tachycardia, irregular small rapid pulse). The mural endocardium (myocarditis) is probably much more often affected than the valves themselves.

Acute endocarditis is apparently rare. Murmurs may often be heard, probably due to the toxic **myocarditis.** The rapid and at times irregular pulse is seen chiefly early in the attack. Later on, the heart sounds may lose the normal tone. This evidence of cardial weakness may be due to endocarditis or myocarditis—probably the latter, because it is usually the endocardium of the heart wall, rather than of the valves, that is involved.

In cases of nephritis, there is, in children, seen acute dilatation and hypertrophy of the left ventricle. A. Stegemann, from an examination of 49 cases, found in toxic cases of scarlatina of short duration, the parenchymatous changes in the heart muscle was slight. In infectious cases of long duration, there were acute parenchymatous degenerations and necrosis. The number and size of the Nissl bodies were markedly decreased in severe toxic cases, in contrast with the infectious cases. He believes that in severe toxic cases of scarlatina, of short duration, the cause of the heart weakness lies in pathologic changes in the heart ganglia.

Adenitis.—Fisher reported that in 6,000 cases 14% had adenitis. The frequency of this complication varies considerably; it often occurs in the early stage of the disease or at times in the second or third week.

Scarlatinal Synovitis is comparatively common. (1) Serous (simple) synovitis is more common; and (2) purulent arthritis may occur, but not frequently seen. Synovitis occurs in about 7% of the cases, is usually transient, and nearly always appears from the fourth to the tenth day, and in 72% of the cases affects the **wrists,** according to Marsden. Carslow in 533 cases found synovitis in 60. Most frequent in children past 5 years of age.

Phlebitis is very rare. **Bronchopneumonia** and even true croupous pneumonia (in nephritis cases) occurs more frequently than we believe. **Acute psychosis** may occur in convalescence. **Pyemia** and **abscess** of the lungs may occur.

Diphtheria. — Diphtheria complications occur as a rule later in the course of the disease and often after complete subsidence of all the primary throat inflammation. Paralysis may occur in these cases. Henoch has never seen oculomotor or palatal paralysis following scarlatina angina, except only in those few cases complicated by a true diphtheria. Richardson states that he had only about one to three cases of diphtheria develop among 200 to 300 cases of scarlatina every year. R. J. Wilson, New York Department of Health, states that diphtheria is an infrequent complication, and since the advent of the Schick Test, it has almost entirely been eliminated as a complicating development in the wards of the hospital. It should be remembered, however, that secondary infection by the Klebs-Loeffler bacilli may occur, and most likely **after** the first week. This may be easily overlooked, and it is therefore advisable to examine the throat at each visit, and if suspicious to take a culture smear at once.

Diagnosis.—Must be made from measles, Duke's (fourth) disease; drug eruptions due to quinine, belladonna, antipyrine, opium, iodoform, chloral, potassium, potassium iodide, mercury and antitoxic sera; rubella (German measles); toxic transient erythema, sometimes seen in diphtheria; erythema scarlatiniforme, erythema scarlatiniforme desquamativum, and simple erythemas with or without tonsilitis (streptococcic). However, suffice it to say that in the

large majority of cases the short incubation period (stadium incubation is 2-7 days), the very short prodromal stage (stadium prodromorum, of a few hours—24 or less), the early vomiting, the early sore throat, the characteristic punctate fiery red eruption (stadium eruptionis); the very rapid pulse—140-165, out of all proportion to the temperature and general condition of the patient, Pastia's sign—an intense continuous linear exanthem in the skin folds at the bend of the elbow, the Rumpel-Leede phenomenon, the presence of "inclusion bodies" in the polynuclear cells of the blood prior to the sixth day, true leucocytosis (an absolute and relative increase of the polymorphonuclears) the rapidly growing cultures (throat) of the Class coccus and the "strawberry" tongue—several or all of these symptoms will aid in making the correct diagnosis of scarlatina. **In measles,** we have a leucopenia, Koplik spots, the peculiar rash, and the catarrhal symptoms and the marked contagiousness of the disease render valuable aid in diagnosis. Measles is liable to be mistaken for scarlatina only in special cases. In scarlatina we get tenderness about the neck, with pain on palpating the submaxillary glands, which are often swollen. In scarlatina, too, the congestive disturbance of the mucous membranes is mainly confined to the pharynx tonsils and larynx. There is much more photophobia and dread of light in measles than in scarlatina. In measles, too, there is a much more general catarrhal condition of the upper air passages, with coryza and the characteristic dry, croupy, hoarse, barking cough. The buccal mucous membrane in scarlatina as a rule is of a bright-reddish tint and the uvula is very much injected,—in **measles** (rubeola), we get a more pale-bluish tint, with a coated tongue (whitish fur) with a few scattered enlarged reddened papillae; the rash in measles does not appear until the fourth day, while, as stated above, the prodromal stage in scarlatina does not last longer than twenty-four hours. The **dark-red** maculae and papules of measles, with the slightly cyanotic features certainly differ from the bright red punctato rash of scarlatina. The first lesions in measles appear on the upper part of the forehead, on the temples behind the ears, and on the sides of the neck. Later it appears about the eyes, mouth, and on the chin. In scarlatina, the rash first appears on the upper thorax and neck. Diarrhea is often seen in measles, rare in scarlatina, although it does occur at times early in the disease.

In **rubella** the rash appears first on the face and is very evanescent and is never entirely confluent, being always "measly" or "spotty" in appearance. Constitutional symptoms, otitis, severe pharyngeal involvement, and albuminuria, are almost unknown in rubella (German measles). This is a most benign short and mild infectious disease. The onset even is mild and slow and insidious, while in scarlatina it is always sudden. In a report of 150 cases **Griffith** found some confestion of the upper portion of the anterior pillars of the fauces with some swelling of the tonsils in rubella, and **Forcheimer** described his small, discrete, dark red (not dusky) papules on the soft palate remaining only about 12 to 15 hours and appearing simultaneously with the exanthem in rubella. Rehn also observed similar lesions on the **soft palate** and in the conjunctivae. Bolognini's "pathognomonic" sign of measles consists of a fine peritoneal crepitation or friction—as if two bottles were rubbed together, when the pulps of the fingers are applied with gentle pressure to the relaxed abdomen, while the legs are flexed. However, this sign is present in other affections and **not** of much diagnostic significance. In **rubella,** too we have adenopathy in 96-98% of all cases—the superficial or post-cervical and the maxillary glands are most frequently involved. The occipital and the anterior and posterior auricular are frequently palpably enlarged. Finally, in rubella, the **pinkish** maculae and papules, very often discrete, but frequently becoming confluent in a few hours, first seen on the face and scalp, and **next** the neck and upper chest, without any tendency to form groups, crescents or clusters (as in measles) and most important of all the prominence of the eruption varies in different parts of the body; thus the eruption has already begun to fade on the face before it is fully developed on the trunk, and it is usually nearly gone on the face before it begins to fade on the trunk, and it is usually nearly gone on the trunk before the legs are involved. This characteristic appearance of the eruption on various parts of the body helps to separate this disease from scarlet fever and measles.

Erythema Scarlatiniforme Desquama-

tivum, Erythema Scarlatiniforme, Erythema Scarlatinoide. There are several grades of this condition, mild and severe. The rash is often almost continuous over the entire surface. In some cases the rash is of a morbilliform type, and in others of a scarlatinous form, which at times is even punctiform in appearance at first, then becoming a uniform bright pink or fiery red or sluggish livid red color. Usually, the attack is ushered in with mild or more severe febrile symptoms. Often the constitutional symptoms abate when the erythematous blush appears. In other cases, the general symptoms continue for several days after the eruption appears. The rash begins to subside in 2, 3 or 4 days with desquamation. Recurrences are frequently seen. The later attacks are usually mild. The rash is not usually quite so general as in scarlatina. The course usually runs from 10 days to three weeks. Typical **"strawberry" tongue** and **adenopathy** are usually absent. The anginal symptoms are very slight or entirely absent, and the disease is non-contagious.

Case Report.—Charles S., attorney, 24 years of age, male, white. Had scarlet fever when 6 years old. Had attacks of red rash, some itching and swelling and puffiness of head and face, with a trace of albumin in the urine with some sorethroat, in 1917 and 1918; the attacks lasting about ten days. With this diffuse uniform red rash he would also get urticaria, large wheals appearing over various parts of the body. Later, followed by some desquamation. The third attack began early in December, 1919, with itching and burning, swelling of the entire face and scalp, numerous large wheals appearing all over the trunk, back of neck and thighs, with some fever and sorethroat. Shortly afterward, a uniform fiery scarlatinoid (punctate) rash appeared all over the body—particularly marked over the abdomen, neck, and back. The throat was considerably congested, and soreness was complained of. Typical **"strawberry" tongue** was absent. **Throat cultures** showed at first only streptococci, later also staphylococci. The rash began to fade after the 5th or 6th day. There was still some eruption over the abdomen and back on the 7th and 8th days of the attack. **Urine** showed trace albumin, S. G. 1.013, few R. B. C., squamous, renal epithelia; few pus cells; ammonium urates; total solids 30.3 gms. per litre; urea 1.3%; no acetone, no indican, no sugar, no casts. Desquamation was a prominent feature of the case, but was scarcely noticeable on the hands and feet. At first, the case certainly strongly suggested scarlatina, and this, therefore, would be a fourth attack, if the patient is correct in his description of the attacks of 1917 and 1918, and if the history of true scarlatina (?) when 6 years of age, had reference also to a similar attack of recurrent erythema. In my opinion this was a case of erythema scarlatiniforme desquamativum (erythema scarlatinvides recidivans or recurrent exfoliative erythema). Dr. Carter describes and reports a similar case in a young woman, age 20, who had four attacks. This was Dr. Corlett's patient, and shows the difficulty of establishing a diagnosis without reference to the history, and the importance of remembering that the appearance of a characteristic desquamation is by no means always an infallible sign of recent scarlatina. In my case, albuminuria even, with headache, sore throat, fever, extensive eruption, and marked desquamation occurred in three attacks in 1917, 1918 and 1919. Whether the attack in childhood was indeed scarlet fever or the first attack of scarlatinoid erythema resembling the others, I do not, of course, know. The typical changes seen in the tongue from the 3rd to the 6th day in true scarlatina, were absent in my case, although the edges and tip of his tongue were "raw-like" and congested. Desquamation in this case continued for only a few days when it ceased. In true scarlet fever the desquamation usually lasts for two to six weeks before it stops.

Recurrent attacks of scarlatina are as stated very rare. Holt has never yet seen an undoubted instance of a second attack in the same patient. Kinnicutt reported in a boy of five years two attacks within eight months. Pritchard reported a case having three attacks within two years. Henoch only knew of one authentic case of a second attack of scarlatina. Statements by physicians that they have seen two and three attacks of scarlatina in the same patient should be accepted with some doubt because of possible errors in diagnosis and mistakes in the history of the cases.

Most Important to Remember are the Facts.

(1) that at present there is **no certain** test for scarlatina, just as there is no certain test for influenza, and a few of the other very common infectious diseases.

(2) Many cases are not even sick enough to have a physician, and have only faint unnoticeable eruption—later followed, however, by desquamation. This is the best sign we have.

(3) If a child has a desquamation of the skin two or three weeks after a slight attack of illness with slight fever, it is usually safe to say that the child had scarlet fever.

(4) The causative organisms of scarlatina are found in the discharges of the nose and mouth, and are **not** found in the skin, nor in the scales (even during desquamation). The organisms may be present in the discharges from the ear and abscesses.

(5) The mild cases, the unrecognized cases—with discharges from the nose, throat, ears, abscesses, are the "carriers" that cause most of our scarlatina cases.

(6) Scarlatina is transmitted by contact with fresh discharges of active cases or with the discharges of "carriers." The organisms produce the disease in from 2 to 7 days after infection (exposure). Therefore, if a child has been exposed to infection and does not become ill within a week, it may safely be allowed to mingle with other children.

(7) One attack of scarlatina usually confers lifelong immunity. Carriers working in dairies, or in milk establishments may contaminate the milk, and so help to spread the disease through infected milk.

Prophylaxis. — I. Early discovery of cases is an important factor in the prevention of the spread of this disease. We know that every case of scarlatina comes from a previous case. Unrecognized cases, missed cases, "24 hour" cases, and atypical cases—are the ones that may be caught if the physicians, health officials, and school doctors and school nurses and school teachers will make more thorough and complete examinations. The suspected cases should all be completely stripped and examined; II. prompt isolation; III. proper disposal of all discharges and excretions; IV. protection of school children; V. proper treatment at home or in a contagious disease hospital; VI. public health propaganda; VII. proper attention to personal cleanliness, and suitable precautions taken by the attendants and those coming in contact with the case or cases including the physician; VIII. proper attention to toilet articles, dishes, milk bottles, doorknobs, and any other article that may have been contaminated with the fresh discharges of the patient.

Disinfection or fumigation after recovery is unimportant. Desquamation is unimportant, except, of course, the possibility that the skin may be contaminated by the infected or organism-bearing discharges from the nose, throat and ears. The infective material in scarlet fever is found in the discharges from the nose, throat and ears and in the urine and feces. Proper attention to these should be given—as above mentioned. It has been shown that ordinary cleanliness is sufficient to render articles free from scarlatina germs and that these germs are not long lived and are readily killed. Children who live in a house where there exists an active scarlet fever case must not be allowed to attend school or play with other children, because they may come in contact with the sick child in the house unbeknown to anyone. However, if children who have had the disease and are immune, leave the house, they may be allowed to return to school. If non-immune children leave the house, and after a period of observation for 7 days do not develop any symptoms, they may be allowed to return to school.

Treatment.—Avoid meddlesome treatment, avoid overtreatment.

Nose and Throat.—Salt solution is the simplest and most efficient cleansing agent for the nose and throat. Liq. antisept. alkalinus may also be used, with a nasal douche, every 2 or 3 hours. An ice bag constantly applied over the throat gives relief. Avoid strong, irritating, unpleasant throat-gargling solutions.

Blood Serum.—From recovered cases of scarlatina has been used with excellent results. An easy and practical way is to withdraw a few ounces—4 or 5 or 8 ounces—of the blood from the donor and to immediately inject the whole blood into the gluteal region of the patient. (Citrate solution is first drawn through the luer syringe.) This blood is soon absorbed and the dangers of intravenous injection and marked anaphylactic reactions are thus avoided. It is important to know that the donor is not syphilitic.

Rest and Fresh Air.—The patient should be kept in bed, even in the mildest cases. Patient is not to be covered too heavily. Plenty of fresh air and thorough ventilation are most important. The temperature of the room should be kept at about 65-70° F. (23° C). Avoid exposure to drafts. Patient should be kept in bed for a week, if possible, after the subsidence of the active febrile stage. In this way only can the danger of late **renal complication** be avoided, while daily examination of the urine is the only guide as to just what changes may be taking place. The 'Phthalein renal function test may be tried.

Skin.—Throughout the course of the disease a tepid sponge-bath should be given once or twice a day. These sponge-baths diminish the tension of the skin and aid in skin elimination besides being extremely grateful to the patient. For the itching, and later for the desquamation, cold cream or cocoa-butter or a mixture of lanolin, vaselin and olive oil with a little phenol (1 or 2%) may be used. Menthol (½%) may also be added for the relief of the itching.

Unfortunately, there is as yet no specific treatment for scarlatina. Huber and Blumenthal reported in the Berliner klin. Woch. No. 31, 1897, pp. 671 et seq. the use of serum from the blood of convalescent scarlatinal cases with varied results (in a series of 13 cases). E. M. Landis in Amer. Med. Assoc., April 8, 1899, reported a striking case of recovery following the use of antistreptococcic serum. A. Babinsky in the Berliner klin. Woch., 1896, No. 33, pp. 340 et seq., reported a series of 48 cases of scarlet fever, treated with Marmorek's antistreptococcic serum (mortality 14.6%). Antistreptococcic serum and streptococcic vaccines may theoretically at least, be of real value in all cases of scarlatina complicated by streptococcic angina, ear infections and abscesses. In these latter a mixed staphylo-streptococcal sero-bacterin may be tried.

In all **septic cases,** and in cases threatened with uremia, the use subcutaneously and even intravenously of large amounts of sterile normal salt solution has been advised by Forcheimer, E. P. Carter and others. The object is to dilute the poison circulating and as a mechanical aid to diuresis and the elimination of toxins. It is possible that in the severe toxic cases much might be gained by such measures if adopted early.

In the vast majority of cases with slight sore throat, little fever, and only mild constitutional symptoms—(a) isolation; (b) rest in bed; (c) diet and nursing; (d) local care of the nasopharynx and skin—and the administration of an alkaline mixture as follows:

(e) ℞ Sodii Citratis, drm. iii.
Syrupi, fl. dr. iv.
Liq. Ammon. acetatis.
Liq. Potasii Citratis, aa q s 4 oz.
M. sig. i fl. dr. in sweetened water every two or three hours.

This constitutes all the treatment necessary.

Fever.—In reference to the use of antipyretic drugs, Osler has properly stated that "Medicinal antipyretics are not of much service in comparison with cold water." Osler, Henoch, Moizard, Steffen, Currie, von Jurgensen, Jacobi, Carter and many others have recommended cool tepid sponge-baths as the best means, the safest and most reliable method we have for reducing the temperature in scarlatina.

Bowels.—Mild saline laxatives or small fractional doses of calomel, followed by an evacuating enema.

Stimulation.—When the pulse is weak, soft and of low tension, digitan, or digipuratum or digalen or digifoline may be used. As soon as the first sound of the heart becomes weak, or the heart sounds lose their normal tone and any threatening change is noted in the pulse stimulation should and must be resorted to and insisted upon. **Brandy or whiskey** in suitable doses may be given cautiously. Strychnine 1/100 grain (0.00065 gramme) in small doses with or without iron may be given. Camphor 1/3 grains (0.064-0.2 gramme) hypodermically or caffein sodium-benzoate are of the greatest value in this condition. Sometimes, especially if the cardiac weakness is associated with marked restlessness, delirium and grave toxic symptoms, very small doses of morphine as recommended by Jacobi, seem efficient, together with bromides and hot baths. Musk, if obtainable, can be tried in doses of ½ to 3 grains (0.032-0.2 gramme).

All my cases receive alkaline enteroclysis. Bicarbonate of soda solution is given by rectum in all cases, together with alkaline drinks by mouth. Plenty of orange juice, lemonade and water, milk, buttermilk, ice cream, orange-albumin, kalak water, and Vichy, are allowed.

Other complications such as earache (otitis), lymphadenitis, severe anginal complications, arthritis, endocarditis, pericarditis, bronchitis, pneumonia, pleurisy, stomatitis, gastroenteritis, diarrhea and nephritis—all require attention and treatment as in any other infectious disease. It is unnecessary to go into details in the treatment of these complications in a paper of this kind. Diphtheria may be a complicating infection in scarlatina, and when it does occur, as shown by positive throat cultures of Klebs-Loeffler Bacilli, diphtheria antitoxin should be immediately injected and the heart stimulated.

I do not believe that either belladonna or arsenic have any protective powers against scarlatina. Illingworth suggested that biniodid of mercury would cut short an attack and cause the rash to disappear rapidly. Mehary believed salicin had some abortive power. Chlorate of potash should not be used in scarlatina. Very often I have found **warm tub baths** relieve nervousness and restlessness and to reduce the temperature one or two degrees very promptly. Sponging—continued for ten minutes—with warm water (90°F.), with or without alcohol, may be substituted for the bath. Water should be applied freely and if necessary cooler water (70°-80° F.) may be used. A good reaction should be obtained—the patient must not get blue or remain cold.

Moser reported excellent results from a **polyvalent antistreptococcic serum.** The serum may be used against the septic manifestations. Its early use may be of value in protecting patients against subsequent streptococcic infections and other serious complications.

L. Axenow used Moser's serum in 1,335 cases of severe scarlatina with 27.3% mortality. He gave 50 c.c. up to 100 c.c. daily. No child under one year should be injected. The serum should be given in a single large dose to get best results.

McCollom has recommended **insufflations of calomel,** instead of irrigations, for the nasopharynx. R. Koch reports excellent results in the treatment of scarlet fever with intravenous injection of 100 c.c. of serum taken from convalescents, that is, at about the third week of the disease. Among 280 patients with extremely severe scarlet fever only one died, and this was a child who was moribund when first seen, dying in an hour. Convalescent and normal serum act alike, but the former is more powerful. It requires 50 c.c. for very young children and 100 c.c. for older ones; it is better to mix the serums of several convalescents. It is most efficient during the early stages of the disease. Koch regards it as an almost absolutely certain weapon during the early stages of the disease if given intravenously and in sufficient doses.

A. Zingher, New York City, treated scarlatina with fresh blood from convalescent patients. He directly injected or first citrated by adding 1 c.c. 10% sodium citrate solution to 1 ounce of whole blood, making the final dilution of the citrate 0.33%. 4 ounces can easily be injected in a young child and 8 ounces into an older child. He reported treating 14 toxic cases in this way. The majority of the patients were very toxic and often delirious.

Gabritschewsky in 1905 introduced the use of streptococcic (cocci from cases of scarlatina) vaccine for preventive inoculation and was used quite extensively in Russia. R. M. Smith concludes that Gabritschewsky's vaccines do appear to have some influence in controlling epidemics of scarlatina and should be tried. Russian physicians used it extensively. Watters tried this preventive inoculation on 21 nurses who had not had scarlet fever previously. Reiss and Hertz used the mixed serum from several scarlatina cases (convalescent), injected it intravenously in large doses. They believe in its pre-eminent efficacy, and as actually life saving in many cases. 50 c.c. for children and 100 c.c. for adults. Injections must be commenced before the 4th or 5th day to be promptly effectual. Normal serum seemed entirely impotent. They took the serum from convalescents between the 18th and 24th days, after negative Wassermann and excluding tuberculosis and septic cases.

Meltzer and Auer and Morgenroth and Levy have shown that absorption from muscle is very much faster than it is from subcutaneous tissue. In fact, the rapidity of action of substances so injected approximates very closely that following an intravenous injection. 23 patients treated at Willard Parker Hospital with intramuscular injections of blood. Distinct beneficial results were noted in the very severe cases by Abraham Zingher. D. MacIntyre treated sep-

tic scarlet fever cases with autogenous streptococcic vaccine in the acute stage. All the patients recovered. John A. Kolmer does **not** think streptococcic immunization has any value as a prophylactic measure against scarlatina.

Epinepprin, in 10 to 20 drops at a dose by mouth, was used by Paoloantonio, in kidney cases of scarlatina, and in urgent cases with hematuria he gave it subcutaneously.

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THE DEVELOPMENT OF AN AMERICAN EVACUATION HOSPITAL, WITH A BRIEF OUTLINE OF THE INITIAL TREATMENT OF WAR WOUNDS.

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I have no doubt that by this time many of our friends are heartily weary of hearing any more about the war and war surgery, so I will make this paper rather brief, dwelling for a few moments on the development of what was destined to become that important branch of the medical department, "The Evacuation Hospital." These organizations were stationed from five to fifteen miles back of the actual front, and were to be the scene of the first definite surgical operations upon the wounded; also to act as a clearing house for all other cases. In brief, all cases sent back from the front, had to pass through an Evacuation Hospital on their trip to a base.

As many of you know, the theoretical Evacuation Hospital, according to the Manual of the Medical Department, was supposed to consist of a personnel of 16 medical officers and 179 enlisted men, and with the equipment of two Field Hospitals, namely accommodations for 432 patients. The development and growth of these small organizations into enormous Casualty Clearing Stations, with a personnel of over 500 officers, nurses and enlisted men, and capable of caring for as high as 1,500 cases in a single day, was a most interesting, and at the time, a strenuous process. It was my lot to be assigned to one of these units as Adjutant at the time of its organization, and although I made repeated and strenuous efforts to get out of that administrative

position, and into strictly professional lines, it was only by combining my duties that I succeeded in taking an active part in the professional work.

A number of these organizations, with the original skeleton personnel and no equipment, were sent abroad early in 1918, and by devious means procured such material as the Medical Department of the A. E. F. could supply. There was considerable discussion as to what this equipment should consist of, and as a result each organization acquired what the Commanding Officers and his advisors thought they needed, or what was most readily obtainable. There was no standard equipment, although some progress was made in that direction before the Armistice.

None of our officers had had any previous experience in work of this kind, and it was a great privilege to be permitted to go visiting, for a week or two, on trips of observation to one of the actively functionating American Evacuation Hospitals at Sebastapol, near Toul. This organization was most attractively quartered, and doing very excellent work on a small scale. It being a comparatively quiet rector, many cases could be retained for definitive treatment.

It is a well-known fact that practically all of the Evacuation Hospitals fell down to a greater or lesser degree at their first attempt to functionate, and the organization to which I was attached was no exception to this rule. When it is considered that in order to properly operate, aside from being a hospital, you must be a complete city in yourselves, entirely independent of all outside aid, except supplies, and must have the most perfect co-ordination in every department, it is not to be wondered that some parts of the machinery would be found faulty. Our general lack of actual experience, also precluded that perfect coordination that is so essential to the proper functioning of one of these units. But little opportunity was afforded for getting set during our quick moves, and at the first stop we were compelled to admit several hundred patients before we were entirely prepared. An Evacuation Hospital must be so equipped that it can be set up in a field with no buildings, around a chateau, or in barracks if available.

Perhaps our most precarious position was just outside of Chateau Thierry, after it had been reclaimed. Here a defensive operation by the Allies had been suddenly turned into a glorious offense, and we were thrown in, and operated the only American hospital in the area for several days. During the day, our adversaries shelled the neighboring bridges and our nights were made interesting by their frequent presence above us, necessitating the shutting down of our small electric plant, which furnished our admitting and operating tents with light, and the continuance of treatment by means of tiny candles. A large Besseaneau tent, with a dozen patients under ether, and with doctors, nurses and orderlies, helmet clad, in the dim light, was a picture that would bear production. Due to the large amount of work and insufficient teams, we had great difficulty in keeping ahead of the gas infection cases at this stop. Unless a hospital has a very large operative area, and a large number of surgical teams, it is a mistake to attempt to accept only severe surgical cases during a rush. When permitted to take all classes of cases, a limited number of surgical teams, say 12 or 15, can keep up the work very satisfactorily in a 500-bed hospital, but let that same hospital try to take only the seriously wounded, each case requiring about 40 minutes, and appreciating the fact that a team cannot with justice to itself or the patients, work more than 12 hours a day, it is obvious that to admit only surgical cases, you have over 30 surgical teams each with a personnel of from 5 to 7 members, and a very large operating area. The most efficient surgical team, as finally worked out consisted of an operator, an assistant, an anaesthetist, 2 nurses and 2 orderlies. Each team should have two tables assigned to it, so that there will be no delay between cases. When possible the gowns and gloves were changed between operations; otherwise they were changed only after a dirty case. At all times, however, the hands and gloves were cleansed and washed in an antiseptic solution.

The above facts regarding personnel were recognized after actual experience, and as the experience, confidence, and speed of the teams increased, we were able to handle as high as 1,504 mixed cases in a single day, at Souilly, although our bed capacity was only 1,200. Of course our capacity was always limited by our ability to get patients evacuated

back to the bases, and at times all sorts of conveyances were used, including canal boats. This boat transportation was of particular value in the fracture cases.

One surgical team at Souilly under Dr. George Davis of Chicago performed over 100 operations under ether, in a single night. This, I believe, was a record and was made possible by giving this team four tables and an especially efficient anaesthetist, who used the Rausch method. The patient was strapped to the table, and the closed cone loaded with ether was applied, with instructions to breathe deeply. While under primary anaesthesia, the operation was begun, and sometimes completed while the patient was still struggling. On questioning the patient later, he had no recollection of pain when the incisions were made. This method, however, was not adopted as a routine by the other teams. A quarter grain of morphine by hypo, preceeding ether anaesthesia, was generally conceded to be the best method.

Some excellent surgeons at home proved to be entirely too slow for this type of work. Many interesting incidents developed when it was decided to pool all instruments, and adopt a standard set for the various types of cases, i. e.: heads, chests, abdomens, extremities, etc. A number of men were very reluctant about turning in the sets in their possession, but other teams were sent to us without any, so on the whole it was a wise move; it speeded up the work and standardized the technique. Individuality and originality had no place in the rushes, and the more nearly we could get the teams to adhere to a standard technique and standard procedure in the more common operations, the greatest amount of satisfactory surgical work was accomplished.

In requisitioning supplies or quarters from the French, they were always most courteous, but very exact in the final accounting, as we found out when we tried to return a hospital which we had occupied for a few months. They also tried to make us speak their language, even though they spoke some English. At one time I was called upon to interview a French officer regarding some additional cots we needed in anticipation of a big offensive. After laboriously struggling along, and presenting the case in my few words of French, to which he paid very respectful attention, he hesitated a moment and replied, "Perhaps if the Officer will state his mission in English, I shall be the better able to understand him."

Much has been said about the discomforts of traveling with an organization in France, but I want to state, from an experience of eight days in one, that there are few more comfortable conveyances than a box car, properly fitted out from hospital equipment, meaning tables, chairs, cots, mattresses, oil stoves, lanterns, screens, G. I. cans, etc.

In concluding this little historical sketch of the development of an Evacuation Hospital, I should say that an ideal organization of this type should consist of sufficient tentage for the field, operating equipment for 12 tables, and 1,000 beds, divided as follows: 100 for shock and preoperative cases, 200 for hospitalization of patients who are in shock or who have been operated but are not fit to travel, and 700 evacuable beds for patients already treated, who are ready to be evacuated, and who can stand the trip. The personnel should consist of about 80 medical officers, 80 nurses and 400 enlisted men, including those on surgical teams. It should have the following departments, each carefully organized and equipped, and under competent officers: Receiving, Triage, Bathing and preparation, X-ray, Preoperative area, Shock, Operating area, Hospitalization wards, Evacuable wards and Laboratory.

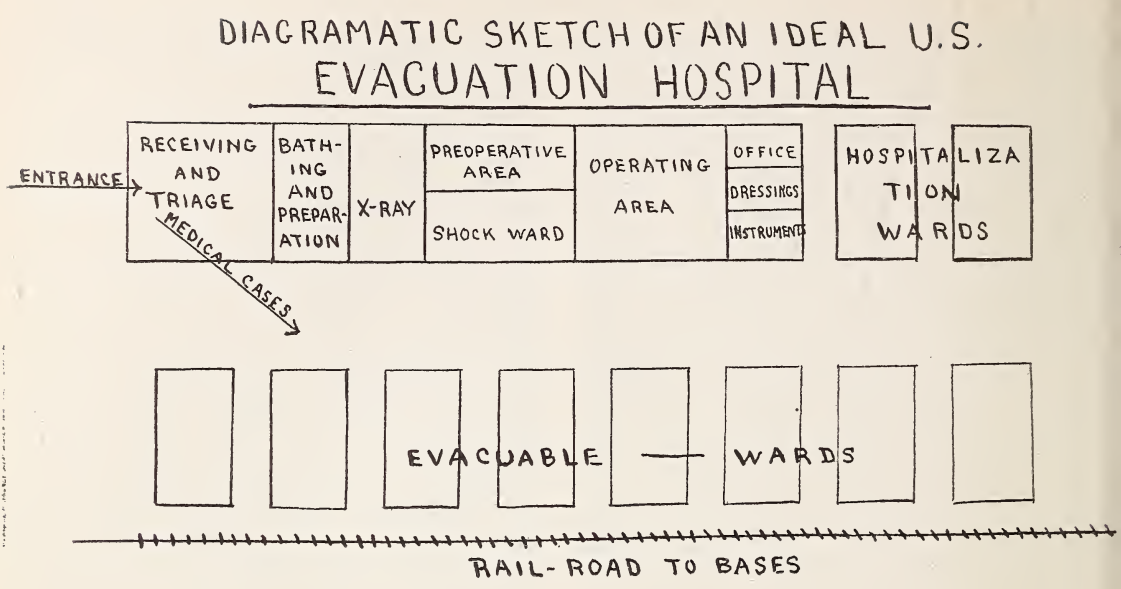
See Diagram on next page.

An ideal condition, in rushes, is where two such organizations are detailed to one station or rail head, receiving patients on alternate days. Thus one gets a chance to get cleaned up and the major portion of its patients evacuated, while the other is actively receiving and operating. Most patients can be evacuated within a few hours, the following exceptions to this rule being made—gas gangrene, head cases, thigh fractures, abdominal cases, amputations, shock cases, and cases with pulmonary complications.

Treatment of the Wounded.

Regarding the actual treatment of cases, which I think will interest the surgeons more than the above, there is much more to say than time and space will permit, and many are perhaps more qualified than I to present the subject.

It was my privilege to meet, observe and consult with many of our most prominent men abroad, and I wish to express



my gratitude for assistance in the preparation of this particular portion of this paper to Dr. George D. Rice of Minnesota. Frequent conferences were held after and between the various engagements, where the surgeons would exchange views, and endeavor to standardize the treatment of the more common wounds. The following remarks are based on the concensus of opinion of the majority of the men who have done war surgery.

Dependent upon the character of the fighting and position of the armies, the character of the missles producing wounds would vary. At Chateau Thierry there were mostly machine gun bullet wounds, the enemy not having time to set up his artillery for effective use during his retreat. Where they resisted hard along the Meuse, wounds by high explosive shell fragments predominated. Regiments in reserve or support suffered mostly from shelling, while those at the actual front suffered mostly from bullets. Men would much prefer to be in the front line and active than to remain in reserve, in the cover of a forest, and be shelled.

We did not see a great number of inhalation gas cases, there being triaged or sorted out, and diverted to special hospitals equipped and manned for this sort of cases. The shell shock cases were evacuated very rapidly, many of them appearing to me to be a combination of exhaustion, lack of sleep and proper food, and not true shell shock. After a couple of good meals and a rest, they were as trim as ever. I shall never forget a lieutenant of infantry who arrived at our station crying, trembling, and scarcely able to speak. He was not wounded, and was greatly chagrined at having been sent back. He told of how on that day, on three separate occasions, shells had bursted alongside of him, behind him and directly in front of him, killing or wounding everyone in the immediate vicinity, but leaving him unscratched.

Every wound was x-rayed, with some surprising results, but almost always with an exact localization and estimation of the size of the foreign body. The size of the wound of entrance was sometimes at great variance with the size of the missle. Dr. Angel of our hospital considered the near point method the most rapid. He informs me that he localized 26 foreign bodies in a single case. Two machines were used, one for ambulatory and one for litler cases, our record being 720 cases x-rayed, some with multiple wounds, in a single day.

The debredmont was one of the greatest surgical developments of the war, and was the basis of all war surgery. It was performed to prevent the almost sure development of infection, due to the laceration of tissue by the irregular shell fragments, the infection being carried in from the clothing or skin, which was contaminated by the richly cultivated soil over which the fighting took place. For the benefit of those who are not familiar with the procedure, I will say that it con-

sisted of the excision of the wounds, and the removal of devitalized tissue in the tract of the missle down to the foreign body. An ideal debredmont consisted in removing en bloc a funnel of the wound, avoiding large blood vessels, tendons and nerves and then leaving it open, to be closed at a future date when the danger of infection had passed. Frequently during the debredmont, the tract would be lost, and it would be necessary to manipulate the part, or move the limb to recover it again. It was of utmost importance to carefully examine the bed of the foreign body, as particles of clothing are frequently carried in and are only recognized by careful search. All bleeding must be controlled by catgut ligatures or sutures. Catgut is used exclusively because of its resistance to destruction by Dakin's solution. In deep wounds and compound fractures, Carrel-Dakin tubes were inserted at this primary operation, but no injections were made for 12 hours. Early injections were said to be painful and increase the danger of hemorrhage, but this theory has since been disproved, and the solution should be used at once.

This debredmont was practised on all wounds caused by shell fragments. Through and through bullet wounds were not operated upon, unless they involved important structures, or showed symptoms of infection. After debredmont hemorrhage was controlled, tubes placed in deep wounds and gauze laid over shallow wounds, but not packed in. Some advocated rubber tissue or vaseline gauze laid alongside of, and down into the wound, but our informants from the bases seemed to prefer to have cases, where no tubes were inserted, sent down with only the superficial gauze dressing, which was easily removed, the wound cleansed and Carrel-Dakin tubes inserted if necessary. It must be borne in mind, that following this first operative procedure, most patients were quickly evacuated to a base, and it was sometimes two or three days before they were again attended by a surgeon, except in a real emergency, as secondary hemorrhage or high fever.

Gas gangrene was found in some cases that arrived late, and occasionally occurs in cases that have been apparently carefully debrided. There is a distinct rotten odor to these cases, that has been described as a cross between ancient eggs and fresh manure, with a brown fluid secretion. The muscle in these cases looks cooked and does not bleed or contract in cutting. My own feeling is that a high amputation in a well-developed gas case combined with gas antitoxin gives the greater number of recoveries; local removal of portions or groups of muscles, being generally followed by the prompt reappearance of the lesion higher up. We understood that a mixture of antitetanic and gas serum was being prepared for our use, but did not receive any. Tetanus antitoxin was administered at his first dressing and it was rare to see a severe case of tetanus in our area. A serum was supplied for the prevention and treatment of gas infection and was used with considerable success in conjunction with radical surgery. It should be given with tetanus antitoxin as a prophylactic in all compound fractures and late cases.

Muscle wounds of the back, loins, buttocks, thigh and calf were most prone to gas bacillus infection. We made it a rule, at one time, that with a compound fracture of the leg involving the posterior tibial artery, amputation should be performed at once, as this combination was most prone to gas infection. Some even went so far as to say that every leg should be amputated if the artery alone had been damaged by a shell fragment.

Primary suture, meaning the debredmont of the wound followed by suture, was promptly discarded as applicable only to the cases seen very early and which could be retained and kept under constant observation until healed. I saw a number of these cases that were done at a hospital in a quiet sector, and in only about half of these selected cases had a satisfactory result been obtained, although some have reported more favorable results. This method might be well applied to some industrial accident cases in civil practice. As our average case was not received inside of 12 hours and had to be promptly evacuated, this method was not used.

Regarding fractures, the Thomas splint or some modifications thereof was another great development of the war, its use being principally to secure reduction and fixation for transportation, and more or less permanent use during the course of treatment of a compound fracture. It is essential that the foot be kept at right angles, and that the pressure of the ring of the splint should be at the tuberosity

of the ischium. To avoid irritation in the groin, soap was applied to the ring. After debredmont, and the removal of loose pieces of bone and attention to hemostasis, Carrel-Dakin tubes were inserted at once. Gas serum was given to all of these cases when available. In fractures involving joints, excisions were performed in the shoulder and elbow for severe comminution. In knee joint injuries, a typical debredmont was performed with removal of the foreign body and careful examination of its bed, and then closure of the joint cavity. I will state here that heads, chests, abdomens in most cases, wounds of the sexual organs and joints were closed at the primary operation, the skin wounds being sutured in some and not in others, depending upon the time at which the case was attended, and the condition of the parts. Before closing a joint, ether was poured in, but the virtue of this procedure seemed to be questioned. At any rate it did no harm, and when we could spare it, we used it freely. Joints were not fixed after operations unless long transportation over rough roads was necessary. Joints so treated, of course, must be carefully watched and aspirated at the first sign of disturbance, considerable early temperature alone, however, was not a sign for opening a joint.

The maxilo-facial cases were fairly numerous, and were always treated in co-operation with the dental surgeon. An intra-dental splint was usually applied, so that the alignment of the teeth was preserved. In case of loss of bone substance, a moulded piece of dental compound was placed to fill the gap, and the soft parts were drawn over to cover the defect, undercutting the skin if necessary to accomplish this task. Our maxilo-facial colleagues made a great point of removing all loose teeth at or near a point of fracture, and of providing for sufficient inferior drainage.

The head cases, with brain injury, that reached us were mostly all operated upon under local anaesthesia preceded by ⅓-½ grain morphin. Fragments of bone or foreign bodies were removed, if possible, through the wound, the wound in the brain carefully sponged, and gently irrigated, hemorrhage controlled, and an attempt made to close the dura and part of the superficial structures. A catheter and syringe were used when Cushing's brain irrigator was not at hand, and the area was grently irrigated with saline followed by a sucking out of the excessive fluid. As a rule these cases did very well during the brief period in which we had them under observation, but later reports from the bases showed that most of them developed abscess or encephalitis. When possible these cases were not evacuated for one week.

Where evidence of nerve or spinal cord injury existed, the part was exposed and examined. Nerves were repaired after freshening the ends. Neglect to do this is a frequent cause of failure, as the ends are devitalized following gunshot injury. I have seen some cases with an evidence of spinal or nerve injury, show at operation no lesion, the symptoms being probably due to the severe contusion caused by the missile passing through neighboring tissues.

Abdominal wounds, if seen in the first eight or ten hours, were treated by laporatomy, with attention to the damaged organs, practically the same as has always been done in civil surgery. These on the whole were a very unsatisfactory class of cases to treat, as a rule not being received sufficiently early for proper treatment. If not operated upon in the first few hours the chances of recovery were better without operation.

Wounds of the chest, when large and sucking, were closed, the immediate relief to the patient and improvements of his shock being remarkable. I have seen men absolutely exhausted, and who looked as if they were gasping their last breath, obtain great relief, and go to sleep following the introduction of a few silk-worm gut sutures to close the wound. Of course if they later developed abscess or empyema this could then receive appropriate treatment.

Bladder wounds, if accessible, were repaired at once. Most extra-peritoneal wounds however, at the base of the bladder, are inaccessible and must be left to heal spontaneously, after proper urinary drainage. Catheterization of the bladder for retention of urine was not performed, because the danger of infection, sooner or later, is far greater than the danger of damage to the kidneys from a temporary retention. There is practically no danger of bladder rupture, and all cases where no obstruction exists, sooner or later will void, and the residual urine gradually becomes less. Such cases, suffering from retention, and all wounds of

the urinary tract, should receive hexamethylenamine and acid sodium phosphate. The catheter was, however, used for diagnostic purposes in wounds of the rectum, pelvis, buttocks, thighs or hips.

I will just add a few words regarding shock, whether preoperative or postoperative. An area was designated and men especially trained in the work looked after all of these cases. They had apparatus for warming the patients, hot enemas, drinks, stimulants, and intravenous preparations of saline and gum solution ready. Occasionally whole blood was transfused by the citrate method. Here the blood of recipient and donor was each tested on a slide using Nos. 2 and 3 stock serums, the specimens being very quickly classified microscopically. Gum solution on the whole was satisfactory. In waiting for a preoperative case to react against shock, we were, of course, increasing his danger of developing gas infection. Attempts were made to get his blood pressure up to 90 before operating. An operation on a man with a pressure under 70 is almost always fatal.

The paper work incident to one of these organizations was appalling, and shortly before the armistice all of the specialties insisted upon a lengthy chart being made out for each case in their line, neurological, orthopedic, maxillo-facial, etc. The impracticability of this in a rush is obvious..

In conclusion I would like to comment upon the fidelity and quick adaptability shown by medical officers, nurses and enlisted men to this new work of war surgery, and to meeting and overcoming the various trying conditions under which they sometimes had to work. The only kicking I heard was in times of inactivity; when a push was on everyone pulled together, and I think that same spirit was manifest in the other departments of the A. E. F. and resulted in the spectacular advances and final triumph of our cause.

The People a League of Health.—There are public health laws galore, but these form only the machinery which sets in motion the regulations under which the public health is controlled. And, yet, machinery, however much it can accomplish, is still a soulless thing; that is the defect of the machinery of the public health laws. It is powerless to influence the personal voluntary assistance of those who benefit from it.—Medical Press and Circular.

PRACTICAL METHODS OF INFANT FEEDING.

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Any so-called simplified method of infant feeding must be practical as well as simple. In other words, there must be no sacrifice in the results that are obtained in order to gain simplicity; and a lack of knowledge or skill is no sufficient excuse for the avoidance of any difficulties, provided they can be shown in the long run to be of benefit to the patient.

In the feeding of infants there is no system or lack of system that is universally successful. To a degree each child is a law unto itself as regards not only the kind but the amount of nourishment that it will assimilate. This individual variation is of importance. Furthermore no method of infant feeding can do away with a thorough understanding of the fundamental problems of infant feeding and their skillful application. These are matters of personal equation which must be considered in our judgment of every feeding case.

The time to begin infant feeding is the day and hour of birth. The first three weeks of life are most important not only from the standpoint of the formation of correct habits, but also in the establishment of a proper food tolerance. It is a strange fact that a well baby will seemingly thrive on almost any food for a few days. Under such circumstances digestive disturbances sufficient to attract attention do not commonly appear until two or three weeks have elapsed, even though the food formula is obviously unsuitable. When the difficulty in feeding is once established its rectification is frequently out of all proportion to the cause of the upset.

The simplest type of infant feeding is maternal feeding. An insufficient number of mothers are nursing their babies at the breast. The attentive physician knows that our women do not suffer from organic degeneration of the mammary gland, and it is probable that there is no such thing as absolute absence of milk secretion.

By what means can breast feedings be

increased? It has to be confessed that breast feedings often do not succeed because of the mother herself. The importance of maternal feeding in the life and growth of her baby should be emphasized. The nursing must be made as little of a burden to the mother as possible. It is rarely necessary to have an interval between feedings of less than three hours and more often a four-hour interval is best employed. The child should not be allowed to remain on the breast longer than 15 or 20 minutes. Long intervals and short nursings will often change an unsuccessful burdensome lactation into a real pleasure. Night feedings, so far as possible, are to be avoided; and it will frequently be found that what appears to be a necessity is nothing more than a habit, which disappears with two or three nights' training. Not infrequently breast nursings have failed because the mother's appetite rebelled against a diet made up almost exclusively of gruels, cocoa and various fluids. As a matter of fact, a nursing mother can eat what is proper for any woman, with an increase in food value and a reasonable addition of fluids to cover the loss through the milk. A fundamental requirement for the continuation and the stimulation of the milk flow is the regular and complete evacuation of the breast. If the mother's own baby is too weak to empty the breast it may be assisted by artificial evacuation or by the use of another and stronger infant. According to Sedgwick the expression of the milk from the breast is to be accomplished by a stripping motion which starts from 1 to 2 cm. back of the colored areola and is carried forward toward the nipples. No massage of the breast is allowed. The reason for emptying the breast in this manner is found in the fact that the ducts which contain the milk extend but a short distance back of the areola.

It is probably a rare thing for breast milk not to agree with the baby. In most instances where there is no gain in weight the real difficulty is that there is not enough milk, and such cases should be treated by the use of complemental feedings, regulation of the hours and duration of the nursing, and most important of all repeated complete evacuation of the breasts patiently persisted in.

The weaning from the breast should be begun in the last quarter of the first year and be carried out gradually. A breast feeding is supplanted by an artificial feeding, and when the breasts have adjusted themselves a second nursing is dropped. This is continued until all the breast feedings have been given up, which should require an interval of from three to four weeks.

Artificial feeding is rarely if ever desirable, though it is for many reasons often a necessity. The requirements of a balanced food are simple. The food elements are made up of fats, carbohydrates (sugars), protein and salts. In addition to these food elements a baby, in order to thrive and gain weight, must have a sufficient amount of food. The food values are not measured in terms of ounces or pints but in terms of heat units or calories. A sufficient number of calories does not nessarily indicate a suitable food for any baby, or if suitable for one baby it may not be for another. Fit the food to the digestive capacity of the individual baby.

The simplest artificial feeding for infants is based upon dilutions of whole or skimmed cow's milk with the addition of some form of sugar. As breast milk contains from 2-4 per cent. of fat, 6-7 per cent. of sugar and 1-2 per cent. of proteid, it would appear that artificial foods which contained the same food elements in the same relative proportions would be a perfect food. As a matter of fact, an artificial food made by various methods of diluting cow's milk so that it approximates these percentages is not easily digested. While babies thrive throughout the nursing period on human milk of uniform strength, they cannot ordinarily take an artificial food as strong as this during the early weeks and months and need a stronger food during the latter months. Simple milk sugar and water mixtures are easily prepared and easiest of digestion. It is possible to fulfil the caloric requirements by consulting the table below:

	Fat	Sugar	Proteid
Whole cow's milk contains	3 -4 %	4 %	3 %
One part cow's milk and two parts water contains	1 -1.3%	1.3%	1 %
Equal parts cow's milk and water contains	1.5-2 %	2 %	1.5%
Two parts cow's milk and one part water contains	2 -2.6%	2.6%	2 %
Skimmed cow's milk contains	1 %	4 plus %	3 plus %

It is evident that these mixtures are deficient in their fat and sugar content as compared with breast milk.

One or two per cent. of fat in cow's milk is digested with ease by the average infant, while larger amounts are frequently the cause of digestive disturbances. This is due to the fact that cow's milk contains a relatively large amount of volatile fatty acids as compared with human milk. The fat that is assimilated in infant's food is principally in the form of neutral fats. It is for this reason that it is rarely wise to increase the fats in artificial feedings much higher than 2 per cent., at least during the early months of infancy. An intolerance for fat is easily established in a week or ten days; and manifests itself by regurgitation, loss of appetite, irritability and restlessness, a stationary weight curve, and a diarrhea which alternates with constipation. The correction of a fat intolerance is rapidly accomplished by a withdrawal for a few days of most of the fat.

The fats save nitrogenous waste, supply heat and energy and add to the body weight by storing up fat. To a certain extent the deficiency in fats may be made up by additions of sugars to the food. It should never be forgotten that one gram of fat has a heat value of 9.3 calories as compared with 4.1 calories for a similar amount of carbohydrate or of the proteids. Milk mixtures are always deficient in the amount of sugar that they contain. This deficiency may be made up by the addition of cane sugar, milk sugar or one of the many malt sugars. Milk sugar has not proven as satisfactory in our experience as either cane sugar or members of the malt sugar group. It is to be remembered that approximately

2 scant tablespoonfuls of malt soup extract equals I ounce by weight.
2 level tablespoonfuls of cane sugar equals I ounce by weight.
3 level tablespoonfuls of milk sugar equals I ounce by weight.
4 level tablespoonfuls of dextri-maltose sugar equals I ounce by weight.
4 level tablespoonfuls of flour equals I ounce by weight.

Cane sugar is used for older children that have no gastro-intestinal disturbance and malt sugars for infants that have had much intestinal trouble. By the use of one or the other of these sugars the percentage is gradually increased to 6 or 7 per cent., the same as in breast milk.

The sugars are perhaps the most frequent source of indigestion in infancy. All foods should be started with a low sugar content and the sugar is slowly but constantly increased until the desired amount is obtained. If there is vomiting, diarrhea or loss of appetite, no sugar is added to the food mixture until these conditions are corrected. An intolerance for sugar differs from that for fats in that it is corrected with difficulty. Such an intolerance manifests itself by an acid diarrhea, a temperature of 99 to 102 F. and a loss in weight. The infant may appear to be only moderately sick and there is usually no vomiting. Indigestion, whether due to sugars or fat, lowers the infant's tolerance for any food. Feeding weak dilutions of milk without sugar gives the gastro-intestinal tract a chance to recuperate from the fat and sugar indigestion and thus raises the tolerance so that the milk can be gradually made stronger, increased in quantity and later the sugars added cautiously.

The proteids of cow's milk are not often the direct cause of indigestion in infants. Even the curds are not so indigestible as was formerly supposed; and are much more often derived, as they are seen in the stools, from the fats than from the proteid content of the milk. This conception of the relative digestibility of the proteids has resulted in an elimination of the complicated food formulas whose aim was to split the proteids either physically or chemically. Whey, cream and sugar mixtures, the peptonization of the milk, and the addition of lime water, of gruels and of strong alkali have, at least in our own practice, been discarded. If it appears wise to break up the curds and make the proteid more digestible this is easily accomplished by boiling the milk. Boiling the milk has the added advantage for certain cases that it tends to cause constipation, which is usually overcome as sugar is added to the food. As a matter of fact it is usually wise to boil the milk when artificial feeding is being started and during the time immediately following a digestive disturbance. The boiled milk is continued for a varying length of time, the change to raw milk being accomplished by a temporary decrease in all the elements of the food and especially of the sugars. If the milk is boiled for any great length of time it

should be accompanied by regular feedings of orange juice.

What milk mixture may be used to start a baby on artificial feeding? It will be remembered that an intolerance for the fats and the sugars is rarely an immediate result of an unsuitable feeding. At first there will be no attempt made to meet the food requirements, the aim being to start with a food that the infant can surely digest. With an increase in tolerance for the new food it is gradually increased not only in amount but also in strength. One ounce of food that is easily digested and assimilated is better than five ounces that is disposed of with difficulty. At the same time it is wise to approximate as rapidly as possible the normal digestive capacity, as a gastro-intestinal tract that habitually functions below the normal level never does attain to its full digestive capacity. Simple dilutions of whole milk are used, being started at a point which cannot cause digestive disturbances. An increase in the amount of milk is made from day to day. When the milk has been increased to approximately the desired quantity a small amount of sugar is added. The sugar is increased by small amounts until the mixture contains 6 or 7 per cent. of sugar. The type of sugar that is preferred is one of the malt sugars of the general character of dextri-maltose or in older children cane sugar may be used. If there is vomiting or diarrhea, skimmed milk is used in place of the whole milk. In a return to milk mixtures following a period of starvation and cereal diet, one-third whole milk and two-thirds water is generally used. If the feeding is being started for the first time, or if the infant is just recovering from a gastro-intestinal upset, the milk mixture is boiled.

How shall the amount of food that an infant requires be determined? This is easily accomplished by a knowledge of the caloric value of the food used in making up the milk mixtures. In the mixed diet of adults it is often a complicated matter to reckon the number of calories taken in 24 hours, for the food is varied and the amount is often hard to measure. In infants it is a simple matter to figure the caloric value of the food, which is limited to milk, sugar and possibly one of the cereal flours. Practically there are only five figures to remember: One ounce of whole milk equals 20 calories; one ounce of skimmed milk equal 14 calories; one ounce of sugar equals 120 calories one ounce of flour equals 100 calories one ounce of malt soup extract equals 90 calories. It is thus seen that the caloric value of a simple milk and sugar mixture is easily determined.

The caloric requirements of an individual is to a certain extent based upon the body surface. A fat infant, having less surface in proportion to its weight, will radiate less heat from the surface of the body than the emaciated infant. The result is that the poorly nourished baby needs in proportion to its weight a food of higher caloric value than does a well-nourished infant. The caloric requirements of a bottle-fed infant are as follows: (1) The average infant under four months of age and any infant that is moderately thin requires from 50 to 55 calories per pound; (2) Emaciated infants of any age require from 60 to 65 calories per pound; (3) the average fat infant over four months of age requires from 40 to 45 calories per pound.

It is theoretically possible, having these figures in mind, to determine the amount of food that is necessary to give an infant in order to get a gain in weight. Such determinations will also be of assistance in arriving at a determination as to whether or not a baby is being overfed or underfed. After all, the secret of successful infant feeding is in having a clear conception of first what constitutes the immediate difficulty, and second of what is the objective. The first is a matter of diagnosis in which a knowledge of a few of the fundamental caloric food values is a prime necessity. The second is essentially a problem of caloric requirements and the satisfying of these requirements. Such determinations are the measuring stick by which is determined not only the amount of food required to make an infant thrive, but also to determine the actual value of the food that the baby is receiving. For instance, a thin baby weighing 10 pounds is receiving in the 24 hours 15 ounces of whole milk and one-half ounce of milk sugar. Such a baby would require 50 calories per pound or a total of 500 calories. As a matter of fact the whole milk yields 300 calories (15 ounces of milk times 20 calories) and the milk sugar 60 calories for a total of 360 calories. This is 140 calories less than the requirements of the infant and a loss in weight should be looked for.

It must be remembered that we do not feed a baby calories any more than we feed them ounces or pints. A sufficient number of calories does not necessarily indicate a suitable food, or if suitable for one baby it may not be for another. In other words, it is necessary to fit the food to the digestive capacity of the individual baby. It thus comes about that the infant that has had little or no sugar in its food or has been getting no milk or small quantities of milk, will have these ingredients of the food gradually increased. There will be no effort made to supply the caloric needs of an infant that has diarrhea, vomiting or loss of appetite, for the food that will supply its needs will increase these symptoms. When these symptoms have been successfully treated the food may be increased.

The number of feedings in the 24 hours will be based upon a three or four-hour period. My own practice is to use a three-hour period up to the fourth or fifth month and after that time a four-hour feeding. The total number of feedings in the 24 hours with this division will be at first seven feedings, which will drop to six feedings when the night bottle is eliminated and will finally, at about the fifth month, be down to five feedings.

The quantity which is given at each feeding is dependent upon the size and age of the infant. A small, undersized feeble child may not be able to take more than an ounce for each month of its age. It is never necessary to have more than 8 ounces in a feeding (48 ounces in 24 hours). During the first weeks of life the quantity is small and is increased as rapidly as possible up to 3 or 4 ounces to each feeding. The baby's appetite and the absence of any untoward symptoms will be a general guide as to the rapidity with which the quantity in each feeding may be increased. In most instances it will be found that an infant can take from one to two ounces more than the number of months of its age. It is good practice not to pass beyond equal quantities of milk and water much before the fourth month; and to keep below one ounce of sugar until the infant has passed a weight of ten pounds. It is rarely necessary to increase the sugar at any time beyond one and a half ounces, and two ounces should be considered as the maximum.

A certain number of infants have a very narrow limit between their digestive capacity and the amount of food they need to make a gain in weight. This is most apt to occur in infants who have previously had many attacks or one prolonged attack of diarrhea. It is in this type of case that malt soup extract will often succeed. A set formula is not to be used. Begin with one level tablespoonful of flour and one scant tablespoonful of malt soup. If the baby is small the milk should be in the proportion of one part milk and two parts water; and in older children should be in the proportion of half milk and half water. The malt soup extract and flour are gradually increased in quantity, a tablespoonful at a time, as the infant needs more food and its tolerance increases. The dried milks are often very useful in difficult feeding cases. They have a number of advantages over the ordinary condensed milk, and have in my own practice largely displaced the use of the malt soup extracts. An analysis of the "Honor Brand" dried milk shows the following composition: Fat, 12%; milk sugar, 44%; salts, 7%; moisture, 3%, and proteid 34%. A level tablespoonful has a value of 16 calories. The food is made up at each feeding, the powder being simply added to boiling water. The amount of dried milk that is used in the 24 hours is determined by the caloric requirements of the child. Beginning with a small amount of the food, the quantity is rapidly increased to the desired amount. This is the simplest of all methods of infant feeding and it must be confessed is often successful. It does not displace ordinary milk mixtures, for babies brought up on dried milk mixtures appear to be less resistant to disease. In a general way the objections to the use of dried milk are similar to those for condensed milk. The dried milk is superior to condensed milk, in fact that it is easier to prepare, is more portable and has better keeping qualities. It is invaluable for making up the food for infants that are traveling and in districts in which the milk supply is not a safe one. The time may come when the dried milks will displace the ordinary milks in the large centers of population, for when they are properly produced they have the flavor of fresh milk.

During the sixth or seventh months, if the infant is healthy and of normal weight, cereal feeding is cautiously started. The cereals that are used are

cream of wheat, farina or vitos. They are cooked over the direct flame for ten minutes and then for two hours in a double boiler. At the start a part of a teaspoonful is given and this amount is gradually increased to two or three tablespoonsful twice a day. The cereal is given before the nursings. No milk is used in making up the cereal, and it should have a consistency which will allow it to barely pour. A month after the cereals have been started (the seventh or eighth month), vegetables are added to the diet. Carrots or spinach are cooked until they are tender and put through a sieve. The vegetables are given once a day, beginning with a teaspoonful and are increased gradually until two tablespoonsful are given. The cereal is given in the morning and in the evening and the vegetable in the middle of the day. Sometime during the ninth or tenth month chicken or beef broth, from which the fat has been carefully skimmed, are added to the diet. Baked potato is cautiously added to the diet during these months. By the end of the year the infant is getting many other vegetables, such as string beans, asparagus, peas and cauliflower; and the cereals have been increased to include oatmeal, Pettijohn's and rice. Orange juice frequently is a part of the diet even as early as the fifth or sixth month, especially if the infant is on boiled milk mixtures. A small amount of baked apple or stewed prunes may be allowed about the tenth month, and by the end of the first year cooked peaches, pears and plums are a regular part of the dietary. Eggs must be given with a good deal of care, as they sometimes cause hives and other skin troubles.

It is hardly necessary to state that the milk which forms the basis of artificial infant food must be clean and of the best obtainable quality. The standards in these respects cannot be too high. This applies to milk in all its forms. Boiling the milk does not rectify a spoiled milk. Condensed and dried milks should be made from milk that has a high standard of purity. Milk used in making up milk mixtures should be obtained from a herd, rather than from a single animal, as such milk is less liable to fluctuation in its individual food elements. Certified milk should be used if it can be obtained. Failing such a milk supply, pasteurization may be resorted to, though it must be remembered that such a treatment of the milk does not necessarily render an unsafe milk safe.

The common errors in the artificial feeding of infants are: (1), Underfeeding; (2), overfeeding; (3) indigestion from fats (generally too high fats); (4), indigestion from sugars (generally too high sugars); (5), an attempt to force feeding after an intolerance (generally due to the fats and sugars) to the food has been established.

These errors result in: (1), Loss of appetite, which is frequently the result of overfeeding, inanition or a limited digestive capacity; (2), vomiting that is due to too high fats or too high proteids or to errors in the administration of the food; (3) constipation which is most often the consequence of too high fats, too high or too little sugar and to a food that contains too little residue; (4), diarrhea that is due to overfeeding, to fermentation and to intestinal indigestion resulting from an inability to properly digest the fats, the carbohydrates or the proteids; (5) a lowered tolerance for food, usually the result of overfeeding of one or more of the food elements, long continued underfeeding or recurrent diarrhea. If the difficulty is properly analyzed at its inception, the remedy is usually obvious, and the cure is prompt if the proper measures are courageously instituted. (Difficulties of feeding due to specific infections of all kinds in whatever location or due to organic lesions are not under consideration).

Summary: Simple mixtures of whole milk or skimmed milk are used. The food is started well within the limits of food tolerance and below the food requirements of the infant. In a new-born infant this may be two to four ounces of whole milk in the twenty-four hours. Babies under four months of age will be started on one-third milk and two-thirds water, e. i., eight to fourteen ounces in the twenty-four hours; and infants older than this will receive half and half milk and water.

The sugar will be added to the food only after the desired amount has been nearly or wholly reached. The desired amount of milk is that quantity which is necessary to make up the caloric requirements less the caloric value of the sugar that is to be added. Enough sugar is added to give the entire mixture a total value of 6 to 7 per cent. of sugar (4 per

cent. of milk sugar naturally in the milk plus enough sugar to make up the difference). For a baby under ten pounds this will be from one-half to one ounce and over ten pounds from one and one-half ounces to two ounces of sugar. The amount of food given in the twenty-four hours will be determined by the caloric requirements of the child. The interval between feedings will be from three to four hours; and the amount given at each feeding will be roughly from one to two ounces more than the infant is months old. Cereal feedings will be started at the sixth to the seventh month; and vegetables at from the seventh to the ninth month. All increases in the quantities or in the values of the food will be made gradually.

This outline of a practical method of infant feeding is subject to modification dependent upon the appearance of untoward symptoms; and generally will be of the nature of a partial or complete withdrawal of the fats or sugars or both. The so-called percentage method of feeding is not advocated, though it is essential to success that there should be a very clear idea of the amount of the various food elements (fats, carbohydrates and proteids) present in the food as represented by percentage values.

The method as outlined is not only simple in its application, but it is also practical. The chances of error are reduced to a minimum and the food values fluctuate only slightly from day to day. Furthermore, it fulfills the requirements of a successful way in which to feed infants, in that the children remain healthy and gain in weight in a normal manner. It does not take the place of breast feeding, though in many instances there will be no more or even less trouble than one ordinarily encounters with maternal feedings. The most important thing is to make a correct beginning and to avoid the first gastro-intestinal upset. Accidents of infection are often unavoidable, but indigestion due to errors in diet are usually the result of a human agent and when they are once established they frequently require much patient effort to affect a cure, i. e., a steady gain in weight.

Thousands of children are killed every year because parents say, "They will have it anyway," and permit the little ones to expose themselves to whooping cough, measles and scarlet fever, says the United States Public Health Service.

THE UMBILICAL COLIC OF FRIEDJUNG IN OLDER CHILDREN.

By Arthur Stern, M. D.,
Pediatrist to the Elizabeth General Hospital and St. Elizabeth Hospital, Elizabeth.
Elizabeth, N. J.

Friedjung described in 1904 a typical form of hysteria in older children from 3 to 10 years, which is characterized by sudden attacks of abdominal pain in the neighborhood of the umbilicus. He gave these attacks the name of umbilical colic. The most prominent symptoms in these children are sudden attacks of pain, which come on, while the child is running or jumping and which disappear sometimes rapidly, so that the child has almost recovered by the time it reaches home. This pain lasts as a rule from a quarter to half an hour and during this time the child feels sick, becomes pale, complains about a very severe pain in the upper abdominal region, puts its hand to the stomach and afterwards appears to be weak for the whole day. These attacks repeat themselves at irregular intervals and last sometimes through months and even years and cause a great deal of worry to the parents and the attending physician because both cannot free themselves of the idea that there is at the base of these attacks some anatomical disorder in the abdomen and the question of an acute or chronic appendicitis will forever be weighed and discussed. The bowel movements are normal and from the history of previous attacks it is not difficult to make a diagnosis of this condition. Often the Chvostek Facial symptom is present also Taches Cerebrales, heads painful zones over the skin of the abdomen, also psycho-pathological signs such as exaggerated fear of lightning, chewing of fingernails and so on. The disease is never observed in institutions such as orphan asylums, or foundling houses. Sometimes we find also in these children enuresis, pavor nocturnus and inclination to fainting spells. There are, however, a few symptoms which help us in our diagnosis. In the first place vomiting, during the attack is rare, then there is no temperature, furthermore all of these children show a hyperaesthesia especially of the cervical and thoracic vertebrae and of the skin of the abdomen. They complain severely if moderate pressure is made on

these vertebrae and similarly if the skin of the abdomen is touched. The diagnosis of course has to be made with the greatest caution especially on the basis of the history and it is equally important to recognize appendicitis, if present as well as not to subject the child to an unnecessary operation. The disease is undoubtedly a disturbance of the nervous system and can probably be classified among the hysterical group.

The final prognosis is good, there is no special treatment. Moro has recommended the application of the faradic current to the abdomen and Extract of Belladonna internally, Friedjung suggest to give these children small doses of Tincture of Valerian and impressing on them that the medicine given will cure the attacks.

Case 1. Baby M., Male, 3 years old, seen after the first attack February 18, 1918, and thereafter at frequent intervals. The child, a picture of health, had a small umbilical hernia which was easily reducible. The attacks came at irregular intervals until May 14th and frightened the parents very much. At this time one of our surgeons examined the child with me. The neighborhood of the appendix was free, in fact there was never any pain when I saw the child. We advised the mother to have the child wear an umbilical truss and from the time the truss was worn there were no more attacks. Whether post hoc or propter hoc I am unable to state.

Case 2. C., 6 years old, male. Strong healthy child, mentally unusually developed, had attacks since 1917 at intervals of two to three months. Never any vomiting, pains, as mother describes them excruciating, around the umbilicus. Comes home and lies on the lounge for an hour and then perfectly well. Highly nervous child of nervous parents. Has not had an attack within the last half year. This child showed an unusual degree of hyperaesthesia over the spinal processes.

Case 3. B., 4 years old, female. Developed attacks after scarlet fever. Attacks followed each other first with a few days intermission. No vomiting, duration of attacks about half an hour. Parents state that the appetite of the child is poor. Of late the attacks have disappeared.

I have reported this condition and these cases, because the literature on this subject is still meagre and because others like myself might have to decide the question, when called to see one of these children, whether they have to deal with a surgical abdomen or an umbilical colic.

224 East Jersey Street.

Miscellaneous Items.

Chicago Doctors Form Union.—A movement has been started, according to Dr. Thomas P. Foley, chairman of the contract practice committee of the Chicago Medical Society, to organize a union among the members of that body which will correspond to the lawyer's association and other such organizations of professional men. It is said not to be aimed at the public, but rather at industrial and other corporation employers of physicians to force them to increase salary scales for regularly employed physicians and surgeons.

Chiropractors Enjoined.—The department of registration and education of Illinois reports that 26 more temporary injunctions have been issued against individual chiropractors who are practicing in Illinois without licenses. The injunctions restrain these individuals from paying assessments to the Universal Chiropractors' Association of Davenport, Iowa, and forbids them from accepting money from that association with which to pay fines, penalties and costs assessed against them by the Illinois courts. It also restrains them from accepting the services of attorneys of the association in defending cases brought against them in the Illinois courts. The result of the injunction is that each chiropractor must finance his own defense.

Victory for Alabama Medical Association.—The Supreme Court of Alabama recently confirmed the decision of the Montgomery Circuit Court whereby the Alabama Medical Association will continue to be the chief authority for the enforcement of all State laws relating to health.

Crime May Bar Bay State Physicians from Practice.—The Attorney General of Massachusetts has recently ruled that a physician who is convicted of any crime may be barred from practice in that State, even though such crime is committed outside the practice of his profession.

A Doctor Who Paved the Way for a President.—After finishing his third year at Williams College, James A. Garfield was stuck for money to pay his final year's tuition. Dr. Robinson of Hiram, O., who saw in the young man a future of much promise, went to his rescue with a loan of $800, taking as security an insurance policy on his life. We now know Garfield made good the promise that Dr. Robinson saw in him. That $800 loan paved the way for Garfield to the Presidency, proving that if to date a physician has himself been unable to reach the highest honor in the gift of the people, he could effectively assist another to reach it.

Continued on page 286.

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Your Debt

"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—Theodore Roosevelt

This year it looked as if it might be the doctor's turn to reach the presidency. Dr. Leonard Wood, it was believed, would be the first of his profession to stand before the electorate for that greatest office in the world, but the controlling powers in the political world seem to have ordered otherwise; nevertheless our profession was honored by his candidacy.

Secretary Chandler expects to have the Official Transactions ready for insertion in the September issue of the Journal. Members who receive proof for approval or correction are, therefore, requested to return to him **very promptly** all such matter.

The absence of so many of our members on their vacations, who prepared "original articles" for our annual meeting, has caused us to defer insertion of their papers until the September issue of the Journal, as we wish to give their authors an opportunity to correct proof. We expect to insert in that month's issue the two Orations, the Third Vice-President's Address and possibly the Banquet Addresses.

We also defer insertion of two partially prepared editorials till next month, as an extraordinary pressure of work and the illness and death of the Editor's brother disarranged his plans for July, causing even the postponement of a greatly needed season of rest until the early part of August. We give instead some excellent editorials from other medical and secular journals, to which we invite special attention.

The Editor takes special pleasure in extending not only his own, but he believes also our entire membership's heartiest congratulations to two of our most prominent and active officers—Dr. William G. Schauffler and Dr. John C. McCoy. The former, who served with ability in the M. C., U. S. A., at home and abroad—for several months practically as Mayor of Coblenz most efficiently—has recently been promoted from the lieutenant colonelcy to that of full colonel, and Dr. John C. McCoy, lieut. col. M. C., U. S. A., was decorated on April 30 with the Distinguished Service Cross at Governor's Island by Lieut. General Bullard, commander of the Department of the East. Col. McCoy was cited for exceptional bravery under fire at Jang-sur-Nurin and Chateau-Thierry, where he commanded Red Cross hospitals.

We suggest—yes, urge—that every member of our Society who has been, for any reason, unable to enjoy a vacation this year, shall keep a close watch on the enemies of our profession's and our patients' and humanity's highest health interests, in order that we may be prepared for an earnest and aggressive defense this coming fall and winter. No legislator who in the present year showed himself super-serviceable to the cults that threaten the health and lives of our citizens should be re-elected.

We need two able physicians in the

Senate and five or six in the Assembly—men who can be depended upon to DO AND VOTE RIGHT, regardless of consequences—such doctors as Kentucky has had this year. See our June Journal, page 208. We should have none of the trading, log-rolling variety.

We give the following editorial from the West Virginia Medical Journal:

There are times when the spirits of your editor reach a very low point. This is one of them. It seems that the members have such a detached interest in the publication of their official organ in any way other than a critical one.

Suggestions are always sought for and welcomed, together with deserved criticism. A number of times in the last four years the request has been made that news items be sent in by any of our members and that the county secretaries send in reports of their meetings. It is not done. There are a few of the men who do send in these and our thanks are extended.

At the recent meeting a number came to us and asked why it was that the county society reports and State news was so meager. It was explained that the Editor was not omnipotent and could not personally attend each local meeting; neither did he know that Dr. Jones was the father of a perfectly new son; nor that Dr. Smith was recently married; nor that Dr. Brown has moved his location. Each promised he would go home and take some action to see that the reports of such matters of interest were furnished.

It has been a month since we got back home. To date we have received no communications. You will note that there are reports from but two societies of their meetings. And the State news is only what can be found in the daily papers which come to our notice and from the personal mention columns of other medical journals.

We have requested Dr. Anderson, State Society Secretary, to furnish a list of the secretaries and it is intended to send a card to each one requesting some information as to their activities and the news of interest to the profession from their neighborhood. We shall see how much this will accomplish.

Please assist in this matter, Fellow Members, or if you will not, then do not be critical of the pages of our Journal devoted to this particular section. If you do not aid in providing material then you are remiss in your duty to our organizations and unfair to your editor in your criticisms.

The Editor of the New Jersey Journal has had somewhat similar experiences. Occasionally a member of a county society dies and the Editor hears of it two or three months after his death. It is a singular fact that the busiest doctors have been the most faithful contributors to our columns. They have commendable State pride, knowing that our Journal goes to nearly every State in the Union and beyond—as Dr. Bennett told our trustees that "we not only have subscribers in the various States, but beyond, even one in Central Africa and two in Manila." We know the splendid work our profession in New Jersey is doing and we wish to report it as fully as possible.

IS THE NURSE JEOPARDIZING THE PUBLIC HEALTH SERVICE?

Are School Nurses Not Practicing Medicine Within the Meaning of the Law?

A conviction quite universally prevails that the increasing tendency to overemphasize the importance of the public health nurse in public health service is rapidly precipitating a situation which not only will prove intolerable but will be the means of giving public health work a serious setback.

Between the women's clubs, the Red Cross, child welfare and other extra-governmental health agencies, as well as some well-meaning but shortsighted public health authorities, the nurses have been lauded and cajoled to such an extent that they not only feel that they are an indispensable factor in public health service, but that they are really the whole thing and that the service would be much better off if the physicians would withdraw and leave the field to them.

In witness of this statement note the attitude of certain nurses who are engaged in public school inspection work. In some instances they stoutly refuse to admit the necessity of a "supplementary" medical service, maintaining that they are fully as competent, if not more so, than physicians to make diagnosis, not only of communicable affections, but also of physical defects. In this connection the Health Department program issued by the nursing service of the Springfield

schools, published below (which is typical of many we have seen) is confirmatory.

We hold that school medical inspection service maintained only with a force of nurses, no matter how competent, is less than one-half efficient. To maintain such a service without physicians is about as absurd as trying to run a hospital without medical attendance. It implies, furthermore, that the nurse is extending an authority of her license if not actually violating the law regulating the practice of medicine.

As we see it, the one thing which has done more than all else to emphasize the importance of the nurse is the fact that she is willing to give her whole time to the service and does so at a lesser cost to the community than the services of a physician could be obtained.

In this connection the important thing to remember is (a) to emphasize the efficiency of any public health service dependent wholly or chiefly upon a nursing force; (b) urge less clamor for public health nurses and more attention to the demand for a full time medical health officer service; (c) the closest co-ordination of all public health nursing services with the constituted health authorities and the strictest supervision of such service by such authorities.

No extra-governmental body organized for engaging in public health work, which is the rightful function of State or municipality, should be permitted to engage in such work excepting and under the supervision of the only legally constituted authorities. There should be a law to this effect.

Again, it may be emphasized that the calling off of so large a body of nurses into the public health field not only deprives the hospitals and the sick in homes of necessary nursing attendance, but also tends to increase the cost of nursing service to a point that is prohibitive excepting to the rich. Salaries paid to nurses in the Red Cross public nursing exceeds the income which any nurse steadily employed in nursing the sick can now command. The Red Cross is also disrupting municipal public health nursing service by reason of the higher salaries it is paying nurses in its service

The tendency of nurses to unionize has lately become apparent in Chicago. Instead of affiliating with the professional group, we understand the matter is still under discussion whether they shall affiliate with the Federation of Labor or not. It is argued that they have been forced to this through the uncertainty of their employment occasioned by the fight between the factions in the Board of Education and the failure of the Chicago City Council to allow them adequate compensation.—Illinois State Journal.

THE ENTERING WEDGE.

Abolition of Medicine as a Private Enterprise.

Dr. G. Frank Lydston of Chicago, in the Illinois Medical Journal, says:

The Bolshevik is at the medical door—rapping faintly but still rapping. I previously have called attention to the obvious fact that the medical profession is the weakest link in the "bourgeois" chain. Naturally, it is here that the red has begun "hammering." The first blow aimed was compulsory health insurance. Marvel 'tis that a single doctor in this broad land of ours should favor this wolf in sheep's clothing—but there are plenty who do. Still greater marvel that so many of these microcephali should have been permitted to enter medicine. Cheap colleges? Alas! no; the crowd of "Class A," self-labelled "highbrows" that stands behind the "We Are Its" who are trying to establish a medical bureaucracy in Washington, would make an equal number of morons look like Solomons. The bill recently introduced in Congress proposing the abolition of medicine as a private enterprise, had all the earmarks of bolshevism but, all the same, I will wager a large red apple that behind it stood the "We Are Its."

Blow number two was State Hospitals and the rest of the ill-begotten brood of schemes to take medicine out of the hands of the profession and hand it over to the bolshevists—plain "reds" and medical highbrows who, having climbed to the top via the favor of their professional clientele, are ready to kick the ladder out from under themselves at any time if sufficiently tempting honors or emoluments are offered. Having "got theirs," to hell with the little fellows.

Apropos of the proposed State Hospitals: A certain number of the Illinois State Legislature was asked if it wouldn't be rather expensive to secure the services of high grade medical men for the proposed institution. "Hell, no," he replied, contemptuously, "We can get all them fellers we want, for nothin'."

And the politician was right. The

cheapest thing on earth—and with the least esprit de corps—is the eminent physician. His ethics begins and ends with keeping the little medical pigs out of the clover patch while the big hogs wax fat.

Speaking of the pernicious compulsory health insurance scheme, a splendid article by Dr. M. L. Harris, appears in the J. A. M. A., April 10, 1920. Every doctor should read this—and then write Dr. Harris and ask how he stands on the proposed gobbling up of American Medicine by the Government, through the medium of a Medical Cabinet officers, large appropriations for medical "advancement," etc.

By way of wasting some more perfectly good ink and nice white paper I will venture a prediction viz.: Within a very few years practitioners of medicine will have resolved themselves into: 1. Fellows who are content to pass a civil service examination to acquire a job with the usual pitiful salary paid to men in political jobs. (Everybody knows the sort of service the public would get from men who haven't the self respect of a bricklayer, and knows also, how much they contribute to medical science.) 2. A few eminent consultants who will monopolize the rare bird who is willing to pay well. 3. "Quackopaths" in infinite variety. 4. Christian Scientists and faith healers. 5. Voodoo doctors. 6. Patent medicine men.

The good old family doctor and the independent specialist will be as extinct as the dodo, the great auk and the archeopteryx.

Meanwhile let the profession sleep on. The lowbrow "red" and the highbrow bolshevik will attend to everything for us. The "red" will work unmolested because the profession doesn't take him seriously, the "highbrow," because the average doctor doesn't know that some lofty human fronts are like certain houses with imposing front elevations. One tumbles down the back steps immediately he enters the front door.

Remedy? Sure, but the rank and file haven't perspicacity sufficient to grasp it nor backbone enough to put it in practice. Let the medical rank and file list the "We Are Its" who favor schemes inimical to the best interests of the profession at large and serve notice on them that "referred work" has stopped—ther watch the eminent consultants and operators climb trees.

25 E. Washington Street.

TO HIM THAT HATH.

The young doctor who sits in his office all day, feet on desk, waiting for patients, is passing. Let him go; and may the place thereof know him no more. In these days of preventive medicine of statistical study, of research, more and more "jobs" with pay are available for the energetic young M. D. with adequate training. And if he is sensible enough to realize the advantages of dispensary work, opportunities for seeing cases and doing original work are abundant. In other words he cannot only seem busy, but must be the thing he seems. Every medical graduate should be given a card reading, "If you would get patients, get busy." It is a matter of pride with the layman to be able to say of his doctor, "He is awfully busy. always on the go; more to do than he can handle; better call him in." Lay standards are such that big business gets bigger. It is as true of medicine as it is of oil or steel. To him that hath shall be given. Of the young man in the incipient stages of practice, it may safely be said that he "hath nothing" but an M. D. and a license. What these are worth depends upon the individual—except in the case of him who has a pull with some older man who "hath." Advertising, that time-honored "starter" on which our lay friends depend for launching a new venture, is rightly withheld from the young professional man who has skill, not wares, to sell. For honesty and industry, those two cardinal virtues in medicine, have no disposition to advertise, to claim authority, to display.

To become known through hard work is the only safe road to publicity open to the young medical man. Let him take any job that comes along, provided it will increase his value to the profession. Let him spend himself and be spent on it. And unless we mistake the signs of the times, patients and opportunities galore will be added unto him.—Medical Record.

Few men lack opportunities. Almost every man misses them.

The man who drops his friendliness to you never really was a friend.

The man who shows you base ingratitude after receiving long and faithful service is unworthy of your friendship.—Jour. Exc.—True, Mr. Editor, we have had such experience. Some time we will

give our younger members some of the causes and preventive measures to save them sadness in their later years as they retrospect their experiences.

Secular Press Editorials.

Passing of Country Doctors.

From the San Antonio Light.

A medical magazine published somewhere "up north" reports that the country doctors are "all moving to town." Everybody must know that country doctors are becoming comparatively scarce. In so far as it describes a tendency, the statement that the country doctors are "all moving to town" is probably not far from the truth, although, as one of O. R. Cohen's characters would say, "are moving" ain't "have moved." Nobody could justly blame the country doctor for moving to town. There are few hardships in life more severe than those which make up his routine work. He has to perform his duties with inferior facilities, and is expected to produce results as favorable as though he were under no handicap. It is little short of marvelous that he succeeds so well in fulfilling those expectations.

His greatest hardships are experienced in winter time. One midnight call after another, with little if any rest during the day; long rides over the roughest roads, sometimes through boggy fields in a downpour of rain, only to find, at the end of his journey, that the patient has an aching toe; home again with his feet and hands so benumbed that he can hardly dismount his horse, and with his breath formed in icicles on his mustache; then another call before he has time to change his clothes—and so on, until sheer exhaustion alone prevents him from going farther. Such have been the experiences of thousands of country doctors in all parts of the land. Their contribution to the welfare of mankind has been a double one. Not only have their services been indispensable to their immediate patients, but the very handicaps under which they work have led to valuable scientific discoveries. Other things being equal, the doctor who practiced in the country is more capable, more resourceful, than one whose practice has been limited to the city.

Best Doctors' Fees Only a Dime.

From the N. Y. Evening Sun.

Not everyone can visit the best of New York's physicians and surgeons for ten cents a call. But some can. If you can show that you are not able to pay more, you may have the attention of a specialist in your ailment for a dime. And your drugs you may have at cost. The budget of a wage earner in New York's East Side does not include any allowance for the unforeseen sickness or accident that may befall him or his family. But New York's dispensaries and clinics—150 of them—offer their services. Ten cents or a quarter a visit admits the patient to the attendance of a physician, who in a similar case in private practice may get a thousand times as much.

Consider having a famed specialist offer treatment free to a mental defective or the best of the city's orthopedists straighten the club feet of a child whose parents must otherwise allow the deformity to go unheeded. The New York Post-Graduate Medical School and Hospital offers its services for 10 cents a visit to needy persons. And in some cases the charge is set aside altogether.

Hospitals have found that the difference of only a few cents in their charges to poor patients is often of tremendous importance to the patient. One hospital, greatly overcrowded, abolished the practice of making no charge for service in its dispensary and inaugurated the practice of collecting a fee of 10 cents. But the attendance was still too great, and a charge was put on bandages and dressings. But then the attendance fell off to too great an extent. Finally a fee of from 15 to 20 cents was tried, and the attendance was brought to the desired point. Drugs are supplied free to those unable to buy them.

There is little abuse of the dispensary, in the opinion of Dr. F. E. Sondern, president of Post-Graduate. Occasionally a patient will come who is obviously able to pay for his medical treatment and advice, and in this case he is shown the dispensary law printed on the reverse side of the card of admission. This, with its suggested punishment of a heavy fine, is generally effective in terminating the intruder's visits. In other cases a patient desiring the attention of the best practicians in the medical or surgical field comes to the dispensary, where he knows he will be placed under the care of a specialist in the treatment of his ailment rather than by a physician of general practice. The patient in this class is willing to pay for the treatment that is given him, but he is not admitted to the dispensary. He is given the address of the private offices of physicians that might attend him.

At the present time the Post-Graduate Hospital is raising a $2,000,000 endowment fund to enlarge the scope of its work, and of this amount a part will be used to provide ten new consulting rooms for the dispensary. Tabulations made by the endowment fund committee show that the total number of visits made last year to six of New York's large non-municipal dispensaries and to the largest of Boston's were as follows: Post-Graduate, 173,285; Presbyterian, 67,818; St. Luke's, 65,895; New York, 65,283; Roosevelt, 54,010; Mount Sinai, 189,959, and Massachusetts General, Boston, 152,025. About 4,000,000 visits are made to the dispensaries of New York City each year.

Dr. De Forest's Paper.

From the Nebraska Med. Journal.

The Journal of the Medical Society of New Jersey issue of June, 1920, published a clinical study of seventeen original cases of Raynaud's disease, with ten illustrations, by Henry P. deForest, that merits careful pedagogic study. As a preliminary to gaining and holding the attention of those to whom the clinical data was presented, Dr. deForest exhibited a portrait of Auguste Maurice Raynaud, M. D., and then gave an authentic, concise and most interesting biography of him. Raynaud was born in Paris, France, July 5, 1834, and died June 9, 1881. The unexcelled, exhaustive clinical history of that disease given by Dr. Raynaud in

his thesis for the degree of medicine, linked his name with its nomenclature.

Following the biography is a historical resume of early recorded facts relative to the disease in discussion; a definition of it, with a grouping and clinical picture of three characteristic stages in its development. He then briefly reviewed the seventeen cases which came under his personal observation. The clinical description in every case was made more interesting and instructive by clearly outlined photographic pictures from life, supplemented by pencil sketches giving exact coloring to the diseased parts. He gave a complete anamnesis of each patient, which is a pedagogic factor often greatly underestimated by speakers desirous of impressing their hearers with the message presented.

Dr. deForest merits commendation by the medical profession for his persistent work in collecting data and formulating an entire syndrome of that human malady. The New Jersey Medical Society is to be congratulated on obtaining and publishing his valuable manuscript.

LATE ITEMS RECEIVED.

Toms River Hospital.—The physicians of Toms River, co-operating with other citizens have formed a Hospital Association for the purpose of acquiring the hospital owned by Dr. T. J. Buchanan recently deceased. It is said to be one of the best-equipped hospitals in the State.

The Millville Hospital reported for June: Total number of patients treated, 49; number of operations performed, 30; number of accident cases, 4; number of births, 6.

"Watch your Step" is a fine slogan to be observed in buying shoes, says the United States Public Health Service. Get them large enough, built on sensible lines and most of your corns and bunions will disappear.

Dr. William R. Broughton, Bloomfield, and wife motored to Camp Tahoma, Pike, N. H., recently and from there to Bass Rock, Gloucester, Mass., where they will spend the month of August.

Dr. Watson B. Morris, Springfield, and wife are spending the month at their summer cottage, Cedar Lake.

Dr. Charles A. Schneider, Newark, and family spent two weeks recently at Lake Mohonk, N. Y., and took a motor trip through New England afterwards.

Dr. Charles D. Bennett, Chairman of the Publication Committee, returned from his vacation spent in Maine on July 31st.

Dr. D. C. English, Editor of the Journal, expects to spend about a week early in August in Massachusetts and Maine.

Proposed Health Museum.—W. J. Simpson, professor of hygiene and public health in King's College, London, has suggested the establishment of such a museum to celebrate the means by which we can triumph over preventable disease. In such a museum the causes of preventable disease and the means by which they can be prevented would be illustrated practically. The museum would be open to all. Lectures and demonstrations illustrated by models and the cinematograph should be given, and there should be attached a bureau of information.—Medical Press and Circular.

MISCELLANEOUS ITEMS.

Continued from page 280.

Hudson County "Chiro" Assemblymen.

Six of the Hudson County Democratic Assemblymen who voted for the "Chiro" law, and against the amendments which the physicians offered, have been put forward by the Democratic organization of Hudson County for renomination. These men are Messrs. Gaede, Donovan, Schultz, Silver, George and Hansen. Their nominating petitions have been filed with the Hudson County Clerk. Others of the Hudson delegation who voted for the law and who were not nominated were simply retired because they had served the allotted terms and gave way to others.

Mr. Joseph H. Gunn, the agent of the Welfare Committee of the State Society says: "I suggest that a meeting of the Hudson County Medical Society be called and that a protest be lodged against the nomination of these men, as well as a campaign of education to defeat them at the primaries."

The Medical Profession Not a Substitute for the Saloon.

The Beloit, Wis., Physicians' and Surgeons' Club at a recent meeting unanimously passed the following resolution:

Whereas, By constitutional amendment the United States has adopted a prohibition law; and

Whereas, The legal right to prescribe and dispense intoxicating liquor is in the hands of the physicians of our country; be it

Resolved, That we, the members of the Beloit Physicians' and Surgeons' Club, as patriotic citizens of the United States, do hereby place ourselves on record as absolutely upholding the letter of the law and do hereby agree not to dispense or prescribe any intoxicating liquors except in cases of extreme need; that this club will aid the federal government in every way possible in the enforcement of this law.

Hearing and Speech Defect—300 Cases.

The Federal Board for Vocational Education estimates that there are among the injured veterans of the world war between ninety and one hundred cases of men whose speech became absolutely unintelligible as the result of mouth or neck wounds, aphasia, or other causes. Twenty-five per cent. of these men are still in the hospital and fifty per cent. are in training or approved for training. The courses followed are agriculture, auto mechanics, commercial courses and chemistry. There are probably several thousand men throughout the country who became deaf in one ear, or who have suffered slight impairment of hearing in both ears. However, there are only about

two hundred for whom lip-reading is necessary. Therefore, the approximate number of hearing and speech defect cases will be about three hundred.

Uncle-Niece Marriages.—This subject has been agitated by the Eugenic Society of Sao Paulo. Coelho quotes authorities and cites cases which make against such unions. Nevertheless there is some opinion which sanctions such unions and the author has sent out a questionnaire which seeks to ascertain the views of medical men pro and con. Two leading medical men received these questions and one replied that he was opposed because a consanguine union doubles any family taint. The inference is that there is a movement on foot to remove this inhibition.—Brazil Medico.

Compulsory Health Insurance. — The Medizinische Klinik reproduces the communications that have been published in the Journal on the subject of compulsory state health insurance and in American journals and chamber of commerce reports, etc., the Berlin journal adding editorial comment as follows: "We must admit that these American expressions of opinion portray with sharpness and onesidedness, but not without a certain justification the influence which compulsory state health insurance and the legislation in regard to it, in Germany, has had on the practice of medicine and which they continue to exert along the same lines, so that the representatives of a free profession are being forced into the position of paid public servants..... It is interesting for the German physician to read these antagonistic views of the American profession in the matter. It remains to be seen whether America will succeed in finding a way to solve the problem of protecting against sickness and caring for the sick without introducing the dreaded 'German system' of compulsory health insurance." The contracts with the sickness insurance companies in Germany expire July 1, and the Leipsig League is conducting negotiations for renewal. The representatives of the former left the room when the fee of 12 M. per visit and 8 M. per office call was suggested by the League. Recent proposals to enlarge the scope of state insurance had a tendency to eliminate private practice almost entirely.

We may now sleep undisturbed by nightmares. New York and New Jersey have laid the bogey of Compulsory Health Insurance, which would cut millions from our income and put us on a factory wage basis, in our treatment of the industrial masses. This is the fifth year that the legislature of the former state has killed the measure, but the proponents of the Utopian plan say they will come back next year. Look out! With Cromwell let's put our trust in God, but keep our power dry.

Narcotic Dispensaries.—Death does not result from sudden deprivation of the drug in the case of a healthy addict—an addict without any therapeutic reason for addiction—a case of cancer, painful tic, etc., naturally not being included in our consideration, as all of these cases are under either suitable institutional or private physicians' care. The suffering caused by the sudden deprivation is not as severe as it may appear on the surface, and it is of short duration. If hospital facilities can be provided, there is no excuse for a public or private narcotic dispensary. If they cannot, it might be desirable to make arrangements for personal administration of drugs to addicts as a temporary measure of relief. A dispensary where the drugs are dispensed to the addicts for self-administration is so harmful in its effects that it cannot be recommended under any circumstances.—S. D. Hubbard, Pub. Health Rep.

County Medical Societies' Reports

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

The society held its July meeting at the Hotel Maretti, Vineland, N. J., July 14. In point of interest and attendance it exceeded any held in Vineland for a long time. President L. F. Hatch presided. The treasurer, L. H. Connell, showed a substantial balance in the treasury. The report of the arrest and fine of "Dr." J. W. Glover, "pick doctor," was of interest. He had pursued his practice for several months and after having left the State, the evidence and inquiries from the insurance companies led to his being induced to return to the State, whereupon he was summarily arrested and put under $1,000 bonds. He waived the hearing, and paid the $200 fine for violating the medical practice act. There is no disease in the catalogue which he did not treat and at some time promise a cure. The effects of some of the treatments were fatal, and the suffering from picking the body from shoulders to below the waist with the subsequent pustulation from the infection and counterirritant, was excruciating.

Dr. W. P. Glendon read an able paper on "Acute Nephritis Complicating Pregnancy." The paper has been forwarded for publication. There was difference of opinion as to the method of terminating gestation. His experience in six cases led him to advocate the Cesarean operation; others claimed to have had equally as good results by the use of acouchement force. Individual experiences with the use of petuitrin indicated that everybody used it but in different doses, and at different times in the course of labor; none used it to induce labor; all agreed that the os should be dilated before giving it. The benefits from its use in pneumonia at the time of syncope with weakened thready pulse was emphasized. A unanimous vote to hold the annual picnic in August was passed and Fortescue was favored as the place. The next meeting will be held in Bridgeton in October.

GLOUCESTER COUNTY.

Henry B. Diverty, M. D., Reporter.

The regular monthly meeting of the Gloucester County Medical Society was held on Thursday, May 27, as the guests of the Hallowell School of Adjustment, Margate Park, Atlantic City. In the absence of the president, Dr. James Hunter acted as chairman.

Prof. F. X. Dercum, M. D., of Philadelphia,

was to have read a paper, but was unable to attend because of pressing professional duties.

Dr. Henry B. Diverty was elected reporter to fill the vacancy caused by the death of Dr. H. A. Wilson.

Dr. Madeline A. Hallowell gave a most interesting address, after which the members were invited to inspect the schools and we were all delighted to see how thoroughly the children were trained and we bespeak for the school a great future. Before we left Dr. Hallowell invited us to a most elaborate luncheon, which we all enjoyed, and we will not forget the many kindnesses of our hostess.

SOMERSET COUNTY.

Lancelot Ely, M. D., Secretary.

The regular meeting of the Somerset County Medical Society was held in the Court House, Somerville, on June 10, 1920, at 3.30 P. M. Dr. A. J. Casselman, Chief of the Bureau of Venereal Control, N. J. State Board of Health, gave a very interesting and instructive talk on "The Public Health Aspect of Venereal Diseases," and demonstrated by a two-reel motion picture "The Modern Diagnosis and Treatment of Syphilis."

Dr. W. G. Schauffler, late Colonel in the M. C., U. S. A., explained the purpose of the aims of the "American Social Hygiene Association and of the "N. J. State Social Hygiene Association."

The program was greatly appreciated by a good attendance of the members and several friends.

UNION COUNTY.

Russell A. Shirrefs, M. D., Reporter.

The regular quarterly meeting of the Union County Medical Society, attended by about 40 members, was held on the evening of July 14th at the Westfield Golf Club. The essayist was Dr. W. H. Lawrence, who presented an interesting and instructive paper on "Sacro-Iliac Strain," for which the thanks of the society were tendered him. Dr. Cladek reported the recovery of a patient from encephalitis lethargica, which case had been described at a previous meeting. Dr. Harrison, on behalf of the annual delegates to the State Society meeting, made a detailed report, which was received and recorded. One new member was elected, and ten applications for membership were referred to the proper committee to take the usual course.

Our society feels much indebted to its members from Westfield, through whose efforts the privileges of the club were obtained for the day. Its golf course afforded pleasure to a number of medical devotees of that ancient and honorable game, and a delicious repast marked the close of a perfect day.

American Public Health Association.

The forty-ninth annual meeting of the American Public Health Association will be held September 13th to 17th in San Francisco. Preceeding this meeting there will be gatherings of the California Tuberculosis Association and the Southwestern Tuberculosis Conference, while for the week following the meeting of the Public Health Association there is to be a meeting of the International Association of Industrial Accident Boards and Commissions.

Therapeutic Notes.

Pain and Uneasiness in the Stomach After Eating.

Tinct. nux vomica, ℥ij.
Liquor diastos, ʒij.
Casca laxative, ʒj.
Acid. hydrochlor. dil ℥ij.
Elix. lactated pepsin, q. s. ℥vj.
M. Sig.: Teaspoonful after meals.

Pelvic Neuralgia.

In neuralgia of the uterus and ovaries, with great tenderness and a bearing down sensation, pains shoot up the sides down the thighs, and across the lower part of the abdomen.

The above symptoms indicate Tr. cimicifuga, 20 drops in half a glass of water, a teaspoonful every two hours.

Syphilitic Ulcers.

Balsam of Peru.
Bismuth subnitrate, a.a.z.v.
Ichthyol
Glycerin, aa℥xxiiss.
Water, q. s. ad., ʒviii.
M. et ft. pasta.

The raw surface of the ulcer is first cleansed with alcohol and the edges cleared. Strips of gauze impregnated with this paste, heated, are applied over the wound. This dressing can be left in place for ten days or a fortnight.

Weeping Eczema.

The following lotion is effectual in relieving the irritation and smarting:

Zinci oxidi, ℥i (4 grams).
Lapidis calaminaris, ℥ii (8 grams).
Glycerini, ℥ss (2 c.c.).
Liquoris calcis, q. s. ad., ʒvi (180 c.c.)
M. et ft. lotio.

When the exudation has ceased, a powder such as the following may be used:

Zinci oleostearatis (N. F.), ℥i (30 grams)).
Amyli pulveris, ℥ii (60 grams).
M. et. ft. pulvis.

Burns.—Burns of the second degree are invariably arrested in their development when magnesium sulphate solution is applied early, while those of the third degree run a more favorable course under this treatment than under any other method. A solution of 25 per cent. strength, or even stronger, should be used.

Ipecac for Infants' Digestive Disturbances.—Dr. Saint-Philippe, of Paris, France, gives systematically minutes doses of tincture of ipecac to bottle-fed babies with digestive disturbances. He gives it by drops in progressive doses, aiming to act on the digestive juices, and on fermentation and putrefaction. The ipecac, he says, tones up the liver and secretion of bile.

Emetin in Hepatitis.—Drs. Gunn and Savage recommend that acute cases be treated with one grain of emetin for twelve days, followed by three grains of emetin and bismuth iodid for fourteen days.

If the condition is very severe when treatment is first begun, and may probably prove fatal if not rapidly brought under control, they

recommend an intensive course of treatment of one grain of emetin hypodermically daily in the morning and two or three grains of emetin and bismuth iodid at night. The patient should be carefully watched for any untoward effect of treatment.

Acute cases which relapse with symptoms of dysentery might also be treated with the last mentioned course. They further recommend the carriers to be treated by the method first stated. Carriers which relapse after treatment should be discharged if they have no symptoms. They should be informed that they are in no danger themselves, but are a danger to others. They should not handle food, and should be instructed about the spread of dysentery from feces. In the event of the patient subsequently reporting sick, the medical officer could see by the pay-book that the patient was a dysentery carrier, and would thus be on his guard against liver abscesses or any other sequelae of dysentery.—Jour. Royal Army Med. Corps.

Treatment of Infantile Paralysis.—Dr. Blasco Reta, in Medicina Ibera, from a consideration of the last epidemic in Granada, outlines the treatment of acute anterior poliomyelitis as follows: 1, Absolute rest in bed for several weeks after the febrile period is past; 2, calcium chloride to diminish exudates and transudates; 3, urotropin 0.3 to 1.5 gram daily according to age; 4, lumbar puncture once or twice during the febrile period according to the pressure and generalization of the paralysis; 5, diet and symptomatic treatment in accordance with the initial manifestations of the respiratory or gastrointestinal tract; 6, disinfection of the mouth, nose, and pharynx, not only of the patient but of all the members of the family, with hydrogen peroxide, and iodine in glycerine; 7, hygiene appropriate to an infectious and contagious disease.

Treatment of Senile Debility.—Many men between sixty-five and seventy have well preserved vital organs and good appetite and digestion, yet have small physical and mental vigor and tire easily. The mental state is apt to be one of depression and discouragement. Some of these patients will later show cerebral softening, while in others the disturbance is functional and due to diminished endocrinic activity. The best drug for these subjects is some form of phosphorus, preferably the glycerophosphate of magnesia. The diet should be restricted to the calory requirements. The writer believes in the formation of an issue on the shoulder to avert the probable cerebral hemorrhage in the organic form of debility, and he seems not to regard it necessary to caution against any danger of sloughing of the skin.—Il Policlinico.

Salicylates in Acute Rheumatic Fever.—At one time the salicylates were regarded almost as specifics for rheumatism. Then while they did not fall exactly into disrepute, they were deposed from their former high therapeutic pedestal. At the present time salicylate therapy is looked upon as useful in the treatment of rheumatism but secondary on the whole to diet, except for acute rheumatic fever, in which form of the disease its effects are often striking. Dr. Paul D. White, writing in the American Journal of the Medical Sciences for May, 1920, is enthusiastic concerning the results of salicylate treatment of acute rheumatism. He had seventy-three soldiers under his charge at U. S. Base Hospital No. 6, and states that the most striking lesson learned from the series of cases of acute rheumatic fever at the hospital was the remarkable response to forced salicylate treatment. Almost invariably there was an abrupt ending of joint pain, swelling, fever, and malaise. White remarks that at one time there were two wards full of cases of rheumatic fever. Salicylates were given in large doses to patients in one ward. It was their only medicinal treatment, and they did wonderfully well. The other patients in the other ward were given no salicylates internally at first, but received local treatment and phenacetin and veronal by the mouth. Their pain and discomfort were dulled to a slight degree, but after two or three days of suffering the salicylates were given to them in large doses, followed by great and rapid relief.—Medical Record.

Hospitals; Sanatoria, etc.

Hospital Gifts.—The Memorial Hospital, Morristown, will receive $10,000 as an endowment for the Dorcas Harris' room, under the will of Mrs. Elizabeth Davis.

State Hospital, Morris Plains.

May Report.—In hospital May 1st, 2,712; admitted during May, 50; discharged, 49; remaining on May 21st, 2,713.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, reports the following for June, 1920: On June 1st there were 228 patients present in the Sanatorium, 114 males and 116 females. This number includes 26 males and 47 females in the Preventorium. During the month 32 patients have been admitted, 17 males and 15 females. Six of these admissions went to the Preventorium. Among these admissions there were five re-admissions. The admissions are classified as follows: Pretubercular, 6; moderately advanced, 5; far advanced, 21. The largest number of patients at any time during the month was 235, smallest 222, present June 30th, 222.

State Village for Epileptics, Skillman.

That tuberculosis is a serious menace among the patients at the State Village for Epileptics at Skillman is emphasized in the annual report of that institution which has been submitted to the Department of Institutions and Agencies by Dr. David F. Weeks, superintendent of the colony. The report stresses the necessity of adopting adequate measures for the segregation of tubercular patients, the number of cases having increased to such an extent that further delay would be regarded by Dr. Weeks and the managers as unfortunate. The managers renewed their recommendation for the erection of two buildings where tubercular

patients may be given proper care and medical treatment.

The report shows that there were 810 patients under treatment during the year, making a total of 1,603 since the village opened. There was 110 patients admitted during the year and of fifty-six deaths that occurred, thirty were due to epileptic seizures.

Marriages.

DUCKETT-HOPKINS.—At Jersey City, N. J., April 19, 1920, Dr. Warren J. Duckett, to Miss Clara B. Hopkins of Dover, N. H.

ROOP-TAYLOR.—At Jackson, N. C., June 26, 1920, Dr. William O. Roop of Atlantic City, N. J., to Miss Emma L. Taylor, of Jackson, North Carolina.

Deaths.

BUCHANAN. — At Tom's River, N. J., July 14, 1920, Dr. Thomas Jefferson Buchanan, aged 61 years. He graduated from Jefferson College, Philadelphia, in 1889; was the first to experiment with the x-ray in Jefferson Hospital; he established the Tom's River Hospital five years ago.

LANGDON.—At Englewood Cliffs, June 21, 1920, Dr. Marie G. Langdon, aged 51 years. She graduated from the Baltimore University School of Medicine in 1904, and the Woman's Medical College, Philadelphia, in 1905.

PARSONNET.—In Newark, N. J., July 20, 1920, Dr. Victor Parsonnet.

Dr. Parsonnet graduated from the Long Island College Hospital in 1898. He was a member of the Essex County Medical Society and the State Medical Society, and a Fellow of the American Medical Association.

PAXTON.—At Paterson, N. J., June 16, 1920, Dr. John P. Paxton, from heart disease, aged 69 years.

Dr. Paxton graduated from the Long Island College Hospital, Brooklyn, in 1872. He was a member of the Passaic County Medical Society and of the Medical Society of New Jersey.

WELLS.—In Trenton, N. J., on June 11, 1920, Dr. Joseph M. Wells, aged 63 years.

He graduated from the Jefferson Medical College, Philadelphia, in 1878. He was a member of the Mercer County Medical Society and of the State Medical Society, and a Fellow of the American Medical Association.

Personal Notes.

Dr. Elias M. Duffield, Glassboro, was recently elected by the Pocahontas Council, No. 48, Jr. O. U. A. M., of Glassboro, as it representative at the State Council.

Dr. Harry E. Lore, Cedarville, and wife spent a week last month at Schenectady.

Dr. Noble H. Adsit, Succasunna, and wife returned last month from a two weeks' motor trip of 1,100 miles in New York State.

Dr. Harry H. Bowles, Summit, of Overlook Hospital staff, who was seriously ill some weeks from pneumonia, was taken from the hospital to his home early last month and is recovering.

Dr. W. Homer Axford, Bayonne, and wife spent a few days in Atlantic City last month.

Dr. Francis H. Glazebrook, Morristown, and wife are spending the summer at Bay Head.

Dr. Alfred C. Benedict, South Orange, and family motored to Grindstone, N. Y., to remain there until September.

Dr. Enos E. B. Beatty, Newton, is having erected a garage in the rear of his house.

Dr. Robert R. Sinclair, Westfield, spent his vacation last month at Culver's Lake.

Dr. Henry C. Pierson, Roselle, spent a few days last month at Mayor Slauson's Camp at Camp Rich, Lake Champlain.

Dr. William G. Schauffler, Princeton, addressed the W. C. T. U. convention at Ocean Grove, July 13th, on "Social Hygiene."

Dr. Edward P. Uptegrove, Verona, was quite ill last month.

Dr. Howard C. Voorhees, New Brunswick, and wife are spending the month of August at Belmar.

Dr. George W. Fithian, Perth Amboy, and wife spent a few days recently at Cedarville, N. J., the wife's former home.

Dr. Charles F. Halstead, Somerville, and wife are spending a month in Maine.

Dr. Charles A. Knox, Ridgefield Park, and family spent a few days last month in Branchville.

Dr. William P. Thorne, Butler, and wife entertained the Butler Tennis Club at their bungalow at Glen Wilde Lake recently.

Dr. Edward O. Cyphers, Belleville, wife and daughter, spent two weeks at Beechwood last month.

Dr. Ralph J. Faulkingham, New Brunswick, is spending his vacation this month at Booth Bay, Maine.

Dr. Morgan D. Hughes, Bloomfield, spent last month on an auto and fishing trip to Maine.

Dr. J. Samuel Stage, Newark, and wife recently returned from a trip to Bermuda.

Dr. Carl H. Wintsch, Newark, was recently awarded an honor medal for life saving, by the National Court of Honor of the Boy Scouts of America. He saved a woman at Asbury Park who had been carried out beyond the ropes.

Dr. Augustus L. L. Baker, Dover, has been elected foreman of the Vigilant Engine Company.

Dr. Freind B. Gilpin, Cranford, has been elected a member of the Cranford Business Men's Association.

Dr. Walter Post, Bloomfield, and wife are spending their vacation at Bryant Lake, N. Y.

Dr. Robert H. Woodruff, Hackettstown, has been elected vice-president of the Musconetcong Country Club of that city.

Dr. John V. Smith, Perth Amboy, was recently appointed by the Governor as Health Officer of the Port of Perth Amboy.

Dr. James Hunter Jr., Westville, and family spent the month of July on Bustin's Island, Casco Bay, Maine.

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ORATION IN SURGERY.

Delivered at the 154th Annual Meeting of the Medical Society of New Jersey at Spring Lake, N. J., June 15, 1920.

A CONSIDERATION OF RESULTS IN THE TREATMENT OF SIMPLE FRACTURES.

By Wm. Lawrence Estes, A.M., M.D.,

Surgeon-in-Chief of St. Luke's Hospital.

South Bethlehem, Pa.

The late war brought into the consciousness of surgeons that too little attention had been paid in America to the treatment of fractures, and the standardization of mechanical contrivances for the proper retention of fractured bones. America too, it was found, was not supplied with any proper standard of functional result, nor particulars as regards the especial features which bring about disability after fractures.

Which of us, for instance, is prepared to say definitely the percentage of disability which results from an inch shortening after a fracture of a femur? We cannot at present say whether disability is produced because of the lack of proper length alone or to the imbalance produced in other parts of the skeleton on account of the shortening. Is it the lack of length or the disturbance of alignment which overlapping produces, more or less, after a simple fracture which results in disability in any given case?

The very large experience in treatment of fractures gained in the war has resulted in some important improvement both in splints and methods of treatment, but these apply especially to compound and complicated fractures. Very little additional matter of merit has been brought out for the management of simple fractures except the exploitation of certain methods of traction to be obtained by means of frames and apparatus which may be used only in institutions and which are entirely beyond the ability of general practitioners to obtain and to use.

One cannot boast of the average results obtained by surgeons of our army in the treatment of fractures, as the records of the department of compensation show; for instance, of 2,000 cases discharged it was estimated when they left the hospital that 60 per cent. were not permanently disabled. About 15 per cent. of these cases reported for re-examination after fifteen months, of these 70 per cent. had disability estimated to be over 25 per cent. In civil practice this would be considered not very good results.

Some time ago the American Surgical Association appointed a committee to make a study of the results of the treatment of fractures in America. This committee set itself to the task of trying to find out:

1st. The best average method of treatment for fractures of the long bones in the several regions.

2nd. The limit of permissible distortion in order to retain former capacity for activity or work.

3rd. The difference in result in various age groups.

4th. The average period of disability after simple and compound fractures of the long bones in the several regions.

5th. The average percentage of disability which should be expected after simple and compound fractures of the long bones in the several regions.

6th. The comparative results of the closed and open methods of treating fractures of the long bones.

Unfortunately this committee found

when it began its work that the surgeons of North American do not generally keep good records of their fracture cases and only a very few of them follow up their cases and examine them carefully in order to determine the actual result of the treatment. The work of the committee has been slow and is not yet by any means completed.

In order to facilitate the work the committee suggested and the association adopted a special record sheet which it is earnestly desired shall be used by the leading surgeons of the United States and Canada. The fulness of data and uniformity of the records would not only assist in improving hospital records but be of immense assistance to the committee and would become of inestimable value in compensation cases and medico-legal investigations.

As Chairman of this Committee on Fractures I wish to enlist the aid of every active surgeon who works in a hospital to introduce these uniform record blanks and earnestly to beg that he will see to it that they are faithfully kept, and that he follow up all his fracture cases and determine the actual result in every case.

With this work in hand, with the result of my experience in trying to collect data, especially on account of the conviction I have of the lack of technical skill so common in the treatment of fractures, and on account of the tremendous importance of it in America for industrial efficiency, I have concluded, Mr. President and members of the Medical Society of New Jersey, to ask your indulgence and your attention while I bring before you some of the important measures for obtaining good functional results in the treatment of fractures.

The subject would be too big and would take too much time to discuss the treatment of all kinds of fractures. I shall attempt today to speak to you only in regard to simple fractures.

A fracture of any bone of a living human being is not simply "a solution of the continuity of the bone," but an injury which, in the large majority of instances, is a complex traumatic condition, consisting of the break in the bone and injury to the soft tissues of the part involved, of greater or lesser severity. In some cases the injury to the soft tissues is of more importance than the fracture of the bone itself; only in the rare cases of so-called "green-stick fracture," may they be neglected or forgotten in treating the case.

Causes of Fracture.—While it is generally true that a fracture is caused by some sort of violence, it is well known that much less force is required to produce a fracture in some individuals than in others. We must, therefore, recognize two general causes of fracture: 1st, predisposing; 2nd, determining.

Predisposing Causes of Fracture.—(1) Old age certainly predisposes to certain classes of fractures, notably to fracture of the neck of the femur.

(2) Some persons undoubtedly have bones which withstand strains less sturdily than do normal bones. This brittleness of bone, or "fragilitas ossium" may occur in all the age periods.

(3) **Disease** condition may impair the resistance of one bone only or the osseous system generally: (a) malignant diseases, osteomyelitis, etc.; (b) rickets in childhood, and in adults osteo-malacia, rheumatoid arthritis, etc., all these serve as predisposing causes of fractures.

B. **Determining or Immediate Cause of Fractures.**—Force is always the immediate cause of a fracture.

The cause of fracture is usually stated as (a) direct and (b) indirect violence. In civil life fracture by direct violence is comparatively rare. Of 739 cases analyzed 120 were from direct violence and 619 resulted from indirect violence.

I have analyzed the conditions and histories of a large number of fractures from indirect violence and I feel sure, in nearly every instance, the fracture of the bone, if it were a long bone, was produced by inco-ordinate leverage.

When a human being uses his extremities voluntarily for motion and locomotion he accomplishes these acts by co-ordinate leverage, the motion to the levers (the bones) being applied by the co-ordinate use of the proper muscles. If taken unawares, the position of the extremity or the position of the trunk may be such that even slight momentum results in violent inco-ordinate leverage, and a fracture may result.

As regards the number of fractures in the several age periods, the British and American statistics differ somewhat. They are as follows:

American—No. cases studied.....	344
Under 10 years	90
10 to 20 years.....	65
20 to 30 years.....	122

50 to 70 years	55
70 to 90 years	12
British—No. cases studied	716
Under 10 years	394
10 to 20 years	155
20 to 30 years	77
50 to 70 years	90
70 to 90 years	0

Diagnosis.—Distortion, "false mobility," great pain and local tenderness, ecchymosis, swelling and crepitus; if all are present in any case, one may easily conclude a fracture has occurred. Sometimes distortion is difficult to appreciate, no crepitus is felt, and there is fixity of the extremity, only great pain and local tenderness are present, perhaps considable swelling and some ecchymosis. Such cases may be extremely difficult to determine, especially if the lesion be near a joint.

Care, ocular examination, and comparison with the uninjured limb, **if the uninjured one is a normal member,** careful measurements and the gentlest possible manipulation, continued for a very short time, may be employed. If this does not suffice to establish the diagnosis, fixation in the position assumed by the extremity should be secured and a radiographic investigation by a competent operator should be made as soon as practicable.

Prolonged manipulation and careless handling, or forceful attempts to elicit crepitus should always be avoided. The dreadful pain from these methods of diagnosing causes spasm of the muscles, and on account of the incongruous positions which follow may make the determination doubly difficult.

In obscure cases, difficult to diagnose, if manipulation is necessary to establish the diagnosis, it should be postponed until the physician is prepared and ready to make his permanent dressing; then a general anesthetic should be given, if the patient's general condition will admit of it, and setting should immediately follow the manipulation; or, better still, the manipulations should accomplish the setting, and the permanent splint or dressing be applied at once. Much better, however, is it to reach the correct diagnosis by a skiagram or by fluoroscopic examination. I very much doubt that a physician who cannot give his patient the benefit of a well-taken skiagram, or himself be able to make a fluoroscopic examination, should, in these modern days, attempt to treat major fracture cases.

The first thing to do is to find out the condition of the individual as regards his strength, condition of shock, manifestations and result of his pain, etc. The general requirements should first be done, then the special ones be attended to.

Shock in many cases is marked and requires care and discrimination in managing it. The early shock, that which comes on immediately after the injury, is a psychical one, or due to "noci associations". this is best treated by morphia given in full doses. Persistent or late shock means hemorrhage, as a rule. This may require exploration by incision, and packing of the lacerated cavity, or ligation of bleeding vessels.

Pain and muscular spasm are the special ever-present and over-powering immediate sequels of fractures. The pain is so severe and trying in many cases that it rapidly exhausts the patient. The position of the fragments sometimes aggravates the pain. One should try rapidly and gently to ascertain in a general way whether the fragments are pressing against the skin or the nerves, and place the limb in such a position that this pressure shall be relieved. Then give a full dose of morphia, and immobilize and fix the extremity, unless one is prepared at once to reduce and splint the fracture. In this latter case a general anesthetic should be given and all manipulation be done in anesthesia.

Prolonged attempts at reduction, or manipulations for the establishment of the accurate relative positions of the fragments, when the examiner is not prepared immediately to put on his permanent or final dressing are reprehensible, because they are unnecessary and brutal.

When the patient must be transported, the limb should be fixed in the position in which it is found, unless the fragments are evidently pressing on the skin or on some nerve trunk. In the latter case sufficient variation of the position must be made to relieve this pressure, then the limb should be fixed. Experience of surgeons in the late war showed that **traction and fixation** should be employed. Thomas splints proved of immense value for this purpose.

General Management of Fractures.—It should always be borne in mind that textbook statements are at best average

statements; as a rule, they try to note what the ordinary displacements, signs and indications of a particular fracture should be. Usually these statements are based on anatomic and mechanical considerations entirely. The physiologic and pathologic forces are not usually recognized or regarded. For instance, fractures of the upper third of the shaft of the femur are stated to be followed by upward and outward displacements of the proximal fragment and upward and inward displacements of the distal fragment, according to the books, and anatomically it should be so. As a matter of fact, in some cases almost the reverse condition prevails.

Displacements and distortion in every case will depend upon the extent and severity of the injury to the contiguous soft tissues. A muscle which ordinarily should produce a certain special deviation of the fragments may be almost or completely paralyzed by the severity of the injury, and another muscle which ordinarily cannot successfully oppose it may be stimulated to tetanic spasm, and by its super-violence produce an entirely different or widely varying distortion and displacement from what the books and ordinary experience have taught us to expect.

Again, most of the innervating nerves may be severed, or the main nerve trunk be almost crushed by the leverage and weight of a fractured bone. Paresis of the muscles may follow; gravity and leverage alone will then determine the displacement. Congenital or acquired previous distortions also influence displacements. Therefore, a safe postulate for the handling and treating of any case of fracture is, never take anything for granted, determine each individual case accurately and carefully, and treat it according to its individual requirements.

Some years ago I was called in consultation and asked to reduce a fracture of the lower third of the femur in the case of an old man. The physician in charge told me he had tried repeatedly, always unsuccessfully, to reduce the fracture. It was a fracture almost transverse and the old gentleman was rather thin. I thought by etherizing him I should certainly be able to reduce and retain the fracture in place. I was astonished and greatly chagrined to find that my assistant and I by any of the ordinary means and methods could not reduce the fracture. Finally, it occurred to me to examine the uninjured lower extremity. I found the most exaggerated case of bowlegs I had ever seen. This gave me the necessary indication. By changing the direction of the traction and using a fulcrum just above the knee-joint, the adjustment was quickly and easily done.

The study of a large number of reports from some of the best and most experienced surgeons shows there are five points of great importance to be considered in establishing the proper treatment for every case of fracture of a bone of the human body.

1st. The particular individuality and surroundings of each case.

2nd. The age period of the patient.

3rd. The time after the injury the permanent dressing or the restitution of the fragments is accomplished.

4th. Proper alignment of the limb and good anatomical reduction of the fracture.

5th. The methods of fixation and the proper apparatus, splints or dressing necessary to maintain the fragments in proper position without serious injury to the soft parts and with the least discomfort to the patient.

First.—The individuality, etc., of the patient. This point is so obvious it is not necessary to do more than to call general attention to it.

Second.—The age period: A study of 1,745 cases of end results of fractures of the long bones indicates that the age period 1-15 years shows an inherent tendency to recover from fractures with good functional results, though anatomical adjustment of the fragments may not have been good. The asymetry produced by angulation is soon overcome by adjustment of the other members of the skeleton. Overlapping of fragments with resulting local bulge rounds off, and in process of time disappears, unless the fragments have been allowed to unite in an unpardonably bad position **and the alignment is bad.** As the age periods advance it becomes more and more necessary to obtain good anatomical adjustment of the fragments in order to assure good functional results.

Senile cases demand attention to their general condition at once. They are usually in shock on account of the great pain produced, and will require full doses of morphia the first twenty-four hours. While it is not true of all cases by any means that old people cannot stand con-

finement to bed, one must early judge this feature and be guided in his treatment by this determination. As a rule, a dressing and apparatus should be employed which will enable the patient to move about a little in bed and to change position from time to time. It is rigid fixation in one position in bed and pain which prove so exhausting to old people. Strong traction and the necessity of remaining fixed on the back are very irksome, and are apt to be painful, hence the ordinary traction devices should not be used for any length of time in cases of old people.

Third.—The sooner the adjustment or setting is done after the injury the better and quicker the recovery. Reparative processes begin early, much earlier than surgeons have hitherto seemed to think. If setting the fracture is delayed what already has been done by natural processes will be destroyed and the second attempt to do the osteocementation will not be as quick nor as energetic.

Fourth.—Anatomical, or accurate adjustment of the fragments, other things being equal, always results in shorter disability and better function. This, however, is not always true when the open method is employed to secure accurate adjustment. Many cases of plating, with anatomical adjustments, take longer periods for recovery than do less accurately replaced fragments treated by the closed method. Except in children, however, the function is better in the accurately adjusted cases.

Fifth.—The methods of fixation and the dressing of fractures, while most important, is today perhaps more varied and various than ever they were. From the great mass of material and methods it is impossible to cull any special one to recommend. None of them are applicable to every case, even to the fracture for which it was originally advised. A surgeon of a mechanical turn of mind and training, if he has the necessary anatomical knowledge, usually can adopt a proper dressing and fixation for his cases of fracture, and he will be able to vary them as the individual case requires.

There are certain general principles, however, which should be kept in mind by every surgeon and should be sedulously practiced by the average practitioner.

(a) If the surgeon be a practitioner not accustomed to treating fractures, he should always consult an experienced man before doing anything.

(b) Never attempt to set a fracture unless there is at hand splints or apparatus to retain the fragments in place. It is unnecessary and it is brutal to subject a patient to the suffering produced by the necessary manipulations for temporary adjustments. The extremity should be fixed so that the ends of the fragments will do no further injury, or occasion any unnecessary pain, and nothing else should be done until the permanent dressing may be applied.

(c) If the patient's condition will permit, a general anesthetic should always be used in setting a fracture.

(d) Always try to obtain good alignment even though anatomical restitutions is not practicable.

Proper apparatus after reduction, as was said before, must be adapted to each individual case. In my own clinic I find that plaster of Paris moulded splints, put on during general anesthesia just as soon after the inury as possible, is the method of dressing preferably employed. But since the war we are using in many cases, Blake's suspension method with a Balkan frame.

The position of the limb as regards flexion, extension, abduction and adduction is maintained according to the indication of the case. When steady traction is necessary for reducing the fracture and maintaining it during the application of the splints a Lemon Extension Apparatus has been found exceedingly useful and efficient. A Harley table is equally good. Bardenheurer extension and counter extensions at various angles and in several directions are very irksome and trying for the patient.

Since the war this method modified by Blake and others is often employed however by the use of the Balkan frame. With suspension this method may prove very efficient, but it requires skill and careful watching and adjusting. For traction in difficult cases for continuous extension the Steinmann nail or the tongs method is sometimes useful.

The old Buck's extension method or some modification of this method is still the favorite method of the older surgeons for continuous traction. Too little weight is used as a rule in Buck's Extension. Analysis of reports of about 1,000 cases of fracture of the femur shows the average weight employed has been less than ten pounds. Manifestly this is absurdly too little. "The gauge of the proper

weight required is that necessary to overcome the shortening." As stated a little while ago, surgeons who served in the war are now using some form of Balkan frame and are suspending the fractured limb, and at the same time employing traction by weight and pulley. Daily measuresments should be taken and weight be added or reduced according to whether the limb shows shortening or elongation as compared with its fellow.

Rigid board or metal splints are rarely applicable for permanent dressings. They cannot be adapted to limbs without causing pain from irregular pressure (except perhaps the Thomas Splint, of which Jones speaks so highly); extension with them is very uncertain and difficult to maintain. The forearm is a region which is an exception to this rule.

Championnere's method of treating fractures by massage carries with it many suggestions of great value, though it has not been at all generally employed in this country. The principle of keeping up the nutrition of the muscles and encouraging an active circulation of the injured part is certainly one to be recommended. The massage should, however, be begun after the spasmodic stages are passed. Then the fixed dressing may temporarily be removed, the limb massaged and the dressing reapplied. This should be repeated every few days. This massage shortens the period of weakness, prevents atrophy of the muscles and promotes bony union.

The question of operative or non-operative treatment must be determined by each surgeon in every individual case. Operative treatment requires skill and thorough aseptic technic and surroundings. It should not be attempted by a novice. As was said, children under 15 years of age do not require operative treatment of fractures as a rule.

The Committee on Fractures of the American Surgical Association collected 1,745 cases of fractures, the end results of which were ascertained and the patients examined. Of these 1,358 cases were non-operative and 387 were operative cases. 258 cases of simple fractures, and 129 cases of compound fractures were subjected to operation. A little over 25 per cent. I find that of major fractures of long bones treated in St. Luke's Hospital we operated upon about 37 per cent. The Committee of the American Surgical Association found that the anatomical recoveries were better under operation, but that the percentage of functional recoveries were higher in the non-operated cases. In my own cases the functional and anatomical recoveries were higher in the operated cases.

There are certain regions which fractures are particularly difficult to treat successfully without operation.

In the Upper Extremity—(1) Fractures about the anatomical neck of the humerus. These fractures as a rule require an open operation for proper adjustment. Good functional results may be obtained without good anatomical adjustment however.

(2) Fractures about the condyles of the humerus are also trying ones to treat. Since Jones of Liverpool has taught us the value of fixation of the forearm in extreme flexion and the very general applicability of this method for most of the fractures of the lower end of the humerus, these fractures may be regarded with less apprehension than formerly they were.

3. Fracture of the bones of the forearm anywhere below the end of the tuberosity of the radius to the middle of the lower third of the bones are exceedingly difficult ones to adjust. Fractures in this region in many cases are absolutely irreducible without an open operation.

In the Lower Extremity.—(1) Fractures of the neck of the femur within the capsular ligament. Royal Whitman gave us the key to this treatment when he showed the importance of abduction in treating these cases. Dr. John B. Murphy contended that it is absolutely necessary to have the distal and proximal fragments in apposition at their fragmented surfaces in order that the osteogenesis may extend from the shaft fragment to the head fragment. He thought the head fragment has no osteogenetic qualities at all and would atrophy if not so apposed. Therefore, he recommended an open operation and nailing the fragments together. In my practice a Nathan Smith's anterior wire splint, or perhaps better still a Hodgen's wire apparatus to support the extremity while it is swung outwards in abduction by proper placing of the overhead beam from which the extremity is swung, has proved especially efficient and agreeable to the patient.

2. Fractures of the upper third of the femur. These are always very difficult fractures to treat. Fractures in this region especially lend themselves to the open method of treatment. Direct fixa-

tion by means of a plate seems much the best way to meet the ever-present tendency to elevation and external rotation of the upper fragment. Besides, this region of the bone is much nearer the surface than those lower down, so the wound required will not be so deep, nor otherwise as extensive as that which is required lower down.

3. Fractures of the lower third (supercondylar fracture), with posterior displacement of the distal fragment into the upper popliteal space sometimes prove very intractable fractures to reduce. If one fails to reduce the fracture under general anesthesia by flexion and manipulation an open operation should be done at once, for the pressure of the distal fragment on the vessels is apt to result in thrombosis and possible loss of the leg. For this fracture Jones of Liverpool especially recommends the Thomas Extension Splint. I have recently treated a very refractory case by a Thomas splint curved at the kneejoint to produce the necessary flexion.

4. Fractures of the tibia below the level of the tuberosity, if the fractures are spiral or very oblique, are exceedingly difficult to retain in position, if reduced. Reduction sometimes is practically impossible without an open operation. This is true also, but in a lesser degree of fractures of both bones of the leg. This region, on account of the prominence of the tibia, is especially apt to be observed by the patient and his friends. A lack of proper apposition, with a local projection of bone and angulation, and the resulting distortion are very objectionable. Hence open operations should be employed when careful attempts under anesthesia to reduce and hold the fragments have failed.

Pott's fracture, viz., fracture of the fibula in the lower third with a fracture at the lower part of the internal malleolus, or tearing away of the internal lateral ligaments, and always a luxation of the ankle joint, is also a difficult fracture to treat. The important feature of this fracture is the proper reduction of the dislocation. When the lower end of the proxymal fragment gets behind or between the tendons nothing short of direct vision will assure proper reduction. This can only be accomplished by an open operation.

The up-to-date treatment of fractures of the long bones therefore resolves itself into the two general methods:

1. The conservative, non-operative;
2. The open or operative method.

In this country the non-operative method still has by far the largest number of adherents.

The study of the reports of a large number of cases, and persistent inquiry indicates that though numerically in the minority, the surgeons who especially favor operative treatment of fractures are those who have a very large clientele of fracture cases, and who have especial opportunities and facilities for noting and observing the end results of fractures—Fractures of the femur, concerning which the statistics and reports are especially full and accurate, are those particularly recommended for the open method of treatment.

It is obvious that the treatment of fractures still requires a great deal of study. I would urge the simplification of methods and the standardizing of results.

The mechanical devices for the treatment of fractures are entirely too many and too complex. The simpler the method usually the better it is. For this reason careful reduction under general anesthesia and the application of a plaster of Paris splint appeals to me. The fragments should be kept in place by strong mechanical **unvarying traction** (as by a Lemon or Lambotte or Hawley traction apparatus) while the plaster splint is applied **and until it has hardened.**

Prognosis.—It will be well for a surgeon always to be very cautious in predicting the result in any case of fracture of a human bone. As was noted in the foregoing pages, many conditions, some of them very difficult to determine, may serve to modify or prevent the expected average result of any given fracture.

The following statistics taken from the British and American Fracture Committees reports indicate the average result of fractures of the long bones.

	NON-OPERATIVE				OPERATIVE			
	British		American		British		American	
	Good	Moderate	Good	Moderate	Good	Moderate	Good	Moderate
Humerus shaft	64.5%	21.9%	84%	10%	83.3%	16.6%	13%	62%
Radius & Ulna shaft	55.2%	31.5%	90%	4%	75 %	25 %	71%	25%
Femur: Whole shaft	75.9%	14.8%	67%	17%	63 %	28 %	66%	23%
Tibia & Fibula shafts	70 %	20 %	46%	17%	68 %	22.7%	13%	4%

The average period of disability (that is the time lost from work) in simple fractures, is as follows:

For fracture of the shaft of the humerus	14.0	weeks
For Fracture at head and neck of the humerus	11.5	"
For fracture at condyles of the humerus	9.0	"
For fracture of the shaft of both bones of the forearm	10.8	"
For fracture of the femur, all sites	7.37	months
For fracture of the leg, all sites	4.75	"

Note.—This determination must still be held as not quite conclusive on account of the comparatively few clear reports on this point.

The average period of disability for compound fractures:

For fractures of the femur	13	months
For fractures of the leg	6	"
For fractures of the upper extremity	4	"

The above figures show that the result of treatment of the majority of fractures of the long bones is good, this refers to the **functional** result. Skiagrams show, however, that the **anatomical** results by the closed method is in about **90% of cases only moderate.** If one is to judge results, however, he should take functional results as his standard.

Unfortunately laymen are not convinced of this. So many opportunities are given laymen to obtain skiagrams for themselves they not infrequently possess themselves of an x-ray picture of their fractured bone on their own account, especially if they are not quite satisfied with the result of the treatment. To forestall this and to protect himself, as well as to obtain data for a positive diagnosis a surgeon should always insist upon having a skiagram made and direct the patient to a first-class roentgenologist to take the picture.

The Workmen's Compensation Laws, now so general in the United States, will undoubtedly operate towards the better record, better study and better treatment of fractures. This will lead to the establishment of the average period of disability of fractures in the several regions of the extremities. Standard treatment and standard results will unquestionably follow.

The fracture committee of the American Surgical Association ends its preliminary report with the following recommendations in which I heartily concur:

"Neither the non-operative nor the operative method is to be recommended exclusively. Each has its indication and should be employed when required. Generally speaking, the age period under fifteen years is the period in which non-operative methods are especially effectual. In the other age periods up to 60 years, operative methods may with confidence be employed when non-operative treatment has proved ineffectual in reducing, or controlling the fragments in proper position. The operation should not be delayed longer than one week after injury.

"The open method when adopted should be employed early. It may be used at any age period, except in senile cases, whenever a skiagram shows a deformity or a position of the fragments which obviously cannot be reduced or when proper efforts at reduction have proved unavailing.

"Some form of rigid plate applied directly to the bone, or an Albee "inlay" seems to be the best fixation method in operative cases.

"Open operations for simple fractures should be undertaken only by experienced surgeons who are thoroughly equipped by training and who have proper instruments and apparatus to meet all the possible indications of the operation."

ORATION IN MEDICINE.

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THE INTERNIST: HIS DUTY TO HIS PROFESSION AND THE PUBLIC.

By W. Blair Stewart, M.D., F.A.C.P.,

Atlantic City, N. J.

It was near the dawn of a hot September day in the late seventies when a group of children were playing by the roadside in a country district of Southern Pennsylvania. The sun shone like a large ball of fire as it was gradually sinking from sight behind the beautiful blue mountain in the distance. The birds were carroling and singing their songs at the close of another day. The cattle were lowing in the distant fields. The noisy play of the children was suddenly hushed and all was quiet as an old horse came trotting slowly

down the country road. Seated in the carriage was an elderly man, the lines of whose face showed a kindly yet decisive character. His soft hat drawn well down over his forehead; his mixed gray beard; the driving lines held loosely in his hand as he slept; an old brown dog ran lazily under the shadow of the carriage as it rolled slowly past and down the road. The children had done reverence to a man dear to their hearts and for whom every one had respect—the old Country Doctor—my father.

But yesterday another group of children were playing at the same place, when a cloud of dust appeared in the distance, a piercing shriek of an electric horn and everybody scattered in terror as an automobile shot past and was gone. The boys resumed their play without comment and the incident was forgotten. It was "The Doctor" of today, too busy to lose one moment in his hurry to reach his next call or his office; too busy for a friendly salutation to the children. A sad contrast within a short generation.

We are living in a day that demands greater activities, more speed, higher nerve tension, more work and less time for pleasantries; greater preparation for the exacting demands of a more nervous and impatient clientele and, too often, your entire time irrespective of hours of sleep, meals and recreation. But such is our chosen profession, and proud is that man whose record stands untarnished in the performance of his duties to suffering humanity. The medical teachings of our elders were but the stepping stones to a new era of the medical and surgical practice of the future. Many of the old methods seem crude to us in their execution, but we are doing today those same old things in a different manner and clothed with a new vocabulary.

The world demands that the doctor shall be intelligent, forceful, learned, decisive, a good mixer, sober, honest and frank—in fact he must be a shining light in his community if he expects to win the respect and confidence of the people. The internist owes his time to his professional brothers, the public and himself.

Some one has said, "Show me a doctor who does not attend his medical societies and clinics and you will usually find an automaton interested largely in the teachings of the past and self-satisfied." No physician can afford to miss one society meeting without fear of sacrificing some fact that will help him in the treatment of his next case. Many of our perplexing problems are solved by mutual contact with our professional brothers in the office, society or clinic. Our methods of treatment should never be so exact and selfsatisfying that some one may not show us some new plan that will be an improvement. We owe it to our patients and to ourselves to make use of every means at our command to improve our knowledge and skill. Lend your every effort to make your society an interesting factor to yourself and your fellows. There is no excuse for the many petty quarrels and jealousies that have disrupted some of our best societies. We can not all have the same viewpoint nor always fully agree with the political plans of the majority, but we can at least be men and accept the situation for the good of ourselves and others until right prevails. Give the other man a boost and, if he is wrong, there are legitimate methods of reaching amicable adjustments.

If it were within the power of every internist to take post-graduate work under the masters, after he had wrestled with the problems of active practice for ten years, he could more fully enter into the spirit of modern medical teaching and technique and the better appreciate what to and what not to do. He must keep track of all new methods of diagnosis and treatment whether they are of practical use or merely fads and fancies. It is unwise to attempt to practice medicine in a rut or by fixed rule and set prescriptions. Seek for something better, but do not be carried away by some new innovation that promises much and produces little. An old professor frequently repeated an old axiom, "Be not the first by whom the new is tried, nor yet the last the old to lay aside." We are prone to hobbies in medicine and are often too easily led to follow the false methods that are given undue publicity. A little blarney and short lecture given by some smooth tongued pharmaceutical representative on the merits of his preparations too often trap the unsuspecting internist into a short cut to supposed specific medication, irrespective of clinical symptoms and indications. In these days of liquor abolition great pressure is brought to bear upon the physician to align himself to bolster up a tottering liquor monopoly. Testimonial letters are written and, not infrequently, public

addresses in favor of the use of alcoholics by the lay public, as well as the dire distress of the doctor on account of government regulation. Can we as a profession allow the use of our names in this manner? The Government has provided reasonable methods whereby the internist may properly prescribe if, in his judgment, the occasion requires, but it is dragging down the good name of the profession when any one of us aligns himself in favor of a return to old unrestricted conditions.

How many physicians take one-half hour's time each evening before retiring to review the day's work, analyze their cases, hunt for possible errors and make important professional notes? Too busy! Yes, many a time and too tired. Try it in the solitude of your office and you will retire to sleep with a clearer conscience and a better preparation for the morrow.

It is refreshing to see a closer relationship between the internist and surgeon. Neither can work without the other even though great rivalries have arisen in some centers. The greater part of surgical patients consult the internist and family physician first for examination, study and advice and it becomes necessary to work together for the best results. The internist owes it to himself and his patients to faithfully attend the surgical clinics and grasp the opportunity to see every surgical operation, for thereby he is brought into direct contact with a living pathology that is more instructive, impressive and practical than all of the hidden and postmortem pathology. Every operative case seen and studied in the living makes the next like condition more easily recognized and often prevents delay in necessary operations. When your case is referred to the surgeon, study it with him, advise with him and insist upon being present at the operation both for the moral support of your patient, your own enlightenment and encouragement to the operator. Follow up the cases after operation with the surgeon until discharged, for they come under your care again. These considerations have led to a new era in medicine and surgery called team work, where internists, laboratory workers and surgeons study, discuss and map out their treatments in a most exhaustive manner. The gastric and duodenal ulcer belong to the internist and surgeon jointly and, while many operations are avoided as unnecessary, too long delay is prevented in strictly operable cases. My plea is for greater harmony and less contention on both sides. Your consulting work may be done in the office or the home, but a good hospital is preferable. The hospital should be used as a base of study and should be a medical and surgical center for professional and lay uplift.

It should never be used as a loafing place for idle, jealous and political medical groups where professional vituperation, medical politics and profanity too often comprise the daily routine. If the local hospitals do not command the confidence and respect of the public and are subject to ridicule, there is something radically wrong with their medical staff, board of managers or both and a thorough housecleaning is needed to infuse new life and more approved methods of management and treatment. The medical profession must realize the importance of the hospital in the community for the good of the public and not for the benefit of any group or clique. The moment commercialism and politics enter the hospital doors its utility is immediately impaired.

Preventive medicine will be the practice of the future. Recognize disease before it starts rather than after it has gained a foothold. Good health is the first requirement for a normal life of work and enjoyment. The public will never be driven by laws. It is necessary to educate and show how to gain good health as well as to establish and maintain proper sanitation. It is appalling how indifferent we as internists have been as a class when it is shown by the workings of the United States Selective Service Draft that one-third of the young men, twenty-one to thirty-one, are physically below normal standard and unfit for severe strain or hard work in service. A larger percentage of defectives holds in the class over thirty-one years. Ten years inspection in the public schools in England showed over one million children so defective that they could not follow their school work. It was also shown that one-half of the insured working population of England and Wales received medical treatment during 1914-1916. Fourteen million weeks of sickness, most of which could have been prevented by public instruction and proper hygiene. What an enormous economic waste of time and money. The lost money, fig-

ured in dollars and cents, would have driven poverty entirely from that realm.

If manufacturers and merchants would give greater care to the physical welfare and sanitary housing and diet of employees, their output would be more than doubled and our economic problems as a nation would be greatly relieved and it would be entirely unnecessary for our own workers to lose an average of nine days each year largely from preventable diseases. It is necessary to show each household the path to health. The State must not be lenient with landlords and tenement house owners but must exact as nearly perfect sanitation as possible. The doctor, the nurse, the minister and social workers must organize campaigns for health in every community and keep everlastingly at it during the entire year instead of having spasmodic "clean-up weeks" that are soon forgotten. No State Health Insurance scheme, manned by pauper doctors, will ever accomplish ideal public health, but instead we must have voluntary intelligent co-operation with our industrial heads.

Tuberculosis, typhoid fever, contagious diseases, venereal diseases, malaria, hook worm and a long list of other diseases have no other excuse for their existence than public ignorance or carelessness and could be avoided almost universally. Many of the classic diseases of past years have practically disappeared and are rarely, if ever, seen by the average practitioner. One of the greatest American sins is that of intemperance in eating and a paucity of exercise. We have acquired the lazy habit of riding to every place we go; of eating soft predigested foods leached of their health-building elements; of too much tea, coffee, tobacco and liquors; too much protein and too little of the vitaman containing foods. We neglect the best-known free remedies, fresh air and sunshine and breathe imperfectly —in fact, between the extraction of our teeth by the dentist, the excision of our tonsils by the throat man, the sacrifice of our appendix to the surgeon and the multiplicity of inoculations by the internist, we hardly know whither we are drifting or how much will eventually be left of the body for future generations. We can not all be like the athletes of ancient Greece and Sparta, but we can at least aspire to their perfection of body and race. We must not be lazy in our good intentions but should be busy. Some one has said, "It's all right to put your best foot forward but don't forget to use the other one too." "The doctor who wastes his time does not seem to realize that he will need it all before he dies." "The doctor who never makes a mistake must lead a mighty monotonous existence."

In the exercise of your work do not forget the social side, your family and your vacation. "All work and no play ...." applies to the internist as well as to the less exacting professions. You will live longer if you make a practice of taking not less than two weeks' vacation twice yearly. Yes, you can do it. Give your patients a vacation and they will excuse you and you will return to do better work. Please bear in mind that your wife (the *doctor's wife*) should not always be compelled to meet your social engagements alone. Unreasonable trivialities are too often allowed to interfere and afford an excuse for a not over-enthusiastic husband. Meals on time? Yes, if you will. Just try a new adjustment of your work and do not allow any engagement except extreme emergencies of birth or death to interfere with social duties, and be reasonably on time to meals and take time to eat them. You have no excuse, busy as you are, to neglect yourself and the good housewife and your ruling kitchen lady by tardiness. Try it for one month and you will live in a new world and get better acquainted with your wife and children. The internist is brought face to face with the inception and dissolution of life and should command that respect for religious belief that is due to all creeds and races. The doctor is never so busy that he cannot attend his church at least part of his time, if he so wills, and thereby increases his own respect for the Unseen and is better able to administer comfort, consolation, kindness and good cheer in his daily routine.

Miscellaneous Items.

Child Hygiene Bureau Stations Opened.— The Bureau of Child Hygiene of the New Jersey State Department of Health has opened two stations, one at Lambertville, and one at Frenchtown, the latter to be the center of work which will include Milford and Stockton. A social worker has been appointed to work under the direction of Camden Board of Health. Her salary will be paid by the Child Hygiene Bureau, which will also sug-

gest her policies. The Child Hygiene Bureau has taken the initiative in securing cheaper or free ice for families who could not afford to have it otherwise.

Physiatric Institute Opened.—An institution, known as the Physiatric Institute, devoted to diabetes, nephritis, vascular hypertension and other metabolic disorders, has been established at Morristown. The site is the former estate of Otto H. Kahn, comprising some 200 acres. Dr. Frederick M. Allen is the director. The backers are a group of prominent New York and Philadelphia men, and financial support is sought chiefly from the individuals and families afflicted with these diseases. The organization is in three divisions. One is a sanatorium for the treatment of paying patients, the income from which helps to support the other two divisions. The second is a charitable branch, which offers treatment to poor patients at reduced rates or free, as far as the available funds can provide. The third is a research division, aiming to advance the knowledge and treatment of these conditions by all the facilities for clinical and laboratory study which a specialized institution of this kind can offer.

The federal district court for the Eastern District of New York holds that section 8 of the Harrison Narcotic Act, making it unlawful for any person who has not registered and paid the special tax to have in his possession any of the drugs named, applies only to the classes of persons required by the act to register and pay the tax. It holds that the act is constitutional except so far as section 8 is concerned.—United States v. Denker, 255 Fed. 339.

Bubonic Plague in Texas.—Eight cases of bubonic plague have been reported at Beaumont, Texas, by the State Health Officer. Three of the cases were fatal. Three cases with two deaths have been reported at Galveston. The State is waging a vigorous crusade against rats.

Went to Europe a Good American and Came Back a Ten Times Better American.

Sounds good, doesn't it? It was brought out by Dr. Edward H. Ochsner of Chicago before the Michigan State Medical Society at their annual meeting, May, 1920. Dr. Ochsner in opposing the propaganda for paternalistic government in America, said: "If you get this thing fastened on a country there can be no step backward. There are so many men in the employ of the state and they will keep blowing the horn so hard that you can't say a word about it! Lloyd George went over to Germany (he was so hard pressed that he had to have some scheme) and spent three whole weeks studying Compulsory Health Insurance through an interpreter! He went to the heads of departments and asked 'How is the scheme working?' and, of course, they told him 'It is lovely, it is splendid, it is the utopia on earth. I make forty marks out of it and the doctor down here is getting twelve marks' (this last as an aside).

"I did not do that. I went to Germany and I wore German clothes, and I wore a German moustache (laughter), it was not much of a moustache, but it answered, and I talked the German language. I spent many months there and I lived among the people and never slept a night in a hotel. I spent seven months in Vienna and never slept in a hotel. I spent several months in other places and spent my time among the people and they did not know I was an American physician. I didn't let the Eagle scream on every occasion. I am proud of that Eagle, he's a grand bird, but there's no use over-doing it! I went to Europe a good American and I came back a ten times better American. I went to Europe with six hundred years of ancestry behind me that hates paternalism, and I'll do everything I can to defeat paternalism in this great country of ours!"

Secrecy on Part of Physician Not Obligatory in Case of Communicable Disease.—A guest in a small hotel in a small town in Nebraska consulted a physician, who found the patient to be suffering from a communicable disease, presumably venereal. Being medical adviser to the family who ran the hotel, the physician warned the landlady as to the nature of the guest's affliction, and instructed her in measures to guard against contracting the disease while caring for the room. The landlady ordered the guest to vacate, whereupon he brought an action against the physician for damages for "alleged breach of duty arising from confidential relationship between defendant, who is a physician, and plaintiff, who was his patient." The Nebraska Supreme Court directed a verdict in favor of the defendant, holding that a physician is not compelled to maintain secrecy in the case of communicable disease when the health of other persons is endangered.

Raynaud's Disease.

From the Maine Medical Journal.

We have lately received a copy of the New Jersey State Medical Journal for June, and on its front and various successive pages we have discovered and read with great pleasure and gratification a very remarkable paper on this rare disease by Dr. H. P. De Forest of New York. Not only does the paper contain a list of seventeen cases treated by the writer, but it has illustrations of the various portions of the body attacked by this strange affection, remarks on its pathology, suggestions for successful treatment, and so on, but there is in its columns an unique portrait of Raynaud, together with a very satisfactory biographical notice of the discoverer of the affection which takes his name. Precisely speaking, however, it might be useful for certainty of nomenclature to call it local syncope, or local asphyxia, or finally, symmetrical gangrene.

It is not often that we note so valuable a paper in contemporary medical literature, and in our inability to condense it so that it can be made of practical value to our readers, or to reproduce any of the very curious and invaluable illustrations, case histories, and suggestive treatment, we make it a particular point in this way to call the attention of those interested in the topic of Raynaud's disease. Additionally, it will give us the greatest pleasure imaginable to show the paper, with its pictures, to inquiring colleagues in internal medicine throughout the State.

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OF THE

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PUBLICATION COMMITTEE:

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

Your Debt

"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—Theodore Roosevelt

DON'T FAIL TO READ.

County treasurers and all members of county medical societies will please take notice of a change in the by-laws (Chap. XII, Sec. I, Paragraph 2), the word "March" in the first line is stricken out and the word "January" inserted in its place. By this change treasurers are directed to send a list of the names of the members (it is also best to add the addresses of the members, as this list is the basis of the annual list, which is published in the Journal and should contain the names of all members, who desire to have their names appear therein), who have paid their dues, also the amount of such dues, to Dr. Mercer.

Our year begins on January 1st of each year and all dues are **payable in advance.** Therefore, any member who does not pay his dues in advance, on or before January 1st of each year, **is a delinquent and not in good standing.** His name is dropped from the mailing list of the Journal, he loses the benefit of medical defense for any act of alleged malpractice occurring during his delinquency and also loses the privilege of fellowship in the American Medical Association.

As most of our county medical societies hold their annual meetings in October, it would be well for all members to pay their annual dues to the State Society ($3.00 for 1921) at that time. Of course, they must also pay their county society dues at the same time, otherwise they are not in good standing. When this is neglected it is apt to be forgotten and, as delinquents, they are liable to have a suit for malpractice sprung upon them. In such cases the State Society cannot defend them and they must pay the expense themselves. MORAL. — PAY YOUR DUES PROMPTLY IN ADVANCE.—W. J. C.

THE DOCTOR'S VACATION.

There probably has never been a year when the doctor needed a vacation more than this year. Of all lives the life of the physician has ever been the most responsible, the most exacting and most self-denying. The great World War and the great influenza epidemic intensified his activity to such an extent that self-denial meant to many self-sacrifice, even to the yielding of life itself, and to most physicians a lowering of vitality, if not a lessening of their ability to serve with their accustomed fidelity and efficiency.

We are pleased, therefore, to note the fact that an unusually large number of our members have been and are still enjoying vacation, most of them of longer duration than usual. We offer them our heartiest congratulations, wishing each and all a return with greatly increased strength, and we also congratulate their patients on what that rest and increased vitality will mean to them.

We shall not attempt to characterize the value of the doctor's life and services to his patients, the community and to humanity at large. We remind ourselves and those who return from their vacations that we have satisfaction, comfort and encour-

agement from the fact that the world is not unmindful of the service and devotion of the true physician. We cite the following editorial which recently appeared in *The Outlook,* as an evidence of that fact:

The Doctor.—Of all lives the life of the physician is the most self-denying. He has no time that he can call his own. His home is his office, and furnishes him no sweet retreat from irksome care. The night can never assure him unbroken rest. Sundays are often, whether he will or no, his busiest days. He has no holidays, and few and fragmentary vacations. Friendship furnishes him fewer solaces than to other men, for his friends are generally also his patients. He meets men in their morbid conditions—when they are sick and miserable; when they are well he knows them not. He can hardly make a friendly call without the hazard of having it converted, before the evening is over, into a professional one. He fights a battle in which, no matter how many victories he wins, he is sure to be defeated at last—for he is fighting death. And when the defeat, which must come sooner or later, does come, he is fortunate if unreasonable friends do not charge the defeat upon his lack of science or of care. But no man renders a more grateful service; no man comes nearer to our hearts; no man is more beloved. Other services may be as great, but none is more deeply or tenderly appreciated. He summons back from death the child, and puts him in his mother's arms; the wife, and reunites her to her husband. No fee can ever compensate for such a service. He to whom it is rendered is forever debtor to the doctor.—The Outlook.

But we also need to be deeply impressed by the words of ex-President Roosevelt on "Our Debt" that appear at the head of our Editorial Columns, as we shall take up the work of the coming fall and winter, for never in the history of our profession has there been a time when false cults and demagogic politicians have to so great an extent combined to drag down and destroy the scientific standing and efficiency of our profession. We must hear and heed the words that remind us of our Debt, and freely give time, influence and organized effort to maintain our profession at any cost.

Not only the Profession, but also the Family, the Community, Humanity, the World Demands that we shall stand ready to give up ease, comfort and, if needed, OUR ALL—*even* LIFE ITSELF *in the effort.*

SECURE ABLE AND HONORABLE LEGISLATORS.

We urgently appeal to every county society Welfare Committee to scan well their legislature nominees this fall. Secure, if possible, the defeat of every nominee who voted for the separate Chiropractor board of examiners. Let not the secret propaganda of last fall, that secured bank officers and leading merchants' appeals to legislators to vote for that bill, be repeated successfully this year. We urge this—not for the profession's sake but for the public's welfare, as the dragging down of the regular profession's scientific standing and efficiency means loss of health and lives of our citizens.

It has been suggested that in cases where a candidate is nominated who cannot be relied on to guard those sacred interests, that our Welfare Committees have nominated independent candidates—a democratic doctor in a democratic district and a republican in a republican district. Defeat by all means any candidate who is likely to work and vote for his own sordid interests rather than for the public welfare. We are told that many legislators do not even read the bills they vote for, but vote as the bosses direct—that would seem to be true from the definition of chiropractic practice in their bill passed last winter—one of the most absurd, nonsensical jumbling together of words we have ever read.

"Many politicians prefer the danger of losing with a machine candidate to the risk of winning with a people's candidate."

"CHRISTIAN SCIENCE"—SO-CALLED.

We have not used our columns to discuss at length this misnamed cult that pretends to have wonderful healing power over disease, for we do not believe it is either christian or scientific, or that it has any claims on the medical profession's recognition. We have recently received a communication from one who claims to be the "Christian Science Committee on Publication for the State of New Jersey," which takes us to task for a lack of professional dignity in "permitting to creep into the columns of the Journal," "a would-be epigrammatic satirical definition of Christian Science," as "the Religio-Medical Masquerade, unscientific, devoid of truth and healing power," (page 244, July Journal).

We do not propose to enter into any "professional discussion" as the gentleman seemed to wish, as we fail to recognize the professional cult as having medical standing, but we wish to state that the insertion of the item referred to was not due to any "oversight which permitted to creep into the columns of the Journal, the definition

of Christian Science." Our readers will observe that the said definition was the ending of an Osteopath's criticism of Chiropractors, in which he seemed to place the latter on a par with Christian Scientists. At first we thought of omitting that reference, but concluded that it was possibly the best part of the item and put it in. There are two references in the communication received that we noted. Speaking of "Christian Science," he said: "It has come to minister to a mind diseased," and he quoted Mrs. Eddy: "Until the enemies of Christian Science test its efficacy according to the rules which disclose its merits or demerits, it would be just to observe the Scriptural precept—'Judge not.'" We did not before know that Mrs. Eddy admitted that the cults' rules possibly disclosed any "demerits." It is easy to quote, sometimes still easier to misquote Scripture. There is something said therein about "the love of money"; she did not ever seem to despise it and she certainly knew how to acquire it, and her followers are very apt to want $25 or $50 down before undertaking to "minister to a mind diseased."

We will not discuss at this time the more serious aspects of this delusion, even if it might save us from the admonition—"Judge not," or relieve us from the charge of censoriousness, uncharitableness or even the lack of "professional dignity." We refer to the loss of life it has occasioned by the withholding of medical treatment in severe illness, e. q., where parents have allowed children to die in cases of diphtheria, etc., and where the courts have expressed severe judgment.

Our readers will pardon us for occupying so much space on this subject and we will only add what is the substance of our estimate, and we believe that of our entire membership: We have no use for the so-called Christian Science or any other money-making scheme that seems to work upon the credulity of people who have "a mind diseased," believing that it is neither Christian nor scientific but a perversion of both Christianity and science. Money seems to be its Idol and costly buildings are erected for the glorification of this cult, rather than for the advancement of Christianity and for scientific research.

We suggest that our readers carefully note a quotation from *The Outlook* which appears in another editorial; then consider how it would seem if either of the words—"Christian Scientist," "Osteopath" or "Chiropractor" were substituted for the words "Doctor" or "Physician," in the Outlook's estimate of the doctor.

GENERAL W. C. GORGAS.

No American has ever passed into the great beyond, whose fame will more justly endure, than Dr. William C. Gorgas, who died in London on July 4th, from the effects of a cerebral hemorrhage. As the Kentucky Medical Journal says: "Gorgas' fame will endure as a practical sanitarian and servitor of mankind. No other one man, by his personal work, worth and influence has so extended human life nor has made it safer. As Hippocrates is the recognized founder and patron saint of medicine so will Gorgas be estimated by the world as the *beau ideal* of preventive medicine.

We congratulate the medical profession of Wisconsin on the nomination of Dr. Gilbert E. Seaman for Governor of that State. He served his country with distinction through the Spanish-American War and was surgeon in charge of the 32d Division during the World War. As a man of decided executive ability, he will make an excellent Governor. Never has there been so great a need of active, trained physicians in public life. New Jersey needs men of Dr. Seaman's type as Governor and legislators, but give us no self-seeking, log-rolling medical politicians for they entirely misrepresent and degrade the spirit of the profession and hinder its progress.

We are compelled to defer insertion of much matter prepared for this issue of the Journal, because of the length of the Official Transactions of the 154th annual meeting which, as usual, are published in the September Journal.

We refer again to the fact that our "Personal Notes" are, as a rule, confined to our members and are gathered from the newspapers that exchange with our Journal. We regret that we have but few such exchanges—none from Jersey City, Paterson, Elizabeth, Belvidere, Lambertville, Trenton, Camden or Atlantic City. We, therefore, are obliged to omit references concerning the activities of members in a large portion of our State that would be of interest to our members.

NEW OR REINSTATED MEMBERS OF THE CAMDEN COUNTY MEDICAL SOCIETY.

Deibert, Irvin E., 601 Walnut st., Camden
Haine, Wm. H., 217 Lafayette st., Audubon
Shaw, Abraham B., West Collingswood
Faunce, Matthew D., Haddon Heights.
Hirst, E. Reed, 586 Federal st., Camden
Strohm, Lloyd E., White Horse Pike, Audubon
Fox, Roger Talmadge, Gloucester City.
Lashman, Wm. M., 1314 Broadway, Camden.
Eaton, Arthur T., Haddon Heights.
Meyer, George P., 203 Pearl st., Camden.
Donoho, Albert P., Merchantville
Johnson, Charles H., 632 Benson st., Camden
Schall, Elmer R., 7th and Elm sts., Camden
Mackler, Lewis, 956 Newton ave., Camden
Patton, Gordie C., 501 Haddon ave., Camden
Wood, Walter F., 932 Haddon ave., Camden
Ward, Lettie Allen, 613 Cooper st., Camden
Boker, A. W., 3005 Keasarge ave., Fairview
Bentley, David F. Jr., 919 So 5th st., Camden

Hospitals; Sanatorium.

Barnert Memorial Hospital, Paterson.

The managers of this hospital have opened a radium clinic under the charge of Dr. William Spickers of that city. The institution has acquired fifty-five milligrams of radium and is prepared to treat patients referred from other hospitals as well as those who go directly to this hospital.

Bridgeton Hospital.—This hospital for the month of July reported. Number of patients admitted, 61; operated upon, 42; discharged, 52; deaths, 3; births, 7; remaining in hospital, 21.

Cooper Hospital, Camden.

The Cooper Hospital Board of Managers has entered into a contract amounting to $72,395 for the erection of a concrete and brick addition, 85 feet, 3 inches by 51 feet 10 inches, to be located north of the operating room building, consisting of a basement and three stores. Other changes increasing the efficiency and capacity of the hospital are being planned to follow these improvements. It is estimated that the entire cost of these changes will amount to about $150,000.

Salem County Memorial Hospital.

Dr. W. H. James, Pennsville, send the report of the hospital for July as follows. Patients in hospital, July 1st, 12; admitted during July, 62; operations, 38; discharged, 53; deaths, 2; remaining in hospital August 1st, 11; births, 5.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, Superintendent, makes the following report for the month of July, 1920: On July 1st there were 228 patients present in the sanatorium, 117 males and 111 females. This number includes 32 males and 45 females in the preventorium. During the month, 38 patients were admitted, 25 males and 13 females. Nine of these admissions went to the preventorium; there were five re-admissions. The admissions are classified as follows: Pretubercular, 9; incipient, 4; moderately advanced, 4; far advanced, 20, non-tubercular, 1. The largest number of patients at any time during the month has been 237, smallest number 228, present July 31, 1920, 235.

The Bonnie Burn School reports: Total days possible attendance, 1,374½; total days absent, 95½; total days personal illness, 23; per cent. of attendance, .930; total on roll July 31st—67—33 boys, 34 girls.

Marriage.

HORNER-RODGER. — At Camden, N. J., May 22, 1920, Dr. Clara Louisa Horner to Rev. J. C. Rodger of Shanghai, China.

Deaths.

HILL.—At Pequannock, N. J., July 9, 1920, Dr. Charles Frederick Hill, of Newark, N. J., aged 38 years.

Dr. Hill graduated from Baltimore Medical College in 1908. He was a member of the Essex County Medical Society and of the Medical Society of New Jersey. He died from tuberculosis.

LONG.—At Haddonfield, N. J., July 14, 1920, Dr. William S. Long, aged 65 years. Dr. Long graduated from the University of Pennsylvania Medical School in 1878; was a member of the Camden County and the State Medical Societies and a Fellow of the American Medical Association.

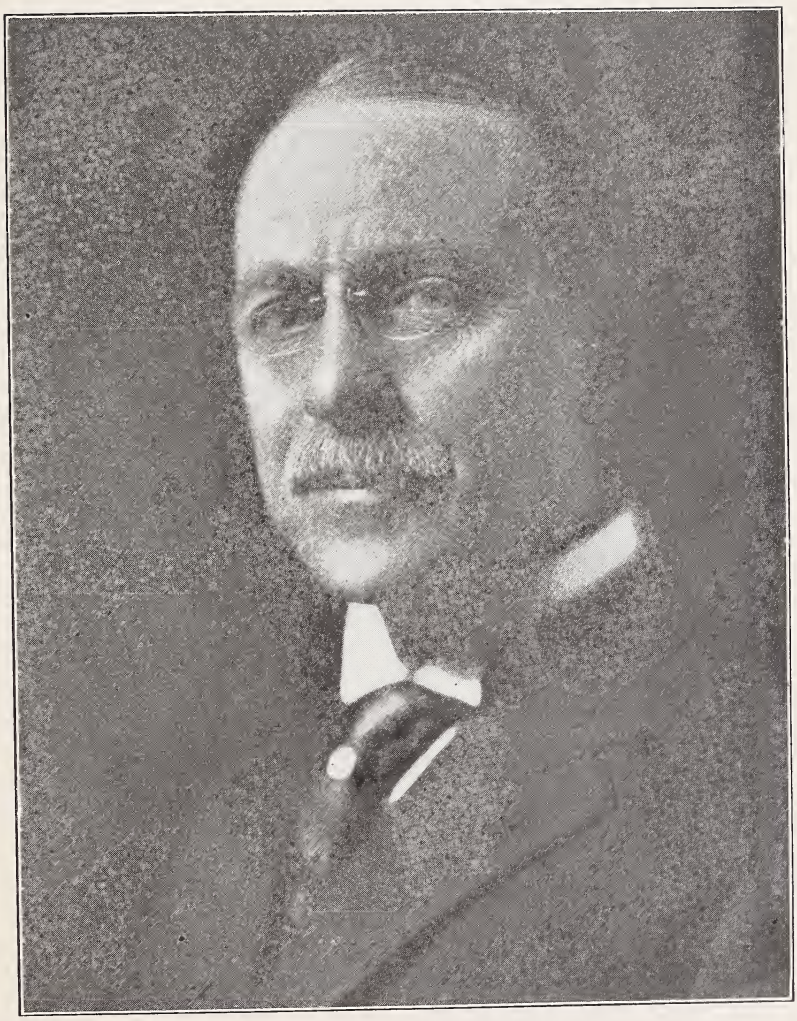
LATE ITEMS RECEIVED.

International Congress Against Alcoholism.—The fifteenth annual congress will meet in Washington, D. C., September 21 to 26 under the auspices of the State Department. The liquor question in all its phases will be discussed by scientists of world-wide reputation, a large number of whom will be from abroad.

New Jersey Doctor for Congress.—Dr. William E. Ramsay, Perth Amboy, has agreed to enter the race for nomination in our Third Congressional District. He is an able man.

Dr. D. C. English, New Brunswick, and wife will, in an entirely informal way, observe their Golden Wedding anniversary by inviting the Middlesex County Medical Society to hold its monthly meeting at their residence on the afternoon of September 14th, when Dr. Fred H. Albee, chairman of the Commission appointed by the Government on Rehabilitation by the State of New Jersey, will present an illustrated paper on that subject. The doctor also expected to have had Dr. Howard A. Kelly of Baltimore present, but regretted to hear that a recent accident which fractured his leg will probably prevent his attendence. There will also be a brief meeting of the Board of Trustees of the State Society following the above meeting at the doctor's residence.

For Public Health Items, see page 332.
For Personal Notes, see page xxiii.



GORDON K. DICKINSON, M. D., F. A. C. S.
JERSEY CITY, N. J.

President of The Medical Society of New Jersey during the fiscal year 1919-1920

OFFICIAL TRANSACTIONS OF THE 154th ANNUAL MEETING OF The Medical Society of New Jersey

Held at Spring Lake, N. J., June 15th to 17th, 1920

FIRST SESSION.

Tuesday, June 15th, 1920.

MEETING OF THE HOUSE OF DELEGATES.

The meeting was called to order at 10 A. M. by the President, Dr. Gordon K. Dickinson, Jersey City.

The report of the Committee on Credentials was presented by the Chairman, Dr. Harry A. Stout, Wenonah, as follows:

Dr. Stout: The credentials are in proper form and indicate that more than enough members are present to constitute a quorum.

On motion duly seconded the report was received.

The next order of business being the reading of the Minutes of the 1919 meeting, a motion was made that, as these had been printed in the Journal, and had been sent to every member, the reading of them be dispensed with and that the Minutes as published be approved. The motion was carried.

The report on Permanent Delegates was read by Dr. William J. Chandler, South Orange, as follows:

Report on Permanent Delegates.

June, 1920.

One year ago we reported the total Permanent Delegate membership as 137. We then elected six new delegates, bringing the total up to 143.

We have lost by death during the year six of these delegates, viz.: Frank M. Donohue of New Brunswick, Emery Marvel of Atlantic City, S. O. B. Taylor of Millstone, Geo. H. Balleray of Paterson, Wm. H. Carroll of Passaic and Livingston S. Hinckley of Newark. Three delegates have resigned: Henry B. Costill of Trenton, Philander A. Harris of Paterson and James Hunter of Westville. One delegate was dropped from the roll for two consecutive unexcused absences. Our present number of Permanent Delegates is therefore 133.

The following nominees for Permanent Delegates have been presented by their component societies, their credentials are in the proper form, and their names will be presented for election in the next order of business: George E. Tuers of Paterson, William Neer of Paterson, to fill the vacancies occasioned by the deaths of Geo. H. Balleray and William H. Carroll; Charles H. Schlichter of Elizabeth, to fill the vacancy occasioned by the death of Theo. F. Livengood. Dr. James H. Underwood of Woodbury to fill the place of Dr. James Hunter Jr., resigned; Josiah Meigh of Bernardsville, in the place of S. O. B. Taylor, deceased; Frank C. Henry, Perth Amboy, in place of Frank M. Donohue, deceased; Chas. J. Craythorn, Trenton, in place of H. B. Costill, resigned, and Geo. H. Franklin, Hightstown, in place of Elmer Barwis, dropped.

1921 is the year for filling quotas, and all county societies at their annual meeting in that year can select candidates for Permanent Delegates to the number of one-tenth of their membership. If any secretaries are in doubt as to the number to which they are entitled, they can communicate with the Recording Secretary and be informed.

Fewer errors have occurred in the selection of candidates for Permanent Delegates during the past year than usual and if county secretaries will study the article on Permanent Delegates they can easily avoid all errors. This matter was so fully explained last year and there is no need of taking more time on the subject this year.

Respectfully submitted.

Wm. J. Chandler, Secretary.

On motion, the report was accepted.

The next item of business was the election of Permanent Delegates. It was moved, seconded and carried that the Secretary cast a ballot for the election of the gentlemen whose names had been read by him as candidates for Permanent Delegates. This was done and the above named candidates were declared elected.

The report of the Committee on Arrangements was presented by Dr. William G. Schauffler, Princeton.

The chairman reports that arrangements have been made to accommodate the members of the Society and their guests for this meeting.

The banquet will be held on Wednesday evening, and will be followed by dancing. Arrangements are being made to provide amusements for the visiting ladies.

The exhibitors are situated in the basement at the foot of the stairs, and the members are urged to visit the exhibits frequently and thus encourage our exhibitors.

W. G. Schauffler, Chairman.

On motion, duly seconded, the report of the Committee on Arrangements was accepted.

The report of the Committee on Program was presented by Dr. William J. Chandler, the Chairman.

The program is its own best spokesman. It gives you an orderly outline of the business of the House of Delegates and of the sequence of papers presented to the scientific sessions. The number of papers to be read is greater than ever before presented at any of the meetings of this Society. Over 2,000 programs

were mailed to the members of this Society, to sister State societies and to many medical societies in this country and abroad. We trust it will meet with your approval.

Wm. J. Chandler, Chairman.

On motion, duly seconded, the report of the Committee on Program was accepted.

The report of the Committee on Scientific Work was presented by the Chairman, Dr. George N. J. Sommer, Trenton.

On motion, which was seconded, the report of the Committee on Scientific Work was accepted.

The report of the Committee on Publication was presented by the Chairman, Dr. Charles D. Bennett, Newark.

REPORT OF THE COMMITTEE ON PUBLICATION.

To the Medical Society of New Jersey.
Mr. President and Gentlemen:

Herewith is submitted the Business and Comparative Statements of the Committee on Publication for the year 1919.

It will be noted that while the net gain is a little less than for the year 1918, it is still on the right side of the ledger and we are well pleased for even this.

Conditions of publication have been very hard, with continuing increases in cost and persistent retrenchments on the part of advertisers.

During the year, the advertising rates were slightly increased although not sufficiently to meet the added expenditures, but the full benefit of this will not be apparent before January, 1921, as we extended to old advertisers the privilege of renewing their old contracts on the old basis; but with 1921 the new rates will be in force for everyone.

It seems desirable here to call attention to our reprint system. We give to writers 100 reprints free and the Journal pays the printer for this. For additional reprints a charge is made, and many may have supposed that this was a source of income to the Journal. This, however, is not correct, as the charge for these reprints goes directly to the printer, and the Journal receives none of it. Reprints are always an expense and not an income for the Journal.

Your committee continues to receive frequent complaints from members that they are not receiving the Journal and investigation usually shows that this is because of the failure of the county treasurers to collect and remit the dues of these members to the State Treasurer, who then has no reason but to consider them in arrears and delinquent. Only members in good standing are kept on the mailing list and probably many have been so deprived of the Journal and also of the benefit of the Society's Medical Defense. The list has just been revised with a net gain in names of about 200, some of which should probably have been added months ago. Will the county treasurers kindly note this matter and promptly make return of collections?

Committee on Publication in its effort to make a favorable showing becomes a bit discouraged at times, and it is hard to see how we can show any profit at all for the coming year, even with the new rates; this, not because of any lack of advertisements, but because of the ever swelling tide of expenses. However, your Editor and committee are loyally doing all they can to make your Journal as much of a success financially as it seems to be from the literary standpoint, concerning which the Chairman is often in receipt of complimentary notes from exchange editors, referring to its value as a distributor of medical information.

Respectfully submitted,
Charles D. Bennett, Chairman.

Business Statement.

From January 1st, 1919 to December 31st, 1919

Accounts	Gains	Losses
Journal	$ 10.00	
Advertising	3,354.05	
Extra Subscription Account	63.55	
Printing and Mailing		$2,983.12
Reprint Account		26.65
Stationery & Supplies		5.00
Editorial Salary & Expense		1,400.00
Expense Account		82.85
Cuts and Plates		9.54
Commissions		415.62
Discounts		79.04
Subscription Account	1,750.00	
Gains and Loss Account	36.12	
Net Gain		211.90
Total	$5,177.60	$5,177.60

Business Statement.

Accounts Showing Income or "Receipts."		
Advertising	$3,354.05	
Subscriptions (Regular)	1,750.00	
Subscriptions (Extra)	63.55	
Sales of Journals	10.00	
Dividends	56.42	
		$5,234.02

Accounts Showing Expense or "Disbursements"

Printing and Mailing—		
Journal	$2,763.37	
Official List	219.75	2,983.12
Reprints		26.65
Editorial Salary & Expenses		1,400.00
Commissions on Advertising		415.62
Discounts		79.04
Expenses		103.15
Stationery and Supplies		5.00
Cuts and Plates		9.54
		$5,022.12
Net Gain		$211.90

Comparative Statements.

	1918	1919
Advertising	$3,655.30	$3,354.05
Subscriptions (Regular)	1,760.00	1,750.00
Subscriptions (Extra)	55.00	63.55
Sales of Journal	6.63	10.00
Dividends Received		56.42
Printing and Mailing	2,821.89	2,983.12
Cuts and Plates	1.50	9.54
Editorial Salary	1,321.00	1,400.00
Reprints	29.40	26.65
Commission on Advertising	457.38	415.62
Discounts	74.59	79.04
Stationery and Supplies	28.75	5.00
Miscellaneous Expenses	230.52	103.15

On motion, duly seconded, the report of

the Committee on Publication was accepted.

The report of the Recording Secretary was presented by Dr. William J. Chandler, as follows:

Report of the Recording Secretary.

In looking back over the history of this Society we find that when it was organized in 1766, it had a total membership of fifteen. It met annually and often held a semi-annual meeting. The State was divided into four sections—each section held meetings at intervals of one or two months, as do our present county societies.

The membership grew slowly and during the Revolutionary War the annual meetings were suspended entirely, so many of its members being engaged in the defense of their country, but after the war, meetings were resumed even though the membership was small. In 1820 the total number of members was only fifty. In 1866, at the time of its centenial, with 600 physicians practicing in the State, it numbered only 279 members.

From that time on it has quite steadily increased by from ten to twenty members annually and one year fifty new members were added. Last year we had 1,753 members. This year we are assembled with a roster of 1,920 members in good standing—a gain of nearly 170 over that of last year. This is by far the greatest gain made in any one year of the Society's existence.

This is such an extraordinary increase that it is well to find out, if we can, what causes have brought it about.

In the latter part of 1919 the American Medical Association sent a special representative into this State to canvass all the counties and find out how many physicians, not members of the Society, were engaged in practice here. He first obtained introductory letters from the Secretary of the State Society to the different county secretaries and then went to work. He interviewed most of the eligible non-members in this State. He put before them the advantages of membership in the county societies and urged them to apply for membership at once. Many took his advice and were added to the county society's roll. This is especially noticeable in the larger counties of Essex and Hudson, where, owing to the denser population, new comers are often overlooked. He has not yet quite completed his work and we shall find additions being made from now on.

There is an important lesson for us in these results. They show what can be done by one trained, systematic worker. The advantages of membership in a county medical society are so great that no rational physician can decline them when once they are fully explained to him. Every county society ought to have a committee of active men, fully acquainted with these advantages, whose business it should be to search out all new comers and explain to them the benefits of uniting with their county society. They will seldom fail to bring into the society all who are worthy of an election.

It is a very important matter to get new members, but there is another matter of equal importance and that is to retain all of our old members in good standing. Delinquency is the bane of our societies and a bugbear to the county treasurers. You would be surprised if you knew that the delinquency of our various county societies on the first day of January, 1920, varied all the way from ten per cent. to over seventy-five per cent. of its total membership. County treasurers send out notices and make some effort to spur up the delinquents, but we know too well what generally becomes of such notices—the delinquent pays whenever it happens to suit him or not at all. Such men do not realize that during all the time after January 1st that their dues remain unpaid they are deprived of the benefits of medical defense and that their Journal may cease to come. Their payment of dues at a later time does not secure them a medical defense for an alleged act of malpractice occurring during the period of delinquency. Suppose, for instance, that a man does not pay his dues until February 1st, and suppose also that some time afterwards—months perhaps, he is sued for some alleged act of malpractice occurring during the month of January. Upon investigation it is found that during the month of January he was a delinquent and that consequently the State Society could not defend him. His payment of dues in February does not protect him for the month of January, when he was a delinquent.

The moral of this is to pay your dues on or before January 1st of each year **in advance.** You will then secure all the benefits of medical defense. In this connection it might be well to remind county society treasurers to promptly send to our State Society treasurer all the dues paid by new or delinquent members, with their names and addresses. In this way it will be possible for the Recording Secretary to know whether and when a member is entitled to a medical defense by the Society. It is not easily possible to determine this in the present method of collecting and forwarding dues.

When the reports of the county societies due on March 1st began to come in this year, it was very evident that there was a large delinquent list. It amounted to over 300 members. The county secretaries were reminded of this fact and urged to get in the delinquents. The results were not very apparent and for the good of the Society the Recording Secretary took up the work and sent out over 300 personal letters to delinquents in different parts of the State. As a consequence of these efforts we have now fewer delinquents and a far larger membership than ever before.

When we remodeled our constitution and by-laws in accordance with the suggestions of the American Medical Society we followed their form quite closely and much to our benefit. Indeed it would have been well if we had followed it verbatim, except wherein it conflicted with our charter. The A. M. A. are organizers, and understand their business and their suggestions were for the best interests of all county societies. No one can appreciate this fact better than one who has been your secretary for so many years and has always held the interests of this Society close to his heart.

You will pardon my consuming so much of your time with the subject of delinquency, but it is too important to be overlooked. It is generally the result of thoughtlessness and negligence. If some of the suggestions herein

made are followed up, let us hope that next year we may assemble with no **delinquents** and an even larger number of new members than this year's record.

Respectfully submitted,
William J. Chandler, Secretary.

On motion, seconded, the report of the Recording Secretary was accepted.

The report of the Board of Trustees was read by the Secretary of the Board, Dr. David C. English, New Brunswick, as follows:

Report of the Board of Trustees.

The Board of Trustees reports that a meeting of the Trustees was held January 14, 1920, in the Board of Trade Rooms, Newark, Dr. O. H. Sproul, chairman, presiding with an unusually large number of Trustees in attendance.

Dr. T. W. Harvey, Chairman of the Welfare Committee appointed by the State Society at the last annual meeting, presented a report of the committee's work with suggestions as to the importance of securing a paid agent who should give his time for some weeks or months in carrying out carefully prepared plans under the committees guidance and control, and that liberal appropriations should be made by the Society for such work, and especially for the defeat of the Compulsory Health Insurance Law that is proposed for enactment by our Legislature. He reported that the committee met with Mr. Colby's Commission on Old Age Insurance, heard his exposition of the Health Insurance Bill; they thoroughly discussed the bill and the Welfare Committee decided unanimously to oppose it, while believing that it is possible to have a health insurance bill drawn that is not detrimental to the public and to the medical profession, which the Colby Bill undoubtedly is.

Dr. Harvey also referred to the good work done by President Dickinson in having a committee of five in each of the county medical societies to co-operate with the Welfare Committee.

The Board of Trustees after considerable discussion unanimously adopted the following resolutions:

1. That $1,000 be appropriated by the Board of Trustees for use of the Welfare Committee until the next annual meeting of the State Medical Society, to be used for the employment of a competent representative who shall operate under the direction of the committee, the object being to perfect the organization of the profession, to place them in a proper light before the public, and to give publicity to such matters as may be of importance to the welfare of the profession.

2. We advise that the influence of the Medical Society be used to oppose the passage of the Compulsory Health Insurance Bill, through its regular committees, or through special counsel and that $1,000 be appropriated for such purposes and such further sums as the Board of Trustees shall approve.

Several members of the New Jersey Pharmaceutical Association were present and assured the Board of Trustees of the co-operation of that organization in opposing the Compulsory Health Insurance Bill.

The Board of Trustees met again last evening, June 14, in the Monmouth Hotel, Spring Lake, sixteen members being present. In the absence of Chairman Sproul, Dr. P. A. Harris was chosen temporary chairman.

Dr. O. H. Sproul was then elected chairman of the Board for the coming year and Dr. D. C. English was elected secretary. After approval of the minutes of the January 14, 1920, meeting, Dr. Chandler presented an outline of his report as Secretary of the Society, which showed a gain of 172 members.

Dr. C. D. Bennett read the report of the Publication Committee, which showed an excess of receipts over expenditures of $211. The Board unanimously passed a vote of thanks to Dr. Bennett for his efficient work as chairman of the committee. The committee was requested to report to the Board during this annual meeting some plan to improve the mailing list methods to prevent irregularities and delays in the transmission of the Journal through the mails.

Treasurer Mercer read his annual report of receipts and expenditures of the last year, showing a balance on hand January 1, 1920, of $1,619.22, and a Chicago & Alton Bond of $1,000 and $3,000 in Liberty Bonds. Drs. Fisher and Costill were on motion appointed a committee to audit the treasurer's accounts and report to the Board. A bill for $7.50 from the Fidelity & Casualty Co., New York, for the bond of the treasurer, expiring July 21, 1921, was ordered paid.

Dr. D. C. English was re-elected Editor of the Journal for the year ending June 30, 1921, his salary, including all expenses, to be $1,500. Dr. T. W. Harvey gave a report of the work of the Welfare Committee showing the work of the committee, its expenses, also the work of Mr. Gunn, his salary and all his expenses, which expenses had been examined and found correct.

The following resolutions were on motion adopted. 1. That Drs. Costill, Halsey and Marcy be appointed a committee to consider the plan proposed for the Registration of the Legalized Practitioners of New Jersey.

2. That the Counselor of the State Society be requested to report his opinions on the constitutionality or legality of the Chiropractic Bill and whether in his opinion we can successfully attack it.

3. That the salary of the Secretary of the State Society shall be the same as that of last year, including all ordinary expenses.

The Secretary presented the regrets of Drs. W. B. Johnson and O. H. Sproul for non-attendance at this year's meeting and of Dr. Philip Marvel for his absence last evening and today.

The Board will present a further report to the House of Delegates at its session tomorrow.

Respectfully submitted,
D. C. English, Secretary of the Board.

It was moved and seconded that the report be received. Carried.

The report of the Judicial Council was postponed, at the suggestion of Dr. William H. Iszard, owing to the absence of Dr. John C. McCoy, Paterson, who had been acting as President of the Council during the year.

Dr. Iszard's condition of health had not permitted him to fulfill his duty in that capacity.

The report of the Committee on Honorary Membership was also postponed, its Chairman, Dr. Walter B. Johnson, Paterson, not being present.

The report of the Treasurer, Dr. Archibald Mercer, Newark, was read by him, as follows:

Report of the Treasurer.

1919	Dr.	
Atlantic County	Assessment	$ 164.00
Bergen "	"	188.00
Burlington "	"	78.00
Camden "	"	158.00
Cape May "	"	42.00
Cumberland "	"	48.00
Essex "	"	784.00
Gloucester "	"	46.00
Hudson "	"	400.00
Hunterdon "	"	56.00
Mercer "	"	136.00
Middlesex "	"	148.00
Monmouth "	"	72.00
Morris "	"	102.00
Ocean "	"	32.00
Passaic "	"	280.00
Salem "	"	40.00
Somerset "	"	52.00
Sussex "	"	24.00
Union "	"	145.00
Warren "	"	60.00
		$3,035.00
Receipts from Journal, 13 months		3,236.69
Interest Chicago & Alton Bond 3½%		35.00
Interest Liberty Bonds		152.90
		$6,459.59
Interest bank deposits		49.82
Receipts from exhibitors, annual meeting		211.00
Bank balances January 1, 1919		1,250.64
		$7,971.05
Chicago & Alton Bond, 3½% cost		786.50
Liberty Bonds, 3½%, cost par		4,000.00
		$12,757.55

1919	Cr.	
Jan. 1	Dr. W. J. Chandler, Secretary Salary for December	$ 79.16
" 8	The Constitution Com., Publicity Com.	15.50
Mar. 10	Dr. W. J. Chandler, Secretary Salary for Jan. and Feb.	158.33
April 10	Dr. W. J. Chandler, Secretary Salary for March and April	158.67
June 25	Orange Pub. Co., Printing	126.75
" 25	Dr. D. C. English, Secretary Board of Trustees	8.85
" 25	Dr. W. J. Chandler, Secretary Salary for May and June	158.33
" 25	Dr. A. MacAlister, Scientific Committee	33.60
" 25	Dr. H. A. Stout, Cor. Sec.	96.90
" 25	Dr. A. Mercer, Treasurer	29.49
" 25	Dr. W. H. Iszard, Councilor	41.70
" 25	Dr. C. C. Beling, Councilor	20.00
" 25	Dr. Jas. Hunter, Councilor	25.00
July 7	Dr. H. B. Costill, Arrangements Committee	25.00
" 7	The New Monmouth Hotel, Guests	58.15
" 14	Albert C. Wall, Leg. Retainer	100.00
" 14	Dr. A. MacAlister for Dr. McCrea	5.00
Aug. 5	Fidelity & Casualty Company, Treasurer's Bond	7.50
" 8	Orange Pub. Co., Printing	45.75
Sept. 8	Dr. W. J. Chandler, Secretary, Salary for July and August	158.33
" 11	Lulu Gray, Stenographer	100.00
Oct. 6	Vredenburg, Carey & Wall, Medical Defense	79.83
" 22	The Addressograph Co.	1.08
" 28	Dr. W. J. Chandler, Secretary, Salary for Sept. and Oct.	158.33
		$1,701.83
Dr. C. D. Bennett, Pub. Committee		4,650.00
		$6,351.83
Cash Balance in Bank Jan. 1, 1920		1,619.22
		$7,971.05
Chicago & Alton Bond, $1,000, 3½%, cost		786.50
Liberty Bonds, 3½%, cost par		4,000.00
		$12,757.55

Respectfully submitted,
Archibald Mercer, Treasurer.

Dr. Dickinson: You have heard the report of the Treasurer, whose books have been audited. If there are no objections, the report will be filed. We will now have the report of the Auditing Committing.

Dr. C. R. P. Fisher, Bound Brook: The Auditing Committee wish to report that they have gone over the books, vouchers, etc., of the Treasurer, and have found everything absolutely correct.

Dr. Dickinson: Now the Secretary will read the report of the Committee on Legislation.

Dr. Chandler was asked to read the following correspondence as the only report from this committee:

February 9, 1920.

Dr. George T. Tracy,
Beverly, N. J.

Dear Doctor Tracy:

I have heard indirectly that you have resigned from the work of the Legislative Committee of the State Society. I can hardly believe that such is the case, but it came so straight, and as things are very pressing at Trenton, I have taken the liberty to ask Dr. Costill to help us out. The Welfare Committee have selected a Mr. Gunn who will work in co-operation with Drs. MacAlister, Costill and the State Board of Medical Examiners.

I would like to hear from you if this rumor be true—that you have refused to act. I am sure the State Medical Society in meeting would feel grieved to have this announced to them.

Yours truly,
Gordon K. Dickinson.

Dr. Gordon K. Dickinson,

My dear Dr. Dickinson.

I find it absolutely impossible for me to give my usual time to the legislative matters at Trenton as I have been prostrated with influenza and now have an aggravating pleurisy. My office nurse, who has always been an invaluable assistant in writing letters, etc., has pneumonia, so my ability for work is very much limited. I feel the situation is such now it requires some one constantly to watch the moves of legislation, particularly in the Assembly, as they will pass almost anything. Fortunately, the Senate is a little more conservative and we have a good friend in Dr. Barber.

It has never been possible for me to get the members of the Legislative Committee together. Last year we arranged for meetings in Camden and Trenton, and the only ones interested enough to attend were Dr. Lee of Camden and Dr. Costill of Trenton, who was not a member of the committee.

It is not my desire to weary you with a long explanatory letter, but it will perhaps make it less complicated for you if you would accept my resignation. The vacancy could be filled by some one whom you think might handle the situation.

I am enclosing samples of some of the vicious measures before our legislators for their consideration.

Respectfully,

George T. Tracy.

February 12th, 1920.

Dr. Gordon K. Dickinson,

Jersey City, N. J.

Dear Dr. Dickinson.

Kindly accept my resignation as member of the Legislative Committee of the Medical Society of New Jersey.

Respectfully,

George T. Tracy.

February 12th, 1920.

It was moved that the report and the resignation of Dr. George T. Tracy, Beverly, be accepted. Motion was seconded and carried.

The report of the Prize Essay Committee was presented by the Chairman, Dr. Alexander Marcy Jr., Riverton, as follows:

Dr. Alexander Marcy Jr., Riverton: For the first time in history of this ancient and honorable Society, there has been dissension in this committee. Therefore, I have two reports to present, a majority and a minority report. I regard it as very providential, gentlemen, that no essays were submitted during the past year to this committee, because, from what I understand of the expenditures of the Welfare Committee, there would have been no money in the Treasury to pay these prizes. The following is the majority report.

Report of the Committee on Prize Essay.

Mr. President and Members of the Medical Society of New Jersey.

Gentlemen:

It is with feelings of disappointment and regret that your committee are compelled to report no essays presented on either of the subjects chosen by the Society at its last meeting.

The reason for this we cannot say, the topics were thought to be timely and of sufficient interest, and the prizes offered large enough to attract attention.

The conditions were not onerous, and in the first instance open to the profession of the United States, while that of the second was open to the profession of others of the world.

Whether sufficient publicity was given the matter we cannot say, but in only two instances was any inquiry even made in relation to the subjects or the conditions, and neither of these bore fruit.

In the opinion of your committee the same subjects might be chosen again, and the same conditions imposed, and the Editor of the Journal be requested to call especial attention to the subject in each issue of the Journal for at least six months.

Respectfully submitted,

Alex. Marcy Jr., Chairman.
Norton L. Wilson.

Dr. Marcy: The minority report is from Dr. George T. Welsh, Passaic, the dissenting member of the committee.

Report of a Dissenting Member of the Committee on Prize Essay: to the President and Members of the Medical Society of New Jersey.

Gentlemen:

I look upon the matter of offering large or even small prizes for essays as being antiquated and useless, and believe that the money thus expended, if awarded, could be much better disposed of for the benefit of our State Medical Society in many useful ways. For instance we should have in some central place an ample fireproof building for our archives. Our Medical Journal should be fostered to the extent of our means. An historian should be appointed, and salaried, to preserve the honorable records of our past progress, with biographical sketches of the members whose talents and genius have contributed to the development, the security, and the renown of our profession.

I therefore recommend the abolishment of a Committee on Prize Essays, and the establishment of another of different character for the fostering of the objects herein suggested.

George T. Welch.

June 15, 1920.

Dr. Marcy: Gentlemen, the Committee on Prize Essay is not one of the standing committees, and, therefore, it continues its existence entirely at your pleasure. Personally, I am not sure whether it would not be a good thing to, at least, get rid of the present committee, although I think that there still should be a Prize Essay

Committee. For many years I have been Chairman of this committee, and there has not been a single essay presented. Whether the fault is with the committee or with the subject, I do not know. I suggested to the Board of Trustess that they select subjects, and they did so for a couple of years. They had no essays submitted either, and got tired. Last year, I had an inspiration. It was hard to get this through the Board of Trustees, but some of my friends promised to underwrite it, and got this appropriation. But now that is gone.

Dr. Dickinson: I brought up the report of the Legislative Committee first, so that we would have time to hear what Dr. Marcy had to say about the Prize Essay Committee. We will now hear what Dr. Harvey has to say regarding the Welfare Committee.

Dr. Thomas W. Harvey, Orange: Before reading this report, I want to register my sincere thanks to the members of the committee. We never had one more ready to serve with us at meetings all over the State. We held a good many of them, and always had a quorum; and I think that we owe the men who came from a distance many thanks for their constant attention to work that was quite new and unexpected. This is the report of the Committee on the President's Address, later known as the Welfare Committee:

This report has been published in full in the July, 1920, number of our Journal (pages 244-247) and can there be found.

Dr. Dickinson: As these two reports are associated in a financial way, and as the exchequer of the Society cannot finance two big propositions without taxing the members to a considerable extent, I thought I would bring both up and have you discuss them at the same time. I should like to have a discussion on Dr. Marcy's proposition first, and then on Dr. Harvey's.

Dr. F. J. Quigley, Town of Union: I move that this year no prize be offered for any essay submitted, inasmuch as the report of the Welfare Committee certainly leads us to believe that there is going to be enough expense attached to our work next year, and as the money in the treasury at this time would be better spent in the promotion of welfare work.

(The motion was seconded).

Dr. Dickinson: Is there any discussion? I remember that Dr. Marcy had one beautiful thought, and that is, a historian; an honorary historian, a man who would be interested in such matters, would be a very important addition to the Society. That thought you must keep in mind, and not allow it to be buried.

All in favor of Dr. Quigley's motion will say "aye"; those opposed, "no." It is carried.

Now I want a motion of thanks to Dr. Marcy and his friends for what they tried to do.

(Such a motion was made, seconded and carried).

Dr. Marcy: The minority report makes a specific recommendation which might be acted on.

Dr. Dickinson: That is what I referred to, the matter of the historian.

Dr. Marcy: The minority report contains two distinct suggestions. (He read the report again).

It was moved that the matter be referred to the incoming Board of Trustees. The motion was seconded and carried.

Dr. Dickinson: I think we ought to hear more on the matter of the Welfare Committee.

Dr. Berth S. Pollak, Secaucus: I beg to express my personal appreciation to the committee for their extensive report; but, in the event of the publication of their work, there should be a small correction. In the first column it stated, "The Essex County Medical Society, which took a very active part from the first, at a meeting on December 18th, 1919, took up for consideration the question of Compulsory Health Insurance," etc. I want to say that Hudson County took the initial step on December 2nd, when, at your suggestion, we invited the presidents of the various county medical societies to hear Dr. O'Reilly's exposition of the bill; and the Essex and Bergen County meetings were held subsequently. I should like to have Hudson County given credit for calling the first meeting.

Dr. Frank W. Pinneo, Newark: The past Legislature has been exceedingly active, and much of the legislation has been vicious, or the result of ignorance, to be more charitable. To go over all the bills would take up too much time at this meeting. But it is clearly shown that the medical profession of New Jersey must adopt a different method for the safeguarding of medical legislation, viz.: by informing the medical profession of what bills are coming up.

I would, therefore, make the following suggestions:

1. Inasmuch as the problems of medical legislation demand, on our part, in addition to our own activities, association with

the Health Board of the State, which has a status in law, we commend to our new Welfare Committee such action as will render this Society more influential with that State Board which will best work with us.

2. Inasmuch as members of professions allied to medicine—notably, dentists and pharmacists; also other individuals—are concerned in medical legislation and have organizations beneficial to the common purpose, we commend to the Welfare Committee the plan of a Professional Guild, through which publicity, which we consider our most important aid, can be made more efficient and extended more widely.

Dr. Harvey: I move that the committee be discharged. The only question which arises in that report is the matter of registration which is going to be brought before the Board of Trustees and this matter of change of organization, which would have to be a question for discussion as to whether we want to do away with the Legislative Committee and substitute a new committee. If we are to take action, it should be formulated soon and acted on at this meeting. So far as the committee's work is concerned, we are through. We have nothing yet in our hands to do.

Dr. Dickinson: Courtesy would allow you the permission to make some request, or a motion is in order to refer the matter to the Board of Trustees, to report back with something more concise to act on.

Dr. Harvey's motion was seconded and carried.

Dr. Quigley: I move that a special committee of three be appointed by this body to take up the recommendations of the Welfare Committee, and to report back at a later session, with some specific recommendation as to the things that the Society would like to have acted on by the Welfare Committee during the coming year.

The motion was seconded.

Dr. John B. Morrison, Newark: I should like to suggest to this committee, when appointed, that they confer with the Trustees and find in what way the functions of the Judicial Committee, the Welfare Committee and the Legislative Committee overlap, so that they may not be working at cross purposes, and that they may carry out the suggestions of Dr. Harvey's report, that we have one man in control of the whole affair.

Dr. Wells P. Eagleton, Newark: Dr. Harvey's committee has made definite recommendations to us, and this is the time to discuss them and decide whether we shall take concerted action to influence the legislation of this State in the interest of public health matters. To do this will require the expenditure of a certain amount of money. All the recommendations have been made in the report. To refer them to a committee will be dodging the issue. Does this Society wish to enter on such a campaign? or do we want to return to the policy formerly adopted by the Society of waiting until something appears, and then in a hurry trying to get someone interested? The Legislative Committee have definitely stated that they could not get a meeting. The Chairman has resigned. I remember what trouble Dr. Harvey had to get a few men to go down when he wanted them. It will always be so, if we go back to the old method. He has recommended that a certain amount of money be raised, and has formulated a constructive plan as to how it shall be expended. As he says, it would be better to go down to defeat than to spend five cents for the purpose of influencing the Legislature. He has said that the State Board of Examiners were willing to accept a compromise, and that his committee refused. The State Board of Health, being a political body, thought it expedient that such a compromise be accepted; while the committee, from an altruistic standpoint, thought it better to refuse it.

I think we want to take up specifically each recommendation, and decide now whether the State Society wants to enter such a campaign.

Dr. A. J. Mitchell, Newark: What Dr. Eagleton has said is just about what I was going to say. I think that is what we should do. Instead of trying to put it up to the Board of Trustees, the House of Delegates should get together and do something. As for the Legislative Committee, as Dr. Eagleton knows, several of us in Essex County were down at Trenton last year, and had a lot of hard work. We ought to get together and work out some scheme by which we could make our work effective.

Dr. Henry B. Costill, Trenton: If this is going to be a discussion as to whether we are to resolve the Society into a political proposition or not, I suppose we should all get into the game. After a good deal of work, Dr. Harvey has made an exhaustive report. He could not have covered the ground better; but his conclusions boil themselves down into two things: as to whether the physicians of New Jersey are going to resolve themselves into a political proposition or not. We spent a great deal

of money last year, and accomplished very little. That will repeat itself each year. The physicians are taxing themselves for work for the benefit of the citizens of this State. It is a work that is not only bringing our Society into financial difficulties but into disrepute among the people of the State. They accuse us of working in the interests of ourselves, and against the interest of everyone else. They do not look upon it in the same way as we do. We must fight it in a political way. We must have a stronger organization than they have and influence as many votes as they do, or more.

We are wasting time in doing something that is not appreciated by the people of the State. There is a better solution of the problem. If our Society would get back of a movement to reorganize our State Board of Health, create in it a Department of licensure and place the whole responsibility on the State, and not on the physicians, we would accomplish something and not incur expenses that are going to increase year by year.

Dr. Clinton H. Read, Trenton: Dr. Costill is right. I have had experience with these bills. It is time that we got busy and played politics. You cannot play the game in any other way. The people go there with seventy-five thousand dollars in their clothes, and get it over. They start early and put it in the charge of a member of the Senate who is a lawyer and expects to get a fee. He quietly gets the members to vote for his bill and promises that he will vote for theirs. The doctors go to sleep and then howl because something is done. You must get busy at your primaries, and send men to Trenton to fight bills that are contrary to the interests of the public and the financial interests of the medical men. I should think that we might offer a plan to repeal the whole medical act and give the people a stomach full of the old-time method. That would cure them. People go and get well of some nervous condition that did not exist, and then they say that the medical profession is trying to kill the fellow who cured them. Our three men in Mercer all voted for the Chiropractic Bill, because one offered an amendment that did not go through, and then voted for the bill. They said, "We followed the medical man, who voted for the bill when he did not get his amendment through." It is time that the medical men got after those fellows, not the day after the bill is passed, but at the primaries. The medical men in New Jersey can control almost every member of the Legislature. There is not a man who has not a family physician; and if his physician tells him what is for the the best interest of the public and medical profession, he will go to Trenton determined to do what his family physician thinks is right. Now is the time to get busy and try to select the men who will fight the pernicious bills.

Dr. Marcy: I agree with both the speakers who have preceded me. I agree with Dr. Costill, because for years I have advocated and recommended it before the Board of Medical Examiners and the State Legislature. My experience as a member of the Board of Examiners showed me that the whole system of licensure was wrong. I have found that the proper function of the State Department does include the registration of physicians, dentists, nurses and any other class of citizens that need to be licensed to perform their functions or follow their calling. The idea of the State Medical Society's becoming a political organization seems to me very appalling. There are, perhaps, only one or two doctors that are anywhere near being politicians—Halsey and Eagleton. Be that as it may, politics is the curse of the nation and the State; and so long as it exists, you cannot have the medical profession a unit on any candidate or any bill before the Legislature. If a man is nominated for the Legislature in your county, and is of a different political faith from yours, even if he is a doctor, you will not vote for him. That is the kernel of the whole situation—personal politics. If you all became Democrats, there would be no trouble about it.

Dr. Luther M. Halsey, Williamstown: I want to take this opportunity to thank the Welfare Committee for their work and report. They say that all things come to him who waits. I remember that a number of years ago there was a marked discussion in the Society—the Board of Trustees, particularly—regarding the expenditure of about fourteen hundred dollars for the expenses of the Legislative Committee, not in one year, but in three years, during which we had a legislative agent and assistant, and I had a stenographer. During that time, we made three distinct positive canvasses of the whole State, and at the opening of the Legislature, we were fairly well informed as to what would be the possibility in the matter of legislation introduced during the session. I am not saying this egotistically, because a good deal of credit is due to the committee of which I was a member; but

during the fifteen years that I was Chairman of the Legislative Committee, there was not a single measure passed by the Legislature that was detrimental to the medical profession or bad from a hygienic or sanitary point of view.

This expense account during the past year has been quite high. It does seem to me that we must either go down into our pockets and agree that we will meet the necessary expenses or adopt some other plan by which we can accomplish legislation on a more economical basis. I know that during preceding sessions of the Legislature, most of the prominent men in the State who were identified with politics were interviewed, and asked their opinion as to just where they were to stand in the matter of legislation that would probably be referred to the incoming Legislature. In that way, I feel that we accomplished a great deal. We must either let the public have anything they want or go into it determined to pursue a campaign of education, that the people of the State may know what the medical profession stands for and, if possible, accomplish our results. These are vital questions to think over and consider, and should be taken up carefully and systematically.

Dr. Thomas H. Mackenzie, Trenton: One part of the report seems to cover the ground. I think that the proper thing to do is to appoint one man, whose business will be to look after legislation, to be a detective and tell us what legislation is coming up. That was your suggestion, was it not, Dr. Harvey?

Dr. Harvey: Yes.

Dr. Mackenzie: If Dr. Harvey would make a motion, putting it in a specific manner, I think it would meet the requirements of the Society. I think that every man would be willing to pay additional dues for the sake of having this done. The man in Trenton must have the assistance of the other members in the Society, and I am sure that any member that he would want to assist him would be willing to go. Doctors are willing to act, but they must have someone to take the lead. The man that you would appoint would take the lead. While Dr. Halsey was there, he devoted all his time to it; and, as he says, there was no legislation detrimental to medical science while he was there. He knew everything that was coming up. He had his ear to the ground. He had an agent who was paid. He accomplished much. If you want to accomplish anything, you must have a man to watch and work for you.

Dr. Edward J. Ill, Newark: I believe this ought to be discussed right here; and when we all understand it, we can appoint a committee later on. I want to agree with what Dr. Costill has said. As a dignfied profession, why not go into the legislative business? If we need to spend more money let us raise it.

Dr. J. Boone Wintersteen, Moorestown: It has been proposed that the medical men go into politics on this matter. From personal experience, I want to tell you that unless the medical men of the State are different from those of my county, it cannot be done. I was unfortunate enough last fall, after coming out of the army, to listen to the siren voice of politics and enter the campaign. I appealed to every man in the medical profession in Burlington County and two medical men outside of the county, and except for two men in the County of Burlington, who did active work, I doubt whether the members of the medical profession in my county even voted for our cause.

A rising vote was taken on Dr. Quigley's motion, and it was lost.

Dr. Marcy: I move that the recommendations of Dr. Harvey be presented to the Society, one after the other, and that action be taken at this time on the specific recommendations.

(The motion was seconded and carried).

Dr. Harvey: The first recommendation is that there shall be a reorganization of our work, and funds must be provided for the carrying on of the work. The committee will work in different parts of the State and I do not think that the State has the right to ask men to do these things and pay their own expenses. We must have a man for that kind of work, and pay for it.

In the second place, we suggest that the Legislative Committee and the Welfare Committee's work shall be concentrated in the hands of one man, who should be the executive officer of the committee, should be salaried and should have personal control of all welfare work. Does this body want such an officer?

That requires a standing committee on professional welfare. To establish such a committee, we must have an amendment to our By-Laws.

Dr. Morrison: I think that we cannot adopt an amendment at this meeting.

Dr. Chandler: We can. The amendment

must be proposed at one session and laid on the table for one day. It may then have a second reading and be presented for adoption.

After considerable general discussion Dr. Harvey presented the following amendments to the By-Laws:

(1) Chap. IX, Sec. 1 (a), "Strike out the word 'Legislation.'"

(2) Chap. IX, Sec. 1 (b), Add the name of another committee to be known as the "Welfare Committee."

(3) Add a new section to Chap. X, to be known as Sec. 5, as follows:

Welfare Committee.

Sec. 5. The Welfare Committee shall be composed of at least five members to be appointed by the President. One of these members shall be the executive officer of the committee and shall receive a salary. The duties of this committee shall include the work of the Committee on Legislation (Chap. IX, Sec. 6), and to it shall also be referred all questions of professional welfare not included in the specific work of the Judicial Council. This committee shall establish a close alliance with the county medical societies, shall be empowered to employ a special agent or agents, and to expend such moneys as may be approved by the Board of Trustees. This committee shall file monthly reports of its work with the Secretary of each component society in this State.

Dr. Harvey: As these are amendments to the By-Laws, they will lie on the table for one day.

Dr. Dickinson: Is there any other business to come before us?

Dr. Chandler: The following amendment to Chapter XII is proposed:

In Chapter XII, Sec. 1, in the first line of the second paragraph, strike out the word "March" and insert the word "January."

This will be read again tomorrow. It pertains to the time of sending in reports.

Dr. Dickinson: It seems fitting to have a brief word relative to those who left us during the last year. Is Dr. Hagerty here? If not, I will call on him later. I will now ask Dr. Marcy to read a sketch of Dr. Emery Marvel.

In Memoriam—Dr. Emery Marvel.

Dr. Emery Marvel, the subject of this sketch, was born in Kent County, Delaware, on the 22d of December, 1869, and came from a family of which Andrew Marvel, poet and satirist, was a member.

He attended the public schools of his neighborhood, and during vacation periods assisted his father on the farm.

Always ambitious and of studious habits, he found this life not entirely to his liking, and at the age of 21 began teaching in the public school of his native county, which experience stimulated his desire for a broader life, and after two years he entered Delaware College at Newark, Del., pursuing studies which were preliminary to the study of medicine.

In 1892 he entered the University of Pennsylvania, and graduated from that institution in 1896.

He served as interne in Cooper Hospital, Camden, N. J., for one year, and then began the practice of medicine with his brother, Dr. Philip Marvel, in Atlantic City, which association lasted for a little more than two years, when he withdrew in order to establish a private practice of his own, wishing to specialize in surgery; from this time on he was conspicuously successful.

He became a member of the surgical staff of the Atlantic City Hospital and served this institution faithfully and well for a number of years, resigning in order to devote all of his time and energy to his own private institution, which he had established in order that his patients might have all the advantages of the institution with many of the home, and which had grown to sufficient proportions to require his entire time and attention.

His work was careful, painstaking, successful, much of it progressive, and some of it original and epoch-making, attracting attention of surgeons in this country as well as abroad.

He was a hard and earnest student, and in order to better fit himself for the practice of his chosen profession spared not himself or his means.

Every hospital of special note in this country, and many in European countries, were visited by him for the purpose of familiarizing himself with the newer operations, methods and improved technic.

He spent much time at the Mayo Brothers Foundation, and became their warm personal friend, seeking to increase his knowledge both as to the causation of diseased processes and their alleviation by surgical means.

He was a member of his State, county and city societies, the American Medical Association, of which he was second vice-president; of the American Gynecological Association, the Philadelphia Orthopedic, Pediatric and Medical Club, the New Jersey Pediatric Society and a fellow of the American College of Surgeons, and was constant in his attendance at their meetings, usually having a part in their deliberation where he was helpful and earnest in discussion, constantly seeking some means by which he might improve or alter conditions.

He had a personality which won him a host of friends, was generous to a fault, very kind to the poor, doing always a lot of charitable work among the Italians of Atlantic County, and frequently supplying medicines as well as dressings from his own purse.

Dr. Frank Martin of Chicago wrote: "His summons was altogether too soon. It removed from us an advocate of truth and science, one whose knowledge in the subject he practiced gave him a wise discernment of what to do and when to do it."

He was well known throughout the country, and was becoming better known abroad; Sir Shirley Murphy in noting his death in the

British Medical Journal makes the following statement.

"Dr. Emery Marvel was held in high esteem for his professional knowledge as well as his personal charm, which latter contributed much to the success of the recent meeting of the American Medical Association held in Atlantic City. He possessed a mind well stored with knowledge, and a kind genial personality which made him an ideal host. He will be remembered by those privileged to meet him at the recent convention at Atlantic City as representing the best type which our profession produces."

The exacting duties in connection with this meeting helped in a measure to exhaust his vitality, and perhaps contributed something to his untimely death.

He was married to Jessie Kiem of Philadelphia on September 9th, 1903, who with one daughter, 15 years of age, survives him.

His domestic life was particularly happy and his cordial, generous hospitality will ever be remembered by those who were fortunate enough to know him intimately.

He took a prominent part in civic affairs, and was always advocating and working for the things which would benefit and improve his home city.

In religious affairs he also took a leading part and was member of St. James' Episcopal Church, serving on the vestry for many years.

An enthusiastic golfer, he was a player of no mean ability, and frequently took part in tournaments on his home course, and on those in other parts of the country.

Dr. Emery was a well equipped, practical surgeon, a cultured, courteous gentleman, a Christian man, whose success was due entirely to his own efforts, and whose career was cut short at a time when he was reaping the rewards that were due him because of his high ideals, his untiring efforts, and his loyal devotion to duty.

We, the undersigned, although acting as a committee appointed by the president for this specific purpose, desire to have recorded as a part of this minute our own personal sense of loss on account of Dr. Marvel's death, and wish to extend to his family and friends our sincere sympathy, feeling that while deprived of his presence at our meetings, we will ever be encouraged by the remembrance of his fidelity to this Society, and his willing service to any and every call made upon him, either by his profession or his community.

Alex. Marcy Jr., Chairman.
H. B. Costill,
W. Blair Stewart,
Committee.

Dr. Dickinson: As Dr. Hagerty is now present, I will ask him to present a brief memorial on Dr. Frank M. Donohue.

In Memoriam, Dr. Frank M. Donohue.

Mr. President: It is fitting that we pause in the midst of our activities and give thought to the memory of those who have "gone before," and, especially to one, who by the uprightness of his personal life and skill as a physician and surgeon had won the respect and esteem of the profession and people of the State in which he was born and had labored for nearly forty years. I am glad of the privilege of paying tribute to Dr. Frank M. Donohue, who was my preceptor and who combined in a rare degree a comprehensive knowledge of medine and surgery with the sterling qualities of a man.

Dr. Donohue was born in New Brunswick, N. J., in 1859. He attended the local schools, graduated from St. Francis Xavier's, New York. and entered the office of Dr. Clifford Morrogh. Dr. Morrogh was a giant in medicine, with great natural tact and urbanity of manner, and a resourceful and skillful surgeon who then had a State-wide reputation. He took a paternal interest in his young student who graduated from the New York University in 1881, standing first in his class and winning several special prizes, and after graduation a partnership was formed between the two. Dr. Morrogh died, I think, two years later, and Dr. Donohue carried on the work without any interruption and soon acquired a prominence throughout the central part of the State. He was endowed with a splendid physique, engaging personality, and performed a tremendous amount of work. He had a large office and consulting practice, was a competent ophthalmologist, and very able and skillful as a surgeon. His office was daily filled with patients, visited by two or three physicians from neighboring towns and his consulting work took him almost daily to various parts of the State. He was very dignified and even formal in his professional relations, but very cordial and warm-hearted in the circle of his family and friends. He was exceedingly reluctant to criticize, but generous to fellow practitioners who sought his advice, and had to an unusual degree the esteem of his patients. His manner in the sick room was such as to inspire the utmost confidence in his ability to cure. Interested in the civic welfare of his city and proficient to an unusual degree in financial matters, he occupied positions of trust in his home town. While of a modest, retiring disposition, he was yet very hospitable as many can testify who had the pleasure of visiting his beautiful summer home at Bound Brook, and while not a prominent figure at society meetings, his interest in medicine was always keen and he rarely missed these meetings of our State Society. The profession of our State lost in the death of Dr. Donohue a capable, courteous and dignified physician and an honorable, upright gentleman. John F. Hagerty.

Dr. Dickinson: The Committee on Hospital Standardization. Is Dr. McCoy here? If not, we'll postpone this report.

The Committee to Co-operate with Psychopathic Clinics and Children's Courts? Dr. Halsey.

Dr. Halsey: Dr. Hallowell was sick and we have not been able to formulate what we thought was the proper bill. If the committee is continued, next year we shall perhaps be able to present an adequate report for your consideration.

Dr. Dickinson: I will use my influence.

Committee to Consider Problems of Drug Addicts. Dr. Chris. C. Beling.

Dr. Beling: The committee reports progress.

Dr. Dickinson: The Committee on Venereal Diseases, of which Dr. Stanley R. Woodruff of Bayonne is Chairman, reports, I understand, in a letter to the Secretary, which will now be read.

June 9th, 1920.

Dr. Wm. J. Chandler,
South Orange, N. J.

Having only been recently appointed to the chairmanship of the Committee on Venereal Diseases to fill the vacancy caused by the death of Dr. Emery Marvel, I can report no great activity on the part of this particular branch.

I endeavored to get in touch with Dr. Marvel's ideas and expectations in order to follow out any particular line of thought that he might have had under consideration, but was unable to find that he had any fixed purpose in view.

The past year has been one of marked activity in the fight on venereal disease. The legislators in New Jersey have at last awakened to the necessity of placing a curb on its dissemination, and have passed, and seem about to pass laws relative to marriage and the treatment of the infected cases. The reporting by physicians of venereal disease in this State has been more or less of a failure, but it has been a stepping stone to further progress and sufficient legislation will no doubt be passed, so that in co-operation with local Boards of Health the complete treatment, and if necessary, the segregation of infected individuals will be carried out.

The free clinics established throughout the State by the efforts of the U. S. Public Health Service in conjunction with the State Board of Health are a step in the right direction in order to eliminate the excuse of poverty in any one who needs treatment for venereal disease. There are now fourteen of these clinics and they are constantly growing. By the aid of these, and the enactment of constructive, common sense legislation, it will be an easy matter to rid our State of 95% of its venereal disease.

Yours very truly,
S. R. Woodruff.

The Committee on Hygiene and Sanitation, "no report."

The Committee on Public Health Education, Dr. Fischer? No report.

Report of the Judicial Council.

Dr. Christopher C. Beling, Newark: Dr. McCoy is unable to be here today and asked me to present this report to you.

Report of the Judicial Council.

June 15th, 1920.

Mr. President and Gentlemen:

The chairman reports for the Judicial Council that seven meetings were held during the last year to consider ethical and legal matters affecting the welfare of the members of the Medical Society of New Jersey. There were six malpractice suits last year in strange contrast to the preceding year in the period of the war when there were none. One of these cases has been successfully defended. The others are pending. No action was taken in the case of a member, who elected to have his defense undertaken by his insurance company.

Considerable delay and embarrassment were caused in the case of a member who applied for defense by the failure of the secretary of his county society to notify promptly the Secretary of the State Society as to his standing in his society and to forward his dues. To establish the status of this physician it was necessary for the Judicial Council to take the matter up with the secretary of the county society and the Board of Trustees. Until this was done the attorney of the State Society could not be instructed to undertake the defense of this member. This emphasizes the importance of each county secretary notifying the State Secretary as to the good standing of its component members.

Another matter of importance which the Council deems necessary to bring to the attention of the State Society is that concerning suits, which may result from the over-prescribing of drugs and alcohol. Two members of the Society were summoned before the Federal authorities for violation of the Volstead Act. One member applied for defense under the State Medical Society's Act. As the Judicial Council was of the opinion that the matter did not properly come under the Medical Defense Act, the advice of the attorney of the State Society was obtained. It is herewith submitted:

"As I understand it, your Society's theory is that you are defending innocent physicians from suits, and that you do not defend a man unless you are satisfied that he is innocent and has a real defense. The kind of suit you now mention is not in that category, as I understand. If a doctor has given more whiskey or drugs than he is allowed by law, and he deliberately breaks that law, I do not see that you are called upon to defend him. Of course, if you wanted to defend him that would be a matter apart from the actual resolutions of your Society and its purpose as I understand it. It is not a thing for your Society to defend. I believe the act was intended to protect reputable physicians from fradulent suits, to protect them from prejudiced attacks on insufficient grounds, and not to stand by a doctor and defend him from all actions. The charge being an infraction of the Volstead Act no question of medical practice is involved. The suit lies entirely outside of the scope of the Medical Defense Act. I don't think there is any question about it."

Report of Councilor for the First District.

(Essex, Morris, Union and Warren Counties).
Dr. John C. McCoy,
Chairman.

The county medical societies comprising this district have held regular meetings during the past year.

They have all maintained their usual high standard of scientific work. Following the activities occasioned by the war, the societies in this district have been displaying a militant spirit of a civic character, engendered largely by proposed and enacted legislation of a most

pernicious kind. Never before has the medical profession been awakened to the necessity of thorough organization to combat the deleterious influences at work to destroy the high standards which have been laboriously built up for the rendering of efficient service to the community. Delegates from these societies have met to co-operate with the officers and appointed committees of the State Society. The bulletins issued by the State and county socieites have already dealt with these important matters.

During the year there was one malpractice suit, which is still pending. A member of the Essex County Society was charged with the violation of the Volstead Act. Another member was tried for violation of the Harrison Narcotic Act, and convicted. This case is now in appearl.

Respectfully submitted,
Christopher C. Beling,
Councilor for the First District.

Report of the Second District.

(Including the Component Societies of Hudson, Passaic, Bergen and Sussex Counties).

The Hudson County Society has conducted its regular scientific meetings throughout the entire year. These have been well attended and there has been free scientific discussion.

Passaic County has had its full quota of scientific meetings, starting at the beginning of the year with a program covering the entire year. Each meeting being a symposium upon a medical or surgical subject. Attendance has been full.

Bergen County Society has also had its full quota of meetings during the year and appointed a committee to consider the establishment of a guild composed of the medical and dental fraternities,. and also the druggists This guild to have charge of legislative matters pertaining to the profession in the county. The final report of this committee is still to be made.

Sussex County has had its two regular scientific and social meetings with full attendance.

There was one damage suit brought in this district—in Bergen County—which was directed successfully by the Judicial Council.

Respectfully submitted,
John C. McCoy,
Councilor for the Second District.

Report for the Third District.

June 1, 1920.

The Third Judicial District composing the component societies of Mercer, Middlesex, Somerset and Hunterdon, has had an unusually good year.

The men in service have in the main returned and resumed their practice and former affiliations with their county societies. We welcome them back.

The meetings in this district, I am informed, have been held regularly and a great deal of interest manifested. There has been a fair increase in membership, yet many more should be brought within the judicial care of the county and State societies.

By getting new men in the county society we not only do the new man good, but we also help the local society and make it a stronger factor for good in the community.

Edward S. Hawke,
Councilor of Third Judicial District.

436 East State Street,
Trenton, N. J.

June 2, 1920.

Dr. John C. McCoy,
Chairman of Board of Councilors.

Dear Sir:

By reason of my continued illness I have not been permitted to mingle with the profession throughout this district, and but very little among my home society. I understand, however, that Burlington County has had good and well-attended meetings and increased her membership. Camden County Society has had regular and well-attended meetings—both city and county. The city society has a membership of 75, an increase of 4 this year. The county society has added 25 to its roster this year, making a total membership of 110. Monthly meetings are held regularly except in the months of July and August.

I have no doubt that Ocean and Monmouth have kept pace with the advancing times.

Very respectfully submitted,
Wm. H. Iszard.

Report of the Fith District.

June 1, 1920.

Dr. John C. McCoy,
Chairman Judicial Council,

Dear Doctor:

It was my pleasure to attend one meeting of the Cape May County Medical Society, two meetings of the Cumberland County Society and, of course, most of the meetings held by Atlantic County Society. I suppose through an oversight, I was not favored with an invitation to the meetings in either Gloucester or Salem counties.

The attendance at both the Cape May and Cumberland County meetings was rather small, but the men were quite active and very much interested in their work. The programs were instructive and enjoyable. Atlantic County had a much larger attendance, partly on account of the increased membership. Here, also, the programs were of an unusually interesting type and elicited considerable discussion.

No damage suits or reports of unethical conduct have been brought before the council from the fifth district. A case of malpractice on the part of a chiropractic practitioner who agreed to cure what proved to be a case of malignant glandular disease, was reported from Bridgeton. This was referred to the secretary of the council.

Very truly yours,
Walt P. Conaway,
Councilor for Fifth District.

Dr. Dickinson: This report will be filed as read if there are no corrections.

Adjourned at 1 P. M.

MEETING OF THE HOUSE OF DELEGATES.

Tuesday Afternoon, June 15th, 1920.

The meeting was called to order by the President at 2.55 P. M.

The Rev. Dr. Matthews of Spring Lake offered the invocation, as follows:

O, God, Holy Ghost, Sanctifier of the Faithful, bless, we pray Thee, the members of this convention here assembled with Thy loving favor. Enlighten their minds more and more with the light of the everlasting Gospel. Give them a love of the truth. Increase in them true religion. Nourish in them all goodness, and keep them in the same, O Blessed Spirit, who with the Father and Son together we worship and glorify as one God world without end.

Address of Welcome by Rev. Mr. Lippincott.

Mr. President and Gentlemen of the New Jersey State Medical Society: Mayor Brown is a ubiquitous man, and is here and there and everywhere; and he always tries to keep his engagements. He takes great pleasure, in his kindly way and with his courteous and gentlemanly dealing, in welcoming such a body as this to the Borough of Spring Lake. He was called away suddenly yesterday afternoon, and he asks this speaker if he would take his place. He being a member of my official board, and I being his pastor and knowing the relationship that exists between salary and popularity, I consented. He told me, before he left, that the Address of Welcome was limited to three minutes, whereupon my face fell. How can a preacher, and a Methodist preacher at that, limit his remarks to three minutes? It never has been done; it never will be done. "But," he said, "you have got a restless, quite fussy bunch to talk to, and if you talk over three minutes, they will get restless, and may show their restlessness." I said, "I do not care, I will take a chance."

Now I do not know what an Address of Welcome is. I never met one. I should not recognize it if I met it on the street. So that charge cannot be made against me, that I have failed to address you with a welcome to the Borough of Spring Lake; and yet I do welcome you in behalf of Mayor Brown and in behalf of the people of Spring Lake.

I have a sort of filial relation with this Society, inasmuch as I have a brother who has been a member of it for many years. I have been amazed at the celerity with which he has climbed the ladder of success; but more at the celerity with which he has gathered in the sheckles. To a poor Methodist preacher, it is an interesting sight to see anyone gather in the sheckles. I only knew one Methodist preacher with plenty of money, and he died.

Everything here is yours to command. Everything belongs to you. You have the keys of the city. That is all I know about welcoming any body of men to a town. May your deliberations enhance the situation that exists in this State with respect to the opinion that the people hold of the New Jersey State Medical Association. May the ethics that you have maintained through the year involate, and that have made you the Society that you are, be maintained through the coming year. May your forensic battles be bloodless and entirely brotherly. May your banquets be seasoned with attic salt. May your past be the mother of wisdom, and may you realize it greatly. May your presence be the sire of endeavor, and may that endeavor be grand and masterful. May your future be the door of hope until medical science shall become the deliverance of intuitive wisdom.

Mr. President, in behalf of the Mayor, I welcome you. (Applause).

Dr. Chandler, the Secretary, read the names of the members of the Nominating Committee, so far as they have been presented:

Passaic County, Andrew F. McBride; Union County, Norton L. Wilson; Warren County, James M. Reese; Hunterdon County, George L. Romine; Burlington County, Marcus W. Newcomb; Essex County, Royal M. Whitenack; Morris County, George H. Lathrope; Somerset County, Philip Emburg; Atlantic County, Elisha C. Chew; Mercer County, Henry A. Cotton; Bergen County, George H. McFadden; Camden County, A. Haines Lippincott; Gloucester County; Harry A. Stout; Hudson County, John Nevin; Ocean County, Vanderhoof M. Disbrow.

The following counties failed to present the names of their members of the Nominating Committee: Cape May, Cumberland, Middlesex, Monmouth, Salem and Sussex.

There being still twenty minutes before the time for the beginning of the Scientific Session, the President said that he would like to give a few thoughts that had come to his mind, and spoke as follows:

It seems to me that, as the times are changing and ideas are changing, our profession has got to change also. Our experiences this last winter with the Legislature and with the great problems that are going to disturb our minds in the months and years to come, ought to lead us to a different type of activity. You will note by Dr. Chandler's report this morning that there was a time, in 1860, about, when we met twice a year. If we are going to be true citizens and be wider awake to things that ought to receive attention, I feel that we ought to have, at the end of the fall or the beginning of the winter, a meeting, say in Newark, where we can discuss just simply business and social matters, leaving out the truly professional papers. If we could have men address us who are alive to the big topics of the day, such as public health education, health insurance and the different topics that are bound to spring up, it would be a very good thing. We could consider these questions at that time, and not wait until the time of the meeting of the Legislature. Now, if a man falls sick, everything goes flat. We had a big movement in Essex. I hoped that they would come down today and tell about it. I hoped that Mr. Gunn would be here and make some kind of report of what he had done. If we could have a one-day session, an afternoon and evening, in the latter part of the year, in a convenient place, where we could discuss those things which, even if we do not discuss them, the Legislature will, and will handle us roughly, it would be far better for us.

Then there is another matter. The county society is a component part of the State Medical Society, and the latter is a component part of the American Medical Association, but I

feel that there should be a closer society than the American Medical, where there could be a circulation of the great knowledge that the American Medical Association has. We have to find out, by hook or crook, what California or any other State is doing, and how well it is doing it. If the American Medical Association could get into closer and more frequent touch with the State Society, we would not be so much in the dark, and occasionally do fool things.

Now here are two thoughts which are worthy of your serious and mature consideration.

Dr. Norton L. Wilson, Elizabeth, made a motion that when the Society adjourned, it should do so at the call of the President. The motion was seconded and carried.

Dr. Chandler: Last year Dr. Dickinson introduced an amendment to the By-Laws. It was laid over until this meeting. It is an amendment to Chapter VI, Section 4. "Omit the words' Board of Trustees.'" These words are found in the "duties of the Treasurer," where it is stated that he shall not pay out any money except by the written order of the President, approved by the Board of Trustees. The second reading of this amendment and a vote thereon can come up at this meeting of the House of Delegates.

Dr. Dickinson: As we have it now, our bills are sometimes held up; because they have to float around from one man to another. If you order it be simply "O. Ked" by the sponsor of the bill, endorsed by the President, and then sent to the Treasurer, I think it will be sufficient. It will save time and enable us to pay our bills more quickly.

Does any one wish to move the adoption of this amendment?

The motion was made, seconded and carried.

Dr. Henry Wallace, Glen Ridge: Mr. President and Gentlemen: Some years ago, when I came back into the State of New Jersey, I found that when I moved to the Montclair section and looked up in the Green Book of New York, New Jersey and Connecticut the names of men practicing in New Jersey, there was nothing to show where or what they were, or what their special lines of endeavor were. It simply showed that Dr. So-and-So belonged to such-and-such a school. When some patient was referred to us by some physician in New York, and we looked up the doctor's name in order to find out who had referred the case to us, we found that he was attending physician at this or that hospital or was engaged in some special line of work, and this gave us an inkling as to the man's endeavors, his standing in the profession and the line of work in which he was most proficient.

Some time ago I asked a member of the New York Medical Society why the New Jersey men were not favored with the same privileges, and he said that it was a matter of money. The New Jersey Society did not pay enough money to cover the extra cost for time and the expense of printing.

It seems to me that it is a great advantage to men living in the suburban districts of New Jersey to have something of this kind, and I thought that it might interest the Society to have the matter brought up.

(As the time for adjournment had arrived, discussion of this matter was postponed).

House of Delegates adjourned at 3.25 P. M.

GENERAL SESSION.

Tuesday Afternoon, June 15th, 1920.

ARTHROPLASTY, WITH DEMONSTRATION OF PATIENTS AND EXHIBITION OF X-RAY PLATES.

George H. Sexsmith, M. D., Bayonne.

Discussion opened by Sidney A. Twinch of Newark and Norman H. Bassett, Salem.

HEART IRREGULARITIES, THEIR CLINICAL RECOGNITION AND INTERPRETATION.

Charles E. Teeter, M. D., Newark.

Discussion opened by Henry Wallace, Montclair; G. H. Lathrope, Morristown; Hyman I. Goldstein, Camden; Philip Marvel, Atlantic City, and Chas. E. Teeter, Newark.

OBESITY.

Frederick C. Horsford, M. D., Newark.

Discussion opened by Harrison S. Martland, Pathologist, Newark; Theodore Teimer, Metabolist, Newark; Fred C. Horsford, Newark, and H. I. Goldstein, Camden.

CO-OPERATION OF THE SPECIALIST AND THE FAMILY PHYSICIAN.

Linn Emerson, M. D., Orange.

Discussion by Norton L. Wilson, Elizabeth, and Linn Emerson, Orange.

Tuesday Evening, June 15th.

ADDRESS OF THE PRESIDENT.

Gordon K. Dickinson, M. D.

PULMONARY TUBERCULOSIS AND CONDITIONS SIMULATING THE SAME.

Samuel B. English, M. D., Glen Gardner.

Discussion opened by Alexander Armstrong, White Haven, Pa., and M. W. Newcomb, Browns Mills, and Berth S. Pollak, Secaucus, and S. B. English.

GASTROSPASM, AND ITS DIAGNOSTIC SIGNIFICANCE, WITH LANTERN SLIDE DEMONSTRATION.

J. Roemer, M. D., Paterson.

Discussion opened by Edwin Reisman, Newark; H. I. Goldstein, Camden, and J. Roemer.

PHYSICAL DIAGNOSIS IN OBSTETRICS.

John Francis Condon, M. D., Newark.

Discussion opened by P. D. Bunting, Elizabeth, and H. B. Kessler, Newark.

DIVERTICULOSIS OF THE COLON WITH SPECIAL REFERENCE TO THE CECUM.

M. W. Reddan, M. D., Trenton.

This paper was read by Dr. Hagerty. There was no discussion.

Wednesday, June 16th.

Morning Session.

9 A. M.

THE PROBLEM OF VENEREAL DISEASE CONTROL

H. J. F. Wallhauser, M. D., Newark.

Discussion opened by Arthur J. Casselman, Camden; Wm. G. Schauffler, Princeton; Leo A. Koppel, Jersey City; Chas. V. Craster, Newark; A. H. Lippincott, Camden; Philip Embury, Basking Ridge; H. I. Goldstein, Camden, and H. J. F. Wallhauser, Newark.

CEREBRO SPINAL FLUID; ITS CHANGES IN VARIOUS DISEASES AND THEIR SIGNIFICANCE.

E. G. Hummel, M. D., Camden.

Discussion opened by Arthur J. Casselman, Camden; H. I. Goldstein, Camden, and E. G. Hummel, Camden.

ESSENTIAL UTERINE HEMORRHAGE.

Wm. A. Dwyer, M. D., Paterson.

Discussion opened by Edward J. Ill, Newark; Edwin Field, Red Bank; P. A. Harris, Paterson; S. G. Lee, Orange, and Wm. A. Dwyer, Paterson.

A STUDY OF ACUTE INFECTIONS OF THE EAR AS SEEN BY THE PHYSICIAN.

J. Clarence Keeler, M. D., Philadelphia, Pa.

Discussion opened by Harry R. North, Trenton; W. B. Stewart, Atlantic City; Linn Emerson, Orange; R. B. Scarlett, Trenton; H. I. Goldstein, Camden, and J. C. Keeler, Philadelphia.

Wednesday Afternoon, June 16th.

2.30 P. M.

MEETING OF THE HOUSE OF DELEGATES.

The meeting was called to order by the President at 2.45.

Dr. Chandler read the report of the Nominating Committee as follows:

Report of the Nominating Committee.

The Nominating Committee presents the following nominees for each of the offices to be filled for the ensuing year, also nominees for the councilors, standing committees, delegates to the American Medical Association and to State medical societies.

For president, Philander A. Harris, Paterson; first vice-president, Henry B. Costill, Trenton; second vice-president, James Hunter Jr., Westville; third vice-president, Wells P. Eagleton, Newark; corresponding secretary, Harry A. Stout, Wenonah; recording secretary, William J. Chandler, South Orange; treasurer, Archibald Mercer, Newark.

Councilors—First District (Union, Warren, Morris, Essex), Christopher C. Beling, Newark; Second District (Sussex, Bergen, Hudson, Passaic), John C. McCoy, Paterson; Third District (Mercer, Middlesex, Somerset, Hunterdon), Edward S. Hawke, Trenton; Fourth District (Camden, Burlington, Ocean, Monmouth), William H. Iszard, Chairman, Camden; Fifth District (Cape May, Cumberland, Atlantic, Gloucester, Salem), Walt P. Conaway, Atlantic City.

Committee on Arrangements—Elisha C. Chew, W. Blair Stewart, Wm. J. Carrington, Wm. W. Fox, Atlantic City; Ernest G. Hummel, Camden; Philander A. Harris, ex-officio, Paterson; William J. Chandler, ex-officio, South Orange.

Committee on Program (one member)—Walt P. Conaway, Atlantic City; term expires 1923.

Committee on Scientific Work (one member—George N. J. Sommer, Trenton; term expires 1923.

Committee on Publication—Edward J. Ill, Newark; term expires 1923.

Delegate to the American Medical Association—Henry A. Cotton, Trenton; term expires 1922.

Alternate Delegate to American Medical Association—C. R. P. Fisher, Bound Brook.

Committee on Public Hygiene and Sanitation—Gordon K. Dickinson, Jersey City, and Walt P. Conaway, Atlantic City, for three years.

Committee on Standardization of Hosptals—

Henry B. Costill, Trenton, and Edgar B. Grier, Elizabeth, for three years.

Delegates to the Medical Society of the State of Pennsylvania—Clara K. Bartlett, Atlantic City; Harry A. Stout, Wenonah; Howard F. Palm, Camden.

Delegate to the Medical Society of the State of Connecticut—Herbert W. Nafey, New Brunswick.

Delegate to the Medical Society of the State of Delaware—Philip Marvel, Atlantic City.

Delegate to the Medical Society of the State of New York—Henry A. Cotton, Trenton.

Other members desiring to go as delegates to the various State societies can apply to the President for appointment and will be furnished with the necessary credentials by the Recording Secretary.

It was recommended that the Society meet next year in Atlantic City, the exact date to be fixed later by the Board of Trustees.

On motion of Dr. Schauffler, the report was accepted (the name of Dr. L. P. Runyon of New Brunswick being added to the list as a delegate to the New York State Medical Society, at the suggestion of Dr. English), and the Secretary directed to cast a ballot for the election of those nominated.

Under Unfinished Business, the report of the Board of Trustees was read by Dr. English, as follows:

At a meeting of the Board of Trustees held this morning, the following actions were taken:

The Committee on Publication reported, as requested, the following plan to prevent irregularities and delays in the transmission of the Journal through the mails: That there be inserted in a prominent place in the Journal an item asking every member of the Society who fails to receive any issue of the Journal to promptly notify the Chairman of the Publication Committee, Dr. C. D. Bennett, 167 Clinton avenue, Newark, of his failure to receive the Journal in every case.

The report of the committee was approved by the Board. The committee appointed to consider the question of the Registration of the Physicians of the State, reported as follows:

We recommend that an amendment be added to the legislative act creating the State Board of Medical Examiners that will require all physicians in the State to register annually on blanks furnished them by the said Board; that Board furnish each physician so registering a complete copy of such registration; and that the cost of such registration be borne by the State. To make the act effective, a penalty for non-compliance on the part of the physicians should be a requirement of the act; such penalty should not be a forfeiture of the right to practice.

The report was accepted and referred to the House of Delegates for consideration and action.

The following resolution was offered and after discussion was, on motion, referred to the House of Delegates for consideration and action.

Resolved, That the physician's right to prescribe alcoholics in the treatment of disease should not be restricted to the detriment of the patient of which the physician is the best qualified judge. The present law should be amended so as to allow such use as the physician deems necessary in the individual case under treatment. In cases where the patient requires a larger quantity than usual the quantity should be decided by a consultation of physicians for a more or less definite period of time.

On motion it was unanimously voted that Dr. C. D. Bennett, Chairman of the Committee on Publication, as the Business Manager of the Journal, shall be paid for the year beginning July 1, 1920, the sum of five hundred dollars for salary and ordinary expenses.

Respectfully submitted,

D. C. English, Secretary.

On motion of Dr. Halsey, the report was accepted.

Dr. William A. Tansey, Vailsburg: I wish to say something regarding annual registration. I have investigated the matter personally, and found out who started it. It was started by F. Shepherdson of Chicago, a politician, who said that the only good doctors are dead. He did it so that the doctors would come under the rule of a convention of politicians; and that if the doctors did not do as the politicians wanted them to, their licenses might terminate automatically at the end of the year. The attempt to get such a law through in New York failed; and in Illinois, it was beaten completely. I do not see why we should have it in New Jersey. It is not for the benefit of the patients, but for the politicians, so that they can make the doctors comes across.

Dr. Harvey made a motion to amend the motion of Dr. Halsey by providing that the recommendations of the Board of Trustees be considered separately.

Dr. English stated that Dr. Halsey was willing that this should be done. The motion was seconded and carried.

Dr. English: The committee appointed to consider the question of registration of the physicians of the State reported as follows: We recommend that an amendment be added to the legislative act creating a State Board of Medical Examiners that shall require all physicians to register annually on the blanks furnished by the Board of Examiners. This was approved by the Board of Trustees and referred to the House of Delegates for consideration. Let me state, in presenting this recommendation, that others have made a good many investigations. You will recall the discussion of last year. The main objection to it last year was the assessment of two dollars

on the physicians. In this recommendation today it is stated that the State shall pay any expenses of registration. This has received the approval of a great many physicians on account of the fact that we shall then have a perfect list of the physicians of the State, which we have not now, and that it will give an opportunity to consult with those who are not members of our Society. Another argument in favor of it is that the dentists have had such an act for years, and are finding it helpful in prosecuting quacks in their profession.

Dr. Philip Embury, Basking Ridge: I have been through all this fight in New York; for I began, many years ago, with a small body in the New York County Medical Society to take up these economic questions. I want to warn you, before you take action, that, however innocuous it may appear, this act will prove the thin edge of a wedge that may make trouble. This thing may be used against us in the passage of the Workmen's Compensation Act; so that if a doctor refuses to work or does not work to the satisfaction of whatever lay persons are placed in charge of the Compensation Act, it will be used against him.

It looks fair enough to have a registration of physicians, and better to have it paid for by the State than to assess the doctors two dollars a year; but cannot the same thing be accomplished by a census of the physicians practicing in New Jersey? If the State Board of Examiners cannot state positively who is and who is not licensed to practice, cannot it be done by a census? We have got along for thirty years without this annual registration, and if we submit to any curtailment of our privileges, I am afraid we shall be sorry for it.

Dr. Harvey: This matter came up in the shape of a bill intended to be introduced in the last Legislature by the Board of Medical Examiners. It carried with it the provision that a charge of so much a year be made to the physicians. That, of course, would be objectionable; but here you have something even worse. Naturally, if this went to the Legislature, it would be amended almost at once. The Legislature would never load up work of that kind on the people at large, but would say, "If the doctors want this, let them pay for it." We do not want it. Only two or three men connected with the Board of Medical Examiners are in favor of it.

Why should we have to send our names in every year, even at the expense of postage, and, if we fail, be fined ten dollars? It is a great mistake, and I hope to see this suggestion of an amendment to our medical law voted down.

Dr. Dickinson: I think we have a very easy way of accomplishing what we want. Our State Board of Health has all the data that we need, and it is available. There is not a doctor who has not a death to report, and all the death certificates go through the office of the State Board of Health. This Board of Health can make a list of the names and report them for us.

Dr. Marvel: I merely want to add to your suggestion that, as a means of correcting that report, an application to the county clerk's office for the number of registrations in the particular county will help the State Board of Health to correct its report before it is sent out to the profession.

Dr. Dickinson: That will not work in the large counties, for the men change their addresses, and we do not know where they have moved, or whether they are dead or alive.

The question of approving the suggestion of the Board of Trustees that they recommend the addition of a clause requiring the annual registration of physicians to the legislative act creating a State Board of Medical Examiners was voted on and lost.

Dr. English: The following resolution was offered and, after discussion, was approved by the Board of Trustees and referred to the House of Delegates for consideration and action:

Resolved, That the physicians' right to prescribe alcoholics in the treatment of disease shall not be restricted to the detriment of the patient, of which the physician is the best qualified to judge. The present law should be amended so as to allow such use of these alcoholics as the physician deems necessary in the individual case under treatment. In instances in which the case requires a larger amount than usual, the quantity should be decided by a consultation of physicians for a more or less definite period of time.

Dr. Schauffler moved that this resolution be adopted, and his motion was seconded.

Dr. C. Morris, Newark: I deny that any physician has had given him the right to prescribe medicines or drugs. He has had given him the privilege, granted by the State. When the matter of Prohibition came up, the amount of alcohol that any physician should be allowed to prescribe was settled by the Federal authorities after

consultation with the medical profession of the United States. Certain limitations were put on the amount. At first, the amount was liberal—a quart in ten days. Within a few months the abuse of this privilege was so great that the Government was compelled to cut down the quantity to a pint. The abuse was still so great after this (millions of prescriptions coming in under the diagnosis of "general debility"), that the Government had to further restrict the privilege. The fault is ours, that there is any limitation of the quantity, and if the abuse of the privilege continues, we shall be allowed to prescribe only four ounces. I do not believe myself in the theory of Prohibition. I think that there are times when we need alcohol as medicine, but the occasions are diminishing rapidly in number.

Dr. Marvel: In the face of the statement regarding the situation of the Government —a statement of facts—I feel that it would be poor policy to go on record as endorsing the resolution of the Trustees. I move to amend the motion of Dr. Schauffler, as follows: That the resolution be referred back to the Board of Trustees.

The motion of Dr. Marvel was seconded and adopted as a substitute for Dr. Schauffler's motion.

It was then moved that the report of the Board of Trustees as amended be accepted and filed. The motion was seconded and carried.

Dr. Chandler: The following Permanent Delegates have presented excuses for absences to the Judicial Council and the excuses were accepted:

William H. Hicks, Essex County, for absences, 1918 and 1919; E. Zeh Hawkes, Essex County, for absences, 1918 and 1919; William B. Graves, Essex County, for absences, 1918 and 1919; D. Edgar Roberts, Monmouth County, for absences, 1918 and 1919.

Dr. Chandler: Dr. Dickinson has asked me to read the following report of our delegate to the U. S. Pharmacopoeal convention:

June 1, 1920.

Dr. Gordon K. Dickinson,
President, N. J. Medical Society,

Dear Dr. Dickinson:

In accordance with the instructions contained in my credentials, I transmit herewith report of my attendance as one of the delegates from the N. J. Medical Society at the convention held in Washington, D. C., on May 10th, for the election of members for the Revision Committee of the U. S. P.

The convention met and organized by the election of Dr. Reed Hunt as president.

A Revision Committee of 50 members was elected—17 of this number being members of the medical profession. Two of the members from the N. J. Medical Society were elected members of the Revision Committee, these two members being Dr. Isaac F. Leonard and Dr. John F. Anderson. Dr. Anderson was also elected one of the vice-presidents of the convention.

The general principles to be followed in the revision of the Pharmacopeia were agreed upon, and copy is transmitted herewith.

Very truly yours,

John F. Anderson.

Dr. Chandler: There is another amendment to come up. It was read yesterday, and I will read it now for the second time. It is to strike out "March" and insert "January." If there is no objection, we can put it to a vote at once. I will, then, move that Chapter 12, Section 1, 2nd Paragraph, be amended by striking out "March" and inserting "January." The purpose of this is that the reports hitherto made in March shall be made the first of January. The reason for that is that the fiscal year, since these By-Laws were written, has been changed to run from January to December; so our reports should be from January to December, and all who have paid their dues on or before the first of January will be recognized as members in good standing. It is important that a record be kept as to the time when every man pays his dues, because the first step in medical defense is to learn from the Recording Secretary whether the man is in good standing. If he does not pay his dues, he is not in good standing and cannot be defended.

The motion to adopt the amendment was seconded and carried.

Dr. Harvey then presented his amendments to the By-Laws for a second reading. After a short discussion they were unanimously adopted.

Dr. Dickinson: I want to introduce to you Mr. Gunn, who has been doing noble work for us at Trenton. Some of you have never met him. (Mr. Gunn was then formally presented).

The report of the delegate to the American Medical Association was presented by Dr. George E. Reading, Woodbury.

I was the only delegate from this Society to attend the meeting of the American Medical Association at New Orleans in April. Contrary to expectations there was a very large attendance—one of the largest meetings ever held. It was an excellent one, also, as regards the scientific work, although I did not hear much of it because, as a member of the House of Delegates, I was otherwise occupied.

There was no especial work accomplished that would interest you. It was mostly routine

work; but the meeting seems to have aroused great interest in that section of the country. I heard it commented on by members of the Louisiana State Medical Society, who said that it had helped them a great deal in their work and that the interest developed by the meeting of the American Medical Association would largely increase their own membership. That was one reason for holding the meeting there. Although the place seemed undesirable on account of the lack of hotel accommodations, yet the local committee was very efficient and managed to find quarters for us all.

The next meeting, as you probably know, will be held in Boston, the date to be set by the Board of Trustees of the American Medical Association.

The report was received.

Dr. Halsey: I should like to suggest that Dr. Hummel be added to the Committee on Arrangements. He is a live man, and will be of benefit to the committee.

The motion was seconded and carried.

Dr. Marcy: The Medical Society of the State of New Jersey has always stood for law and order, and I believe it will always stand for what is right. I wish to offer the following resolutions:

Whereas, The Eighteenth Amendment to the Constitution of the United States as well as the enforcement act, better known as the Volstead Act, has been declared constitutional by the Supreme Court of the United States; and,

"Whereas, The Governor of this State has declared that he will use all the power at his command in order to prevent the operation and enforcement of Prohibition in this State and has stated that he will make New Jersey as wet as the Atlantic Ocean, and

Whereas, Such statements hold the citizens of this State up to the ridicule of the people not only of this country, but of the world.

Therefore, be it resolved, By the Medical Society of New Jersey in meeting assembled:

1st—That we, its members, declare our unalterable faith in the Government of these United States and pledge ourselves to uphold its laws and assist in their enforcement to the limit of our ability.

2nd—We accept the challenge of the Governor that New Jersey shall be as wet as the Atlantic Ocean, and pledge ourselves to help make it as dry as the Desert of Sahara so long as the organic laws of the land remain as they are at present.

Dr. Quigley: I move that they be tabled.

The motion was seconded, and, on a rising vote, lost.

It was moved by Dr. Kraker and seconded that the resolutions be adopted.

Dr. Marvel: Would the gentleman who offered the resolutions be willing to amend it by changing its wording so that it will not seem as if we are trying to slap at our Governor?

Dr. Marcy: I have no wish to criticize him. I only wish to say that the State Medical Society is in favor of making the State dry as long as the law *is* as it *is*. The resolution can be amended on the floor. I shall be glad to have it amended.

Dr. English: I move that it be amended by striking out the last section. There is nothing wrong with the rest of it.

Dr. Marvel: Will the gentleman who made that amendment accept another suggestion that the second "whereas" be left out?

Dr. Dickinson: There are no "whereases" here.

Dr. Sexsmith: In justice to the Governor, it may be said that he did not make that statement since the decision of the Supreme Court. I wish to mention an incident that will appeal to all of you. I attended a meeting of the Rotarian Club, and the question was raised as to whether we should have cocktails. I said, "Yes." One of the members of the club is a worthy citizen who gets intoxicated every few weeks. He is a highly respected man and a member of a hospital board. When I said, "Yes, come on," for I felt like it, he immediately spoke up and said, "Gentlemen, you will probably be surprised to hear me say 'No.' But are we not good American citizens? Don't we want to be good American citizens? Has not the Supreme Court decided that the Eighteenth Amendment is proper?" I said, "Yes; that is splendid; I withdraw my proposal."

Does not the Medical Society of New Jersey (cutting out the reference to the Governor, because it was said before the decision, if said at all) want to put itself on record as standing by the decision of the Supreme Court.

Dr. Pollak: Dr. Dickinson received word from the State Board of Medical Examiners at Trenton, saying that they had received a massage from Dr. Watson of the State Board, asking them to gather all the facts in connection with the Chiropractic Act, which the Governor of New York vetoed; because, if we present the facts to Governor Edwards, Dr. Watson believes that the Governor will not appoint the Commission. By his failure to appoint the Commission the act would be invalid.

Dr. Fisher: The Eighteenth Amendment was passed and is valid; the Volstead Bill and the Chiropractic Bill also were passed and are valid. How can the Governor refuse to appoint the Commission?

Dr. Rosewater: I can tell how they can do it. They can have the bill vetoed by an-

other bill wiping it out. The Legislature is still in session. All their acts are loose. The greatest authority on the alcohol question in America is a man named Wheeler, who wrote the Volstead Act. He said, the other day that whereas the Volstead Act applies to the manufacture and sale of beverages containing one-half of one per cent. of alcohol, it does not apply to beverages made in anyone's home. So the condition is that a thousand homes are manufacturing the intoxicating beverages. If you wish to put yourself on record, do it; but do it with your eyes open. Anyone who says this is a dry country makes an ass of himself.

Dr. Marcy: I am willing to withdraw that part of the resolution which applies to the Governor.

Dr. David A. Kraker, Newark: We are decent American citizens, and I do not think that it is necessary for us to put ourselves on record in this way. (Applause).

Dr. English: I want to second the amendment just made by Dr. Sexsmith, and to state positively that I do not abate one jot of my estimate of the Governor, as declared in the original resolution.

Dr. Samuel A. Cosgrove, Jersey City: The whole question was embodied in the original resolution, and Dr. Sexsmith's is supererogatory. It should be assumed that we are law-abiding and will obey the laws, and it is not necessary to declare that we will do so. I think that it is bad policy to take any action in regard to the various "whereases" of the original resolution. Whatever Governor Edwards may have said was said in more or less conformity to the wishes of his constituents, who defeated the State action on the Eighteenth Amendment, and whatever other weight it may have is merely what may be accorded to a personal utterance for obvious political reasons.

Dr. Carpenter: I think that we have a right to announce that we are law-abiding citizens. What harm does it do? Does it not do us honor?

A rising vote was taken on the question, with the resolution that thirty-four delegates voted in favor of the adoption of the resolution as amended and thirty-five against it. Lost.

Dr. Quigley: The Legislative Committee of the Hudson County Medical Society, after considering the Compulsory Health Insurance Bill, have found that the feeling has grown that inasmuch as this bill and similar bills of a socialistic tendency are apt to come up from time to time, we, as a society, should be prepared to either favor or combat such bills, according as we believe it necessary. We, therefore, think that the State Medical Society should make a comprehensive survey of the public health needs of the State. There are agencies from which a part of this information may be procured, but sufficient data can not be obtained from them. I, therefore, make a motion that the State Medical Society, through the Welfare Committee, make a comprehensive survey of the State through the component county medical societies, and ascertain the public health needs of the State.

The motion was seconded and carried.

Dr. Pinneo: I wish to suggest that we try to form a close association with some State Board, having the authority of law, which we have not,—either the State Board of Health or the State Board of Medical Examiners; so that we may be able to support this State Board in health matters. It is necessary that we shall have such confidence in some State Board, and they such respect for us, that we may be able to obtain appropriate legislation. We should instruct the Welfare Committee to try to develop such a relationship.

Another point is that the State Society should try to do as was done in Essex County, form an alliance with the pharmacists, dentists and one or two other professions, in regard to the matter of a bill that will bring into association many of the men who are not members of our Society. Such an alliance has been successful in New York, particularly in Kings County. By this means, we can get more publicity and acquaint a larger constituency with the merits or demerits of bills before the Legislature. Therefore, the second item is a motion that the Welfare Committee be requested to consider an alliance that will bring us in touch with a larger constituency for State legislation.

The motion was seconded and carried.

Dr. English: We have not yet fixed the annual dues for the coming year. It is necessary that we decide whether the dues shall be two dollars or three dollars.

Dr. Chandler: We have drawn considerably on the treasury this year. I move that the dues be three dollars, instead of two. That will increase our income by two thousand dollars, which, I think, will be sufficient for our needs.

The motion was seconded and carried.

Dr. Halsey: It has been reported to the medical men of South Jersey that during this last session of the Legislature Dr. Harry A. Stout of my county, appointed to fill the unexpired term of Dr. Emery Marvel on the Board of Medical Examiners, was dropped. He is a capable man, and one able to fill the position. It is reported that a list of names was submitted to the Governor of the State, in which Dr. Stout's name did not appear. This was probably an oversight, but was unfortunate, as he was certainly entitled to fill the unexpired term of Dr. Marvel. If there is any way that the matter can be adjusted, I should like steps taken by which Dr. Stout may have due recognition as a member of the Board of Medical Examiners of New Jersey.

Dr. Dickinson: I was rung up by someone in Newark, who said that if I would nominate certain men, the Governor desiring it from me, and desiring it immediately, that list would be considered. I had no axe to grind, and let the Newark men present such names as they had, and added that of Dr. MacAlister, because I knew that he desired election. It is the privilege of this Society, through its President, to nominate men for the Board of Examiners and the Board of Health. I am glad that Dr. Halsey has brought this up. It should be a part of the routine business every year to discuss names suitable for these positions. I knew nothing of Dr. Stout being on the Board or that his time was up. If it can be changed in any way, I shall be glad to assist.

Dr. ———— I understood that Dr. Marvel had resigned and that Dr. Stout was appointed in his place. Dr. Stout was appointed, not ad interim, as would have been the case if it were necessary that his appointment should be approved by the Senate at the next meeting. Therefore, he still has a year to serve, I take it. The thing to find out is whether there is a vacancy. If Dr. Stout was appointed for the unexpired term of Dr. Marvel, there is no appointment to be made; because he still fills the office. Would it have value to have the Council look into the matter?

Dr. Dickinson: It would be better to have it referred to the Welfare Committee.

It was moved by the previous speaker that the matter be referred to the Welfare Committee, to see whether a vacancy had occurred and to act in the premises.

The motion was seconded and carried.

The report of the Committee on Hospital Standardization was read by Dr. Costill, in the absence of Dr. McCoy, the Chairman of the Committee.

Report of the Committee on Hospital Standardization.

To the Medical Society of New Jersey:

The Committee on Hospital Standardization held two meetings the early part of the year, at which, plans were formulated for a systematic visitation of the various hospitals of the State.

Before these plans were consummated, the American College of Surgeons requested that we defer making our inspection until the college had gotten out its new forms for the classification of Hospitals, and that the Hospital Standardization Committee of the New Jersey State Medical Society represent the College of Surgeons in the inspection of the hospitals of the State. About this time a fund was placed at the disposal of the College of Surgeons by the Carnegie Corporation, which was to be used in defraying the expenses incident to the inspection of the hospitals throughout the country.

After a conference with the representatives of the college, it was deemed wise to employ a competent hospital man to visit the hospitals of our State this year. The report of his inspection to be filed with the College of Surgeons for their use in classifying the hospitals, and a duplicate of this report to be placed with the Hospital Standardization Committee of this Society. This was agreed to by your committee, inasmuch, as the time was limited, and it appeared superfluous to have inspections made by two bodies, since the objective in each instance was the same.

The college employed Mr. Thomas R. Zulich, superintendent of the Paterson General Hospital. The inspector was first summoned to the college headquarters in Chicago, where he was made familiar with the methods the college wished pursued in the inspection of the hospitals, and the points to be covered in his reports.

The inspector visited all of the hospitals of fifty beds and over in the State, excepting those in Paterson. It was deemed wise to have an outsider inspect the hospital in that city. Dr. Slobe of Chicago was therefore assigned.

The inspection has been most thorough, not only has the inspector visited the hospitals for the purpose of obtaining data for the College of Surgeons and the committee, but the visits have been both educational and constructive. In many instances the inspector not only going carefully over the institution, but at the request of the management or staff, has at a subsequent visit, met with the medical and lay boards for a conference as to the best methods to be pursued to meet the minimum requirements of the college, it is at once apparent, that the three salient points upon which so much stress is laid: 1, case records; 2, monthly staff meetings, to consider the character of work, relative to the right care of patients, and 3, properly equipped clinical laboratories, make up the sum total of hospital efficiency. If these three subjects receive due attention by medical staffs and boards of managers, all, and more of the details in other re-

quirements for standardization, will automatically take care of themselves.

When one recalls the condition of our hospitals five years ago, the chaotic state of historical data, and the little interest manifested in the majority of our institutions in reference to this most important part of hospital work, and compares the condition with those existing today we are impressed with the improvement made in many of our hospitals.

The results of the inspection for this year has been most gratifying. There has been evident in the majority of our hospitals a hearty co-operation, and in most instances a keen enthusiasm on the part of both the lay board and the medical board to meet all suggestions made by the college or committee, which were calculated to bring the hospital up to 100 per cent. in the care of the sick.

In a few instances, I am sorry to say, there still exists an attitude of aloofness on the part of the hospital officials, and there is a decided lack of interest so far as bettering conditions is concerned. Usually this is due to ignorance on the part of those directing the institutions, and I am satisfied that as they see the advantages accruing from an endeavor to meet the minimum standardization, and the example of those hospitals which are operating under the new regime, they will enthusiastically join the ranks for better and more efficient hospital service.

The meeting of these requirements depends largely, if not entirely, upon the doctors, your committee would, therefore, urge that each medical man, who may be honored by a hospital appointment co-operate with the management in an endeavor to bring the records of his individual department up to the standard. Without such completed records, our monthly staff conferences will be of little real value, and unless the staff at such conferences has the data from each department it is impossible to gauge the departmental efficiency.

The plan this year was to inspect only the hospitals from 50 beds up. One hospital of 45 beds is included. The total bed capacity of these hospitals, including ward and private is 6,678. There are 31 hospitals with a bed capacity of 100 beds and over. 14 hospitals with a bed capacity of 50 to 100. One hospital of 45 beds.

The affiliation of the various hospitals and bed capacity is:

Protestant	32	Bed capacity.... 3,961
Catholic	12	Bed capacity.... 2,530
Jewish	2	Bed capacity.... 187
Total		6,678

Following is an analysis of Important Points in Administration:

1. Does the staff meet at regular monthly intervals to review and analyze the clinical experiences in the various departments.

36 hospitals yes.

10 hospitals no.

2. Is the practice of division of fees permitted:

29 hospitals—No declaration against.

17 hospitals—Rule forbidding same.

3. Are complete case records written for all patients and filed in an accessible manner in the hospital; a complete case record being one, except in one of emergency, which included the Personal History, the Physical Examination with clinical pathological and x-ray findings when indicated, with the Working and Final Diagnosis and treatment medical and surgical. Of the 46 hospitals: 18 hospitals had complete records. 16 hospitals had incomplete records. 13 hospitals had no records.

4. Hospitals equipped with proper clinical and pathological and x-ray departments. 30 had full equipment. 16 were lacking in equipment.

5. Are autopsies routinely done in the hospital. 28 hospitals yes. 18 hospitals no.

It has been our observation that the efficiency of a given institution is dependent to a great extent upon the attitude of its medical department. Those hospitals having a wide-awake, progressive body of medical men come nearest to meeting the standard requirements. It has also been noticed that, the co-operation of the lay board, and the interest the lay element manifests in the hospital is largely commensurate with the activities of the medical department. There is more interest being shown by the public in the care of the sick in our institutions than ever before, and consequently better support of our hospitals. Three of the cities in the State have gone over the top in the collection of a half million dollars for each of the communities for hospital expansion, and many of the hospitals in the State have under consideration plans for the improvement of their plants.

John C. McCoy, Chairman.
Wells P. Eagleton.
Wm. E. Darnall.
Howard S. Forman.
Henry B. Costill.
Edgar B. Grier.

Dr. Costill: Since this report was written, all the Roman Catholic hospitals have agreed to come up to the standard of minimum requirements by July 1st. This is very encouraging.

Dr. Dickinson: This interesting report will be filed and published.

Dr. Luther M. Halsey, Chairman of the Committee Appointed to Co-operate with Psychiatric Clinics and Children's Courts, reported as follows:

Dr. Halsey: At the present time, according to the statistics, we have in the State of New Jersey ten thousand mental defectives and six thousand epileptics. The time is opportune for taking steps looking to the amelioration of this condition. We have a proposition to submit. We have taken no definite stand regarding the psychopathic resolution, which was introduced here, in view of the fact that the State purposed to make a survey of these conditions between now and the fall, but we should just like to bring this matter before you. These people ought to be looked after in some manner. We have various buildings throughout the State which have been used by the United

States Government, and which are practically abandoned at present. Many of these would be useful and, in all probability, could be purchased for a small amount. Dr. Nevin informs me that a careful inspection of these conditions in regard to the Reformatory show that they have been utilized to put this institution on a paying basis. They were able to purchase a sufficient amount of ground and some buildings for a very small price.

What I should like to ask is this: That this committee investigate this matter and report to the House of Delegates at a future meeting of the State Society.

The motion was seconded and carried.

Business Session adjourned at 4.35 P. M

Wednesday Afternoon, June 16th.

ORATION IN SURGERY.

William L. Estes, M. D.,
South Bethlehem, Pa.

No discussion.

BANQUET.

Wednesday Evening, June 16th.

After the banquet, speeches were made by Drs. Dickinson, Harris and O'Reilley, also by Rev. Dr. Everett and Judge Carey.

Thursday Morning, June 17th.
9 A. M.

ORATION IN MEDICINE.

W. Blair Stewart, M. D.,
Atlantic City.

ADDRESS OF THIRD VICE-PRESIDENT.

James Hunter Jr., M. D., Westville.

THE CAUSE OF THE CONTINUED HIGH MORTALITY IN INTESTINAL OBSTRUCTION.

Damon B. Pfeiffer, M. D.,
Philadelphia, Pa.

Discussion opened by Dr. H. B. Costill, Trenton; followed by Drs. Harris, Chandler and Dickinson.

Symposium on Focal Infections.

THE HOSPITAL, THE DOCTOR AND THE DENTIST

Fletcher F. Carman, M. D.,
Montclair.

ETIOLOGY AND TREATMENT OF MENTAL DISEASES WITH SPECIAL REFERENCES TO THE GENERAL PRACTITIONER'S DUTY IN PROPHYLACTIC WORK.

Henry A. Cotton, M. D., Trenton.

These two papers were discussed by Drs. Rosewater, Goldstein and the authors of the papers.

FOCAL INFECTIONS IN RELATION TO EYE DISEASES.

W. D. Olmstead, M. D., Trenton.

No discussion.

On motion the general session adjourned.

Thursday Morning, June 17th.
11.30 A. M.

MEETING OF THE HOUSE OF DELEGATES.

Dr. English: I have a report to present from the Board of Trustees that at their meeting this morning they unanimously voted to grant to the Committee on Welfare five hundred dollars in advance—further sums to be authorized later.

I also want to move a vote of thanks be given to our retiring President, who has served us faithfully, devoting a large part of his time to the Society during the past year.

The motion was seconded by Dr. Chandler and carried.

There being no more Unfinished Business nor Miscellaneous Business, the Society adjourned at noon, to meet at the call of the President.

Wm. J. Chandler, Secretary.

Attendance at the Annual Meeting.

Fellows.

David C. English, C. R. P. Fisher, Luther M. Halsey, Alex. Marcy Jr., Edward J. Ill, Thomas H. Mackenzie, Daniel Strock, Norton L. Wilson, Enoch Hollingshead, William J. Chandler, Philip Marvel, William G. Schauffler, Thomas W. Harvey.

Officers.

Gordon K. Dickinson, Philander A. Harris, Henry B. Costill, James Hunter Jr., Harry A. Stout, Wm. J. Chandler, Alexander Mercer.

Permanent Delegates.

W. Blair Stewart, W. Edgar Darnell, J. Addison Joy. Elisha C. Chew, Edward Guion, Walt P. Conaway, Edwin H. Harvey, George H. McFadden, Frederick S. Hallett, Alva A. Swayze, Joseph Payne, J. Boone Wintersteen, Marcus W. Necomb, Ephraim R. Mulford, William H. Iszard, Alexander McAlister, John F. Leavitt, Henry H. Davis, Howard F. Palm, William A. Westcott, A. Haines Lippincott, H. Garrett Miller, William J. Chandler, George R. Kent, George A. Van Wagenen, James T. Wrightson, Theron Y. Sutphen, Charles F. Underwood, Charles D. Bennett, William B. Graves, David E. English, George B. Philhower, Theodore W. Corwin, Edward Staehlin, William S. Disbrow, Wells P. Eagleton, William Buerman, Jesse D. Lippincott, Linn Emerson, Henry J. F. Wallhauser, John F. Hagerty, Carl E. Sutphen, E.

Zeh Hawkes, John B. Morrison, Christopher C. Beling, Jas. Minor Maghee, John F. Condon, Emanuel D. Newman, Theodore Teimer, Frank W. Pinneo, Samuel E. Robertson, Francis H. Haussling, George E. Reading, Joseph M. Rector, George E. McLaughlin, Mortimer Lampson, Talbot R. Chambers, John J. Broderick, Henry H. Brinkerhoff, Arthur P. Hasking, Immanuel Pyle, Charles H. Purdy, George M. Culver, Chas. H. Finke, Henry J. Bogardus, William L. Pyle, J. Morgan Jones, John Nevin, Stanley R. Woodruff, George L. Romine, Charles F. Adams, Nelson B. Oliphant, Henry A. Cotton, A. Clark Hunt, Edgar Carroll, Edwin Field, Harry E. Shaw, Cuthbert Wigg, James Douglass Alfred A. Lewis, Henry W. Kice, Ralph R. Jones, Charles H. Scribner, John T. Gillson, Andrew F. McBride, Frederick F. C. Demarest, Francis H. Todd, John V. Bergin, John S. Yates, Aaron L. Stillwell, James S. Green, Edgar B. Grier, Ellis W. Hedges, Stephen T. Quinn, John P. Reilly, Joseph B. Harrison, Walter E. Cladek, G. Wyckoff Cummins, James M. Reese, Louis C. Osmun.

Annual Delegates.

A. B. Spiegelglass, R. Gilady, J. Bennett Edwards, H. F. Bushey, Thomas B. Lee, E. G. Hummel, J. W. Bissett, Frank Devlin, Wm. A. Tansey, Richard J. Brown, M. R. Whitenack, Alfred Stahl, David A. Kraker, Harry P. Perlberg, F. F. Bowyer, John Hemsath, E. E. Downs, Frederick C. Horsford, A. E. Jaffin, S. A. Cosgrove, John M. Cassidy, Joseph Koppel, Seth B. Sprague, B. S. Pollak, Donald Miner, E. K. Fee, Edgar L. West, A. B. Coultas, Geo. H. Lathrope, C. E. Saulsberry, Anthony Gruessner, Wm. H. McCormick, C. J. Larkey, Harry B. Slocum, V. M. Disbrow, Wm. A. Dwyer, T. A. Clay, Wm. W. MacAlister, James P. Morrill, Thos. A. Dingman, Richard M. A. Davis, M. A. Shangle, F. J. Quigley, Alvin R. Eaton, H. R. Livengood, Jacob Reiner, D. B. Ackley.

The following Permanent Delegates have been absent for two consecutive years without excuse by the councilors: Edward Guion, James W. Proctor, John E. Pratt, Charles Calhoun, J. Morgan Dix, John J. Baumann, Wallace Pyle, Edward L. Bull, Geo. N. Best, John G. Wilson, Daniel E. Roberts, Wm. Flitcroft, Wm. H. James, John F. Smith, Walter E. Cladek.

The total attendance at this, the one hundred and fifty-fourth annual meeting, was as follows. Fellows, 13; Officers, 7; Permanent Delegates, 100; Annual Delegates, 47; Associate Delegates, 120; Corresponding Delegates and Guests, 219. Total, 506.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed	Failed
Alabama, April	2	1	1
Arizona, April	12	8	4
Arkansas, May	18	13	5
Hawaii, May	9	3	6
Idaho, April	13	11	2
Illinois, March	118	102	16
Indiana, Feb.	38	37	0
Kentucky, May	30	30	0
Massachusetts, May	21	6	15
Minnesota, April	62	61	1
Nevada, May	9	6	3
New Mexico, April	5	5	0
New York, Jan.	169	90	79
Oregon, Jan.	39	22	17

Public Health Items.

One man in every three was rejected by draft boards for physical disability. According to the United States Public Health Service, a great many of these defects might have been eliminated and probably will be in the next generation.

Germ diseases kill off more people than the deadliest wars, says the United States Public Health Service. In 1917 pneumonia and tuberculosis killed 223,000 Americans, more than seven times the number killed in action in France.

Heart diseases caused more deaths in 1917 than any other ailment (115,337), says the United States Public Health Service. Right living would materially reduce this. Don't wait for the disease to develop before you see your physician.

Newark Health Report.

The review of the first six months of the year 1920 shows there were 3,292 deaths recorded, making an annual death rate of 15.9 per 1,000 population. The following table gives a comparison of the first six months of 1919 with the same period of 1920:

	1919	1920
Death rate	14.8	15.9
Birth rate	25.4	28.9
Death causes less in 1920:		
Typhoid fever	3	2
Scarlet fever	10	5
Influenza	265	221
Tuberculosis of lungs	341	258
Apoplexy	169	157
Diarrheal disease under 5 years	85	68
Accidents	166	149
Homicides and suicides	47	22
Death rate increase in 1920:		
Mealses	1	43
Whooping cough	1	29
Diphtheria	34	36
Meningitis	13	22
Lobar-pneumonia	342	354
Broncho-pneumonia	157	240
Bright's diseases	272	276
Organic heart disease	279	298
Congenital debility and malform.	176	217
Diseases reported:		
Influenza	4,048	9,270
Diphtheria	917	517
Lobar-pneumonia	1,205	1,697
Broncho-pneumonia	924	1,404

Progress in Health Work.—Towns, cities and states are beginning to realize that the cheapest form of health insurance may be obtained from well organized and efficiently operated health departments. The demand for trained public health workers has grown so rapidly that it now greatly exceeds the supply. The call for public health nurses alone is so great that several years must elapse before enough women can be trained in the work to supply the communities now calling for the essential service which only a public health nurse can furnish.—Connecticut Health Bull.

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ARTHROPLASTY — A SAFE, SANE AND PRACTICAL SURGICAL PROCEDURE.*

By George H. Sexsmith, M.D., F.A.C.S.,
Bayonne, N. J.

The arthroplastic operation, especially as applied to the large and weight-bearing joints, such as the knee and hip, is at the present time in bad repute, and that such joints can be successfully reproduced giving permanent, durable, painless, properly functionating joints, and in the knee, that will stand the test of the plumb line, is hardly credited. The bad repute of this particular operation as above referred to is due in a large degree to the improper choice and preparation of an interposing substance between the bone ends entering into the formation of the reproduced joints.

The arthroplastic operation in the reproduction of the large as well as small joints is as safe, sane and practical an operation as is the one performed for ununited fractures, which is so universally and successfully done at the present time. The particular differences in the two operations as applied to the large bones and joints are that in arthroplasty there is likely to be a more decided shock to the patient, greater length of time required for operation and a higher degree of mechanical skill exercised by the operator. The relief from disability is as great, yes, greater in the restoring of proper functionating joints from those ankylosed than in the reproducing of weight-bearing, normal length bone shafts from ununited fractures.

There are no greater disabilities caused by defects in the anatomical structures than some of those due to ankylosis of the joints, as for instance: ankylosis of the radio-ulnar articulation causing a loss of supination and pronation of the forearm; or of the hip joint, which makes taking anywhere near the normal sitting position an impossibility, and if both of these joints be ankylosed, a disability of such a degree as to prevent the taking of the sitting position at all, with locomotion being practically out of the question. Again, take the double ankylosed knee or elbow joints. What more disabling condition could exist? Of the two forms of ankylosed joints, complete or partial, the former causes the least disability, the latter being accompanied not only by an inability to use the joint to any great extent, but with excruciating pain on account of the breaking from time to time the partial bony union as well as the grating of denuded surfaces upon each other. These patients are practically at all times bedridden, as are the ones with double ankylosed knees or hips.

The experience of the last eight years has proven to us that the dangers and difficulties connected with the arthroplastic operation in all classes of joints have been much exaggerated. The principle dangers, especially as applied to the knee, are two. First, where ankylosis exists with the knee more or less completely flexed on the thigh, the distal portions of the limb, both as to circulation and nerve supply, must necessarily be jeopardized if the amount of bone removed from the head of the tibia is not sufficient to admit of a complete extension of the lower leg without undue stretching of the tissues in the popliteal space which have, as a result of the ankylosis in the flexed position, contracted; second, injury to or division of the ex-

*Read at the 154th Annual Meeting of the Medical Society of New Jersey, at Spring Lake, June 15th, 1920.

ternal popliteal nerve during the formation of the external flap, with the disability that necessarily follows paralysis of this nerve.

As to the substance to be interposed between the denuded bone ends of the reformed joints, surgeons are quite agreed that the only choice is the autogenous pedacled flap, experience proving that foreign substances sooner or later are absorbed, with a return to ankylosis.

The essential points in the operation are: first, free incision of the soft tissues over the affected joints, making possible the complete exposure and displacing of the bone ends that need re-forming. The displacement after the freeing of ankylosis should be such as makes chiseling, use of motor burrs, curetting and other changes in surface formation readily possible. Second, sufficient removal of bone end or ends to insure easy interposition of the flap or flaps with space left to prevent pressure necrosis of the interposed tissue. Third, the proper formation of pedacled flaps not too meagre in thickness or size, securely anchored when in place with twenty-day Chrome catgut sutures and completely covering all denuded bone surfaces. The free removal of bone referred to will cause a very loose, unstable appearance of the reformed joint, but the contraction of the soft parts, muscles, tendons, remaining ligaments, etc., will, as in a fracture with overlapping fragments where muscular pull causes a shortening, in the same way take up the slack, bringing the bone ends entering into the formation of the joint in close contact with the interposed tissue. This tendency of soft parts to contract must be overcome or controlled by a proper extension apparatus, especially in the large joints, or the result will be early and permanent destruction of the flaps from pressure necrosis and necessarily failure to attain good results.

The late Dr. John B. Murphy of Chicago did more than any other surgeon in the world toward perfecting the arthroplastic operation, and while often criticized, no doubt had a good degree of success in this line of work. We never had the good fortune to see Dr. Murphy operate, but like all surgeons who had an opportunity to see him work or have read his cliniics, believe in his originality and skill. Most men are able to copy, but few have the gift of originality to the degree that Dr. Murphy had. We have read the descriptions of the arthroplastic operation as performed by him, and have no desire to criticize his plan of operating; still, there are certain procedures that we have adopted in our arthroplastic operations differing from those of Dr. Murphy, especially as applied to the knee joint (which you will remember Dr. Murphy claimed was the most difficult joint of the body to reproduce). Dr. Murphy emphasized the importance of having sufficient thickness of interposing pedacled flap to insure permanent and complete separation of the bone ends and in his writings referred to the use of, especially in the knee, the capsule, the forward portion of the lateral ligaments and a goodly amount of adipose tissue. In our operations, we have used the same tissues, but have always included the entire lateral ligaments, using two flaps, each being at least three inches long, or of sufficient length to reach the opposite border of the head of the tibia, the tip of the first flap introduced being attached to the base of the inner side of the opposite one, the second flap being placed immediately over the first and extending through to its base on the opposite side where it is sutured, using Chrome gut to fasten the two flaps to each other, the posterior ligament of the joint and to the periosteum of the tibia in front. An objection has been made to the removal of the whole of the lateral ligament on account of the liability to lateral dislocation. This was possibly the reason why Dr. Murphy left a part of the lateral ligament intact. At this particular point, we have a step in the performance of this operation, as applied to the knee, which is most essential. We have reference to the proper preparation of the ends of the bones, having in mind the prevention of lateral displacement. The semilunar cartilages and crucial ligaments, the functions of which in the normal joint are in part or whole prevention of lateral displacement are in all cases destroyed or removed. As a substitute for these lost parts, we believe it necessary in re-forming the condyles of the femur to make their convexity more prominent and the depressions or concavities on the upper end of the tibia much deeper than in the natural joint. This precaution, together with the much more important one of the formation of an unsually deep intercondyloid notch of the femur and a correspondingly more prominent intercon-

lyloid ridge on the tibia, will act to prevent all possibility of lateral dislocation. These particular precautions we have used in all our knee joint arthroplastic operations, and in no case have had a dislocation or any evidence of luxation. While Dr. Murphy may have made use of these same precautions, we cannot recall that he made mention of them.

As applied to the hip, the amount of space left between the bone ends entering into the re-formed joint should be from one-half to three-fourths of an inch in width, a portion of which is produced by reaming out the acetabulum, and the remainder from re-forming or lessening the size of the head of the femur; in the knee joint, the space should be from three-fourths to one inch, all of the bone to be removed from the head of the tibia, the space varying according to the thickness of the flaps made possible or necessary, as for instance, in heavyweights a considerable amount of adipose tissue is included in the formation of the flap and is most essential inasmuch as the increased weight of the patient makes necessary the thicker interposed tissue.

The success in the permanency of the results attained in these operations is dependent largely upon the character and thickness of the flaps used. In the thin person, it is not always possible, nor is it so necessary, to have the adipose tissue. In such subjects three-fourths of an inch of space between the opposing articular bone surfaces is sufficient. Of this space, a large part will be taken up by the interposing flaps, the remaining portion being necessary to prevent pressure necrosis of these tissues, especially as their circulation is at low ebb.

We have never had the opportunity to post mortem a knee joint following an arthroplastic operation, but believe it altogether probable that a fibrous tissue is formed, which to an extent takes the place of the lateral ligaments which at the completion of the operation are entirely lacking.

In practically all cases of ankylosis of the knee joint it is found that there is union between the patella and the head of the tibia or condyles of the femur, making necessary the turning of the patella upside down, bringing the anterior and covered surface in contact with the denuded surface of the femur and tibia, otherwise, there would be reunion, with returning ankylosis.

We have used the lateral incision in the knee operation in all cases except one, where the U-shaped flap was used with the usual resulting slough. The lateral incisions with the displacement of the skin and such portion of fatty tissue as may not be required in the formation of the interposing tissue, make possible the formation of the flaps which are immediately completed, their bases being situated on the head of the tibia on a line slightly below where the resection of bone is to be made. Their displacement downward exposes the lateral aspects of the joints as it does also of the relation of the patella to the condyles and head of tibia. The intervening skin between the lateral incision with the tissues immediately beneath, including the patella, the latter having been detached, if ankylosed, are displaced outward, which, if found at all difficult, is made easy by separating the vastus externus and internus muscular attachments from the rectus femurus tendon upward and slightly inward for a distance of from two to three inches. After the displacement or dislocation of the patella with its attached tissues, the joint can be freed of ankylosis, flexed acutely, making possible the remodeling. especially the removal of the necessary portion of upper end of tibia, which can be quickly done with the ordinary three-fourths or one or one and one-fourth inch, curved, carpenter's chisel, forming practically the required concave surface on each side, leaving a decidedly prominent intercondyloid ridge which can be trimmed to its required heighth. The condyles in a large proportion of the cases need but little re-forming. The deepening and widening of the intercondyloid notch made necessary for the reception of the unusually prominent intercondyloid ridge on the head of the tibia lessens the width of the condyles to a moderate degree to correspond to the deeper and slightly narrower depressions on the head of the tibia. At this particular juncture, with the patella displaced outward with its attached ligaments, the only tissue that appears to be holding the tibia to the femur is the posterior ligament and popliteal tissues, and even after the interposition of the flaps and replacement of patella with a suturing of the vastus externus and internus to the adjoining rectus femurus from which they were separated and in the case, as Dr. Murphy expressed it, "turning turtle" of

the patella, are attached to the opposite edge of the rectus femurus which has been given a half turn, the whole appearance of the joint is one of instability, which in our early operations was rather appalling, but we have learned from experience, will give a good, firm, weight-bearing joint within three to six months.

While this whole procedure as applied to the knee joint has been criticized because of the undue exposure and displacement of tissues, as jeopardizing the welfare of the patient, there is no greater exposure than in the operation often performed for ununited fractures of the femur where the average surgeon does not hesitate to cut down exposing the femur for a considerable distance, dislocating or bringing the ends of the fragments up to the position where they can be prepared for the transplant or intermedullary plug.

It is possible and advisable to manipulate these joints to a very moderate degree at not a later period than two weeks from time of operation, allowing the patient to leave the bed at the end of from four to six weeks, and with assistance or use of crutches, bear some weight on the limb at the end of two months. There is a gradual and continuous improvement in the freedom of action in these joints for a year, most of the patients being able to walk about with the aid of a cane at the end of four to six months. The length of time required for the return of the functions of these joints can be shortened very much by manipulation and massage. In none of the cases that we will demonstrate here today has massage or any particular system of manipulation been practiced, their circumstances not admitting of the expenditure of money required for such treatment.

As to the length of time to elapse from termination of active symptoms of the ordinary infective types of arthritis as the cause of ankylosis before operative procedures are safe, we believe six months is the limit, and where the infection has been tubercular, one year should be allowed before operative procedures are undertaken.

The only type of ankylosed knee joint that we are justified in allowing to exist permanently is where there is a shortening of at least one or more inches. Our reasons for making this statement are two. First, that in the ankylosed joint, and this we would make applicable only to the knee, the one-inch shortening makes possible comfortable locomotion because of the ability to walk about without stubbing the toe or striking the foot against obstructions to a very much greater degree than in the case where the leg is of the same length as the sound one; second, in the leg that is already one inch short, the arthroplastic operation would produce a limb from one and three-fourths to two inches short. This operation, it must be remembered in all cases of the hip or knee, produces from three-fourths to one inch shortening.

Considering the reasons for failure in the arthroplastic operation, we would state that there are three. First, infection; second, improper formation or application of interposing tissues, leaving possibly some denuded bone surfaces, which if of very great extent would cause returning ankylosis, or if of very small area would at least cause a very painful joint, and third, the failure to remove a sufficient portion of bone, and as applied to the knee, an equal amount from each side of the upper surface of the tibia to give a limb that would stand the test of the plumb line, a slight variation making either an inward of outward bowing with an unsightly deformity.

One of the most troublesome conditions met with immediately following the arthroplastic operation, especially of the knee, is the accumulation in most cases of a large amount of fluid, a portion of which is blood as a result of an oozing from the denuded bone ends, as well as as quantity of synovial fluid which is produced by any remaining portions of the synovial membrane that may be left intact in or about the joint. One is tempted after performing some of these operations upon the knee to insert a small gauze drain on each side at the most dependent points of the operative field. This procedure we have never adopted, but have found it necessary after ten days to two weeks to aspirate the accumulated fluid which causes considerable bulging on one or both sides of the joint, repeating this aspiration every three or four days until the accumulation has ceased. Or, as in our later operations, make an incision after five or six days on both sides, allowing the fluid to escape. The latter, we believe, gives better and quicker results.

In the knee operations, we place the limb in a molded posterior plaster cast or

trough in a slightly flexed position, which, with a Buck's extension apparatus with from fourteen to twenty pounds pull, the amount varying according to the size of limb, is less likely to cause undue pressure on the interposed flaps, than would either the completely extended or acutely flexed position. The traction is lessened by two pounds every third day, beginning with the fifth day following operation. The limb is retained in the plaster form for at least four weeks to prevent undue action of the joint in any direction. After this time the patient is comfortable without support, and passive motion is kept up as already adopted from the fifteenth day after operation.

The most grateful patients I have ever had have been those relieved from ankylosis.

We would summarize as follows:

1. That the arthroplastic operation on either the large or small joints is practical and safe.

2. That it gives as great relief from disability, if not greater than does the restoring of bone shafts in ununited fractures, and requires practically no greater skill.

3. The pedacled autogenous flap for interposition between bone ends in reproduced joints is superior to all other substances.

4. In the knee, special attention to reforming of bone ends, having in mind the possible tendency to lateral displacement.

5. The essential points in the successful arthroplastic operation are: First, free incision of soft parts with complete displacement of bone ends, making possible and easy re-forming steps in the reproduction of articulating surfaces; second, leaving ample space between reformed bone ends which is most essential; third, sufficiently large and thick pedacled flaps to insure complete covering of all denuded bone surfaces, with, in the large joint, some form of traction to control contraction of muscles, etc., about the joint.

Case 1. Figures 1, 2, 3 and 4.—Patient weighing 250 pounds with ankylosis of both knee joints; bed ridden for a period of three years. Arthroplastic operation on left knee March, 1913; right, September, 1913. The U-shaped skin flap used in first operation with the usual sloughing of tip. Second operation, lateral curved skin incisions. Patient has from May, 1914, been able to do the complete housework for a family of six, going up and down stairs, getting in and out of automobiles, trains, etc., with but little trouble and no pain.

Figure 1.—Showing alignment after operation.

Figure 2.—Lateral view showing alignment.

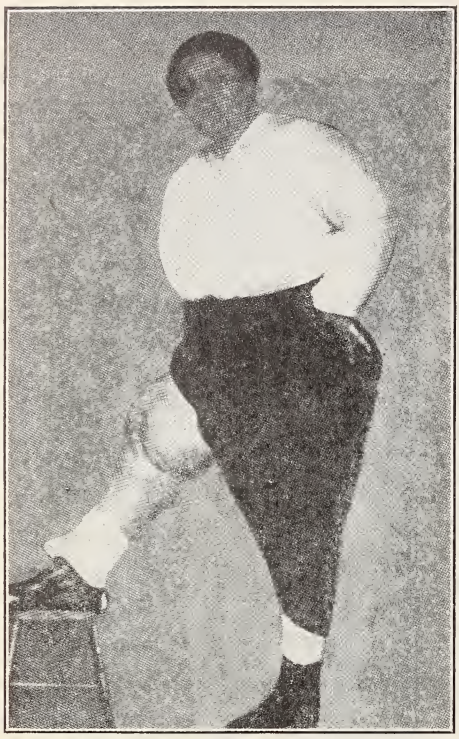

Figure 3.—Present possible flexion of left knee.

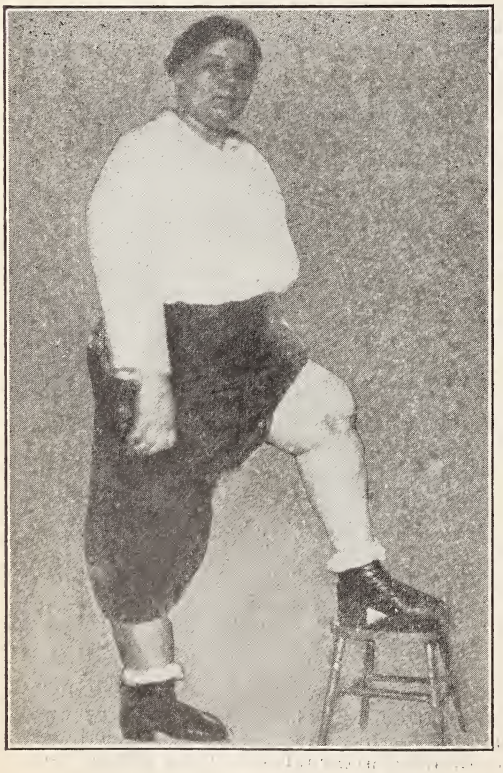

Figure 4.—Present possible flexion of right knee.

Case 2. Figures 1 and 2.—Patient weighing 190 pounds with ankylosed of left knee, with complete disability on account of excruciating pain on every effort to use affected joint. Arthroplastic operation performed November, 1915, with resulting painless, useful joint.

Figure 1.—Showing alignment attained.

Figure 2.—Flexion of joint made possible.

Case 3. Figures 1 and 2.—Ankylosed left knee (as result of infection following severe injury) existing over a period of two years, patient only being able to walk about with crutches. Operation during 1916. Skilled laborer, resumed his usual occupation five months after operation and continues to fill his position up to the present time when he is earning $6 a day.

Figure 1.—Alignment attained.

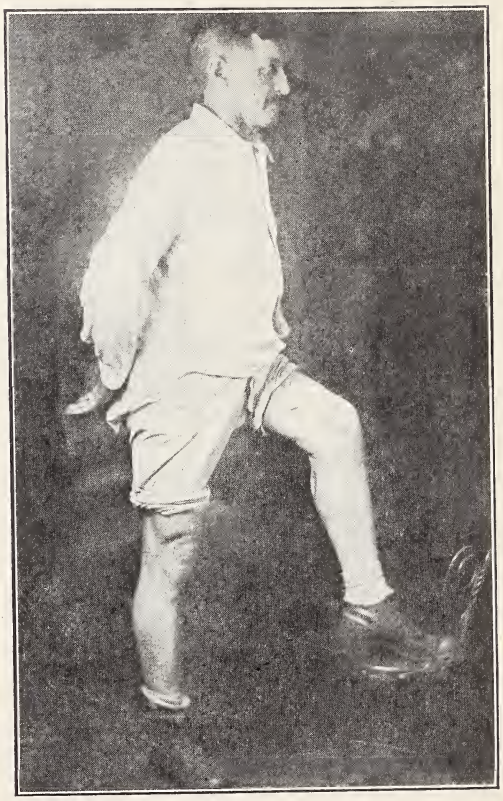

Figure 2.—Flexion possible.

DISCUSSION.

Dr. Sidney A. Twinch, Newark: I think Dr. Sexsmith is quite right in refusing to put any foreign substance into the joints, what we need is autoginous substance only. When we put extention on the joints, of the knee or the hip, it is very important to use sufficient weight, for instance five pounds on the knee joint is usually insufficient, speaking generally, most adult knees require ten to fifteen pounds and adult hips 18 pounds to 28 to 30 pounds. I have not had any practical experience with this particular operation because after doing it six times on the cadava I decided that there was not sufficient tissue left to maintain the stability of the joints, and therefore decided to leave stiff knee joints alone. Dr. Sexsmith had more courage and as he says, he to also feared the operations that the joints would lack stability but that after a period of four months the joints seemed to tighten up and the beautiful results obtained we are seeing today.

An excellent feature of Dr. Sexsmith's paper is that he gives such clear details of the operation. Sometimes we listen to papers in which the important details are left out. That was not so in his paper, and I wish to thank him for giving the essential details, such as the extension on the joints afterwards and the deepening of the condyles. The latter I had never thought of. Murphy does not mention it, and as Dr. Sexsmith says, it helps to hold the joint in place. The union of the patella is one of the old bug-bears. Unless you turn the patella inside out, you will have union again. That was Dr. Murphy's idea, I believe.

Dr. John N. Bassin, Chief Surgeon, N. J. Rehabilitation Commission, Newark: Dr. Sexsmith's paper is especially commendable because it is so opportune at this time. Perhaps the minute details of interposing flat joint surgery of the Murphy type vary with those applied in the doctor's knee joint cases. To my knowledge, there are but two men in this State who have practiced deepening of the condyles. Dr. Sexsmith is to be congratulated upon the excellent results obtained. I would like to draw attention, digressing somewhat from the knee and hip joints to the radio-ulnar articulation, and especially the elbow joint. The doctor mentioned that he immobilized his joints for some length of time. I am especially convinced from the observation of forty or fifty such cases in which poor functional results followed an arthroplasty of the elbow because of prolonged immobilization, that in order to obtain satisfactory functional results, one must begin passive motion within ten or twelve hours immediately succeeding the operation. I have operated on several such cases within the

last six or seven months and the results have been gratifying. In none of my cases did I use the interposing flap as Dr. Sexsmith has applied in his lesions of the knee joint. Dr. Moorehead gives a substantial reason for starting physio therapy early following arthroplasty of the elbow joint. He claims that it is because of the persistance of embryonal osseous tissue cells in the capsule of this joint, unlike that of any other joint in the human body, that the tendency to ankylosis is so prevalent if active and passive motion does not soon follow operative procedure. Past experience has proven that on about the ninth or tenth day of immobolization, there is palpable a firm bone-like layer of tissue about the joint which resists passive motion, a matter which is entirely preventable if manipulation is begun as soon as the acute surgical stage has passed—long before all swelling has subsided.

In the industrial surgical cases, out of two or three hundred joint lesions examined last year, evidently treated by the old method of unduly prolonged fixation, there has been practically total joint disability due to ankylosis. In several such cases secondary operations are now indicated. It would be interesting to know what effect it would have upon joints other than those of the knee, either with or without interposing flap. It might be mentioned, incidentally, that out of sixty-three hospitals in the State, only three have any semblance of physio-therapeutic department or apparatus as an adjunct to therapy of initial surgical lesions involving bones and joints. Evidently this is not the fault of the profession, but should be laid at the feet of the board of hospital managers who do not always comply with the requests of the hospital staff. In the majority of traumatic cases, physical deformity and disability is preventable with the aid of such apparatus. Another feature that has not been especially dwelt upon in connection with the paper—that of fractures of ends of long bones, involving joints, followed by ankylosis. The Blake-Balkan Frame treatment of these cases does not give as satisfactory results as when the shaft alone is fractured.

War surgery has apparently not contributed much of value over the old method of treating these cases, so that the death-knell to plaster paris treatment has not yet been dealt. Immobilization of joints referred to in the paper would present a special indication as to the manner and the time of immobilization in accordance with the age of the patient and the surgical anatomy of the particular joint, so that too long or faulty immobilization should not defeat the ultimate purpose of the operation with or without interposing joint flaps. The main object, after all, is complete restoration of function if possible, at least the maximum degree thereof.

Dr. Berth S. Pollak, Secaucus: I should like to ask one or two questions In the case of tuberculous knees of the child, would you expect to find a lesion in the lung? In the adult, where apparently the tuberculous knee would be a secondary lesion, would it act on the orginal lung lesion?

Dr. Sexsmith, closing: In line with Dr. Twinch's statement that the results obtained by him in his arthroplastic procedures on the cadaver had not been satisfactory, I would say that our experience on the cadaver has been the same as the doctor's, and in fact our arthroplastic operations on the knee joint have seemed, at the time of the closing of the wound, quite unsatisfactory, the reproduced joint being in each case so loose and unstaple, one could hardly imagine that good results could be attained. I believe if we had failed, through infection or lack of stability and proper action of the first one or two knee joints that we operated upon, we would never have had the courage to undertake another. This rather appalling and disturbing loose condition, especially of the knee joint, following an arthroplastic operation is very quickly remedied by the muscular contraction which brings the bone ends in close apposition to the interposed tissue, which contraction, if not controlled by extension, would be sufficient to cause necrosis of the flaps.

I take it for granted that Dr. Bassin in his reference to the early mobilization of ankylosed joints following operation without interposition of flaps, referred to joints with restricted action due to changes not in cartilages or the bones, but in ligaments and other soft parts. I quite agree with the doctor that, following operation in this class of cases, early and continuous passive motion should be practiced. With eroded or disintegrated cartilaginous covering of the bone ends entering into the formation of the joint, with or without the actual denuding of the underlying bone, I can hardly believe it possible to have free and painless action of a joint following an operation without the interposition of flaps.

Answering Dr. Pollak's questions, I am not inclined to believe that you will find as a rule a lesion in the lung in cases of children with tubercular joints. As to his second question, which is a most interesting one, I would state that we have operated upon only one case where our attention was called to this particular possibility, and that was about six weeks ago, when we did an arthroplastic operation for an ankylosed knee joint, the trouble with the joint having extended over a period of some six years. The history would indicate that it was of tubercular origin, there having been a quiescent period for the last two years. The patient reacted well, giving a normal temperature and pulse on the fourth day, but on the sixth day and for ten days following, the temperature range was from 101 in the morning to 103 in the evening, then, quickly abated, the patient making an uneventful recovery, being out of bed and walking about with crutches after thirty days. During the time of this run of temperature, I believed that just what the doctor has referred to, the lighting up of an old tubercular lesion in the lung, had taken place, but from her having continued a normal temperature for the last four weeks, the tubercular condition as a cause for the fever evidently did not exist. I have not satisfied myself yet as to the real cause of the ten-day run of temperature in this case. There was no infection of the parts operated upon.

The Editor is obliged to postpone insertion of two papers read at the annual meeting because of the absence on vacations of those taking part in discussions.

ADDRESS OF THE THIRD VICE-PRESIDENT.

Delivered at the 154th Annual Meeting of the Medical Society of New Jersey, at Spring Lake, N. J., June 15, 1920.

THE ECONOMIC ASPECT OF THE MODERN DIAGNOSTIC SURVEY.

By James Hunter, Jr., M. D.,
Westville, N. J.

The trend of medical thought toward more accurate diagnosis, leading as it does to closer co-operation between the attending physician, the laboratory-pathological and x-ray—and the consulting specialists, must sooner or later bring most of us to realize the importance of the economic phase of such studies.

About three years ago Dr. Barker of Baltimore delivered a most illuminating address before the New York Academy of Medicine, upon the theme of "The General Diagnostic Study by the Internist—co-operating with the groups of medical and surgical specialists." This address was published in full in the New York Medical Journal for September 21, 28 and October 5, 1918.

A careful reading of the address leaves one with the impression that Dr. Barker has said all but the last word upon the subject of modern diagnostic methods and procedures. He brings before us in such a virile and masterful way the manifold advantages of such general diagnostic study by the internist, that we cannot help but feel that the methods so outlined should meet with more general application in the daily work of the physician.

One of the chief reasons this has not come about, I believe, is the economic phase of such studies—the cost. Until quite recently the cost of a diagnostic study as outlined by Dr. Barker has been all but prohibitive to the large class of patients, I mean those standing between our well-to-do and charity patients. Patients for whom regular consultations are no hardship, pay the consultant a minimum fee of one hundred dollars for the general supervision of the study, the taking of the history, the making of the physical examination, the ordering of the special tests and the collecting of the reports of these, the analysis of the findings, the making of the diagnosis, the outlining of the therapy and the preparation of the complete report for the family physician. Included in this charge is a routine x-ray examination of the paranasal sinuses, the chest, and abdomen. The patient pays a laboratory fee of twenty to thirty-five dollars, according to the studies made. Additional x-ray examinations may cost anywhere from ten to seventy-five dollars. The consultants by specialists vary from ten to twenty-five dollars, and there may be several of these according to the case. A diagnostic study under such circumstances will average three hundred dollars in cost to the patient.

Such fees are prohibitive to the bulk of general patients, but in the larger clinics there are enough well-to-do patients who pay the regular charges to take care of the overhead and permit of the study of those who really need it, without hardship.

The clinics in extending the survey to the patient of small income, do so by making a blanket fee. The patient is told what the regular charges are for such a study and he is then allowed to pay whatever part of this he can without hardship or inconvenience. In many instances the amount is reduced to fifty, twenty-five or ten dollars or cancelled altogether. Supposing the regular charges were $150 and the patient paid $15, then this $15 is distributed pro rata among those participating in the study, each receiving 10% of his ordinary fee.

The figures of one of the largest clinics for 1919 show that 25% of the work going through the clinic was charity, 30% paid the actual cost of the services rendered them. Many of the patients classed as charity cases have sufficient money to pay for the board and room at the hospitals.

The average cost to the hospitals for these studies will run from thirty dollars upwards. Until a very recent period but two types of patients received the advantages of these complete diagnostic surveys, viz., the well-to-do patient, to whom the fees were no hardship and the charity patients in the wards of the large hospitals connected with a teaching school of medicine and who happened to be selected for the purposes of clinical demonstration. The large group of patients who stand between the groups just mentioned, between the wealthy and the charity patients, the group with limited income, yet with all a high degree of self-respect and who make up the bulk

of the practice of the average physician, were until quite recently unable to avail themselves of the survey, except in a very limited sense, for purely economic reasons.

How then shall the advantages of modern diagnostic methods be extended to this large group of patients without making ward or charity patients of them on the one hand, and on the other, doing no injustice to the skilled specialists and technicians participating in the studies.

I am well aware of the altruism of those interested in this special type of work, as well as of the medical profession in general, ever ready to care for the patient of modest means, also of the help so freely and generously given by the clinics and hospitals of the cities, but there is an ethical side attached to the patient's point of view upon the matter that we would do well to stop and consider.

Patients of the class under considerations have their personal pride upon such matters and give all sorts of excuses in their efforts to escape obligating themselves by accepting such gratuitous service in their hour of need. They would rather pay their way and retain their self respect, but in order to do this the fee must be within their limitations. They resent any charity, under whatever guise it may be proffered, and they appeal to our sympathetic efforts in the strongest way to adjust this matter for them in a way that will not lower their self-respect.

I am not overlooking here that other class who are ever ready to avail themselves of every form of free medical attention, and who do not hesitate to resort to all types of deception to obtain it. This class we can leave to the discretion and efficiency of the social service bureaus now so generally connected with the work of the larger hospitals. Effective legislation looking to the effective control over this part of our charity work is urgently needed, and should receive the attention of our Committee on Legislation. It is the self-respecting patient of limited income that I would see benefit from a diagnostic survey.

The solution of this important economic problem is being slowly worked out, but I believe it lays with the diagnostic groups of specialists and the modern x-ray and pathological laboratory run upon a strictly business basis, where the volume of work assigned by the profession places the cost within the reach of all. These laboratories, now located and doing work in most of our large cities, are able to meet the overhead, pay the salaries necessary to secure competent technicians and diagnosticians. They do the work for the profession upon a strictly confidential basis, for physicians only. No information, opinions or diagnoses are furnished to the patient, but the data, findings and the interpretations thereof forwarded to the physician directly they are completed. The physician can then select the necessary consulting specialists, complete the study and diagnosis and thus care for his difficult or obscure cases without the cost to the patient becoming a burden.

Further, a diagnosis reached by such methods is accurate, clears the way for treatment scientifically directed, thus materially shortening the usual period of illness, ultimately decreasing the overhead to the patient. With the ever-increasing volume of work assigned to the laboratories, we may look for still further reductions in cost.

Another material advance along the same line is the organization now going on of groups of skilled specialists, the fruit of their appreciation of the working benefit experienced in their work in the army and navy during the recent war.

It would seem then that we are about to arrive upon the time when all classes of patients, rich, poor and middle will receive the advantages of the modern diagnostic survey, so essential to their interests and to the advancement of the profession along the line of scientific attainment.

ADDRESS OF THE RETIRING PRESIDENT OF THE MORRIS COUNTY MEDICAL SOCIETY.

Marcus A. Curry, M. D.,
Greystone Park, N. J.

Members and Guests of the
Morris County Medical Society:

In running over the list of formal subjects for a paper fitted to this occasion, I found that most of the suitable topics had already been treated by previous presidents, and with such thoroughness, knowledge and distinction that I could not hope to contribute anything of further value along those particular lines. Accordingly, I decided to place before

you in a simple and informal manner a few remarks regarding matters in which I feel that we as a society should do well to interest ourselves.

Medicine can never remain a thing apart from the general social conditions of the community. The physician's office is a local barometer and his finger is on the neighborhood pulse. There can be no inflammation of the body politic without a reaction upon the medical profession. Since this is true, what is to be the effect, for instance, of the Socialistic and Bolshevistic movements upon us as doctors, and what is our duty in the matter?

There is no question, in my mind, that the Bolshevik influence tends toward a commercialization of the medical profession. As a self-named Socialist said to me recently: "It is the people who produce something who should have the money. You are a doctor; you produce nothing. You are the servant of the people." God knows that medical men and women have always been servants of the people, but it is one thing to offer voluntary service, and another thing to have a bunch of uneducated, unwashed recent immigrants loftily demand attentions, simply as the rightful dues of the real producers. Doctors will be required until the millenium, but if they are forced to the contract level they will respond automatically with contract services,—just as little as they can "get away with." The profession of Galen and Hippocrates will mean nothing more than a method of livelihood—hours scheduled, pay scheduled, patients scheduled, so that the ancient art of healing will become as impersonal as the art of feeding steel pellets into a machine.

But what can we as individuals and as a society do about this? In the first place, through professional contacts and standing in the community, the physician is in a position to exert a considerable degree of influence. As an old-time politician said to me the other day, "If the doctors would work together, I would rather have them on my side than any other body of men in the State." Every ounce of this influence should go into the fight against Bolshevism. The ideals for which this country stands, zeal for its system of government, the spirit of true-blooded Americanism must be fostered and stimulated. The Reds are using every means of propaganda, appealing to every passion, and it is no time for us as loyal citizens to remain silent. We consider ourselves open to serious charges if we do not inoculate our patients to render them immune when a contagious disease is sweeping the country. It is even more vital that they be rendered less susceptible to the consuming fever of Bolshevism.

To come down to the concrete: for evidence of organized action tending toward commercialization of the medical profession, we need only run over some of the bills placed before the legislature of this State in the past year. Compulsory health insurance, for example. If that bill should ever pass it would mean the death-knell of the old family doctor, with his kindly personal interest including three or four generations, and his thorough knowledge of constitutional resistances and defects which makes each patient's diseases an intimate proposition in which he is intensely concerned. The bill would be equally vicious for the young man starting in practice, as its operation would leave no incentive to stimulate ambition. What is the use of working your head off if patients are sent to you because you are in their district, not because you are a good diagnostician, and if your fees are determined by standard rules and not by your personal reputation?

This year that bill did not get out of committee, but it will be heard from again. The fact that we as individuals do not want it passed is not going to be much of an obstacle to legislation unless we do something. People in general, when they have been shown the matter in its true light, do not want compulsory health insurance any more than the doctors do. The right to choose his physician and the best one he can obtain is a privilege which every man, millionaire or millhand, claims for himself and his family. Tell your patients what the passage of this bill will mean to them personally and what they must do to throttle it, and you will find them eager to respond.

But the medical profession must act as a unit and it must have trustworthy information and reliable representation. Why did the chiropractic bill pass? Simply because we were not on the job. Have you read that bill? If God Himself can find any clear meaning in it He is the only one! In fact, as far as I am able to see, the education and qualifications required might fit anything from peeling

potatoes to painting the sky—and yet these men have been admitted by the statutes of New Jersey to practice medicine in this State. And we have only ourselves to blame. If the medical men will not trouble themselves to protect their own interests, they cannot expect anyone to do it for them. We must be informed. We must be ready to meet any move. We must work as a unit, and we must make ourselves heard.

In this connection I might say that the State Society has appointed a Welfare Committee for the purpose of keeping posted on legislative matters, and has asked each of the county societies to name a similar committee, which shall act in conjunction with that of the State Society. Such committees can easily be dead-letters, but if alert, interested, active members are appointed they can serve a valuable purpose in placing data before the Society. It must be realized, though, that no committee, however brilliant and efficient, can relieve us of our individual responsibility and the necessity for personal effort.

Now, to change the subject from preventing legislation to preventive medicine, it seems to me that the growing sentiment for community welfare offers a wide field for physicians in various forms of social service, to use the broad sense of that much abused term. Personally, I have always felt that the Chinese have the right idea when they pay their doctors for keeping them well. There is no doubt that we are merely on the threshold of work in preventive medicine. Most of the social and industrial maladies can be handled efficiently only from this direction. Cutting off a few leaves never does much toward weeding a garden, so long as the roots remain undisturbed.

In the matter of venereal disease, for instance, we have followed too long the policy that to ignore is to cure. As a result, any thorough investigation reveals appalling conditions. We as a profession have known for ages that any untreated venereal infection is a menace to the community, and yet we are just beginning to make it decently easy for those infected to obtain medical attention when they so desire. But the venereal peril will never be stamped out by treating those who come to our offices and clinics. The only sane method of approaching this proposition is by prevention, by instructing the healthy in the dangers and the way to avoid infection.

Many of you are school physicians, and it seems to me that it is through this approach that instruction in matters pertaining to the hygiene of sex can best be given. Boys and girls might be grouped according to age and sex and given simple lectures or talks, perhaps illustrated by slides when convenient, and they should be allowed the opportunity of asking questions in order to correct any misinformation already received. Such instruction when given by a physician carries weight and dignity. It may be natural for us to feel some hesitation about informing young boys and girls in regard to conditions and diseases which have so long been held secret and evil subjects. It is unfortunate they need such knowledge, but probably the majority of those infections which produce locomotor ataxia, general paralysis, and pus tubes are obtained before the age of twenty. It seems to be a choice between knowledge by instruction and knowledge by experience.

There are numerous other lines along which we may wisely employ preventive methods. Mental hygiene offers a big opportunity. We can throw our influence on the side of healthful and sane diversions and amusements. We can oppose those interests which tend to produce unwholesome reactions — crude dancing, inordinate religious zeal, occult seances, excesses of all kinds. To a great extent all these matters are controlled by public sentiment, and for the education of public sentiment in points pertaining to health and disease, the medical profession is responsible.

In this connection, I might mention that in my annual report of the affairs of this institution, I referred to the relationship between psychic phenomena and the state hospital, and what I said has been so variously misquoted in the newspapers that I take this opportunity to repeat the exact statement incorporated in the report:

"A State Hospital must always, to a certain extent, reflect any variation from normal conditions in the surrounding community. Seasons of great financial panic, great religious revivals, war conditions, even the lighter fads and fancies of the people produce a degree of mental stress or conflict, which acts in certain individuals as the culminating factor for

a psychosis. At present a wave of interest in occult and psychic phenomena is sweeping the country, which is calculated to bring an unusual number of patients into the institutions.

"The people who seize upon spiritualism in its varied forms are too often either those who are naturally of a highly strung, neurotic tendency, or who have just passed through some great trouble which has temporarily deprived them of normal resistance. The conditions of mystery and emotional strain which surround the seances are particularly dangerous for people of this type. Their minds are fixed on unhealthful topics; they are induced to make every effort to feel sensations, hear voices, and receive messages from the world of spirits.

"In individuals of neurotic or hysterical makeup, the step is allto short from the seance to actual hallucinations of sight, touch, and hearing, and from the idea of direction by some dead friend through the medium of the ouija board to definite delusions of influence and guidance. In fact, it would be difficult to imagine conditions more favorable to the development of a psychosis than those furnished by repeated visits to mediums and seances with constant morbid dwelling upon supernatural manifestations, and if popular taste does not soon swing to some more wholesome diversion, the State Hospitals are destined to receive a new influx of patients."

To proceed still further along this line of mental hygiene, I wish to say that for some time at this hospital we have been quietly carrying on a certain amount of investigation in regard to dental and surgical treatment in the various psychoses and research studies at the pathological laboratory, including blood chemistry. Owing to serious overcrowding, we have been handicapped by lack of proper facilities, and so as yet have reached no precise conclusions. Now, however, plans are being made for new buildings at this institution,—a neuro-medical and surgical building and a psychopathic building. These are to be fully equipped with operating rooms, x-ray and electrotherapeutic apparatus, and facilities for baths of all kinds. We expect to be in a position where we can give not only most detailed and comprehensive mental examinations, but also thorough physical examinations with extensive laboratory tests, among them detailed work in the chemistry of the blood which seems to offer considerable promise in our search for the ultimate cause of mental diseases; also, wherever indicated, dental and surgical treatment will be provided for the removal of any foci of infection. In fact, all of the most up-to-date methods of examination and treatment will be available, in order to give the patients the full opportunity for any possible benefit.

But, on the other hand, we do not intend to lose sight of the possibilities in the way of prevention,—rather to emphasize this phase of the work. Any neurological or psychopathic cases may be referred to this department for examination and treatment. In this way it should be possible to do much to ward off actual psychoses. Early recognition, readjustment of wrong living or working conditions, and opportunities for special treatment will do wonders in incipient mental cases. We hope that both physicians and laymen will come to look upon the State Hospital, not as the last resort for the hopelessly insane, but as an active agent for community welfare, to be utilized freely, and with no more stigma attached than any other form of hospital or clinic.

In conclusion, I wish to express my deep appreciation of the honor which you have done me in making me your president for this past year. I profoundly regret that circumstances have rendered it impossible for me to devote as much time and effort to the affairs of the Medical Society as the duties of the office really demand. As you all know, the past year has been one which brought many sorrows and problems to those connected with this hospital. This is the first annual meeting for many years at which Dr. Evans has not been present as host. He was always closely in touch with the society and vitally concerned in its welfare. In his death we have lost not only a friend and comrade, but a most valued member whose wide influence and prestige contributed in no small degree to forwarding the interests of the Morris County Medical Society. Much of the spirit of good fellowship and cooperation which now exists between those physicians in independent practice in this community and those in the State service here is due to his personality, and on behalf of the hospital staff and of myself as superintendent, I wish to register the hope that this friendly attitude, fos-

tered by Doctor Evans for twenty-seven years, will still endure, even though he has left us, and that the Morris County Medical Society will continue to feel as loyal an interest in the State Hospital as the hospital physicians feel in the society, and will continue to make this the regular gathering place for the annual meeting.

ADDRESS OF JUDGE ROBERT CAREY.

Jersey City, N. J.

At the Annual Banquet of the Society at Spring Lake, June 17, 1920.

Ladies and Gentlemen: I take, of course, the keenest kind of pleasure in bringing to you doctors tonight, the greetings of the legal profession. We lawyers are certainly some philosophers, and one of the characteristics that we are supposed to develop is the study of human nature. We are supposed to try to get an understanding of the people we come in contact with, so that we may get an appreciation of their minds and the trend of their thoughts. As I look around this room, the thought that comes to me is that old sentence which we sometimes hear from the stage, and sometimes from the pulpit, "On with the dance!" I am going to restrain the legal impulse tonight to show the keen appreciation that the bar has for the school of medicine, and will supply and pronounce the benediction of a most happy evening, and let you, "On with the dance"; for I know the ball-room is waiting.

Yet, perhaps, there are one or two things that I ought to say. I am going to make them brief. You have had an inspiring three days of fine activity, and almost wound up in a riot this afternoon when you began to study the details of the Eighteenth Amendment and Hudson County outvoted the rest of you as usual. It is a fine thing that it has been so. We do not have in our professional lives enough of these jolly times. We do not get together often enough to become accustomed to the whims of each other and know where our thoughts are trending. We lawyers do not get together often enough; nor the clergymen either. You doctors do not get together with the clergymen enough; your office hours on Sunday morning stand in the way, but that was not what I was going to say. This is a fine climax to the convention. I assume that you had your troubles and your pleasures. This fine climax at the banquet enables the ex-presidents to show themselves at the head of the table. These are the distinguished men of the profession. It is fine, too, to get here with the women; and like Dr. O'Reilly, I am going to talk to the women. But not as Dr. O'Reilly did. No man can talk to you as he did. You should dub him the "Evangelist of the medical profession." You see what I mean? You need a few evangelists in the profession.

But you ladies, just a moment. I am inclined to direct these few words to you, because you must get a point of view that will make the remarks of Dr. O'Reilly effective, if you follow the suggestions in his talk to you; for possibly what he told you will be repeated. If I talk to a doctor or a lawyer he will not repeat anything. He does not dare, it's a part of the ethics of his profession to keep the matter secret. Pastor Everett was talking coming down in the train. He wondered whether there would be ladies here. He told me a story about ladies. I do not vouch for the truth of it, but it was told by a minister. He said that when God made the earth, and the sea and all that in them is, He looked around and said, at the end of six long days that He set for the work of building this wonderful earth, "Here is this beautiful Garden of Eden, as well as Jersey City, Shakertown, and places of that kind, and no one in it to enjoy it." Then He made man, and rested. Then He saw how handsome man was, and how useless alone; then God made woman and rested; but neither God nor man has rested since.

Is it not a fine thing that that is so? What a sad world this would be if everything had been peaceful from that time to this! If Adam had left Eve and the apples alone, it would have been very different. Is it not fine that you have made the world restless, and that the world is restless?

A suggestion by Dr. O'Reilly made me think of another illustration. I came down to this neighborhood twenty-four years ago, one nasty, foggy night, riding on a bicycle from Jersey City. I had a companion, now one of the judges of our court. We came down to meet two girls at Asbury Park. The fog was thick, and we made a short cut from Red Bank. We

got on the back roads near Metuchen and had lost our way. We went along for a while, and then my companion said, "We have lost the road." I said, "I think it is wrong, but we are in the right direction." He said, "We ought to get somewhere." We kept on. After awhile, I said, "Have you seen anything on your side of the road?" He said, "No, but we'll stop at the first place where there is a sign of life." I said, "This looks like a gutter; just follow it." He said, "There is a lamp post, but I can't see what the sign says." I said, "Why don't you climb up it." He said, "You'd better do it." So I climbed up and I lit a match, so I could see the sign. I then read the sign, which said these beautiful, strong, impressive words, "Wet paint."

It made me think of that tonight, the only pair of trousers I had to spend Sunday in Asbury Park in were spoiled. Dr. O'Reilly has been painting that sign for you doctors tonight, to picture the things you ought to see, not that you ought to worry about it. I am an optimist. There is nothing of a pessimist about me. Things are not quite as bad as we think they are going to be. I read an editorial coming down. It said, "We sometimes picture the bad conditions in which we are living, and wonder whether things were ever like that before"; but, it said, you could have read that same editorial in any other age. The time you are living in is probably the best in the world. This illustrates the spirit in which we should operate—not a spirit of despair, but a spirit of hope.

Among my duties when I was County Judge in Hudson County was the function of changing people's names. They wanted them changed. A fellow came before me named Isadore Mark. I had known him for years and was surprised. I said, "What do you want your name changed for?" He said, "You know my name?" I said, "Yes, for fifteen years. It is a fine name. Anyhow, names don't mean anything. Don't you know what Shakespeare says, 'A rose by any other name smells as sweet.' Don't you like the name of Isadore?" He said, "Yes; but they don't call me Isadore, they call me Issy." I said, "Calling you by a nickname shows they are fond of you." He said, "Yes, but they call me Easy, Easy Mark. I wouldn't care for that, but I got married and they call my wife Mrs. Easy Mark." "Well, what name do you want?" I asked. He said, "Irving Marshall." I said, "Why Marshall is one of the chief justices of the United States." "That will be an inspiration," he said. "That is what I want, an inspiration for our boy." How old is he," I said. "Well," he answered, "We don't expect him for three weeks." That's the spirit we want, the spirit of confidence. You see what I mean?

I came down here to give you the compliments of the bar. I am a lawyer, yet somehow I feel pretty much at home with you tonight. I think it is rather a good thing that a clergyman and a lawyer should be here with you doctors, for in the words of Bobbie Burns, we can say, "Give me your hands, for we are brothers." We have something in common; we who are following intellectual pursuits have common interests, for which we must strive and for which we must act. In this day, the doctors should associate together to save this Republic of ours, which has been developed at the cost of so much labor and suffering. I am not afraid of you doctors not doing your duty. I never knew a doctor who would not do his duty. The trouble is that you are not on your job. The public has a peculiar conception of the medical fraternity. In the mass, they think the doctors are speculators. They think we lawyers are all burglars. Maybe some of us are; but all the good offices in the land are filled by lawyers. They suspect us en masse. They will not trust us as a class. Individually, they respect us, however; for of the twenty-seven Presidents of the United States, twenty have been lawyers. One doctor tried to get a nomination for President. You see what I mean? Dr. O'Reilly is right. The doctors want to do what the lawyers have been doing, to take their position in the public life of the land. They do not need to be afraid of that life. They have to play their part on the game of life; they cannot do big work in any other way.

We have doctors in our town that are called politicians. They are the best doctors in the town. They get everything they want. They are respected by everyone. Why? Because, like lawyers, they are willing to meddle in other people's business affairs occasionally. Let me try to drive that thought into the heads of these women. I want them to know that there is a place for the doctor in the public life of the land.

Let me tell you something. The Chiropractic Bill would not have passed the Legislature if it were not for you. The three thousand doctors in this State, if they are on the job, can beat any kind of legislation that comes up. You can get whatever you really want, but not by passing resolutions in the Hotel Monmouth in the middle of June, and praying the rest of the year. Praying is all right in its place, and the place is anywhere; but if you wish to beat legislation, it requires more than prayer. Shortly after I began to practice law, I was invited to join a law firm. After I had been in the office a short time, every case that came that there was nothing in was turned over to me as the junior member of the firm. One day a clever Hebrew came to us from New York about a patent case. He had lost the case in the District Court and wanted us to take care of it in the Circuit Court of Appeals. They called me in and turned the case over to me. I said I did not think he had a leg to stand on. He asked, "How can you tell?" I said, "It is plain that you cannot win." He said, "I cannot do more than lose." "Where is it going to be tried?" he inquired. "Before three judges," I answered. "Then there is a chance," he said. We went to Philadelphia, and the judges slept quietly and peacefully while I argued. After that he said, "I am going to Paris and shall be there three months. Cable me the result." "I can tell you now," I said. "No, you can't tell what three fools of judges will do," he replied. After that, I forgot about the case until one day we were advised that we had won. I went to the New York cable office to cable him and started to write the cable. I asked the clerk the price, and he said, "What do you want to say?" I told him and he said, "Just cable him, 'Justice has triumphed.'" They found the code, and I cabled. A few days afterwards I got a return message from him, saying, "Take an appeal at once, no matter what it costs." There is everything in the viewpoint, and you can look at these things as they are and treat them as they are; but do not get worried about them.

I believe that the American people are the kind that will not tolerate long the kind of propaganda that has been sweeping over this land during the last ten years. They are beginning to learn that the thing to admire in life is the exhibition of courageous citizenship. That is why Governor Coolidge was nominated by the Republican Convention—not because he was Governor of Massachusetts. The thing that we need in America today is the courage of Belgium; and we need more that that. We need the pugilistic character of Ireland to boot. What a wonderful combination!

The profession of a practicing doctor is one of the finest occupations in the world. There is only one better. A wonderful opportunity of all sorts opens ahead of you in our land. History has never presented the picture that this land presents to you and me. Even in these days of troubles, when the Supreme Court says that Prohibition means Prohibition, and even though three days ago a convention of distinguished clergymen said, "Now that we have Prohibition, is it not time that we took a vote on smoking?" The proposition was lost, because clergymen do like to smoke.

We are living in a most wonderful age, in a land where education counts, where American citizenship means something, that is always looking up and up. Someone said, "Today is better than yesterday." The man that said that just said words. Yes; but he spoke a wonderful philosophy with tremendous meaning. Why is today better than yesterday? Because men and women have made it better. Because we have men of the type of Harry Everett, preaching the gospel of Jesus Christ. Because we have evangelists of the Dr. O'Reilly type operating on the public, developing the culture of their life. Because of the service of your president, Dr. Dickinson, has given the medical profession of New Jersey in the year that has closed. Because we are waking up to doing things. In Jersey City it is better because Dr. John Nevin has developed there the finest hospital in New Jersey. Today is better than former days because of what man and women have done.

The man who said that did not stop there. He went on to say, "and tomorrow will be better than today." So let us, who have been at this banquet tonight, go away with this benediction: May your souls and hearts ring with power. Let us stop worrying about Chiropractics and things of that character. Let us not go away with that kind of spirit.

On the other side of the sea there are sixty thousand little white crosses that

tell the story of the Great War in a way that every American can understand. They mark the last resting place of our boys who went to give all they had, that this glorious Republic might go on with its career of destiny.

Let us go away from this banquet here, taking the benediction of what that means. Let us go away dedicating our service in a bigger, better way, a big American way, a big Christian way, to the development of the civilization which God has allowed you and me to enjoy.

Clinical Reports.

CHOLECYSTITIS COMPLICATING GASTRIC ULCER.

By Harry G. Macdonald, M. D.,
Hackensack, N. J.

Mr. F., age 38, merchant of Hackensack; negative family and past personal history; called on me on May 1st, complaining of the following symptoms: Pain. Constant gnawing pain in epigastrium, with irregular paroxysms of intense gastralgia, in which attacks pain radiated to back and sides, usually relieved by taking food, but recurred from 1 to 2 hours later; nausea and vomiting, about 1 to 2 hours after meals; no hematemesis or vomiting of bile; no melena present; moderate loss of weight. Physical examination practically negative save for tenderness over epigastrium and left upper abdominal quadrant; no tenderness over Robson's point; no tumor mass palpable, and no jaundice; urine negative; blood showed slight polyleukocytosis and moderate anemia; gastric analysis demonstrated hyperacidity, with excess of free H.Cl and no lactic acid.

Diagnosis of gastric ulcer made and confirmed by x-ray findings, which demonstrated an hour-glass stomach, emptying poorly, and the presence of two small ulcers, one at pylorus and one on anterior wall of stomach about two inches from pyloric ring. Routine x-ray of appendix and gall bladder were reported negative.

Posterior gastro-enterostomy advised and patient was operated at the Paterson General Hospital on May 21st. The upper mid-line abdominal incision which was made was immediately filled by the gall bladder, which was distended to the size of an apple. Palpation showed no adhesions to stomach and no stones. The x-ray gastric findings were confirmed and the ulcers located. It was deemed advisable to relieve the cholecystitis at this time, leaving the gastric condition to a second operation. Hence the gall bladder was opened and found to be the seat of an acute inflammation, filled with tarry bile, with no stones in bladder or duct. Drainage was instituted and continued for two weeks, after which patient returned home. There was some relief of acute pain and vomiting for this period, followed by a recurrence of even greater severity.

On June 21st, patient was again operated, and the classical posterior gastro-enterostomy performed. At this time the gall bladder was found to have returned to nearly normal size, and the drainage wound in same closed. The patient made an uneventful recovery, left the hospital within three weeks, and has had no recurrence of any of his former symptoms since the date of the second operation.

MISCELLANEOUS CLINICAL CASES.

Cyst in the Brain.—Dr. A. V. Neel, in Uges-Krift for Laeger, Copenhagen, reports that an apparently healthy woman of 76 developed severe chorea following a fright. The chorea was ascribed to hysteria, but it persisted with progressive dementia. Necropsy the third year revealed an old subdural cyst behind a depression in the frontal bone from a fall.

Fever with Extremely High Temperature.—Drs. Lesne and Binet, in Presse Medicale, Paris, report the case of a woman of 38, inclined to be ultra-nervous, who in the course of a meningeal reaction during mild pulmonary tuberculosis had the temperature run up to 43.7 C. (110 F.) and again six days later to 44 C. (111.2 F.), measured in the rectum with three thermometers. It kept at 43.2 C. (109.5 F.) for more than twenty-four hours. The nervous system is undoubtedly responsible for this hyperpyrexia, and treatment should aim to reduce the nervous excitability and induce sleep.

Calculi in the Pancreas and Diabetes.—In the case described by Apolloni, in Policlinico, Rome, the young woman had been presenting symptoms of diabetes for a year and the pancreas was found 12 cm. long, with nothing left but a shell crowded with sand and calculi. The extreme hemosiderosis in the liver was a further necropsy surprise. Marchiafava has reported a case in which compression of the bile duct by calculi in the pancreas proved fatal, but there was no glycosuria.

Diabetes from Syphilis of the Pancreas.—Drs. Carnot and Harvier in the Paris Medical, summarize from the literature, four cases in

which diabetes developed in syphilitics, but necropsy showed only ordinary sclerosis of the pancreas. In a case from their own experience, however, a woman of 53 had been presenting symptoms of diabetes and of neurosyphilis for about two years. The pancreas was almost entirely transformed into a sclerogummatous mass. They believe this to be the first case to be recorded of diabetes from unquestionable syphilitic lesions of the pancreas.

Traumatic Aneurysm of Subclavian Artery.—A case of this is cited in the British Jour. of Surgery, which was associated with a concurrent brachial monoplegia; was treated by ligature of the first portion of the subclavian trunk and vertebral artery. Relief from great suffering and pain followed the application of the ligature. The patient's general condition improved rapidly, and active motion in the shoulder became normal.

Reformation of the Elbow Joint.—Dr. W. F. Buckley, in the London Lancet, cites a case in which, after gunshot injury of the left elbow joint with fracture of the humerous and extensive loss of bone, the joint was ultimately re-formed. Over a period of three years, there was a steady growth downward of the lower end of the humerous toward the ulna and an actual re-formation of the joint, with hardening and rounding off of the lower end of the humerus on the inner side to fit into the cavity of the ulna. The downward growth of bone continued for two years, the new joint forming in the third year.

Tuberculosis Hemorrhoids with Ulcer of the Tongue.—Reported by Dr. Frank Smithies, Chicago, in the Quarterly Medical Clinics.

This interesting case had a history of nine months' duration. The first symptoms were a few hemorrhoidal projections. These were followed by bleeding, and the gradual formation of a large peri-anal ulcer. One week before examination by the author, the patient developed a sore on the tongue, of an herpetic character. Examination of the tongue showed a shallow, oral ulcer near the tip, with ragged edges, and covered by a greyish, yellow, easily bleeding membrane. There was a large perianal ulcer, involving two-thirds of the perianal zone, and extending into the right buttock, with areas of necrosis and exuberant granulation tissue. This ulcer was very painful and also bled easily. Sections from the tongue ulcer, showed enormous numbers of tubercle bacilli. The lungs showed evidence of old tuberculosis. Repeated examinations of the perianal ulcer failed to show tubercle bacilli. The Wassermann reaction was negative. However, the peri-anal ulcer was undoubtedly of tuberculous origin. The subsequent history was disappointing. There was practically no improvement, after x-ray, cauterization or curettage, or medical treatment.

Quincke's Edema.—Dr. Sieben reports a case of influenza in a 13 year old girl which was followed by chorea and a concurrent angioneurotic edema. He has observed a number of cases, in which not only chorea but also other nervous diseases were associated with influenza, so that he does not hesitate to count the chorea and edema among the after-effects of influenza. Furthermore, he reports as after-effects of influenza: serious maniacal emotional conditions, and even genuine mania of the severest type, necessitating confinement of the patient in an asylum but with final complete recovery. If Quincke's edema follows one infectious disease (influenza), it may possibly follow other infectious diseases. If there are no intestinal symptoms that point to the origin of the disease, it would be well to look for some infection that may have played an important part in its genesis.

Postdiphtheritic Paralysis.

A case of general postdiphtheritic paralysis in a 3-year-old boy and another in one aged 7, are reported by S. W. Boorstein, New York. He describes the symptoms and varieties of this disorder. While severe, the disease may be curable. In the first case, he credits orthopedic treatment as probably of more value in hastening the recovery than the antitoxin administered. In the second case, which had lasted altogether two months, antitoxin was early administered, but still paralysis developed. In this case what skepticism he had as the value of the orthopedic treatment in the previous case was dispelled by the greater and more notable success. The article is illustrated.—(J. A. M. A.)

Gangrene of the Penis in Old Men..—De San Antonio of Madrid saw recently two cases which much resembled each other and which were unlike anything he had hitherto seen. The first patient was a man of sixty-five who had contracted a venereal sore, which had evidently been vigorously cauterized, the resulting inflammation having been attended by sphacelation. The second patient was also over sixty, and was a stable helper, doing rough and dirty work and addicted to drink. The gangrene in his case was of the subpreputial type, beginning in an ulcer. In both cases the process was selflimited, recovery occurring under simple antiseptic measures—Da Medicina Ibera.

Retention of Urine Due to Prostatic Enlargement and Fibroid Tumor Within the Bladder.

Dr. Frank F. Russell reports the following case in the Wisconsin Medical Journal. He says: I am taking the liberty of reporting this case from the interesting aspect of urinary retention due to a tumor within the urinary bladder.

Patient was a man 72 years old with acute retention that could not be relieved by catheterization, so I did a superpubic trocar puncture, following which for a week patient could urinate fairly well. Another retention occurred and another puncture was done. On the same day, February 22, 1920, the patient was taken to the hospital and, under apothesine anesthesia, drainage of the bladder was instituted. At this time I could feel the tumor in the bladder and thought it the enlarged median lobe of prostate. Six days later, February 28, 1920, under ether, I removed prostate, and the tumor that was attached to the base of the bladder. The tumor was a fibroid the size of a large hen's egg.

At this date, April 1st, 1920, patient is up and feeling good, the abdominal wound is healed and urine is discharged the natural way without any distress.

Imperforate Anus.—Dr. C. Skinner, Louisville, Ky., says: I recently delivered a male child who had a complete imperforate anus. The mother had borne four children within four consecutive years. The first two deliveries were eleven months apart, the next two about twelve months apart. The other children show no abnormality and are in perfect health. There is no specific history.

About sixty hours after birth Dr. J. G. Sherrill performed a colostomy upon this child. He lived for three weeks and appeared to be doing fairly well, then rapidly failed and died within two days. There seemed to be a communication between the rectum and urinary bladder, as feces were passed through the urethra upon two or three occasions.

Ilio-cecal Value Insufficiency.

The following case is reported by Dr. E. Reissman, Newark, in a paper in the Amer. Jour. Surgery, on "The Roentgen-Ray in the Diagnosis of Ilio-cecal Value Insufficiency."

Miss H. S., a nurse, forty-four years old, was referred by a gastro-enterologist for an intestinal examination, January, 1918. She complained principally of abdominal distension and pain reflected to the left side. Roentgen examination of the colon by enema showed a return flow into a large portion of the ileum and its terminal end closely approximated to a contracted cecum. No other defects were seen. The Roentgen findings were, incompetency of the ileo-cecal valve with adhesions at the cecum and terminal ileum. The patient was referred to a surgeon who, unfortunately, considers ileo-cecal incompetency of no significance. He operated without giving the valve condition any or sufficient attention. At least the result was unsuccessful. The symptoms persisted. Five months later, getting no relief, the patient was re-examined and the original defect was again demonstrated. The patient was again operated upon by another surgeon who performed a Kellogg operation with success. To confirm the diagnosis and the mechanical result of the operation, a barium enema was given on October, 1918, and no return flow was observed. The patient has been well to date.

Uterus and Both Ovaries in Indirect Hernia Sac.—Dr. N. A. Ludington, New Haven, Conn., says:

The unusual contents of a hernial sac is the reason for recording this case. I have been unable to find record of similar condition.

Case.—V. S., female child aged nineteen months. Full term, normal birth. About a month after birth a swelling was first noticed by the mother over the left external inguinal ring. This swelling remained constant in size, and did not disappear when child was asleep. No truss was applied.

The patient first came under the observation of Doctor Smirnow who failed in several attempts to reduce the sac. He noted the hard nodular character of the mass and inclined to the diagnosis of a cyst under tension. The examination showed a symmetrical swelling over the left external inguinal ring the size of a silver dollar, not adherent to the superficial tissues and freely movable on the deep structures. It was dull to percussion and gave only a suggestion of an impulse when the child cried vigorously. To palpation, the mass under the skin was hard and nodular, apparently not very sensitive, and refused to yield to taxis. In spite of the history of irreducibility and the absence of a history of vomiting, I felt that it was probably an omental hernia.

At operation the sac was found to contain the uterus, both tubes, both ovaries, the broad ligament, and a small knuckle of gut presented itself during the procedure. The presence of the ovaries lying close to the uterus gave the nodular sensation which was found on examination. The deep epigastric artery was seen on the mesial side of the sac, which should therefore be classed as an indirect hernia. The sac was intimately adherent to the cremaster fibres and infundibuliform fibres. I believe the hernia was congenital. The operation performed was a routine herniotomy. The convalesence was uneventful.—N. Y. Med. Jour.

Induction of Labor by an Unusual Method.

Reported by George L. Brodhead, M. D., New York, in the A. M. A. Journal.

Mrs. A., aged 24, at term in her first pregnancy, was sent to the Harlem Hospital, March 2, 1920, by her family physician, who suspected that she was suffering from toxemia of pregnancy. Her chief complaint on admission was edema of the vulva and extremities. She had no headache, dizziness, nausea or vomiting; her vision was not disturbed and she had no epigastric pain. The urine showed only the faintest trace of albumin. The vulvar edema had been gradually increasing for the three weeks prior to her admission.

The patient was pallid, sat up in bed, and was slightly dyspneic, with a systolic blood pressure of 130, and diastolic, 80. The abdomen showed a full term pregnancy with the vertex well engaged in the left occipito-anterior position. The fetal heart was 142, and of good quality. The vulva showed a very extensive edema; the labia were tremendously swollen, and pitted on pressure, and were so large that the patient could scarcely bring her thighs together. The heart showed hypertrophy and dilatation, due to the decompensated double mitral disease. The pulse was irregular at times both in rate and in rhythm. The lungs showed many rales of all kinds over both chests, anteriorly and posteriorly. The patient's general condition was only fair, and as she appeared to be seriously ill, we believed that pregnancy should be terminated. Remembering a former experience in a similar case, acupuncture of the vulva was performed, March 4, 1920, at 4 P. M., with the escape of considerable amount of edema fluid. The patient was immediately improved, slept much better, and felt a great deal more comfortable. At 1 A. M., March 5, she complained of rather severe pains in the back and lower abdomen, and on that day she delivered herself normally of a female child weighing 7 pounds 14 ounces. After her delivery the patient was more comfortable, and the edema of both the vulva and the extremities, which had markedly decreased

immediately after the puncture, rapidly disappeared. The puerperium was uneventful. She left the hospital, March 13, in good physical condition, except for her cardiac disease.

The interesting feature in the case was the onset of labor following the puncture of the edematous vulva, obviating the necessity for any intra-uterine manipulation to bring on labor.

An Unusual Foreign Body in the Esophagus.

Dr. C. J. Imperatori, of New York, reported this case at the annual meeting of the Association of American Peroral Endoscopists in 1919.

The radiographs in this case show a wire within the esophagus. This wire, a heavy copper one, was ten inches long, the upper end of it being located just above the bronchial crossing, while the lower end was in the stomach.

The history of the case was that the patient had been in the habit of swabbing his throat with this wire, one end of which was wrapped with cotton. During one of these manipulations the wire was pushed down so far that attempts to get it out were without avail. Within a few hours after the accident he was seen by a laryngologist who made several unsuccessful attempts to get hold of the upper end of the wire by the indirect method. The next day he went to the Volunteer Hospital where I was asked to see him. A radiograph was taken and the foreign body located.

Asophagoscopy showed the upper end of the wire embedded in the lateral wall of the esophagus at a point about nine cm. below the cricopharyngeal constriction, that is, about twenty-five cm. from the upper teeth. Rotating the wire and relieving the upper end from the lateral wall of the esophagus brought it into the end of the esophagoscope. As there was considerable edema and swelling of the tissues of the larynogpharynx, a seven mm. Jackson esophagoscope was used. On making attempts to withdraw the foreign body it was necessary to pull with considerable force—the lower end seemed to be firmly held.

The x-ray of the lower end of the wire was not definite and the exact description of how the cotton was wound around the lower end of the wire had not been definitely described to us by the patient. From the necessary force required to pull the wire it was thought that the end of the wire was hooked in the mucous membrane of the stomach, and further attempts were not made until an x-ray of sufficient clearness could be made and the patient further questioned.

The case was an exceedingly difficult one to esophagoscope and a general anesthetic was used. The surgeons in charge decided against further manipulations by the natural route and decided to do a gastrostomy. This was done the following day and the wire removed. However, the patient died thirty-six hours after the operation from pulmonary embolism.

The reasons for reporting this case are: 1. The unusual length of this foreign body and the method of entrance; 2, the unsuccessful attempt at removal because of the conditions noted. Examination of the lower end of the cotton wound wire after its removal by gastrostomy showed a mass of cotton—pear shaped—five cm. long and three cm. at its greatest diameter. The cotton mass undoubtedly was held by the cardiac constriction; 3, the final outcome of the case.

Gonorrheal Infection.

Dr. S. E. Earp of Indianapolis, reports this case in the Medical Record:

Case II.—E. M. White. Female. Age 23. Married. Family History—Mother had two strokes of paralysis; after last, dragged right foot. Wassermann positive. Was given salvarsan. Has had tonsillitis and rheumatism. Father a rheumatic and helpless from it. Previous History.—Good health during childhood, Menstruated at 10 years. Miscarried at age of 16 years. At 20 years gave birth to a child. Has had some vaginal discharge. Soreness and swelling in joints of legs and arms two years ago. Has been in skin clinic on account of eczema of hands, and gynecological clinic on account of vaginal discharge and painful urination. Tonsils removed six months ago. Present Illness.—For three weeks stiffness in left elbow; some swelling. Pain in right hip and knee during past few days. Physical Examination.—Weight, 175 pounds. Well nourished. Wears glasses. Teeth good but gums sore and bleed easily on pressure. Right arm semi-ankylosed, and left swollen and painful. Cervical and inguinal glands enlarged. Joints elsewhere tender on palpation. Chest and abdomen negative. Temperature 100° F. and pulse 88 to 90. Respiration 20. Laboratory Findings.—Smear from vagina reveals gonococcus. Wassermann negative. Blood Count.—Red, 6,130,000; white, 16,500; poly., 58 per cent.; small, 30.5 per cent.; large, 10 per cent.; eosin, 5 per cent.; bass, 1 per cent. A second Wassermann negative.

We have here presented almost a typical case of gonorrheal infection usually denominated gonorrheal rheumatism. It has no bearing, of course, upon the Micrococcus rheumaticus or other forms of infection. When even a few of these manifestations are present, if there is a complication of ankylosis, we are fairly sure that the type is gonococcal.

ABSTRACTS FROM MEDICAL JOURNALS.

Gall Stone Disease Complicating Pregnancy.

The following is from an excellent paper in The Medical Times, N. Y., of February, by Dr. Aime P. Heineck of Chicago, Ill:

It is agreed that cholecystectomy is attended with more technical difficulties than cholecystostomy. It requires greater care to avoid injury to the bowels, vessels and the main bile ducts. It is wiser to choose the safer operation until the technic of the more complicated one has been mastered.

Cholecystostomy is the operation of election:

1. Whenever the patient's condition is so bad that the difficulties attending a cholecystectomy render its performance unsafe;

2. When the gall-bladder is not seriously damaged and when the cystic duct is not ulcerated or narrowed by stricture. It is believed that the gall-bladder has some other function than that of a mere receptacle of bile.

3. When the common duct is strictured.

4. If jaundice and pancreatitis complicate the gallstone disease.

Cholecystectomy is indicated:

1. For very thick, acutely inflamed, or gangrenous gall-bladders in which a stone is impacted in the cystic duct.

2. For chronically thickened gall-bladders. A thick walled gall-bladder which has become functionless should always be removed. When the gall-bladder becomes thickened and hardened from long continued inflammation, it is manifestly impossible that it should dilate no matter what obstruction there may be in the common duct.

3. For large gall-bladders distended with clear fluid and resulting from the impaction of a stone in the cystic duct.

4. For the "strawberry" gall-bladder (chronic thickening with ulceration).

5. For a calculus gall-bladder adherent to the stomach, intestine or omentum.

6. When the walls of the gall-bladder are so modified by disease that neither the storage nor the expulsion of bile is possible.

Summary.

1. Gall-stone disease occurs with far greater frequency in women than in men; with far greater frequency in women that have borne children than in women that have remained sterile. Its period of greatest incidence is the child-bearing period.

2. Gall-stone disease, alone or associated with one or more other related or non-related pathological states, not uncommonly complicates a pregnancy otherwise normal or abnormal.

3. The first manifestations of cholelithiasis may date from the existing gestation or from a previous pregnancy; may precede, coincide with or follow an abortion or premature labor, accidental or induced.

4. All conditions that are associated with, that favor or cause; a. bile stasis; b. inflammatory or degenerative changes involving the gall-bladder or bile tracts; c. pathological alterations in the composition of the bile, such as hypercholesterinaemia, etc., predispose to gall-stone disease.

5. Pregnancy is an important etiological factor in the causation of cholelithiasis.

6. The pathology of gall-stone disease complicating pregnancy is the pathology of gall-stone disease occurring in the non-pregnant. There may be present: a. an inflammation of the gall-bladder or bile ducts in which one, two or many calculi are lodged, or impacted; b. a distension of the gall-bladder or bile ducts by mucus, pus or calculi; c. a pericholecystic inflammation, calcuous in origin, leading to adhesion formation, to fistula formation, etc., and corresponding disturbances of function; d. changes in the liver; e. changes in the pancreas.

7. Some of the symptoms of gall-stone disease are due to the irritation inherent to the presence of gall-stones, to their migration through, or impaction in the bile ducts or neck of the gall-bladder. Other symptoms are due to the concomitant inflammation of the gall-bladder, bile ducts and neighboring organs, causative of or resulting from the presence of calculi.

8. Rupture of a gall-bladder distended by calculi, fluid, mucous or purulent in nature, can occur during gestation or during or immediately after labor.

9. In the differential diagnosis of this condition one should bear in mind:

a. That not infrequently gall-stone disease originates during or may complicate pregnancy.

b. That cholelithiasis and cholecystitis owing to their reflex symptoms are often mistaken for gastric disease;

c. That appendicitis and gall-stone disease frequently co-exist;

d. That digestive disturbances associated with acute pain and tenderness in the right hypochondriac region, with or without jaundice, with or without symptoms of biliary colic are in themselves ample justification for operative exploration of the gall-bladder and ducts.

10. Cholelithiasis is a surgical disease; it calls for operative relief. Medical measures in this disease are merely palliative; appropriate surgical measures are curative.

11. Gall-stone disease in itself is never an indication for the artificial termination of pregnancy.

12. Whenever, for some cause or other, the abdomen is opened in women of the child-bearing age or past the child-bearing period, the gall-bladder and larger bile ducts should be examined if it can be done: a. without or with only slight traumatizing of the tissues; b. without exposing the patient to too much additional risk; c. without contaminating clean peritoneum. Should the patient give a history of chronic digestive disturbances, the indication is absolute.

13. Women exposed to pregnancy, suffering from calculous cholecystitis, or any other form of gall-stone disease, should be operated, the calculi removed, and the gall-bladder drained.

14. Pregnancy does not contra-indicate operations upon the gall-bladder or bile tracts. Peterson reported only three miscarriages in 23 reported operated cases. In only one (Roith) of the cases which we considered, did abortion follow the operation.

15. It has been repeatedly demonstrated that the operative relief and cure of cholelithiasis does not unfavorably influence gestation, does not unfavorably influence parturition. Icterus, whether acute or chronic, is a constant menace to the foetus.

16. Early operation is now, in proper hands, a safe procedure. It is an effectual cure of the symptoms produced by gall-stones; it has low mortality and guarantees against serious complications in the future.

17. Cholecystostomy, cholecystectomy, and choledochotomy have been successfully performed upon pregnant women for the relief of gall-stones. After these operations, drainage is to be employed until the bile ceases to flow spontaneously through the wound, until complete subsidence of whatever degree of cholangitis existed.

18. The prognosis of operative intervention is not unfavorably influenced by the existence of pregnancy.

19. In persistent gall-bladder disease, trouble changes in the urine manifested by the presence of casts and albumen are not uncommon and are not necessarily a bar to operative interference.

Hemorrhage is one of the important early symptoms of cancer of the uterus, and may appear when the victim is in apparently perfect health. It may be only a trace following coitus or straining at stool.—J. E. Gilcreest.

County Medical Societies' Reports

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

The annual outing of the Cumberland County Society was held at Tumbling Dance Park, Bridgeton, August 25. After many days of rain, the day proved pleasant. The park looked its best. Delegates came from Salem County. The afternoon was spent in canoeing driving through the park and the enjoyable exchange of experiences. Twenty-nine sat down and ate of the bountiful chicken dinner provided by the host, Mrs. Ovid Davis.

MIDDLESEX COUNTY MEDICAL SOCIETY.

Herbert W. Nafey, M. D., Reporter.

On the afternoon of September 14th, a large number of friends of Dr. and Mrs. David C. English, together with the Middlesex County Medical Society, met at his home at 65 Paterson street, New Brunswick, N. J., in order to celebrate the 50th anniversary of their wedding. The meeting was made a most enjoyable occasion by the presence of a large number of out-of-town friends, including the following members of the New Jersey State Medical Society: President Dr. Philander A. Harris; Second Vice-President Dr. James Hunter Jr., Third Vice-President Dr. Wells P. Eagleton, Recording Secretary Dr. Wm. J. Chandler, Trustees Drs. C. R. P. Fisher, Norton L. Wilson, Wm. G. Schauffler, Thos. W. Harvey, Enoch Hollingshead.

The business meeting of the Middlesex County Society, which preceded the informal reception, was largely attended by nearly all of the physicians throughout Middlesex County. The subject of Chiropathy and Osteopathy as is practiced in this State under the legislation as passed by the last session of the State Legislature was widely discussed and steps taken in order to bring before the State legislators at their coming session the necessity for modifying or repealing the acts as passed at the preceding session. In this discussion Dr. Fred H. Albee of New York and Colonia, made an earnest appeal to the medical profession to co-ordinate their efforts in trying to repeal or modify the obnoxious practice law as it exists at the present time. Dr. Albee pointed out the propaganda which is going on throughout the country at the present time in an effort to lower the standard requirements for practice in the individual States throughout the country. He stated that the Palmer School of Chiropathy in Davenport, Iowa, is the source of most of this propaganda. That there men can receive a license as full practitioners of Chiropathy after six months' training; that this six months need not be taken at one time; from one to two months may be taken at a time with intervening periods of varying duration, the only requirements being that the total attendance be six months. Here gather aspirants for the degree of Doctor of Chiropathy from all walks of life. No educational requirement is asked, the only stipulation being that the fees for the course be paid promptly and much of the revenue obtained in this manner is immediately turned back into the various States to carry on the propaganda for the object stated above.

Dr. Albee gave, as a case in point, the use or control of the one newspaper in our neighboring town of Rahway, and the publication therein of frequent articles supposedly of news value but in reality of advertisements for the Chiropractors and their supposed curative powers. Dr. Albee stated that it was with the greatest efforts he has been able to suppress this misleading advertising. He states that this is going on in many of the small towns throughout the county, and also that it is incomprehensible that our State, which was the only State in this country, and in fact the only place in the world where a State Rehabilitation Act had been passed, could at the same time pass legislation as was done last year, to reduce the requirements of practice in this State almost to the vanishing point. He spoke especially of the Chiropractic bill. The speaker stated that in every talk which he had had with any of the legislators who voted for that obnoxious bill, they gave as their reason some case in which the doctor had made a mistake in the practice of their profession, making this excuse for their act in supporting a bill which otherwise had no merits whatsoever. In each instance the legislator was asked if he knew what the requirements for the practice of medicine in this State had previously been. Before it was possible to practice medicine here a man must at least have graduated from high school and a reputable medical college requiring at least four years' training followed by at least one year's hospital work. They were asked if, in their opinion, mistakes were made by medical men after such training it was their belief that the way to reduce the possibility of similar mistakes in the future was to remove these requirements completely and to allow anyone to practice regardless of what his standing in the community or what his educational requirements might be or of what his character may have been.

Dr. Albee spoke of a case which he has had at the Colonia Hospital. A boy was brought to him after six months' treatment by a Chiropractor. The parents had noticed a swelling about the boy's ankle, had taken him to this man who had told them that by adjusting his spine the swelling would be reduced. They continued this treatment for three months. During this time the practitioner never once looked at the ankle but continued the manipulation of the spine. When at the end of this time the ankle had become so greatly swollen the parents requested that he at least inspect it, he did so, and told them that it was doing nicely and after he could get the spine into proper alignment this tumor would shell out as an onion could be shelled out of its skin. Treatment continued three times a week for another three months. At the end of this time the destruction of tissue had become so extensive that they took the boy to a physician who immediately referred him to Dr. Albee. Dr. Albee stated that the tumor growth is a spindle-cell sarcoma, the most malignant and surely fatal type of growth known, that there was nothing now to do but to alleviate the suffering of this boy, as far as possible, until the end comes, which cannot be long postponed.

It was the unanimous consent of the mem-

bers present that a concentrated effort must be made by the medical men to make the members of our State Legislature understand that they are not voting in these cases for bills the effect of which can be measured in dollars and cents but for bills which effect the lives of every resident of this State.

We believe that it is ignorance of facts on the part of our legislators which permit them to give their vote for a measure on the promise of a return vote for a measure of their own without regard to the merits or demerits whatsoever of the measure under discussion. Do the people of this State know that measures are bargained for between their legislators regardless of the merits of the bill to be considered?

In continuation of the discussion Dr. Albee gave a brief outline of the Rehabilitation Bill as was passed by our Legislature. He emphasized the scope of this rehabilitation work and what it means to the laboring man; that at the present time an injury resulting in the loss of a finger, hand, arm or foot cannot be repaid and the case closed by the mere payment of a sum of money. The real work to be done in these cases is to so reconstruct and so educate this injured person that he will again be able to fill some position in life and to become self-supporting and self-sustaining. This is the work which Dr. Albee has been doing during the war among the soldiers and which he now continues in civil life.

His talk was illustrated by many of the most instructive and interesting lantern slides, illustrating this work as carried out in the Rehabilitation center at Newark.

A vote of thanks was given Dr. Albee for his most instructive paper; also to Col. Schauffler for operating the magic lantern so effectively.

Dr. English read letters from Prof. Howard A. Kelly of Johns Hopkins University, Baltimore, and President Simon Flexner of the Rockefeller Institute for Medical Research, New York, regretting their inability to attend this meeting.

At the conclusion of the program the president of the Middlesex County Medical Society, Dr. Laurence Runyon of New Brunswick, presented Dr. English with a purse containing three hundred dollars in gold as a token of the esteem and best wishes of the medical society for his many years of service to the community, the profession and the State. Dr. English was much surprised as his reply in accepting the gift indicated.

The meeting was adjourned following which bountiful refreshments were served and an informal reception held.

MORRIS COUNTY.

Marcus A. Curry, M. D., Reporter.

The New Jersey State Hospital at Morris Plains was the scene of the annual meeting of the society on the evening of September 14th. The meeting was presided over by President Dr. Marcus A. Curry, who also is superintendent of the State Hospital. There was a goodly attendance of members and guests, among the latter being Drs. Allen, Mitchell and Swirl of Convent, New Jersey; Dr. Annie F. Colley, resident dentist of the hospital; Miss Myrtle F. Smart, eugenist, and Miss Mary Clark.

Dr. Augustus S. Knight, medical director of the Metropolitan Life Insurance Company and chairman of the medical committee of the Board of Managers of the hospital, welcomed the members and guests in an address of cordial warmth in which he outlined definite improvements contemplated for the institution which embrace and increase in the medical staff, enlarged capacity and facilities for caring for the patients on the highest scientific plane, without publicity and without commercializing, and where as many persons as possible can be treated to prevent their entrance into the institution as patients and to return to their homes as many as possible of the patients either cured or so improved as to be able to take their normal stations in life. Dr. Knight exhorted the members to closer affiliation with the institution, its facilities and advantages and invited their more intimate interest in its conduct, welfare and progress, especially as it is located in Morris County and deserves their best efforts to place it at the top of group one in any survey of the hospitals of the country that may be made.

President Curry thanked Dr. Knight for the exercise of his good offices in behalf of the society and emphasized that part of his address which urged closer co-operation on the part of the members and more frequent visits to the institution and a display of enthusiastic interest in its affairs.

A nice tribute was paid to the honored memory of the late Dr. Britton D. Evans, which was read by Secretary Kice and which was ordered spread upon the minutes of the society and an engrossed copy sent to the bereaved family of the deceased member.

A letter was received from Dr. D. C. English, editor of the State Society Journal, explaining that he was detained at home to celebrate his golden wedding. The explanation was deemed by the members to be sufficient and they were enthusiastic in their desire that the secretary dispatch a letter to Dr. English condoning his absence from the meeting and congratulating him on the cause.

A report was made of the assistance rendered to the dependent members of the family of a member who is making a prolonged stay in New Mexico in an effort to recuperate his health and the report showed the members to be more than generous in coming to the assistance of a trying situation.

Communications were read by the secretary on the importance of welfare work in behalf of medical men in order that they may unify and concert their efforts and exert themselves en bloc to combat measures and laws hostile to the honored profession.

Two new members were elected unanimously: Dr. Laurence M. Collins and Dr. Franklin C. Young, both of Greystone Park, and members of the State Hospital medical staff.

The officers for the ensuing year are as follows: President, Aug. L. L. Baker, Dover; vice-president, William F. Costello, Dover; secretary, Henry W. Kice, Wharton; treasurer, James Douglas, Morristown; reporter, Marcus A. Curry, Greystone Park; Executive Committee, Marcus A. Curry, chairman; Samuel C. Haven, Morristown; Francis H. Glazebrook, Morristown.

Permanent delegate to State Society, Leonidas L. Mial, Morristown.

Annual delegates to the State Society: Clifford Mills, Morristown; Ellery Newell Peck, Boonton; Aldo B. Coultas, Madison. Alternate delegates: Alvan Spencer, Kenvil; Aug. L. L. Baker, Dover; Noble H. Adsit, Succasunna.

Welfare Committee: Clifford Mills, Morristown; Gustav A. Becker, Morristown; William F. Costello, Dover; Frederick W. Flagge, Rockaway; J. Willard Farrow, Dover.

Retiring President Dr. Marcus A. Curry read an interesting paper which covered comprehensively several subjects not only of interest to the members but to the medical profession in general, the more salient of which were "Preventing Legislation" and "Preventive Medicine." The paper is promised for publication in the Journal.

An interesting study in general paralysis was afforded by Dr. John V. Donnet, pathologist at the State Hospital, which was illustrated by lantern slides.

At the close of the very interesting meeting Warden O. M. Bowen of the hospital conducted the members and guests to an appetizing spread which was much enjoyed.

Summit Medical Society.

William J. Lamson. M. D., Secretary.

The annual meeting of the Summit Medical Society was held at the Highland Club on Friday, September 24, 1920, at 8.30 P. M., Dr. Bensley entertaining and Dr. Lawrence in the chair.

Present—Drs. Bebout, Bensley, English, Johnson, Keeney, Krauss, Lamson, Lawrence, Moister, Morris, Prout, Reiter, Tidaback and Wolf; and Drs. Meeker and Beverlin of Summit as guests.

A letter was read from Dr. Jaquith, tendering his resignation from the society on account of removal to Chicago, where he is to assume the duties of vice-president and medical director of the National Life Insurance Company. His resignation was accepted with regret.

Announcement was made of the death of Dr. Robert H. Hamill, the founder of the society, at his home on September 5th, and a committee consisting of Drs. Prout, Lamson and Moister was appointed by the chair to draw up resolutions of sympathy for his family. The resolutions were as follows:

"At a meeting of the Summit Medical Society held on September 24th, 1920, the following resolution was adopted:

"In the death of Dr. Robert H. Hamill, the society recognizes the loss of its founder and a valued member, and records its high regard for his noble character, his ripe judgment and excellent professional ability, the memory of which it cherishes as a permanent heritage of the society.

"Dr. Hamill's ideal of the relationship of the physician to his patients and to his confreres was of a generous type that directly permeated his professional associates. To know him was to unconsciously absorb the ethical principles he lived. His success in harmonizing and uniting the profession in Summit is a great community asset, and an enduring monument to his character.

"The society begs to extend its sincere sympathy to Mrs. Hamill and her sons in their bereavement."

Dr. R. D. Baker, an honorary member of the society, who has returned from New York to resume practice in Summit, was proposed for active membership by Dr. Prout, seconded by Dr. Keeney.

Dr. Charles P. Clark of Summit was also proposed for membership by Dr. Lamson, seconded by Dr. Keeney.

The paper of the evening was read by Dr. Bensley, on the subject of "Painful Foot." After mentioning the various causes of this condition he discussed fully three abnormalities, viz.: (1) Falling of the anterior arch. This occurred very frequently in the army, and is caused by relaxation of the ligaments under severe strain or fatigue. It is frequently overlooked in civil life, and can be readily cured by padding and strapping with adhesive plaster, and wearing long narrow shoes; (2) fracture of the base of fifth metatarsal also is often unrecognized, but can be easily diagnosed by the x-ray; (3) painful heel, due to exostosis on os calcis, with, frequently, a history of an antecedent gonorrhea, is another source of disability, and removal of the exostosis is often necessary.

After discussion of the paper, reports of some interesting cases were given.

International Congress Against Alcoholism.

The Fifteenth Congress met in Washington, D. C., last month, delegates from ten of the countries represented at the conference participated in the discussions. Among those on the program were Vi Kyuin Wellington Koo, the Chinese Minister, for an address on the anti-alcoholism movement in China, and Prohibition Commissioner Kramer for a talk on "Enforcement of Prohibition in the United States."

Secretary Daniels declared a Congress could never be elected that would agree to the modification of the Volstead enforcement act. He also traced the history of prohibition in the navy, asserting that the effectiveness of seamen had increased since the dry order went into effect. "Wherever the navy is, it is dry," declared the Secretary, adding that recently alcohol had been discarded in the navy for medicinal purposes.

Dr. Harvey W. Wiley, former chief of the Bureau of Chemistry of the Department of Agriculture, expressed the belief that the Prohibition party should not have nominated a national ticket. He believed its work was practically finished when the Eighteenth Amendment was adopted, he said. A delegate interrupted to inquire where he would "ask a Christian to cast his ballot." "I would leave that to your conscience," Dr. Wiley replied. "But I do not think a vote on the Prohibition ticket will get anybody anywhere."

Dr. Wiley also declared the prohibition amendment never would be repealed or softened because the "country's business would stand like a rock against it," since it had found that "prohibition pays."

Papers by Dr. P. Amaldi, director of the Hospital for the Insane, Florence, Italy, and Dr. Eudo Monti of Turin, dealing with problems confronting dry workers in their nation, were read in absence of the authors, who were unable to attend.

THE JOURNAL

OF THE

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PUBLICATION COMMITTEE:

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

Important Meeting

THE WELFARE COMMITTEE

of the

Medical Society of New Jersey

will meet in the

Council Chamber of

The City Hall, Newark, N. J.

on

Wednesday, October 13th

at 3 o'clock P. M.

The Welfare Committee of every County Society is urgently requested to attend this meeting.

Let no county be unrepresented at this meeting, as business of vast importance will be considered.

"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—Theodore Roosevelt.

Arthors of papers and those discussing papers are requested to return proof sent them for correction at the earliest possible time.

TO ALL COUNTY SECRETARIES.

The month of October is the one in which the majority of the component societies hold their annual meetings, at which new presidents, secretaries, reporters, etc., are elected.

In order to keep the printed list of these officers (published each month in the advertising pages) up to date, it is necessary that a corrected list be sent to the Recording Secretary, Dr. William J. Chandler, South Orange, N. J., as soon as possible after the annual meeting, so that he may have the necessary changes made in this list.

Will the secretaries of each and every county medical society kindly heed this request and if convenient, send a full list of all officers elected at the annual meeting?

I would again call attention to the change in the by-laws, by which a full list of all paid-up members, with the amount of the assessment, is required to be sent to the treasurer of the Medical Society of New Jersey on January 1st of each year. Members, who pay their dues for 1921 at the annual meeting in October, 1920, will insure the insertion of their names in the list, which will be published as soon as possible after January 1st.

Only the names and addresses of members who have **paid their dues in advance** for the year 1921 can be inserted in this list.—W. J. C.

SHALL OUR PROFESSION LIVE AND PROSPER?

We cannot emphasize too strongly the importance of attending the meeting of the Welfare Committee in Newark on October 13th. Every member of every County Medical Society's Welfare Committee should attend, if possible, and it would be well if the president of every Medical Society in the State shall be present. The question as to whether the scientific standing of our profession shall be maintained and its efficiency shall be increased as our scientific knowledge is increased is a vital question, affecting not only our profession's welfare, but the life and health interests of the citizens of our State and of humanity at large.

We call our readers' attention to the address of Dr. Curry on page 342; to Dr. Albee's remarks concerning chiropractors which appear in the Middlesex County

Medical Society's report, and to some of the editorials from other medical journals on page 361-364, which have a bearing on this subject. The average income of the doctors in the United States is said to be about $700. Will it be half that if a compulsory health insurance law is passed and the false cults continue to increase?

"CHRISTIAN SCIENCE" STILL BUSY.

The Editor has received another communication in reference to our attitude toward the so-called Christian Science cult, taking us to task for the least important item in our editorial—what Mrs. Eddy's followers are "apt to want" before they "minister to a mind diseased." As we said, we will have no discussion with these critics even when they say that if we fail to answer them—"I shall be compelled to conclue that you had no basis whatever for your libelous charge." We are not their servants doing their bidding, and we would only prescribe in this case, without prepayment therefor, some of their own medicine—"Judge Not."

But for our Publication Committee's and our readers' information, we state that on the matter referred to we gave information we had received and believed to be true. We reiterate what our previous editorial said about parents who followed this cult allowing their children to die from diphtheria and other diseases without proper medical treatment. The following appeared in the A. M. A. Journal, May 22, 1920:

"A New Jersey salesman, who claims to have been a member of the 'Christian Science' faith for three years, was found guilty of manslaughter because he had permitted his 9-year-old daughter, who was suffering from diphtheria, to die without medical treatment. The little girl was given 'treatment'—'absent' and otherwise—by a professional 'Christian Science' practitioner. The man was fined $1,000 and costs."

We are aware, however, that some of the C. S. leaders, as well as many of their followers, do sometimes get medical advice. One of their "readers," living in a large city, once in the editor's home said: "If I should be taken very sick, my children would insist on my consulting a physician and I would do so."

THE MEDICAL PROFESSION IN ENGLAND IS ENTIRELY DESTROYED AND DISINTEGRATED.

Dr. Eden V. Delphey, New York, before the Society of Medical Jurisprudence, New York, January 12, 1920, said:

The freedom that was delivered into our hands by the Pilgrim Fathers recognizes but one kind of socialism and that is the socialism that makes a man work for the benefit of mankind and do the best he can do. That kind is not to be condemned, but that is not the kind of socialism that is being fostered. They are trying to put over on us a variety of Bolshevism, which is in reality the law of the jungle and of the Hun. Its principle is to get all you can, to keep all you get, and to make the other fellow work for you. You need only to look at Germany and Russia to see what that brand of socialism does for a man. Dr. Hoffman tells me the medical profession in England is entirely destroyed and disintegrated. I cannot think that the medical profession in this country would ever strike, but they have struck in Germany and are on the verge of striking in England. We are not opposed to compulsory health insurance simply because of its pecuniary effect on the medical profession. In a discussion of the economic side of the question a short time ago, Mr. John Lapp tried to show that under compulsory health insurance each physician would get an annual income of $5,400, but he did not tell how this was to be done when a physician would get 25 cents for an office call and for a house call not quite a dollar; and then he thinks the physicians ought to like it—but we don't and we won't.

CHIROPRACTIC—LUX ON SUBLUXATIONS.

Members of the medical profession have long been at a loss to know just what "chiropractic" is. They know what "chiropractors" are but "chiropractic"—that has been a mystery. It remained for the Senate and General Assembly of the State of New Jersey to elucidate. An Act to Regulate the Practice of Chiropractic recently signed by the Governor of New Jersey gives to a palpitating medical world this vital information. Here is the opening paragraph of the act:

Definition of Chiropractic: The term chiropractic, when used in this act, shall be construed to mean and be the name

given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms, to harmonious quantities and qualities by placing in juxtaposition the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have now assumed their normal size and capacity for conduction as they emanate through intervertebral foramina—the expressions of which were formerly excessive or partially lacking—named disease.

Lucidity itself! The New Jersey Legislature said, "Let there be light on Chiropractic"—and, behold, it became the "art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms, to harmonious quantities and qualities....." Simplicity to the nth power. Bring on your Einstein theory—the New Jersey solons may oblige with a snappy definition.—Journal A. M. A., May 15, 1920.

THE FUTURE OF MEDICAL PRACTICE.

An important investigation was recently made by a special committee of the Cleveland Academy of Medicine on the subject of the organization and program of the Academy. The report says:

"Only the great medical profession, as widely as it touches public life, has been blind to the desirability of such influential participation in community life and has failed to appreciate that the trend of the times in all other professions, businesses, and trades is toward a policy of assertiveness and aggressiveness in pushing the profession, if not the individual members of it, into the life of the community. That the profession of medicine as now practised is in danger of being engulfed in 'state medicine,' and that unless the profession is properly forewarned and prepared, the doctor, whether general practitioner, surgeon, specialist or laboratory worker, may become a mere tool of capital, labor, and the politicians are also emphasized.

"The pauperization of the profession can be prevented by concerted and united action of its individual members."

The report results in these ten points:

(1) The inefficient condition of the profession.

(2) The need for effective organization.

(3) The tendency of all classes in modern society to organize for attaining common purposes.

(4)) The importance of the economic feature, if only for the maintenance of a scale of remuneration which will make good medical work possible.

5) The need of an organization to secure: (a) scientific programs; (b) economic justice, and (c) proper influence in legislation.

(6) It is desirable from an altruistic standpoint that organized medicine, i. e., Doctors of Medicine, have due influence in public health education.

(7) A full time executive secretary is essential in a really efficient organization.

(8) To accomplish the purpose additional funds must be secured. This could be done by raising the dues.

(9) By the proposed division of membership into classes with a differential scale of dues no hardship would be inflicted on any member.

(10) Action must be taken promptly on account of pending legislation.—(Ohio State Med. Jour., March, 1920.)

THE HIGH COST OF PUBLISHING THE JOURNAL.

We take the following editorial from the Illinois Medical Journal. It applies with equal force to our Journal:

Owing to the marked advance in the cost of paper, union labor, etc., the expense of publishing the Journal has advanced over 100 per cent. in a comparatively short time.

At the present time the cost of labor is the highest in the world's history. In order to whip the Journal into shape for publication each month it requires the constant attention of several people. This service costs money, yet little consideration is given to this item by the average doctor and even by many of the officers of the county societies.

Little details that should be looked after by the author or the county secretary are very frequently overlooked and this accumulative neglect is heaped up on the editor's office, and the cost of unravel-

ing it is many times greater than if looked after at the sources as it should be.

Papers are frequently sent for publication without even the title, the name of the author or the name of the county society before which it was read. It costs time and money to trace this paper to its source and get the necessary data. Recently we received a batch of ten papers sent by the secretary of a medical society and not one of them contained the title, name of the author, or the name of the organization before which the paper was read. Ultimately, we were sent a program with a suggestion that we could dig the information out ourselves.

This "Let George Do It" spirit is a very shiftless way of doing business and is an extra tax on the treasury. The details mentioned should be attended to by the author and in case he fails to do so it should be detected and remedied by the secretary of the respective society.

If these little details are looked after as they should be, a considerable saving could be made annually in getting out the Journal. We ask the co-operation of all in helping to maintain the efficiency of the Journal and at the same time keep the cost of publishing as low as possible.

INEFFICIENT MEDICAL SERICE IN PLACE OF PRESENT SCIENTIC TREATMENT.

The present trend of the times is the attempt to put the doctor out of business, and substitute for the present scientific care of the people cheap, inefficient medical service in the form of State Medicine.

Another great danger that is upon us is the disposition on the part of the authorities at Washington to try and set up a bureaucratic form of government in America and attempt to extend wartime powers to peace conditions. We feel that state rights must be preserved, otherwise all initiative as well as the individual will be destroyed. This vicious trend of the times has got to be corrected at once, otherwise we will soon be the most governed people on earth. It is an old and true saying that "that country is governed best, that is governed least."—Illinois Med. Jour.

Appointment of Medical Officers.

In the July examinations the following New Jersey physicians were granted commissions: Major, T. R. Marshall, Camp Dix; captains, S. H. Ackerman, Fort Mott; H. A. Callahan, Camp Dix; J. E. Campbell, Hoboken; first lieutenant, W. L. Thompson, Andover, N. J.

Medico-Legal Items.

Unlawful Practice of Medicine.

The Court of Criminal Appeals of Texas, in affirming a judgment of conviction of defendant Black of unlawfully practicing medicine, for which he was fined $250 and sentenced to one day in jail, says that it was entirely undisputed that he had and maintained offices where he treated any and all persons who might apply to him for various and sundry disorders and diseases, for compensation; and that he had not registered with the district clerk of the county, as required by the provisions of Chapter 6, Title 12, of Vernon's Penal Code. That act, passed by the legislature in 1907, makes it unlawful for any one to practice medicine on human beings in Texas, without registering with the district clerk in the manner and form provided by said act. By the terms of Article 755 of said chapter, what is meant by "practicing medicine," within the proscription of said statute, is defined. Subdivision 2 of that article is: "(2) Or who shall treat, or offer to treat, any disease or disorder, mental or physical, or any physical deformity or injury, by any system or method or to effect cures thereof, and charge therefor, directly or indirectly, money or other compensation." This act has been held constitutional both by this court and by the Supreme Court of the United States. It has been held to apply to a masseur; also to an osteopath; also to one who claimed to cure by means of laying on of hands and prayer—and this wholly regardless of whether such persons claimed to be physicians and practitioners of medicine or not.—(Black v. State (Texas, 216 S. W. R. 181)).

Opinion Evidence as Against Positive Testimony.—In an action for malpractice it was insisted by the plaintiff that the defendant in performing a mastoid operation severed the seventh or facial nerve, which was unnecessary, in consequence of which the plaintiff sustained damages. The trial court directed a verdict for the defendant. On appeal, the question involved turned on whether there was evidence sufficient to carry the case to the jury. It was contended by the defendant that there was no evidence that the nerve was severed; hence a verdict was properly directed. Paralysis of the face was shown, and there was evidence that severance of the nerve would cause that condition. But the evidence also showed that the paralysis might well follow an operation skilfully and properly performed from various other causes. It was shown by the evidence that the paralysis might have been caused by a "dehiscence," or by bandaging after the operation, or by cold drafts, and possibly other causes. Although it appeared that after the operation one side of the plaintiff's face was paralyzed, it was held that in order to warrant the trial court in submitting the case to the jury there must be some evidence that the defendant severed the facial nerve; and the appellate court found none in the record. There was positive evidence, not only by the defendant, but by Dr. B., a Chicago specialist, that the nerve was not severed. Dr. B. opened up the old scar in an effort to relieve pressure on the nerve, and testified that it had not been

severed. Claim was made by the plaintiff's counsel that Dr. B. admitted the nerve was severed. The evidence did not support this contention. The claim was based on evidence of one Mrs. H., but her evidence as to what Dr. B. said when he was not under oath was not competent, except as laying a foundation for impeachment. Moreover, Mrs. H. admitted on cross-examination that Dr. B. might have said that the nerve was injured, but not severed. Some reliance was placed on the opinion of another physician. But it was held that his opinion could not raise a conflict with the positive undisputed evidence that the nerve was not severed, and that other causes existed for the paralysis. Proof of bad result raised no presumption of negligence in this case. Judgment for the defendant was therefore affirmed.—Finke v. Hess, Wisconsin Supreme Court, 174 N. E. 466.

Due Care and Skill in Setting Fracture.—In an action for alleged negligence in resetting a broken leg so that the ends of the bone overlapped it was held that in the absence of a showing that such a condition would have been at least improbable had the leg received reasonably prudent and ordinarily skillful surgical treatment, it could not be said that the mere pathological condition of the leg in and of itself sufficed to show negligence on the part of the defendant. "The difficulties and uncertainties in the practice of medicine and surgery are such that no practitioner can be required to guarantee results, and all the law demands is that he bring and apply to the case in hand that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by practitioners of the medical profession under like circumstances."—Zoterell v. Repp., 187 Mich. 330, 153 N. W. 695. With respect to the failure to attain a complete bony union, the plaintiff's experts themselves testified that there was no way for an average or even a skilled surgeon to tell whether ligamentous or bony tissue was being deposited between and around the fractured ends of a broken bone in the process of reuniting, without opening the wound. While one exeprt testified that it was good surgery to open the wound and staple the bone, especially where, as here, there was an oblique fracture, none of the experts gave it as their opinion that it was not good practice to rely altogether upon casts and splints, as the defendant did. It appeared that a plaster of Paris cast was put on the leg on April 9, 1912; that another cast was put on on April 12, and possibly another on April 17; that the cast was removed on April 25, and that a yucca splint was then put on and held in place by a light bandage. The patient wanting to go to his ranch, the defendant told him he could go by being careful and using his crutch all the time, keeping the splint on for about two weeks. No further treatment was given. There was no testimony that anything covered by this treatment was improper. It was held that the evidence failed to show any lack of care and skill on the part of the defendant in setting and treating the fractured bone, and judgment for the plaintiff was reversed.—Perkins v. Trueblood, California Supreme Court, 181 Pac. 642.

Therapeutic Notes.

Chancre.

Lapere and Laurent find that intravenous injections of novarsenobenzol prevent the development of the syphilitic chancre, and cite cases of exposures to infection in which this post-prophylactic measure was successful. It is advisable to give several doses, though one may suffice. Very weak doses should be used at the start.

Intestinal Affections.

Following the work of Giani Moruzzi and Zoja, with the use, clinically and experimentally, of a serum peptone, fermented by the lactic acid bacillus, in the treatment of intestinal affections, Gpeza employed a liquid diet composed entirely of lactic lemonade according to the following formula:

Ox serum, 500.
Lactic acid, 14.
Sugar, 250.

Pneumonia.

H. J. Mathison recommends the administration of the following:

Potassium iodid, ʒj.
Creosote, fʒss.
Alcohol, fʒij.
Fld. ext. licorice, fʒiij.
Water, q. s. ad., fʒvj.
M. Sig.: One tablespoonful every four hours.

Pruritus Scroti.

Acid salicylic, 1 dram.
Bet naphthol, 1 dram.
Acid chrysophanic, 2 drams.
Paraffin molle, 2 ounces.

Make an ointment. First wash the scrotum with 2 per cent. solution of copper sulph., then apply the ointment.

Germicidal Value of Potassium Mercuric Iodide.—Douglas Macfarlan, in the American Journal of the Medical Sciences, submits experiments which go to show that potassium mercuric iodide is a powerful germicide which exhibits marked bactericidal efficiency in high dilutions. Organic matter diminishes its potency to a relatively slight degree. These facts, taken in consideration with its great solubility, its freedom from irritant action, and its comparatively low toxicity in the solutions efficacious for germicidal purposes, would seem to recommend this double salt of the iodides of potassium and mercury as the most desirable of the inorganic germicides.

Whooping Cough.—Dr. T. E. McMurray of Wilkinsburg, Pa., says:

Satisfactory and immediate results can be obtained in the treatment of whooping cough by the use of benzyl benzoate. The dose given was from five to thirty minims every four hours, depending upon results. In some cases decided improvement was noticed from the smaller dose, in other cases larger doses were employed. In almost every instance the treatment determined subsidence of the paroxysms. The effect usually made itself felt within for-

ty-eight hours and in one instance there was relief after the second dose.

Zinc Oxide in Diarrhea.—Drs. Durand and Dejust in Presse medicale, state that zinc oxide acts better than the astringent agents generally prescribed in acute diarrhea. Its effect is rapid and progressive, and is due to its precipitant action on mucin and serum albumin. It also possesses antispasmodic properties. Its beneficial effects are likewise exerted in mucous colitis. It acts well in combination with opium, in cases in which the latter is indicated owing to pain.

Chocolate and cocoa are exceedingly nutritious beverages, containing a large percentage of flesh-forming material. A very rich food is obtained when either of them is prepared with milk and then whisking in a raw egg.

The belief that fried or moderately greasy foods give the stomach appreciably more trouble than others has not been supported by experiments.

Hospitals; Sanatoria, etc.

Bridgeton Hospital.—This hospital reported for the month of August: Number of patients admitted, 52; operated upon, 31; died, 7; discharged, 51; remaining August 31st, 13. One birth during month.

Overlook Hospital, Summit.

Dr. Russell Beverley, a graduate of the University of Indiana, has succeeded Dr. Peter Noe as house physician at Overlook Hospital. Dr. Noe left a few days ago to enter private practice in New York State. Dr. Beverley comes to Summit from the Post-Graduate Hospital of New York.

Overbrook Hospital.

The hospital committee of the Essex Board of Freeholders gave Drs. Earl Snaveley and Robert Bolton, the two first assistant physicians the use of the warden's cottage, the office of warden having been abolished. The committee concurred in Dr. Payne's appointment of Dr. Fred Pringle as a resident physician to succeed Dr. John C. Hughes, who resigned several month ago.

State Hospital, Morris Plains.

The July report of this hospital shows: Remaining in hospital June 30th, 2,713; admitted during July, 63; discharged, 43; remaining July 31st, 2,733.

Salem County Memorial Hospital.

The following is the hospital report for the month of August: Patients in the hospital August 1st, 7; admitted during the month, 49; operations, 34; discharged, 51; births, 5; no deaths.

St. James' Hospital, Newark.

The executive committee has decided to begin an active campaign on October 10 to raise $200,000 for the St. James' Hospital.

Toms River Hospital.

The backers of the Toms River Hospital have received formal notice from the estate of Dr. T. J. Buchanan that the offer of $25,000 for the hospital property owned by the doctor would be accepted. The new corporation will float a bond issue of $25,000, to be known as "founders' bonds."

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, makes the following report for August: On August 1st there were 231 patients present in the Sanatorium, 118 males and 113 females. This number includes 37 males and 42 females in the Preventorium. During the month 33 patients have been admitted, 20 males and 13 females. Two of these admissions went to the Preventorium. Among these admissions there were seven re-admissions.

The admissions are classified as follows: Pretubercular, 5; incipient, 2; moderately advanced, 4; far advanced, 22. The largest number of patients at any time during the month was 240; smallest number 230; present August 31st, 233.

Paid Dispensary Service.—The time is coming, and may not be far distant, when hospital staff physicians will receive compensation for their professional services to so-called free patients, not because they have not given their best service in the past, but because the public demands a greater service than doctors are able to give freely and at the same time earn their livelihood. The patient who, by reason of circumstances, is obliged to seek free medical advice is entitled to the best treatment that can be provided, not alone for his own sake, but for the sake of the community, which is thus spared the danger from spread of disease, and from the necessity of caring for dependent individuals.—Lucy C. Catlin, The Hospital as a Social Agent in the Community.

Deaths.

BRADNER.—In the Presbyterian Hospital, New York City, August 31, 1920, Dr. Frederick Clark Bradner, of Hackensack, N. J., aged 45 years. Dr. Bradner graduated from the College of Physicians and Surgeons, N. Y. City in 1899. He was a member of Bergen County Medical Society and the Medical Society of New Jersey. He was a member of the medical board of the Englewood Hospital and one of the visiting surgeons. He was at one time a member of the Englewood Board of Health and city physician.

HAMILL.—In Summit, N. J., September 5, 1920, Dr. Robert H. Hamill, from bronchopneumonia, aged 65 years.

Dr. Hamill graduated from the University of Pennsylvania Medical School in 1878. For a short time he practiced in Philadelphia and

moved to Summit about twenty years ago. He gave up active practice a few years ago, excepting a few families whom he had treated many years. He was deeply interested in Overlook Hospital and took an active part in the campaign for funds to buy the institution from Dr. William H. Lawrence Jr. For several years he delivered the address at the graduating exercises of the Overlook Hospital Training School for Nurses.

He was a member of the Union County Medical Society and the Medical Society of New Jersey and a Fellow of the American Medical Association.

STOUT.—In the Memorial Hospital, New York City, September 7, 1920, Dr. Stephen V. W. Stout of Jersey City, N. J., aged 74 years. He graduated from the College of Physicians and Surgeons, New York City, in 1868. He was County Physicians of Hudson County from 1873 to 1876 and was a member of the New Jersey Assembly in 1898.

WHITNAUL.—At Basking Ridge, N. J., Sept. 15, 1920, Dr. Horatio G. Whitnaul. He was at one time chief surgeon of the Union Army during the Civil War. He lived at Basking Ridge about fifty years, going there from Morristown where he lived after the war. He was a graduate of the New York University Medical Department and was for a few years a member of the staff of the Nashville (Tenn.) Hospital.

IN MEMORIAM.

Victor Parsonnet, M. D.

A tribute by Charles A. Wallenstein, M. D., a Friend.

On Tuesday morning, July 20th, 1920, Dr. Victor Parsonnet died suddenly at the Newark Beth Israel Hospital—an institution of which he was one of the founders. His death was due to heart disease.

By his death the Newark community lost one of its leading and most enlightened citizens; the profession of medicine, one of its ablest surgeons and noblest members; the people of Newark a true friend and an unselfish servant. The poor, the humble loved; for them he worked; for them he sacrificed his personal comfort, his health, his life! They—the poor, the unfortunate—sustained the greatest loss through his untimely death.

Victor Parsonnet was born December 15, 1871, at Balta, Province of Podol, Russia, and came to this country at the age of nineteen. He attended the Gymnasium at Odessa for eight years. Soon after completing his preliminary education he came to the United States.

He intended at first to enter the legal profession and accordingly matriculated in the law department of Boston University, where he studied law for a year and a half. But it seems that the profession of medicine had greater attraction for his gentle nature. He began his medical studies at Tufts Medical College, remained there for one year and then entered Long Island Medical College and Hospital, from which school he graduated in 1898. After an internship in the Women's and Children's Hospital of Newark, he entered the practice of medicine.

At the time of his death, Dr. Parsonnet was reputed to have had one of the largest practices in the City of Newark. He specialized in gynecology and was attending surgeon to Beth Israel Hospital and president of its medical board. He was a member of numerous medical associations, including the Essex County Medical Society, the Medical Society of the State of New Jersey, the Academy of Medicine of Northern New Jersey, the Association of Newark Physicians, etc.

He leaves a widow, Augusta Parsonnet, and three sons, Eugene, Thomas and Marion.

Victor Parsonnet was a man of exceptional qualities, as all who knew him will bear testimony. Endowed by nature with a handsome physique and magnetic personality, one felt himself irresistibly drawn to the man. But it was only after closer acquaintance that one really appreciated him. Of brilliant mentality, well informed on all subjects whether they pertained to medicine, art, music, statesmanship or political economy, it was a pleasure and delight to engage him in conversation.

A splendid surgeon, he was withal conservative in the handling of his cases. Tactful by nature, his very presence in the sick-room had a soothing influence upon the patient and imbued him with the confidence so necessary for his recovery.

In their great bereavement, may his wife, who loved him dearly, and his children, who adored him, take comfort from this: That he lived his life for his fellow men! That their sorrow is shared by thousands who 'knew him but to love him.'

Probably the sincerest and most spontaneous tribute that I have seen paid to any man was given him at his funeral. The streets were lined for blocks and blocks by those who knew him, by those who loved him and those he

had befriended. When the body was carried out, a sob, a moan went up from that vast throng that lasted until the hearse passed on. It was a cry of anguish from the heart.

Victor Parsonnet! How little can cold point do justice to your memory! Cut off in your prime, at the acme of your usefulness, who knows to what even greater heights you may yet have attained. Only too well have you fulfilled the noble task allotted to you. "Faithful unto death," your deeds speak for you. You have sacrificed your very life on the altar of duty. May you rest in peace!

"His life was gentle, and the elements
So mixed in him that Nature might stand up
And say to all the world, 'This was a man!' "

Doctors Nominated at the Primaries.

Congress—2nd district, Dr. William E. Jonah, Democrat, Atlantic City; 3rd district, Dr. William E. Ramsay, Democrat, Perth Amboy; 11th district, Dr. Archibald E. Olpp, Republican, West Hoboken.

State Senate—Dr. Thomas Barber, Warren County.

Assembly—Dr. H. M. Fooder, Republican, Gloucester County; Dr. John A. Connolly, Democrat, and Dr. Clinton H. Read, Republican, Mercer County; Dr. L. F. Meloney, Democrat, Passaic County.

Mayor—Dr. Elias M. Duffield, Republican, and Dr. Charles D. Pedrick, Democrat, Glassboro.

Personal Notes.

Dr. Elvira Dean Abell, Morristown, attended a clinic on x-ray work in Minneapolis, Minn., last month.

Dr. Julius A. Caldwell, Montclair, will act as medical director of the Montclair Infant Welfare Station and Clinic, in place of Dr. Elizabeth Marcelis, who has resigned.

Dr. William S. Colfax, Pompton Lakes, took a trip through Massachusetts last month.

Drs. W. Leslie Cornwell and W. P. Glendon, Bridgeton, and Harry E. Lore, Cedarville, spent two weeks last month in an automobile trip to Gettysburg and other Pennsylvania towns.

Dr. Morgan D. Hughes, Bloomfield, has returned from a month's stay in Maine.

Dr. Arthur L. Smith, New Brunswick, and family spent two weeks last month at Cape Cod, Mass.

Dr. Elber B. Peace, Florence spent some days at Port Norris last month, owing to the illness and death of his father there.

Dr. Richard G. Savoye, Westfield, and wife spent a month at Harvey Cedars.

Dr. Charles M. Williams, Washington, and wife spent two weeks in Delaware last month.

Drs. Charles H. Jennings, Merchantville, and W. A. Westcott, Berlin, were drawn on the Camden Grand Jury last month.

Dr. James P. Schureman, New Brunswick, and family returned recently from West Hampton Beach, L. I., where they spent some weeks.

Dr. Ernest Tutschulte, Newark, and wife returned last month from a three months' stay at their summer home at Walton Lake, Monroe, N. Y.

Dr. John E. Anderson, Nashanic, and wife spent two weeks last month in Berwick, Pa.

Dr. Norman N. Forney, Milltown, recently returned with his wife from a motor trip to New York State.

Dr. Charles D. Pedrick, Glassboro, has been appointed medical examiner of the Glassboro public schools for the ensuing year.

Dr. Mefford Runyon, South Orange, and wife recently returned from their vacation stay in Northern New York State.

Continued on page XXI.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed.	Failed
Alabama, July	28	27	1
Arizona, July	8	7	1
California, Feb.	44	26	18
Dist. Columbia, July	26	24	2
Georgia, June	52	46	6
Kansas, February....	8	6	2
Louisiana, June	71	69	2
New Mexico, July...	3	3	0
Virginia, June	49	46	3

The New Jersey Board of Medical Examiners will meet in Trenton, October 19 and 20, 1920. Secretary, Dr. Alex. MacAlister, State House, Trenton.

Public Health Items.

Bridgeton and Millville Health Reports.

Bridgeton had a clean bill of health for August so far as contagious diseases were concerned except for three cases, one of tuberculosis and one of whooping cough, this remarkable record being brought to light at the September meeting of the Board of Health.

Millville's health officer reported for August as follows: Scarlet fever, 4 cases; tuberculosis, 1; diphtheria, 1; whooping cough, 1; typhoid fever, 1 case; inspected 110 places, fumigated 6 places.

Newark Health Report.—The report of the city Board of Health for August shows. 363 deaths as against 399 same month, 1919; the death rate was 10.5 per 1,000 population; among death causes were: Tuberculosis, 32 cases; cancer, 29; apoplexy, 19; pneumonia, 17; diarrheal diseases, under 5 years, 44; Bright's disease, 28; puerperal diseases, 9.

Health Week in Sussex.—The New Jersey Tuberculosis League has began plans to hold a health week in Sussex County, beginning October 12th. The high rate of infant mortality in the county as shown by a recent survey of health conditions there led to this result.

Sickness and Poverty.—So much of destitution is due to sickness that the separation of the two problems is inconsistent with success. "One third of all the paupers are sick one-third children, and one-quarter either widows encumbered by young families, or certified lunatics." There are economic causes of poverty apart from sickness, but it is essential to remember that every disease which is controlled frees the community not only from a measurable amount of sickness, but from the amount of poverty implied by this sickness.—Arthur Newsholme, Commonhealth.

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HEART IRREGULARITIES; THEIR CLINICAL RECOGNITION AND INTERPRETATION.*

By Charles E. Teeter, M.D., F.A.C.P.,
Newark, N. J.

Irregularities of the heart, due to recent advances, have come to assume a good deal of importance, and medical literature is crowded with material from which it is increasingly difficult to separate that which is essential and important, from that which is non-essential and relatively of little importance. It is my purpose in this paper to attempt from this mass of literature to select and elucidate the particularly important clinical diagnostic criteria by which each form of irregularity may be recognized and differentiated one from the other, as well as to indicate their symptoms and their relative degrees of importance; this to be done in as practical a manner as possible.

For a great many years attention had only been paid to heart murmurs, analyzing, classifying, differentiating them, their direction of transmission, whether systolic or diastolic in time, and whether they were loud or soft. If there was an arhythmia present, it was merely stated that the heart was irregular. It was only when Mackenzie, a general practitioner in a small city in England, conceived the idea that a study of the jugular pulse in reference to the radial or apex, in cases of arhythmia might furnish valuable data for classification, and later intelligent treatment of these obscure conditions that a more scientific study of heart irregularities began. His work was materially aided by his improvement of the polygraph.

*Read at the 154th Annual Meeting of the Medical Society of New Jersey, at Spring Lake, June 15, 1920.

To those of us who have practiced medicine for the last twenty years and have followed the progress of cardiac physiology and pathology, this subject has a fascinating interest. We have lived through the period when the knowledge and meaning of heart irregularities were totally unknown, to the time when Mackenzie's epoch-making discoveries began to clear many of the obscurities from the path, to the crowning period when the mystery was solved. In the words of Mackensie, "The study of heart irregularities is of the greatest service, as their presence is easily detected and their significance has never been fully understood, a close study of irregularities throws an unexpected light upon the functional derangements of the heart, and affords grounds for an intelligent diagnosis upon which a rational treatment and prognosis can be based," and again, "an irregular heart may be evidence of a profound and fatal exhaustion, or it may be a perfectly normal sign."

In order that we may approach the subject in as orderly a manner as possible, we must first take up briefly the anatomy and physiology of the conduction apparatus of the heart.

The cardiac muscle differs morphologically from ordinary muscle fibre both voluntary and involuntary elsewhere in the body, and this difference is associated with difference in physiological action. Stimulation of a voluntary muscle is followed by a contraction, and the amount and force of the contraction depends on the amount of the stimulus. With the heart muscle on the other hand, the reaction has no reference to the amount of the stimulus, also when the stimulus is started and the muscle begins to contract, the contraction becomes complete before any amount of stimulus will

start a new contraction. At complete systole, the heart is insensible to stimulus and most susceptible during and at the end of diastole.

In 1883 Gaskel, working with the heart of the tortoise, saw that the primary movements started at or near the great veins. Between that time and 1907, when Keith and Flack made the discovery that histologically a specialized tissue could be seen in this vicinity, many observers corroborated the findings of Gaskel.

The wave of contraction of the heart starts in the region of the great veins and travels from the auricles to the ventricles. The Node of Keith and Flack is situated at the junction of the superior venae cavae and the right auricular appendix. The impulse begins here and travels through the auricular musculature by paths, which as yet have not been definitely isolated, to the Node of Tawara. The Node of Tawara is situated on the right side of the interauricular septum close to the anterior edge of the coronary sinus and immediately above the insertion of the median cusp of the tricuspid valve. The fibres as they leave the node are collected together into the auriculo-ventricular bundle of His, which passes forward in the interauricular septum, and turns abruptly downwards to the interventricular septum and divides into two branches, one to the right and the other to the left ventricle, to terminate in a network covering practically the whole of the endocardial surface of the ventricles. These aborization fibres are known as the fibres of Purkingie. The sino-auricular node contains many ganglionic cells which are connected with the vagus and the sympathetic system. The auriculo-ventricular node contains many fibres but no ganglionic cells. At the present time it is believed that the rhythmic contractions of the heart depends on the integrity of these primitive tissues, and it has been definitely shown that disease or destruction of the connecting fibres is followed by a delay or obstruction of the impulse which extends from the auricles to the ventricles, in other words, heart block. All normal stimuli arise in the sino-auricular node, it is therefore called the pacemaker of the heart.

With this general statement by way of introduction we first take up the simplest form of irregularity, sinus arhythmia or the youthful heart of Mackenzie, characterized by periodic slowing and increase in rate. The cardiac arhythmias in children are confined largely to those alterations in rhythm which are governed by the rate of stimulus production in the sino-auricular node. Its function is stimulated or depressed by the extra cardial nerves, the vagus and the sympathetic. Of these arhythmias the simple respiratory form is the most common. Experimental evidence proves that fear, anger, the act of swallowing, deepened respiration may so affect the vagus as to produce this form of arhythmia. There is a delicate balance between the vagus and the sympathetic, and when the balance is disturbed sinus arhythmia is produced." In the most outspoken form there is a quickening of the pulse during inspiration and a slowing of the pulse during expiration, occasionally this condition is reversed. Perhaps 90% of the irregularities in children are of this type.

This form of arhythmia is easily recognized by palpation of the pulse or by auscultation of the apex. Polygraphic tracings of the jugular show that the auricle participates in the irregularity as does the ventricle. It is of importance that this condition be recognized as much needless alarm may be occasioned by its presence. Again when it appears after a febrile disease, and, when particularly, that febrile disease happens to be rheumatism and if associated with a systolic murmur, it has often been looked upon as an undoubted affection of the heart. Mackenzie states "He has come to the belief that the presence of this form of arhythmia is evidence that the heart has escaped infection when the rate is low, 70 to the minute, for the reason that when this arhythmia is present the heart is free from excitation. It is only at this time when the vagal effect, which produces this type of arhythmia is capable of acting, for any form of excitation removes the influence of the vagus. If the heart slows down and this type of irregularity appears, we then know that the heart has escaped infection."

The second most common form of irregularity are the extrasystoles. They may arise from impulses generated in the auricle or in the ventricle, or they may arise from impulses in the Node of Tawara.

Extrasystoles are usually easily recognized by auscultation, the regular sequence of events is interrupted by two

short sharp sounds followed by a long pause, the time consumed by the two sounds and the pause should equal exactly the time of two normal heart beats in ventricular extrasystole. On palpation of the radial, the pulse seems to miss a beat as the extrasystole is often of insufficient force to reach the radial. An extrasystole can then usually only be diagnosticated by auscultation at the apex or, of course, by graphic methods. It is to be differentiated from the dropped beat of partial heart block, where at the apex the beat drops out entirely.

Extrasystoles may or they may not mean grave cardiac trouble. An extrasystole does not mean more beats than normal, but it does mean a beat whose origin is not in the normal situation at the sino-auricular node, but in some other part of the cardiac musculature, which for some reason has become sensitive. The reason for the long pause, which follows the premature beat, is that the normal impulse which comes down from the sino-auricular node reaches the ventricle in the refractory period of the muscle wall and no contraction results.

When an extrasystole arises in the auricle the same succession of sounds occur at the apex and the features of the radial pulse are the same, and it is only by a simultaneous tracing of the jugular and the apex can the origin of such an extrasystole be determined. In Nodal extrasystoles the auricles and the ventricles contract prematurely and together. They can only be recognized by polygraph or electrocardiagraphic tracings.

Extrasystoles may be present at all ages, rare before 20, increasingly frequent up to 40, very frequent between 40 and 50 and in almost everyone over 60. In rheumatic affections of the heart after the acute stage is passed and where the heart muscle has been affected, extrasystoles are very common. Indiscretions in diet or drink and the abuse of tobacco may occasion them. Digitalis frequently produces them particularly in those cases where the heart is slowed in cases of auricular fibrillation.

"Extrasystoles in themselves are not signs of any specific injury to the heart, nor should a prognosis of gravity be based on their appearance alone, also they are no signs of special significance as far as the efficiency of the heart is concerned. Where there is heart failure it will always be found that there is other evidence present and the prognosis can be based on that other evidence. It may, therefore, be stated that when the extra systole is the only evidence the prognosis is good and when there are other evidences the prognosis must be based on that other evidence." Therefore to regard the presence of extrasystoles except in acute infections as an indication for the administration of heart remedies is a grave therapeutic blunder. The attitude should be expectant, and if indications arise, the institution of such measures as will relieve the cardiac embarrassment in a heart perhaps more prone to damage.

The Alternating Pulse is a term applied to an irregularity in force of the heart beats, each second beat varying in strength, a strong beat alternating with a weak beat. The rhythm is perfectly regular. It is recognized by graphic tracings of the pulse, or by the sphygnomanometer, when it is found that at the maximal blood pressure one-half of the apex beats will go through, by reducing the pressure a point will be found when all of the apex beats will go through; in other words there is an irregularity in force where with each alternate beat the blood pressure is higher than each succeeding beat. If a systolic murmur happens to be present at the apex, the variation in intensity of the murmur can often easily be noted at each succeeding beat.

This condition was first described by Traube in 1872, no other case was reported until 1892 when Sansom in his book on the "Heart and Aorta" refers to a case of cerebral hemorrhage, with Cheyne Stokes breathing where typical alternation of the pulse occurred. Rihl, in 1906, reported four cases of clinical alternation, all accompanied with chronic myocarditis, arterio-scerlosis and hypertension; autopsy showed marked myocardial changes. In 1905 Vollard discussed pulsus alternans and published two cases, one a case of mitral stenosis, and another a case of chronic Bright's disease, both died in a few weeks. Engleman has shown by experiments on animals that alternation is due to a defect in contractility and not conductivity.

Mackenzie explains the alternating pulse as follows: "When contractility is depressed, if time be allowed for a full and strong contraction, the longer duration of contraction encroaches on the period of rest, so that by the time that the

next impulse arrives, the contractility has not sufficiently recovered and the smaller and shorter beat is the result, as this contraction is shorter in duration, the period of rest is increased before the next stimulus arrives, so that this contraction is stronger and larger, being larger it will again encroach upon the period of rest and the process of alternation goes on."

Alternation indicates exhaustion of the heart muscle. Temporary exhaustion often occurs with the production of typical pulsus alternans in any disease producing exhaustion of the cardiac musculature, as in pneumonia or other infectious disease, or in paroxysmal tacchycardia, auricular flutter, or fibrillation, or in the long continued tacchycardia accompanying Graves' disease. It most frequently occurs where the heart is beating at a normal rate, and it denotes a grave pathological condition of the myocardium with failing contractility. Most of the cases have occurred in cases of general arterio-sclerosis and hypertension associated with chronic nephritis. It frequently comes on during a period of Cheyne Stokes respiration and continues till the fatal end. It is not uncommon in the greatly dilated heart of mitral stenosis, or insufficiency, where decompensation has set in. It also occurs during or directly after recurring attacks of angina.

Pulsus alternans is a sign of grave prognostic import in cases which have suffered grave myocardial changes from a variety of causes. Its existence indicates a heart hardly able to perform its function even under the most favorable conditions. To quote Lewis, "It is the faint cry of an anguished and fast failing muscle, which when it occurs, all should strain to hear, for it is not long repeated, a few months, or a few years, and the end comes." Mackenzie and Windle both state that with the inception of the alternating pulse in elderly people the duration of life has invariably been not more than two or three years. I have observed alternation at the beginning of pneumonia, and in one case the difference in blood pressure between each succeeding beat was as much as 60 mm. of mercury. This patient recovered from her pneumonia, and the alternation disappeared.

The alternating pulse is to be distinguished from the bigeminal pulse. In the reguarly recurring extrasystoles of the bigeminal pulse, the pause following the small beat is of longer duration, while in the alternating pulse the beats are equidistant from each other, or the longer pause follows the large beat.

Heart Block consists of a defect in the conduction of the impulse from the auricles to the ventricles. The excitation wave may be blocked in any part of its course. If the impulse is blocked in the sino-auricular node, the auriculo-ventricular node, or in the bundle of His, where only one path is available, the result is a dropped beat. Sino-auricular block is due to a blocking of an excitation wave in the node itself, or between the node and the muscle of the auricle. There is no evidence of auricular activity, and the heart comes to a complete standstill for a period of one or more cardiac cycles. Where the block is in the node of Tawara, or in the main stem of the bundle of His, the result is complete heart block or complete dissociation between the auricles and the ventricles. In such a condition the ventricle takes up a rate of its own, usually about 30 to the minute. This condition of the ventricle is known as idio-ventricular rhythm. When the block is complete, the rate is not changed by exercise, vagus pressure, or by atropine.

Heart block may be functional or organic; functional due to disturbed function, as from digitalis or any thing increasing the activity of the vagus. Functional heart block is usually relieved by the use of atropine, which increases the conductivity of the bundle of His and paralyzes the terminal filaments of the vagus in the heart. Organic heart block occurs as the result of degenerative changes along the course of the primative tissues, as from acute infections, rheumatism, pneumonia, influenza or sclerotic or calcific degenerative changes, or gumma along the bundle, or in Tawara's node.

Sino-auricular block is usually ascribed to a vagus influence acting on the sinus region of the heart in which lies the pacemaker. Sino-auricular block is usually of no particular consequence as the functional power of the heart is rarely lessened. I have had a case under observation for the last five or six years, which presents frequent periods when sino-auricular block begins, and in a varying period the normal rhythm is resumed. Another case of complete heart block, when there are periods in which the auri-

cular rate corresponds to the ventricular rate, thirty to the minute.

Partial heart block is rather frequent and is characterized by a period of a dropped beat. Following a series of regular heart beats, one beat will be completely dropped out, it is best ascertained by auscultation of the apex. It is to be distinguished from an extrasystole, because the pulse characteristics may be similar, the extrasystolic may be too weak to reach the radial. Auscultation of the apex will easily differentiate them. In a dropped beat, the beat drops out completely; in extrasystole you hear a beat, then an early short beat like a click, then a long pause. This is very important as one usually means nothing while the other is serious.

In complete heart block the ventricular rate may and usually is perfectly regular, but very slow, about thirty to the minute, and frequently in the neck the veins can be seen pulsating rapidly, showing that the auricles are contracting at a rate much faster than the ventricles. In complete heart block where the rate falls unusually low, there may be attacks of syncope, due to anaemia of the brain from slow heart action. This condition is known as Stokes Adams syndrome. Heart block may occur without the Stokes Adams syndrome, and usually when the heart block becomes complete, attacks of syncope are much less frequent or disappear.

In acute infections, as pneumonia, or rheumatism, or influenza, the occurrence of dropped beats from depressed conductivity, indicated that the myocardium is being invaded; also in the administration of digitalis the presence of these dropped beats indicates that a sufficiency of the drug has been administered, and it should be stopped at once.

In complete heart block a person may live some years. I have had a case under treatment where the block has been complete for four years, and another case of Stokes Adams disease of three years' duration, and beyond a limitation of their physical activity, the patients are in fair health. It is a serious disease, however, and indicates grave myocardial changes.

In these days when digitalis is given so freely, and in such large doses, it becomes increasingly important to recognize the character of the arhythmia produced when a sufficiency of the drug is given.

This is usually of two types:

1. There is the dropped beats produced by depression of conductivity, the result of the action of digitalis on the bundle of His, and also its effect of stimulating the vagus. If the digitalis is pushed complete heart block is produced.

2. The production of regularly recurring extrasystoles, as in the bigeminal pulse, first a strong beat then an early weak beat, then a long pause; the weak beat is usually of insufficient force to reach the apex, therefore the radial pulse is half the apex rate.

This condition is of considerable importance. I have seen in cases of pneumonia and in cases of cardiac decompensation, the occurrence of this rhythm occasion the greatest alarm on the part of the attending physician. Should this rhythm supervene, a hypodermic of atropine, which paralyzes the terminal filaments of the vagus, and increases the conductivity of the bundle of His, will destroy the block. The digitalis, of course must be discontinued.

Paroxysmal Tacchycardia is an affection of the heart characterized by attacks of great rapidity, beginning suddenly and terminating abruptly. There are usually two types:

1. Where the rhythm is regular. 2. Where the rhythm is irregular. The heart rate usually increases suddenly, and the attack may last a few minutes, or a few hours, or several days. If it lasts only a few hours there are usually no special symptoms beyond a fluttering in the chest, but if the attack progresses, and, after lasting several days, there are usually some signs of cardiac failure such as dyspnoea, rales at the bases, cyanosis, increase in size and tenderness of the liver, perhaps some oedema of the feet, and albumen in the urine. It is often surprising how long an attack may last without any evidence of heart incompetency developing. I have under my care a lady, who has had several attacks of paroxysmal tacchycardia with a ventricular rate of 200 to 250, and lasting often for from one to two weeks, without symptoms other than occasional vomiting and great prostration. Her attacks end with an attack of syncope, when her pulse rate drops to normal. When her pulse rate is normal a presystolic murmur and thrill can easily be made out. Another case, however, within a few hours after her attack would begin, her con-

dition would become desperate, she would become cyanosed, her liver would enlarge and a large amount of albumen would appear in her urine. A prompt phlebotomy always relieved her, although it would not necessarily stop her tacchycardia.

In paroxysmal tacchycardia the pacemaker is no longer situated at the sino-auricular node, but some other part of the auricular musculature has become sensitive, and by reason of its increased irritability has for the time being assumed the role of pacemaker. One should be exceedingly guarded in prognosis in cases of paroxysmal tacchycardia, for a case may look exceedingly desperate, and yet in a few minutes the attack may cease and the patient recover very quickly. Lewis has called attention to the fact that in cases of paroxysmal tacchycardia effort does not increase the ventricular rate, while in case of palpitation it does, and Mackenzie has made the statement that he believes most cases of paroxysmal tacchycardia will turn out to be cases of auricular flutter when the heart is regular, and auricular fibrillation when the rhythm is irregular.

Auricular Fibrillation is a type of irregularity characterized by an irregularity in force of each ventricular contraction, and an irregularity in rhythm. 60% of all cases of cardiac failure are due to this type of arhythmia. It is the most common kind of irregularity in failing hearts, accompanied with oedema, and other evidences of heart failure. It was first described by Lewis, and also Rothberger and Winterberg, who showed that electrocardiagraphs from dogs whose auricles were induced to fibrillate by the electric current, were the same as in human beings with this type of irregularity. The first work was done by Mackenzie in 1890. The pulse beats are exceedingly irregular, no two beats being equally spaced, also there are many apex beats which do not go through to the radial, so there is a large pulse deficit.

Auricular fibrillation occurs in two types of heart conditions: 1. Rheumatic diseases of the heart, and particularly mitral stenosis. 2. In the senile heart, that is, chronic fibroid degeneration of the heart muscle, as seen in arterio-sclerosis and kidney disease, and associated with hypertrophy and dilatation.

This condition may be transient or it may be continuous. Transient usually in acute conditions as in pneumonia, diphtheria, and it may also occur in digitalis poisoning; in this latter instance the rate is always slow. Attacks of paroxysmal tacchycardia, where the rhythm is irregular, may be due to attacks of auricular fibrillation. When fibrillation begins, in cases of mitral stenosis, the presystolic murmur usually disappears, but a diastolic murmur, due to the blood rushing from the auricles to the ventricles, may still be present.

In auricular fibrillation the auricles do not contract, but remain in the position of diastole. To the gross appearance, the auricle seems to be inactive, but, on careful examination, the muscle is seen to be twitching or jerking, and the auricle seems to be alive with movement, but not regular or orderly. Some of these irregular movements are of sufficient force to be carried through to the ventricle and produce the irregular and disordered action of the ventricles. The pathology is not clear, but it is due to some disturbance of the auricular tissue, and when the condition sets in it is apt to be permanent.

The recognition of this form of irregularity is of much importance, as it presents positive indication in cases of heart failure for the use of digitalis, and it is in this form of irregularity in failing hearts where digitalis medication gives its most brilliant results. Auricular fibrillation is not necessarily a sign of heart failure, however, as this type of arhythmia may exist in cases of mitral stenosis for many years without evidences of heart incompetency. It is particularly to be noted, however, that hearts with mitral stenosis and presenting this type of arhythmia are apt to embolize, so that one should prepare the friends of such a patient for such a contingency,

In cases where digitalis produces complete heart block, or in cases of complete heart block from other cause, the auricles may be fibrillating and yet the ventricular rate and the pulse rate may be slow and regular. The diagnosis is made on the fact, with the exception just noted, that the pulse is grossly irregular, irregular in force and irregular in rhythm. Irregularity in rhythm can be determined by palpating the radial, irregularity in force can be determined with the sphygnomanometer, where the systolic readings of blood pressure are very variable. This condition can only be mistaken for

frequent occurrence of extrasystoles making the pulse very irregular, and very infrequently the sino-auricular node gives forth impulses irregularly, so distorting the rhythm as to resemble this form of irregularity. 95 out of every hundred cases of grossly irregular pulse are cases of auricular fibrillation.

In auricular fibrillation exercise always makes the irregularity worse, while in the extrasystolic form of irregularity, exercise makes the heart more regular. A rate of 120 in an absolutely irregular pulse nearly always means fibrillation, and when the heart rate under treatment slows in auricular fibrillation, the irregularity is less marked, while in other form of irregularity the irregularity seems worse. In the sino-auricular form graphic methods will be necessary to differentiate them.

Auricular Flutter is a name arbitrarily given by MacWilliams to a condition of the auricles where they move at an extremely rapid rate. He produced it in animals by electric stimulation. In 1908 Hertz and Goodhart reported a case in the human subject, where the auricles were beating at a rate of 230 to the minute, while the ventricles were beating at 80. Jolly and Ritchie applied the term auricular flutter to those cases of rapid auricular contractions, where they contract from 250 to 350 times to the minute, associated with partial or complete block, so that the ventricular rate was much slower. Summaries of these cases with new ones have been reported by Lewis in 1912, and more recently by Ritchie in 1914. At present this cardiac condition is well recognized as a clinical entity, and appears in modern text-books on the Heart, such as Lewis, "Clinical Disorders of the Heart Beat"; Cowans, "Diseases of the Heart," and Mackenzie "Diseases of the Heart," etc.

Flutter is caused by foci of stimuli in the walls of the auricle outside of the normal pacemaker at the sinus node. Causes: 1. Infections causing local injury as pneumonia, diphtheria, endopericarditis, and also in chloroform poisoning. 2. General or local myocardial degeneration, as in hypertension, valvular disease and in goitre. 3. Local malnutrition of the auricular wall, as in coronary sclerosis. It occurs four times as frequently in men as in women, and usually between 40 and 60, and it may be transient or continuous.

Symptoms. The symptoms vary with the length of the attack and the amount of the cardiac damage which existed prior to the attack, usually palpitation, breathlessness, flatulence, pallor, vertigo, polyuria, faintness and syncope come on as the attack progresses, though sudden relief may come on at any time if the attack ceases.

Chronic flutter is important to recognize, as the condition can usually be relieved by the administration of digitalis; in the process of relief under digitalis, the auricles usually go into a condition of fibrillation, and then return to their normal rhythm.

The most constant symptom of chronic flutter is obscure tacchycardia and weakness. Rapid regular venous pulsations in the neck usually suggest this condition, and any patient more than 30 who has tacchycardia unaccounted for, and particularly if he is subject to weak spells, should be under suspicion. There is apt to be present some form of heart block, because the ventricles do not respond to each auricular contraction, and usually the ventricular rate has some definite relation to the auricular rate as 2-1, or 4-1, or 6-1, or occasionally 3-1, or 5-1. Stimulation of the vagus, by pressure or otherwise, may slow the ventricular rate, but will not have any effect on the rate of the auricles, contrasting strongly with auricular tacchycardia, where vagus pressure will restore the normal sinus rhythm.

Ritchie states that whenever a patient complains of sudden attacks of palpitation and dyspnoea, with or without precordial pain, syncope, or other symptoms, and the pulse rate during the attack attains or exceeds 130 to 140 to the minute, auricular flutter should be thought of, if the pulse is perfectly regular the attack is very probably flutter, moreover if the pulse rate while under observation and while giving digitalis, suddenly falls one-half while the rate is perfectly regular, it is almost certainly flutter.

Again, if under slight exercise the rate is suddenly doubled it is most suggestive. Positive diagnosis can only be made by graphic methods.

In conclusion, an attempt has been made, first to bring out the important facts concerning the usual forms of heart irregularities, and second, the fact, that many of the various types can be approximated by the usual bedside methods and without elaborate apparatus, for

many of these cases are bed cases, acutely ill, where elaborate apparatus may not be available.

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DISCUSSION.

Dr. Henry Wallace, Glen Ridge: I should like to express here my appreciation of Dr. Teeter's very complete and scholarly paper. Before the meeting I asked the doctor for a suggestion as to my part in the discussion and he said, "Give them a few words upon the electrocardiograph." I have passed around among you samples of curves taken in my laboratory at the Mountainside Hospital, Montclair, with a Hindle electrocardiograph. They show normal curves and a variety of cardiac irregularities. I am sorry not to have included one showing "auricular flutter," a condition in which though the ventricles may be beating one hundred times to the minute, yet the auricles are contracting three times this rate. It is a form of heart block, possible of conversion into auricular fibrillation by digitalis medication after which some cases have returned to the normal rhythm. There should be no misunderstanding as to value of the electrocardiograph or the status of the laboratory in the study of cardiac cases. Dr. Teeter has demon-

strated in a very practical way his interest in and a careful study of the subject. He has worked with a polygraph, has acquainted himself with cardiac mechanics and when the time comes for him to add an electrocardiograph to his equipment he will be more than delighted. Laboratory findings form one leg of a "diagnostic tripod," the other two being the anamnesis and the clinical examination. To be sure any two of these legs may suffice to make a fairly accurate diagnosis in any given case, but when we get all three in conjunction we have a very firm foundation on which to base an opinion. I lack the time to discuss the advantages of the electrocardiograph over the polygraph.

The former records photographically by the deflections of a galvanometer string electric reactions taking place in various sections of the heart, while the latter records graphically synchronous impulses at the jugular bulb and radial pulse. The electrocardiographic curve records the passage of an electric current which starts at the point of greatest negativity in the heart, the "sinus node" and which travels rapidly over the auricular surface and down the "Bundle of His" to the "Node of Towara" and thence by the right and left branches to the ventricular masses. Disease may produce what we call a "block" at any point along this so-called "conduction system." Speaking of heart block, have any of you heard the auricles beat? I had the good fortune to do so in the case of an old man with total heart block in one of MacKenzie's wards in the London Hospital, some seven years ago. His pulse rate was twenty-eight or thirty to the minute and between the ventricular sounds could be heard at times the auricular contractions. He was very comfortable and I think was retained in the hospital as much for the benefit of medical students as his own welfare. The study of such cases is most fascinating and were groups of men to add an electrocardiograph to their laboratory equipment they would find that they had added a great stimulus to their study of cardiac cases. By this means, and by this means alone, would they be able to thoroughly comprehend the various arrythmias, recognize many times myocardial changes otherwise unsuspected, study the effects of digitalis medication and thus be enabled to more scientifically and intelligently treat their cardiac and cardiovascular cases.

Dr. George H. Lathrope, Newark: Dr. Teeter has presented an extremely important paper, and I think that one of the very essential points that comes from it is this: That it centers our attention upon the heart muscles, and in contradistinction to the heart valves. The heart muscle lesion is always the **sine qua non** of any case of cardiac failure. I do not believe that there are any exceptions. Any of the autopsies you see on cases of cardiac failure will show very definite lesions in the heart muscles, as well as the associated lesions in the values. I do not believe that patients die of valvular lesions **per se.** They die of a weakened heart muscle, which is not able to compensate for the valve lesion. We have too long had our attention centered upon murmurs and the interpretation of murmurs as applied to the flow of blood through the heart. A valve may be widely opened, and yet the heart be doing fairly competent work; because the muscle is still in good condition and able to make up for the increased burden that the back flow of blood puts on it. When the muscle begins to weaken, we commence to get signs of failure. It is a study of just these cases by means of the electrocardiograph, and the polygraph which is going to help us in the future to get a better notion of the symptomatology and pathology of the heart muscle conditions.

With regard to treating these conditions, as in treating any cardiac condition, when one makes a diagnosis of a heart muscle or heart valve condition, the first thing to bring into play is not digitalis, but common sense, and that can only be brought about through a careful interpretation of the patient's history. I believe that a careful history with regard to heart cases is of more importance than the rest of the examination, because from that you learn just what that particular patient can do with that heart. Your instrumental methods do not tell you anyhing about that, and your exercise test is often very faulty; but a close watch of the patient over a period of some time and a careful history of what he is and is not able to do, should be the things on which our treatment is based.

Just one other point regarding treatment: I think that all of these irregularities which crop up, especially where they have not lasted very long, indicate damage to the heart muscle somewhere. If you can remove the thing that is causing that damage, for example, a focus of infection, and do it fairly promptly, you may be able to clear up the whole condition before you have actual gross changes in the heart, or while there is still a chemical process going on, a poisoning of the muscle.

Hyman I. Goldstein, Camden, N. J.: Dr. Teeter has given us a very valuable paper and merits discussion. There are only two electrocardiographic stations, as far as I know, in this State. None in South Jersey. There are as yet, very few men expert and efficient in electrocardiographic work. The complete outfit is expensive. I would urge the group acquisition of apparatus for electrocardiography, ortho-diagraphy, for basal metabolism studies, etc. Dr. P. Ribierre of Paris states that in all Paris there are only two public hospitals now equipped for electrocardiography. Medical societies might acquire equipment of this kind in smaller cities for the use of hospitals and physicians.

There are only three or four heart stations with complete outfits in so large a city as Philadelphia,—Presbyterian Hospital, University of Pennsylvania, Jefferson, Pennsylvania Hospital, and a well-known clinician in Philadelphia had the good fortune to receive a complete outfit as a gift from a grateful wealthy patient. Of course, we can make very accurate diagnosis by the use of ocular pressure, blood pressure readings in standing and sitting position (auscultatory method), use of stethoscope; exercise—hopping across floor, or climbing stairs, deep breathing; taking pulse at wrists and over the heart (this latter is very important); the use of atropine, adrenalin, digitalis for testing purposes, etc.; polygraphic trasings and so on. Digitalis is certainly a very valuable, the most valuable cardiac drug we have—but much harm can be done, if not used properly, if not begun at the right time

and especially if not stopped when indicated. In atrial fibrillation, it should be stopped when the heart rate reaches 90 to 100 per minute—(stethoscope over heart, do not rely on pulse at wrist alone). Use an active preparation of digitalis—powdered leaves or assayed tincture; digipuratum, digalen, digitol, etc.

Heart block—some patients get along very well for many months—are able to work, etc. There is a relative infrequency of a rheumatic or syphilitic history. Pain is quite a frequent symptom. Stokes-Adams fits are often associated with mitral disease and heart block.

Partial heart block is considered to be one of the most serious of all heart lesions shown by electrocardiography. In these patients the impulse is blocked by a diseased spot in the heart, so that it must travel around in a circuitous course to reach the whole of the ventricular muscles, usually first to one ventricle and then to the other ventricle.

Fibrillation of the auricle practically amounts to a chronic paralysis of the auricle—and many patients with this trouble get along very well. The "digitalis habit" is necessary for these patients. After all, the heart muscle is the essential basis of the mechanism, and the study of the functions of the heart as in modern cardiology is more important and of more value to the patient than the diagnosis of this or that valve lesion and murmurs.

The electrocardiograph is of value in prognosis and diagnosis. It tells us about auricular standstill, ventricular escape, which are dependent on the activity of the junctional tissue pacemaker and are apt to result from digitalization. In auricular standstill—the ventricle continues to beat from junctional tissue pacemaker, but in which the auricle is completely paralyzed. In ventricular escape—an irritable ventricle beats regularly, but more rapidly than the auricle. The electrocardiograph tells us what type of auriculoventricular block we are dealing with— (1) Simple delay in auriculo-ventricular conduction without dropped beats (digitalization), or (2) 2 to 1 block auricular rate 100 with ventricular rate 56, or (3) complete auriculo-ventricular heart block, which is a serious condition.

It tells us about the existence of **intraventricular heart block**, as seen with angina pectoris: (a) Right bundle—branch block—the left ventricle beats first an inverted Q. R. S. complex in lead III more than 0.1 second in duration; (b) left bundle branch block—a very rare condition. (An inverted Q. R. S. complex in lead I more than 0.1 second in duration); (c) arborization block—seen in lead II (increase duration of Q. R. S. complex beyond 0.1 second).

We learn also of the left or right ventricular preponderance. Left ventricular preponderance being most commonly seen in cases of aortic regurgitation or chronic hypertension. The use of digitalis can be admirably controlled—thus, digitalis will ordinarily flatten and invert the T wave of the lectrocardiogram, which in lead II is normally upright. This change is seen in beginning digitalization before the pulse is slowed or heart block or bigeminal pulse appears. Finally, electrocardiography is of value not only in irregular or very rapid or very slow abnormalities of the cardiac ryhthm—as sinus arrythmia, heart block, extrasystoles or premature systoles (whether of auricular or ventricular origin); parobysmal tachycardia, auricular flutter, ectopic auricular rhythm, etc., but also in heart cases with a regular pulse of 60, 80 or 90 per minute, as in auricular hypertrophy in mitral stenosis, atrioventricular (auriculo-ventricular) rhythm, auricular standstill, ventricular escape, etc. In ventricular fibrillation, we can positively say the patient is serious and going to die.

Small doses of chloral—fifteen grains a day, are sometimes of value in cases of complete heart block with frequent syncopal attacks. In some bad cases of paroxysmal tachycardia and arrythmia, codeine and morphine may do good in fairly large doses. I have tried with success in these arrythmias—fresh tincture (concentrated) cactus grandiflorus m. III to V; fresh fluid extract convallaria majalis m. III to V, and tincture of prunus virginiana fzj-fzI three times a day. Sir Clifford Albutt of England has used the last mentioned drug for forty years, with excellent results in myocardial disease. Satterwhaite of New York City suggests the application of a 30-candle power light over the heart for the relief of pain and anginal attacks. Remember—in auricular fibrillation when (heart rate) pulse gets down to 90 or 100 beats—stop digitalis, or you harm or even kill your patient. We owe much to Einthoven (1903), Waller, Mackenzie, Thomas Lewis, Williams, Paul White, Oppenheimer, Patterson, Sailer and others. Einthoven invented the string galvanometer or electrocardiograph.

Mitral stenosis above all other valvular lesions will give a rapid irregular pulse, intermittent and uncountable, and auricular fibrillation. Often, in these cases of mitral stenosis with auricular fibrillation the pulse feels deceptively regular until the stethoscope is placed over the heart. Cardiac pain is sometimes severe, but usually the "anginoid" paroxysms are not so marked as in true angina of aortic lesions and luetic aortitis. The rapid pulse, dyspnoea, cyanosis and fibrillation indicate decompensation—the auricle begins to fibrillate because it becomes decompensated and paralyzed after having been distended by the obstructed mitral valve for sometime. Digitalis gives the most brilliant results in auricular fibrillation by lengthening the diastole and strengthening the pulse beat by its action on the heart muscle, and has a retarding and inhibitory effect on the pacemaker and the conductivity of the heart and its effect on the conducting mechanism, blocking some of the impulses from the auricle. The ventricle, in these cases, is chronically tired out by the myriads of bombardments sent down by the auricle to the Bundle of His and some of these get through to the ventricle and it gets tired out. These patients are tired out and often sleepy. The auricle is really only a sac holding the blood for the ventricle. Fibrillation of the ventricle as stated, being fatal always—and the electrocardiagraph in these cases can usually give an absolutely correct prognosis. Ventricular tachycardia may occur, but usually tachycardia originates in the auricle. Heart block and Adams-Stokes' syndrome are **not** synonymous. Atropine does good. Digitalis may be used if dilatation demands its use.

Dr. Philip Marvel, Atlantic City, N. J.. This is a valuable paper and one that is well worked out in the interest of the majority of general practitioners, particularly those who are dealing more or less with the chronic cases of cardiovascular types. The arrangement of the paper is admirable, and the treatment equally so. There are a few suggestions that may be emphasized and a few questions I would like to ask. I would like to ask Dr. Teeter what his observation has been in paroxysmal tachycardia with reference to the fluroscopic study of these cases—whether, in his experience, he has found an increase of fluroscopic shadow in the transverse diameter of the aorta, in particular; and also in the ventricular shadow. I have recently had an opportunity to watch two cases of chronic paroxysmal tachycardia. One man had been having the attacks more than nine, and the other about five years. In each case, it has been my privilege to fluroscope the patient and take measurements of the transverse diameter of the aorta, and of the right and left ventricular shadows, and in each case the shadows have been much increased beyond the normal, which have changed (diminished) in the interim between the attacks as much as two centimeters. This has been particularly interesting to me from the fact that the pulsation wave seemed to extend all the way from the apex of the heart to the base of the heart in both cases, and through the aorta, giving you a small wave, as it were, not only through the cardiac muscles, but also up through the aorta.

I am not prepared, from the short study that I have made in these cases, to give information as to why we have dilatations and subsidences of dilatations represented by the shadows. It is more or less, no doubt, like the dilatation that we have with the participants in the marathon races. Also, I want particularly to emphasize another point which Dr. Teeter brought out; and that is with reference to the administration of digitalis in auricular flutter, and also in auriculo-fibrillation. I have a case under my charge that four days ago was running a cardiac beat of 132 at the apex and a radial count of only 60, showing a deficiency of 72. I put that patient on a thirty drops dose. tr. digitalis (the fat-free tincture) twice in twenty-four hours; and on the following day I took the count and found that the difference between the beat at the apex and the radial was eighteen, dropping from seventy-two to eighteen. I administered twenty-five drops to the same patient the following morning, and omitted the evening dose. The following day the deficiency was only eight beats. I gave another dose of thirty drops of the digitalis in thirty-six hours, and found the following day that the radial and apex beats were within two beats of being synchronous—seventy-four at the apex and seventy-two at the radial. I then dropped down to ten drops of digitalis twice daily, and found the next morning (yesterday) that both apex and radial were synchronous. This method I have been following now for more than two years and am much impressed with the results. I try to regulate the action of the heart with the amount of the drug to be administered, feeling that it is a much safer way to give digitalis—guiding oneself by the amount administered according to the results obtained on the heart muscle—than to give a small definite amount for two or three days or a week. in regular doses. We should oscultate the heart and determine the rhythm in connection with the radial pulse, and administer the drug accordingly for definite results.

It is my judgment (and I should like Dr. Teeter's opinion on the question) that in the most of the conditions of cardiovascular disease in which we meet auricular flutter and fibrillation, digitalis is the remedy supreme that we have to do with, and is the only one that will control these conditions.

Dr. Teeter, closing: In answer to Dr. Marvel's last question, I will say that I believe digitalis is the most valuable heart remedy, the second being strophanthus, and the third squills. Aside from these, I do not think that there is any remedy of value acting on the heart except atropin. Most of my paroxysmal tacchycardia patients have been so sick that we have not taken a roentgenogram to determine heart enlargement. We have always found clinical evidence of enlargement, because, due to excessive rapidity of the heart, the left ventricle does not empty itself, the blood is dammed back on the venous side and there are evidences of enlargement of the liver, rales at the bases of the lungs and albumin in the urine. There is only one point that I want to add in closing, and that is the importance of the alternating pulse. It is very easily determined with the sphygmo-manometer, and it is a matter of the greatest importance in prognosis. Nobody with an alternating pulse could stand a surgical operation. The pulse is perfectly regular, but if the cuff of the sphygmo-manometer is applied and the systolic and diastolic blood pressure readings by the auscultatory method taken, and if they vary regularly, i. e., each alternate beat the pressure being higher than each succeeding beat, it is evidence of grave and serious myocardial difficulty.

OBESITY.*

By Frederick C. Horsford, M. D.,
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In the construction of the human "House Beautiful," nature makes use of fat, which she disposes in varying amount in various locations. The average effect is pleasing. A considerable degree of fat, though it may in no way add beauty or grace to its wearer, may nevertheless, be a very valuable asset. In virtue of its material presence, it gives a picture of weight and stability, which is quite assuring to many persons. Nature combines aesthetic considerations with utilitarian, and fat has its essential use as a source of heat and energy.

*Read at the Annual Meeting of the Medical Society of New Jersey at Spring Lake, June 16, 1920.

Obesity, as a disease, has received comparatively little attention from essayists on medical subjects, and overfatness, as a sign of disease, is not so often recognized as the need would warrant. Obesity takes into account a disorder of metabolism which has for its outstanding symptom, overfatness. Overfatness may exist, while the processes of metabolism remain within normal bounds and, as between simple overfatness and the overfatness which is a sign of obesity, it is difficult to define even in theory, where the physiological condition ends and the morbid begins. Overfatness may be said to have a significance analagous to glycosuria, and one might speak of an alimentary overfatness, as one does speak of an alimentary glycosuria.

As between fatness and overfatness, there is no hard and fast line to be drawn. There are rules which serve as aids to judgment, and where one uses English weights and measures, the formula of Guthrie answers the purpose. By this formula, ideal weight is computed as 110 pounds plus 5½ times the number of inches the individual is taller than 5 feet. That is, a man of average height, 5 feet 7 inches, should weigh 110 pounds plus 5½ times 7, roughly 150 pounds. Under usual conditions, such a man would be entitled to carry 25 pounds more, that is, to weight 175 pounds and still be within normal limits. Anything above this figure would be accounted an unnatural and unwarranted burden. Relative overfatness, to which von Noorden has directed attention as of great practical importance, exists in persons suffering from congenital or acquired heart weakness, emphysema or other disease, where a relatively small load of fat constitutes a dangerous burden.

Some accumulation of fat takes place in healthy individuals when an abundant supply of food is afforded. Appetite acts to regulate the amount of food which is needed, and thus in some measure, at least, to keep the amount of fat within a proper limit. This regulatory mechanism is often at fault on account of the unnatural stimulation of appetite, so that with wine, hungry companions and an abundance of salted, peppered and especially sweetened food, it is easy to transcend the requirement. Some individuals and members of some families appear to put on fat with much greater facility than the average, and this observation suggested that there was in these persons, an inherited constitutional anomoly in the rate or in the direction of metabolic processes. Zuelzer and others express the view that where this individual and family predisposition exists, it is more probably due to differences of a tempermental kind, as between the nervous and phlegmatic types, so that the latter, who expend a minimum of energy have left over from their food intake, a maximum for conversion into fat. The hypothesis of diminished oxidation applies to those cases of overfatness associated with such diseases as interfere or prohibit active muscular exercise.

It goes without saying, that to become fat requires an intake of food above the caloric need, or as Kindborg puts it, "To become fat conditioned on an intake of nourishment above actual body needs, is not strange, does not prove anything, for from nothing, nothing can come." But, as he says, "The contrary will not hold, that is, that all people who eat more than the body requires will become fat, for if this were the case, most men would be spherical in shape." In simple overfatness some accumulation may take place derived from fat in the food which becomes available for storage, on account of the abundant supply of protein and, especially, carbohydrate which the cells use for their immediate requirement.

Fat, obtained as such from the food, is principally absorbed by the lacteals and emptied from the thoracic duct into the venous blood. The consequent alimentary lipaemia is of short duration. The fat is rapidly taken up by the cells and burned or stored, so that the normal fasting plasma maintains an approximate level of from 30 to 40 one hundredths per cent. The situation is analagous to that which obtains in respect to sugar in the blood. Fat is said to exist in the blood in three physical forms which are presumably various combinations of neutral fat and fat-like substances called lipoids. Lipoids are combinations of fatty acids with phosphorous and nitrogen. These lipoid substances, "Exist in every living cell; are evidently of the most indispensable importance; but their definite function is practically unknown."

In obesity one might expect disorder of metabolism to favor the accumulation of fat, either by some defect in the process of fat oxidation, or as the result of an in-

crease in the production of fat from carbohydrate and protein. So far as concerns the power of the organism to oxidize fat, there is no definite evidence that this function is interfered with, except in respect to the incompleteness of end products. When fat is burned in the body, it is split up into the successive members of the fatty acid series, including butyric acid, oxybutyric acid, diacetic acid, acetone, CO_2 and H_2O. In severe diabetes and, to a lesser degree, in obesity and some other diseases, there may be failure in the complete combustion of some fat, so that intermediate products of metabolism, so-called acetone bodies, remain unoxidized.

Fat is manufactured in the body from chemical substances which are intermediate products in the disintegration of carbohydrate and protein. Carboyhydrate, represented by glucose, is burned in the body and the successive steps in its oxidation, though these are not at all definitely known, may be considered as passing from glucose through lactic acid, acetic aldehyde, beta-oxybutyric acid, diacetic acid, acetone, CO_2 and H_2O. In the synthesis of fat from the intermediate products of carbohydrate disintegration, it is conceived that there is a reversal of this process of disintegration, perhaps beginning with beta-oxybutyric acid. The proteins which are more complex substances than fat or carbohydrate yield, on analysis, relatively simple molecules called amino acids. These amino acids are regarded as ammonia in which one atom of hydrogen is replaced by an organic acid. The breaking down of amino acids results in the separation of the ammonia group which is converted into urea, and the organic acid or carbon moiety, which is capable of being transformed into carbohydrate. From this carbohydrate portion, fat may be made in the same manner as from carbohydrate, ingested as such.

These allusions to the chemistry of metabolism indicate the direction which morbid processes may take in the disorder characterizing obesity; that intermediate products in the metabolism of protein, carbohydrate and fat are similar in structure and, as the processes of disintegration proceed, become identical. These intermediate products are organic acids, and it is conceivable, that where processes of metabolism are delayed or otherwise disordered, organic acids may accumulate in the tissues. The disorder of metabolism in diabetes is due to a perversion of enzyme formation, and it has been suggested, that in obesity there is an analagous situation. In true diabetes the pancreas is at fault. There are other causes for obesity than are to be found in a single disorder of internal secretion. Obesity is associated with diminished secretion from the pancreas, the pituitary and the thyroid.

It has been declared by von Noorden that obesity is, in some cases, a stage of pancreatic diabetes. It would appear that the obesity associated with a diminished carbohydrate tolerance is definitely, a first stage of pancreatic diabetes, and a plausible explanation would seem to be that, with beginning failure in the mechanism for burning sugar, the unburned, intermediate products of carbohydrate catabolism are converted into fat, according to possibilities which have been indicated. This mechanism would appear to be compensatory. It is a clinical observation that, especially in adults, glycosuria is very frequently preceded by a considerable accumulation of fat; but that, later in the disease, there ensues a more or less rapid loss of weight. It is evident that the mechanism for converting unburned carbohydrate into fat is maintained for a longer or shorter time, after the mechanism for burning sugar has broken down.

It is in the type of obesity characterized by diminished carbohydrate tolerance that quite constant evidence is found of the efforts produced by toxic substances, and it is in this metabolic disorder that we see most clearly how such toxic substances may accumulate. On the one hand due to a slow and disordered catabolism of glucose and, on the other hand, to a failing process of fat production. The evidence at hand supports the view that the pancreas has to do directly with the metabolism of carbohydrate and fat, while the internal secretion from the thyroid and pituitary act indirectly to modify the activity of pancreatic function. It may be that the enzyme concerned with the building up of fat from carbohydrate, is a product of cells in the Islets of Langerhans, of which cells two types have been described, one, having to do with the catabolism of carbohydrate, the other, so-called Alpha cells may, according to Al-

len, have to do with the metabolism of fat.

The toxaemia caused by unoxidized fatty acids is most pronounced and belongs particularly to the obesity of pancreatic disease. According to Allen, "It is well known that intoxication with fatty acids and their soaps has been suspected in the etiology of some anaemias." And, "Aside from the anaemia producing effects, fatty acids and their soaps are highly toxic." Waldvogel asserts that sometimes the bodies of obese persons have been proven to contain unburned fatty acids.

Irritation of the tissues by acid substances is not to be taken literally as signifying that the blood or body tissues are at any time actually acid in reaction. Such a condition is incompatible with a continuance of life. It is assumed that an actual acid reaction in the tissues can exist only locally and perhaps, transiently. Acid products of catabolism are at once neutralized by alkaline bases which it is the property of protoplasm to store for that purpose. Acidosis is characterized by a deficit in the alkalie reserves. In disorders of metabolism we observe the clinical symptoms and the morbid anatomy which appear to be the result of injury. We are able at present to affirm only, that the disorder of metabolism may be the cause of this injury, is probably the cause, but as to just what chemical substances are actually responsible, we may not say with assurance. It may be that tissues are injured by the alkaline starvation; it may be that there is tissue injury at the site of catabolic activity, where the acid by-products are transiently or intermittently in excess; it may be, in the case of the walls of the blood vessels, that the injury is not dependent on any change in the chemical reaction of the plasma, but rather to differences in the quantity or quality of substances which it contains.

Of course it is not assumed, that pruritus, eczema, neuralgia or disease of blood vessels is always caused by the disorder of metabolism characterizing obesity. On the contrary, the irritants associated with this disorder are to be accepted only as capable of producing results similar to those caused by poisons from a variety of other sources.

Overfat persons may suffer some mental discomfort on account of their size and unwieldiness and perhaps, some of the self-conscious sort may be distressed by a word or look that seems to them to suggest ridicule. Fat women, on account of the prevailing mode, have cause for disappointment. Overfat persons become easily fatigued and short of breath on exertion. They are a good deal affected by heat; perspire profusely, and are often annoyed by the irritation induced by opposed surfaces of skin. However, for these symptoms of simple overfatness, inconveniences perhaps, comparatively few persons, in my experience, ask relief. For the most part those who present themselves to the physician, suffer from the obesity which is a disorder of metabolism and complain of symptoms referable to the effect of an acid intoxication.

An intense general pruritus is the chief complaint in some obese patients. One such patient whose ideal weight was 135 pounds, weighed 191. She excreted a highly acid urine and exhibited a marked alkaline deficit. Eczema is, in many patients, an evidence of the irritation caused by acid products excreted by the skin. Neuralgia is a frequent symptom constituting a chief complaint in obese persons. Neuralgia, neuritis and myalgia are closely related conditions expressed by the subjective symptom of pain. The clinical evidence is very suggestive indeed, that the irritating substance which may be held responsible for the neuralgia, neuritis or myalgia of obese persons is a product of their disordered metabolism. Nervous tissues are very rich in cholesterin, in the phosphorous-containing lipoid lethicin, and lipoids called cerebrosides, which on disintegration yield a fatty acid. We may conceive that, besides the localized accumulation of acids, in or about nervous structures and derived from other sources than nervous tissue, there may be as well, undue accumulation of products of the disordered metabolism of the nervous tissue itself. Sellards found that the average figure of 25, representing urinary acidity, is in a fairly large number of patients suffering from neuralgia, neuritis and myalgia, increased to figures ranging from 40 to 120. Thomas K. Brown in the Bulletin of Johns Hopkins Hospital presented a group of cases of neuralgia, neuritis and myalgia in which examination of the urine showed marked increase of acid, and he suggested that this is due to a disorder of metabolism, and that pain is

a symptom of acid intoxication. We have been able to demonstrate in many obese patients suffering from neuralgia and myalgia, a marked increase in the figures for urinary acidity, and that many of these patients evidence a definite increased tolerance for alkalie. It is pertinent to add that all cases showing increased urinary acidity do not, at the same time, present an alkaline deficit. The body mechanism for the excretion of acid by way of the kidney is calculated to conserve in a large way the alkaline reserves and, in some cases, as occurs in diabetes, an increased production of ammonia serves the same end. From our own experience, the treatment of some cases of nervous disorder, including functional states of exhaustion, according to this conception of metabolism, is very satisfactory indeed. Here it is well to repeat what has been said in respect to the toxaemia associated with some cases of overfatness, that is that there are other causes of irritation and exhaustion, but in the presence of obesity, we should always have it in mind as a probable exciting factor.

Obesity and diabetes, as signified by overfatness and glycosuria, are frequently associated conditions. Allusion has been made to the relation existing between the catabolism of sugar and the synthesis of fat. It is probable that, in the severe type of pancreatic diabetes, the mechanism for the synthesis of fat from carbohydrate is as von Noorden states, "simultaneously impaired," along with the power to utilize carbohydrate. As a consequence, the compensatory mechanism of fat formation cannot act, the patients show severe glycosuria, lose flesh and strength. In less severe cases the ability to utilize carbohydrate is only moderately impaired and a compensatory process is established by reason of the power to convert unoxidized sugar into fat. Von Noorden speaks of the ensuing obesity as "masking the diabetes," a "diabetogenous obesity," and he says, "It is advisable, therefore, to test the urine of obese people from time to time for alimentary glycosuria, in order to recognize in good time any tendency to diabetes and thus, by immediate regulation of the diet, afford real assistance to the patient, saving him, perhaps, from a later attack of diabetes.

Thyroid secretion has to do with the metabolism of carbohydrate, probably in an indirect way, through the inhibitory effect which it exercises on the pancreas. Thyroid disease is not associated with such serious results in respect to carbohydrate metabolism as is the case with disease of the pancreas itself.

Hyperthyroidism is accompanied by diminished tolerance, and hypothyroidism by an increased tolerance for sugar. In hypothyroidism there is no increase in fat formation from intermediate products of unburned sugar, because the latter is burned with increased facility. The moderate overfatness observed in cretinism and myxedema is due to a lowered metabolic activity which exists when thyroid secretion is diminished.

Obesity as a symptom of hypopituitarism is most frequently observed in children, associated with signs of failure of development of the sexual and other bodily and mental characteristics. (Dystrophia Adiposis Genitalis of Froehlich). This syndrome develops infrequently in adults who show a gradually increasing obesity and a reversion to the infantile type. It is the posterior lobe of the pituitary which is said to influence the metabolism of carbohydrate by its internal secretion. A lessened tolerance for carbohydrate is produced by hypersecretion, and increased tolerance, together with the storage of abnormal amounts of fat, is caused by diminished secretion from this gland. Obesity with hypopituitarism is accompanied by increased tolerance for sugar, as is the case with hypothyroidism, though perhaps for a different reason. A test for sugar tolerance will serve to distinguish the pancreatic type of obesity from that due to the thyroid and pituitary.

Obesity is very frequently observed complicated by the cardio-vascular-renal syndrome and hypertension. There are cases of obesity of long standing which do not show any considerable degree of cardio-vascular damage, so it may be inferred that a varying measure of resistance is opposed by the vessel walls to irritating substances. Not infrequently, patients present themselves with cardio-vascular symptoms who, at the time, are not much or not at all overweight, but from whom a history may be obtained of previous existing obesity, so that the etiological factor is apparent.

Cardiac insufficiency is the immediate cause of the chief complaints from which many of these patients suffer. More or

less dyspnoea on exertion, oedema, nocturia, one or all of these, may be the subjective symptoms associated with the physical signs of high blood pressure and cardio-vascular damage. Epigastric and precordial distress occurring after the principal meal of the day and, perhaps, associated with the moderate exertion of walking, is often interpreted by the patients in their complaint as indigestion. Blood pressure readings may approach normal figures and one might be misled if the discrepancy between these figures and the other objective signs were not recognized. A low pulse pressure or the unequal force of cardiac impulses observed in the procedure of taking the blood pressure, and which is responsible for the so-called "alternating pulse," afford evidence of the serious grade of heart failure.

There are cases of hypertension seen in comparatively young people and comparatively early in the course of the obesity, which respond promptly to treatment, and must be considered as functional vascular hypertonus. Between these functional cases and the advanced organic scleroses, there are all grades and combinations. As of value for prognosis, some deductions may be drawn in respect to the degree of vascular damage, from the results of treatment, which will relieve a measure of hypertonus not compensatory and not due to actual organic changes in the vessel walls. Heart failure supervenes more or less early, according to the inherent vitality of the heart muscle and in connection with myocardial changes, i.e., fibrosis and fatty infiltration.

The treatment of obesity takes into account first, those overfat persons who present themselves before any serious tissue damage has been sustained. If the disorder of metabolism of which overfatness is a sign is recognized as a probable cause of the symptoms constituting the complaint, treatment by diet with gradual loss of weight will not only result in a cure of symptoms but will protect the individual against the development of cardio-vascular damage. As a first step in treatment, an effort should be made to correlate in the patient's mind, the relation between overfatness, his complaint and the disorder of metabolism which lies at its foundation. The patient will be compelled to admit the overfatness as self-evident, and some comprehension of disordered metabolism may be gained for him, by a comparison of body metabolism with the combustion which takes place in a gas engine or furnace when there is a disproportion between the mixture of air and fuel and when the "engine smokes."

It will be asserted by many overfat persons that they do not eat more than an average diet and this may be the fact in those patients in which there is a diminished carbohydrate tolerance. In respect to the complaint by obese patients that they eat less than their lean and envied friends, von Furth quoting Friedlander makes the interesting statement that "Abnormally fat animals like whales and seals, as well as abnormally fat men, contain to the unit of weight less active substance than lean animals of the same age periods," that is "ballast" and not "live substance," so that fat men, with actually less living substance, require a smaller proportion of food than would be computed necessary for individuals of the same weight, who were not carrying so much dead weight. When the condition exists in which excess of food is converted into fat, such a very moderate excess as is represented by 200 calories a day will, according to von Noorden, result in an average yearly increment of fat amounting to 25 pounds.

It is interesting and instructive to know how easy it is to transcend the food requirement. Two glasses of milk furnish 320 calories. An average piece of cake 230; a piece of pie 250; a very moderate portion of pudding 175; a quarter of a pound of candy, something more than 400 calories. One piece of sugar or a teaspoonful weighing 5 grams, yields 20 calories. Three teaspoonfuls to each cup of tea or coffee, taken three times a day, furnish 180 calories. A pint of beer will afford 250 to 300 calories, and so examples might be multiplied to show how material for the production of fat may be furnished in a manner quite seductive, and which does not cause, in the individual, any suggestion of over-feeding. If people were confined to natural foodstuffs for the satisfaction of appetite, there would be much less chance of overburdening the machinery of metabolism. However, so far as concerns us, a recent newspaper article announced that this country had acquired the world's available supply of sugar for the next year.

We shall not describe the various re-

duction methods which are all based on the same principle and vary only in respect to the kind of food permitted. The Banting treatment gives preference to meat, Ebstein to fat, Rosenfeld to potato, etc. All allow some 1200 calories, instead of perhaps the average, 2500 required. Oertel's treatment restricts the amount of fluid as well as food. The Karrel Cure is essentially an intensive reduction treatment. Three pints of milk give the patient about 960 calories with a considerable restriction of fluid, and so relieves the embarassed circulation, where cardiac insufficiency is a complication. The rational treatment of obesity will take into account a diet which affords sufficient protein to maintain nitrogenous equilibrium, say 75 to 100 grams, and such an amount of bulky foodstuffs of low caloric value as will bring the ration to a value of about 900 or 1000 calories. The carbohydrate molecule contains a sufficient number of oxygen atoms for its complete combustion. The fat molecule has a very large number of carbon and hydrogen atoms, and only two atoms of oxygen. For the complete combustion of fat, therefore, a large supply of oxygen must be furnished by the tissue in which fat is burned. When disorder of carbohydrate metabolism exists, a diet over-rich in fat at the expense of carbohydrate, favors the incidence of acid intoxication, and so it is best to cut fat out of the diet of obese patients, since in reducing weight, these patients are to consume body fat already on hand.

With a fairly intimate knowledge of the caloric value of foodstuffs, one may arrange and vary the diet for obese persons so as, in some measure, to cater to individual peculiarities and relieve the monotony of their menu. It is well to have at hand a printed scheme of diet with which to begin treatment, and which will afford about 900 calories. The bulk of protein of such a diet, averaging about 75 grams, consists of one or two slices of meat, a pint of milk, a little cheese. The balance of the ration is made up of fruit, green vegetables, a little bread, and some tea and coffee without sugar. After a trial of this ration to determine the result on weight, one may add or subtract to the end desired. In addition to the food mentioned, some patients may be allowed a small portion of potato or, in lieu of it, a moderate portion of 10% vegetable. As a matter of fact, in the treatment of obesity, as in diabetes, advanced pupil patients may be taught to utilize most natural foodstuffs, by a knowledge of their relative caloric values. It is not good practice to reduce the weight of patients more rapidly than eight to twelve pounds a month, and in the beginning of treatment, patients should be observed and weighed as often as once in two weeks.

Heart weakness, which is so frequently a symptom in long standing obesity, is only a relative contra-indication to reduction treatment. The presence of so much dead weight aggravates the insufficiency so that, in most cases, either preceded by or in connection with digitalis and strychnia, an effort should be made to relieve the patient of some fat. The considerable initial loss of weight in these patients is often dependent on dehydration of oedematous tissues, and is accompanied by a very satisfactory improvement in the general condition. Obese patients with any serious degree of heart weakness should be in a hospital or in the care of a competent nurse.

Not infrequently obesity develops as a result of overfeeding tuberculous or suspected tuberculous patients. The treatment of the obesity under such circumstances should take into account the danger of extremes in either direction. It would appear that nothing is to be gained by inducing overfatness in tuberculosis but, on the contrary. In diabetes, it is recognized that the disorder of metabolism lowers resistance and that tuberculosis is a not infrequent complication. So in obesity, we may conceive that diminished resistance may be induced and militate against favorable progress. Muscular exercise accelerates processes of oxidation and the removal of waste products, and so has an important place in its application to individual cases.

In hypothyroidism associated with overfatness, the anomoly of the thyroid is the essential feature for treatment. Stimulating metabolic activity with thyroid extract in the obesity not connected with thyroid disease, is bad practice and is generally condemned.

The treatment of overfatness in children and the aged requires, in general, only that one take into account such a modification of diet as will certainly prohibit any further increment of fat. In children the body will soon catch up by growth with the weight; the aged may be

permitted to take with them out of the world of life, what really belongs to the dead world.

Women after they have borne a child or after the child-bearing age have a definite tendency to put on fat, and by some this has been assumed a part of nature's plan to substitute fat as a support to abdominal viscera, to take the place of lax and flabby muscle. The assumption can be valid only to a limited extent and should not serve as an indication for overfeeding and the induction of over-fatness. On the contrary, if an overburden of fat has been acquired in middle life, there is good reason for moderate reduction and imperative reason for the interdiction of overfeeding, either by too much food or a badly balanced ration. To restore muscular integrity and tone to the abdominal wall, either as a result of child-bearing or in the course of moderate reduction of fat, one should advise exercise and massage, and have recourse, if need be, to an abdominal binder rather than an abdominal tumor.

DISCUSSION.

Dr. Harrison S. Martland, Newark: Obesity is one of the most important subjects that we have to deal with and one which is being grossly neglected by the medical profession. Fat people die early, and we see at the autopsy table every day stout individuals who have died from lesions which might have been delayed or even averted.

Obesity may be divided into four main types, as follows: 1. Exogenous form, or obesity due to outside causes, of which there are only two—overeating and lack of exercise. This is the most important form, and the one on which I wish to dwell. It is commonly encountered in individuals over thirty years of age, who overeat and take no exercise.

2. Endogenous form, or obesity due usually to abnormalities in the glands of internal secretion. This form of obesity is seen in dystrophia adiposogenitalis, probably due to hypopituitary disease. We have early forms of obesity due to thyroid deficiency. We have obesity in eunuchs, due to castration. We have obesity following menopause, and obesity due to pregnancy and lactation, all related to disturbances in the internal secretions.

3. Mixed forms, in which we have both exogenous and endogenous causes.

4. Localized forms. Obesity being the collection of fat between the muscles, in the subcutaneous tissues and in the mesentery of intestine, we have certain well-recognized clinical types of localized fatty tumors, such as Dercum's disease, the nodular and circumscribed forms of fatty tumors occurring over various parts of the body and the lipomas of the neck.

If we go back to the first form, or obesity due to exogenous causes, we find that there are several etiological factors, which play some role in causing the obesity, and that applies also to the endogenous forms. Certain races are more apt to have fat individuals than others. Man may be divided into two main classes, the herbiverous and carniverous. The herbiverous type of man is apt to be stout, has thin hair, tendency to baldness, etc., his intellect is not brilliant, but wins success by constant plugging. The greatest work of the world has often been accomplished by individuals of this type. They are subject to obesity and have a high morbidity from cardio-vascular-renal lesions. The carniverous type, who, for some reason or other, has a bowel which does not allow the caloric intake to increase over the amount necessary for that individual, remains thin, is wiry, has coarse hair, etc., and is more apt to die from bacterial infections. His mind is quick, often exceptionally brilliant, but he rarely survives defeat and lacks plugging powers. Many females are more susceptible to obesity than males. Certain periods of life, such as marriage, incline to produce fatness. People get fat after they become prosperous and have financial success. There is a well-known comic classification of obesity formulated by Ebstein. The first or majestic stage of fatness is where the individual feels proud of his slight increase in rotundity. The second is the comical stage, in which stoutness increases and he becomes awkward. The third is the pitiful stage, in which the fat effects the heart muscle and dyspnoea, cyanosis and oedema results.

We have certain lesions that are more apt to occur in obese than in other patients. You can have edema of the legs due to pressure of abdominal fat on the veins producing stasis, often mistaking for a symptom of cardiac insufficiency. Varicose veins are common. The tendency to arteriosclerosis, hypertensive cardio-vascular disease, enormous fatty infiltration of viscera, and to sudden death from cardiac lesions or cerebral hemorrhage is important to realize. Obese patients do not stand bacterial infections of the lungs well, especially pneumonia.

There are only three things in the treatment. The first is to cut down the caloric intake; the second, to increase the exercise; and third, if the metabolic rate is below normal, which can be now easily determined by use of the simplified respiratory calorimeters, by thyroid feeding to stimulate combustion and bring it up to normal. In each case you should find out whether you have exogenous, endogenous or mixed causes, and then, if necessary, cut down the caloric intake, increase the exercise and stimulate metabolism. There is no doubt about the danger of early death in obese persons and it is foolish and neglectful to allow our patients to become obese.

Our country is vitally interested in athletics and has always produced a winning Olympic team, yet, why is it that after the age of thirty years we let all forms of exercise drop and grow old and fat. I should like to call attention to the neglect of physical exercise after thirty years of age and the value of simple setting up exercise used in the army for keeping men in physical condition.

Dr. Theodor Teimer, Newark: The paper read by Dr. Horsford represents a great amount of work, more even than it would appear at first impression. It contains a good deal of original thought and for this reason it may perhaps be well to emphasize the points in

which the speaker has taken an advanced view, a view which may prove to be the correct one in the future, but which up to the present has not been generally accepted.

It is only natural that we should understand each other about the terms obesity and fatness, or overfatness, as the term is used by the author of this paper. It appears that the term "obesity" is not used in the generally accepted meaning, but reserved to pathological forms of fatness, while "overfatness" is taken as a benign form of adiposity. It is well to keep this distinction of the author in mind, as it will avoid considerable confusion and misunderstanding. Dr. Horsford considers obesity a metabolic disorder, but exempts overfatness from this group. It is only just to point out that he allows one group to merge into the other, assuming that cases of overfatness have a strong tendency to become obese, that is, to become victims of a metabolic disorder.

This leads us immediately into a discussion of the whole problem. Cases of overfatness are, as generally recognized at present, those in whom the intake of food exceeds the demands of the body. The surplus is stored in the form of fat. We cannot use protein as such beyond the requirements of the body for cellular growth and cellular repair. Proteins conveyed in greater amount are simply used as fuel and, after the caloric requirements are satisfied, are stored principally as fat. Similar conditions prevail in the use to which carbohydrates are put in the body, except that carbohydrates are not used for repair and growth, but mainly as supply of fuel for the energy requirements of the body, and to a limited extent as a reserve carbohydrate, immediately available for use, namely glycogen. Beyond these requirements carbohydrate is also stored as fat. Fat is also used as fuel, but it is not so readily available as carbohydrate, and a surplus is therefore bound to be deposited as fat. It may be observed in passing that fat plays a very important part in cellular metabolism, more than would be indicated by these casual remarks, but for our purpose it is sufficient to point out that a surplus of fat is bound to be deposited in form of adipose tissue. Now, nature has provided a number of wholesome checks against excessive overloading, which take care of this contingency, checks provided by the organs of elimination, by the organs of assimilation, which refuse to perform their work when pressed to do so beyond physiological limits, and further checks, which are doubtless due to a finer regulatory mechanism of metabolic origin, namely those provided by a feeling of being satisfied, aversion to food, etc. Nevertheless, there are persons in whom these checks do not operate in the same degree or in whom they are overcome by artificial means, like stimulants, condiments and such, by whom a greater amount of food will be tolerated than by others, and such persons will become fat. A vicious circle will be started, increased deposits of fat leading to a diminution of activity and thereby perpetuating and gradually increasing the deleterious effects of overeating. It is, therefore, the disturbance of the regulating mechanism that is at fault in such subjects, brought about, as must be emphasized, by abuse of food, similarly as other abnormal and semi-abnormal conditions may be brought about by abuse of drugs or stimulants, or even abuse of exercise and abnormal taxing of any of our organs. Another group of persons, those in whom a greatly increased amount of food does not result in a material gain of weight, are simply those in whom these checks are too readily set in motion; their appetite fails promptly as soon as they exceed their usual consumption of food. They are unable to get away with it without experiencing all sorts of distress. The underlying principle is the same, the checking influence are simply mobilized earlier than in the other group. Can either of these conditions be considered pathological? That depends on the point of view. Those of the latter group who remain thin and spare are not exposed to a great many lurking dangers, but may be subject to others that are comparatively rarely met by the other group. The fat man certainly is handicapped, though this fact has not been recognized to its full extent until during the last twenty years.

While fatness was considered so far mainly as an abnormal condition, Dr. Horsford tries to fasten on it the stigma of a metabolic disorder to add to the dismay of the unhappy victims.

There are several forms of actual metabolic disorders which are characterized by obesity, to a greater or lesser degree. I briefly mention cases of thyroid and pituitary disorder of the hypo type. The obesity in these groups bears certain characteristics which distinguish it from the type of obesity presented by the cases of the former groups. The diagnosis of their existence is, however, not made on the strength of the symptomatic obesity alone, but on the strength of a number of concomitant symptoms. Then there is a group of obese persons in whom a metabolic disorder has been demonstrated, persons with a limited carbohydrate tolerance, with an abnormal development of adipose tissue. These people are in fact diabetics, and the mechanism of their fat production is very interesting.

Von Noorden has the merit of having first described this type, and it may be well considered as a form of masked diabetes, because diabetes usually makes itself manifest by loss of weight and in these persons that is masked by tissue. It was a very important observation from the point of view of the clinician and important because it allows us a glimpse into the inner workings of the body.

What actually happens is: that the tolerance for carbohydrates becomes lower, and is gradually failing. The carbohydrate ingested in excess of the existing tolerance is switched off to be converted into fat and is stored as such. In this way the appearance of glucose in the urine and blood is prevented. Yet we have, doubtless, to deal here with a case of beginning diabetes, characterized temporarily only by a lowered carbohydrate tolerance and by an increasing adiposity. These cases, if not recognized in time, and, if not treated as diabetics, will finally become manifest diabetics, of a type more serious than the ordinary type, because of the increased risk given by the overwhelming fat decomposition.

It is this type of diabetes, characterized by obesity, that has been selected by Dr. Horsford as the foundation of his theory that obesity is a metabolic disorder. While he has clinical material to support his facts, I feel that his reasoning is too bold and too sweeping. While,

perhaps, destined to be the accepted belief of the future, I prefer to consider these cases as cases of diabetes masked by obesity, because nature makes use in these cases of lowered carbohydrate tolerance of one of her many devices to preserve the organism in a state of temporary efficiency. It is a **compensating device** which is given **primary importance** by Dr. Horsford, and the existence of this compensating device obviously depends on the existence of a previous or concomitant disturbance in the carbohydrate metabolism.

To my belief the fat formation in these cases plays a more passive part and I believe that, if another outlet were possible in these cases, nature would have provided for that outlet with equal readiness before discarding unusual carbohydrate material.

In one respect, however, I am able to fully agree with Dr. Horsford, that is, that abuse of food will in time damage the organs charged with the metabolization of the abnormal amounts thrust upon them. That the fat metabolism can break down, is theoretically possible, but the fact that heretofore it has been found associated with the breaking down of other fundamental metabolic functions, makes me hesitate to adopt the views so skillfully presented by the author of the paper under discussion.

Dr. Hyman I. Goldstein, Camden: In adult males fat comprises roughly about one-twentieth of the body weight. This proportion is greater in the female. Edwin Locke emphasizes the fact that obesity requires treatment only when symptoms of definite functional trouble of the organs or nervous system are present. I wish to speak principally of several clinical conditions in relation to obesity: (1) **Bronchitis** of the chronic types when occurring in obese people is often very intractable and difficult of cure because of the vascular obstruction, pulmonary obstruction and cardiac weakness. The removal of excess of fat, therefore, is necessary in these cases and is best done by the administration of saline laxatives in the morning, by water freely drunk between meals, and lean meat diet, as recommended by George Sutherland (Edin. Med. Jour., 1906, 587), and the avoidance of strong wines and brandies of high caloric value because, as is well known, alcohol is, or rather was, an important factor in the production of obesity. Obesity in most cases is due to a disproportion between the food intake and the energy output. This is practically the chief and sole cause of excess of fat, after making allowance for the effects of heredity, certain pathological conditions, diabetes, lessened activity of the thyroid, myxedema, pituitary disease, castration, climacteric (artificial or normal).

(2) Especially do I wish to emphasize the great amount of good that we can accomplish in **cardiac insufficiency** of the obese, as soon as the regulation of food ingested and the energy expended is properly carried out. A very gradual reduction of food and a gradual increase in the amount of measured work is the important line of treatment in cardiac insufficiency is myocardial disease in the obese. I may also mention (3) **arteriosclersosis**—by the abnormally heavy body, obesity throws increased work on the part of the heart and arteries and therefore plays a very important role in the production of arteriosclerosis, especially seen in the cornoary arteries and in the arteries of the extremities (lower). As a substitute for sugar in sweetening in the treatment of obesity I would suggest the use of **sodium benzo-sulphinide,** as brought forward by R. W. Wilcox of New York City—one-tenth to one-quarter grain in cup of coffee, five grains may be taken daily. In connection with the treatment of obesity by **thyroid,** I wish to call attention to the fact that it has been shown by Frazier that thyroid distinctly inhibits the seretion of the cerebro-spinal fluid, and according to Hoshimoto, Tokio (Endocrinology, 1920, No. 1, 4, Jan.-March), thyroid decreases the diastatic activity of the pancrease. (American Society for Clinical Investigation).

Dr. Horsford, closing: I was led to study the subject matter of this paper, because I saw so many patients who were overfat or had been overfat, and who came to me suffering from neuralgia, myalgia, etc., and especially, from the symptoms of disease of the blood vessels, cardio-vascular disease and hypertension. I desire to emphasize that overfatness is something to be looked on with suspicion. Every overfat person is not going to become diabetic or develop cardio-vascular lesions, however, obesity is a disorder of metabolism associated with toxaemia, and a large number of people who suffer from obesity develop cardio-vascular disease and hypertension, and die a long time before they should. Overfat persons, who do not show evidence of organic damage, may properly be counseled that obesity is something more than an aesthetic fault. Medical men in their effort to benefit mankind by prophylaxis, should see the overfat man and get him going right before he comes to the stage of failing heart.

THE SPECIALIST AND THE FAMILY PHYSICIAN.*

By Linn Emerson, M. D.,
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Dr. Roswell Park in his Epitome of the History of Medicine, divides medical history into several periods. The latest he designates as the Period of Reform comprising the past three centuries.

Early medicine was so influenced by mysticism, ignorance and superstition, that it may be considered as a science and art during only this later period.

The mental processes of mankind are beyond man's comprehension. The riddle of the universe remains unanswered and will no doubt so remain.

In theology, dogmatism is rampant, each sect only having found the true sal-

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vation. Medicine so recently divorced from religion must need have its pathies, schools and isms. In medicine as in religion, the more primitive the mind, the greater the stress laid upon the psychic or unknown, and the less regard paid to the material or manifest.

Agnostics are found only in the ranks of students and thinkers. In early medicine the exorcism was as essential to the cure as the remedy. Empiricism and experiment almost entirely dominated the healing art.

Infection, sanitation, prevention, and operative surgery, except in its crudest form were unknown. The hair of the dog was the cure for his bite.

Diagnosis was based entirely on crude and manifest symptoms. Alas! How much of this do we see today, particularly in the work of the so-called healer and irregular practitioner?

In view of the tremendous strides made in hygiene, sanitation and preventive medicine during the past twenty-five years, it is truly discouraging to see our presumably intelligent legislators so subservient to the demands of the quack and the irregular.

Since they are so ready to propose retro-active tax and financial legislation which would be calamitous to the business and financial interests of the country, can we expect any more intelligent action on medical legislation?

It is not the custom for legislators to consult financiers on matters of finance, so why hope for them to consult doctors on things medical. Each and every cult seeking recognition as practitioners of the healing art, cry loudly for medical freedom, expatiating on the evils of our vast medical trust, which sits so heavily and ruthlessly on the public, poisoning them with deadly serums and vaccines, and gagging them with nauseous decoctions of mephitic herbs.

Is there really any curtailment of medical freedom in this country? Is there any foolism, any absurd claim, any sort of eny, meny, miney mo business of any sort or kind whatever, that the individual is not privileged to try on his poor diseased or tortured body, if he be so minded? None.

Who was but yesterday frantically and supplicantly in demand upon those long battle lines in Europe? Was it the Chiropractics? Was it the Osteopaths? Was it the Christian Science Healers?

A legislator with average business acumen would seldom listen to a promotor who guaranteed 100%, 50% or even 25% on his investment. But he swallows pole, line, hook and sinker when the Chiro glibly unfolds his universal panacea for **all** the ills to which the flesh is heir, despite the fact that the premises on which the whole scheme is founded is manifestly false, turning a deaf ear to the doctor who sadly confesses, "I don't know."

As an instance, take the recent act signed by our Governor to regulate the practice of Chiropractic. The opening paragraph might well grace the pages of Lewis Carroll or Edward Lear. Definition of Chiropractic: The term chiropractic when used in this act shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, and science of the cause of disease and art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms, to harmonious quantities and qualities by placing in juxtaposition the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have now assumed their normal size and capacity for conduction as they emanate through intervertebral foramina—the expressions of which were formerly excessive or partially lacking—named disease.

And gentlemen, the Governor of our State put his signature to this bunch of twaddle and verbosity, making it a part of one of the laws on our statute books.

Our unwillingness to meet misleading and dishonest arguments with similar camouflaged smoke screens, explains our frequent defeats. The practice of the healing art is a struggle against the inevitable, so we must needs meet failure almost as often as success. Comparatively recent statistics from both American and European hospitals, compiled from autopsy findings, indicate that in nearly 50% of fatal illnesses, incorrect or at least incomplete diagnoses were made. How much higher must this percentage have been fifty years ago, and how much higher must it be now, in su-

burban communities when the general practitioner is obliged to "go it alone," without adequate hospital facilities.

At the word specialist, I can again hear the indignant snort of the good old family doctor, who sarcastically informs us that his only remaining duty is to act as a filter or sorter of patients, that they may be directed to the specialist to whom they rightfully belong. His animus for the narrow, prehensile, patronizing, individualistic, psuedo-specialist is easily understood.

Such a specialist may be justly accused of viewing the world through a tube and the condition sought is always found. But to the true specialist, and to team work, must be given all the credit for the advancement of modern medical science.

These are the days of specialism, and the more highly specialized the industrial plant, the greater and better its output. Henry Ford leads the world in value given, wages paid, and profits. The reason specialism. Where do we find analogous conditions in medicine? I mention the Mayo Clinic, as they were pioneers in so-called group practice or team work.

Since 50% of our diagnoses in fatal illness are wholly or in part wrong, is it not obvious that our hope of improvement in diagnostic ability lies in specialists working in groups. There is no reason why practically all hospitals can not be conducted to conform with this ideal of group practice.

Under group practice the patient of moderate means is given a thorough examination at a much less cost than if the individual specialist is consulted. The success of this plan is so well established that I need spend no further time in praising or advocating it. It seems to be the ideal of modern medicine, and if properly carried out, gives promise of giving more frequent correct diagnoses, and thereby relief from suffering, and prolongation of life.

If our legislators could make a pilgrimage to the Mayo or some similar clinic, be shown the value of blood, urinary, fecal, sputum, x-ray, ophthalmic, aural, nasal, vaginal, rectal and various other examinations too numerous to mention, and have it impressed on their minds that the crux of the whole matter is a **correct diagnosis**, would they be so ready to listen to the healer who says there is no illness but of the mind, or the Chiro who looks wise and says that the bellyache due to a tin whistle in the oesophagus, gall stones, appendicitis, cancer of the stomach, intestinal obstruction, or abscess of the liver is due to a misplaced steenth vertebra and that manipulation and replacement will afford immediate relief.

God knows we are wrong often enough, but they are always wrong.

The American College of Surgeons in its efforts at hospital standardization, is rapidly changing many boarding houses for sick people into real hospitals, where group medicine can be successfully practiced.

The toilsome journey of mankind along the road of civilization for the past thousand years affords the pessimist little occasion for joy or hope. The recent conflict in Europe causes one to almost doubt the fatherhood of God and the brotherhood of man. To many of us likewise the evils and misfortunes of our professions seem insurmountable.

Just when we of ourselves seem to have found means for the improvement and development of this ideal of group practice, the ubiquitous politician must needs rush in, and throw a monkey wrench into the machinery by attempting to foist upon our profession, that horrible nightmare of Mr. Lloyd George, compulsory health insurance. Iniquitous as it seems, I fear we are doomed to defeat if we continue to fight it as we are now doing.

First, because the sincere altruistic, misinformed misery hunters and reformers think it is to be of great good to the poor.

Second. The politicians are fostering this belief and it thus becomes a good vote getter.

Third. The underlying principle is inherently right.

The British medical profession fought it, and were beaten.

In a recent discussion, one of its strongest sponsers in the State of New Jersey offered to wager me any amount that they would put the law through within five years. This I conceded, but declared the law would be in such form that it would be a very bad law. His reply was that it would be our fault, as we were fighting the law in any and all forms when we should co-operate in drafting a good law.

It is manifest that any such law ad-

ministered by politicians and the usual political machinery, will be bad for everybody concerned, except the political administrators. To be of benefit to the patient, who should obviously be the first consideration at all times, its working must be largely left to the medical profession.

In a paper presented to the Orange Practitioners' Society, five years ago, on the "Future of the Medical Profession," my conclusions excited considerable critical discussion.

I have seen no reason to change my views and I herewith append what then appeared to me as the future of our profession:

1. The entrance on the study of medicine with the frank avowal of a career for service to one's country and suffering humanity.

2. Medical departments for State universities, with the expense of medical education, largely borne by the State. This will obviate the exclusion of poor but worthy and capable young men from the profession on account of the high cost of medical education.

3. A National Bureau of Health supervising and co-operating with State bureaus of health having supervision and control of all matters pertaining to sanitation, public health and preventive medicine.

4. Public medical service for industrial workers and their families, similar to our present public school system. Compensation of physicians engaged in this work to be regulated by the character of the work done, and time given to the work.

5. Uniform State licensure.

6. More than one grade of practitioner, thus shortening the period of preparation for those who wish to do only routine sanitary, public health, laboratory or industrial work. Opportunity for study and advancement for such as may desire to become internists, surgeons or specialists, and special licensure to those who attain this greater proficiency.

The American Ophthalmological Society, the American Academy of Ophthalmology, and the Ophthalmic Section of the American Medical Association have established a licensing board that the profession and the public may know which of our members are competent to practice ophthalmology.

7. Hospitals and dispensaries largely under the supervision of the Bureau of Health. All internes, and members of staff salaried. Heads of departments able men with adequate compensation as in the Peter Brent Brigham and Johns Hopkins hospitals. If service is not large enough to occupy all such physicians' time, payment in proportion to the time spent.

8. Old age pensions and employment in departments of medical service for which the aged medical man is fitted.

DISCUSSION.

Dr. Elbert S. Sherman, Newark: Dr. Emerson refers in his usual forceful style to three current topics of considerable interest to the medical profession, viz.: group practice of medicine, recent chiropractic legislation in this State, and compulsory health insurance. When he wrote the paper he was apparently enveloped in a dense cloud of pessimism and despair and I cannot agree with his gloomy prognostications. He finds little to afford the pessimist joy or hope in the journey of mankind along the road of civilization during the past thousand years. Thank God, most of us are optimists; and so is Dr. Emerson when he is in his usual good health and things are going right. It is not necessary to go back a thousand years. Even a moment's retrospection of the elapsed portion of the present century recalls many wonderful achievements—too many to even begin to recount here—that bring joy to the joyous and hope to the hopeful.

The passage, by a supposedly intelligent legislature, of the chiropractic act which the essayist has so aptly styled "a bunch of twaddle and verbosity," is indeed sufficient reason for sadness and a feeling of humiliation by every physician in the State, but it is no reason for discouragement. The medical profession, now, as always, the guardians of the health of the State, was caught napping. A few days after the enactment of this pernicious law, when a delegation of physicians that nearly filled the Senate chamber and galleries appeared at Trenton in opposition to the amending of the osteopathic law, and other unhealthy health-legislation then pending, the legislators were sufficiently impressed to yield to the demands of the profession. We physicians, for the moment at least, seem to be more fully awake than for a long time, to the necessity and duty of guiding and watching health legislation. If we keep awake and united, and have efficient leaders, we can almost surely get anything we want at Trenton.

In the last Kentucky legislature there were 13 able physicians. We should have several members of this Society in our legislature every year. It would mean some personal sacrifice on the part of those elected, but would afford an opportunity for great public service. This is something which the county societies might well encourage. For the benefit of those volunteering for duty, rules should be made for the vicarious care of their practices, as was done for the men who entered the public service during the late war, so that their financial loss would be as little as possible.

Before the spectre of compulsory health insurance, Dr. Emerson abjectly throws up his

hands in complete surrender to the wicked politicians and "misinformed misery hunters" and concedes the passage of such a law. I don't believe we will have compulsory health insurance in this State or this country, because nobody wants it sexcept the small class of individuals mentioned by Dr. Emerson and the shirkers and idlers and incompetents. Even labor's great protagonist, Mr. Gompers, condemns it. It has been a failure wherever tried. When the essayist says the underlying principle is inherently right, he takes direct issue with Mr. Frederick L. Hoffman, our best outhority on the subject, who says, "the principle is unsound and has been proven unsound," and who clearly shows in his many writings on the subject that it is both unsound and impracticable. The independent, well-paid American workman does not want it or anything else that breeds class distinction. We can all agree, I think, with what Dr. Emerson says in commendation of group practice, but it will be a long time before we can dispense with that useful and well-beloved member of the community, the general practitioner. Much more often than in the case of the specialist, is his fee a "God bless you, doctor," but the public needs the "sorters" (and so do we specialists).

We should have more politico-medical papers and I am glad Dr. Emerson has brought these subjects up for discussion.

Dr. Norton L. Wilson, Elizabeth: There are three points in this paper that I should like to emphasize; and, strangely enough, they are identically the same points that Dr. Sherman has brought up. So it shows that they must have been the leading three points. They are the chiropractic bill, group medicine, and compulsory health insurance. How shall we deal with the quality of brains shown at the last session of the Legislature. These men are incompetent, so far as reasoning goes. Therefore, it is necessary to deal with them in the only way that they can understand; and that is, through the ballot. I suggest that our legislative committee send us the names of every representative who voted for the chiropractic bill, and that every member makes it his business to see that such a representative is not returned to the Legislature. Also that they consult with the legislative committee whenever they wish to talk over medical matters pertaining to the public welfare.

Group medicine has two sides. The danger is in commercializing medicine. Unless the best men are associated, it may do harm by unnecessary operations. Take a case in my line, which I recently saw: This patient was told that he need to have a small spur removed from his nasal septum immediately, and that it would cost only one hundred and fifty dollars. On the other hand, another patient would have had his adenoids and tonsils removed, if a competent man had seen the case. I am inclined to favor group medicine only in hospitals where it can be controlled.

Compulsory health insurance, as I recall the remarks of Mr. Colby at the banquet last year, he said that he had talked with Mr. Lloyd George, who said that it was the only thing and the right thing. I saw a gentleman who had recently come back from England, who had talked with a friend of Lloyd George's, and he told my friend that Mr. George had changed his mind on the subject, because it had not come up to his expectation. A patient of mine went to Europe in January. He went through England, Scandinavia, France and Germany and sent me the literature of these countries on this subject. He tells me the doctors are on strike in some of these countries, and they were disgusted with this form of insurance and they were giving it up.

Dr. Emerson, closing: I want to assure you, first, that I am not a pessimist. I am the reverse. Dr. Sherman seems to have read between the lines. I must say that I do feel that the underlying principle of compulsory health insurance is right; but the keynote was touched by the words, "class distinction," and that is a thing that we are not going to stand in this country. If we are going to have compulsory health insurance or compulsory care of the individual by a bureau of health it shall be all-embracing, there is nothing contrary to American institutions in that, provided that it is carried out in the proper manner. Years ago, the public school system was condemned; but now education is not only given at the expense of the State, but it is compulsory on the child that it shall take this education. Is not health more important than education? Is not a man's material welfare and that of his child more important than education? Not that I am belittling education. If we have this thing, however, there must be no distinction. Every individual family and person in the land must have public health free service at the expense of the State, borne by the State and by everybody; and this must be paid for adequately to a doctor worthy of his hire. If we socialize the whole medical profession, we must pay them enough to justify the service that they render. Then let the individual do as we now do in the public schools. I am not compelled to send by child to a public school; if I have religious reasons or wish to send a child where it can get better teaching, I can do that; but otherwise, I must send it to the public school. There is nothing inimical to the profession in a service administered so that there is no class distincton, and the individual who feels that he is able to avail himself of the services of a doctor of superlative skill and ability, and large fee, and who fails to avail himself of the public service and picks out a high-class man, can do so. But when you pick out a certain class, socially or industrially, and foist on them a system and have it administered politically, it is bound to be a failure and work harm, not only in the medical profession, but in the public at large. If there is any system which injures us as a profession, it is bound to lower the standard of that profession; and if it does, it is indirectly going to inflict on the public a hardship, and they are not going to get as good service as they are now getting.

Liquor Removed from Navy Supply Table.— By an order recently issued by the Bureau of Medicine and Surgery, the U. S. Navy medical supply depots are prohibited from issuing whiskey except to hospitals. When the present supply becomes exhausted no further purchase will be made and whiskey will be stricken from the supply table of the medical department of the Navy. It is estimated that the supply now on hand will last not more than two or three weeks.

County Medical Societies' Reports

ATLANTIC COUNTY.

Clara K. Bartlett, M. D., Reporter.

After a summer's vacation the Atlantic County Medical Society resumed its regular monthly meetings October 8th, at Hotel Chalfonte, Atlantic City.

"Angina Pectoris—Its Diagnosis and Treatment, with Some Remarks on a Possible Surgical Treatment," was the subject of a paper by Dr. David Riesman, Philadelphia. There are three theories advanced as the cause of this condition: aortitis, disease of coronary arteries and fatique of the heart muscles.

Symptoms: Typical vise-like, squeezing pain, radiating to the left shoulder, down the arm to the wrist. There is a sense of impending death, due to intelligence of the patient. The attack may pass off with belching due to swallowed air; it subsides with sweating or urination, or both. It seldom lasts more than five minutes, but may last 20, although unusual. Some attacks occur at night. Best explanation of these symptoms is based on the theory of coronary disease.

The atypical symptoms are very important because they are so often overlooked. The pain may start in the arm and then attack the sternal region; it may radiate to the back; into both arms; it may radiate from the sternum into the face and eyes. Such cases are apt to be due to aortitis. There are cases without pain. They are usually diagnosed by the outcome—sudden death.

Physical Signs: An examination may show nothing at all. The pulse is usually not disturbed; the blood pressure is not abnormally high; some cases show low blood pressure. There is usually no dyspnea, neither palpitation except in certain cases. The x-ray should always be used but frequently it shows nothing. A Wassermann test should be made but it is generally a negligible quantity.

Aneurysm may produce pain like angina; also pericarditis. Pseudo-angina means pseudo-diagnosis. Hodgkin's disease, Pott's disease, intercostal neuralgia, herpes zoster, and gall stones are cases which give history of anginal pains.

Etiology: Focal infections, acute indigestion. Prognosis: You cannot tell. Treatment in attacks: Nitroglycerin or nitrites under the tongue; morphia and atropine. Chloroform used to be used. A mustard plaster over the heart, or rubbing the chest may give relief.

Treatment during intervals: Regulate life; avoid worry and effort. The food should be light; there should be restriction of starches and proteids. The heavy meal should be at noon; the supper should be light to ward off nocturnal attacks. Hill climbing should be avoided and if living on third floor or higher, must move. There must be abundance of sleep. All local foci of infection must be removed. Smoking is harmful. Drugs in interval of no great value. Iodides have been used; also diuretin.

There is no possible surgical treatment for a living patient, but it has occurred to Dr. Riesman upon seeing patients immediately after death, that cardiac massage through an abdominal incision might be of avail; no harm could be done.

Dr. Lester J. Unger, New York, then gave "Blood Transfusion," a motion picture of the author's technique.

CUMBERLAND COUNTY.

Elton S. Corson, M. D., Reporter.

The Cumberland County Medical Society again enjoyed the hospitality of the Hotel Commercial on October 12th. The meeting was largely attended by physicians from various parts of the county and delegates from Salem and Gloucester counties. The weather was propitious and the gathering auspicious. The number of new members elected was the largest of any recent meeting and was due largely to the canvas made by the A. M. A. representative; those elected were: Drs. C. Percy Lummis and H. H. Wilson, Bridgeton; D. King Webster, Leesburg; Frank Sheppard and Cornelius Franckle, Millville.

The officers elected for the ensuing year were: President, Dr. Charles Sharp, Port Norris; vice-president, Dr. W. P. Rickert, Millville; secretary, Dr. H. G. Miller, Millville; treasurer, Dr. W. Leslie Cornwell, Bridgeton; reporter, Dr. E. S. Corson, Bridgeton. Permanent delegates to the State Society: Drs. H. G Miller, W. P. Glendon, Charles M. Gray, W. L. Cornwell. Annual delegate, Dr. W. Sherman Garrison.

The communication from the State Welfare Committee, in influencing voters against those candidates who were antagonistic to the health needs of the community as presented by the medical profession, was discussed. It was thought advisable for the committee on public health to inform all legislative officials of the desire of the committee to keep them informed.

Dr. Bertha Whaland of Bridgeton read a paper on "Asthenopia." She gave the classical divisions of the condition and ably discussed the subject. Dr. H. S. Branin reported his experience in the correction of defects in the eyes of school children; most parent cooperate in procuring the necessary glasses; occasionally the Red Cross furnishes them. Dr. W. Sherman Garrison reported that but few parents neglect the second notification, even if they do the first.

The next meeting will be held January 4th in Millville.

ESSEX COUNTY.

Eugene W. Murray, M. D., Reporter.

The annual meeting of the Essex County Medical Society was held in Newark, October 5, 1920. Dr. G. B. Philhower, president, in the chair, with a large attendance.

The following officers were elected for the ensuing year:

President, Harrison S. Martland; vice-president, Francis S. Haussling; treasurer, Robert H. Rogers; secretary, Frank W. Pinneo; reporter, Eugene W. Murray.

Councilors—August J. Mitchell and Herbert W. Long.

Dr. Philhower read his address as retiring president, which is sent for publication in the Journal.

There have been added to our roll this year 95 new members.

The Essex County Welfare Committee gave a report of their legislative activities in preparing a questionnaire to be sent to the can-

didates of the two political parties, requesting answers as to their attitude on public health matters. The following comprises the questionnaire, with reasons preceding for its issuance:

Dear Sir: The Essex County Medical Society, composed of over 530 physicians, licensed to practice by the State under laws made by the people's own legislature (not by the doctors) in conjunction with the similar organizations of the Dentists, the Pharmacists, and the Nurses, comprising a membership, altogether of nearly 1,000, and representing many more thousands of voters, are now organized in a non-partisan body aiming to promote the health and welfare of the people of the State of New Jersey.

We have no propaganda and no selfish scheme; only one object, maintaining the standards for requirements to practice healing which the State has, by its legislature, long been erecting in the interests of the people; and to the honor of the State, so that licentiates here could practice in other states without re-examination. Methods of treatment have no concern in law-making.

We consider the tendency to hasty, self-interested legislation, as exemplified by the last legislature in the enactment of certain pernicious bills, and consideration of others, to be hazardous to the health and welfare of the people because they overthrow even the standards of preliminary education under supervision of the Department of Education.

To prevent further enactment of such pernicious laws we demand **publicity** before enactment of all contemplated measures on Health Legislation, and wish to know the attitude of all candidates for the legislature upon licensing candidates who lack ample qualifications.

Therefore that your attitude may be clearly known, we respectfully submit the following questionnaire with the request for your reply by at least October 25th, 1920:

Questionnaire.

1. Do you favor the principle of **publicity,** before enactment, of all proposed Health Legislation, so that those who favor and those who oppose, may have equal opportunity of being heard in public hearings before such measures are acted upon?
Yes ..... No ..... Remarks .....

2. Would you favor such legislation as will secure **public hearings,** when requested, on all health matters of state-wide interest, such as questions on the practice of medicine and surgery, compulsory health insurance, rehabilitation work, workmen's compensation laws, smallpox vaccination, the prevention, isolation and reporting of communicable diseases, quarantine regulations at ports of entry, etc.?
Yes ..... No ..... Remarks .....

3. Are you in favor of **maintaining existing standards** of education for the State's license to practice healing (whatever the treatment), this including (1) preliminary general education, as supervised by the Department of Education, and, (2) technical training to the extent that will cover the general subjects applicable alike to all kinds of treatment, leaving to the individual only his choice of method of practice?
Yes ..... No ..... Remarks .....

4. Would you oppose laws which **lower** these standards and make it easier for applicants to procure license, and practice, by either (1) abbreviating the time of preliminary education, or, (2) limiting the subjects requred for license?
Yes ..... No ..... Remarks .....

The society is also forming a professional guild, consisting of physicians, dentists, pharmaceutists, and nurses, through which organization, the political campaign will be carried out.

GLOUCESTER COUNTY.

Henry B. Diverty, M. D., Reporter.

The Gloucester County Medical Society held its annual session at Hotel Pitman on September 23rd, 1920, from six until eleven o'clock in the evening. In the absence of Dr. DeGroff, our president, the social session was presided over by Dr. George E. Reading, who acted as toastmaster, and discharged his duties with the ease and grace expected of one of his experience. We continued our custom of inviting the ladies. The wives of those of us fortunate enough to have one, and the sweethearts of those of us less fortunate, were very much in evidence.

Hon. E. J. Cattell, statistician of Philadelphia, entertained the society for half an hour with his quick witted oratory, bringing great truths in digestible morsels, was enjoyed by everyone.

Professor Hobart A. Hare of Philadelphia was also our guest and favored us with a most instructive and interesting address. A much appreciated talk was given by Dr. E. M. Richardson of Camden and toasts upon timely subjects were made by Drs. Halsey, Fooder, Hunter and Stephen Campbell of the local society.

HUDSON COUNTY.

William Freile, M. D., Reporter.

The Hudson County Medical Society met at the Elks' Club, Jersey City, October 5th, 1920. The meeting was called to order at 9.15 P. M. Drs. B. S. Pollak and O. C. Frundt were elected permanent delegates.

The meeting then proceeded to election of officers for the ensuing year with the following result: President, Dr. F. J. Quigley, Weehawken; vice-president, Dr. Samuel A. Cosgrove, Jersey City; secretary, Dr. W. L. Yeaton, Hoboken; treasurer, Dr. H. H. Brinkerhoff, Jersey City; reporter, Dr. Wm. Freile, Jersey City.

The paper of the evening entitled "Some Points in Early Diagnosis of Clinical Tuberculosis," was read by Dr. B. S. Pollak, and illustrated by army moving pictures.

We hope to have published shortly a synopsis of the essential points made in this interesting paper in the State Society Journal.

The discussion on this topic was opened by Dr. G. K. Dickinson, and followed by Drs. Curtiss, Bortone, Sexsmith, Jaffin, Little.

Dr. D. C. English of New Brunswick was present and made a short address, complimenting the society on its increased membership, its activity in fighting the chiropractic and compulsory health bills and urged the members to make sure that they give their political support to legislators who are not inimical to the interests of the medical profession.

Dr. G. P. Curtis moved a vote of thanks to Dr. Pollak for his paper and pictures, which was unanimously carried.

Dr. Kublam had moved and carried a motion

that one meeting be set aside for discussion of legal matters and of the welfare of the organization.

It is expected that the program for next meeting will be "Matters pertaining to the welfare organization."

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Reporter.

The regular monthly meeting of the Middlesex County Medical Society was held at the City Hospital, Perth Amboy, Wednesday afternoon, October 20th, 1920.

Following the regular business meeting a discussion of the political situation brought out the fact that in this work the Middlesex County Medical Society seemed to have made more progress than any of the other county societies in combating the election of members of the State Legislature who endorsed the Chiropractic Bill at the previous session of the State Legislature.

Dr. B. M. Howley, as chairman of the Welfare Committee, reported that a most successful organization to be known as the "Professional Guild of Middlesex County" had been formed throughout Middlesex County with the sole purpose of defeating those members whose actions are detrimental to the medical profession's efforts to guard the health and the lives of our citizens. This "Professional Guild" is to have as its members all physicians, surgeons, dentists, druggists and nurses of Middlesex County and are holding meetings to discuss ways and means every Friday night previous to the coming election.

Following the reports of this committee a very interesting and instructive paper was read by Dr. William London of Perth Amboy, entitled, "Breast Feeding and Medical Supervision of Infancy and Childhood." Discussions of the paper were by Drs. Runyon, Brown, Hunt, Fithian, Merrill, English and others.

Following the regular meeting refreshments were served by the matron of the Perth Amboy Hospital.

SALEM COUNTY.

William H. James, M. D., Reporter.

The annual meeting of the Salem County Medical Society was held at the Nelson House, Salem, October 6, 1920, at 2 o'clock P. M. It was one of the largest meetings in the history of the society. Those present were Drs. Hilliard, Green, Davis, Bassett, Hummel, Ewen of Salem; Glendon and Loper of Bridgeton; Knight of Woodbury; Ashcraft of Mullica Hill; Downs of Swedesboro; Harrison of Canton; Good of Alloway; James of Pennsville; Husted and Thomas of Woodstown.

Drs. C. A. Mentzer of Carney's Point and Franklin Church of Salem were elected as members.

Dr. Knight, District Health Officer, gave a very interesting talk. Resolutions relative to the death of Dr. C. L. Lamborn were adopted. (See under Deaths.)

The following officers were elected: President, Dr. Norman H. Bassett; vice-president, Dr. David W. Green; secretary and treasurer, Dr. John F. Smith; reporter, Dr. William H. James; censors, Drs. W. L. Ewen, J. M. Summerill, W. H. James.

At the close of the meeting the members partook of a bountiful repast, for which the hotel is noted.

SOMERSET COUNTY.

Anderson Lawton, M. D., Reporter.

The annual meeting of the Somerset County Medical Society was held at the County Court House at one P. M., October 15th, followed by the annual dinner given at the Hotel Somerset.

Dr. J. H. Cooper, the retiring president, presided, and the usual preliminaries were disposed of.

The Legislative Committee gave an interesting report relative to the needs of the society to assist the profession in destroying the harmful influence of the present Chiropractic Bill and outlined a means of combating the Compulsory Health Insurance Bill, which will be acted upon at the coming meeting of the legislature.

A guild is to be formed known as the "Professional Guild." Eligible members are to be selected from all professional medical classes which will include doctors, dentists, nurses and pharmacists. The object of the organization is to take concentrated political action in the election of representatives who will be a support to the existing medical standards which have been built so painstakingly by our profession; to protect the people of the State against "Unscientific Treatments" and "Quackery." It was truly said by Old Man P. T. Barnum that the people are easily fooled, but there should be laws to protect people against such "tomfoolery" which will interfere with their health and lives.

After the usual committee reports, the election of officers for the ensuing year took place.

Dr. J. Howard Cooper, the retiring president, was succeeded by Dr. Daniel S. Renner of Skillman, N. J. The society extends its most hearty appreciation of the efficient administration of Dr. Cooper, who has used his every effort to make each meeting interesting and agreeable.

Dr. Lancelot Ely of Somerville, the retiring secretary, was elected vice-president. Dr. Ely's untiring work and ability as secretary for the past years makes him well qualified to support the chief executive. The unanimous thanks of the society were given Dr. Ely for the services he has rendered, making his record second to none who have held this office.

Dr. Ely was succeeded by Dr. Embury of Bernardsville, N. J., a gentleman conversant with executive work, a man who impresses us with thorough capacity for the work with which he has been entrusted.

Dr. D. F. Hageman of Somerville, N. J., was elected to succeed himself as treasurer.

Dr. D. F. Weeks of Skillman was elected as State representative—'nuf said. Dr. Weeks can thoroughly represent Somerset in any capacity, and we are secure in the knowledge that our interests will be taken care of by our representative.

Dr. A. A. Lawton of Somerville is trying to hold down the job of reporter—urged on by the knowledge that if he does not send something to "The Journal," the editor, Dr. English will blacklist, black ball and blue pencil all his stuff in after years.

The annual dinner was held at the Hotel

Somerset under the careful tutorage of Dr. A. H. Stillwell and his committee, and it was some dinner, all the way from clams to nuts, not forgetting the boiled lobster and fried chicken. We had guests, Dr. D. C. English, edtitor of the State Journal, and too, a State Senator and an Assemblyman—no, we didn't invite 'em to "shoot any chill," but some of the after-dinner "speelers" told 'em what was on, and we all kinder felt we had a "cupla" friends when the next session of the legislator opens—Oh! yes; she was a four plus dinner all right—other societies please notice and don't forget the law-makers.

SUSSEX COUNTY.

H. D. Van Gaasbeek, M. D., Reporter.

The 91st annual meeting of the Sussex County Medical Society was held at Franklin October 12, following the meeting of the Tri-County Medical Society of Morris, Warren and Sussex, same day and place.

Only the regular business of the society was transacted. The following officers were elected for the ensuing year: President, Dr. F. Morrison, Newton; vice-president, Dr. S. Voorhees, Newton; secretary, Dr. F. R. Wilbur, Franklin; treasurer, Dr. T. R. Pooley Jr., Newton; reporter, Dr. H. D. Van Gaasbeek, Sussex.

One new member was elected, Dr. Voorhees of Newton. Dr. Smith will send you the report of the Tri-County Society.

UNION COUNTY.

Russell A. Shirrefs, M. D., Reporter.

A largely attended annual meeting of the Union County Medical Society was held at the Elizabeth General Hospital on the evening of October 13th. At the election of officers, Dr. R. T. Munger was chosen president; Dr. T. P. Prout, vice-president; Dr. I. Lerman, secretary; Dr. G. T. Banker, treasurer, and Dr. Russell A. Shirrefs, reporter. Drs. Dolan, Eaton, Livengood, Funk and Reiner were selected as annual delegates, with Drs. Keeney, Steincke and Lampson as alternates. The permanent delegates are Drs. Ard, Prout, Stern and Shangle. Dr. E. W. Hedges was elected to the board of censors. Our membership list of 114 was increased by 12, these gentlemen being admitted as members at this meeting: Drs. Nittoli, Tilton, Beisler, Carstarphian, Oakes, L. H. Leggett, Dennin, T. H. Leggett, Bensley, Falvello, Pratt and Brock. Dr. Stern, chairman of the milk commission, made a report, giving some interesting reasons for a slight deterioration in the quality of certified milk. These unfavorable conditions having been largely removed, the milk is now improving. Dr. Green, for the legislative committee, reported an active year, co-operating along certain lines with the Essex County committee, to mutual advantage. The action of Assemblyman Sidney W. Eldridge, the nephew of a highly esteemed physician, in voting favorably to the chiropractors was freely discussed and vigorously condemned. The annual report of Treasurer Banker showed a comfortable balance of $333, in addition to $250 in Liberty Bonds. Suitable resolutions on the death of Dr. Robert H. Hamill, who passed away September 5th, were spread upon the minutes, ordered printed in the Summit papers, and a copy sent to his bereaved family. It was decided to form a professional guild in this county, to be composed of doctors, dentists, druggists and nurses. The preliminary steps are under the direction of the legislative committee. The essayist of the evening, Dr. N. W. Currie, who was to have spoken on "The Causes and Treatment of Hallux Valgus," was unfortunately prevented from coming.

MERCER COUNTY.

Wilbur Watts, M. D., Reporter.

The Mercer County Medical Society held its first regular meeting, after the summer vacation, on October 13th. The treasurer called the attention of the society to a change in the by-laws of the State Society which makes the fiscal year begin January 1st instead of November 1st, as heretofore. The treasurer also stated that hereafter only one statement of dues would be sent to each member and if this was not paid in due time he would be dropped from membership. Two applications for membership were voted on, one being accepted and one rejected. Seven applications for membership were received and disposed of in the usual manner. Two transfers from other county societies were requested, one being from Dr. Wm. G. Schauffler, a former president of the State Medical Society.

Dr. Schauffler, who was formerly located at Lakewood, now practicing in Princeton, was one of the speakers of the evening. As a representative of the American Social Hygiene Association he addressed the meeting on the subject of "Social Hygiene." He called attention to the "American Plan" of the American Society Hygiene Association which divides the subject into four parts; viz.: 1, education; 2, medical treatment; 3, law enforcement; 4, recreation. Under "education" he called the attention of the profession to the fact that in all other contagious or infectious diseases the public had been educated to the importance of prophylaxis and the proper methods to persue to obtain it. He stated that because of the strict moral code or attitude which has always existed in this country and the seeming disinclination of any one to start the ball rolling, the public had been permitted to continue in absolute ignorance of this subject, and while they (the public) were anxious and willing to be enlightened, the profession itself was not qualified to act as instructors. Not that the profession did not have a proper knowledge of the subject but they did not know how to impart this knowledge to the public. Therefore, the first thing to be done is to educate the profession how to impart the knowledge and the second thing educate the teachers of our schools on this subject. 2nd. Under "treatment," he made the following points: 1st. It is the duty of every medical man to see that all cases receive treatment. If the doctor does not treat this condition himself he should see that the patient goes to some competent man who does, and not simply say, "I do not treat these conditions," and permit his patient to leave his office possibly to take up with some "quack doctor" or resort to the use of patent medicines. 2nd. That while compulsory municipal prophylaxis is the ideal situation, it is not yet possible in civil life. 3rd. That therefore we "can't tie to prophylaxis" but can to education. Under "law enforcement," he

said "the profession again fails in its duty. We should influence the legislatures, report venereal disease, and having gotten satisfactory legislation passed, should back up the legislatures." His remarks on "recreation" were very brief, simply saying "keep the people busy and healthy and they will have less inclination to stray from the straight and narrow path to the primrose way which leads to the everlasting bonfire."

An interesting paper was also read by Dr. R. W. Davison on "X-ray and X-ray Treatment," which I enclose.

A special meeting of the society was held October 22 to pass resolutions on the death of Dr. Mackenzie. Another special meeting was held October 26th to discuss medical legislation, when the society endorsed the candidacy and pledged its support to the election of Dr. Clinton H. Read, Republican, and Dr. John Connolly, Democrat, for the Assembly. Both men are members of our county society.

A legislative committee of five members was appointed to act until the next annual meeting, when the usual legislative committee will be appointed. The Chiropractic bill was discussed and denounced as a menace to the health of the community. Charles H. Cook, president of the Mercer County Health League appeared before the society and asked that a week be set aside to be known as "Health Week." The doctors agreed to the proposition and will devote a week, as was done last year, to educating the public to avoid disease.

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY.

Dedication of Their New Home.

The new home of the Academy of Medicine of Northern New Jersey, at 91 Lincoln Park, Newark, the former home of the late Judge Andrew Kirkpatrich, was turned over to the board of trustees of the organization by Dr. J. Bennett Morrison, chairman of the building committee at dedicatory services at St. Columba's School Hall on the evening of October 20th. Bishop Edwin S. Lines of the Episcopal Diocese of Newark, Rev. Charles B. Moulinier, S. J. Regent of the Marquette University, Milwaukee, Wis.; President John F. Hagerty of the Academy; Ex-Presidents Edward J. Ill, G. K. Dickinson, J. B. Morrison, H. B. Epstein; Secretary E. D. Newman, Librarian W. S. Disbrow, and D. C. English, editor of the State Journal, and an honorary member of the Academy, occupied seats on the platform.

Fully 500 people, mostly physicians and their families, attended and later accepted the invitation of the academy to inspect the new home. The academy building is a three-story structure, outfitted to be adapted to the organization's needs. The first floor consists of lounging, reception and conference rooms, while the second floor has a small auditorium, consisting of approximately 100 seats. A portion of the second floor and the entire third floor is taken up by a collection of books, instruments and curiosities bearing upon the history of medicine, presented to the academy by Dr. William S. Disbrow, one of its members. A most valuable gift.

The principal speaker at the dedication exercises was the Rev. Charles B. Moulinier, S. J. Regent of Pere Marquette University of Milwaukee.

His topic was "Ideals, Aims and Importance of an Academy of Medicine."

Father Moulinier said, "No group of men are doing more for the community than the medical men who so unselfishly have brought about the existence of the Academy of Medicine.

(This address will appear in our next month's Journal.—Editor.)

The invocation was given by Bishop Edwin S. Lines. Dr. John F. Hagerty, eighth president of the academy, made the address of welcome, while Dr. Edward J. Ill, chairman of the board of trustees made the speech of acceptance.

President Hagerty read a telegram from the New York Academy of Medicine, extending its best wishes to its "sister academy."

The present officers of the academy are Dr. John F. Hagerty, president; Dr. James H. Lowrey and Dr. John P. Reilly, vice-presidents; Dr. Emanuel Newman, recording secretary; Dr. William Gauch, corresponding secretary; Dr. Edward W. Sprague, statistical secretary; Dr. H. J. F. Wallhauser, treasurer; trustees: Drs. J. B. Morrison, E. J. Ill, H. A. Tarbell, B Epstein and Linn Emerson.

N. J. Medical Society Golfers.

The New Jersey Doctors Golfers' Association held their semi-annual tournament October 21 at the Shackamaxon Country Club with large attendance. Dr. Milton A. Shangle of Elizabeth won the first prize for low gross, Dr. Charles J. Sullivan of New Brunswick got the prize for low net score, his card was 91, 20-71; Dr. Laurence P. Runyon of New Brunswick got the afternoon net prize with 96, 20-76. The Newark Evening News of October 22 gave an excellent cartoon entitled "Helping the M. D.'s Take the Pulse of Colonel Bogie," giving pictures of Drs. Shangle, Sullivan, Conlon, Washington, Ard, Hawkes and Beling.

American Public Health Association.

At the forty-ninth annual meeting of this association, held in San Francisco, in September, the following officers were elected for the ensuing year: President, Dr. Mazycke Porcher Ravenel, professor of preventive medicine at the University of Missouri; vice-presidents, Dr. Theodore Bruce Beatty, Salt Lake City, Dr. Louis I. Dublin, New York City, Dr. William C. Hassler, San Francisco, and Dr. Roger I. Lee, Boston, and secretary, Mr. A. W. Hedrich, Boston.

Washington Society of Clinical Medicine.

This society met at the home of Dr. C. B. Smith, Washington, N. J., on Tuesday evening, October 5. Dr. Smith and Dr. Correll of Easton, who recently visited the Mayo Brothers Clinic in Rochester, Minn., gave a conversational report of their impressions. These officers were elected: President, Dr. E. P. McKinstry; vice-president, Dr. C. M. Williams; secretary, Dr. F. J. La Riew; treasurer, Dr. T. S. Dedrick.

For Local Societies' Reports, see page 397.

American Association of Obstetricians, Gynecologist and Abdominal Surgeons.

At the 33rd annual meeting, held in Atlantic City Sept. 20-22, Dr. George W. Crile presiding, the following New Jersey surgeons took part:

Dr. W. Edgar Darnell, Atlantic City, reported a case of Hernia of the Ileum through rent in Mesentery: A woman, aged 46, weighing 200 pounds, married, with one child, had never been seriously ill. Recently she noticed a "lump" in the abdomen and began to suffer with menorrhagia. Examination revealed a fibroid tumor of some size, freely movable and uncomplicated, and a very slight laceration of the cervix. July 18, 1918, a supravaginal hysterectomy was performed. She made a perfect recovery. August 12, she ate a large dinner. The next morning about 6 o'clock she was seized with a most agonizing pain in the epigastrium, and vomited. The pain was so severe that morphin was administered. Her bowels were irrigated, producing a copious stool. The next day her pains were considerably improved, but distention and signs of intestinal obstruction appeared. Operation was performed at 5 P. M. Through an opening in the mesentery of the second convolution of the ileum there had slipped a loop of the ileum belonging to the first convolution high up on the left side under the spleen. There was a volvulus of this loop, and it was gangrenous and perforated. There was an abscess in the left kidney pouch, and foci of pus was found at various locations in the upper abdomen. The whole abdominal cavity was filled with fluid and intestinal contents. The hernia was released, and the rent in the mesentery was closed. Twelve inches of ileum was resected, and a button for anastomosis was employed. Drainage and counterdrainage were used. Proctoclysis with Locke- Ringer solution was instituted, and the patient placed in the Fowler position. She died from shock about five hours later.

Dr. Gordon K. Dickinson, Jersey City, spoke on The Toxic Thyroid: Its Treatment by Ether-Oil Colonic Anesthesia. He said excessive action of the thyroid is always associated with an overactivity of the suprarenals and glycogenic function of the liver, and a mental state analogous to fright. Surgery of the thyroid under these conditions demands recognition of component states. In ether-oil colonic anesthesia we have the ability to anesthetize patients safely and without their knowledge.

Dr. Edward J. Ill, Newark, speaking on the Gehrung Pessary, said: In the mechanical treatment of cystocele, I urge the use of the pessary in those who are old and decrepit, for those with decompensated heart disease, diabetes and extreme renal affection; also for those with pulmonary disease that contraindicates anesthesia, and lastly the timid ones. It is by no means to take the place of the Watkins operation.

National Academy of Sciences, Washington.

A site for the new building in Washington, D. C., which is to serve as a home for the National Academy of Sciences and the National Research Council has recently been obtained. It comprises the entire block bounded by B and C streets and Twenty-first and Twenty-second streets, Northwest, and faces the Lincoln Memorial in Potomac Park. The Academy and Council have been enabled to secure this admirable site, costing about $200,000 through the generosity of friends and supporters. Funds for the erection of the building have been provided by the Carnegie Corporation of New York.

New Jersey Conference for Social Welfare.

This conference met in Lakewood, N. J., October 20-22, 1920, at the Laurel-in-the-Pines Hotel. The opening meeting was held in the evening of the 20th, when an address by Allan McCurdy on "The Changing Social and Economic Order."

On Thursday, section meetings were held as follows: On Family Welfare, with address by A. M. MacDougal of Newark on "A State Program for Family Social Work Agenies"; 2. on Co-ordination of State Agencies, discussed by Hon. Alfred Gaskell and Mrs. H. S. Buttorheim; 3. on Housing, discussed by Dr. C. V. Craster of Newark and others. At the General Session in the morning an address was made by Hon. Francis Perkins of New York on "Social Reconstruction from the Industrial Point of View. In the afternoon Group Meetings were held as follows: 1. "Health Insurance," discussed by John A. Andrews, secretary of the American Association for Labor Legislation, and by Dr. John A. Lapp. 2. "Hospital Problems," Dr. W. P. Eagleton, chairman, with address by Frank I. Liveright, Dr. James A. Miller and Rev. Thomas A. Hyde. 3. "Delinquency and Correction," discussed by Judge H. V. Osborne of Newark, Ex-Warden Moyer of Sing Sing, Commodore A. V. Wadhams, U. S. Navy, and Dr. Mary B. Harris of the State Home for Girls. 4. "Children's Work," discussed by Dr. Julius Levy of Newark, Mr. A. W. MacDougal and others. 5. "Health Teaching in the Public Schools," with paper by Dr. F. W. Maroney, discussed by Dr. A. J. Casselman, Dr. A. L. Johnson and others.

At the General Session Thursday afternoon the general topic was "Rehabilitation," with an address on "Americanization" by S. Glover Dunseath and an address with moving pictures on "Rehabilitation" by Col. Fred H. Albee, M. D.

Appointments—Officers in the Medical Corps, Regular Army.

Major—H. W. Stucky, Fort Hancock.
Captain—H. T. Wickert, Camp Dix.
First Lieutenant—J. M. Fontaine, Camp Dix.

Bosses Advice Rejected.—The Editor of this Journal gives notice to certain Assemblymen who voted for the dangerous and nonsensical chiropractic bill, that he utterly rejects their impudent advice that we "keep our hands off on that matter"—of the action of the members of the 1920 Legislature. Most of the men who voted for the chiro bill have been manly and honorable enough to acknowledge their serious mistake. We renew with emphasis the truths contained in the Welfare Committee's report, pages 244-247 of the July Journal. Certain politicians' "word may be as good as their bond," but we desire neither, especially when ignorance is manifest in what they say and write.

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OF THE

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NOVEMBER, 1920

DO NOT FORGET—That your annual dues—to the State Society—Three Dollars—should be paid on or before January 1, 1921, and should be in the hands of Treasurer Mercer of the State Society before January 15, 1921. Otherwise, members become delinquent and forfeit medical defense; will fail to receive the Journal and cannot be reported to the American Medical Association as in good standing.

COUNTY SOCIETY MEETINGS.

There is no question but that the members of our profession throughout the State should give serious thought to the consideration of the importance of and of their responsibility in sustaining the regular meetings of their respective county societies. The non-attendance on the meetings is not creditable and it is certainly not conducive to the scientific standing of the profession, its unity, its cultivation and maintenance of ethical and fraternal relations with each other; it does not tend to inspire the respect and confidence of the public; it encourages the formation of false cults and enables those cults to succeed in their socialistic and Bolshevistic propaganda to secure the help of designing politicians and bosses and even—as in the recent propaganda—of business men in dragging down the high educational qualification standards which the profession has for the past forty years been endeavoring to raise to protect the profession and the public alike from ignorant and mercenary quacks.

We have recently received the following from a reporter of one of our county societies:

> There exists a feeling among the members that much of the business detail should be transacted by an Executive Committee, leaving more time for scientific discussion at the meetings of the society. At two of our meetings business and social affairs occupied our time almost exclusively. We should either have more meetings or arrange in some manner for more helpful discussion, so that it will be felt worth while to attend the meetings, and one will feel that he has missed something if he fails to attend.
>
> We attempted to meet this situation and correct it by having the meetings in the evening, but that failed to correct the trouble. Something else must be tried and tried yet again if necessary to rehabilitate the society in the good graces of the members. Perhaps the greatest reason for indifference is the habit of calling the meeting for one hour and then calling it to order about 60 minutes later; almost invariably half an hour later.

Whatever may be the reasons given for non-attendance on meetings, they are generally inexcusable and unworthy the members of such a high, most honorable and holy calling as that of the medical profession, especially when the real reason is negligence or the damning sin of selfishness. Our older and ablest physicians generally are the most faithful in attendance and in their efforts—often at considerable sacrifice—to uphold the profession's high standing.

The members should seek to make the meetings both interesting and profitable by preparing papers or reporting clinical cases. In some societies the reporting and discussing of such cases has awakened much interest and increased largely the attendance. Beginning the meetings on time, or as nearly as possible, is advisable; delay is not just to the members who are prompt in attendance. We repeat again Hon. Theodore Roosevelt's wise saying: **"Every man owes some of his time to the upbuilding of the profession to which he belongs."**

We had an interesting report of the work of the State Society's Welfare Committee for insertion in this month's Journal, but the very late arrival of County Societies' reports and other important matter compels us to defer it

until next month. The committee has been meeting weekly and is doing much good work. At the last meeting the State Society's counselor was present and gave some excellent suggestions.

THOMAS H. MACKENZIE, M. D.

The Medical Society of New Jersey has met with another great loss in the death of one of our oldest, ablest and most honored officers—Dr. Thomas H. Mackenzie, a Fellow and Trustee, who was elected President of the Society at the 145th annual meeting in June, 1911. He served with conspicuous ability. His address at the close of his term of service was an able one, entitled, "A Plea for Attaining and Maintaining a High Standard of Medical Education," in which, after dwelling upon the enormous amount of original research work done by the profession and the wonderful scientific progress and achievements of the profession, he asked: "Does it not seem strange that the legislators hesitate to do everything in their power to aid, support and foster, by the enactment of wise laws, a profession that has achieved so much?" Dr. Mackenzie was one of the men who helped in making the progress and achievements and he will be greatly missed in these days when we are striving to maintain high standards.

Dr. Mackenzie was a true man in every relation of life and a true Christian gentleman. A fellow worker and a most highly esteemed friend whose departure the Editor of the Journal deeply mourns.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY.

There will be found elsewhere in this issue of the Journal an account of the dedication of the new home of this Academy. It was a memorable occasion when the splendid work done and the great progress made by this Academy was rehearsed by able speakers, including Drs. E. J. Ill, J. B. Morrison and J. F. Hagerty, the first, third and present presidents respectively, to whom is largely due the fact that this is one of the best equipped Academies in the United States. Dr. Morrison, in making the presentation, gave an exceedingly interesting historical account of the remarkable progress made under the former presidents and the large share of present prosperity that is due to the active work of Dr. Hagerty, the present incumbent. We are glad to give on another page the excellent address of Dr. Ill in accepting the building for the Board of Trustees.

The address by Rev. Dr. Moulinier, S. J., Regent Marquette University, Milwaukee, Wis., was a masterly one, setting forth the "Ideals, Aims and Importance of Our Academy of Medicine," in which he paid a beautiful tribute to the medical profession for its devotion to the best interests of humanity. We were fortunate in securing a full outline of the address and will give it to our readers next month. Dr. W. S. Disbrow's gift to the Academy is worthy of special mention. It consisted of a very large and remarkable collection of books, instruments and curiosities bearing upon the history of medicine, that he had been gathering for many years. It is of inestimable value and its possession has raised the question whether the present home will long be adequate to meet the needs of this growing Academy.

CHIROPRACTIC MISREPRESENTATION.

In one of the newspapers published in South Jersey last month appeared a full page advertisement by a Chiropractor in conspicuous large type giving what purported to be strong endorsements by prominent doctors. The first one was as follows:

"The chiropractic healer is one of the best things that has come into the life of the present.—Chas. Mayo, M. D., Rochester, Minn."

Believing it to be a fraud, the Editor of this Journal wrote to Dr. Mayo and this is his reply:

Dear Doctor English:

Your letter of October second is received. There is no truth whatever in the statement which the chiropractors are making. A similar statement recently appeared in an Iowa paper and one somewhere further out West; it has been going the rounds in different journals and newspapers all over the country for several years and as soon as it is suppressed in one place it bobs up in another.

Very truly yours,

C. H. Mayo.

This is one of the methods false cults use in deceiving the public. We refer it without comment to the members of the Legislature who voted for the Chiropractic bill.

See Item at the end of page 394.

ACCEPTANCE OF THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY BY ITS BOARD OF TRUSTEES.

Address by Dr. Edward J. Ill.

Dr. John B. Morrison: The Board of Trustees, through its president, wishes to express its high appreciation of your own and your committees efforts. Your excellent and painstaking work has been performed with rare ability and zeal. We accept from your hand this commodious new home of the Academy with sincere thanks. Be assured the Board of Trustees will take good care of it.

Mr. President, Ladies and Fellows: Mr. President, you have asked me to make a short address on this auspicious occasion. You have asked me, sir, because the Academy did me the very great honor to make me its first president. An honor which I highly appreciate and which makes me a debtor to the Academy.

It would hardly be becoming for me to give you advice as to the conduct of the society nor is that my intention. Let me say, however, that we have made many sacrifices, until this stately home can be called our own. This institution has been consecrated for the benefit of the profession. Medical knowledge of today is not the medical knowledge of yesterday. We are a progressive profession. Neither dogma nor precedent hampers us in our work. All this necessitates constant study and the application of that which is new in the sciences. Even greater benefit is bestowed by this institution on the community as a whole, than it is on the profession. For this physicians of the community will be better fitted for their tasks. We have asked no assistance from the laity. But we would have a perfect right to do so since it is the laity that profits most. We have a perfect right to expect their co-operation in this regard, just as we expect to and do help the community in matters not medical. A noted statesman has said, "We must look to the past for guidance, but to ourselves for success. To despise the past is to destroy the future. It is not in a desire for constant change but ratification in the contemplations of established truth, as well as unyielding effort for improvement, that character in man is revealed." The medical profession might well hang up this little quotation as a motto. If this statesman had been a doctor he could not have spoken our truth better. It is in ourselves to work unceasingly for that improvement. Our beloved Academy is only a means to that end. Our Academy is first of all an institution of education. It is surely a democratic institution as every institution of learning should be. It beckons to every physician with heart-felt welcome to be one of us, but we demand this: that he be earnest in his efforts to improve himself in his learning and attainments, to the end that every Fellow may be an honor to his profession and beyond all, that he be a conscientious and painstaking physician, so that his patients will receive the best that is in him. Every other consideration is remote and secondary. On another occasion I said, "The people know little of our aims and attainments. They take greater care in the selection of the person who looks after their worldly possessions or after their sinful souls than they do of him who looks after their sick bodies. They scoff at medical ethics which have only been introduced to protect the patient."

It takes the utmost tact and circumspection to let the people know what our work means. Beware of the belittlement of the cults and aberations in medicine before the laity, for they may think of us as egoists, which is far from us. Our Academy has been the means of bringing together many who rarely see each other on other occasions, much to their mutual profit and respect. I want to say to those who are not attendants at our regular scientific or business sessions that we are a remarkable harmonious body of men and women. Squabbles and politics we know not. We meet to learn, and as time goes on we are ever-increasing our mutual usefulness. Your first president prays that this institution may outlive us all and be an honor to the profession and the community of Northern New Jersey.

Local Medical Societies' Reports

The Associated Physicians of Montclair

The Associated Physicians of Montclair and Vicinity held the first meeting of the season on Monday evening, October 25th, 1920, at the Montclair Club, Montclair. Members of the medical and dental professions were present. The evening was devoted to a "Symposium on Focal Infections." The paper was read by Dr. John W. Draper, surgeon-in-chief, Second Division, St. Bartholomew's Clinic and Hospital for the Diseases of the Alimentary Canal, New York City. The paper was discussed by Dr. Henry A. Cotton, medical director, New Jersey State Hospital, Trenton, N. J., from the viewpoint of the alienist; Dr. Jerome M. Lynch, surgeon-in-chief, First Division, St. Bartholomew's Clinic and Hospital for the Diseases of the Alimentary Canal, from the viewpoint of the abdominal surgeon; Dr. G. Reese Satterlee, attending physician, St. Bartholomew's Clinic and Hospital, from the viewpoint of the internist; Dr. Edward S. Pope, attending surgeon, St. Bartholomew's Clinic and Hospital, from the viewpoint of the head surgeon.

The following meetings will be held on Monday evenings at 8.30 at the Montclair Club. These meetings are open to members of the medical and dental professions:

November 22nd—Paper from the Mayo Clinic, Rochester Minn. Speaker and subject to be announced later.

December 27—Paper by Dr. John A. Kolmer, assistant professor of Experimental Pathology, University of Pennsylvania. Subject to be announced later.

January 24th—Paper by Dr. David M. Kap-

lan, director, Brooklyn Diagnostic Institute. Subject, Endocrinology. Exact title to be announced later.

February 28th—Paper by Dr. William W. Downes, assistant professor of Clinical Surgery, New York City. Subject, Surgery. Exact title to be announced later.

March 28th—Paper by Dr. Harlow Brooks, professor of Clinical Medicine, University and Bellevue Hospital Medical College. Subject, Internal Medicine. Exact title to be announced later.

April 25th—Paper by Dr. Charles Gilmore Kerley, attending physician, New York Nursery and Child's Hospital. Subject, Pediatrics. Exact title to be announced later.

May 23rd—Paper by Dr. James T. Case, surgeon and roentgenologist, Battle Creek Sanitarium and Hospital. Subject, Roentgenology. Exact title to be announced later.

Officers for 1920-1921: President, Dr. William H. Areson, Upper Montclair; vice-president, Dr. Martin J. Synnott, Montclair; secretary, Dr. Archer C. Brush, Verona; treasurer, Dr. Harvey M. Ewing, Upper Montclair; historian, Dr. Henry Wallace, Glen Ridge.

Executive Committee—Drs. Martin J. Synnott, Montclair, chairman; William H. Areson, Archer C. Bush, Harvey M. Ewing, Philip E. Krichbaum, Leslie C. Love, John D. Moore, Walter B. Mount, Victor B. Seidler, David C. Thompson, Henry Wallace, John H. Young.

Summit Medical Society.

William J. Lamson, Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, October 29, at 8.30 P. M., Dr. Johnson entertaining and Dr. Prout in the chair. Present—Drs. Bebout, Bowles, Campbell, Embury, English, Keeney, Krauss, Lamson, Meigh, Moister, Morris, Prout, Reiter, Smalley, Bensley, Johnson and Tidaback, and Drs. Berverlan of Summit and Krichbaum of Millburn as guests.

Dr. R. Baker's resignation as an honorary member was accepted and he was then elected to active membership. Dr. Charles P. Clark of Summit was also elected an active member.

On motion the chair appointed a committee consisting of Drs. Lamson, Reiter and Bowles to revise the by-laws, to report at the next meeting. An amendment was proposed by Dr. Lamson as follows: The officers of the society shall consist of a president, vice-president and secretary, who shall be elected at the annual meeting. These officers shall constitute the executive committee.

A committee was appointed by the chair, consisting of Drs. Moister, Krauss and Morris, to arrange for three or more clinical meetings a year to be held at Overlook Hospital, in conjunction with the medical staff of the hospital.

The paper of the evening was read by Dr. Johnson, on "The Pathology and Etiology of Eclampsia." He contrasted the lesions of pernicious vomiting and eclampsia. In the former the centre of the hepatic lobules show fatty degeneration or necrosis, with acute degenerate in the kidneys, while in eclampsia the peripheral portions of the hepatic lobules show hemorrhage and necrotic areas, and the kidneys show edema, degeneration of the tubular epithelium and hemorrhages in the cortex, together with hemorrhages in other organs. The typical lesions of eclampsia are thrombosis of the smaller vessels, hemorrhages and areas of necrosis.

Taking up the etiology of eclampsia, he outlined the various theories which are as follows: (1) Bacterial origin, perhaps due to focal infection; (2) temperature and climate; (3) fetal metabolism; (4) maternal origin—renal, hepatic, ductless glands, breasts; (5) placental theory (a) toxemia caused by excess of placental cells entering maternal circulation; (b) anaphylaxis by placental protein; (c) insufficiency of placenta; (d) ferments in excessive amount. This last theory, the placental ferment theory, seems to the essayist the most probable and hopeful one. Extracts from the placenta produce coagulation both in vivo and in vitro. A sudden and overwhelming invasion by this placental ferment gives rise to the thrombosis and increased coagulability, with subsequent hemorrhage and necrosis which are characteristic of eclampsia.

Dr. Tidaback presented some interesting x-ray pictures of: (a) pericarditis in an infant; (b) enlarged thymus, and (c) congenital hypertrophy of heart occupying nearly the whole of the left chest.

Miscellaneous Items.

Venereal Disease Conference.

The All-America Conference on Venereal Diseases, to be held December 6th to 11th in Washington, D. C., under the presidency of Dr. William H. Welch of Johns Hopkins University, is the first of a series of regional conferences suggested by the International Health Conference held at Cannes under the auspices of the League of Red Cross Societies. The administrative committee consists of Dr. Thomas A. Storey, United States Interdepartmental Social Hygiene Board; Dr. C. C. Pierce, United States Public Health Service; Dr. Livingston Farrand, American Red Cross, and Dr. William F. Snow, American Social Hygiene Association. Subjects to be discussed are: Present status and recent progress in medical investigations; education as a means of controlling venereal diseases; law enforcement and protective social measures with individuals; social influence in the control of venereal diseases; administrative measures in the United States, Canada, Latin-America, and other countries.

"Christian Science" and the Press Agent.

The letter from the "Christian Science Committee on Publication" which appears in the correspondence department of the June 5 issue J. A. M. A., is further evidence of the smooth functioning of the publicity department of the late Mrs. Eddy's organization. Let there appear anywhere a published item that may seem, either directly or remotely, to refer unfavorably to "Christian Science" and forthwith the editor receives a letter from the local "Committee on Publication" supplemented, possibly, with a flood of letters from members of the cult. Woe to the newspaper man who exposes, be it ever so gently, the fallacies of "Science" which is miscalled "Christian." One can but admire the well-oiled publicity machinery of the "Christian Science" organization. Its upkeep must be heavy but it hits on

all cylinders. If the medical profession maintained a publicity department that cost a hundredth part of the "Christian Science" press agency, hands would be raised in holy horror and from the house-tops would come the cry: The very foundations of our civil liberties are threatened. Whatever the "Christian Scientists" believe about the immateriality of disease —and just what they do believe is not clear— they are obviously of a mind when it comes to maintaining a material publicity department with material funds.—A. M. A. Jour.

Chiropractic Defined.

The expositions of the Einstein theory seem quite lucid when compared with the following definition of chiropractic, offered in a bill passed by the Senate and General Assembly of the State of New Jersey and signed by the Governor, regulating the practice of chiropractic. If such legislation can be gotten away with, it seems to us that there is no hope for the medical profession:

Defintion of Chiropractic: The term chiropractic when used in this act shall be construed to mean and be the name given to the study and application of a universal philosophy of biology, theology, theosophy, health, disease, death, the science of the cause of disease and art of permitting the restoration of the triune relationships between all attributes necessary to normal composite forms, to harmonious quantities and qualities by placing in juxtaposition the abnormal concrete positions of definite mechanical portions with each other by hand, thus correcting all subluxations of the articulations of the spinal column, for the purpose of permitting the recreation of all normal cyclic currents through nerves that were formerly not permitted to be transmitted, through impingement, but have now assumed their normal size and capacity for conduction as they emanate through intervertebral foramina —the expressions of which were formerly excessive or partially lacking—named disease.

Of what type of men must the New Jersey Legislature be composed, and from what level of society must the Governor of that State be drawn, when such officials can seriously consider and approve an act couched in the foregoing language and encouraging such a system?—Medical Times.

Hospitals; Sanatoria, etc.

Hospital for Vineland.

Attorney Leverett Newcomb of Vineland has given two well located lots for a hospital in that city and has offered $50,000 for a building and $30,000 for an endowment fund if it is called the Newcomb Hospital.

Salem County Medical Hospital.

The following is the report for the month of September. Patients remaining Sept. 30th, 15; patients admitted, 67; patients discharged, 59; operations, 32; births, 8; deaths, 4.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent, send the following report for September:

On September 1st there were 225 patients present, including 33 males and 32 females in the Preventorium; 21 patients were admitted during September, three of whom went to the Preventorium. The admissions were classified as follows: Pretubercular, 3; incipient, 1; moderately advanced, 1; far advanced, 16. Number in the sanatorium September 30 is 213.

Sanatoria.—There are in the United States approximately six hundred sanatoria, for the treatment of tuberculous patients, and about 120,000 cases are cared for in these institutions annually. The Metropolitan Life Insurance Co. asks if the results justify the cost of construction and upkeep of these institutions. It claims that no satisfactory data have been furnished and that only a very few of the best of these institutions have attempted to keep in touch with cases after they have been discharged and the reports from these are not very favorable. In the best cases, entered as incipient and discharged as arrested, the subsequent mortality is from three to four times as great as that of the population at their respective ages. It is suggested that a central bureau be established which shall follow up the course of the cases discharged from all the sanatoria.—Exchange.

Marriages.

CURRY-SMART.—At the State Hospital, Morris Plains, N. J., October 16, 1920, Dr. Marcus A. Curry, superintendent of the hospital, to Miss Myrtle Frances Smart, who has been engaged in research work at the hospital.

SATTERER-BANNER.—At Newark, N. J., October 2, 1920, William Satterer to Miss Sarah Kathryn Banner, both of Newark.

SICA-STEWART.—In Trenton, N. J., October 20, 1920, Dr. Samuel Sica to Miss Mary Elizabeth Stewart, both of Trenton.

WADE-McMAHON.—At Ethelwold, N. J., October 6, 1920, Dr. Francis Wade of the All Souls' Hospital staff, Morristown, to Miss Eleanor McMahon.

Deaths.

DE MARCO.—In Atena, Lucana, Italy, October 19, 1920, Dr. Gaetena De Marco, formerly of Somerville, N. J.

LAMBORN.—In Philadelphia, Pa., July 2, 1920, Dr. Cary L. Lamborn, aged 49 years.

Dr. Lamborn graduated from the University of Pennsylvania School of Medicine in 1896. He was a member of the Salem County and the State Medical societies and a Fellow of the American Medical Association. He formerly practiced in Pennsgrove, N. J.

Drs. Wm. H. James, David W. Green and Richard M. A. Davis, committee, reported at the annual meeting of the Salem County Society on October 6th, the following resolutions which were adopted, in memory of Dr. Carey L. Lamborn:

Whereas, The Salem County Medical Society wishing to give expression to the loss it has sustained by the death of Dr. Carey L. Lamborn:

Would resolve, That in preparing an appropriate tribute to his memory, we cannot overestimate the value of the services that was rendered by him to this society, and the community in which he has practiced his profession.

This splendid service in the cause of relieving suffering humanity was best exhibited in his untiring, self-sacrificing devotion to their needs, and reached its hghest attanment in conscientious duty well performed.

His genial manner made him a more than welcome visitor to the sick and depressed—to many of whom the dispensing of cheer and encouragement, rather than drugs, made the path easier for their convalescence and return to health.

It is further resolved, That a copy of these resolutions be entered upon the minute book of this society, a copy forwarded to the family, also published in the Salem papers and the Journal of the New Jersey State Medical Society.

MACKENZIE.—In Trenton, N. J., October 19, 1920, Dr. Thomas H. Mackenzie suddenly of heart disease, aged 73 years.

Dr. Mackenzie was born March 14, 1847, at Mackenzie's Point, Nova Scotia, named after the doctor's ancestors who came from Scotland during the period of the Revolutionary War. He received his early education in the public schools, later at the Normal School of the province of Nova Scotia for two years; taught for five years in the country schools; at the age of twenty-one he entered Dalhousie College, Halifax, afterwards attended Harvard University, from which he graduated as a physician in 1871. He expected to practice in the West, but on visiting his brother in Trenton was persuaded to settle there, opening an office at 229 Centre street, after five years going to 116 Centre street for nineteen years, and after that moved to his East State street office, practicing his profession forty-nine years.

St. Francis Hospital was opened in 1874 and Dr. Mackenzie and Dr. Charles P. Britton were the first physicians to assist the sisters in their charitable work. He continued taking an active interest in the hospital and was a former president of the medical staff. He was also one of the consulting and visiting surgeons of Mercer Hospital.

He was the first county physician; was the Pennsylvania railroad surgeon and for many years was physician to the New Jersey State Prison. He was a member of the Mercer County and State Medical societies, and a Fellow of the American Medical Association.

He was elected a member of the school board and was superintendent of schools for three years. He was connected with several business enterprises, as president of the Star Porcelain Company, a director in the Utah Potash Company and other concerns. He was a Christian gentleman of the old school.

The State Gazette, Trenton, October 21, contained the following editorial:

An Ideal Physician.—Dr. Thomas H. Mackenzie was not only a good physician, but he was the ideal type of physician. Wherever he went he carried a sunniness of disposition that was almost as healing and comforting as his professional ministrations. He has dispelled gloom and forebodings and dark broodings from hundreds of sickrooms; and by ministering to the minds and hearts of his patients, he has given them the courage and the spirit to face ordeals and endure suffering. He preached and practiced the gospel of good cheer, and every one who has looked upon death or who has wrestled through many dark hours with disease knows how much that means to a sufferer.

Personal Notes.

Dr. Charles D. Bennett, Newark, and wife on October 16 celebrated the twenty-fifth anniversary of their wedding in their home.

Dr. B. B. Ranson Jr., Maplewood, has been appointed a member of the Senior Surgical Staff of the Orange Memorial Hospital, succeeding Dr. J. H. Bradshaw, resigned.

Dr. J. Floyd Bowman, Irvington, entertained the Forum there recently with a paper on "The Doctrine of Evolution as Bearing on Man."

Dr. Edward J. Ill, Newark, read a paper at the annual meeting of the New York State Medical Society on "Surgery of the Uterine Fibrosis." It appeared in the October N. Y. State Journal.

Dr. John L. Chamberlin, Sergeantsville, and wife spent a few days last month in Atlantic City.

Dr. Herbert W. Nafey, New Brunswick, and wife recently returned from a motor trip through the Berkshire and White Mountains.

Dr. Elton S. Corson, Bridgeton, is a member of the membership expansion campaign committee of the local Chamber of Commerce.

Dr. Hyman I. Goldstein, Camden, read papers at the Northern Medical Association of Physicians meeting of Philadelphia, on "Primary Sarcoma of the Appendix," and on "Hemorrhagic Heritary Telangiectasia with Recurring Epistaxis," on October 8th.

Dr. J. Allen Patton, Newark, and wife returned from California last month. They spent some weeks in that State.

Dr. William P. Thorne, Butler, and wife spent some time on Long Island last month.

Dr. Benjamin S. Van Dyke, Cranbury, and wife spent two weeks at Ocean Grove last month.

Dr. Jacob S. Wolfe, Bloomfield, and wife, on the twenty-fifth anniversary of their residence in that city, entertained members of their church who welcomed theim on their arrival in that city.

Dr. F. M. Hoffman, New Brunswick, attended the meeting of the American College of Surgeons held in Montreal, Can., last month.

Dr. Fred W. Owen, Morristown, spent a few days at Oyster Bay recently .

Drs. Laurence P. Runyon and Charles E. Saulsberry, New Brunswick, attended the meeting of the American College of Surgeons in Montreal, Can., last month.

Drs. Henry L. Sinexson and M. J. Doolittle, Paulsboro, have been appointed to fill vacancies in the Paulsboro Council by the mayor.

Dr. Douglas A. Cater, East Orange, was elected one of the vice-presidents of the American Electrotherapy Association at the annual meeting in Atlantic City, September 14-17.

Dr. J. Floyd Bowman, Irvington, and wife enjoyed a ten days' motor trip through New York State last month.

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PULMONARY TUBERCULOSIS AND CONDITIONS SIMULATING THE SAME.*

By Samuel B. English, M. D.,

Superintendent of the State Tuberculosis Sanatorium.

Glen Gardner, N. J.

For years it has been the teaching that the great mortality for TB. has been the result of the failure of early diagnosis. This has caused a definite diagnosis of TB. and subjectment to treatment in many exceedingly doubtful cases. As, but few physicians are specialists in the work, the responsibility for diagnosis must in nearly all cases rest upon the general practitioner. When the tubercle bacillus is present the microscope will make the diagnosis. In its absence, however, there is no other pathognomic sign or symptom. In no disease other than those affecting the nervous system is it so necessary to secure data upon which to build in many cases our evidence to sustain our diagnosis. As a result thereof, when the picture is not definite, a diagnosis of TB. is often made when the patient is in reality suffering from some other pathologic condition.

While the primary infectiousness of the disease among adults is questioned, it being the prevailing opinion that disease in adult years is but an activation of childhood infection, the value of a search-history cannot be overestimated. While in adults the value of association or exposure may mean but little, stress should be placed upon association in early age, the liability to later disease of course being dependent upon the greater opportunity for massive infection in childhood.

*Read at the Annual Meeting of the Medical Society of New Jersey, Spring Lake, June 15, 1920.

Too little attention is usually placed upon illness of the past in that statements of patients are too quickly passed over. It does not do to simply ask an adult "Have you ever had lung trouble before?" Find out all about the past and general health, childhood, environment and infections, particularly measles and whooping cough, early occupation—if a female inquire as to disturbance to early menstrual flow, number of children, improvement during and after the puerperium. It often takes considerable searching concerning the past. We may find, however, that what was believed by the patient to have been a nervous breakdown, two or three attacks of la grippe, etc., were in reality mild exerbations of TB., and that the condition under study is the result of many slight activations, the sum total of which means considerable disease. Evidence as to whether or not bacilli have ever been present needs considerable more stress than is usually given. While we agree that but little dependence should be placed on one or two negative returns, it is my observation that many patients are advised that they are non-TB. as the result of too few sputum examinations.

In my opinion, but little attention should be paid to negative results unless many are secured. This applies, of course, to early cases. In later disease when signs are present in both lungs associated with rales which persist, a negative result becomes greater evidence. To put it in another way—the diagnosis of early disease should not rest upon the presence of bacilli, but a diagnosis of advanced disease should in many cases be questioned when repeated specimens are negative, or the finding of tubercle bacilli in more ways than one resembles the findings of an autopsy, for not only may

the microscope, like the post mortem examination, demonstrate irrefutably the presence of the disease, but often it demonstrates it too late to be of any benefit to the patient. When, however, we consider that the absence of bacilli does not preclude a positive diagnosis, we must consider the history and symptoms together. In most writings on the subject, the frequent and less common symptoms of early disease are enumerated one by one, some attention being given to the relative importance. The reader learns that a certain symptom is of great value—that another one should make one strongly suspicious. He is informed that an early diagnosis can and should be made, and on the same page learns that any one symptom or physical sign or even many such may be present and the disease be other than TB., or on the other hand, that many signs may be absent and the case be one of TB.

The too frequent result is that the physician becomes side-tracked and concludes he is in the presence of some other pathological condition, or he may delay coming to a decision for fear he has not quite enough evidence upon which to diagnose the condition as TB., in the latter case he tells the patient he has weak lungs or that he is threatened with TB., or in some other indirect way expresses that a tentative diagnosis is made. While there are some diseases in which occur a single pathognomonic symptom, the presence of which is equivalent to a diagnosis, and others which are recognized by certain co-existing symptoms, a difficulty is encountered in early TB. in that there is not only no pathognomonic symptom, but no one group upon which we may hope to have a diagnosis in the majority of cases. The profession does not so much need to know how many symptoms may be present in early disease, but to know what symptoms and how few may justify a diagnosis.

It cannot be too often repeated that it is impossible to exaggerate the importance of the early diagnosis. When we consider that it is in the early stage that the patient has the best chance to recover if he has a proper understanding of his condition and promptly begins appropriate care. Even if not cured, he will have learned from the start certain precautions he should take to benefit both himself and society at large. When it is agreed that the presence of bacilli in the sputum is not an early sign of pulmonary disease and cannot find a place in the clinical picture, we will consider the symptoms of early disease in reference to a diagnosis, and I will divide them into two classes—Warning and Diagnostic.

1. **Warning Symptoms:** Those pointing toward the possibility of TB. These are very important, as they often cause the patient to consult his physician before the disease has made much progress. They are always of great value because they lead the physician to make a thorough examination of the chest and to obtain a personal history.

2. **Diagnostic Symptoms:** These are of such a nature that we must have at least one of them before we can make a diagnosis. The warning symptoms are those that make us think of the possibility of incipient disease, when we encounter them in every day practice.

The diagnostic symptoms are those that oblige us to consider the patient as TB., unless it can be proven that they are the result of some other pathological condition. When, for example, a patient complains of a slight cough, unaccountable fatigue or loss of ambition, the alert physician must bear in mind that TB. may be present. When on the other hand there is a history of pleurisy, haemoptysis, and the physical signs of modified breath sounds with or without impaired resonance and fine crackling rales, these being persistent and circumscribed, he must consider the patient TB. until the symptoms can be accounted for in some other way. To consider it another way, if anyone disputes a diagnosis of early disease, based among other signs, upon pleurisy or haemopysis, he must bear the burden of proof and show conclusively that there is a non-TB. cause for the existence of these symptoms. Should this simple division of symptoms be made, it would tend to do away with the bewildering array of signs so much deplored.

Warning symptoms, however, frequently occur when there is no TB. and consequently may be produced by other morbid conditions. Nevertheless, if they cannot be quickly and satisfactorily explained the possibility of TB. being present should never be ignored or thrust aside until after careful and repeated examinations.

Now that we have a definite idea as to

the diagnosis of pulmonary TB., let us refer briefly to some pathologic condition, which may on account of their symptomatology and signs be mistaken for TB. Any one having considerable experience is constantly meeting patients in whom the question as to a differential diagnosis arises, and while the recognition of somewhat advanced TB. is regarded as simple—this is, however, not always the case. It may, however, be asked what difference is made in that the treatment accorded the TB. patient will be effective for the non-TB. one. This may be true, but when we consider that our capacity for the care of the TB. is now sadly overtaxed and that the treatment and maintenance is financed by public expense and that in many cases valuable time will be lost and great harm be done, the answer becomes evident. Syphilis might be cited as an example.

In Ashes series at the Boston City TB. Hospital of 198 cases, 23 or 11% were found to be non-TB. He also collected 353 cases from other hospitals with 38 or 10.9% non-TB. Funke & McCrea made, at the Chest Dept. of Jefferson Medical College Hospital, a study of 1,200 admissions and found 72, approximately 6% non-TB.

Pulmonary Syphilis: A chronic disease clinically, often not distinguishable from the common types of pulmonary TB. and producing a similar symptomatic picture. A diagnosis must rest upon a failure to demonstrate bacilli, possible concomitant evidence of syphilis in other parts of the body, the rales are usually of a drier or leathery character than those of TB. and may be a lesser degree involve the apices, although these cannot be depended upon. The patient may not have the appearance of advanced disease, although all other evidence is present. The diagnosis must in many cases rest on the absence of positive sputum in connection with a positive Wassermann and improvement under anti-syphilitic treatment. A word of warning should, I believe, be given concerning the Wassermann reaction in TB. patients. I have seen many cases more particularly in the young who may give a positive Wassermann, which cannot be again repeated. We never pronounce a positive TB. patient syphilitic in the absence of two positive Wassermann's unless a positive history of initial lesion can be illicited. A routine Wassermann test among the supposed pulmonary TB. will assist in diagnosis and treatment of many puzzling cases.

Influenza: Some claim it is exceedingly rare for influenza to be followed by pulmonary TB. In a series of 191 cases of pulmonary TB. at the State Sanatorium, 98 were aware of their TB. prior to an attack of influenza—45 undoubtedly had had activation prior to their influenza. In the remaining 48, no evidence of prior pulmonary activation could be illicited. Of the whole number, 180 had positive sputum, leaving but 11 with negative sputum. From these it would appear that influenza had been an accountable factor in the activation of their disease. The matter of diagnosis, however, in negative sputum cases often taxes our diagnostic power. In some the post influenza lesions are apical instead of basal, but not always so.

Bronchiectasis: This may often be mistaken for TB. The lesions are usually basal and bilateral. Although some cases of apical bronchiectasis have been reported. Dependence should be placed on the characteristic sputum, the clubbed fingers, absence of bacilli and usually the basis character of the lesions.

Mitral Stenosis: Here there is cough, expectoration, haemoptysis, with some dyspnoea on exertion. Attention to the history, cardiac findings and negative sputum will assist in arriving at a proper finding.

Gas Poisoning: These symptoms are varied. Those referable to the respiratory system are cough, pain, chest oppression and dyspnoea. It is easy to make a diagnosis of TB. when haemoptysis is present. While one would be led to believe that the damage done by the gas would be sufficient to activate a latent lesion, it has not, however, been the case. In many of these men no change other than slight peri-bronchial thickenings are evident.

Cardio-Renal Disease: The reasons for diagnosis of TB. are apparent. The patient gives a history of continued and long illness, cough, expectorations. A urinary examination, an examination of the circulatory apparatus, including blood pressure along with a negative sputum will assist in the diagnosis.

Pulmonary Abscess: In this the purulent sputum, the localized signs with negative sputum should lead to a doubt as to TB.

Bronchial Asthma: Many such are diagnosed as pulmonary TB. The diagnosis here must rest upon the negative sputum, the expiratory chest, the history of attacks, and the characteristic microscopic findings of asthmatic expectorations.

Anthracosis: A considerable number of those are encountered from the potteries of Trenton and the cement workers of Warren County. Among cement workers comment is made as to the rarity of TB.

Irregular Fevers: Often caused by focal infection, that much studied, but yet little understood condition, may at times confuse the diagnosis, septic endocarditis, an exaggerated focal infection, may also at times be mistaken for TB.

Most TB. institutions, and in fact in private practice, there are patients who symptomatically might be considered as having early TB. or hyperthyroidism, or both. In many instances the severity of the clinical symptoms appears out of proportion to the pulmonary involvement. At times it is a matter of diversity of opinion among different clinicians. In such cases much assistance can be secured by ascertaining the patient's degree of sensitiveness to adrenalin chloride. Hyperthroiden will give positive reaction to adrenalin. TB. unaccompanied by hyperthyroidism fails to so react. We have seen three cases in which we changed our diagnosis from TB. to hyperthyroidism. In two of these cases the enlarged thyroid was evident, although the symptoms had been those apparently of pulmonary TB.

TB. Infections Versus Disease: When with a slight cough expectoration, and malaise one is led to x-ray chest, a diagnosis may often be made on too little evidence. Nearly all chests will show at the hylus evidence of some glandular involvement and what is generally known as peri-bronchial thickening. Unless, however, this thickening is considerable and the peri-bronchial radiations extend to at least the second interspace and the outer one-third of the lung, they should be disregarded. Many of these shadows only indicate TB. infections, but do not indicate disease. A diagnosis should in but few cases be made from the x-ray interpretations, unless they are accompanied by signs and symptoms and substantiated by a history.

Foreign Bodies in the Air Passages: While one would not expect such to be mistaken for pulmonary TB., such a mistake, is, however, at times made. In the routine diagnosis of pulmonary condition this may be missed unless the work is checked by x-ray findings.

In General: The diagnosis of chest condition cannot help but be of exceeding interest and in many cases evidence upon which to base a final diagnosis may be lacking. Greatest success, however, will crown our efforts when we approach our cases with an open mind and are willing to put time and effort on them. To such as do this, their efforts will be generally rewarded in the satisfaction that they have done their work well and will secure added interest and pleasure therein.

DISCUSSION.

Dr. Alexander Armstrong, White Haven, Pa.: Dr. English has written a paper on a subject of vital importance in more ways than one. We, as physicians who have pride in our work, whose honor is at stake, should want to make correct diagnoses. An error in diagnosing so important a disease as tuberculosis is especially culpable. In the second place, as Dr. English has stated, because the beds devoted to tuberculosis are woefully inadequate, a large number of cases, even active cases, not to speak of cases that are becoming active, are not properly taken care of. Then, from an economic standpoint, there is loss in taking the patient from his work and his friends, and in subjecting his family to want, and himself to living in an environment which is not always pleasing. It is important, also, to remember that these patients come to us for a diagnosis, not because they are not able to work, but because we often tell them that to go on with work will result in something serious; because, in other words, if we have made this diagnosis unless they do take some kind of treatment, tuberculosis will develop. How frequently does this occur! Dr. English has given a number of sets of statistics. Since I knew the character of his paper, I have not gone over the statistics at White Haven, but I remember enough to say that not more than three per cent. are turned away as being non-tuberculous. As syphilis is the disease most frequently mistaken for tuberculosis, the importance of a Wassermann is evident. It must be remembered, however, that both diseases may be present. I have just received the last report of the Trudeau Sanatorium at Saranac Lake, which states that eight per cent. were non-tuberculous. Both of these are lower than the statistics that Dr. English quotes. The reason that ours are lower than those of Saranac Lake is not because we are less capable, but because we take patients for other reasons, while at the Trudeau Sanatorium they insist on taking only very early or incipient cases. We should all strive to use every known means of differential diagnosis and thus minimize the errors and diagnosis which have been pointed out so clearly by Dr. English.

Dr. M. W. Newcombe, Brown's Mills: I think that everyone agrees that the infection of tuberculosis is most frequent in childhood, before ten years of age. It is important to take a careful history of the patient and find out whether the child was in a tuberculous home and was exposed during childhood; also whether it was breast or bottle fed, and whether it had measles, typhoid or pleurisy. Some say that true pleurisy is seventy per cent. tuberculous in origin, or even more.

In regard to blood spitting, Dr. Brown says that of those who spit blood at any time, seventy or eighty per cent. will sooner or later develop tuberculosis. If a diagnosis of tuberculosis is made, say so. What does "weak lungs" or "a spot on the lungs" mean to the patient? Nothing. If you do not tell the patient what is the matter, he does not know how to take care of himself or how to protect others. He had better know the truth early when he has a chance to get an arrest of the condition.

I think that we pay too much attention to physical signs and not enough to symptoms. If the patient gives a history of expectoration, loss of weight, temperature, etc., and you go over the chest and find no physical signs, you give the patient a clean bill of health, so far as the lungs are concerned, and say that the symptoms are due to a rundown condition. We should go by the symptoms, and not so much by the physical signs. If you have a patient with an arrest and dry crackles, you know that the patient is not failing correspondingly. Go by the symptoms, and pay less attention to the physical signs.

Dr. B. S. Pollak, Secaucus: Dr. English's paper places a new query before practitioners of New Jersey. The Glen Gardner Institution has been regarded by many practitioners as being an institution where only incipient cases are admitted; this is a misconception, as the act governing the admission of patients clearly provides for the admission of curable patients. Many incipient cases are not curable and we have known numerous advanced and far-advanced patients in whom the tuberculous process was finally arrested; for, after all, a cure in tuberculosis must be considered as an arrest of the symptoms and the process per se can never be entirely obliterated. If I understand Dr. English correctly, he stated that only 8% of his cases were without positive sputum; now if these cases have positive sputum, of course they are not of the incipient class and are probably moderately advanced or advanced. I hope that we will soon have a new classification or a new standardization.

The important problem of today is the study of childhood infection. Careful observation of children, who are exposed to active disease, will, ofttimes, give us the earliest manifestation of the appearance of active clinical disease. As a matter of fact, incipient tuberculosis is the time when anatomic tubercle becomes clinically active. In pulmonary tuberculosis when sputum is positive, we have caseation—breaking down of tissue. It appears to us that the point at issue is to study carefully, clinical tuberculosis in its earliest manifestations and to differentiate from active pulmonary disease. In order to accomplish this, we need opportunities for such study. This will be afforded when the General Hospital of our State will open its doors to the tuberculous and give the physicians and nurses a chance to study the disease.

Dr. English, closing: I think Dr. Pollak confused what I said with what Dr. Armstrong said about the sanatorium at Saranac Lake. At Glen Gardner, we have 240 patients. Out of 200 of them, 160 we believe are curable. We are expecting to cure these patients and send them home cured. If we waited until we got tubercle bacilli, and are not sure of our diagnosis because they are not found, we are not going to cure these patients. When they are far enough advanced to have tubercle bacilli in the sputum, they have lost fifty per cent. of their chances to get well. We must get the patients early, and before tubercle bacilli can be found in the sputum.

GASTROSPASM.

A CLINICAL AND ROENTGENOLOGICAL STUDY.

An Abstract of a Paper written by Dr. I. W. Held and Dr. J. Roemer. Read at the Annual Meeting of the New Jersey State Medical Society, June 15, 1920.

By Jacob Roemer, M. D.,
Paterson, N. J.

Gastrospasm is not new, it has long been known to physiologists and anatomists. Its diagnostic possibility and clinical importance is the outcome of the x-ray era. Gastrospasm was aptly divided by Holzknecht and Luger into regional, circumscribed and total. Regional gastrospasm may occur in any part of the stomach; the most common locations are at the cardia and pylorus.

Cardiospasm. — Although cardiospasm primarily belongs to the cardiac end of the esophagus, its relation to gastric diseases and its symptomatology are so purely gastric that brief mention of it must be made here. We understand by cardiospasm a spastic contraction of the cardiac end of the esophagus of shorter or longer duration, sometimes lasting for weeks and even months and leading to dilatation above the contraction. From an etiologic standpoint cardiospasm is in the great majority of cases purely functional. This is easily understood when we recall that the propulsion of food from the esophagus into the stomach is mostly controlled by the autonomic nervous system. We should, therefore, look for such clinical manifestations, which indicate instability of the vegetative nervous system. The vago-toniac complex (Epinger and Hess), such as dilata-

tion of the pupils, slow pulse, slowing of the pulse when pressing on the eye-balls (Aschner's phenomenon), slowing of pulse in bending forward, dry skin and palor and spastic constipation. It is surely of clinical importance to recognize the fact that an organic disease like gall-stone or renal colic, when associated with cardiospasm, that vagotonia plays quite a role as a predisposing associated causative factor.

X-ray diagnosis of cardiospasm. The most conclusive diagnostic method is the x-ray, we therefore omit all the other methods. A most important radioscopic and radiographic sign is the visualized active peristalsis above the seat of the spasm. This is more marked in early and transient cases than in the advanced cases where dilatation above the obstruction is very pronounced. The reason for that lies in the fact that the more the obstruction is due to spasm the more the entire esophagus is in a state of hypertonus and the esophagus with its strong musculature tries to overcome the obstruction. In cases of obstruction at the cardia, the result of idiopathic dilatation, where atony of the esophagus musculature is a primary factor, there is no peristalsis. Peristalsis of the esophagus is likewise absent in most of the cases of carcinoma at the cardia because of the associated loss of tone of the esophagus musculature. We differentiate two kinds of spasms, incomplete and complete. The former manifests itself fluoroscopically and radiographically as follows: The contrast substance is seen to hold at the point of obstruction and the esophagus above it fills in an irregularly spindal shaped form, exceeding its normal width two or three fold. For a few minutes nothing may be seen to pass through the obstruction. Repeated empty swallowing often overcomes the spasm. In the latter the esophagus is immensely dilated, sausage shaped, smooth in outline with an abrupt termination at the cardia. The dilatation may become so marked that the esophagus may hold a pint or more of food.

Pylorospasm.—Approaching the stomach proper, the most frequent seat of regional spasm is that of the pylorus, so-called pylorospasm. Pylorospasm is a condition where the part or the entire pylorus is in a spastic state for a shorter or longer duration. When a spasm persists for a long time, it may even lead to hypertrophy and marked thickening of the pylorus, with a resulting palpable mass simulating a tumor.

Etiology.—From the etiological standpoint, pylorospasm may be of intra and extra-gastric origin. (Intrinsic and extrinsic-Carmen). The intra-gastric cause is by far the less frequent and if present is mostly the outcome of a prepyloric ulcer, less frequently due to ulcer on the lesser curvature and still less frequently in duodenal ulcer. We have seen it occur in gastro-enterestomized patients. Like Carmen and Miller we saw it occasionally in carcinoma of the stomach.

The extra gastric causes for spasm are numerous. According to our experience gall bladder disease stands out most prominently. Holzknecht and Luger were the first to call the attention to the frequency of pylorospasm in gall bladder disease, and they pointed out that the existence of a solitary stone on the gall bladder is more prone to give rise to such a spasm than multiple stones. Their observations were since then confirmed by Carmen, Case and others. Our experience, has fully confirmed their views. Other causes are: Chronic pancreatitis, chronic appendicitis, renal calculi, chronic lead poisoning, morphine poisoning, tabes dorsalis, also chronic interstitial nephritis, particularly during the stages of suburemia and uremia.

In the pre-x-ray era, experts on palpation claimed to have succeeded in palpating a spastic pyloris. Experts, however, are the exception. The x-ray, on the other hand, makes us visualize spasm with ease and offers an explanation for the symptoms. The x-ray findings are as follows: Fluoroscopically, the food is seen to stop at the antrum and sometimes even for several mintes, no food at all is seen to pass and what enters the pylorus is either narrow or pivet-shaped. Palpation does not change the contour of the pylorus. The x-ray plat likewise showed the above described prenomenon. The stomach proximal to the contracted pyloris shows dilatation and active peristalsis. It is already stated above that the clinical and x-ray manifestations are such that the differentiation from carcinoma becomes very difficult. We may state, that we, like others, had cases of persistent pylorospasm with an acidity, which we submitted to operation with a

doubtful diagnosis, but inclined to carcinoma. In two cases the pylorus was so hard and thick that the surgeon had to open the pylorus to convince himself that there was no tumor within. In cases where the hypertrophied pylorus gives rise to a palpable mass, and the contrast meal fails to fill the pyloris, the differential diagnosis between spasm and cancer is almost impossible.

Regional spasm may occur also in the fornix or tube of the stomach. In these cases it is brought about by pressure from without. We observed a patient in whom a large spleen made the upper part of the stomach from air bag to mid part of the tube, appear like a narrow, rigid canal with no peristalsis and a very small and deformed air bag. The palpable mass of the left side, which was the enlarged spleen, awakened the suspicion that the tumor might have been due to a malignant disease of the stomach. Inflation of the colon with air made the outline of the spleen to the palpating hand more definite. A more extensive spasm of the stomach, taking in the tube and pylorus and making the cardiac end appear funnel-shaped, was seen by us in a woman with a large fibroid tumor of the uterus.

Regional spasm of the tube or pars media with dilatation of the cardiac end and the pylorus is sometimes met with. It is usually of extra-gastric origin and only the clinical history can establish the cause. A seat of regional spasm is often at the point in the stomach just below the incisures cardiaca. We do not refer to the standing contraction or the incisura on the greater curvature. This is to be discussed below. What we have reference to here is that the contrast substance is held at the point mentioned above. The fornix is seen dilated and sometimes from five to ten minutes either no food is seen to come down or only a thin streak along the lesser curvature. In the former place the fornix presents a pear-shaped or triangular appearance, in the latter case, the narrowing below the dilatation bears resemblance to a cardiospasm with the dilated esophagus above it. We have, therefore, conceived the idea that the spasm is not only local but that it spreads to the greater part of the tube.

Another point of very frequent regional spasm is that of the sphincter pylori. This condition is often brought about reflexly by chronic appendicitis, colico-mucosa, and is also often functional. It has great significance in erosions and ulcer in the region of the sphincter pylori. Such erosions may give rise to periodic gastralgia terminating in vomiting large quantities of fluid, but rarely solid food. Vomiting gives great relief. Morphine, on the other hand, may make the condition worse. If the condition lasts a long time, dilatation and hypertrophy of the pylorus becomes so marked as to give rise to a palpable tumor.

The fluoroscopic and radiographic appearance in such cases is most striking. The pylorus appears as if suddenly cut off and is immensely dilated. Forcing the food out, while fluoroscoping, we see only a narrow stream of contrast substance, which fills the first portion of the duodenum very thinly, giving it the appearance of a goose feather. Sometimes we may watch for several minutes without seeing any food going through the pylorus. If we fluoroscope and take plates of such cases, an hour or two after the ingestion of the contrast meal, very little is seen to have left the stomach. If the spasm is of extra-gastric origin it is usually very transient and there is only a very moderate delay in the emptying of the stomach and as a rule no six-hour residue is present. If there is a large six-hour residue in such cases, we usually find the rest of the contrast substance in the terminal ileum, which becomes considerably dilated. The cecum, as a rule, contains very little or no contrast substance at all. This seems to us to indicate the existence of a spasm in the sphincter of the ileo-cecal valve and that is most likely the primary cause of the sphincter pylori. The delay in the emptying of the stomach may not depend entirely on the persistent spasm in the sphincter pylori, but also, to a great extent, upon the fact that the small intestines are filled and therefore the so-called intestinal hunger (Parlow) is not present.

When the spasm of the sphincter pylori is due to a local erosion, the six-hour residue is large. The terminal ileum containing little contrast substance or, maybe, entirely empty and the distribution through the colon may not be abnormal. The reason that the small intestine contains so little contrast substance, although the stomach contains

much, is explained by the fact that the food is so thoroughly digested in the stomach that it therefore runs through the small intestines rapidly.

Incisura.—The incisura or spastic hourglass has been made accessible of recognition by means of the x-ray. It appears mostly on the greater curvature, a little below the incisura cardiaca. It may, however, appear in any other part of the greater curvature of the stomach. It may be transient or persistent. There is usually one incisura, but two or three may be present. The depth and width of the incisurae vary from that of a small nick to a deep wide contraction reaching the lesser curvature and giving the stomach a bilocular appearance. When there are two or three incisurae the stomach appears as if it were divided into several compartments. These incisurae may be of extra or intra-gastric origin. Such incisurae are met with occasionally in cases of chronic appendicitis and gall stones. Very rarely they appear spontaneously in such cases during fluoroscopic examination, but more commonly, as pointed out by both Case and Carmen in this country, and Borsany and Hurst abroad, the incisura is brought about when pressure is exerted over the diseased organ (appendix, gall bladder and duodenum) while fluoroscoping. Even under such circumstances it is not a common occurrence. It has been our experience that when pressure on a diseased appendix or gall bladder brings about such indentation, it is very transient and lasts only as long as the pressure is continued. More commonly, it is seen in neuropathic individuals, especially where vagotonia (tropia) is predominating. Also, pressure from without as a tumor in the left hypochondrium, large spleen or even gas in the splenic flexure, may produce such spasm. The most important intra-gastric cause for spasm is an ulcer on the lesser curvature of the stomach, just opposite the incisura. The spastic incisura, whether of extra- or intra-gastric origin, may be transient and disappear spontaneously, while fluoroscoping, or may persist during one examination and not be present at the next examination. Deep and wide incisurae, situated opposite an indurated or penetrated ulcer on the lesser curvature, are usually persistent and only disappear under deep narcosis. That is why the surgeon in the early days of x-ray diagnosis contradicted the x-ray finding of hourglass.

The differential diagnosis between spastic incisurae of extra-gastric origin and that due to ulcer on the lesser curvature of the stomach is made by the administration of antispasmodics, like atropin or tincture belladonna, according to the method of Carmen, or papaverin or atropapaverin, as advocated by Holzknecht and Gulitzer. The disappearance of the incisurae, after antispasmodics, according to our opinion, does not exclude an ulcer on the lesser curvature. The persistence of the incisurae, on the other hand, and especially if a niche is seen on the lesser curvature, establishes the diagnosis of ulcer with absolute certainity. A rare type of incisura occurs on the lesser curvature just below the air bag, indicating the seat of an ulcer. Another rare form of spastic incisura is mentioned by Faulhaber. In this type the cardia is to the left and is connected by a narrow isthmus to the rest of the stomach, which lies to the right. Another rare intra-gastric cause for incisura is carcinoma of the stomach.

Total Gastro-Spasm.—This is the rarest of all forms of spasms and is in the most cases of extra-gastric origin. Cases reported in the literature were due to chronic lead poisoning, tabes, dorsalis and morphinism. Two cases were seen by us, one due to chronic appendicitis and the other tubercular peritonitis. Another case mentioned in the literature was due to gall stone disease. Carmen and Miller reported a case of gastrispasm, produced by a small cancer on the lesser curvature of the stomach. Gastrospasm is characterized by an extreme hypertonus. The stomach is considerably diminished in size. It is situated very high in the abdomen, most of it to the left of the medium line and often running transversely so that the pyloris and part of the corpus are to the right of the medium line. The air bag is small, peristalsis is almost absent and the food is seen to pass continuously into the small intestine. It resembles almost entirely a scirrhous cancer. The resemblance of all forms of gastro-spasm to filling defect due to cancer is so striking that, rightfully, do Carmen and Miller make the statement that not only is the novice in danger of mistaking it for cancer but the expert as well.

DISCUSSION.

Dr. Erwin Reissman, Newark: Dr. Roemer has chosen a subject of direct interest to the roentgenologist, and of indirect interest to the physician and the surgeon. Gastrospasm is a symptom, and must be correlated with the findings discovered in our roentgen examinations. There are two intrinsic causes of gastrospasm in which the surgeon is particularly interested, and these are ulcer and cancer. When we find the ulcer, it is immaterial whether the spasm is present or not; and when we have discovered the cancer by x-ray, it is equally immaterial whether there is spasm or not. When, however, we find a gastrospasm, which is really either a hyperperistalsis or a lack of persistalsis, then we must look for a diseased area anywhere below the diaphragm. Anything below the diaphragm may cause a gastrospasm, particularly appendicitis and gall bladder disease. Gallstones alone are not entirely responsible for gastrospasms. Cholecystitis is much more apt to be responsible. When we find canalization or a tubular contraction of the prepyloric portion of the stomach, which is the most symptomatic sign of gall bladder disease, we must make up our mind that the gastrospasm is due to this disease. We are often confronted with the question, from the physician referring these cases, as to whether we can visualize gallstones. I do not think that it is as important to discover the stones as it is to discover the additional indirect findings which symptomatize this disease.

I want to bring out one more point, and that is that we might misconstrue as gastrospasm the ingestion of a meal which is ingested by the patient. Unfortunately for some of our patients we give a sour milk; and very often the patient is not fond of this, and during the fluoroscopic examination we see hyperperistalsis and contraction of the stomach due directly to the ingestion of this particular meal. Another cause is neurosis. The patient is nervous, and the function of the stomach is not the same as it would be in normal circumstances. These are some of the causes to which I wish to call your attention. Rest, belladonna, or anesthesia will cause all the pseudo-spasms of the stomach to subside. We should look more for the causes of spasms than for the spasms themselves.

DIVERTICULOSIS OF THE CECUM.*

By Martin W. Reddan, M. D.,
Trenton, N. J.

With Lane removing the colon for the cure of a cyst of the mammary gland, with Cotton and Draper doing a similar operation for the cure of insanity, and others doing colectomies for the relief of infected joints; with Willey, in the British Medical Journal of May 8, 1920, having no doubt of the very close connection between depressing emotion and pathologic conditions of the large bowel, and suggesting that the mental condition is the first stage in the creation of diverticulitis; one may well feel timid about entering into the turmoil, unless he believes like the Irishman—that it is not a private fight, and that anyone may get into it.

The accumulation of such a great amount of evidence, much of it proved by the end-results, leads us to safely conclude that the colon stands convicted as the source of many ills. But let me sound a note of warning that in our zealous efforts to remove a focus of infection, we may unnecessarily sacrifice useful organs.

Because of this confused state of evidence, it may be of interest to recount the clinical experience and end-results in a series of cases observed during a period of five years. Please do not take alarm at this statement, for I have no intention of boring you with the reading of case histories, or telling you how many of these cases have been done—for I always feel that these statements are of interest only to the writer.

Patients suffering from what I have termed diverticulosis will complain of constipation, often for a period of eight days; will have headaches, nausea, malaise, joint pains, almost invariably pain and tenderness in the right iliac fossa, and may have a temperature of 102 or 103. They tire easily, lack ambition, have a muddy-colored, anemic appearance, and in general, are below par. They are compelled to resort to large doses of purgatives which result in a few liquid stools, and then constipation until the next taking of purgatives. At these times a few hard masses may pass with the liquid stool. The x-ray (Fig. 1) generally shows a stasis in the ileo-cecal region, and the urine contains a large amount of indican. I have observed it at two years of age, and at fifty-six. It occurs about equally in the male and female. On palpation, frequently, a distinct mass, of doughy consistency and tender to the touch, will be felt; and in many cases enlarged glands may easily be distinguished.

It is this class of cases that have their appendices removed on a diagnosis of chronic or gastric appendicitis, feel better for a time, sometimes not over two weeks, and then pass through the same cycle again. The reason for this recur-

*Read at the Annual Meeting of the Medical Society of New Jersey, Spring Lake, June 15, 1920.

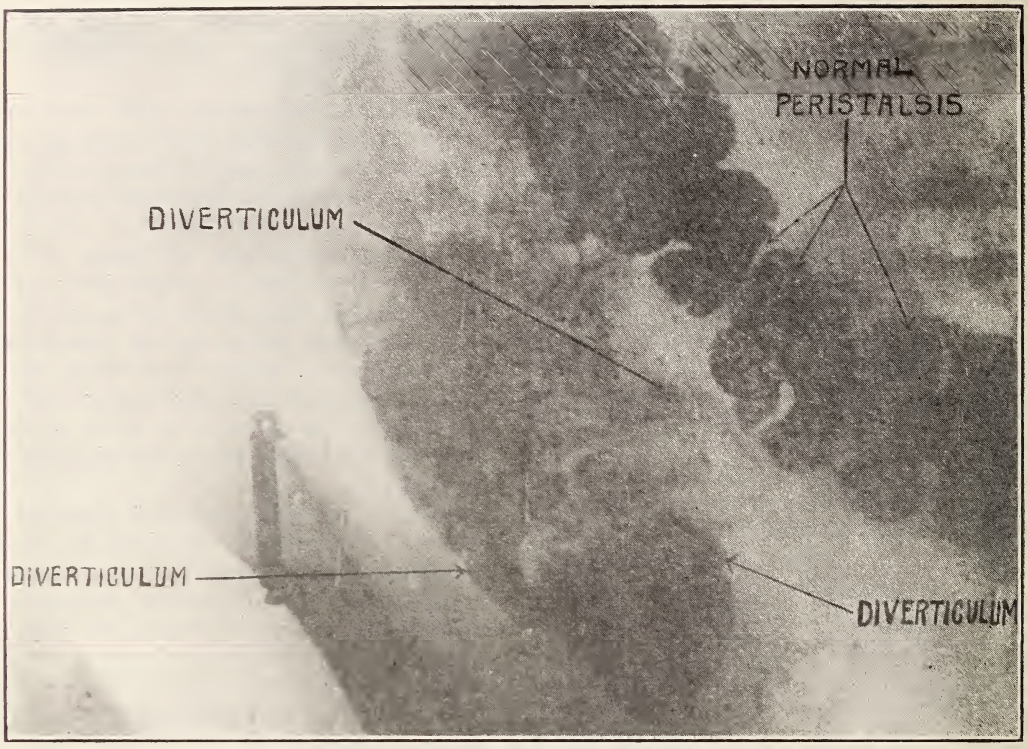

Fig. 1. Comparing normal Peristalsis in transverse Colon with inefficient Peristalsis of Cecum; also showing Diverticuli.

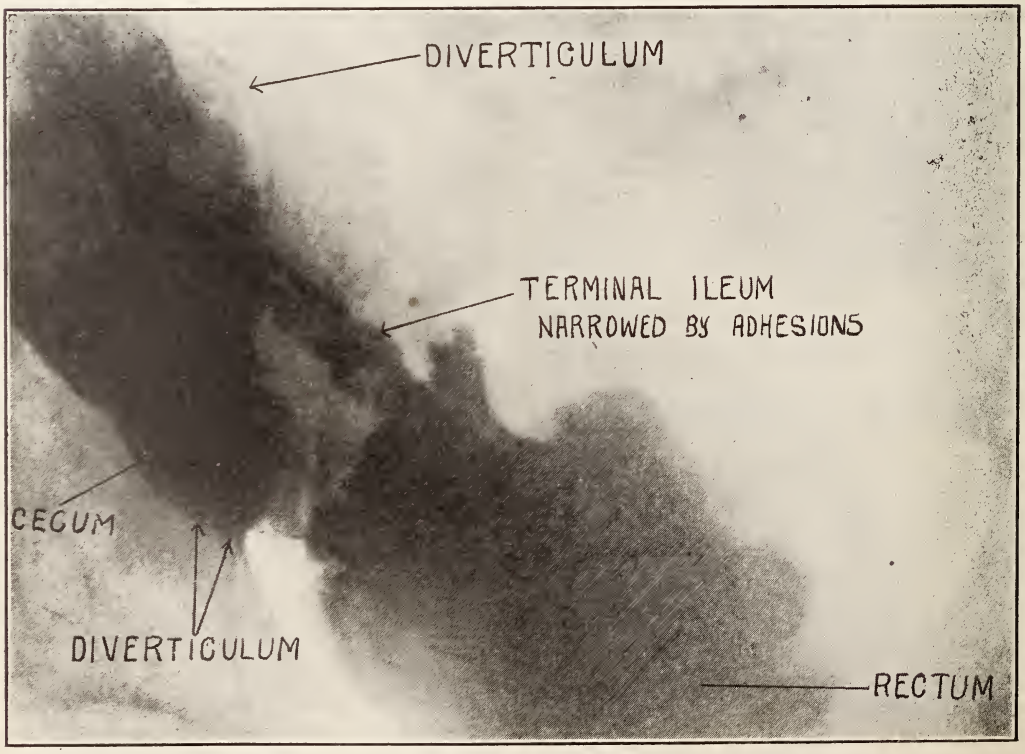

Fig. 2. Showing narrowed terminal Ileum and Diverticuli of Cecum.

rence of symptoms is that while the appendix may be diagnosed as thickened, catarrhal or chronic—very often to ease the operator's conscience—or even if it is thickened and chronically inflamed, yet, neglect to remove the real cause of the trouble, must result in failure.

If a sufficiently large incision be made, permitting the delivery of the cecum and terminal ileum, Jackson's membrane will be found very distinctly in evidence. Mesenteric glands will be found enlarged, and often fecal masses from one-half to five centimeters in diameter may be readily palpated in the pouches, formed by Jackson's membrane, constricting transversely and shortening longitudinally the cecum and ascending colon. Frequently, too, in these cases, a Lane kink of the terminal ileum is found.

The treatment consists of dividing this membrane where it is attached to one of the longitudinal striae of the colon, and then stripping it back from the circumference of the bowel until the smooth peritoneal covering is exposed, and the pouches have been smoothed out. If there has been no recent inflammation of the parts, this is a very simple matter, and may be accomplished practically bloodless. But, if there has been recent inflammation, this membrane will be found adherent, or almost merged with the peritoneal covering, and it will contain blood vessels that will readily bleed, and care must be exercised lest we strip the peritoneal coat off with the membrane. The bleeding, in this latter class of cases often requires ligatures to stop it, but in the former the application of artery forceps for a couple of minutes will suffice. Not infrequently, this membrane will be found extending over the appendix, and at this point, it should also be divided and stripped back. If a Lane kink is present, this should also be freed.

I want to distinctly differentiate between Jackson's membrane and parietocolic bands, which it is not my practice, unless there is a very obvious angulation of the bowel, to divide, because I consider them physiologic, and forming anchorors or guy-ropes to fix the bowel, and from the leverage, increasing the efficiency of the peristalsis.

Practically all of these cases have a Lane kink of the terminal ileum, and this, I believe, should be divided, because this kink causes very distinct narrowing of the lumen of the small bowel (Fig. 2.) After all constricting bands have been divided, the appendix is removed.

Very commonly, the first bowel movement following operation will contain hard fecal masses from the size of a pea to that of a pigeon's egg. These masses may be from five or six in number to forty or fifty, and their centres may be practically dry.

Leaving for a moment, the realm of facts and journeying into the fields of fancy, may we not ask the question: Is it not perfectly reasonable to suppose that the continued retention of these masses in the abnormal pouches of the large bowel may result in true diverticulitis, and that irritation of the diverticulitis may result in cancer?

IDEALS, AIMS AND IMPORTANCE OF AN ACADEMY OF MEDICINE.

Address delivered at the Dedication of the Academy of Medicine of Northern New Jersey, held at St. Columba's Hall, Newark, N. J., Wednesday evening, October 20th, 1920.

Rev. Charles B. Moulinier, S. J.,

Regent Marquette University, Milwaukee, Wis.

Right Rev. Bishop Lines, Gentlemen of the Clergy, Preceding Officers of the Academy of Medicine, and Present Officers, Ladies and Gentlemen: I feel I am utterly unable to tell you what should be told on an occasion like this. The things you have listened to tonight, the description of the Academy building and its contents as supplied by the members of the Academy and as presented by Dr. Disbrow, may have brought to your minds many valuable thoughts and true conclusions. Really, if you were all as interested in medical things as medical men are, there would be nothing for me to say. However, in fear that perhaps we do not all quite appreciate the significance of this dedication of an Academy of Medicine on October 20th, 1920, I am going to be bold enough to say to you some of the things that appear to me to be absolutely wrapped up in the significance of this gathering here in dedicatory services for an Academy of Medicine.

Your program has a motto in Latin: "Prodesse Quam Conspici," rather to be of benefit than to be conspicuous, or to draw attention. I do not know who it was and what committee it was that chose a motto of that kind, but to me it

expresses the great and deep significance of this gathering. I have been dealing with medical men for the last nine years very intimately as a Regent of a Medical School. For the last six years as President of the Catholic Hospital Association of the United States and Canada I have been meeting staffs of hospitals all over this northern continent, and that has brought me in very close touch with the medical mind, and the medical soul here in this country. I know there is much of retardation, of opposition; there is much in the individual medical man, in groups of medical men, in practitioners that are not recognized as belonging to the medical profession, and in the public mind—there is much even in some religious orders in this country, that is in antagonism with what the real scientific, educated, highly ethical members of the medical profession are aiming to bring about.

Do you know that fourteen years ago there were in this country some 212 medical schools, and of those 212 there were perhaps only 8 or 10 that deserved to be classified as medical schools, because they were the only ones teaching the medical students the up-to-date, latest, best knowledge and skill of the medical science? And do you know that the medical profession itself took hold of the cradle in which it is born, the medical school, and in six, eight, ten, twelve, fourteen years wiped out of existence many of those 212 medical schools, brought up to higher efficiency as scientific institutions those that remained; so that today we have 96 medical schools in the United States, and of those 96, 68 are Class A schools, after rigid examination, and the remaining rapidly rising to high-grade efficiency as medical institutions?

Do you know likewise that the medical profession is today investigating all the hospitals of this northern continent with a view to finding out whether modern, up-to-date medicine is being practiced in them by the medical profession? And do you know that of the 700 or more hospitals with 100 beds and up, there are but 375 that are giving the patients anything like 100 per cent. of modern medical standards and care?

Ladies and gentlemen, these are simple facts of events as they are going on today, and I want to ask you, who is doing this betterment and improvement in all things medical? The medical profession. And what does the medical profession get out of it? Mostly abuse; some expense is incurred. And who gets the benefit? We, you, I, everybody, the public, the sick persons. The medical profession, therefore, in a manner that seems to me most extraordinary, has recognized that things were not as they should have been in its own profession, in the kind of men that were trained for it and brought into it in former days. They have remedied that largely, and now they are seeing to it that the hospitals become more and more the kind of places they should be. And both movements were and are for the benefit of the public, because we are all the public when it comes to the question of medical care. And the public hardly knows about it. The public has heard little about the previous movement in regard to medical schools. Every now and then it has heard something about this betterment of hospitals. There was an article in The World's Work; there was an article in The New York Times. But, ladies and gentlemen, the public does not realize how genuinely, sincerely and deeply the medical profession is idealistic. They are looked upon too much by the public as selfish men, as men who are thinking first of themselves and of their advancement and of their compensation. We all know that there are such men; there are such men in every profession. But to me the action of the group of doctors here in New Jersey who have, through nine long years of struggle and of effort and with their own money, started this Academy of Medicine, is of exact parallel in its aim and purpose as has been the action of the great medical profession throughout this continent.

I cannot help, therefore, but pause right here and say to these gentlemen, say to you in whose midst they are, that no words of praise that I or anyone else could utter, can express the value, the significance, the importance not only for Newark but for this great country of what has been done by these men in establishing their Academy of Medicine.

We are in every phase of life in great need of men of vision and of men of determination, who will cary out the things they see that are for the betterment and improvement of our civilization. And there is no other one thing that stands out, with the same depth, seriousness and

consecration perhaps, as this, except religious movements and efforts which look to the soul, the mind, the inner life. But with the single exception of the spiritual needs of man, the bodily needs, the health of mind and the whole physique, is the most important element, the most important constituent of a civilization. If you will take the time tonight to look through the relics the doctor has presented to the Academy, and see how as you go back into the past they reveal a strange, an unaccountable mysteriousness that in much of the past has accompanied the practice of medicine and has gotten into men's minds, as to the bearing and significance of medical practice, and if you will even come up to the present day in your inspection of those relics, you will find that there are evidences there of a still lingering vagueness and darkness in the human mind as to what all this thing of health and cure really is. You have friends, you have acquaintances almost without exception, I make bold to say, who do not today in this enlightened age—and they are people of intelligence, too—understand really what medicine means, what its aim is, what it has to do with those destructive conditions of disease that occur in the human system. And so, if you will pardon me, a layman, I am going to try to say to you in as few words as I possibly can, something about what medicine really is, and perhaps some few things as to what really it is not.

There is no more mystery in medicine. There really never was any, but people did not know it. There may be an intervention of the Creator as to the operations of some of His laws. There may be such a thing as a miracle. But barring that one thing, medicine is nothing more than the use of man's knowledge and skill in trying to preserve in the human system and to restore in the human system, completely or partially, the harmoniuos working out of the biological laws within us. Those biological laws are better known today than they ever have been. They are being studied carefully, and hardly a day, certainly not a week, and beyond question not a month passes but man gets some deeper insight into what the laws of biology are. We are surrounded by an ocean of law. The laws of physics are absolutely in control of us, as are the laws of mechanics and the laws of chemistry. And then when they enter our system and become a part of us in their working, this whole group of laws, physical, mechanical, chemical, become biological, and every motion of mine, every action that I am now going through is nothing more than the carrying out of bio-physical, bio-mechanical, bio-chemical and the more strictly called biological processes in the various tissues and parts of our system.

If, by any mishap, some micro-organism, a biological entity, either animal or vegetable, gets within the confines of my own biologic unit of life, and is strong enough to prevail against the normal biological processes in my tissues, wherever they be in my whole system, I have an infection; I get a fever; I am sick, and the medical man, by his efforts medical, a drug treatment, or surgical, does all he can to restore the balance or the harmony and give my biologic unit by force, a predominance over the invader. All the life history and the life action of those micro-organisms, many in number, hundreds in number, we are just beginning to know about. The great Pasteur, I think it was in 1850, for the first time discovered them. We thought disease was due to all kinds of things, such as we call infectious and which brought about fever; but now we know that all such diseases are due to this invasion of a micro-organism, and we know that there are certain things that can be done that will help towards a cure. And we know this through the study of scientific facts. The medical mind of today, the highly trained mind, the laboratory man's mind and the skilled, experienced practitioner, either knows or does not know just what is the matter and what to do; and they know that they do not know—which is a very important thing, if they are instructed, if they are like that group of men who have established this Academy, if they are men who know these things that I am referring to as masters, who know how tremendously broad and deep and complex medical science is, who know the need for themselves, for their younger brethren and for the public that there be in every community some leadership in medical knowledge, in medical science and in medical skill: And this Academy means that to you.

So then there is no more mystery about medicine. There is much that is not known, much more is not known

very likely than is known. But the typical medical mind of the leader today, of the outstanding and the upper group of medical men, the men who interest themselves in the medical societies, men who travel, men who read, men who study, men who concern themselves with the laboratory sciences—these men are to a community what leaders in thought of every kind, leaders in political thought, leaders in economic thought, leaders in business enterprise are to such a community. And if I may be indulged the privilege of saying something to the non-medical members of this audience, I would say to you, ladies and gentlemen, there is no group of men doing more for your community and capable and ready and eager to do more than the medical men who, as you have heard tonight, so unselfishly, laboriously, have brought about the existence of an Academy of Medicine.

Let me say again, what does that mean? It cannot mean anything else but a scientific spirit in the minds and lives of all the worthwhile medical men in this State and many outside it, because it means men of thought, men of reading, men of research attitudes of mind, men who are eager in the desire to do more and more for the public amongst whom they work for the prevention of disease, for cure of disease, for alleviation of disease.

I do not know that this is an occasion on which I should say anything derogatory to any members of the regular medical profession or to those who are spoken of as outside the regular medical profession, those advertising medical people, those that are sometimes called quacks, those people who have not gone through a medical course and yet undertake to treat human ills. Do you know what kind of a course the regular medical man gets today throughout this country? Due to the efforts of the medical profession itself to bring into its ranks better trained men, after the four years high school they get two years of college called pre-medical work, during which they are obliged to study physics and mechanics and chemistry and elementary or fundamental biology; two years of college life called pre-medical. Then they go to the medical school, and they get four years of the strictly so-called medical sciences, anatomy, histology, embryology, physiology, physiological chemistry, pathology, bacteriology. Two years are devoted to those fundamental sciences that give to the medical man a knowledge of what are called the fundamental causes of disease in man and the fundamental laws affected by disease. And then they spend two more years in the medical school studying the symptoms, the manifestations, the effects of these laws gone wrong within man, called symptomatology. The eye is trained, the ear is trained, the touch is trained to distinguish signs that appear to the eye or to the ear or to the touch indicative of something wrong within the tissues here or there within the system. And the medical man who uses his senses to distinguish the significance of these symptoms as they are called with his training in the fundamental branches, goes back to the cause and thus makes a diagnosis, and it is only on the basis of a diagnosis made most carefully, most systematically, and with all the checks of laboratory tests, that a scientific care of a patient can be given. And that is modern medicine; that is the kind of medicine that the medical profession knows and wants to give. It is the kind of medical care and treatment that the medical profession is trying to bring about in all our hospitals for every man, woman and child that enters into them. And it is that kind of scientific, up-to-date, ever-growing in knowledge medical science and skill that this Academy of yours stands for in your midst as the great protector of the health of your community.

"Prodesse Quam Conspici" is their motto. To do good; to be of benefit rather than to be seeking a reputation. But today, my dear friends, it seems to me the medical profession needs reputation, because all this group of poorly educated, incompletely educated practitioners are deceiving the public. They are doing little superficial treatment of symptoms. They are curing a pain for a short time. They are making one feel just a little better after each treatment, but they are not getting at the causes of disease, and, unless the individual is absolutely exceptional, because of the training they have had, they cannot get at the causes, because they are deep, they are fundamental, they involve a knowledge of bacteriology and pathology and physiology and physiological chemistry, which these men have not. And what is needed today is instruction to the public,

a plain simple statement of the truth in order that the public protect itself against the unscientific, the uneducated, the unskilled so-called practitioner under various forms of therapy.

That brings me to the one fundamental thought that seems to me to be deepest in the significance of this meeting. Science theoretically is knowledge. The philosopher is the one who loves knowledge. The natural sciences, the biological sciences, the ones that make up the basis of the art of medicine, the healing art, are the sciences that deal with the laws of matter, matter actuated by living force, living power. The man or the woman who studies the natural sciences does so under the impulse of medical knowledge. Knowledge in the strict sense of the word is truth. We do not know a thing until we have the truth about it. A mere opinion, a mere vague speculation, a mere hypothesis is not knowledge that is certain, that is sure, and that is worth any ultimate purpose to us. But it is that certain knowledge that science alone seeks to attain as its great and only object—scientific truth: That is in the mind and in the heart and in the soul of every leader of today in the medical sciences, and of all those in the past. There have been great men that stood out in the history of medicine, and have made it what it is;—and so today there are great men who are working at the discovery of the significance of those laws that enter into our system and that make our life or mar it if they be interfered with; there are great medical practitioners, great surgeons, great diagnosticians, great internal medicine men who are renowned throughout the country. What is it that inspires them all? What is it that inspires this group of men who have established this Academy of Medicine? It is the love of the truth; and if it were not that, the Academy could not last; medicine could not last; science could not last. It is the truth of the laws that are at work within us; and it is the truth of the laws that are put into our being by the Creator that the mind of man in his scientific efforts is trying to discover; and as he discovers them, science grows, and scientific men become more and more able to help us poor humans in our struggle for existence here below.

To me one of the most appealing thoughts in all my dealings with the medical profession, one of the most comforting reflections I have repeatedly made, is, that the medical man that stands out, the medical leader, the medical reader, thinker and investigator, whether it be in the laboratory or in the clinics, whether it be in his office or in the hospital—the medical man that stands for the medical profession, no matter what his religious belief, no matter even if he be an unbeliever, still has a love of the truth. He still is seeking for facts. He still is seeking for causes, and he honestly and sincerely is working to advance the bulk of medical knowledge, and he eagerly and earnestly devotes his life to the care of his patients according to the laws of biology as he discovers them through his growing knowledge from the laboratory or from his clinical experience or from reading of the laboratory investigations and clinical experience of his brothers throughout the world.

The medical profession today is the hardest working, the most eager for knowledge, and the most democratic in mind—democratic in so far as that all they want is the truth—that I believe has ever existed in the history of the medical profession.

Do you know, ladies and gentlemen, that we are in a period of unprecedented awakening, unprecedented campaigning in the medical profession, for all that is scientific and right and best in scientific knowledge and practice?

I have read the history of medicine with a fair amount of care and application. Away back before the time of Christ, there were outstanding figures, and along every century or so there appears a man and a group of men that try to arouse their profession to the truth of things as they see them, as they learn them by observation and by experiment as laboratory processes became developed. But today, not only in America, but in Canada and all over the civilized world, the medical profession is constantly searching deeper and deeper into the causes of disease and the means of hindering and curing and alleviating to an extent the like of which, I am sure, the world has never seen before.

Your celebration tonight is a manifestation, an evidence, a demonstration to you that your medical men here of Northern New Jersey are going along step by step with the great movement,

the great advancement of the medical profession on this continent and throughout Europe for better things, higher things, true scientific things.

And, just as a last word, this kind of man is the only kind of man in whom our lives are safe. No one here who thinks as I do—and may I hope that most of you do, in the things I have said. May I feel that I have just said what was in the minds of all of you,—no one here would think of intrusting his or her life to a man that was not trained, that was not a scientific physician, that was not a diagnostician, that was not a skilled operator if there were question of an operation. If that is true, and it is true with all of us that know and can choose, then, ladies and gentlemen, the same thing should be procured for every other human being in this community, because there is no one human being in Newark or New Jersey or in any part of the United States or in any part of this world of ours that has a greater right to life than any other. Our right to life is absolutely an equal right. We do not get our right to life from our color or size or wealth or social position. Our constitution says "All men are born free and equal." Equal in the fundamental right to life and all the rights that necessarily flow from that right to life. We Americans like to talk a great deal about rights. We like to feel that we are standing for right. We like to boast that the human right we will fight for and die for. The great, deep, fundamental right of every human being is the right to life. It is a God-given right, if we believe in a God, and if we do not, it is a right the human has wherever he comes from, because if he has not the right to life, he has no other rights, because all other rights flow out of the right to life; and if we have a right to life, we have a right to health; if we have a right to health, we have a right to the care of health; if we have a right to the care of health, we have a right to the best care of health there is attainable, and that best care of health attainable we get from the scientifically trained medical profession, members such as are found in this Academy of yours. And I honor you, I congratulate you that you have such a body of men in your midst

Cancer of the uterus occurs once in every three cases of cancer in women and is uncommon in nulliparae.

THE PHYSICIAN AS A CITIZEN.*

By Chas E. Humiston, M. D.,

Professor of Clinical Surgery, College of Medicine, University of Illinois. President-Elect, Illinois State Medical Society.

Chicago.

War upon the "Intellectuals" is not confined to Russia nor yet to the battle-scarred nations of Europe. Bolshevistic manifestations are not entirely wanting in our own, the most favored nation of all times. The traditional premium on brains has become largely a myth. The hodcarriers' union commands more consideration than does the County Medical Society.

A carpenter's income based upon an equipment of modicum of training together with an armamentarium of a saw and a hammer puts to shame the pecuniary compensation of a college professor. The profession of medicine is coming to be more and more discredited as a means to a decent livelihood. Laws discriminate against physicians. In the settling of an estate a long list of preferred claims takes precedence over bills for medical services. In personal injury cases a claimant may not settle without the consent of his attorney but the laws afford no such protection to his physician.

In industrial cases the law confers upon the employer the right to select the physician, withholding from the injured employees their natural right to have a voice in the selection of the medical attendants into whose hands their welfare is committed.

State officials are seeking, through annual re-registration, to number and tag the physicians in order that the profession may be still further subordinated and subjugated and the aforesaid state officials become correspondingly more influential and more important politically.

"Uplifter" societies are everywhere combing the community for charity work which physicians are expected to perform. Medical relief to the poor is directed by laymen on salary, while the work is done by physicians gratis.

Educational prerequisites to the practice of medicine by reputable physicians now cover nineteen years of instruction and training, whereas quacks and charla-

*Read before the Tri-State District Medical Association, Oct. 4-7, 1920, Waterloo, Iowa.

tans are permitted greater privilege with next to no educational or moral qualifications; and one particularly pernicious group is specifically exempted from all supervision and restriction, while its own self-imposed conditions are limited to these, namely: A mental twist and an insane desire for money.

Public officials give ear to the voice of organized labor but frown down the solemn declarations and formal requests of organized medicine. The union man who patronizes only union shops and uses only union-made materials never thinks to inquire as to whether or not his physician belongs to the medical society.

Always and especially in its times of peril the nation depends vitally upon its physicians, and always and especially in its times of peril, the nation's trust and confidence in its physicians have been justified by their achievements, yet the national congress passes laws oppressive to physicians and favorable to the vendors of patent nostrums.

In many ways the physician is the most conspicuous and the most important citizen in every community, yet in other ways, and these other ways include the condtiions which dominate his economic affairs, the physician is the **least influential** citizen in every community. That this is true is a misfortune for the general public as well as for the physician. All citizens share the benefits which medical science has contributed to the welfare of mankind. Whenever the proper influence of scientific medicine is curtailed, to the same degree the welfare and safety of the state suffer impairment. In times of war no other class of citizens in the percentage of its numbers or in the efficiency of its service to country equals the medical profession. In times of peace no other class of citizens counts for so little in the everyday affairs of men.

Law-making bodies pay scant attention to sets of resolutions adopted by medical organizations in annual session. No political consideration is shown to expressions of sentiment unless such expressions of sentiment influence elections.

The medical profession lacks solidarity in organization and breadth in purpose. No other class of citizens is qualified to deal with health problems, no other class of citizens should be permitted to dominate health legislation.

The injustices, inequalities and discriminations which political bodies have contemptuously heaped upon the medical profession and which have reacted hurtfully upon the public will be promptly and fully corrected just as soon as the medical profession calls into activity its potential political power. By political power is not meant ordinary partisan politics. The potential political power of the medical profession is neither republican nor democratic, nor does it reside in a new party, but is a moral force to be exerted regardless of partisanship. This wholesome political influence must be exerted by physicians through organization. The traditions and ideals of the profession will not be compromised nor abandoned—rather will a broader and more lofty purpose be attempted.

The advent into the political field of so large a body of citizens characterized by the high degree of culture and intelligence which physicians as a whole possess, will tend to eliminate certain elements that should have no part in public affairs. The medical profession is lacking in moral courage if it continues to surrender to a lower stratum of society the high privilege of controlling the momentous affairs of government.

The well-known hazards of the physician's life in times of peace, as well as in times of war, are conclusive proof that physicians are not wanting in bravery, in fortitude, nor in heroism.

What, then, is the physician's duty as a citizen for his own sake, for the sake of his family, for the sake of his profession and for the sake of society? The plain duty of the physician as a citizen is to assert a broad citizenship, which must include a wholesome and effective political influence. This political influence, in order to be wholesome, must not be partisan. This political influence in order to be **effective** must be exerted through medical organization and above all **it must be carried to the polls.**

The time is ripe for a movement of this kind. Legislative ills are pandemic. Self-preservation demands that the "rank and file" of the medical profession wake up—and when the awakening does occur the way of the quack, the charlatan and the medical parasite in religious cloak will indeed be hard.

Then will come a single standard of qualifications for practicing the healing art. Then will the health and lives of human beings receive at least as much

consideration at the hands of state legislatures as is now accorded to the health and lives of hogs and cattle. Then will the health and lives of working men rank in importance with the health and lives of their employers. Then will medical charity be dispensed by justly compensated physicians. Then will come an end to the wholesale sacrifice of the lives of helpless little children upon the altar of sordid greed—under the cloak of religion. Then will murder by neglect through fanaticism be recognized as such in Wisconsin, in Illinois, and in Iowa, as it is now recognized in New Jersey.

And through it all, and above it all, the medical profession will have advanced on its way toward a higher and a better citizenship.

Clinical Reports.

RADIUM BURN OF THE VAGINA RESULTING IN AN ILEO-VAGINAL FISTULA.

By Thomas W. Harvey, M. D.,

Orange, N. J.

Radium is being used so generally at the present time that the report of a case in which it has been used is only excusable when it presents some unusual features.

Mrs. D. ——, U. S., widow, aged 68 years. Twenty years ago had had a vaginal hysterectomy made by Dr. Joseph Price of Philadelphia. Since that time has had no local symptoms. In March, 1920, she began to have a bloody vaginal discharge. Examination showed a small ulcer on the hysterectomy scar in the vagina. As this did not yield to treatment, Mrs. D. was sent in to Dr. Douglas Quick of the Memorial Hospital, New York City. A section of the ulcer showed that it was an epithelioma and he advised the application of radium. This was done about the first of June. The re-action was quite severe but the local symptoms disappeared with the exception of a slight vaginal discharge.

About August the 10th, a fecal discharge began to come from the vagina. This was very irritating and painful, so painful as to require anodynes for relief. Examination showed that there was a normal radium scar with a small perforation from which there exuded a discharge of the contents of the small intestine. It was evident that it was necessary to meet the emergency of the fecal fistula with active measures. A laparotomy was made and several coils of intestines were found adherent to the hysterectomy scar in the cul de sac. These adhesions were dissected free; the last one to be separated was a portion of the ileum, about one foot from the ileo-caecal valve and two inches in length; the perforation would admit the end of the finger.

Four inches of the gut was excised and an end to end anastomosis made, thorough drainage was instituted. The after course was uneventful and the patient made a very good recovery. At present writing she has no local evidence of disease, only the radium scar. There was nothing else found in the abdomen that was abnormal; no growths and no enlarged glands. The pelvic organs had all been removed but the appendix was intact. The exsected gut was examined by Dr. Ewing, who reported that there "is no evidence of tumor cells, only an extensive chronic ulcerated enteritis."

The accident of a fortuitous adhesion of the intestine to one side of a scar, which became the seat of an epithelioma on the other side; the burning by radium which penetrated the intestine and caused the fistula; the disappearance of all signs of malignancy after the application of the radium are the unusual features. The patient bore the operation very well, although her urine showed albumen and casts, and her systolic blood pressure is over one hundred and sixty.

UTERINE AND TUBAL PREGNANCY CO-EXISTING.

REPORT OF A CASE COMPLICATED BY MISCARRIAGE AND INTRA-PERITONEAL RUPTURE.

By Drs. Harry G. Macdonald and Donald A Curtis.

Hackensack, N. J.

Mrs. W., colored, aged 28 years, married 12 years, no previous labors, one miscarriage, followed by curettage, six years ago. Family and past personal histories negative, no severe illness and no symptoms of constitutional disease. Began to menstruate at age of 15, always regular in type and habit, but suffered co-menstrual dysmenorrhoea. Last men-

struation June 24, 1920, with absolute amenorrhoea lasting until Sept. 6, 1920, when vaginal spotting began, followed shortly by more severe hemorrhage, accompanied by backache and bearing-down pains in lower abdominal quadrants.

On examination cervix was found soft and open, the uterus enlarged and contracting, and diagnosis of threatened abortion made. Usual routine treatment was followed, but that same night miscarriage occurred, and fetal mass and placenta were expelled. Pain and severe flow ceased thereafter, but spotting and passage of clots continued for one week, at the end of which time curettage was advised and performed at the Paterson General Hospital on Sept. 13. Under anesthesia at this time, examination revealed the presence of a rounded mass to the right and behind the uterus, and a presumptive diagnosis of prolapsed cystic right ovary was made. From the general aspect of the case, and from lack of suggestive symptoms referable to the right lower quadrant, the thought of ectopic gestation was not seriously considered. Patient remained in bed one week, at the end of which time she felt perfectly well, and there had been absolutely no vaginal discharge present since date of curettage.

About 6 A. M. on Sept. 26, patient suddenly began vomiting and experienced severe, general abdominal pain. The vomiting continued, the colicky pain grew more unbearable, being equally distributed over both lower quadrants, obstipation was present, and patient felt progressively weaker, suffering fainting spells upon any exertion. Temperature normal, pulse 100, respirations 22, W. B. C. count 14,000, with 90% polymorphs. Abdomen distended, but no intra-peritoneal fluid discernible. Entire belly sore to presure, but greatest tenderness, muscle-spasm, and rigidity centered over McBurney's point. The condition closely simulated an acute fulminating appendicitis. Patient was at once removed to the Paterson General Hospital, where her condition rapidly became worse, temperature subnormal, pulse 140-160 and thready, respirations 32-40, faintness more marked, and patient seemed profoundly shocked. It was deemed inadvisible to operate at such risk, but when, under morphine, Murphy drip, and postural treatment no improvement was noted.

The need of immediate laparotomy, in spite of shock, was apparent. At this time the presence of intra-abdominal fluid was demonstrable, and with the unmistakable signs of internal hemorrhage, a ruptured tubal pregnancy seemed probable. Upon opening the abdomen, under ether anesthesia, profuse intra-peritoneal hemorrhage was found. Immediate exploration of the right lower quadrant revealed a fetus free in the abdominal cavity, attached by the cord to the placenta, half extruded from a rent in the fruit sac, at distal end of right tube. Fruit sac, right tube and ovary were clamped and removed en masse, the hemorrhage ceasing almost at once. Little time was wasted with peritoneal toilet, and the abdomen was rapidly closed, leaving plain gauze packing about stump of amputated appendages, and cigarette drain to cul-de-sac.

Patient left table in fair condition, but upon return to bed began to sink rapidly. Usual treatment of shock was again employed, with hypodermoclysis of saline and adrenalin, and patient rallied perceptibly. For 48 hours she ran temperature 102-103.5, pulse 120-160, respirations 30-50, suffered numerous faint spells, and almost continually vomitted light-colored, foul-smelling fluid. From that time temperature, pulse and respiration dropped, vomiting and faintness ceased, abdominal distention disappeared, and patient defecated and voided per se. The gauze packing was removed in 18 hours, the cigarette drain on the fourth day, and thereafter patient made an uneventful recovery.

The interesting observations in this case seem to be: 1. The lack of tenderness in right iliac fossa during examination at time of miscarriage. 2. The absolute lack of symptoms from time of curettage to date of rupture. 3. The lack of symptoms of primary rupture or fruit sac. 4. Absence of any genital hemorrhage when rupture occurred.

THORACIC TUMOR MISTAKEN FOR ANEURISM.*

By Hyman I. Goldstein, M. D.,
Camden, N. J.

I wish to present before this society an interesting case of a tumor of the an-

*Presented at a meeting of the Camden City Medical Society, Oct. 5, 1920.

terior left chest resembling in its appearance, shape and location an aortic aneurism. This patient has been seen by several physicians and has also been treated for several weeks by a chiropractor. A diagnosis of aneurism, I believe, was made by one or more of the medical attendants, according to the statement of the patient. She was told that there is danger of a rupture of this "enlarged vessel" with fatal hemorrhage and that she must not hurry for a trolley or over-exert herself in any way, on account of this danger. The patient is Mrs. Emma B., white, 73 years of age, and was first seen by me on September 29th, 1920. She has had eight children, five living and well, and three died in early childhood. She has had no miscarriages.

About five months ago she began to have severe pains in the left shoulder and a little later severe squeezing girdle pains around the base of the chest, the back and abdomen, radiating from the region of the thoracic and upper lumbar spine. Patient states that her ailment dates back only about five months; that several months ago she noticed a small "lump" on the left anterior chest, near the left border of the sternum (manubrium). This lump has suddenly begun to grow rapidly during the past seven or eight weeks. The mass itself is not painful nor tender, and does not inconvenience her in any way whatsoever. The chief complaint being the very sharp neuralgic pains in the left shoulder region and around the back and abdomen. She complains of pain along the thoracic and upper lumbar vertebrae. She has no headache, no attacks of dizziness, no flushing or congestion of the face, no unilateral sweating, no cough, is unable to sleep on account of the pains above mentioned, and during the past few weeks has gone down appreciably in her health, with some loss of weight. Previous history is apparently negative, except for constipation and an accident to her chest and leg several years ago, which resulted in a fractured ankle. Her husband died of carcinoma of the stomach.

Examination: Shows a tumor the size of an orange situated on the upper left chest wall, which at first sight resembled a saculated thoracic aneurism. It may be described as fairly round or globular, somewhat hard and fixed. There is palpable an appreciable irregular outline around this definite circular mass, which makes it suspicious of a neoplasm. This patient presents no symptoms and signs characteristic of the typical thoracic aneurisms that occur in this region or in the same region on the opposite side of the sternum. There is no expansile pulsation palpable, no systolic thrill, there is no diastolic shock, apparently no inequality of the pupils except that at times I thought that the left pupil was slightly more dilated than the right. Oliver's Sign, and Cardarelli's Sign are both absent. I cannot make out any distinct ringing or very sharply accentuated second aortic sound as we so often get in cases of aneurism. As stated no tracheal tugging could be made out. There were no palsies of the recurrent laryngeals and pneumogastric. Apparently no derangement of the sympathetic nerve and the typical characteristic pain of growing aneurismal tumors is absent. The radials are equal in time and volume, there is no retardation of the pulse. There has been no bloodstained sputum (hemoptysis), no marked dyspnoea and no dysphagia. Her pain appears to be a symptom of pressure neuritis and is of a neuralgic character. The pain has been an early and important symptom in this case. This is true also of thoracic aneurism. The pain in aneurism may be intrinsic, i. e., due to irritation of the sack, or internal pressure. More commonly, however, it is extrinsic, i. e., due to irritation of nerve trunks implicated in the advancing capsule or subjected to pressure by the aneurismal sac.

An aneurism springing from the concavity of the ascending portion of the aorta, may extend beyond the left sternal border. Aneurism of the descending arch may rarely protrude at the left sternal border in the first and second inter-costal spaces. The most common seat for aortic aneurism, as is well known, is in the ascending portion of the arch, to the right, and usually appears in the second and third interspaces to the right of the sternum, but, as stated, it may occasionally extend in this region where my patient presents this neoplasmic mass. When an aneurism occurs in a patient under 40 it is almost certainly due to syphilis; 70 to 85 per cent. of all aortic aneurisms are attributed to lues (syphilitic aortitis). It is well known, too, that men are very much more frequently affected than women, the proportion being about 5 to 1. The blood Wassermann test in my case is negative. Systolic blood pressure 190-210 (oscultatory over both arms); dias-

tolic 106-100. The urine analysis shows only a faint trace of albumin. The 'phthalein renal function test shows only 5 per cent. first hour, and 15 per cent. at the end of 6½ hours, the patient could not void any urine after the first hour specimen until 5½ hours later for the second specimen, as she fell asleep during the interval and was not aroused. A faint murmur is audible over the apex and over the lower end of the sternum. The right scapula stands out more prominently than the left. There are numerous telangeictases over the arms, breasts, abdomen, left temple, etc. There is an enlarged cervical lymph gland below the left ear which is readily palpable and visible. This is a sign of great significance. Dr. Mulford K. Fisher's fluoroscopic and x-ray examination show that the mass was not intra-thoracic and not connected with the aorta. The pain in aneurism is continuous, with paroxysmal exaccerbations of great intensity, and is particularly severe at the time of erosion of the vertebra or the chest wall. It is described as sharp, boring lancinating or cutting in character. It often radiates along the inter-costal nerves and is often intense suggesting inter-costal neuralgia or herpes zoster. The cough in these cases may be due to irritation of and pressure upon the vagus or recurrent laryngeal nerve, compression of the trachea or the main bronchus. The blood-stained expectoration is due to interference with the venous circulation or possibly from granulations at a point of impending rupture. The dyspnoea is due to irritation of the recurrent laryngeal nerve and is associated with the well-known ringing brassy cough. Hoarseness and aphonia—or may be due to compression of the left bronchus or windpipe, or to compression of one or both lungs if the aneurism is very large and particularly if it springs from the lower wall (posterior) of the transverse arch of the aorta.

Osteo sarcoma may involve the sternum or the ribs, not uncommonly. The overlying veins may become greatly enlarged and tortuous and the mass increase rapidly in size, but the symptom-complex of thoracic aneurism is absent as in this case presented before you tonight. The growth is to **the left** of the sternal border and not, as is usually the case in aneurism upon one side. The heart sounds, of course, are not so loud as in aneurism and diastolic shock is not felt. Glandular metastasis is present sooner or later in the neck, and this must be emphasized as of diagnostic importance. Solid intra-thoracic tumors are very often malignant. This is, I believe, a case of sarcoma of the sternum and rib, with metastasis to the glands in the neck and probably elsewhere, possibly also in the spinal vertebrae, and this metastatic involvement may account for the severe **girdle** "squeezing" and neuralgic pains around the chest and abdomen. Some of this inter-costal neuralgia may be **uremic** or **toxic** in origin.

Operative interference may be considered. However, in view of the circumstances, I believe radium and x-ray treatment is all that we may safely and expectantly use in this case. Several other conditions might be considered in the study of this case. However, I have covered the important features of the subject as presented by this patient and will not wander from the scope of this brief report.

County Medical Societies' Reports

ATLANTIC COUNTY.

David B. Allman, M. D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held on Friday evening, November 12, at the Hotel Chalfonte, Atlantic City, with good attendance.

Dr. Fred H. Albee of New York City presented a paper on "Osteo-plastic Surgery," illustrated by moving pictures and lantern slides.

Dr. Albee discussed the immense number of industrial accidents in this country and showed the tremendous need for osteo-plastic surgery. He emphasized the fact, that the lack of the proper armamentarium precluded the possibility of perfect results. An up-to-date fracture table with traction apparatus for the upper extremity was absolutely essential, as was a motor-driven apparatus.

The time for these operations, he stated, was within the first few weeks. The only thing necessary is to get the fragments together and to hold them there. With an Albee table this apposition of the parts is simple, and it only remains to secure ideal post-operative fixation. Absorbable skin sutures should be used, and the dressings should not be disturbed.

Dr. Albee stated that constitutional disease as the cause of mal-union was not important.

Lantern slides showing some of the wonderful results Dr. Albee has obtained, were then shown and this was followed by a moving picture showing the complete operation for the restoration of a radius, during which Dr. Albee's excellent technic was beautifully shown.

GLOUCESTER COUNTY.

Henry B. Diverty, M. D., Reporter.

The Gloucester County Medical Society met at Hotel Paul in Woodbury. In the absence of the president, Dr. Halsey of Williamstown presided.

Two applications for membership were presented. Drs. William R. Clement and Edward S. Dillon, both of Woodbury.

The society welcomed Dr. Emma Richardson as a delegate from Camden County and Dr. James as a delegate from Salem County.

Addresses were made by Dr. Walter P. Conaway of Atlantic City, judicial councilor for the Fifth Judicial District of New Jersey, who spoke on judicial matters in which physicians are especially interested. Mr. Joseph H. Gunn, a representative of the Welfare Committee of the New Jersey State Society, was also present and gave a short address. He is visiting the various societies of the State, looking up legislative matters of interest to medical men.

Drs. Reading, Diverty and Downs were made the Welfare Committee of the local society; the feasibility of organizing a Professional Guild was left with the Welfare Committee.

Professor J. Torrence Rugh, Professor of Orthopedic Surgery at Jefferson Hospital, spoke on the case of Miss Olive Rhodes, who has been confined in the Underwood Hospital for several months on account of injuries to her back, and who had recently undergone an operation, Prof. Rugh being the surgeon. The society adjourned to the hospital and witnessed the removal of the cast from Miss Rhodes and found her condition to be improving splendidly. After being examined by the physicians another cast was put on.

Professor Rugh stated that the fracture was of the fourth lumbar vertebra; six weeks ago he took a piece of bone from the tibia. The bone measured five and a half inches long by nearly an inch in width and this bone was placed over the seat of the fracture. The object is to get a fixation of the spinal column. He said that he had done in one year for this girl what nature would have done in three or four years.

The society returned to Hotel Paul for dinner.

HUDSON COUNTY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The meeting held at Cartaret Club, Jersey City, was called at 9.15 P. M., with Dr. Quigley in the chair. Motion made by Dr. Rosecrans, Hoboken, that by-laws be suspended and Committee on Public Health and Legislature be appointed by chair instead of elected. Seconded and carried. Committees appointed: Public Health and Legislation, Drs. J. Nevin, chairman; B. S. Pollak, J. J. Broderick, S. A. Cosgrove, G. H. Sexsmith, Wm. Sweeney.

Health Survey: Drs. G. K. Dickinson, chairman; J. Nevin, J. A. Koppel, W. W. Rhia, Charles Larkey, Margaret Sullivan, D. Merritt, Joffin, H. T. Von Deesten, W. Arlitz, Arthur Hasking, Curtis, Evans, Winter.

Membership: Drs. F. Bortone, chairman; Doody, Cornell, J. A. Wheeler, E. H. Salmon, H. Perlberg, Pinkerton, Klaus, Tidwell, Spaulding, R. B. Nattrass, J. H. Rosecrans, F. J. Pflug, L. W. Klugman, Ernst Thum, A. A. Mulligan, J. Schapiro, F. Pindar, Denis.

Banquet Committee: Drs. J. Nevins, chairman, F. Bortone, W. Yeaton, J. Willis, S. R. Woodruff, toastmaster.

Dr. Quigley said in regard to Health Survey that the purpose of the committee was to make a comprehensive survey of all angles of Public Health and Sanitation, investigating the enforcement of existing laws and providing for suitable legislation for evils not covered by any laws, finding out hospital facilities, investigating food and water supply, school laws, sanitary laws, and other similar matters. This committee to co-operate as much as possible with present State Committee.

Report of meeting of State Welfare Committee was read by secretary and ordered filed.

Treasurer's Report: Expenditures, $1,360.10; balance, $757.82. The report received and filed. Bills for printing, $10.50; stamps, $7.00; postals, $6.25, ordered paid.

New business: Motion made by Dr. B. S. Pollak that a letter of appreciation be sent to Dr. Finke, our retiring secretary, for his faithful services. Seconded and carried.

Communications: First, a letter from Dr. Yates of Paterson regarding Post-Graduate course of lectures in conjunction with regular meeting of society was read. Motion made by Dr. Rosecrans that a letter be sent to Dr. Yates stating that H. C. M. S. was in sympathy with plan and would hold communication for further consideration. Seconded and carried. Second, a letter from Aetna Insurance Co. offering to send a "Home Office" man to speak to society regarding Physicians' Liability Insurance was read. Motion made by Dr. G. K. Dickinson that a reply be sent to agent stating that it was concensus of opinion that the society did not wish to spare time for this address. Seconded and carried.

Motion made by Dr. Sweeney that a banquet be held during the first or second week of December, the arrangements for which are to be in charge of a committee. Seconded and carried.

Motion made by Dr. Brinkerhoff that the president be empowered to start a monthly Bulletin, if the plan which he (the president) had suggested was found feasible. Seconded and carried. Plan as outlined by Dr. Quigley as follows: Bulletin to contain—reports of committees, exchange column, personal notes, announcements of meeting, other items of interest.

New members: Having been approved by Board of Censors, motion made by Dr. Pollak that they be elected. Seconded and carried. Drs. C. Sirken, Jersey City; M. Nemser, Union Hill; Buckmaster, West New York; E. C. Hellstern, Jersey City; Wm. Doody, Jersey City.

Motion made by Dr. E. T. Steadman that a letter of congratulations be sent to Dr. A. E. Olpp, successful candidate for Congress from 11th District. Seconded and carried.

A discussion of welfare matters was opened by Dr. Quigley. Dr. Sweeney of Union Hill spoke of need of adequate compensation for services rendered employees under New Jersey Workmen's Compensation Act and mentioned that nurses are doing dressings in many plants and care for injured employees, some cases never being seen by an M. D., unless wound becomes serious or badly infected. Dr. Quigley commenting on Dr. Sweeney's remarks, said that he felt that New Jersey laws should be so amended that time limit and amount of compensation should be made at least as liberal

as those in any other State, and that special rules should be made for serious cases and when convalesence is prolonged. He also mentioned the practice of many insurance companies forcing their injured in New Jersey to go to New York for dressings. Dr. Maras spoke about compensation work, mentioning several instances where a "doctor" did dressings as low as 30 cents each and mentioned prevalence of unskilled men in factories and other plants giving first-aid to injured.

Dr. Sweeney mentioned a case of injury to hand which had been treated by a nurse, and, infection set in, was still treated for four days longer and then sent to an M. D., who advised removal of arm. Patient taken to another M. D. who removed arm and he never recovered from anaesthesia. Dr. Sweeney said that this condition of affairs is prevalent in many industrial plants. He also suggested that the doctor receive a written promise from the Insurance Company, stating that they will pay for all expenses in a complicated or long drawn-out case.

Dr. D. Merritt stated that the profession must stand together and state what their attitude is in these cases. He suggested a counsel for county society. Drs. Bortone, H. T. Von Deesten, Stout, Spence, Chambers, Cosgrove and Miner discussed this matter along similar lines. Dr. Spence made a motion that Legislation Committee be empowered to employ counsel and make an amendment to the present Workmen's Compensation Law of New Jersey. Seconded and carried.

Dr. Cosgrove proposed an amendment to the by-laws—Chapter 5, Section 2, increasing dues to $10 per capita. This amendment to be read and passed upon at the next meeting. Seconded and carried.

Contract practice: Dr. D. Merritt suggested that in contract and lodge practice that a minimum fee be adopted by society. Dr. Sweeney condemned free hospital treatment of patients who could afford to pay. Dr. Dodson suggested need of follow-up and social service system. Dr. Koppell suggested the city poormaster's office as best suited for this work. Dr. Bortone made motion that committee be appointed by chair to investigate lodge practice and establish a minimum fee. Seconded and carried. Drs. Bortone, chairman; Miner and Kuberman, committee.

MIDDLESEX COUNTY.

Herbert W. Nafey, M. D., Secretary.

The regular monthly meeting of the Middlesex County Medical Society was held Wednesday, November 17th, 1920, at the Middlesex General Hospital, New Brunswick, N. J., at 4 P.M.

In the absence of the president, Dr. Laurance P. Runyon, the vice-president, Dr. George W. Fithian took the chair.

Dr. J. H. Beekman, of Sayreville, New Jersey, who was proposed at the last meeting, was elected to membership.

Motion was made, seconded and carried, that Dr. Melvin M. Hunt, of South River, New Jersey, be accepted to full membership in the Middlesex County Medical Society from the Essex County Medical Society provided it is found that he is in good standing in the Essex County Medical Society.

Motion was made and carried that a nominating committee be appointed by the chair to consist of three members to nominate officers of the society for the coming year, this committee to be Dr. F. M. Hoffman, chairman, and Drs. G. W. Tyrell and A. Clark Hunt.

The paper of the afternoon was read by Dr. James O. Carrington, of New Brunswick, on the subject of "Rickets." The paper was well received by the members and a full discussion followed, being conducted by Drs. A. L. Smith, George W. Tyrell, F. N. Hoffman and J. P. Schureman.

OCEAN COUNTY.

Many physicians, dentists, druggists and nurses have formed the Professional Guild of Ocean County. The guild was organized to safeguard its members from adverse legislation. Joseph H. Gunn, executive secretary of the State Welfare Committee, addressed the meeting. The officers elected are: President, Dr. George W. Lawrence; secretary, Dr. H. L. Sexton, and treasurer, Leon A. Taylor.

PASSAIC COUNTY.

Leon E. De Yoe, M. D., Secretary.

The annual meeting of this society was held October 14th, 1920, Dr. Francis H. Todd, president, in the chair, with a good attendance. The following officers were elected for the ensuing year:

President, John S. Yates, M. D.; first vice-president, Elias J. Marsh, M. D.; second vice-president, Percy H. Terhune, M. D.; secretary, Leon E. DeYoe, M. D.; treasurer, J. Roemer, M. D.; reporter, Thos. Glascow, M. D.; annual delegates, Drs. W. W. MacAlister, C. J. Murn, Wm. Spickers, C. W. Harreys and E. J. Marsh.

The retiring president, Dr. Todd, reviewed the work of the year and thanked the members for their attendance and support.

The president-elect, Dr. Yates, in his address proposed a scheme for systematic post-graduate education at the monthly meetings of the society. The scheme would be applicable to all the county society meetings of the State. An extract of this address has already been forwarded to the Journal.

Our November meeting was held as usual on the second Thursday (the 11th) to which were invited the dentists, nurses and pharmacists of Passaic County to hear the speaker of the evening, Dr. J. J. A. O'Reilly of Brooklyn, on Compulsory Health Insurance. Dr. O'Reilly has been heard at other meetings in the State, but this was his first appearance in Paterson. It must be acknowledged that the enthusiasm and thoroughness with which he handled the subject surprised and pleased the audience immensely. He touched on State Insurance and the scheme for a State Registration of the doctors, and showed that the "uplifters" were busy in many directions. The only way to meet the pernicious activity of the "uplifters" is to organize and keep busy.

Dr. Todd offered for the Welfare Committee the following resolution, which was passed unanimously:

"Be it resolved, That a Professional Guild be formed to be known as the 'Professional Guild of Passaic County,' which shall be composed of members of the medical, dental, nursing and pharmaceutical professions in Passaic County, the object of which shall be to oppose any legislation which we may consider detri-

mental to public health and to favor such legislation as we may consider helpful to public welfare."

The president called upon the professions present to each appoint a committee of five to meet with the Welfare Committee of the medical society for the purpose of organizing the Professional Guild of Passaic County and electing officers.

WARREN COUNTY.

F. J. LaRiew, M. D., Secretary.

The annual meeting of the Warren County Medical Society was held November 19, 1920, at the Hotel Belvidere, Belvidere, with Dr. G. C. Mills of Hackettstown, the president, in the chair.

Members present were: Drs. Mills, Shimer, Kline Osmun, Thos. Barber, Bossard, LaRiew, Cummins, Reese, Williams, McKinstry, Burd, Lefferts, Dedrick, Smith and Albertson. Visitors: Dr. A. Zuck of Washington, N. J.; Dr. Paul Correll, Easton, Pa., and Assemblyman Harry Runyon, Belvidere. Dr. A. C. Zuck, now located at Washington, N. J., presented a transfer card from the Somerset County Medical Society and was elected to membership.

The following officers were elected: President, Dr. J. M. Reese, Phillipsburg; vice-president, Dr. T. S. Dedrick, Washington; secretary, Dr. F. J. LaRiew, Washington; treasurer, Dr. Geo. Cummins, Belvidere; reporter, Dr. C. B. Smith, Washington; censor, three years, Dr. C. M. Williams, Washington; annual delegate, Dr. W. C. Albertson, Belvidere.

Health Insurance was the subject of the address delivered by Dr. Paul Correll, Easton, Pa., Chief Surgeon at Correll's Hospital. The summary of the address was: "Health Insurance was not wanted by the physician who had knowledge of the facts in the case and would not be wanted by the public if they understood the matter. That it will increase taxes and was a bribe or sop to labor by the politicians under the guise of giving labor something for nothing. Those wanting it are labor politicians and social busybodies. That it was made in Germany but comes without the label "Made in Germany." Simulates trades unions. Prevents individuality in the profession. Invites commercialism, the thing the profession has fought against since the beginning. Health Insurance does not offer any condition that Boards of Health, clinics, hospitals and physicians are not meeting." Dr. Correll said much more concerning this blundering philanthropy and answered many questions which the physicians asked him.

Dr. Correll was then elected an honorary member of the society.

The following resolution was then presented for consideration:

Whereas, A number of medical men of standing have given their endorsement to a dangerous and un-American scheme and have permitted their names to be used in literature advancing these theories and ideas which are sponsered by radicals whose energies and ambitions are directed towards the ultimate detruction of our profession, and

Whereas, In most instances these endorsements have been given out without consideration or investigation of the subject matter endorsed, while the medical profession has had no opportunity as a body to refute or present before the public the results of its investigation at hand and now being carried on, and

Whereas, The results of the passage and enforcement of laws for Social Compulsory Insurance, of State Compulsory Insurance, or Federal Health Insurance, will be derogatory and an infringement upon the rights of the medical profession to pursue, as heretofore, the practice of the profession, therefore be it

Resolved, That the entire body of the Medical Society of Warren County, New Jersey, here assembled in Belvidere, this November 19th, caution and counsel the profession of the danger of this socialized propaganda with which the country is now being flooded. That we here assembled express to the fullest degree our disapproval of certain physicians lending aid to this radical un-American scheme before there has been sufficient time to investigate and study the deleterious effects of such proposed legislation upon the people and our profession. Be it further

Resolved, That members of the Warren County Medical Society go on record as opposed to compulsory health insurance or any of its allied bills, at this time, in its entirety, and be it further

Resolved, That we will oppose delegates from our county and State societies unless they distinctly show an attitude of opposition to this radical legislation. Be it further

Resolved, That a copy of this resolution be forwarded to the president of the State Society of New Jersey, to the State Medical Society, to the chairman of the State Society Welfare Committee and to every legislator in the State of New Jersey."

On motion the resolution was adopted and ordered to be spread on the minutes and its provisions carried out.

A motion was made and carried "That it be the sense of this society that we recommend to the State Society that a Legislative Committee be appointed to consist of one committeeman from each county and that each member receive a salary and traveling expenses."

The following resolution was offered and adopted:

"To the Board of Chosen Freeholders of the County of Warren, State of New Jersey:

"Be it resolved by the Medical Society of the County of Warren, That this society favors a short term bond issue by the Board of Chosen Freeholders of this county said monies to be applied to the construction of the proposed concrete road from Phillipsburg to Port Colden, N. J., with the understanding that the State Highway Commission will refund to the county the amount thus expended, on or about January 1st, 1922, and that preparation for the said construction be begun at the earliest possible date."

A letter from Dr. C. C. Beling, our councilor, was read, calling attention to the proposed legislation affecting the medical profession.

The following resolution was then presented and adopted:

"Whereas, There has been a constant lowering of medical standing by various cults who have been licensed under state legislation from time to time,

"Be it Resolved, We, the members of the Warren County Medical Society, request the enactment of such legislation as will keep the standards of the medical profession at the usual high grade. Be it further

"Resolved, That all arts of healing or cults treating illness or injury be compelled to fulfill all pre-medical education requirements, complete a full course of medical and surgical education as well as one year of hospital experience—the course as required now by the State Medical License Board.

"Be it Resolved, That this resolution be forwarded to the Welfare Committee of the State Society and to our representatives in the Senate and Assembly."

Local Medical Societies.

Associated Physicians of Montclair and Vicinity

Archer C. Bush, M. D., Secretary.

The second meeting of the season was held at the Montclair Club rooms on Nov. 22 at 8.30 P. M., with good attendance.

The paper of the evening was read by Dr. Alfred W. Adson of the Mayo Clinic, Rochester, Minn., on "The Diagnosis and Treatment of Tri-facial Neuralgia." The discussion was opened by Dr. Alfred S. Taylor, Professor of Clinical Surgery, Cornell University Medical School, and continued by Dr. R. Foster Kennedy, Associate Professor of Clinical Medicine, Cornell University.

Medical Section of Rutgers Club, New Brunswick.

Charles F. Merrill, M. D., Secretary.

The members of the Medical Section of the Rutgers Club and a few physicians from New York and Newark assembled at the residence of Dr. D. C. English, New Brunswick, on November 18th.

Dr. English, after calling the meeting to order as chairman of the club, referred to the great pleasure it gave him and his wife to welcome the members of the club and others who had honored them with their presence, especially when the occasion was one at which reference would be made to the splendid record of the medical profession of New Brunswick and the contribution it has made towards the advancement and efficiency of the profession at large and the welfare of humanity; that he would not dwell on the fact that the profession here stood true in the time of the Revolutionary War, the Civil War and the late World War. He said that as a native New Brunswicker, he took special pride in that record, for here began the existence of the Medical Society of New Jersey more than 154 years ago when a few New Brunswick doctors, with others from Middlesex County, met at "Mr. Duff's in the City of New Brunswick on Wednesday, the 23rd of July, 1766," and organized it.

Dr. English said, "We cannot today rehearse the magnificent record that Society has made; we only affirm that it is second to none in the Union, in the blessings it has conferred on humanity. It is a most pleasing coincidence that our great educational institution—Rutgers College—has a history running parallel with that of the Medical Society of New Jersey in number of years' duration and with a record of work and beneficent achievements that are worthy of highest commendation. It is, therefore, eminently proper that the organization of the medical men of this city should bear the name of Rutgers."

Dr. English then read the brief sketches of the young men who were born here, who studied medicine and went out from the city to practice the profession elsewhere.

Those mentioned were: Dr. Louis Faugeres Bishop, York; Dr. John Francis Hagerty; Newark; Dr. Henry H. Janeway, New York; Dr. John Henry Trainor, Newark; Dr. Eugene Hillhouse Pool, New York.

Reference was also made to Drs. Thomas Alsop and Clarence M. Slack, both of whom practiced here several years; the former having since established a large practice at Atlantic City, and the latter retired from practice and doing much to develop the beautiful city of St. Petersburg, Fla., and each of whom married a New Brunswick lady.

The sketches detailed the names of parents; place and date of birth; preliminary and medical education; place of practice; hospital service; professorial positions and medical, surgical and other scientific societies of which they were members.

Dr. English, in introducing Dr. John F. Hagerty, spoke of the great work he had done in surgery in Newark and also of his faithful service in developing the Academy of Medicine in Newark. He said he recalled the fact that when Dr. Hagerty was a boy, living in New Brunswick, he attended John in an attack of pneumonia, that it was a case of life well saved for great service.

Dr. Hagerty prefaced the reading of his paper on Goiter by giving an account of his recent visit to the great Mayo Clinic of Rochester, Minn., and of the work of the 200 physicians there; of the new medical hospital they are building which would give them in all 1,500 beds; and he spoke especially of the 19,000 cases of goiter treated there during the 20 years of the Clinic's existence.

He then read a most excellent paper on Goiter, in which the disease and its treatment were thoroughly discussed. He spoke of the more than one hundred cases he had treated and of the 200 that had been treated in St. Michael's Hospital in Newark, of which he is the medical director.

Dr. English, in introducing Dr. E. H. Pool, the next speaker, said that while Dr. Pool was not born here, his parents and grandparents were old New Brunswickers; that he—Dr. English—with Dr. Morrogh, with whom he was associated, treated the grandfather, Dr. J. A. Pool, in his last illness and that he personally had been his widow's physician for several years thereafter, and that she became one of his own and his wife's dearest friends and that it was, therefore, a special pleasure to welcome the grandson on this occasion.

Dr. Pool then read a remarkably fine paper on "Suppurative Pericarditis," citing cases that he had treated. It was illustrated by several lantern slides.

The general concensus of opinion expressed by the doctors present was that these two papers were among the best that had been presented to the medical men of the city in their thoroughness, practicability and helpfulness. They were discussed by several of the doctors present.

Dr. H. H. Janeway, who was detained by illness, sent an interesting report of 17 cases of

cancer of the cervix, 14 of which had been traced to date and 10 of these 14 treated with radium have been free from any evidence of disease- 2 for 4½ years; 1 for 2½ years; 3 for 2¼ years; 2 for 3 years and 1 for 1½ years.

The meeting adjourned at 6.30 o'clock, when refreshments were served.

Summit Medical Society.

William J. Lamson, M. D., Secretary.

The regular meeting of the Summit Medical Society was held at the Highland Club on Friday, Nov. 26, at 8.30 P. M., Dr. Meigh in the chair.

Present: Drs. Bebout, Clark, Embury, English, Keeney, Krauss, Lamson, Meigh, Moister, Morris, Prout, Reiter, Smalley, Tator, Tidaback and Wolfe, and the following guests: Drs. Douglass, McMurtrie, Lathrope, Abell and Beaver of Morristown, Dr. James of Bernardsville, Dr. Krichbaum of Millburn and Drs. Alexander, Beverlan and Meeker of Summit.

The Committee on Revision of By-Laws reported that new by-laws had been drawn up which were read by the secretary for action at the next meeting.

The paper was read by Dr. Herman Rosenthal of New York on "Diabetes." He took up the subjects of blood-sugar determination and the renal threshold for glucose, and went fully into the dietetic treatment of the mild, moderate and severe cases by the Allen, Jocelyn and low-calorie methods. The discussion took the form of questions, which were fully answered by the essayist.

Washington (N. J.) Society of Clinical Medicine

F. J. LaRiew, M. D., Secretary.

The monthly meeting of the Washington Society of Clinical Medicine was held at Seip's Restaurant, Easton, Pa., Tuesday evening, November 9, with Dr. Paul Correll of Easton as the host. Dr. F. P. McKinstry, Washington, the president, presided.

Members present: Drs. McKinstry, Lane, Hoffman, Correll, Smith, Struthers, LaRiew, Williams, English, Coleman, Boyer, Fulper, Krebs, Zuck. Visitors: Drs. B. Rush Field, C. G. Harmon, W. B. Thomason, F. A. Sherrer, Cohen, E. Deck, Frank Roberts of Easton; J. A. Stotz, Broadheadsville, Pa.; F. A. Shimer, J. M. Reese, Chas. Lyons, T. Barber, Phillipsburg; F. W. Curtis, Stewartsville; Geo. Cummins, F. Lefferts, Belvidere; H. Bossard, Harmony, and A. Louis Gramch, Glen Gardner Sanatorium.

After a sumptuous dinner the paper of the evening was read by Dr. Correll. The paper follows, on "Compulsory Health Insurance." (We will insert this paper in the next issue of our Journal.—Editor.)

STATE SANITARY ASSOCIATION.

Prominent medical and sanitary experts participated in the forty-sixth annual session of the New Jersey Sanitary Association, held at the Laurel-in-the-Pines, Lakewood, December 3 and 4. Congressman-elect T. Frank Appleby of Asbury Park, as chairman of the council, called the meeting to order and introduced President A. C. Hunt.

The opening session on Friday afternoon included papers by Dr. Eugene Laforrest Swan, Department of Educational Activities, American Social Hygiene Association; Dr. W. F. Draper, United States Public Health Service, and Dr. M. T. Fine, director of division of tuberculosis of the Newark Health Board.

Discussions on these three addresses were led by Dr. W. G. Schauffler of Princeton and Dr. Frank R. Sandt of Paterson. Dr. I. W. Knight, district health officer of the State Department of Health, opened the discussion on Dr. Draper's paper and Dr. Frederick C. Crum of Newark led the discussion on Dr. Fine's paper.

Dr. A. Clark Hunt of Metuchen, president of the association, delivered his address at the Friday evening session when he discussed coordination of various activities dealing with social problems. Surgeon General Hugh S. Cummings, United States Public Health Service, read a paper on plague prevention.

Future needs and sources of water supply in New Jersey were discussed by Frank Bergen of Elizabeth, speaking for North Jersey, and State Forester Alfred Gaskill of Princeton for South Jersey. A discussion followed, led by Chief Engineer Morris R. Sherrerd of Newark and C. C. Vermeule, consulting engineer of East Orange.

At the Saturday morning session Dr. Chauncey M. Egell of Westfield read a paper on oral hygiene, followed by a discussion led by N. J. R. Schandler, health officer of Plainfield. John Enright, assistant commissioner of education, read a paper on the relation of health boards to boards of education. The discussion following this was led by H. B. Willis, superintendent of schools of Middlesex County.

The Board of Medical Examiners reports the following cases: Josephine Ondeo's license to practice midwifery was revoked June 10th, for illegally practicing medicine.

Mrs. Minnie Magnette, Fred Michelbach, Charles Smith, M. D., were arrested on charge of practicing medicine without license, plead guilty and each was fined $200.

Anthony DeVito, Newark, was convicted on a charge of practicing medicine without a license and fined $200.

Noble Prize in Medical Science.—Dr. Jules Bordet of Brussels and Professor August Krogh of Copenhagen have, respectively, been awarded the Nobel prizes in medical science for the years of 1919 and 1920.

Chiropractic Bill Defeated.—Of the initiative measures submitted to the voters of Colorado, November 2, three were of special interest to physicians. The bill providing for an appropriation for a psychopathic hospital and the bill increasing the mileage tax for higher educational institutions were passed, while the bill to establish a separate licensing board for chiropractors was defeated.

"Livable Fees" Demanded by Vienna Physicians.—News comes from Vienna, via Berlin, that the doctors of the Austrian city have struck for "livable fees." The physicians connected with the Kranken-Kaase or State Sick Relief Fund, demand 48 to 110 kronen a day. Under the present system they receive 24 to 55 kronen (approximately 35 to 75 cents) per day.

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Each member of the State Society is entitled to receive a copy of the JOURNAL every month.

Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

All communications relating to reprints, subscriptions, changes of address, extra copies of the JOURNAL books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE.

PROMPT PAYMENT OF ANNUAL DUES NECESSARY.

Now is the time for all the county societies to prepare for the payment of their annual dues to the State Society. A very important change was made in the by-laws at our last meeting. In Chap. XII, Sec. 1, second paragraph, the word "March" was stricken out and the word "January" inserted. The paragraph now reads as follows: On the first day of January in each year the treasurer of each component society shall forward to the treasurer of this Society the amount of its assessment with a list of the members who have paid their assessments and are otherwise in good standing.

All members should, therefore, pay their dues **on or before January 1st** of each year, in advance, for that year. Otherwise they lose some of the benefits of membership. They are liable to be dropped from the mail list of the Journal and more than that they lose the benefits of medical defense during the period elapsed from January 1st until the time they pay their dues. For instance, suppose that a member does not pay his dues on January 1st but delays paying until January 20, 1921. Suppose too, that he is sued for an act of malpractice alleged to have been committed on January 15th, 1921, while his dues were still unpaid, he could not claim defense by the State Society as at that time he was not in good standing. The medical defense act is very clear on this point. He would have to defend himself at his own expense. This is paying pretty dear for his negligence.

The moral of all this is that every member should see that his dues are paid for 1921 on or before January 1st, 1921.

It is also important that county treasurers should forward all dues promptly to Dr. Mercer as soon as received and thus there will be no doubt as to whether a member is eligible to medical defense. It is well also to remind all members that the dues to the State Society for 1921 are **three dollars.**

Another advantage of the prompt and early payment of dues is that it insures the insertion of your name in the list which is printed each year. This list will be issued in the February number of the Journal and as it requires considerable time to arrange the names and address of our members (now over 2,000), it is quite important that all the names should be received as early in January as possible. These names and addresses should be perfectly **legible,** so that the secretary and the printer cannot be in any doubt as to the orthography of a proper name. In the printed list only the names of those who have paid their dues for 1921 will be inserted.

I trust that our **full membership** will appear in this February list. Prompt payment will also permit the secretary of the State Society to report you to the American Medical Association as in good standing.—W. J. C.

A QUESTION FOR TODAY.

In looking over the January, 1905 issue of our Journal we found the following editorial on page 159, written by Dr. R. C. Newton, who was at that time editor:

Are the Dentists of New Jersey Wider Awake Than the Doctors?

A dentist has recently been convicted of illegally practicing his profession in Vineland, in this State, and upon appeal, the Supreme Court has affirmed the conviction. Finding himself unable to continue his illegal practice, the accused has taken steps to comply with the law and sentence was suspended.

Is it not high time that the different county medical societies took steps to prosecute and drive out of practice the irregular practitioners throughout the State?

We have been informed that there are at least fifteen persons illegally practicing medicine in Newark. Doubtless there are a greater number than that. It is the business of the Essex County Society to ferret these people out and bring them to justice. The method is simple enough, the results not always satisfying because it is so hard to obtain evidence strong enough to convict. Therefore each county society should retain a competent attorney who should report to the society regularly all infractions of the law regulating medical practice and who should be prepared to bring the guilty to justice as promptly as possible.

No one will do this except the county societies, and if their members have not enough public spirit, not to mention an eye to their own interests, to move in the matter, they will richly deserve to have the quack flaunting his sign next door to them and to have the public conclude, as they naturally will, that one style of practitioner is as good as the other. For, do not both use the same title, drive about in similar vehicles and to all appearances enjoy the same protection from the law?

Let us remember that only part of our duty is done when we have complied with the law ourselves. We owe it to the public to protect them as far as we may from irregular and incompetent practitioners who have not complied with the law.

That was written nearly sixteen years ago and the question naturally arises why with the marvelous progress in the science and art of medicine and the abounding altruism of the medical profession in the services of the public, not only in hospitals and free clinics, but also in their wonderful work in the great field of preventive medicine, is the same query as pertinent today. Why is it difficult to arouse the public to a realizing sense of the dangers to which their lives and health are exposed by tolerating illegal and utterly unqualified practitioners of medicine And why is it that when doctors who have the interests both of the public and the profession at heart—and the true interests of the one are the true interests of the other party—that it is so difficult to arouse the members of our county societies to action for the correction of this great evil, as illustrated in the present work of our State and county welfare committees.

Is it not a fact that today the dentists are far wider awake than the doctors? Note, for example, the prosecution of the notorious Curtis in Middlesex County where an utterly fallacious public sentiment that was not actively opposed by the entire profession permitted a verdict that surprized all but the quack and his super serviceable adherents and which verdict is still in review by the Court of Errors and Appeals. Then note the later action of the wide-awake dentists in arresting the same man—Curtis—for illegally practicing dentistry in Newark, when a false public sentiment was not allowed to overthrow justice and the man confessed his guilt and was fined $100.

We earnestly and urgently call upon every member of every county medical society to awake out of sleep, to throw aside all indifference and cowardly selfish considerations and to support actively his county welfare committee in its great work of protecting the profession and the public alike from the Socialistic and Bolshevistic enemies of both. Or these enemies will succeed in forcing upon us their compulsory health insurance and other schemes which mean infinite disaster to both educated physicians and public protection. California has shown us what can be done when medical men are awake and do their duty.

WHAT CALIFORNIA HAS DONE.

The four so-called "medical measures" voted on in California at the recent election were all defeated, the people of the state strongly indorsing the position taken by the Medical Society of the State of California and the League for the Conservation of Public Health on these questions. The proposed antivivisection bill was overwhelmingly defeated. The antivaccination measure and the bill for the creation of a separate chiropractic board were voted down, and the efforts of the osteopaths to secure the right to prescribe drugs were also defeated. This is one of the first instances in which medical questions have been submitted to popular decision.

OBJECTION TO MEDICAL SOCIETY DUES.

We recently have heard from a county medical society secretary in Indiana who says that two or three well-to-do doctors in his county resigned from the local medical society when the dues were raised to $5, and have steadfastly refused to reaffiliate with their professional brethren ever since. It seems remarkably strange to us that any member of the regular medical profession can have the nerve to object to the payment of $5 a year toward the support of an organization that is absolutely necessary for the perpetuation of the traditions and pres-

ent position of the medical profession as a whole. Purely selfish interests alone should encourage the medical man to associate himself with the state medical association, and pay any assessment that may be asked when he knows that the money so paid will be for his own as well as the general good of the profession. The medical defense feature of our Association alone is worth double what membership costs, and we believe that every member of the Association will admit that The Journal is worth the membership fee.

One of the reasons why we never have been able to accomplish all that should be accomplished in the way of protective medical legislation and the suppression of incompetents and quacks, has been because doctors do not hold together, and many of them are forever complaining about an insignificant expense which must be assessed on the individual members in order to keep up the organization. Even the chiropractors pay from $10 to $15 a year membership dues, and they cheerfully subscribe from $10 to $100 each toward a legislative fund for the purpose of paying expenses in securing the legislation that is favorable to them.

Certainly the members of the regular medical profession ought to adopt a new spirit of liberality toward the support of their medical societies, and just now there is every reason why they should "cut the belt" and donate to a fund to be used in promoting the right kind of medical legislation, and they are "cheap skates" if they go at it in a niggardly fashion.—The Journal of the Indiana State Medical Association.

BENEFITS FROM MEETINGS OF PROFESSIONAL ORGANIZATIONS.

The president of the American Bar Association, in an open letter to the members, defines that organization as the "tie of fraternal interest in all that concerns the profession that binds it together." While the communcation is addressed to members of the legal profession, its truth applies equally to physicians. The following statement regarding the value of the annual session is paraphrased but little in order that it shall appeal to Fellows and members of the American Medical Association:

The sight of the leaders of the medical profession is stimulating. It adds much to the interest with which a medical paper is read if the author is not an abstraction but a creature of flesh and blood, whose personal appearance is known and whose voice has been heard..... Of these things I am sure: that the sense of brotherhood and the belief in the friendliness and nobility of the profession will be strengthened by such contact, and that faith in the zeal and integrity of members of the profession will be justified by experience. The reserve potential strength of a profession like ours can be summoned to effective exercise only through an association, national in scope, and wielding the consolidated strength of a united and thoroughly patriotic organization.

The meetings of the constituent state medical associations and of the component county medical societies present opportunities both for an interchange of professional knowledge and for an appreciation of personality which must make all better fitted to render professional services to their fellow men.—A. M. A. J.

The Editor sends heartiest greetings to each and every reader of our Journal, wishing each a very

Merry Christmas

and, as the next Journal will not appear until the second week of the new year, he includes his best wishes for a very

Happy New Year

It gives promise of being a year of great opportunities and responsibilities. May we all be enabled to meet them with courage and fidelity.

We call special attention the addresses of Rev. Dr. C. B. Moulinier and Dr. C. E. Humiston, pages 410 and 415 of this issue of the Journal, and also to articles on pages 428-430, relating to the Profession's and the Public's Welfare. The delay in inserting some of the papers read at the Society's annual meeting is due partly to the lack of promptness in returning proof sent to authors for correction.

Miscellaneous Items.

Doctors Elected to Office.

The following members of our State Society were chosen for public office at the November 2nd election:

Congress, Eleventh District—Dr. Archibald E. Olpp, Hoboken.

State Senator, Warren County—Dr. Thomas Barber, Phillipsburg.

Assemblymen—Drs. Lester F. Meloney, Clifton; Walter G. Alexander, Orange; Clinton H. Read, Trenton; H. M. Fooder, Williamstown.

Mayors of Cities— Dr. Victor Mravlag, Elizabeth; Dr. Alfred W. Ward, Closter; Dr. Elias M. Duffield, Glassboro.

Council, City—Dr. George E. Verbeck, Caldwell.

We confidently expect that these doctors will maintain our profession's reputation as guardians of the public's welfare as faithfully as Kentucky's representatives did. See June Journal, page 208.

Regional Health Conferences.

The first of a series of regional health conferences authorized by the International Health Conference in Cannes is to be held in Washington, December 6-13. It will be devoted to a consideration of venereal diseases which, according to conservative estimates, constitute one of the world's most terrible plagues. The conference is being organized under the joint auspices of the U. S. Interdepartmental Social Hygiene Board, the U. S. Public Health Service, the American Red Cross and the American Social Hygiene Association. Prof. William H. Welch of Johns Hopkins has consented to serve as president, and already assurances have been received that some of the foremost physicians and sociologists will participate. Prominent health officers and sociologists from all parts of North and South America will attend.

A Research Information Bureau.

The National Research Council has established a Research Information Service as a general clearing-house and informational bureau for scientific and industrial research. This "Service" on request supplies information concerning research problems, progress, laboratories, equipment, methods, publications, personnel, funds, etc.

Ordinarily inquiries are answered without charge. When this is impossible because of unusual difficulty in securing information, the inquirer is notified and supplied with an estimate of cost. Much of the information assembled by this bureau is published promptly in the "Bulletin" or the "Reprint and Circular Series" of the National Research Council, but the purpose is to maintain complete up-to-date files in the general office of the Council.

Requests for information should be addressed, Research Information Service, National Research Council, 1701 Massachusetts avenue, Washington, D. C.

PHYSICIANS IN FIVE STATES TO WAR AGAINST HEALTH INSURANCE.

Physicians Getting Ready to Organize Professional Guilds to Combat Plans Which Threaten Income.

On the result of the November elections will depend the vital question whether America is to make an experiment next year in the European socialistic doctrine of Compulsory Health Insurance. In the states of New York, New Jersey, Illinois, Michigan, and probably Indiana, the American Association for Labor Legislation, the American branch of the European organization through whose efforts health insurance was introduced into Germany, England and other European countries, intends in 1921 to introduce health bills into the legislatures of all the five states named, to which representatives will be elected November 2nd.

The introduction of Compulsory Health Insurance to these five states—if they accept it—means its ultimate nation-wide application, and this in turn means the universal cheapening of American medicine, the lowering of the morale of physicians, the breaking down of professional standards, the loss of millions of dollars in aggregate income and impairment of prestige.

Alarmed by the prospect, physicians in the five states, through their state presidents, are reported to be now planning concerted combative action to prevent the proposed legislation. The first step to this end will be a fight against the election of any candidate for the legislature who is sympathetic with this socialistic propaganda.

To insure this necessary result, the guild plan, organized and so successfully worked in New York State last year, it is believed, will be generally followed.

The guild plan, conceived by Dr. John J. A. O'Reilly and associated physicians in Kings County, of New York State, is an organization of physicians, dentists and pharmacists into a compact professional protective association, with active working committees in each assembly district.

To achieve results personal political preferences are forgotten, the three professions directing their fire against all candidates, Democrats or Republicans alike, who express themselves in favor of compulsory health insurance or refuse to make known their position on this question.

The physician and dentist in contact with his patient, and the pharmacist with his customer, urge them in their own interest to aid in conserving the higher professional standards and professional efficiency of the doctor, dentist and pharmacist by voting against the candidate who favors health insurance.

As a result of this concerted campaign, twenty or more candidates, unfriendly to the three professions, were defeated in New York last year.

Undiscouraged, the American Association for Labor Legislation has announced its purpose to re-introduce its socialistic bills in the 1921 Legislature of the two latter states and also in Illinois, Michigan and Indiana as well.

The association, which has the backing of rich parlor socialists, social uplifters, settlement workers and professional propagandists, is now more powerfully organized and more abundantly equipped with funds to push its fight than last year—it says it is going to win this time.

If the physicians wish to abort this boast, they will have to fight with all their strength—the enemy is out for our scalp.

Realizing this, Dr. Angus McLean, President of the Michigan Medical Society; Dr. W. F. Grinsted, of Sairo, Ill., President of the Illinois Medical Society, and Dr. Charles F. McCulley, of Logansport, Ind., President of the Indiana Medical Society, are now collaborating with New York and New Jersey physicians in the formation of plans for the establishment of professional guilds similar to those in the Eastern States last year.

If we stand together in this fight, we'll lick

them; if we do not stand together, they'll lick us. If they lick us, we become time servers and the underpaid lickspittles of a system which has taken the heart out of our fellow practitioners in every country in which it has been employed to date. We are already one of the poorest paid professions in the world; the aim now is to make us still poorer paid—to squeeze us tighter, and while all the rest of world gorges on the fat of the land, to draft us into the service of mankind for a pittance. In the face of this there is only one sane, logical, self-respecting thing to do—swat the hand that's reaching for our throat. Swat it!—From M. P. Quarterly.

Medical Society of New Jersey Welfare Committee.

The meeting was held in the City Hall, Newark, October 13, 1920. It was called to order by Dr. Wells P. Eagleton, chairman. Counties represented by delegates: Bergen, Essex, Hudson, Hunterdon, Middlesex, Ocean, Passaic, Somerset, Union, Monmouth; total, 10. Counties reporting by letter or telegram: Camden, Gloucester; total, 2. Counties not represented: Atlantic, Burlington, Cape May, Cumberland, Mercer, Morris, Salem, Sussex, Warren; total, 9.

Dr. Eagleton outlined the object of the meeting as being to perfect an organization among medical men whereby they would take a more active part in legislation affecting public health. He took the stand that the medical profession should be consulted in regard to the enactment of all laws affecting the health of the citizens of the State, and in particular with references to obtaining full publicity on all health legislation. As part of the plan of organization to attain the ends sought, Dr. Eagleton urged the formation of professional guilds in the various counties.

Dr. Martland, president of the Essex County Medical Society, explained the plan underway for the organization of a professional guild in Essex County. He also read the copy of a questionnaire which it was intended to send to all candidates running for legislative office in Essex County. Dr. Pollak of Hudson County reported that we were assured that the Senators and Assemblymen would approve legislation which the medical profession may propose for the public welfare. Dr. Sproul of Hunterdon County reported that the Hunterdon County legislators had voted for the bill lowering the educational requirements for those who would practice the healing art at the last session of the Legislature and that an effort was being made by the medical men of that county to elect other representatives to the Legislature.

Dr. English of Middlesex County reported that a professional guild had been organized in Middlesex County, the first in the State, and that it was functioning. It had indorsed two candidates for the Assembly and that at the request of two Assemblymen who had voted for objectional legislation in the last session of the Legislature, an audience was arranged for them to explain their stand with regard to future legislation which would affect public health. Dr. Howley supplemented Dr. English's report. Dr. Albee suggested that nurses be included as members of the professional guilds, together with physicians, druggists and dentists. This suggestion was adopted.

Dr. Field of Monmouth County reported that Senator Stevens, Republican, who at the last session of the Legislature voted for a lower educational standard, and Mr. Van Note, the Democratic Senatorial candidate, had attended a meeting of the Monmouth County Medical Society. Mr. Stevens said that he "would support legislation which would maintain the high standard of the medical profession." Mr. Van Note pledged himself to support legislation the physicians would favor. Dr. Herbener of Ocean County reported that the Senator and the Assembly candidate of Ocean had pledged themselves to support legislation the physicians asked for.

Dr. Meigh and Dr. Embury of Somerset reported that a conference had been arranged with the Senator and Assemblymen on the Republican ticket in Somerset County to discuss the legislative situation. Dr. Green of Union County reported that assurances had been received from the Union County legislators that they would support the physicians in legislative matters. Dr. Mitchell of Essex urged that action be taken with regard to the modification of the Chiropractic law, passed by the last Legislature, asserting that he did not think the Chiropractic law could be repealed.

Dr. McBride of Passaic reported that the plan to be followed in Passaic was to call a conference with the legislators of that county after election and set before them the objects of the medical profession with regard to legislation. Dr. Harvey of Essex recommended that the physicians ask for a uniform standard of requirements affecting all who practice the art of healing in the State. This suggestion was adopted. Dr. McBride told of the defeat of a proposed plank favoring compulsory health insurance, which was presented in the Democratic State convention. Dr. Quigley, president of the Hudson County Medical Society, asked that an opinion be obtained from the legal advisor of the Medical Society of New Jersey with regard as to who have the legal right to use the title of "Dr." in connection with the practice of the healing art. The motion was adopted.

Dr. English moved that the meeting go on record as being utterly opposed to the so-called Colby Compulsory Health Insurance bill or any other health insurance bills without consultation with and approval by the medical profession. The motion was carried. Dr. English moved that it be the sense of the meeting that the medical profession are opposed to the present Chiropractic law, and that as an organization they favor the enactment of such legislation as will properly protect the health of the citizens of the State. Carried. Dr. Harvey moved that it would be recommended to the various medical societies that they at once organize professional guilds in their respective counties to be composed of physicians, dentists, druggists and nurses; that questionnaires on health legislation be presented to the various legislative candidates in their counties to determine their positions on health legislation; that the members of the professional guild support such candidates as favor such legislation; that an educational campaign be conducted to acquaint the public with the positions of such candidates, and also with regard

to such legislation as the professional men desire. Carried.

Dr. Harris of Paterson, president of the Medical Society of New Jersey, spoke on compulsory health insurance, condemning the project, and warning the physicians that such legislation was one of the greatest dangers to the profession, that the physicians will be called upon to face in the near future. Dr. Rose of Camden reported by letter that the Republican candidates for Senator and Assembly of Camden, will support legislation favored by the physicians in the coming legislation, as they have done in the past. Dr. Hunter of Gloucester reported by telegram that the Senator and Assemblyman of Gloucester would support the physicians in legislation. Dr. Mooney of Hudson reported by telegram that he personally, and as president of the State Board of Medical Examiners, was in sympathy with the objects of the State Society in matters of legislation.

Joseph H. Gunn, Exec. Secretary.

Lay Opinion of Chiropractic.

From the American Citizen, Manchester, N. H.

"A great many people suppose that the issue is between the doctors and the quacks. This is an error. The interest of the doctors is of little importance. It is not the business of the State to interest itself in the welfare of the doctors and it is a mistake to ask the medical men to be especially active in fighting the merchants, dentists, millhands and others who have resorted to illegal medical practice to humbug the public. The issue is between the people of the Commonwealth and the rascals who violate laws passed to protect the public against criminal malpractice and the obtaining of money under false pretenses. The object of the law against such rascality as is involved in the crooked advertising and practices of crooks is to see that the sick are not preyed on as to money, lied to by ignorant or criminal practitioners, or allowed to suffer or die for lack of ability on the part of practitioners they trust.

"No honest man has any quarrel with any school of medicine or surgery carried out by competent and educated men, skilled in its application. It is to prevent practice of medicine and surgery by those ignorant of the human body, its diseases and their proper treatment, that medical laws are passed.

"Those who have in their hands the life or death of a mother or head of a family, a girl, youth or child, ought to know all science can teach. It is a righteous law which forbids the ignorant to practice medicine, endangering the life and happiness of their victims. Practice of medicine by blacksmiths is a form of murder.

"Chiropractors know the reluctance of patients to testify and of doctors to prosecute. A natural disinclination to engage in such warfare as will rid the community of crime is common to most people. A good many are duped by quacks but dislike to own it, and be quietly laughed at for being deceived. Many dread to admit that they were easy marks and thus hurt their own vanity.

"Many have diseases that are chronic and alternately improve and get worse until the patient dies. By treating a patient during a period of improvement the chiropractic may deceive the uninformed while doing them no good and while the disease is hurrying them to the grave. Most chronic cases improve somewhat at times. Many very bright people are not informed as to medical matters, the chiropractor is usually adroit.

"There was never a charm sold or a mixture so vile, nor a method so silly that dignified and otherwise well-informed people did not attribute to it an improvement in their physical condtion. Credulity, ignorance, lack of appreciation of the rascality of a practitioner, unwillingness to own that one has given good money for being duped, are factors in the immunity enjoyed by law-breakers. This immunity will not continue."

"The chiropractors practicing without medical or surgical knowledge sufficient to get them a license to practice without breaking the laws, know that the claim that all diseases are caused by spinal maladjustments, or can be cured by handling the spine, is nonsense pure and simple; bunk, part of a confidence game and unworthy of acceptance by any honest man who is educated or any educated man who is honest."

Justice Hodgins of the Supreme Court of Toronto, Canada, who investigated during 1916 eighteen different institutions in fourteen different cities of Canada and the United States, interviewed 234 people and collected 200 pamphlets bearing on all phases of the problem, covering the origin, progress and practice of osteopaths, chiropractors, manotherapy, christian scientists, and other forms of healing. He was appointed to make this investigation by the government. The reference dates back a bit, but the criticisms are doubtless as good today as they were then. The following are brief extracts from his report:

"Their repudiation of all modern scientific knowledge and methods is such that it would be impossible to recommend any way in which they could be allowed to practice by which the public could be safeguarded. Their case was well presented, but was definitely Ishmaelitish. Those who appeared before me saw no necessity for preparatory equalifications, ridiculed and repudiated diagnosis, bacteriology and chemistry; admitted that a chiropractor acts in all cases on his cardinal principle, without examinaton.

"Dr. B. J. Palmer, the head of the most important chiropractic college in the United States, in giving evidence in the case of the State vs. Janesheski, in December, 1910, when asked whether, when a patient came to a chiropractor, he was asked the history of the case, answered: "No, because it be of no value"; and in answer to why that was so, said: 'A person comes to us without telling us what the trouble is; it makes no difference whether a physician has already diagnosed it as insanity, appendicitis, indigestion, or anything they call it. The chiropractor needs to know nothing about that case from a physician's standpoint; it is immaterial, yet he can take that case, put it down on his benches and analyze that spine just as accurately without knowing those things; in fact, sometimes I think better. * * * It is not essential the chiropractor should know what the patient said he had, but you can adjust the current for it running into the organ, and the patient is well. That is where chiropractics becomes

purely a mechanical proposition, a mechanical and electrical-making circuit proposition in a man.'

"I cannot bring myself to the point of accepting, as part of our legalized medical provisions for the sick, a system which denies the need of a diagnosis, refers 95 per cent. of disease to one and the same cause, and turns its back resolutely on all modern medical scientific methods as being founded on nothing and unworthy even to be discussed."

Therapeutic Notes.

Cardiac Stimulant and Tonic.

Digitalis, fresh leaf (assayed), 2 gr.
Benzyl Benzoate Armoatic,
representing, 5 min.
Tr. Strophanthus (assayed), 1 min.
Strychnine Sulphate, 1-60 gr.
Atropine Sulphate, 1-240 gr.

A valuable heart stimulant and tonic, remarkably effective where there is lack of muscular tone. One pill after each meal.

Coryza.

Phenacetine, 1 gr.
Tr. Euphrasia, 4 min.
Tr. Gelsemium, 1-2 min.
Tr. Belladonna, 1-4 min.
Eucalyptol, 1-6 min.
Strychnine Sulphate, 1-100 gr.

For one dose after each meal and at bedtime.

Expectorant Tonic.

Benzyl Benzoate Aromatic,
representing 5 min.
Guaiacol Carbonate, 1 gr.
Terpin Hydrate, I gr.
Ext. Hyoscyamus, 1-4 gr.
Powd. Ipecac, 1-8 gr.
Eucalyptol, 1-8 gr.

Particularly effective in "winter cough." The sedative and antispasmodic effect of Benzyl Benzoate, the specific action of guaiacol carbonate in antisepticizing the secretions, the direct action of terpin hydrate in liquefying the mucus, eucalyptol on the bronchii, makes this a most useful combination. For one dose after meals and at bedtime.

Intestinal Antiseptic.

Betanaphtol, 2 gr.
Salol, 3 gr.
Resorcinol, 1-2 gr.
Valerian, 1 gr.
Oil Cajeput, 1-4 min.
Oil Cloves, 1-4 min.

In dyspepsia associated with fermentation in the stomach and intestines accompanied with eructations, water brash and flatulence.

Pneumonia.

Quinine hydrochloride, 5 grains.
Creosote carbonate, 5 to 7 minims.

M. Sig.: Administer every three hours and decrease dose according to age.

Fresh air and forced feeding are adjuncts of the treatments.

Prostatitis—Chronic.

Iodoformi, grn. j.
Morphinæ sulphatis, grn. ¼.
Olei theobromatis, grn. xxv.

M. f. suppos. No. 1. Tal. dos. No. xii.
Sig.: One suppository t. i. d.—Medical Brief.

Tonsillitis.

Tr. ferri chloridi, f℥iij.
Pot. chloratis, gr. x.
Glycerini, q. s., f℥j.

M. Sig.: Apply with camel's hair brush to throat t. i. d.

Internally:
Sp. med. bryoniæ, mx.
Sp. med. aconiti, miv.
Sp. med. gelsemii, mxx.
Sod. salic., ℥iss.
Aquæ menth, pip., q. s., f℥iv.

M. Sig.: f℥j q. 2 hrs. until relieved.

Bromidrosis.—Isaac L. Peebles recommends the following local treatment for bromidrosis, with special reference to the feet. The parts should be cleansed night and morning. Also change shoes and socks daily; paint feet lightly twice a week with tr. iodi. Wash feet in weak solution of permanganate of potassium, about 5 grains to the basin of real warm water. Wash at bedtime. Remove feet from basin. Do not dry with towel, but allow feet to dry in the open. Next morning wash feet well in ordinary sterile water, then powder shoes and socks freely with the following powder:

Acidi salicylici, grains xx.
Pulv. amyli, ℥iij.
Pulv. talci, ℥ij.
Acidi borici, ℥ij.

M. Sift into shoes and stockings each morning freely.—The Medical World.

Burns.—Dr. McGeary, in Minnesota Medicine, gives the following formula for the preparation of paraffin dressings used as the routine treatment of burns at the Minneapolis City Hospital:

1. Resorcinol 10
2. Olei Eucalyptii 20
3. Olei Olivae 50
4. Petrolatum 250
5. Paraffin 670

Melt 4 and 5 together.

Dissolve 1 in alcohol and add 4 and 5 while latter is hot, to drive off the alcohol. When cool, add 2 and 3.

The dressing is applied daily until healing is complete. The area is first washed with Dakin's solution.—Minnesota Medicine.

Neuritis: Its Pathology, Symptomatology, and Treatment.

Robinson, in the Journal of the Missouri State Medical Association, states that alkalies, such as bicarbonate of soda in large doses with abundance of water, are usually beneficial in all forms of neuritis. Atophan and pyramidon are helpful in controlling the pain. Quinine should be used in malarial neuritis, iodides of mercury in syphilitic, iodides and sulphates in lead neuritis, and salicylates in rheumatic neuritis. After the acute stage is passed, strychnine is usually helpful, also iron in the form of Blaud's mass and other tonics.

Monobromide of camphor, grains 2, acts like a charm, given on going to bed, in sleeplessness.

Calomel.—The old idea was that calomel was a hepatic only. The new idea is that calomel stimulates all the glands of internal secretion, with a special affinity for the thyroid and suprarenals. Calomel got a bad name from its association with ignorance. There is no other one single agent that will combat as many toxins as calomel given in small doses, sufficient to stimulate the glands of internal secretion.

A Good Veronal Combination.—In small doses veronal often fails to work. To be more or less certain of its hypnotic effect comparatively large doses—8, 10 and 12 grains—have to be given. And such doses are not free from disagreeable after-effects. But if we combine it with some other drug or drugs, it exerts its effect in small doses and without by-effects. In Europe the following combinations is meeting with great favor: Veronal, 4 grains (0.25); phenacetin, 5 grains (0.3 and codeine phosphate, 1/6 grain (0.01). It is claimed that this combination acts promptly and pleasantly and without any undesirable by-effects. The combination is now on the market in tablet form.

Cure of Syphilis.—Dr. Fritz Lesser asserts that cases of very recent syphilitic infection can be cured permanently with 3 injections of neosalvarsan (dose iv) given within 8 days; (interval between first and second injection 2 days, between second and third 3 days). No mercury is necessary; the blood tested several times during a period of two years gave a constantly negative Wassermann.—(D. M. W.

Medical Treatment of Chronic Cholecystitis.—In Dr. Minet's case the woman of 33 had long had disturbances from gallstones, with recurring jaundice and fever so severe that she was clamoring for an operation. when he began to treat her with hexamethylenamin. He gave it by the vein in a series of five daily doses of from 0.5 to 1 gm.; in a second series from 1.25 to 1.75 gm. and in a third series up to 2 gm. The total was thus 21.25 gm. in fifteen days, given in a 0.25 gm. per cubic centimeter solution in distilled water. The clinical cure was then complete, both subjective and objective symptoms having subsided.—Paris Jour.

Treatment of Erysipelas.—Local applications (H. Guy, Journal of Cutaneous Diseases), either one or more, may be used as follows:

1. Ichthyol: (a) ointment, 10, 20 and 30 per cent.; (b) aqueous solution.
2. Boric acid ointment, plain and with the addition of small amounts of menthol and phenol.
3. Collodion.

Spirit of Camphor in Hay Fever and Asthma.—Stuver tells of a blacksmith who has suffered from asthma all his life, the first attack following whooping cough when he was nine months old. After trying all sorts of treatment, from that prescribed by eminent specialists and general practitioners to the cults and sure cures that infest the byways of medicine, all without more than temporary relief, the man used a solution of carbolic acid, camphor, and borax, applying it to the mucous membrane of the nose by means of an atomizer. Later he used spirit of camphor alone. His asthmatic attacks were always ushered in by hay fever symptoms; as soon as he felt these symptoms coming on he would pour some of the spirit of camphor in his hand, hold it to the nose and inhale freely, repeating several times if necessary to check the trouble. He had used the camphor in this way for eighteen months and during that time had not had an attack of asthma.—Western Medical Times.

Infusion of Parsley in the Treatment of Gallstones.—H. Cameron Kidd cites the case of a woman over seventy years of age who had suffered for many years from gallstones. Examination by the writer during a prolonged attack revealed a large palpable mass in the region of the gall bladder, in which gallstones could be felt. Operation was advised, but the patient objected, relating the cure of a friend under similar circumstances brought about by drinking infusion of parsley. She had begun herself to take about 1½ pints daily of an infusion made by soaking a good double handful of fresh parsley leaves in cold water, which was afterward brought to the boil, strained and allowed to cool. She persevered in this treatment, which seemed to have cured her. After nearly two years she remained free from pain and sickness, and the mass in the region of the gall bladder disappeared. She was no longer emaciated and the general condition was satisfactory. The fruit of parsley, and apparently also the whole plant, contains an essential oil, which is pretty well known under the name of "apiol" as a remedy for dysmenorrhea. Common garden parsley is recommended in the French Codex, in combination with other aromatic plants, as a diuretic.—British Medical Journal.

Hospitals; Sanatoria.

Essex County Hospital.—Dr. Guy Payne announces that the proceeds from the fair and exhibition held at the institution last month was $3,300.

The Tuberculosis Preventorium for Children at Farmingdale will receive $5,000 from the estate of Jacob H. Schiff.

Presbyterian Hospital Training School, Newark

The sixth annual commencement of this training school for nurses was held in the evening of Nov. 4, when eight nurses were graduated. Dr. S. E. Robertson awarded the diplomas and the address was delivered by Uzal McCarter, Esq. Rev. Dr. Lusk gave a brief resume of the history of the hospital. In the first two months, eight years ago, it had 38 patients. Last year there were 1,709.

Salem County Memorial Hospital.

The following is the report of this hospital for the month of October: Patients admitted, 58; operations performed, 23; deaths, 2; births, 10; patients discharged, 58; remaining in hospital Nov. 1st, 17.

State Hospital Trenton.

Dr. Henry A. Cotton, superintendent, reported to the Department of Institutions and Agencies that during the month of October sixty-two inmates of the State Hospital in this city were discharged from the institution as practically recovered from their mental disorder, and that this was the largest number of discharges during any month, and that the result was due to the fight made against the existence of infection.

Dr. Cotton cited the cases of two patients readmitted who had previously spent years in the hospital. He also noted the case of a soldier who after several examinations and treatments was restored to his mother. In one readmitted case, that of a woman who had been out of the hospital since December, 1919, it was shown that she had undergone several operations and had done well until about a month ago, when she developed hallucinations and was returned to the hospital. A much more extensive examination of the teeth showed that twenty-seven were infected. These were removed and the patient's condition cleared up so that she is now considered normal. Another case was that of a woman who had been discharged in July, 1919, after having spent three years in the hospital. Until recently she was regarded as having fully recovered, but she suffered a breakdown and it was found that her teeth had been neglected. After the removal of the infected teeth, her mental condition cleared up.

During the month 67 new cases were admitted and six patients were re-admitted. Eleven were discharged as unimproved against the advice of the hospital staff.

Bonnie Burn Sanatorium.

Dr. John E. Runnells, superintendent of the Sanatorium, reports for October the following:

On October 1st there were 209 patients in the Sanatorium, 117 males and 92 females, including 31 males and 29 females in the Preventorium. Among the admissions three were re-admissions. The admissions were classified as follows: Pretubercular, 5; incipient, 0; moderately advanced, 4; far advanced, 18. The daily average for the month was 201.7.

New York Hospitals for Insane Overcrowded.

New York State's thirteen hospitals for insane are overcrowded to 18 per cent. above their normal capacity, it was stated in the annual report of the State Charities Aid Association issued recently. Institutions built to accommodate 30,324 persons now contain 35,845, and congestion brought about by the entrance of patients who must be admitted is causing a serious situation, especially in hospitals in and near New York City, the report added. These conditions are expected to be remedied through new construction provided for in state appropriations totaling $5,000,000.

Better Hospital Facilities in England.—It seems certain that the policy of the ministry of health contemplates a critical review of the hospital accommodation all over the country and, if necessary, its reorganization, so that there shall be no overlapping or waste, and that beds may be available so far as possible for all varieties of disease—Lancet.

Marriages.

RATHGEBER-MENZEL.—At East Orange, N. J., October 23, 1920, Dr. Charles Frederick Rathgeber, to Miss Helene Elizabeth Menzel, both of East Orange.

UZZELL-GUNTER.—On September 8, 1920, Dr. Edward Floy Uzzell of Atlantic City to Miss Marion Elizabeth Gunter of Fredericton, N. B.

Death.

O'BRIEN.—In Orange, N. J., October 18, 1920, Dr. Daniel Jerome O'Brien, aged 45 years.

Personal Notes.

Dr. William J. Chandler, South Orange, recently returned from the meeting of the State Medical Societies' Secretaries, held in Chicago, Illinois.

Dr. Albert Pitts, Plainfield, has bought the Stevens property there and after removing the old buildings, will erect new structures.

Dr. John M. Randolph, Rahway, and wife recently spent ten days at Rochester, Minn., where the doctor attended a medical conference.

Dr. William L. Colfax, Pompton Lakes, returned recently from a month's camping at Pochuck Lake, N. Y.

Dr. Stephen G. Lee, East Orange, recently spent a few days at Schooley's Mountain.

Dr. Henry P. Dengler, Springfield, recently returned from a duck shotting trip at Barnegat.

Dr. Leonard F. Hatch, Vineland, who was stricken with illness while camping in the Pennsylvania Mountains last month, underwent treatment in the Millville Hospital.

Dr. James Spencer Brown, Montclair, has been elected president of the newly organized local Board of Health.

Dr. Edwin Field, Red Bank, chief of the staff of the Monmouth Memorial Hospital, was recently presented with a pearl stickpin by members of the board of governors in recognition of his long and faithful service to the hospital.

Dr. Herbert H. Fritts, Shiloh, and wife spent a few days in Philadelphia last month.

Dr. Millard F. Sewall, Bridgeton, addressed the high school pupils on Armistice Day on the important events preceding the armistence and of armistice day in France.

Dr. Grenelle B. Tompkins, Flemington, has begun the erection of a large office building in Broad street.

Dr. Jennie S. Sharp, Camden, recently addressed a noon-day meeting of the Y. M. C. A. of that city.

Dr. Harvey M. Ewing, Montclair, and wife returned last month from their vacation stay at Jaffray, N. Y.

Dr. John L. Lund, Perth Amboy, and wife recently returned from Mount Clemens, Mich., where they spent a few weeks.

Dr. Howard C. Voorhees, New Brunswick, and wife spent a few days in Boston last month.

Dr. Charles Sharp, Port Norris, who was sued for damages when his auto collided with a motorcycle recently, has been freed by the jury returning a verdict of no cause for action.

Dr. Briscoe B. Ranson, Maplewood, has recovered the leather bag of surgical instruments stolen from his automobile recently. He paid the finder $25.

Dr. Walter G. Alexander, Orange, who is the first representative of the colored race to be elected to the New Jersey Legislature, was given a testimonial dinner recently by the Leni Lenape Club of East Orange.

Dr. Philip Embury, Basking Ridge, is undergoing treatment in St. Luke's Hospital, New York City.

Dr. Frank W. Lockwood, East Orange, and family have been spending some time in Florida.

The Mountainside Hospital, Montclair, appealed to the citizens last month for $25,000 for the maintenance of the institution.

Dr. Clara K. Bartlett, Atlantic City, addressed the Parent-Teachers' Association of Pitman, N. J., recently.

Dr. Marcus L. Clawson, Plainfield, was privileged to attend the 67th anniversary of his father's and mother's wedding in that city on November 6th.

Dr. Edward K. Hanson, Perth Amboy, was elected Coroner of Middlesex County on November 2nd.

Dr. Arthur P. Hasking, Jersey City, addressed the N. J. State Organization for Public Health Nursing in Jersey City November 6, on "Mental Hygiene."

Dr. William B. Jennings, Haddonfield, arrived home from Europe on Nov. 7. He treated en route a patient at sea, 400 miles off. When several days out a wireless message was received by the operator that a man was dying on board the steamer West Compo, 400 miles distant, and bound for Norfolk, Va., and asking if there was a physician on the Arizpa, Dr. Jennings was summoned. He responded with a message for a description of the illness of the man on the other ship. Getting this, he prescribed, and as the West Compo had the medicines on board, the sick man was successfully treated and recovered a few days after, according to reports.

MEDICAL EXAMINING BOARDS' REPORTS.

	Exam.	Passed.	Failed
Conn. Homeop., July	2	2	0
Illinois, June	243	221	22
Indiana, July	31	31	0
Iowa, June	24	23	1
Massachusetts, Sept.	52	23	29
Massachusetts, July	176	144	32
Minnesota, July	15	14	1
Mississippi, July	34	32	2
Missouri, June	85	84	1
Montana, April	17	15	2
Nebraska, June	22	22	0
Michigan, June	146	146	0
New Jersey, October	6	5	1
No. Dakota, July	8	7	1
South Carolina, June	30	25	5

National Board of Medical Examiners.

At the ninth examination of the National Board, held in Philadelphia, May 19-26, sixty appeared for examination of whom 46 passed and 14 failed.

Public Health Items.

Diphtheria.—The L. O. Beers Public School building in Phillipsburg was closed for a week last month because of the prevalence of diphtheria.

Middlesex County Anti-Tuberculosis League.—This league during the past three years had 1,500 persons under supervision. 500 were sent to hospitals for treatment. This number included 80 children.

Newark September Health Report.

The month of September was an unusually healthy one, only 351 deaths occurring, making a mortality of 10.2 per thousand population. The two chief causes of death were tuberculosis of the lungs and diarrhoeal disease under five years, both of which caused the same number of deaths, 34 in each case. Closely following were the deaths from cancer, 33, and organic heart disease, of which there were 29 deaths. Of the deaths under diarrhoeal diseases 27 of the 34 were under one year of age. The deaths from Bright's disease numbered 29, of which 24 were in persons 45 years of age. The total number of reportable diseases during the month of September was 763. The greatest number of diseases reported was whooping cough, 258 cases. Tuberculosis reported 163.

State Board of Health August Report.

During the month ending August 31, 1920, 2,976 deaths were reported to the Bureau of Vital Statistics of the State Department of Health. There were 618 deaths among children under one year, 193 deaths among children over one year and under five years of age, and 907 deaths among persons aged 60 years and over. The death rate for the month was 10.61, as compared with 10.31 for the previous month.

The principle causes of death were: Tuberculosis, 254 cases; cancer, 226; diseases of nervous system, 271; of circulatory system, 405; respiratory system (except tuberculosis and pneumonia), 108; pneumonia, 11; infantile diarrhoea, 330; Bright's disease, 224; diphtheria, 27.

Ban Urged Against Tuberculosis Patients Immigrating to California.

Mrs. Edith Tate Thompson of Fresno, executive secretary of the California Tuberculosis Association, declared recently in an address at the annual meeting of the League of California Municipalities, that California cannot longer handle the increasing immigration of indigent tubercular patients from Eastern States. She said, "The immigration must be stopped if widespread suffering is to be prevented. The time and money spent in roaming the country, if used for treatment at home, would bring health to hundreds who lose out in the uneven battle now."

(3)