



65924



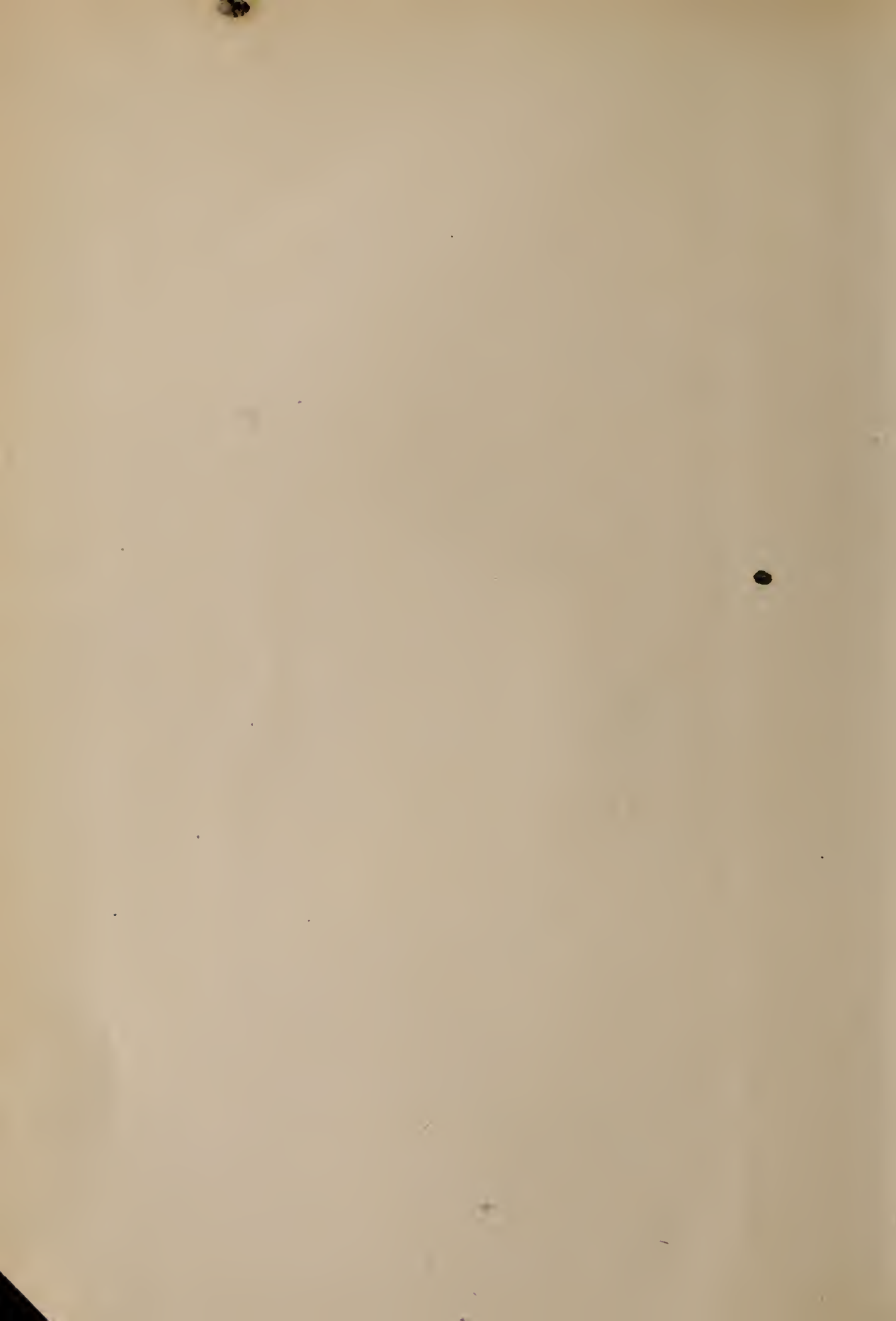
Class _____ No. _____

Presented by

H. A. Hoare, M.D.

4170









THE New York State Journal of Medicine.

Published Monthly by The New York State Medical Association.



VOL. 3. NO. 1.

NEW YORK, JANUARY, 1903.

\$1 00 PER ANNUM.

CONTENTS.

The Physician as a Business Man..	1	Acute Ileus	4	Some Aspects of the Pathology and Bacteriology of Typhoid Fever from the Standpoint of Recent Investigations, by George Blumer, M.D.	15
Anonymous Communications	1	Perforation of the Uterus.....	7	The Serum Reaction in Typhoid Fever, by T. W. Hastings, M.D..	18
Professor Lorenz in New York.....	2	Health Rules from an Old Bible.....	34	On Arteritis and Arterial Thrombosis in Typhoid Fever, by William Sydney Thayer, M.D.....	21
The Overcrowding of Street Cars....	2	Binding of the JOURNAL.....	34	The Modern Treatment of Typhoid Fever, by W. Gilman Thompson, M.D.	28
Simultaneous Publication	2	Dr. Frank Billings	42	Report and Presentation of a Case of Idiopathic Atrophy of the Skin, by William S. Gottheil, M.D., and Robert Abrahams, M.D.....	33
NEWS ITEMS:					
A Warning	3	Dr. Wm. M. Leszynsky	42	Constitution and By-laws of the American Medical Association...	34
Additional Legislation a Need.....	3	The Family Physician and the Children	42	Book Reviews	39
Personals	3	ASSOCIATION NEWS:			
Automobile Ordinance	3	American Medical Association.....	5		
An Unlicensed Physician	3	Erie County	5		
Revised By-laws	4	Kings County	5		
Antivivisection	4	New York County	5		
To Prevent Malaria	4	Orange County	5		
Beth Israel Hospital Fair	4	ORIGINAL ARTICLES:			
New Eye and Ear Hospital.....	4	The Present Ideas of Immunity, by Alexander Lambert, M.D.....	7		
Obituary	4				

Copyrighted, 1901, by The New York State Medical Association. Entered as second-class matter at the New York, N. Y., Post Office, January 18, 1901.

AMERICAN MEDICAL ASSOCIATION.

Next Annual Meeting at New Orleans, La., May 5 to 8, 1903.

President—Frank Billings, Illinois.

First Vice-President—J. A. Witherspoon, Tennessee. Second Vice-President—G. F. Coatsack, New York.

Third Vice-President—C. R. Holmes, Ohio. Fourth Vice-President—James H. Dunn, Minnesota.

Secretary—Editor—Geo. H. Simmons, 103 Dearborn St., Chicago. Ill. Treasurer—Henry E. Newman, 438 La Salle Ave., Chicago, Ill.

THE NEW YORK STATE MEDICAL ASSOCIATION.

President—Frederick Holme Wiggin, 55 West 36th Street, New York.

Vice-President—William H. Thornton, 572 Niagara Street, Buffalo.

Vice-Presidents Ex-Officio—Jeremiah R. Sturtevant, Theresa. E. D. Ferguson, Troy. Chauncey P. Biggs, Ithaca.

James W. Morris, Jamestown. Parker Syms, New York.

Secretary—Guy Davenport Lombard, 6 East 32d Street, New York. Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.

Counsel—James Taylor Lewis, Esq., 180 Broadway, New York.

STANDING COMMITTEES.

Committee on Arrangements.

SAMUEL A. BROWN, Chairman, 23 East 44th Street, New York. Frederick Holme Wiggin, New York. William H. Thornton, Buffalo. Guy Davenport Lombard, New York. William E. Swan, Saratoga Springs. William F. Stone, New York. Bernard Cohen, Buffalo. F. W. Higgins, Cortland. J. O. Stranahan, Rome. Chauncey P. Biggs, Ithaca. John Bruce Harvie, Troy. Johanna B. Leo, New York. Charles Gardner Child, New York.

Committee on Legislation.

E. ELIOT HARRIS, Chairman, 33 West 93d Street, New York. Jeremiah R. Sturtevant, Theresa. E. D. Ferguson, Troy. Chauncey P. Biggs, Ithaca. J. W. Morris, Jamestown. Frank S. Fielder, New York.

Committee on Library.

JOHN SHRADY, Chairman, 140 West 126th Street, New York. J. W. S. Gouley, New York. Ellery Denison, New York.

Delegates to the Annual Meeting of the American Medical Association, May, 1903.

E. ELIOT HARRIS, New York. Joseph D. Bryant, New York.

Committee on Public Health.

J. SCOTT WOOD, Chairman, 172 Sixth Avenue, Brooklyn. Henry M. Silver, New York. Gerrit F. Blauvelt, Nyack. Alexander A. Stern, Rondout. Charles A. Wall, Buffalo. Douglas C. Moriarta, Saratoga Springs.

Committee on Publication.

EMIL MAYER, Chairman, 25 East 77th Street, New York. Charles E. Denison, New York. L. C. Ager, Brooklyn. John J. Nutt, New York. Thomas F. Reilly, New York.

Committee on Nominations.

CHARLES E. QUIMBY, Chairman, 44 West 36th Street, New York. W. B. Reid, Rome; Douglas Ayres, Fort Plain, 1st District. John M. Humphrey, Saratoga; William J. Hunt, Glens Falls, 2d District. J. G. Orton, Binghamton; C. D. Ver Nooy, Cortland, 3d District. A. G. Bennett, Buffalo; T. D. Strong, Westfield, 4th District. J. W. S. Gouley, New York; William H. Biggam, Brooklyn, 5th District.

Charles A. Wall, Buffalo. Elias Lester, Seneca Falls.

AUG - 3 1904

JUST
NOW



WHEN the debilitated and poorly nourished are subject to coughs and colds, the remedy of most value is

GRAY'S
GLYCERINE
TONIC
COMP.

Its specific action on the respiratory organs is second only to its unique value in malnutrition and general debility

THE
PURDUE
FREDERICK
COMPANY,



No. 15
Murray St.,
New York.

THE NEW EDITION (1902-1903, Volume IV.)

MEDICAL DIRECTORY
OF NEW YORK, NEW JERSEY AND CONNECTICUT.

Revised, Enlarged, Wholly Up to Date.
Everywhere Accepted as "THE STANDARD."

THE new volume is more complete and more accurate than any of its predecessors. It will be found invaluable to the busy practitioner and to all who require a concise and complete compendium of information relative to the medical profession, medical institutions, medical laws or medical organizations in the territory covered. Price to all who are not members of the New York State Medical Association, \$2.50; carriage paid. Make cheque payable to

The New York State Medical Association,
64 MADISON AVENUE, NEW YORK CITY.

The New York State Journal of Medicine.



Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:

EMIL MAYER, M.D., Chairman, New York.
Chas. E. Denison, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 1.

JANUARY, 1903.

\$1.00 PER ANNUM

THE PHYSICIAN AS A BUSINESS MAN.

Those who are interested in the work of medical associations find a serious problem in the replies received to requests for payment of dues. A large proportion of our colleagues pay promptly, thus showing their loyalty; another proportion take their time, simply because they do not get at it. Some can but will not pay, and these are promptly dropped from the rolls. Still others hold back because of limited means and their desire to pay first the most pressing demands that come to them. These last have our profound sympathy and sincere consideration. We know that "they have not arrived," as the French say; that they are fighting manfully in the struggle for existence, trying, as best they may, to continue hopeful withal, and to meet their financial obligations when they can. Their position is such that they try in every way to make a coup and fail, alas! too often. One writer said recently, in answer to a letter requesting payment of dues: "I have lost a great deal of money in the past two years in stock speculations, and, consequently, am unable to respond to requests for payments. You know that medicine is an awful slow way of getting money together, even when you are very busy. I am referring to legitimate practice."

Why men fly to Wall street with its history of failures, why they take chances on what is sure to be a losing game, invest money that they actually need only to lose it, when there is always some opportunity of adding to their income without loss of dignity and without the expenditure of their hard earnings, is almost incomprehensible.

We have conferred with several colleagues, and the consensus of opinion seems to be conveyed in the following questions and answers: How many colleagues answer letters sent to them? What business methods do they employ? How many keep their books in order?

How many have a distinct understanding with their patients beforehand as to the cost of services? Do they think that it is inconsistent with the healing art to be thus precise? Or do they fear to give offense to prospective patients? In regard to this last question it may be said that no fair-minded person objects to knowing the cost of the visit, office fee or the charge for an operation.

The failure to collect outstanding accounts is due entirely to the doctor's woful neglect of ordinary common sense in the conduct of his affairs. It frequently happens that the patient asks for his bill and fails to receive it for weeks or months, instead of having it at once. Hence it occurs that the doctor's books are padded with accounts that he never can collect. No wonder he gets discouraged. If he can be independent, let him charge the fee he believes he has earned and let him collect it promptly. If his fee is graded according to the patient's ability to pay, then his books should show only what is really due him. He cannot ask a poor clerk or working-girl to pay him the fee that the wealthy merchant or banker does, so why encumber his books with useless accounts?

Let him adopt new methods, be prompt in his response to all letters, keep his books up to date, make his charges in accordance with his patient's means, promptly pay his lawful indebtedness, use such honorable means to increase his income as may present, do what his hands find to do with all his might and he will soon have that comfort and peace that a well-ordered household brings.

Anonymous Communications.—The Committee on Publication will be glad to take cognizance of all criticism in reference to the JOURNAL or Directory without mention of the name of the writer if so desired. Anonymous communications can not be answered.

Professor Lorenz in New York.—The visit of Prof. Dr. Adolf Lorenz, of Vienna, to New York City during the past month attracted much attention, both from the medical profession and from the laity. That medical men should be interested in seeing the leading exponent of bloodless surgery do his work was to be expected, but that the laity should evince such an interest was rather surprising, unless one stops to consider the power of the press. That Professor Lorenz acted in an entirely ethical manner in all his dealings with the profession and the public is a source of congratulation to all those who believe that a Code of Ethics is a necessary part of the Rules of the American Medical Association. He sought no interviews, he authorized no insertion of photographs of himself or his work, but was perfectly frank and courteous with the reporters, as every gentleman should be. His relations with the profession admit of no criticism, but are deserving of great praise. He saw no patients except upon the request of their family physicians or consultants, and refused to see hundreds of applicants, who offered him thousands of dollars, because in their request for a visit or consultation they did not mention the name of their medical attendant and ignored the proper procedure in such cases. When consultations were held he freely and frankly gave his opinion, always giving due credit to the doctor in charge and heartily approving all things that he could, and in a most modest way suggesting any changes he thought necessary or advisable. He believed the rôle of a consultant to be that of adviser or guide, not that of critic whose sole interest is to find fault, and to magnify such matters as do not admit of his approval.

To the laity he was most considerate, and did much to impress those with whom he came in contact that they owed much to their family medical advisers and should always consider their feelings and consult freely with them as to whether additional medical advice were needed or not.

He deplored deeply the tendency of many people to change doctors so frequently, in most instances for the most trivial of reasons. He refused positively to examine any patients whose ailments were not of a character usually spoken of as "orthopedic," and devoted more than three-fourths of his time to the demonstration of his "bloodless hip reduction" upon charity patients, whereas, had he so desired, this time could have been given up to seeing patients in large numbers and for large fees.

It is indeed a pleasure to find a man of whom we can say so much in praise and whose idea is that which this Association is striving for so earnestly and so successfully.

* * *

The Overcrowding of Street Cars.—The Merchants' Association of New York, through its Committee on Franchises and Transportation,

under the able and vigorous chairmanship of Mr. William F. King, has sent circulars to the physicians of New York City, protesting against the indecent condition which now disgraces the management of our elevated and surface car systems, and makes it impossible for any woman to use the public conveyances without unavoidable and indecent contact with others.

The circular states further that as a result of these conditions, frequent and gross insults, which cannot be resented or avoided, are of daily occurrence. With this circular were blank petitions, to be presented to the Hon. Seth Low, Mayor of the City of New York.

After careful consideration of this subject, and conference with many physicians, we are able to state that it is the unanimous opinion of the medical profession of this city that these disgraceful conditions exist and that they should be abolished. Every help that is possible on the part of the medical profession will surely be given to The Merchants' Association to eradicate this evil. There is no doubt whatever that a change must be made, and we feel confident, from our knowledge of the untiring efforts of this association, that much good will be accomplished.

We wish it all manner of success, and pledge our cordial cooperation.

* * *

Simultaneous Publication.—It is an unwritten law among editors of medical journals that an article sent to them for publication is contributed exclusively to the journal to which it is sent unless previous arrangement has been made to the contrary. An enterprising member of the profession recently sent his article to many medical journals, and it has appeared as an original contribution in thirty-five journals thus far, and the end is not yet.

If it was desired to advertise a specially prepared alkaline solution the result will be a dismal failure, for we hardly think that any firm will try to make use of this manifold publication so disgustingly flaunted before reputable physicians.

If it was an attempt to advertise himself he has in a measure succeeded. He has become known far and wide, and we think that we can promise prompt rejection of an article coming from his pen to the editors of reputable medical journals. If it was done on hire for filthy lucre we trust that he has received his pay in advance, for if it was contingent on the success that followed his tricky dodge, then he surely will be the loser.

We refrain out of respect for ourselves and our colleagues from characterizing this new bunco method in the manner it so richly deserves.

News Items.

A WARNING.

Editor of NEW YORK STATE JOURNAL OF MEDICINE:

Dear Sir—I wish to warn the medical profession against a comparatively new medical fakir who is working his game in various States. I refer to _____, M.D., New York. He is exploiting the "intravenous infusion method for the treatment of tuberculosis." His plan is to demonstrate his method before as many of the prominent physicians of a place as he can induce to attend his "clinic," and then leave the treatment in the hands of one or more of the local physicians. He is a very "smooth" scoundrel, in that he hides behind his "good standing" in the profession. He tries to verify his good standing by sending to each of the reputable physicians reprints of several of his articles on surgical subjects, besides one or two on his new treatment. I am sending you some of the reprints herewith.

Two of the more prominent physicians in Arizona have been giving this treatment for some time, and, so far as I know, are still giving it. A physician who is a personal friend of mine was invited by Dr. _____ to witness the administration by him of a dose of the fluid, and did so. This physician tells me that the fluid is placed in the hands of a custodian, who in this instance was an ordinary layman, and no one but the custodian is allowed to handle any of the fluid. When the doctor finds a patient who will take the treatment he notifies the custodian and the latter makes all further arrangements with the patient. At an appointed time the physician, the custodian and the patient get together for the treatment. The custodian brings the fluid (one pint for a treatment) in a locked hand-bag, and after the physician has gotten his infusion set in readiness, he, the custodian, unlocks the bag, warms the fluid, pours it into the syphon, holds the latter until all the fluid has run into the patient and then goes his way. Ordinarily, the first treatment costs the patient \$75, and subsequent treatments \$50 each, the doctor who acts as a tool receiving \$25 for each treatment. Whether any of the patients are benefited by the treatment I am unable to say. I am told—and it comes quite straight—that Dr. _____ is selling State rights for the treatment, but he is careful to keep this from the knowledge of the physicians, at least until he has obtained what he wants in a given town.

Comment on Dr. _____ or any other physician who will lend himself to such practice would seem almost superfluous.

Yours very truly,

* * *
Additional Legislation a Need.—The attention of the Legislative Committee of the State Association is called to the advisability of prohibit-

ing holders of foreign diplomas, who are convicted of practicing within this State, from taking the State Board examination for at least five years. Some other added punishment must be meted out to this class of offenders to compel them to stop.

* * *

Dr. James Sears Waterman, of Brooklyn, N. Y., was married on Monday, December 15th, to Miss Sara Clifford Brown at the Anchorage, Riverside, Cal.

* * *

Dr. John J. Mahoney, Jamestown, the stalwart member of the Fourth District Branch Association, who was recently married, has been spending a part of his honeymoon in New York City.

* * *

Dr. Churchill C. Carmalt of New York City, was recently married to Miss Alice Kidd, daughter of the late Howard Kidd, at Wilderkill, the country home of the bride.

* * *

Transactions.—The notices which have appeared in the JOURNAL have borne such fruit that we have given to members of the American Medical Association, the New York State Medical Association and to libraries thirty-seven sets of the Transactions, making a sum total of 592 volumes. Among the libraries that have received these sets are:

The Craig Colony Medical Library.

Library of the Manhattan State Hospital, East. Northwestern Medical School and Library, Chicago.

William Pierson Memorial Library, Orange, N. J.

We have still on hand a number of sets without volume No. 1, that is, from volumes 2 to 16, inclusive, which we will be glad to furnish to members of the American Medical Association, New York State Medical Association or to libraries on request, provided they pay the express charges.

* * *

Automobile Ordinance.—It is interesting to note that the ordinance introduced by the Board of Aldermen to compel physicians to pay a \$10 license fee for an automobile, while most others escaped with a \$2 or \$5 fee, has been killed in committee. There may be a legislative bill, however, passed later which may bear watching.

* * *

An Unlicensed Physician.—Magistrate Mayo discharged Carmine Atonna, 346 East 104th street, Italian, who has been complained of several times for practicing without a license, and against whom a charge was made in the Harlem Court. The case turned on the identification of the medicine received by the detective from the Italian.

Revised By-laws.—The Constitution and By-laws of the American Medical Association, which were revised at its last meeting in Saratoga and reenacted at the adjourned meeting in Chicago, have been received recently and are printed in this number of the JOURNAL. Changes may be noted by comparing them with those adopted at St. Paul, June 5, 1902, and printed on pages 930 to 940, volume 4, of the Medical Directory of New York, New Jersey and Connecticut for 1902 and 1903.

* * *

Antivivisection.—Dr. Keen's public letter to the Hon. Jacob H. Gallinger (who is also a doctor, by the way, and a graduate, we believe, of a homeopathic college), in which he sets forth clear and undeniable proofs of the saving of many lives through knowledge which could not have been obtained except through vivisection, will undoubtedly assist many antivivisectionists to appreciate the value of this form of study. If suffering or death had to be endured by a child or a dog, who would take time in choosing? This is not a question of suffering. Under the hands of the skilled surgeon and with the use of anesthetics the dumb beast suffers no more than if he were dead.

* * *

To Prevent Malaria.—To prevent malaria the Department of Health of New York City is taking active measures to instruct the laity in the cause of this disease and the methods of destroying the guilty Anopheles. The department will examine the blood of patients whenever requested and will report to the physician in charge. An inspector will visit the residence of any one who so desires and suggest methods and means of destroying possible breeding places, and explain the methods of successfully using oil.

* * *

Beth Israel Hospital Fair.—The fair and festival of the Beth Israel Hospital will begin at the Madison Square Garden on Saturday evening, January 3, 1903. The fair will be formally opened by Gov. B. B. Odell, Jr., who will be accompanied by the members of his staff. Boxes on the north side of the arena have been set aside for the Governor, and nearly every branch of the municipal government will be represented. Many city officials have promised to attend.

* * *

New Eye and Ear Hospital.—The Board of Directors of the Manhattan Eye and Ear Hospital, at a meeting held at the home of the Hon. Abram S. Hewitt, decided, as soon as sufficient funds could be accumulated, to erect a new building on East 44th or 45th street, somewhere between Lexington and First avenues, which will contain from 125 to 150 beds, more than twice the capacity of the present hospital, which is to be better equipped in every way than the present structure. A communication was read

at the meeting from a gentleman who offered to give \$50,000 to the hospital on condition that \$150,000 more was raised by January 1, 1904, and that the hospital was moved to another part of the city. Another condition was that a children's ward be established, which was to perpetuate the name of the giver. The board accepted both offers. The Manhattan Eye and Ear Hospital was founded in 1869 by Dr. C. R. Agnew.

* * *

Obituary.—Dr. Alexander Demby, a member of the New York State Medical Association, Kings County, died at his home, 140 Sumner avenue, Brooklyn, on December 17th, of typhoid fever, followed by appendicitis. Dr. Demby was born in St. Petersburg, Russia, and came to this country with his parents in early childhood. He was educated in the public schools of Brooklyn and the Boys' High School, and was graduated from the Long Island College Hospital in 1896. He was a member of the staff of the Polhemus Memorial Clinic, connected with the Long Island College Hospital, and with the staff of the Brooklyn Jewish Hospital Dispensary.

* * *

Acute Ileus.—If the bowel shows any signs of paresis after the obstruction is relieved, it is advisable to make an artificial anus low down in one of the sides and attach the bowel. It can be safely opened here without danger of infecting the abdominal cavity. The stomach tube should always be used before giving the anesthetic, especially if fecal vomiting has occurred. Some years ago I was called to a case of obstruction of five days' duration; chloroform was given and I had just opened the abdomen and found the volvulus, when the patient had a violent attack of vomiting; much fecal matter was ejected during inspiration and the patient died on the table from suffocation.—GUNDERSON, in the *Transactions of the Wisconsin State Medical Society*, 1902.

* * *

Know Thyself.—The pride, at times called modesty, which restrains a physician from making himself and his value known, becomes insufferable conceit when he is hurt because people do not come and seek him in his office. Know your own worth and what should be your legitimate share in the professional work; make the former known and demand the latter. There is such a thing as claiming without clamoring—of being known without being blatant. Seek the good opinions of your brethren; the man who is not respected by the members of his calling is not deserving of the respect of other men.

Seek acquaintances among all classes of men; not a soul lives but has a particular lesson to teach us—what a pity so few of us can read the texts!

The Association.

AMERICAN MEDICAL ASSOCIATION.

The local Committee on Arrangements for the next meeting of the American Medical Association, which is to be held in New Orleans, May 5, 6, 7 and 8, 1903, is actively at work under the chairmanship of Dr. Isadore Dyer.

The following committees have been appointed:

Finance Committee—Dr. John Callan, chairman.

Post-office Committee—Dr. E. S. Lewis, chairman.

Transportation Committee—Dr. E. Suchon, chairman.

Exhibit Committee—O. Kohnke, chairman.

Badge Committee—H. B. Gessner, chairman.

Registration Committee—R. Matas, chairman.

Hall Committee—J. F. Oechsner, chairman.

Publication Committee—F. A. La Rue, chairman.

Secretary of the committees—J. B. Guthrie.

* * *

Erie County.—The regular quarterly meeting of the Erie County Medical Association was held in Buffalo, N. Y., at the University Club on Monday evening, December 8, 1902. The president, Dr. Grosvenor, opened the program with an informal address on the county organization. Dr. Marcel Hartwig presented a paper entitled "Hypertrophy of the Prostate." He said that he had noted an inherited tendency toward this condition. The etiology, pathology, symptomatology and treatment were discussed. Injections of iodine into the gland he considers dangerous and leaving in a large sound unsatisfactory. Of the operative procedures he favors the removal of the two lateral lobes by two lateral incisions, thus preserving the sexual function and not injuring the urethra. Later extirpation of the middle lobe may be done if the condition is not relieved by the first operation. Any of the surgical procedures should be performed before the patient is debilitated by a cystitis, or pyelonephrosis.

The paper was discussed by Drs. William C. Phelps and Henry E. Dowd. The following question was discussed: "Is a cyclopegeic necessary for refractive work?"

Dr. I. G. Bennett took the affirmative side and Dr. E. E. Blaauw the negative. Dr. Bennett maintained that a mydriatic was absolutely essential to produce sufficient relaxation for a proper examination; especially is it the case in examining the macula. He believes that the danger of its use in glaucoma is overestimated.

Dr. Blaauw stated that a proper examination could be made in a dark room, with the ophthalmometer, by one experienced in the use of that instrument, without using a mydriatic. Pupillary

spasm is concealed by using the same. Drs. A. A. Hubbell and Elmer G. Starr supported Dr. Bennett and Dr. R. H. Satterlee supported Dr. Blaauw.

Nine new candidates were elected to membership in the association as follows: Drs. Robert E. De Ceu, John H. Grant, Edward W. Jones, Theodore M. Leonard, Arthur G. Sage, Ludwig Schroeter, Adolph Urban, Alfred B. Wright, Abram L. Weil, all of Buffalo.

Dr. A. A. Hubbell gave a report of the recent meeting of the New York State Medical Association.

The following is a list of the nominations for officers for the coming year, the election to be held in March, 1903:

President, Dr. Allen A. Jones; vice-president, Dr. Carlton C. Frederick; secretary, Dr. Jacob S. Otto; treasurer, William Irving Thornton.

Delegates to the State Meeting.—Drs. George F. Cott, Charles G. Stockton, Herman E. Hayd, George A. Himmelsbach, Charles S. Jewett, Joseph W. Grosvenor, Francis Park Lewis, Edward E. Blaauw and Marcel Hartwig.

Alternates.—Drs. Bernard Cohen, William H. Jackson, Julius H. Potter, W. Scott Renner, William G. Taylor, Hiram P. Trull, Grover W. Wende and Horace G. Hopkins.

Following the meeting there was an enjoyable collation and a social entertainment.

There was an attendance of fifty.

* * *

Kings County.—The regular monthly meeting was held at 315 Washington street, on Tuesday evening, December 9th, the president, Dr. Arrowsmith, in the chair. About thirty-five members were present. Dr. F. C. Raynor read a paper on "Antral Disease," with report of a case. In the discussion Dr. Gildersleeve suggested that, according to the general principles of surgery, it was a mistake to pack tightly the antrum or any other bone cavity. Drs. Hoople and Arrowsmith spoke briefly of several cases of cure of antral diseases without operation. Dr. Arrowsmith justified tight packing, on the ground that it was necessary to check hemorrhage.

Dr. Louis C. Ager read a paper on "Summer Infant Mortality in Brooklyn. Its Causes and Preventability." It was discussed at considerable length by Drs. Henry N. Read, Frank W. Shaw, F. S. Kennedy and others.

In executive session the following nominations were made: For president, George H. Treadwell; vice-president, Arthur C. Brush; recording secretary, Frank C. Raynor; corresponding secretary, George F. Maddock; treasurer, Edward H. Squibb; member of Executive Committee, Hubert Arrowsmith; member of Nominating Committee, H. H. Morton.

Fellows.—L. C. Ager, H. Arrowsmith, F. R. Baker, L. G. Baldwin, C. P. Gildersleeve, M. Linderoth, T. A. McGoldrick, L. C. McPhail,

G. F. Maddock, H. S. Pettet, J. O. Polak, F. C. Raynor, W. S. Shattuck, W. H. Steers, G. H. Treadwell, D. W. Waugh.

Alternates.—H. C. Anderson, J. C. Bierwirth, A. C. Brush, A. H. Clements, W. D. Davis, J. C. Hancock, A. N. Hoople, J. W. Ingalls, S. H. Lutz, James H. McCabe, S. J. McNamara, C. D. Napier, F. W. Shaw, H. M. Smith, H. H. Waugh, M. G. White.

Owing to the surplus in the treasury it was voted to reduce the local dues to \$2 for the coming year. The by-laws were amended to conform to the change in the dues of the State Association.

The matter of the abolition of the office of Coroner was referred to the Executive Committee with power to appoint a committee to confer with the committees from the other medical organizations. A collation followed the close of the meeting.

* * *

New York County.—The stated meeting of the New York County Medical Association was held on Monday evening, December 15th. There was a very large and representative attendance. After introductory remarks relating to the treatment of strictures of the urethra, Dr. J. W. S. Gouley read a most interesting and instructive paper on the "Dilatation of Strictures." Dr. L. W. Hotchkiss read a paper on "Internal Urethrotomy" and Dr. Parker Syms on "External Perineal Urethrotomy." (These three papers will be published in the February number of the JOURNAL.) Dr. William H. Lockett reported two successful cases of intraspinal injection of antitoxin for tetanus.

In the executive session the Association adopted the following resolution: "That a committee of ten be appointed by the chair to investigate and report upon the subject of 'Proprietary Medicines,' their use to the medical profession and their relation to the advertising and literary department of medical publications."

The following candidates were elected to membership: Dr. Coleman W. Cutler, Dr. Oscar M. Leiser and Dr. Abram R. Stern.

The resolution requesting the Department of Health to enforce the regulations for the heating of street cars was referred to the Committee on Public Health.

* * *

Orange County.—The Orange County Medical Association held its regular monthly meeting at the office of Dr. M. C. Conner, Middletown, N. Y., on Wednesday, December 17, 1902, at 2 P. M. There was a good attendance of the members. Dr. C. W. Dennis, of Goshen, who intended to be present and read a paper on diphtheria, was delayed by an accident to the electric-car service, and was unable to reach town in time. Dr. W. I. Purdy, of Middletown, opened the scientific session with a report of a recent Cesa-

rean section, performed at Thrall Hospital, Middletown. Dr. Purdy described the case as follows:

"Amy E., a dwarf, age 16 years; father and mother of normal size, three other children in her family, all normal in size. At the age of 2 years her growth ceased; has always been strong and healthy. Patient unmarried, full term, and had been in labor eighteen hours when she was brought to Thrall Hospital by Dr. C. A. Canfield, City Physician of Middletown, about 9.30 P. M., December 7, 1902. Vaginal examination showed that the membranes had ruptured and the amniotic fluid had drained away. The cervix was crowded down into the pelvis and dilated as well as the very narrow conjugate would admit. After a hasty estimate of the antero-posterior diameter, which did not exceed at most over 1 inch, it was decided to do a Cesarean section. The usual preparations for laparotomy were made, and an incision made from the ensiform cartilage to the pubes. The uterus was well contracted. The child was found to be in R. O. A. position. The uterus was with difficulty brought into the abdominal opening and tilted well over the pubes at almost right angles to the body; hot towels were applied to the wound and the intestines. The next step was ligature of the ovaries, uterine arteries, and the broad ligament to the level of the internal os. A piece of rubber tubing was applied to the neck of the uterus, but seemed to have little effect on the hemorrhage. It was noted that the ovaries and tubes were very small and attached to the fundus high up. The anterior median wall of the uterus was then incised and the child quickly delivered. Very profuse hemorrhage occurred, which was controlled by the application of very hot water. The placenta was found attached to the posterior uterine wall and easily detached and with the membrane delivered. The uterus contracted well under the hot water and vigorous kneading. A few more sutures were now passed, and the uterus amputated at the level of the internal os. The usual abdominal toilet was attended to and the wound closed.

"The child was somewhat asphyxiated, but under careful handling soon cried lustily and seemed strong and healthy. On the morning of the fifth day the nurse found the baby dead at the side of the mother, probably due to overlying. The mother has made an almost uneventful recovery, with scarcely a rise of temperature.

"The measurements of the child were as follows: Total length, 17½ inches; vertex-coccygeal length, 11½ inches; weight, 5 pounds 8 ounces. Circumferences: Occipito-mental, 14¾ inches; suboccipito-bregmatic, 13 inches; Occipito-frontal, 14 inches; bisacromial, 12½ inches; bitrochanteric, 8 inches. Diameters: Occipito-mental, 5½ inches; occipito-frontal, 4½ inches; suboccipito-bregmatic, 4 inches; fronto-mental, 3¾ inches; trachelo-bregmatic, 4½ inches; biparietal, 3¾ inches; bitemporal, 3½ inches; bimas-toid, 3 inches; bimalar, 2¼ inches; bisacromial,

4 inches; dorso-sternal, $2\frac{1}{2}$ inches; bitrochanteric, 3 inches; sacro-pubic, $1\frac{3}{4}$ inches.

"The measurements of the mother, taken after the operation, are as follows: Circumferences at the trochanters, 30 inches; at the waist, 26 inches. Diameters: Bitrochanteric, 10 inches; external conjugate, five-eighths of an inch. From second sacral vertebra to anterior superior spine, 6 inches; ilio-cristal (greatest width of the pelvis at the crests), $7\frac{1}{2}$ inches; height, 44 inches (3 feet 8 inches); weight, 75 pounds."

Dr. Purdy stated that he was ably assisted by Drs. Conner, Canfield, Hanmer and Powelson, of Middletown, as well as the very efficient superintendent and nurses of Thrall Hospital.

At the conclusion of his paper the doctor was highly complimented on the successful outcome of the case, and a vote of thanks given him for the excellent report. Some discussion was then engaged in by those present on the subject, and reports of cases witnessed by Drs. Conner, Redfield and Preston.

At the business session following, amendments to the By-laws of the New York State Association were read by the secretary. They were unanimously adopted. A communication from Dr. Squibb was read, in which attention was called to the special inducement now offered to become members of the Association. There being no further business before the meeting, adjournment was made until the third Wednesday in January, at which the annual reports will be read and election of officers for the ensuing year will be held.

* * *

Perforation of the Uterus.—Nowhere in routine practice is the *tactus eruditus* more necessary than in curetting a septic uterus. Twice within my personal knowledge has this accident occurred. Both cases made, I am glad to report, good and uneventful recoveries, and neither ever suspected they had been the victims of so grave and serious an accident. Needless to say, neither was extensively advertised at the time. In my own case, the curette being gently handled, it seemed all at once to meet no resistance and dropped into a bottomless cavern. Its withdrawal was followed by the entrance into the uterine cavity of a generous handful of mesenteric fat. Supposing this to be placental tissue with membranes attached, I attempted to remove it, the fingers replacing the curette. As the mass began to come within the range of vision I saw my error, and as the tissue was too much injured to make it safe to replace, I ligated en masse as near the rupture as possible, removed the mass with scissors, flushed out the uterine cavity with hot sterile water, packed with gauze, put the patient to bed and lived about forty-eight as miserable hours as ever falls to mortal's lot. To my surprise, there was but little shock, and the patient proceeded to make an absolutely uneventful recovery.—I. M. FRAZIER, in the *Texas State Medical Association Transactions*, 1902.

Original Articles.

THE PRESENT IDEAS OF IMMUNITY.¹

BY ALEXANDER LAMBERT, M.D.,
New York, N. Y.

It has seemed fitting that an inaugural address to a society of busy practitioners should endeavor to bring together the facts of some subject of general interest to all branches of the medical profession or should place in review the facts and theories of recent scientific work which have not as yet become diffused through the general literature of the profession, but still remain widely scattered in many periodicals. It has, therefore, seemed that it would be interesting to bring together for your consideration the important facts and theories on the subject of immunity which have been brought out in the past few years. There is no intention, nor would it be desirable to bring before you the minute details of all the experiments, but the salient facts and fundamental theories of the different schools of thought on the still unsolved problems are all we shall be able to consider.

However interesting it would be to study the various changes in the ideas of immunity which at different times have held sway in medicine, it is aside from the present subject.

Certain facts familiar to you all have long been known such as the immunity which is conferred by one attack of the various exanthemata against succeeding attacks and the immunity which various species of animals bear against certain diseases, the immunity of animals against diseases common to man and the resistance of man to the various diseases which are prone to attack either domestic or wild animals. And amongst men we have all doubtless noticed certain racial peculiarities in resistance to disease. This fact is often developed in certain families and sometimes even in individuals alone.

There is, thus, the problem to be considered of natural immunity and of acquired immunity, and scientific research has shown that these two types are further divided into the resistance against bacteria themselves and the resistance against bacterial poisons or toxins. The organism may be resistant to the invasion of a bacterium, but surely succumb to the inoculation of its toxin. Or the reverse may be true. We have, therefore, to further consider an anti-bacterial immunity and an antitoxic immunity.

Such a peculiar scientific jargon, as it were, has grown up amongst the various experimenters in this field of research that it seems necessary to lay before you the various theories of immunity before we proceed with further consideration of the facts which investigation has placed in our possession.

The two main theories are the phagocytic

¹President's address read before the New York County Medical Association, October 21, 1902.

theory of Metchnikoff and various modifications of the old humoral theory, by which various body juices formed the protective elements of the organism, of Flügge, Buchner and Nuttall. These two theories were widely apart a few years ago, but have gradually been drawing nearer and nearer together until most investigators rest now on a compromise in a neutral position between the two extremes.

Ehrlich's theory, as we shall show presently, is a more minute chemical explanation of the reactions that take place. The terms toxine and its antidote, antitoxin, have long been familiar to you in your everyday therapy. In immunity against bacteria it was found that the bacteria under certain conditions underwent what seemed to be a solution in the surrounding fluids. The substances that cause this solution are known as lysines. This lysine is now acknowledged by all to be composed of two substances. The first is present in normal serum and loses its activity when heated to 55° C. This was originally called alexine by Buchner, from *aléo*, to ward off, hence a defender. This term is generally accepted. It is, however, called cytase by Metchnikoff, from his idea that it is a cellular ferment, the termination "ase" being the same as in diastase and such other ferments. It is also called addiment or complement by Ehrlich. The second substance which is sometimes present in normal serum and which is a specific body produced in the organism by immunization, has been called by Buchner the "anti-body," by Ehrlich the "immune body" or the "intermediary body," from its supposed position in the reactions occurring according to Ehrlich's theory. It is called by Müller the "copula" as a bond between the substance attacked and the alexine attacking. It is called by Metchnikoff the "fixative," as fixing the alexine to the substance to be acted upon; by Güber the "preparative" as preparing this substance for the alexine action; by Bordet the "sensitizing substance" from his idea of its supposed mordant action; by London, of St. Petersburg, it is called "desmon," from the Greek *séo*, to bind or fix, from his opinion that bound with the alexine it forms the haemolysine and bacteriolysine. The other complicated nomenclature of Ehrlich we shall mention in discussing his "side chain" theory.

It is further said of the serum that it is "active" when the lysine is intact; it is "inactive" when heated to 56° C., the alexines being then alone destroyed, the immune body remaining untouched by this temperature. It is "reactivated" when to some inactive serum some normal serum is added restoring the alexines, and the lysine is thus again complete and active. All these substances toxic to various cells are called cytotoxine.

Returning now to the various theories, Metchnikoff's theory of the phagocytes has been developed by him from his observations in bi-

ology, and in it the white cells of the blood are the pivotal figures. The leucocytes he divides into macrophages, that is, the large mononuclear leucocytes which are the devourers of foreign elements, such as foreign blood cells, coloring matter, etc., and also under some circumstances, but always to a very small degree, of bacteria; and the microphages, the polynuclear leucocytes, which are the active contestants in the struggle against bacteria. These phagocytes are also capable of absorbing the bacterial toxines and rendering them inert. The action of these phagocytes is to take up foreign bodies of all kinds and by the secretion internally of their own ferments to digest them. Thus he believes that the alexine, or his cytase, is the direct product of these phagocytes. It is, however, never loosened from their interior unless these cells are damaged or die; that is, phagolysis or dissolution of the phagocytes takes place. There is then present in the blood or fluids of the body at the point of infection the necessary amount of alexine. The immune bodies are produced in the lymphoid tissues of the spleen, in the omentum and mesenteric glands and are then secreted into the blood.

In the living organism Metchnikoff believes that the alexine never circulates normally and is not present in the plasma. The immune body and the antitoxine, when produced by immunization, circulate freely in the blood. To Buchner and Gruber the alexines are present normally in the blood and are secreted under stimulation by the leucocytes. Bordet and Buchner believe in the unity of the alexine—that it is a single substance which is the same for the same species of animal, but which differs in different species, although its action is the same for all. All these men believe that the immune body is specific against the micro-organism or the substance which, in the reaction of immunization, has called it forth, being specific against different substances from one animal, and also against the same substance from different animals. Thus we see that Buchner's old humoral theory in which the fluids of the body contained the protecting substance has been brought down to a common ground with Metchnikoff's theory, that the leucocytes take up and destroy the bacteria, differing only in the question of whether the protecting substance is the normal secretion of these cells or only the product of their destruction.

The most complete philosophical and abstract theory that has been brought forward in late years is Ehrlich's. This investigator basing his theory on his observations in testing diphtheria toxine against its antitoxine, and on his profound knowledge of organic chemistry, as well as on the observations on the process of repair brought forward by Weigert, has conceived that the cells of the body are composed of a central radical called its "chief executive chamber," this being characteristic for the individual cell and

differentiating one cell from another, and to this central radical are joined many complex side radicals, the so-called receptors. These are the famous "side chains." These side chains are classed into three groups. The first class are simple, having what he calls the haptophore group, that is, a radical bearing a clamp, which is capable of fitting to the corresponding haptophore group in some substances, as toxins or ferments; the second group is that which possesses one haptophore group and one ferment group, which has a fermentative action and attends to the assimilation of food substances. The third group possesses two haptophore groups, one of which cares for the assimilation of food and the other seizes certain other substances, the complements, circulating in the blood plasma, which occasion a ferment-like action. These third-class receptors are the amboceptors. It is through alliance with these substances designated "complements" because of their completed action that these side chains or receptors, as he calls them, of the third class receive their ability to work over by fermentation what they seize. The complements—and every blood serum possesses different types—are formed similarly to the toxins. These complements possess a haptophore group which enters into combination with the complementophilic complex of the receptor, and an active group, which corresponds to the toxiphore complex of the toxine, and which for the sake of bringing out this analogy is designated as zymotoxic. He believes that the haptophore group of the toxins, for instance, joins to the haptophore group of the single receptor of a cell. If the toxine acts on the cell and too many toxine molecules are joined to too many receptors, the toxiphore group of the toxine produces a toxic action on the cell. But, if there is not enough to kill the main cell, then the receptor attached to the toxine is cast off as neutralized and useless to the cell. The cell constantly regenerates the receptors that have been cast off, and as Weigert shows in the process of repair that the production under these circumstances is overproduction, many more receptors are formed than are needed, and being cast off into the blood, as Ehrlich says, as useless ballast to the cells, are really the antitoxine as found in the blood.

His theory further explains the fact noted by him that in the deterioration of diphtheria toxine the same amount would neutralize a given amount of antitoxine, but the toxine units or the toxicity of the toxine had become greatly reduced. He explains this by the fact that the haptophore group of the toxine combines with the haptophore group of the antitoxine. In the toxine the haptophore group has remained active and the toxiphore group has lost its action, therefore the toxicity will be null and it gives a toxoid reaction. Thus he explains the fact that it still neutralizes by its haptophore group the antitoxine, thus combining with the recep-

tor of the cell and causing a further production of the antitoxine.

Further consideration of other points in Ehrlich's theory will be mentioned as we proceed, but we can see that it endeavors to explain all action in the body as due to a complex interaction of various chemical radicals supposed, but by no means proven, to exist, in the protoplasm of the body.

In studying natural immunity, experiments soon showed that the fluids of an animal immune against a bacterium were found to be excellent culture media for the growth of that bacterium outside of the body. For example, we know that the dog, relatively immune to anthrax, gives a blood serum in which the bacteria grow abundantly, and pigeons immune against the influenza bacillus give by their blood the best culture medium for these germs. On the other hand, the serum of rabbits is intensely bactericidal for anthrax, but the rabbit himself is exceedingly sensitive to the infection. Other examples might be given, but from these we see that in natural immunity it is some mechanism of the body besides substances in its juices which is the dominant factor in protection against germ invasion.

After an injection of anthrax into frogs one may see the phagocytes crowded with the bacteria, and on transferring these phagocytes containing the bacteria to a sensitive animal, such as a mouse or a guinea pig, we find the bacteria possessing their full virulence and quickly causing the death of the latter animals. This same is true in the case of the leucocytes of dogs and chickens with this same bacterium. Thus we see in this infection at least, that the refractory animal is capable by his phagocytes of engulfing fully virulent and active germs without apparently any intervention of his body fluids to produce previous disintegration or injury to the germ. When once inside the phagocyte, Metchnikoff has shown that there is a slightly acid reaction in the cells containing these bacteria, and their digestion takes place by a ferment which he calls "ambo-diaxase," acting, as he says, in a manner similar to trypsin, in that it will act in a faintly alkaline, neutral and even slightly acid medium. Moreover, it has been further shown that the bactericidal power of the polynuclear leucocytes or microphages, is superior to that of the corresponding blood serum. The bactericidal power of the extract from the macrophages is, on the other hand, small or nil.

The greatest difference is shown in the case of the dog, where the serum possesses no bactericidal property, while the extract of the microphages possesses it in a considerable degree. And further, the microphagic extract of rabbits is shown to be much more active than the blood serum in its destruction of anthrax, coli, typhoid and cholera bacilli. This microphagic extract seems to be the same as the bactericidal substance in the serum. It has

further been shown, that rabbits and guinea pigs can withstand the injection of large numbers of virulent tetanus spores, if in the fluid containing these spores the tetanus toxine has been destroyed before injection, and one observes at the point of injection that the leucocytes rapidly engulf the spores before they have the chance of germinating. But if anything interferes with this rapid engulfment of the spores and they have the chance to germinate and produce the slightest amount of toxine, the animal will then succumb to tetanus intoxication. This, then, is the same mechanism as is observed in the animal strongly immune to bacterial infection, and is also an example of an animal immune to relatively large doses of the infecting agent, and yet highly sensitive to the toxine of the same infection.

In animals naturally immune against infection Metchnikoff points out that the symptoms of heat and swelling in the inflammation produced by the injections of bacteria are small in amount, and the amount of liquid is also insignificant, but there is a strikingly large number of leucocytes attracted to the point of invasion, and even, as in tuberculosis, where the macrophages are the more active, the macrophages are also very abundant. That is, the chemotactic power of the leucocytes is very marked, and it is said that they possess a very strong and positive chemotaxis. But this term chemotaxis is but a name without the explanation of why these phagocytic cells are attracted in such great numbers in certain affections in given animals, and not in others. The causal factors explaining this so-called chemotaxis—why under certain conditions it is present and under other conditions absent—remain unknown, and we have but the name to give for the observed phenomena.

The positive chemotaxis and the resulting engulfing of the bacteria seems, however, to be the primordial act of attraction to food of a cell possessing individually independent movement and the subsequent intracellular digestion, as observed in the lowest forms of life outside our bodies.

In the natural immunity against toxins we have many striking examples among the lower animals. Among scorpions we find that they tolerate large doses of tetanus toxine in their blood, and it remains there for many weeks without causing them any inconvenience. Snakes, lizards and turtles are also immune to this toxine, yet in none of these animals does any antitoxine ever appear. The alligator also shows absolute immunity against tetanus toxins and the cholera poison, but in young animals the antitoxine does not appear until after the expiration of two months, while in the old animals a large amount of antitoxine appears within twenty-four hours. These animals, on the other hand, die from a very small dose of diphtheria poison. The most familiar and striking examples of this natural immunity against toxins is

in the case of the hen against tetanus and the rat against diphtheria. These animals will stand respectively large doses of these poisons without any antitoxine appearing in their blood. With enormously large doses, however, they can be made to succumb to these intoxications, but large doses between the maximum indifferent and the fatal doses will call forth antitoxine in their blood. But, strange to say, a milligram of either poison when injected into the brain of either of these animals will cause death; that is, if the poison can obtain access to the cells which are sensitive to it the animal succumbs to a small dose in a short time.

The antitoxic power of the blood is not the essential element in the protection of the organism against toxine, for in immunizing animals, the rabbit can be immunized against the tetanus toxine without any antitoxine appearing in its blood. And, further, rabbits that can resist four to six times the fatal dose of tetanus and whose blood is strongly antitoxic, will surely die if a small dose of tetanus toxine is injected directly into their brains. That is, while the antitoxine present in the blood may neutralize and does neutralize its corresponding toxine, even this condition of immunity in the blood does not extend to the sensitive cell. In hens, after tetanus toxine has been injected into the blood, and has somewhat disappeared from it, leucocytes obtained from exudations and washed in salt solution, can be proven to contain a greater amount of toxine than exists in the blood. This is not only true in rabbits against bacterial poisons, but we find it also, to some extent, with the alkaloids. A rabbit will bear thirty centigrams of morphine hydrochlorate subcutaneously, but will die from a milligram injected into the brain. Other poisons, such as the insoluble salts of arsenic, injected into the peritoneum of rabbits can be demonstrated in their leucocytes, and also the soluble potassium salts of this same metal given in non-fatal doses, can, after their disappearance from the blood, be shown to be present in the same cells. These facts point to the position of compromise between the old humoral theory and the phagocytic theory.

That the protective proteids may exist in the blood and may serve as antidotes to the noxious element is granted, but the question as to where these substances arise is still an open one. Certain it is that the cellular elements, the phagocytes, enter into this immunity as into the immunity against bacterial infections.

It has been shown in typhoid and cholera and the germ of blue pus, that animals immunized by the bodies of the bacteria will succumb to the poisons of these same germs, but if immunized by the soluble products of their growth, they will resist both toxins and germs.

As to the action of toxine upon antitoxine and the reverse, the mechanism of neutralization presents an open question. For Ehrlich it is the haptophore group of the toxine joining the

haptophore group of the antitoxine, the resulting substance being inert. For Behring it was at first a direct neutralization, that is, similar to the reaction between acids and bases. Buchner at first believed in an intervention of some of the cells of the body which brought about the action of neutralization between the toxine and its antidote. More recently, however, he believes that it is a direct action between the two, and that because of its slowness, its retardation by cold and acceleration by heat, and its more active occurrence in concentrated than in dilute solutions, he believes it to be some chemical change such as occurs in the rearrangement of atoms in polymerization. The chemical bond between the toxine and antitoxine certainly does not seem to be strong. Snake venom and its antitoxic serum mixed to inert doses when heated to 65° C. loses its antitoxic element and becomes toxic, the toxine not being destroyed at this temperature. Mixtures of bacterial toxins and their antitoxines, inert on injection, when forced through filters of thin layers of gelatine show separation of the two components, and the toxine alone appears in the filtrate. But the origin of the antitoxine is still unknown. Gruber, Buchner and the French school believe that it is produced by some healthy cell in its resistance against the noxious element. Ehrlich, as I have said, believes that it is the specific cell itself that is affected by the toxine, which casts off the receptors joined to these toxins and thus become antitoxines.

The experiments of Wassermann with the brain of guinea pigs and the tetanus toxine have been cited as proving Ehrlich's theory. Tetanus toxine mixed with brains of a guinea pig, when injected into animals in certain definite mixtures, was shown to be inert. Wassermann said, therefore, that the brain contained the antitoxine in the cell, and Ehrlich's theory was proven. But the brain substance must be injected with the toxine and come into intimate physical contact with it to prevent its toxic action. Simultaneous inoculations of the brain substance in one side of a leg, and toxine into the other side, will not protect animals against this poison. When the toxine and brain substance are mixed together and kept in salt solution, the fluid takes up the toxine, and becomes strongly toxic. These facts are not true of the real antitoxine. Moreover Behring has shown that when brain substance and toxine are mixed together and injected, it requires just as much antitoxine to protect the animal, as it does with the same amount of toxine unmixed with brain substance. Thus, Behring found that .008 c.c. of a certain tetanus toxine required .001 c.c. of an antitoxic serum to completely neutralize it. Mixing .2 c.c. of brain substance with the .008 c.c. toxine and then with the .001 c.c. of antitoxine, and injecting this last mixture into a mouse, he found that there was not an excess of antitoxine, but free toxine,

which killed the mouse. So that the mixture of brain and toxine does not prevent the toxic action but does prevent the antitoxic action.

Further, it has also been shown that it is the cholesterol in the brain to which the toxine joins itself chemically in a loose, unstable compound. Carmine mixed with tetanus toxine will absorb it, and diminish its toxic action, but when placed in water, will give up the toxine to the fluid. Carmine, it will be remembered, is made from the fatty substance of the cochineal. So that it seems to be the fatty substances, such as the cholesterol and lecithine in the brain, to which the tetanus poison is joined in Wassermann's experiments.

It has also been shown by Metchnikoff that an anti-spermatotoxine can be obtained in castrated as well as in entire rabbits and also in female rabbits, so that here again the essential element sensitive to toxic action certainly cannot produce the toxine.

Later Ehrlich has modified his views somewhat, so that he says that the haptophore group of the toxine can combine with any specific haptophore group for which it has an affinity—found in any other cells than the specific cells of the body.

By far the greatest number of facts that we possess have been obtained in the study of the experiments toward acquired immunity against bacteria and against many other substances. When Jenner showed that smallpox, modified by its passage through the calf, could be used to produce immunity in human beings, he discovered and worked out empirically what many have been trying to do since against other diseases. This discovery stood for so long unexplained because of the ideas of the causation of disease which held sway for so many years. Pasteur next immunized animals against chicken cholera by using attenuated cultures, and developing this idea further found that he could produce immunization in human beings and animals against rabies, although the specific agent of this disease still remains unknown.

When Behring and Kitasato discovered the antitoxic properties of the fluids of animals immunized against the tetanus and diphtheria toxins, it was thought that this antitoxic property was general for all diseases, but as a matter of fact it remains confined to a very few. It was soon seen, and especially by the work of Pfeiffer, with cholera and typhoid, that sera produced in the animals immunized against those diseases were bactericidal but not antitoxic, and that animals immunized against these germs would succumb to injections of their toxins. Pfeiffer found in injecting cholera vibrios into the peritoneum of immunized animals that these vibrios swelled, became granular and dissolved, as he says, like wax in a warm solution. He believed that there were two substances, an active and an inactive substance, produced in the body, and that the inactive substance became active

by action of the body cells when necessity called for its action against invasion.

Bordet and Metchnikoff soon proved that these Pfeiffer phenomena also took place outside the body in immunized serum when very freshly drawn, and also with any immune serum when mixed with a drop of peritoneal exudate of an animal, like the guinea pig. They also recognized the action of two bodies, and it was here that the action of the alexine and the immune body to form a lysine was definitely shown to exist.

At the same time it was shown that with the bacteriolytic action the sera also contained the power to agglutinate the germs. At first the agglutinating and the immune substances were thought to be one and the same, but it was soon found that serum may possess strong immune properties but lack agglutinating properties, or may contain agglutinating properties and lack the protective body. Since then it is very distinctly proven that these two substances are separate, and that agglutination is a reaction of infection as well as of immunity, and seems to be of little value as far as immunity is concerned.

Further investigations with bacteria showed that Pfeiffer's reaction in the peritoneum, that is, plasmolysis or dissolution of the bacteria, was not essential to the resistance against infection in that cavity, for bacteria such as anthrax, which did not become plasmolyzed or broken up into granules, are nevertheless taken up by the phagocytes, the point of contention in peritoneal infection being whether the bacteria were all destroyed extra-cellularly, or whether they were simply disabled temporarily and then engulfed. That is, whether the fluids of the body were the defenders and the phagocytes merely the scavengers or whether the essential action here was the phagocytosis.

By many immunity experiments it seems to be proven that certain bacteria, as cholera, sensitive to the bacteriolytic substances, are disintegrated and then absorbed by the phagocytes, but in immune animals this is not necessarily true, many living, unchanged germs being taken up as well as granules. And in bacteria not showing these granules the phagocytosis occurs directly.

By stimulating the leucocytes in the peritoneal cavity by previous injections of an inert substance, such as bouillon, Pfeiffer's phenomenon is reduced to a minimum, and the germs are devoured with a minimum of extra-cellular disintegration taking place. For Metchnikoff there is always a stage of phagolysis or destruction of the phagocytes, and thus the necessary fluids are produced free in the peritoneum, and these are followed by a great increase in the influx of phagocytes to the points of infection. According to Gruber, this destruction of the phagocytes does not occur, but the cells gather on the peritoneal walls, and thus only seem to disappear.

In 1898 Carboni and Bellfanti showed that by injecting the blood of one animal into a different species, the serum of the injected animal became haemolytic for the blood of the animal from which the injected blood was originally obtained. These experiments have stimulated a great number of others, and have brought out many new facts. In truth, most of the recent work on immunity has been performed with the blood.

The haemolysines produced by these injections, are, like the bacteriolytines, formed by the two substances; of the same alexine and of the specific immune body.

It has been shown by Ehrlich and Morgenroth that the immune body will combine with the blood cells, toward which it is specific, at any temperature, but the alexine will not act at zero, so that the dissolution of the haemoglobine does not take place until the temperature of the solution has been raised. But the red cells when centrifuged at zero carry with them all of the immune body in the solution, leaving the alexine untouched, and it requires but the addition of fresh alexine from normal blood, after the temperature is again raised, to cause haemolysis to take place.

It has been further shown that active serum heated at 55° C. loses its haemolytic power because the alexines are destroyed, but the blood serum of some other animal or the blood serum of the animal from which the red cells came, when mixed with this inactive immune serum, will cause haemolysis of the cells.

Ehrlich has shown that by injecting the blood of one goat into another it was possible, in some instances, to form a serum which possessed haemolytic power toward the red cells of the goat from which the injected blood came. That is, an iso-haemolysine was formed, or a lysine produced by the injection of the blood of one animal into another of the same species, and heterolysine is the name given to the body formed by the injection of blood of one species into an animal of a different species. Autoisolysis, by injecting an animal with its own blood, could not be produced.

The blood of certain species of animals is found to be normally haemolytic and agglutinating toward the blood cells of other species, the reaction seeming to increase in strength the farther apart the animals are in zoological relation. Bordet has demonstrated that the same alexine will combine with the various immune bodies, whether they be of bacterial or cellular origin, and that while but one alexine, or at most two, in the blood (that is, one coming, according to Metchnikoff, from the microphages active against bacteria, and the other coming from the macrophages acting against the formed elements of the blood) suffices to combine with any immune body, the various immune bodies are absolutely specific against any kind of bacteria or any kind of blood cell from any species of animal.

Of course, according to Ehrlich's theory, there must be an innumerable number of alexines and an innumerable number of corresponding immune bodies for every possible reaction that can be conceived. But to most observers the conception of a single alexine suffices.

Against these haemolysins immunization has been produced and we have an anti-haemolysin comprising in some cases an anti-alexine, the anti-complement, as Ehrlich calls it, and in others an anti-immune body. In certain animal serums there is also normally present an anti-alexine preventing haemolytic action to certain other bloods. That is, Müller found that the serum of chickens, pigeons, guinea pigs, bees and horses protected rabbit cells from the haemolytic action of duck serum. This anti-haemolytic action, however, only occurred when the anti-serum had been previously heated to 56° C. to destroy their own alexines.

Curiously enough, also, it has been found by Ehrlich that many bloods containing an alexine or alexines only require the addition of the proper immune body to dissolve their own red cells.

Besredka, in studying this subject, has come to the conclusion that men and animals normally produce an anti-haemolysin for their own red cells, and this is also an anti-alexine.

As to the action of the anti-haemolysin on the red cells, there is great difference of opinion. Bordet believes that the immune body acts as a mordant to the red cells, thus preparing them for the solvent action of the alexines, hence his name—sensitizing substance. Ehrlich believes that one haptophore group of the immune body joins to the receptor of the red cells and another haptophore group joins to the complement or alexine and thus his more recent name of intermediary body. According to his theory also the immune bodies must be formed from cast off receptors of the red cells.

Nolf, however, reviewing the brilliant experiments of Hedin on the action of chemical salts on the red cells, in which the latter shows that the chemical substances may be divided into two classes, the non-penetrating and the penetrating substances, the latter alone causing a diffusion of the haemoglobine, believes that the diffusion of the haemoglobine is the result of hydration of the stroma of the corpuscles. Hedin found the chemical substances may be divided into two classes—salts like those of urea which act like water, the action being suspended by isotonic NaCl solutions, and secondly, salts like ammonium chloride, which are the more destructive, and whose action is not suspended by NaCl. Nolf says that the alexines of the serums, contrary to Buchner's theory, do not have any peptonizing action on the haemoglobine or the albuminoids of the corpuscles, hence the theory of the fermentative action of the haemolytic alexines must be abandoned. He says that there is much in common between the action of chem-

ical haemolysins, such as ammonium chloride, and that of substances in normal or immune serum. In both cases the diffusion of the haemoglobine is hindered by sodium chloride or potassium nitrate, while salts of the alkaline earths have a decided neutralizing effect in all dilutions. The alexines, just as ammonium chloride, cause globulolysis by increasing in a marked degree the affinity for water of the stroma of the corpuscles which they impregnate. The body in immune increases the haemolysin action of the alexines by fixing them in greater abundance on the cellular body.

Nolf further says that injecting the stromata of the red cells, thoroughly washed from their haemoglobine, produces agglutination of the cells, but not haemolysis, while the haemoglobine produces haemolysis but not agglutination.

The subject of agglutination, familiar to all in the clinical test for typhoid fever, is still an open subject of discussion. Certain animal serums normally agglutinate bacteria and cells of heterogeneous blood. But immunization against either blood cells or bacteria increases this power of agglutination. There is, therefore, some substance directly stimulating the increase of the agglutinating substance, and there is some substance in the cells and in the bacteria which is agglutinable. What these substances are is not known except that in the red cell it is the stroma of the corpuscle which calls forth this action. Harrison has also found that it is the outside envelope of the bacteria which possesses the agglutinable substance. Sodium chloride, as Joos has proven, is essential for the reaction of agglutination of typhoid bacilli in the serum. The phenomenon of agglutination, while not absolutely specific, is specific within certain limits, although in high dilutions of immune serums it becomes specific. That is, related bacteria in low dilutions may be agglutinated by immune serum; for example, serum produced by the injections of the typhoid bacillus may agglutinate in low dilutions both coli and paratyphoid, but in high dilutions will agglutinate only the typhoid bacilli.

The theories regarding the cause of this phenomena are still diverse. Gruber believes that it is caused by the agglutinating substance rendering the membrane of the micro-organism viscid or sticky and this causes the adherence of the organisms into masses. Dineur believes that the cilia are the main elements and that the adhesive substance forms in these. Paltauf believes that the agglutination of microbes is due to the fact that they are entangled mechanically in the meshes of a coagulum generated in the ambient liquid outside the microbes, and that it is due to the reaction of the agglutinins upon the microbial agglutinatable substance. Nicolle believes that agglutination is a coagulation or coalescence of the external layers of the microbes under the influence of the agglutinating serum. Bordet believes that it is due to a modi-

fication of molecular attraction of the microbes closely approaching the phenomenon of coagulation. Duclaux believes that the agglutinines act in the manner of a coagulating enzyme, causing coagulation of the surfaces of the elements suspended in the liquid, and the coagulation of the substance dissolved in the liquid causes agglutination of the suspended particles.

These are the theories of the phenomenon. As to the origin of the agglutinating substance, the recent work of Ruffer and Crendiropoulo gives interesting information. They draw the following conclusions from their experiments: the cultures of a microbe freed from that microbe by filtration, dialysis or centrifugation, have a definite though feeble agglutinating effect on that particular microbe. The age of the culture and the constitution of the medium are important factors in determining the quantity of agglutinines present in such cultures. The red blood cells of non-immunized and immunized animals contain no traces of agglutinines. On the other hand, polynuclear leucocytes of immunized animals always possess the agglutinating property greater than, or equal to, that of the serum. These may, therefore, be readily considered as producers, or at any rate, carriers, of the agglutinines. In immunized animals the specific agglutinines appear in the polynuclear leucocytes and are, therefore, perhaps formed in them. The quantity of agglutinines begins to increase 30-48 hours after the injections and goes on increasing up to ten days or thereabout. They often pass into the serum, the agglutinating power of which increases correspondingly. The formation of specific agglutinines in polynuclear leucocytes, or in serum, is preceded or accompanied during the first three or four days after inoculation of a given microbe, by an increase of agglutinines for other microbes. This latter increase is of short duration and stops suddenly, whereas the increase of specific agglutinines persists for a much longer time.

Besides red blood cells and bacteria, antibodies have been produced by the injections of epithelial cells and spermatozoa; by injecting various milks into animals a serum has been produced which causes a specific coagulation of the different milks; by injecting the plasma of animals a ferment acting against the fibrin ferment has been produced; by injecting albuminous urine a serum has been formed which precipitates the albumin in the urine; by injecting lymph glands of an animal a serum has been formed which is destructive to the leucocytes of that animal; by injecting kidney cells a serum has been produced which causes acute nephritis, and liver cells produce a serum causing acute yellow atrophy, and brain cells injected in one animal produce a serum of small doses which, when injected into the brain of the animal which supplied the cells, will kill that animal, and in fact many substances of widely different char-

acters when injected into the body seem to call forth a corresponding anti-body as a result of the resistant action. The number of anti-bodies which can thus be produced is at present beyond our knowledge.

Interesting experiments have been carried on under Metchnikoff by using clinically the haemolytic serum. By injecting human serum into goats a serum was obtained haemolytic for human beings. It was found that by injecting small amounts there was a slight haemolysis produced which was followed by a stimulation of the blood-producing organs, and in using this observation in lepers, he increased the cell content and the haemoglobin content of their blood to a great degree, so also the leucocytic action stimulated the increase of their leucocytes so that freshly formed leprous tubercles broke down, and discharged pure cultures of the germs, leaving an eschar which rapidly healed.

There remains only to speak of the phenomenon that when heterogenous serum is injected into an animal there is produced a serum which gives a precipitate with the serum of the animal from which the injected serum came. These bodies are called precipitines.

Nolf believes that it is a globuline in the serum which gives the reaction and that the precipitate formed is also a globuline.

Ullenhut has injected human blood and tested the serum thus obtained from rabbits against eighteen different bloods of animals and birds and found the action specific; none of the bloods except human blood reacted. He also made the important observation that human, horse and ox bloods that had been dried for weeks could be readily distinguished by the test serum added to the solution of these bloods in normal salt solution.

It has been shown, however, especially by the work of Nuttall, that the reaction is not absolutely specific. Nuttall, in working with five hundred different bloods, has shown that while the amount of precipitin is greatest and most marked in the specific blood, allied bloods will show a slight cloudy reaction when tested against a serum giving a strong reaction. Thus human blood causes a cloudiness in baboon and monkey blood. But this slight reaction would never be mistaken for the full reaction such as homologous blood gives. He believes that there is a slight mammalian reaction by one mammal's blood toward the blood of other mammals, and that there is an avian and a reptilian reaction toward the corresponding bloods. He found, however, that a very powerful hen's egg serum only produced marked reaction with the egg white of that fowl, a feeble reaction only was obtained with fowl's blood, more or less clouding in some avian blood. It had no action on any non-avian blood with the exception of some alligators and turtles. It is premature to draw any conclusions from these observations,

so the observer thinks, and he considers this reaction only as suggestive of the reptilian origin of birds.

However, this study of precipitines in blood bids fair to become of great forensic value, as the drying and decomposition of blood does not spoil the reaction.

In the recent Huxley lecture delivered at the opening of the Charing Cross Hospital Medical School, the subject of immunity is treated by Dr. Wm. H. Welch, of Baltimore, in his usual masterful manner. He advances the following new hypothesis which seems competent to explain the source, mode of production and the nature of certain bacterial toxins. We know that the injection of foreign cells, such as pathogenic bacteria, red blood corpuscles, spermatozoa, epithelium, in the tissues of an animal leads to the formation of poisons, called cytotoxins, acting specifically upon these cells; that the substances which stimulate the cells of the host to produce one constituent of this class of toxins consists of certain atom-complexes derived from the infected cells; that certain cells of the host thus stimulated generate and discharge one component of the toxin, called the intermediary body, which becomes the medium of intoxication through union on the one hand with a pre-existent toxophore substance, called the complement, on the other hand with the foreign cell which started the reaction. Such is the response on the part of the host to the entrance of the foreign cells, but how about a possible response of a like nature on the part of the invading cells towards the host resulting in the production of special cytotoxins, of analogous constitution, injurious to the host? This latter response being of vital nature, can take place only when the invading cells are living, as in the case of bacteria and other parasites. Looked at from the standpoint of the bacterium as well as from that of the animal host, according to the hypothesis advanced the struggle between the bacteria and the body cells in infections may be conceived as an immunizing contest in which each participant is stimulated by its opponent to the production of cytotoxins hostile to the other, and thereby endeavors to make itself immune against its antagonist. These mutually antagonistic cytotoxins are capable of injuring the parasitic cells on the one hand or the body cells on the other, only when escaping combination outside of them; they are anchored to the receptors of the cells to which their respective affinities are adjusted. This combination with the cells, if it does not result in too great injury to them, is the condition for further production of the cytotoxic intermediary bodies through overproduction and discharge of receptors. The important factors determining the issue of the contest are the relative proportion and the distribution of the bacterial and host's cytotoxins. Certain experiments not yet finished have al-

ready furnished new facts in support of this hypothesis.

Thus almost each new JOURNAL announces to us some new fact discovered in unraveling the problem of immunity. From the facts which we at present possess we realize that immunity, either natural or acquired, does not depend on any one factor, neither on the resistant and digestive power of the phagocyte alone, nor on the neutralization of noxious substances by antitoxins in our body fluids. Each and both of these factors operate under given circumstances. Our ciliated epithelia in the air passages, the lachrymal secretion protecting the eyeball, all are factors in our natural resistance to disease.

Time forbids that I should go further into this fascinating subject. I realize that I have presented to you but a scant summary of all the interesting facts which could be brought together. But it must suffice.

SOME ASPECTS OF THE PATHOLOGY AND BACTERIOLOGY OF TYPHOID FEVER FROM THE STANDPOINT OF RECENT INVESTIGATIONS.

BY GEORGE BLUMER, M.D.,
Albany, N. Y.,

Professor of Pathology and Bacteriology, Albany Medical College.

IT is obvious to any one who is conversant with the literature of the pathology and bacteriology of typhoid fever that it would be impossible to even approximately cover all aspects of these subjects in twenty minutes. I therefore propose in this paper to briefly review certain phases of the subject, avoiding in the main the purely technical aspects, and laying stress on those points which have more or less bearing on clinical medicine.

First of all I would call your attention to certain changes in our ideas as to the distribution of the typhoid bacilli in the body. Up to within a very few years we were apt to regard the occurrence of the typhoid bacillus outside of certain of the abdominal organs as exceptional, so that within four or five years we find cases in which only a few bacilli were present in the blood reported as exceptional cases, and described as typhoid septiceimia. The observation of typhoid bacilli in rose spots, in the bile, and in the urine is also of relatively recent occurrence, and I therefore propose to briefly summarize our present knowledge on these subjects.

In 1885, three years after the discovery of the typhoid bacillus, Fraenkel and Simmonds succeeded in isolating the organism from the blood in one out of six cases. Following their report a large series of observations were made by different authors with almost entirely negative results, and it was quite generally concluded that the organism only entered the circulation under

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

exceptional conditions. It was not until four years ago that Kühnau, struck by the discrepancy between these findings, and the frequent occurrence of typhoid lesions in situations to which the bacilli must have been carried by the circulation, hit upon the explanation of this apparently paradoxical condition. With his knowledge of the germicidal action of the blood and of the methods of blood culture then in vogue he realized that in all probability typhoid bacilli were present in the circulating blood, and were transferred to the culture media, there to be destroyed by the germicidal action of the blood serum. He thereupon made a series of cultures from the blood of typhoid cases in which he diluted the blood to a large extent before making his final inoculations. His reasoning proved correct, and he was able to isolate the typhoid bacillus from the blood of eleven out of forty-one cases. Since his discovery various authors have confirmed his results, though the percentage of successes has varied. Taking the figures of Kühnau, and the later ones of Schottmüller, Auerbach and Unger, Castellani, Cole, and Hewlett, we have a total of 154 cases in 98, or a little over 63 per cent. of which the typhoid bacillus was isolated from the blood. The experience of all these later observers indicates that in order to obtain success large quantities of blood secured in a strictly aseptic manner and largely diluted are required. Apparently the presence of the typhoid bacilli in the blood does not necessarily indicate a severe case of the disease, though it would seem possible that if some method of computing the number of bacteria present could be devised it might be of prognostic value. The practical value of the test lies in the fact that the bacilli are sometimes present in the blood before the Widal reaction has developed. This was the case in three out of Hewlett's twenty-four cases, and in five out of Cole's fifteen cases.

Closely associated with the presence of the typhoid bacilli in the blood is their occurrence in the rose spots. The same factors which interfered with their isolation from the blood also interfered with their isolation from rose spots. Neufeld seems to have been the first who took advantage of the knowledge that great dilution of the blood from the rose spots was needed. He recommends diluting the blood with sterile bouillon as it escapes from the punctured rose spot, and also suggests scraping the sides of the puncture with a sterile knife and inoculating the juices thus obtained. A series of cultures taken from the rose spots of sixty cases by Neufeld, Curschmann, Richardson and Krause showed typhoid bacilli in forty-three, or over 71 per cent. It is generally necessary to take cultures from several rose spots in each case, and the early spots seem more likely to contain the bacilli than the late ones. Eugene Fraenkel excised rose spots, kept them in bouillon at body temperature for two or three hours, and then sectioned them, demonstrating the typhoid bacilli in the lymph spaces. This method, however, is neither so ac-

curate nor so painless to the patient as mere incision. The value of taking cultures from rose spots is the same as that of taking cultures from the blood; the bacilli can in some instances be detected before the Widal reaction appears.

The occurrence of typhoid bacilli in the urine is of importance mainly from a prophylactic standpoint, though occasionally of diagnostic value also. The points of importance in this connection are the percentage of cases in which typhoid bacilli occur, the time at which they appear, their number and the length of time which they may remain in the urine.

Practically all who have investigated this subject agree that as a rule the bacilli do not appear in the urine until relatively late in the disease. As far as can be judged by the figures at our command, in most cases in which bacilli are present they do not appear until the end of the second week. In some cases their appearance is much earlier; Richardson observed them as early as the eighth day, and they were probably present at an early date. In some cases their appearance is very late; the writer observed one case in which they were not present till the forty-second day of the disease. The percentage of cases which show bacilli varies considerably according to different observers; some of the earlier observers claimed their presence in a large proportion of cases, Karlinski in nearly 50 per cent., for example, but these observations are doubtful, as at that time the methods of differentiating typhoid from colon bacilli were inaccurate. Schüder, who collected 599 cases from the literature, found the presence of typhoid bacilli recorded in 177, or a little over 29 per cent. of the cases. The number of bacilli present in most cases is simply enormous; most writers have not attempted to estimate it. Petruschky, however, did so in three cases, and gives the maximum figures as 20,000, 5,000,000 and 172,000,000 typhoid bacilli per cubic centimeter, respectively. Some idea of the number which may be excreted daily may be gained by these figures. Estimating the urine excreted at 500 cubic centimeters, or about one-third normal, the last case would have excreted 8,600,000,000 bacilli daily when the process was at its height. In a number of cases the bacilli persist long after the convalescence of the patient, and in those cases in which an actual cystitis is present the bacilli have been demonstrated as long as six years after the attack of typhoid. The danger from such cases can readily be appreciated, and the conclusion is forced upon us that it is just as important to carry out routine disinfection of typhoid urine as it is of typhoid stools. It is well to bear in mind also that many of these cases have no symptoms whatever to attract attention to the urinary tract, and, in fact, suffer no inconvenience from the presence of the bacilli. In some instances a definite nephritis or cystitis is present. The isolation of the typhoid bacilli from the urine is of diagnostic value in a few cases in which the Widal reaction appears late; in a small percentage of

such cases it is possible to isolate the typhoid bacillus from the urine before the blood test is positive.

The occurrence of the typhoid bacillus in the bile was first emphasized by Fütterer and Anton in 1888; they detected the organism in two cases in this situation, and from experimental work with other organisms concluded that the bile really had very little inhibitive power over the growth of bacteria. They also suggested that disease bacteria might remain latent in the bile, and later pass into the intestine in large numbers, an idea which was later introduced by certain observers, Chiari in particular, to explain cases of relapse in typhoid. The experimental work of Welch and Blachstein in 1891 called attention to the fact that typhoid bacilli after introduction into the circulation soon appeared in the bile and often remained there for months, long after they had disappeared from other parts of the body. J. L. Nichols showed that in rabbits the typhoid bacilli appeared in the bile six hours after their introduction into the veins. In the human subject, Flexner found typhoid bacilli in pure culture in 50 per cent. of all typhoid autopsies specially examined as to this point. In fourteen autopsies observed by the author the bacillus was present in the bile in thirteen, and in the remaining case contamination of the culture was present, and its presence could not be positively excluded. The practical importance of these observations lies in the fact that a certain percentage of typhoid cases present complications on the side of the biliary system. These may be inflammatory in character and take the form of a cholecystitis or a cholangitis, or gall-stones may occur some time after the attack. The cholecystitis may occur early in the attack of typhoid, and may or may not give rise to marked symptoms. In some cases the lesion has only been recognized on the autopsy table, death being frequently due to perforation of the gall-bladder; in other cases the lesion is perfectly plain during life and may be diagnosed clinically. In certain cases the gall-bladder lesion seems to take the place of the ordinary intestinal lesions which are slight or lacking. Particular interest attaches to the relation of such cases with gall-stones. Undoubtedly gall-stones may antedate the typhoid attack and predispose the gall-bladder to infection. In many cases, however, the gall-stones occur with certainty after the attack of the typhoid, and rarely gall-stones containing typhoid bacilli are found without any history of such an attack. The typhoid bacilli have been isolated from the bile in some cases as long as seven years after the fever. Of particular interest is the observation of Richardson, later confirmed by Cushing, that the typhoid bacilli in the later stages of infection occur in the bile in clumps. Richardson describes the phenomenon as a gigantic serum reaction, and suggests that such clumps may form the nuclei of gall-stones. The bacilli in most of these cases probably reach the bile by the blood, as ex-

periment and their frequent occurrence in pure culture would indicate. In some instances they may pass up the bile ducts from the intestine, but this is probably rare.

In connection with the pathology of typhoid fever I wish to call your attention to the so-called typhoid fever without intestinal lesions, and also to the advance in our knowledge of the histology of the disease.

As early as 1841 Louis had been led to believe from his typhoid studies that cases occurred without the usual lesions in the intestine, and Brunschwig, in 1870, expressed doubt as to the constancy of intestinal lesions. The subject, of necessity, could not be definitely cleared up until after the discovery of the typhoid bacillus, and we find the first instances of this form of the disease in which bacteriological tests were made reported in the late eighties. Doubt must, however, be cast on many of the early cases on account of the imperfect identification of the typhoid bacillus, and Ophüls throws out even most of the more recent ones as not coming up to the strict bacteriological requirements. In view of the recent work on organisms closely allied to the typhoid bacillus, it must be admitted that these criticisms are, in a measure, fair, and that from the bacteriological viewpoint not only cultural criteria are necessary, but also the use of the agglutination reaction. The number of cases now reported with absence of intestinal lesions is considerable if we include those in which the typhoid bacillus was identified by the more modern bacteriological methods. McPhedran, in 1899, collected twenty-seven cases and added one of his own; of these twenty-eight cases twenty-two were in all probability typhoid. The frequency with which such cases occur has not, so far as I know, been estimated. They are probably not infrequent, for in a series of twenty-one typhoid autopsies in Albany we met with three definite cases of typhoid fever without intestinal lesions, and a third case in which typhoid bacilli were found four months after the attack in the liver, bile, kidneys and uterus. As Opie and Bassett pointed out in reporting a case of hemorrhagic typhoid fever with very slight lesions of the intestine, the cases in which there never has been any intestinal lesion are probably very rare. In only a few cases has the autopsy been made during one of the first four weeks of the disease with absolutely no intestinal lesion. Some of the cases reported as typhoid without intestinal lesion show slight lesion of the lymphatic apparatus, and others are made at so late a date that slight lesions might easily have healed, leaving no trace. Some cases, on the other hand, have been associated with intestinal tuberculosis, the typhoid bacilli having entered through the tuberculous ulcers, causing none of the usual typhoid lesions. The possible origin of these cases is of interest. Do the bacilli enter in the usual way through the intestinal tract, or may they reach the circulation by some other route? While the possibility of entrance

through channels other than the ordinary cannot be denied, it seems likely that the bacilli in most cases enter through the intestine. Of sixteen cases from the literature in which the condition of the mesenteric glands was definitely noted, they were enlarged in twelve, and in some of these the spleen was normal. It is to be noted that many of these cases show large numbers of typhoid bacilli in the blood and urine, which should render diagnosis during life possible in most cases where the Widal reaction is absent, as it is particularly liable to be in cases of typhoid septicemia.

It is undoubtedly true that the discovery and study of the typhoid bacillus led for a time to a neglect of the study of the histology of the disease. In fact, up to 1898, practically no histological studies of any great importance had been made since 1875, except those of Reed, in 1895, and Ribbert, in 1896. Our knowledge of the histological lesions was fragmentary, and even an approximate idea of the sequence of events in the development of the lesions was lacking.

Since Mallory's classical work in 1898, all this is changed. The lesions which he describes and pictures have since been seen and confirmed by other observers, and may be accepted for the most part as final. Mallory's work shows that the lesions are almost certainly due to the action of the diffusible toxine of the typhoid bacillus. This causes, in the first place, a proliferation of the endothelial cells, not only in the intestinal lymphatic apparatus, but also in the mesenteric lymph glands, spleen and liver, and to a lesser extent in other organs. The endothelium involved is that covering the trabeculæ of the lymphatic apparatus, and also that of the lymphatics and veins. The proliferated endothelial cells take on phagocytic properties and engulf lymphoid cells and red blood corpuscles. The later changes of the disease, *i. e.*, the necrotic processes in the intestines, lymph glands and liver and spleen, are in a sense accidental. The necroses in the intestine, mesenteric glands and spleen are due to the formation of thrombi, which originate in the veins as the result of the destruction of proliferated endothelial cells, associated with fibrin formation. The necroses in the liver are mainly due to the plugging of the narrowed capillaries by large phagocytic cells carried to this organ by the portal circulation. Such are the main points which Mallory's work brings out.

In conclusion, I must apologize for the incomplete nature of this presentation of the subject, there are so many aspects of it which have been left untouched. The presence of the typhoid bacillus in the bone marrow and its relation to the complications of the disease are of interest, but I have felt that it was better to go into certain phases of the subject with a reasonable degree of fulness than to merely touch on all the phases of this protean disease.

THE SERUM REACTION IN TYPHOID FEVER.¹

BY T. W. HASTINGS, M.D.,
New York City,

Assistant Instructor in Clinical Pathology, Cornell University
Medical School.

SINCE the introduction of the serum reaction as a means of diagnosis of typhoid infection the value of such reactions in corroborating a clinical diagnosis of such infection has been too well established to justly admit of any doubt.

Widal's² first report, in 1896, related to the sedimentation observed in tubes containing a mixture of typhoid cultures and sera from typhoid patients, and later in the same month he reported tests performed with dried blood, dried serum and blood collected in sealed tubes.

The first hint of the importance of the dilution of the serum for establishing the special value of the serum reaction in typhoid infections was put forth by Grünbaum,³ writing from Grüber's laboratory in July, 1896, his publication not appearing until September of the same year.

Grünbaum described a method of collecting blood in curved capillary tubes, and of separating the serum from the blood cells by centrifugalization, and of diluting the serum by measuring off certain small quantities of the serum and the diluting fluid in straight capillary tubes. A drop of the diluted serum mixed with a drop of broth culture or an emulsion from an agar culture of *Bacillus typhosus* was observed microscopically—essentially the method used to-day by most observers.

Grünbaum stated that the serum of enteric fever patients showed a greater agglutinative strength than normal serum, some typhoid sera reacting in dilutions of 1 to 250, and, on the other hand, a reaction with serum not typhoid occurred in dilutions of 1 to 10 and lower.

In the *Lancet* for December of the same year he emphasized the necessity for dilutions above 1 to 10, and better 1 to 20, and the setting of a time limit of from 3 to 20 minutes. By observing these precautions one to-day obtains excellent results, though where dilutions are only roughly approximate, as in the dried-blood method, it is safer to shorten the time limit by 10 or 15 minutes, allowing 3 to 5 minutes for a positive reaction.

Many of us have forgotten these reports of Grünbaum, for we hear occasionally of diagnoses based upon agglutination of the typhoid bacillus by serum in dilutions of 1 to 10, 1 to 5, and even 1 to 2, with no regard for time.

During the last five years the tendency has been to increase the standard of dilution and to extend somewhat the time limit, for which factors the proper limits can be determined only by experience with tests in cases other than typhoid.

So long as one has some respect for dilution and time, it matters not what method is employed for carrying out reactions. Good results will

¹Read before the New York State Medical Association, at its Ninetenth Annual Meeting, October 20, 1902.

be obtained with the methods employed by Widal⁴ and Grünbaum,⁵ or any modification of these methods, by using the leucocyte pipette of a blood-counting apparatus for diluting, with the sedimentation method of Wright,⁶ with the method of observation employed by Tobiesen.⁷

POSITIVE REACTIONS.

In 1899 Curry⁸ reported the results in 445 cases clinically typhoid occurring at Fort Meyer and at Savannah, Ga. Positive reactions were obtained in 417 cases (93.7%). Of the 28 negative cases 13 were subsequently considered typhoid infections, and from one of them the typhoid bacillus was isolated at autopsy.

Cabot's⁹ figures in regard to 3,000 cases collected from various sources show positive reactions in 95% of the cases. Gwyn¹⁰ has reported the highest percentage (99.6%) of positive reactions in a series of over 250 cases diagnosed typhoid fever. In one such case among 265 did he fail to obtain a positive reaction, and subsequent investigation led to the isolation of a "paracolony" bacillus from the patient's blood.

Allyn¹¹ has published statistics of 184 cases of typhoid fever, with a positive serum reaction in 95 cases out of 113 tested, or 84%. The details of his method of carrying out the reactions are not given.

In 350 cases of typhoid fever Tobiesen¹² obtained 329 positive reactions (94%) with sera diluted 1 to 50. Of the remaining cases 17 caused agglutination in dilutions of 1 to 25 or 1 to 10, 2 in dilutions of 1 to 5, and 2 cases failed to produce agglutinative sera.

Withington¹³ reported 259 cases, with a positive reaction in about 94%, including 6 cases presenting clinical evidence not conclusive of typhoid. Excluding these 6 cases, his results were positive for 96% of the cases. His method consisted of using serum diluted 1 to 11 for 15 to 30 minutes.

Libman¹⁴ made 3,514 serum tests in 860 cases, 334 of which were typhoid fever. In 94% of his cases the reaction was positive. He employed, as a rule, dilutions of 1 to 20, and if the "reaction proved positive with this dilution in cases that were not typical instances of typhoid fever, the reaction was repeated in a dilution of 1 to 50. The later reactions were all positive."

THE SERUM REACTION IN CHILDREN.

Several observers, among them Thursfield and Gershel, have reported within the last fourteen months the results of the serum reaction in children. Thursfield's¹⁵ report includes 42 cases of typhoid, all with positive reactions, and 58 cases not typhoid, a few of which had been diagnosed as such with negative reactions, but the subsequent courses and necropsies of these cases proved them not typhoid. He employed dilutions of 1 to 30 for 3 minutes.

Gershel¹⁶ found positive reactions in 81 out of 84 cases of typhoid (96.4%) and no reactions in 115 cases not typhoid. Both of these reports suggest the appearance of the serum reaction

earlier in the child (ages 1½ to 14 years) than in the adult.

In the above reports, which show an average of 94.5% positive reactions in 4,948 cases of typhoid fever, the dilutions varied from 1 to 10 to 1 to 50 and over. The reports of Gwyn, Tobiesen, Libman, Thursfield and Gershel, including 1,075 cases in which the reactions were carried out in dilutions of 1 to 30, and above in doubtful cases, and in Gwyn's cases in dilutions of 1 to 80 and 1 to 100, show an average of 97% positive reactions in typhoid cases.

THE SERUM REACTION IN DISEASES OTHER THAN TYPHOID.

In regard to diseases other than typhoid giving serum reactions with a typhoid culture, it is to be noted that with few exceptions the dilutions of the sera in such cases have been 1 to 20 and under. In 1896 Grünbaum¹⁷ found reactions with non-typhoidal sera in dilutions of 1 to 10 and under. Gwyn¹⁸ writes of 1 case of diabetes mellitus and one of carcinoma of the intestine which gave "but feeble" reactions in dilutions less than 1 to 10. In 2,500 cases other than typhoid Curry¹⁹ found a few cases (number not stated) giving a positive reaction, all of which had had typhoid, 1 case 3 years, 2 cases 2 years, and others 3 to 12 months previously. Kelly and Uhle,²⁰ employing dried-blood methods and approximate dilutions of 1 to 10 and 1 to 15, obtained "positive" reactions in 39 cases in the following diseases: Abscess of liver, acute appendicitis, asthma, acute bronchitis, empyema, influenza, pneumonia, pulmonary tuberculosis, acute gastritis, catarrhal enteritis, colitis, catarrhal cholecystitis, endocarditis, cerebrospinal meningitis, tonsillitis, rheumatism, septicemia, heat exhaustion, nephritis, chlorosis, malaria, postoperative peritoneal adhesions. Six of the above patients had passed through typhoidal infections previously, the periods varying from 4 months to 27 years; 6 had never had typhoid fever, and the remaining cases gave uncertain histories. Kelly and Uhle suggested the avoidance of error in diagnosis by employing dilutions of 1 to 50 and by setting a time limit of 1 hour to 1½ hours for the dried-blood method and 15 minutes for the wet method.

Tobiesen²¹ writes of 151 cases not typhoid which gave 4 positive reactions in a dilution of 1 to 25, 25 reactions in 1 to 10 and 122 cases always negative. He concludes that any result is valueless with a dilution of less than 1 to 50. In the *Münchener Medicinische Wochenschrift* for July 8, 1902, Eckardt²² reports the finding of positive serum reactions with *Bacillus typhosus* and a serum dilution of 1 to 100 and 1 to 1,000 in 2 hours in 2 cases of Weil's disease, presenting the symptoms of epistaxis, hemorrhagic nephritis, pains in the limbs, and jaundice. He remarks that such cases occur where typhoid fever is endemic, and that the fact that intestinal ulcerations have not been described in such cases does

not exclude typhoid fever, and that such cases are in reality typhoid infections.

In a case of psittacosis Nicolle²³ twice obtained a serum active against the typhoid bacillus in dilution of 1 to 30. The patient had not had typhoid fever.

Lommel²⁴ reports an interesting case of puerperal sepsis which gave a serum reaction in dilution of 1 to 80 in 5 minutes, and the necropsy showed no evidences of typhoid fever. A septic condition of the uterus was found. No cultures were reported, and one cannot readily understand why he should conclude that the case was one of severe infection with the colon bacillus. Dobbin's²⁵ case of puerperal infection with *Bacillus typhosus*, in which the Widal reaction was positive, and from which the *Bacillus typhosus* was isolated by culture, suggests that Lommel's case was probably one of typhoid and not colon infection.

NEGATIVE SERUM REACTIONS.

Negative reactions occurring in 3% to 5% of typhoidal cases may be of no value to the practitioner, but to the laboratory worker their value lies in the stimulation to further investigation, particularly of the blood.

Infection with *Bacillus typhosus* without serum reaction has been definitely proved, as in Curry's²⁶ case, from the spleen of which was obtained a culture of typhoid bacillus which was not agglutinated by the patient's blood obtained before and after death, but which reacted to other typhoid sera.

Kasel and Mann²⁷ isolated the *Bacillus typhosus* from the stools and rose spots of two cases of fever in children 1½ years and 6 years old, whose sera at all times failed to give a serum reaction.

What proportion of such negative cases are infections with the typhoid bacillus, it is difficult to determine. In some of them the cause of infection may be determined during life by cultures from the blood, rose spots, stools and urine. The recognition and study of "paratyphoid" and "paracolon" infections have explained some of these negative typhoidal cases.

Coleman²⁸ states that in "all the reported cases of paratyphoid infection a reaction against *Bacillus typhosus* has been absent," and "the only reliable criterions for diagnosis are the absence of the Widal reaction in proper dilution (not less than 1 to 40), with a positive reaction against a known paratyphoid bacillus or the recovery of a paratyphoid bacillus from the blood, urine, stools or complicating inflammatory process."

Hünemann²⁹ has reported the bacteriological findings in 38 cases of paratyphoid infection giving negative Widal reactions. This epidemic of 38 cases and the impossibility of distinguishing, by clinical observation, such infections from those with *Bacillus typhosus* emphasize the importance of carrying out serum tests with the paratyphoid bacilli in typhoid-like cases which give repeatedly negative reactions with *Bacillus typhosus*.

Bacillus "case 7" of Buxton³⁰ and Coleman is well suited for such tests, in that it interacts with the various paratyphoid bacilli described in the cases reported by different observers. It is obvious that in such cases, a small proportion of those negative to the typhoid bacillus, careful observation will not enable one to establish an accurate diagnosis without the aid of the serum reaction.

TIME OF APPEARANCE OF THE AGGLUTINATIVE POWER.

It is well established that the appearance of the agglutinative power in the serum occurs rarely as early as the third or fourth day of the disease and may be delayed for several weeks in protracted cases, and, as mentioned above, in 3% to 5% of the cases no reaction is obtained throughout the course of the disease. The influences controlling these variations are undetermined, nor has there yet been found an explanation for the diurnal and hourly variations recorded by Pamart.³¹

Our laboratory reports from January, 1901, to October, 1902, show 201 serum tests in suspected typhoid in 72 cases, 33 of which were subsequently diagnosed as typhoid infections. Of these 33 cases, 29 gave positive reactions in dilution of 1 to 80 for 30 minutes, 1 case as early as the seventh day, 12 cases delayed until the fourth week, and 16 during the latter part of the second or early part of the third week. Of the 4 remaining cases, 1 gave repeatedly negative reactions at 1 to 80 and 1 to 40, and from the blood of this patient Coleman and Buxton³² isolated in culture their paratyphoid bacillus "case 7." In a second case, a protracted fever in an Italian boy, with symptoms resembling typhoid fever throughout the course of the infection, at no time was a positive reaction at 1 to 80 obtained, although upon three occasions, extending over a period of three weeks, partial reactions were obtained in dilutions of 1 to 20, and 1 to 40 on one occasion, within 30 minutes. No cultures were taken. Two cases gave positive reactions in two tests, with three different typhoid cultures used in the laboratory in dilutions of 1 to 20 in 40 minutes, while a culture from the blood of one of these cases was agglutinated within 10 to 25 minutes by the sera of both in dilutions ranging from 1 to 40 to 1 to 120. The cultures proved to be typhoid.

The 131 negative reactions in 1 to 20 dilution occurred in 101 cases, including empyema, acute bronchitis, endocarditis, malarial fever, acute osteomyelitis, chronic enteritis, salpingitis, purpura, hemorrhagica, jaundice (catarrhal?), and 7 cases with a leucocytosis varying from 14,000 to 30,000, with doubtful diagnoses. One case of severe syphilitic fever gave a complete reaction in dilution of 1 to 20 in 30 minutes. A history of previous typhoid infection was not obtained.

Two cases of æstivo-automneal malarial fever were of interest, in that the negative Widal reactions were supplemented by early examinations

of stained blood smears, and the presence of a number of red cells showing granular degeneration suggested the presence of the malarial parasites which were found, in one case, however, not until several examinations had been made. These cases showed no well-marked anemia.

In conclusion we would mention:

1. The importance of dilutions of 1 to 50 or higher and of a time limit of 30 minutes to 1 to 2 hours, according to dilution, for obtaining serum reactions of diagnostic value in typhoid infections.

2. The similarity of results of the reactions with sera of children and of adults.

3. The importance of applying sera repeatedly negative to bacillus typhosus to the paratyphoid group.

4. The possible value of the granular degeneration of the red cell in suggesting malarial infection in cases clinically typhoid, with negative Widal reaction, and with few parasites in the peripheral circulation.

1. Widal: *La Semaine Médicale*, June 26, 1896.
2. Widal: *La Presse Médicale*, July 29, 1893.
3. Grünbaum: *Lancet*, September 19, 1896, p. 806.
4. Widal: *La Semaine Médicale*, 1896; *La Presse Médicale*, 1896.
5. Grünbaum: *Lancet*, vol. ii, 1896 (September 19th, December 19th).
6. Wright: *Brit. Med. Jour.*, vol. i, 1897 (January 16th); *Lancet*, vol. ii, 1897.
7. Tobiesen: *Zeitschrift f. Klin. Med.* Bd. 43, Heft 1 and 2.
8. Curry: *Boston Med. and Sur. Jour.*, 1899, vol. 141, p. 513.
9. Cabot: *Clinical Exam. of the Blood*, fourth ed., 464.
10. Gwyn: *Johns Hopkins Hospital Reports*, vol. viii, p. 385 (1900).
11. Allyn: *Phil. Med. Jour.*, vol. viii, 23, p. 999 (1901).
12. Tobiesen: *Zeit. für Klin. Med.* Bd. 43, Heft 1 and 2 (1901).
13. Withington: *Boston Med. and Surg. Jour.*, May 9, 1901.
14. Libman: *Med. News*, vol. 80, 13, p. 588 (1902).
15. Thursfield: *British Med. Jour.*, September 7, 1901.
16. Gershel: *Med. Record*, November 23, 1901.
17. Grünbaum: *Loc. cit.*
18. Gwyn: *Loc. cit.*
19. Curry: *Loc. cit.*
20. Kelly and Uhle: *Phil. Med. Jour.*, vol. v, 9, p. 535, 538 (1900).
21. Tobiesen: *Loc. cit.*
22. Eckardt: *Münch. Med. Wochenschrift*, July 8, 1902.
23. Nicolle: *Comptes rendus de Soc. de Biol.* v, p. 1171.
(Quoted by Coleman, *Am. Med.*, vol. iv, 16, p. 624.)
24. Lommel: *Münch. Med. Woch.*, February 25, 1902.
25. Dobbins: *Johns Hopkins Hospital Reports*, vol. viii, 1900.
26. Curry: *Loc. cit.*
27. Kasel and Mann: *Münch. Med. Woch.*, xviii, p. 581 (1899).
28. Coleman: *Amer. Med.*, vol. iv, 13, p. 501.
29. Hünermann: *Zeit. f. Hygiene*, vol. xl, August, 1902.
30. Buxton: *Jour. of Med. Research*, new series, vol. iii, No. 1, p. 224.
31. Pamart: *Comptes rendus de Soc. de Biol.* No. 6.
32. Coleman and Buxton: *Amer. Jour. Med. Sc.*, June, 1902.

ON ARTERITIS AND ARTERIAL THROMBOSIS IN TYPHOID FEVER.¹

BY WILLIAM SYDNEY THAYER,

Associate Professor of Medicine, Johns Hopkins University.

NOTE.—The omission of diphthongs and certain minor orthographical changes from the author's original text are in accordance with the standards of spelling adopted by the JOURNAL.

THE object of these remarks is not so much to bring before this Association anything which is new as it is to call attention to certain complications of typhoid fever which, though infrequent, are, when met with, of serious import. These complications have long been recognized and described, especially by French students. In this country, however, they have attracted but little attention. The recent observation of several cases has suggested that it may be of some value to bring up the subject once more. Let me begin by mentioning these:

CASE I. *Typhoid fever—general convulsions—death. On autopsy: Acute arteritis with thrombosis of branches of the left middle cerebral artery.*

The first case, which has already been reported in part by Professor Osler, was under my observation throughout its course. A strong, vigorous young man, 22 years of age, was seized suddenly, on the ninth day of an apparently mild attack of typhoid fever, with general convulsions. These occurred repeatedly at short intervals for about an hour. During the convulsions he was profoundly unconscious, though between times his mind seemed partially clear. He answered a few simple questions and seemed to understand what was said to him, although he had a confused and frightened look. After an intermission of about four hours the convulsions returned, recurring with great severity at intervals for six hours, when the patient died in a severe paroxysm. The convulsions were general and began apparently at the same time on both sides, though the movements were more marked upon the right. There was well marked conjugate deviation of the eyes upward and to the left.

The necropsy, made by Dr. Flexner, showed a severe hemorrhagic enteritis in addition to characteristic typhoid intestinal lesions with several early ulcers. The ileum was the seat of a marked hemorrhagic enteritis, which also involved the jejunum, though to a less extent. The mucous membrane was hyperemic, and actual extravasations of blood had taken place into the substance. Near the valve and covering an area of 15 cm. in length there were several ulcers in Peyer's patches. They were superficial, partly extending beneath the mucosa, the largest not more than 1.5 cm. in length; above it the mucous membrane was hemorrhagic. The mesenteric glands were enlarged and softened; the heart showed no abnormalities. The lungs were free from adhesions, much congested and edematous. On section blood-stained fluid flowed freely from them.

"Brain. There was an area of thrombosis in certain of the convolutions of the left cerebral hemisphere. At the time of the necropsy this was seen to involve the branches springing from the middle cerebral artery; but at that time the dissection was not completed.

"Subsequently in the formalin-hardened specimen it was seen that thrombi were situated in the ascending parietal and parieto-temporal branches of the middle cerebral artery. The meninges over these vessels contained small hemorrhages and the brain substance corresponding to them, while not softened, showed small extravasations of blood, although the surrounding tissue was quite firm. Small, but quite extensive, punctiform hemorrhages could be seen to occupy the cortex and

¹Read before the New York State Medical Association, at New York, October 22, 1902.

adjacent white substance in the immediate neighborhood of the thrombosed vessels. The areas extend sometimes for a distance of 2 cm. (usually toward the convexity) from the vessels.

"The internal carotid artery was free from thrombosis, as likewise the Sylvian branch. The ascending parietal and parieto-temporal arteries, including the points of their origins in the middle cerebral artery, were occluded by an adherent, partly decolorized and quite firm thrombus. More recent dark thrombi were traceable into the branches of these arteries; for example, into the branches running in the Rolandic fissure, the sulcus between the ascending frontal gyri and the ascending frontal convolutions, and the branches supplying the tempero-parietal region generally. The inferior external frontal artery and the arteries of the anterior perforated spaces were free from thrombi.

"On section of the brain there were no gross anatomical lesions. The ventricles were not dilated.

"The cultures from the spleen, mesenteric glands, liver, kidneys, both lungs and heart muscle showed the typhoid bacillus. From the lungs streptococci were obtained; from the peritoneal cavity the bacterium coli commune. Bile and bone marrow (ribs) were sterile."

I have recently re-examined the gross specimens and, in addition, sections have been made through the plugged vessels and examined microscopically. These show evidences of a most extensive arteritis. In the less affected parts of the vessel wall the muscular coat takes on a very pale stain, while in many places the fibers, which seem swollen, are separated by vacuolic spaces. At some points these are so numerous that the tissue has an almost reticulated appearance, consisting of a loose, wavy, palely staining material in which traces of elastic tissue may still be seen, and containing numerous larger and smaller clear spaces. The muscle nuclei are in many instances swollen and deformed. The internal elastic membrane has in great part disappeared. In many places the distinction between the individual coats of the artery is wholly lost, the entire wall being infiltrated with a mass of cells, the nuclei of which are extensively fragmented. Most of these appear to be polymorphonuclear leucocytes. In some places the infiltration seems more marked toward the lumen of the vessel; in other places it involves the whole wall. In some areas, where the infiltration of the vessel wall is greatest and the nuclear fragmentation most marked, the infiltrated cells are surrounded by a refractive pink (the specimens were stained with eosin and hematoxylin) substance, apparently fibrin. Outside and surrounding the vessels there is an acute meningitis, the meshes of the pia being filled with a fine refractive, somewhat granular, eosin-staining, fibrin network containing great numbers of cells. Many of these contain large vesicular nuclei, while there are also many polymorphonuclear leucocytes. In some places there is considerable fragmentation of the nuclei.

The changes in the walls of the vessels are by no means limited to the larger plugged artery alone. In many smaller vessels the lumen of which is clear, the structure is entirely lost, the walls being packed with a mass of cells with polymorphous and fragmenting nuclei, and fibrin. In some it is almost impossible to distinguish the dividing line between the vessel wall and the surrounding exudate.

The structure of the thrombus presents points of considerable interest. Professor Flexner, who has very kindly examined the specimens, regards it as of undoubtedly agglutinative origin. The thrombus mass consists in great part of a pinkish, irregular framework in which definite corpuscles are contained. This framework is not particularly refractive; it is not perfectly homogeneous and may be seen in places to inclose clear spaces which agree in shape and size with those of the red corpuscles outside. The interior of the framework is almost free from white cells. Toward the periphery there are appearances which suggest that it is formed through the coalescence of undoubted red corpuscles. The transformation from the denser red corpuscles into the finer framework can apparently be

followed. The thrombus appears to contain little or no fibrin. At one or two points there has been an invasion of the thrombus by a number of polymorphonuclear leucocytes, in some of which the nucleus has become fragmented.*

When one considers the brief duration of the clinical symptoms, the character of the thrombi, and the extent of the vascular changes, together with the fact that these changes are also visible in vessels in which no thrombosis has occurred, it would seem clear that the arteritis was the earlier change.

CASE II. Severe typhoid fever—sudden occlusion (probably thrombotic) of the left femoral artery—gangrene of the foot and lower part of the leg—death. Necropsy not allowed.

A young girl, 16 years of age, was admitted to the Johns Hopkins Hospital on June 16, 1902, on what was stated to be the fifth day of a severe typhoid fever. The Widal reaction was sharply positive on entrance. The patient had been delirious from the onset. There was a marked general bronchitis, and on the 19th of June, the eighth day of her illness, areas of dulness with tubular respiration appeared at the left apex and at the right base. Two counts of the leucocytes on this date showed respectively 6,000 and 5,000 to the cubic centimeter.

On the eleventh day there was a slight leucocytosis, 12,000.

On the twelfth and thirteenth days the patient seemed better, the mind being clearer, although the area of consolidation in the right back had increased.

On the evening of the 25th of June, the fourteenth day of the disease, on removing the patient from the tub, her right foot and leg below the knee were found to be very white and much cooler than on the left side. The coolness extended above the knee in front. There was no swelling of the leg or foot. Two hours later there was a purplish mottling of the heel and under side of the calf and popliteal space. The femoral artery could be followed by its pulsation half-way down the thigh. No pulsation was palpable in the popliteal or dorsalis pedis arteries. The patient, who had been growing worse during the day, was at this time delirious and in a condition of profound intoxication. The leucocytes were 17,000 to the cubic centimeter.

On the 26th of June the temperature remained elevated, ranging between 102 and 104 degrees. Dr. Futcher made the following note: "Pulse of fair volume and tension, 148 to the minute. This morning the toes and dorsum of the right foot are absolutely colorless and quite cold. Over the heel and instep and throughout the leg to a point at the base of its upper and second quarters, the skin is of a distinct purplish tint. The entire right leg below the level of the tubercle of the tibia is distinctly cooler than the left. The leg is not swollen. No pulsation of the right popliteal or dorsalis pedis arteries is to be made out. On the left side it is distinct. Both femoral vessels pulsate in Scarpa's triangle. The heart sounds are quite forcible at the apex; no murmurs audible. The aortic second is rather feeble, the pulmonary second distinctly accentuated."

On June 28th, the seventeenth day of the disease, the general condition was much the same. The temperature was slightly lower. The right leg had become decidedly more bluish in color and the color did not disappear on pressure. At one or two spots in the leg and above the heel the skin appeared to be upon the point of breaking. There was a fair degree of warmth down to the ankle. The dorsum of the foot was cold and white.

Two days later, the nineteenth day of the disease, Dr. McCrae made the following note: "Little further extension of the process up the back of the leg. The purple area has rather a greenish tinge. The lower half of the leg is of a plum color with a slight greenish tinge. The upper half of the foot is somewhat colored, though not so much so as the leg. The toes are

*A more complete description of the anatomical changes in this case is reserved for a later communication.

now becoming dry and somewhat shriveled at the ends. The foot is cold. The general condition is fair."

The blood count showed: Red blood corpuscles, 3,212,000 to the cubic millimeter; colorless corpuscles, 19,000.

On the 1st of July the following note was made by Dr. McCrae: "Patient's general condition is fairly good. The tongue is coated but moist. Pulse, 35 to the quarter, small, but regular.

"Heart: Point of maximum impulse is rather hard to make out. By the stethoscope it is localized probably in the fifth left interspace, 8.5 cm. from the mid-sternal line. The sounds are loud and booming and appear to be clear throughout. No murmur heard.

"Lungs: Note now clear over the fronts; slightly impaired over the right back. Over the whole right back there is tubular breathing. Everywhere else the breath sounds are loud and high-pitched.

"Abdomen: Natural, everywhere soft, no fresh rose spots. . . . The patient cries out when the right leg is moved more than she has done previously. It is impossible to determine whether this is because of pain. The color of the skin over the lower half of the leg is gradually becoming deeper purple; the toes are shriveling quite rapidly; the lower half of the foot is quite white."

Measurements of the two legs:

Six cm. above the patella, right leg, 27 cm. in circumference; left, 24.5.

Ten cm. below the patella, right leg, 28½ cm. in circumference; left, 23½ cm.

Largest part of calf, right, 29 cm.; left, 23 cm.

Just above the malleoli, right, 18.5 cm.; left, 18 cm.

Leucocytes, 18,625 to the cubic centimeter.

On the following day the line of demarkation between the dead and living tissue, which was becoming more marked, reached, at its highest point, 12 cm. below the lower end of the patella. The patient, however, was distinctly failing. Leucocytes, 18,700. Despite stimulation she grew steadily weaker and died early on the morning of the 3d of July, the twenty-second day of her disease. The delirium was throughout so marked that it was never possible to determine whether there was any tenderness along the course of the vessels above the area of gangrene. No necropsy could be obtained.

It is, of course, impossible to say with certainty whether this was an instance of thrombosis or of embolism. The heart's action was rapid throughout the disease, but there was no evidence of dilatation, and the sounds were always clear. There were no evidences of embolism elsewhere. In view of all these circumstances it seemed probable to Dr. McCrae, who was in charge of the case, as well as to the writer, who saw the patient from time to time, that it was a thrombosis rather than an embolism.

CASE III. Typhoid fever—swelling and tenderness in the course of the left femoral and popliteal arteries—great diminution in pulsation of all arteries of the extremity—coldness of the foot—slight swelling of the thigh and leg. Recovery, with return of pulsation in affected vessels.

J. H. T., 18 years of age, a laborer in the "make-up department" of a newspaper, entered the Johns Hopkins Hospital on July 5, 1902, the third day of typhoid fever. The Widal test was sharply positive the day after entry. The course of the disease was at first uneventful, the temperature on the thirty-first and thirty-second days having reached nearly a normal point. On the thirty-fourth day, however, it rose to a point above 100 degrees, fresh rose spots appeared and a relapse set in.

On the fortieth day of his disease, the seventh of the relapse, the patient began to complain of pain on the inner side of the left thigh, which was distinctly swollen, the swelling extending also up on to the anterior surface. There was deep tenderness; the skin could be readily lifted between the fingers without causing pain, while deep pressure caused the patient to flinch. No

cord was felt in the course of the saphenous vein. There was a slight leucocytosis, 13,200.

Two days later it was noted that the entire left leg was somewhat swollen, the thigh being hotter than on the right side. There was, however, no redness; the temperature in both feet was about the same, and the pulse was distinctly felt in the left dorsalis pedis artery.

On the next day, the forty-third day of his disease, I made the following note: "The left leg is distinctly swollen as compared with the right, and the temperature is decidedly lower, the foot and ankle feeling quite cool. On the right side the pulsations of the posterior tibial and dorsalis pedis arteries are readily felt. On the left the foot is cold and slightly cyanotic, while the pulsations of the dorsalis pedis and posterior tibial arteries are with difficulty to be made out. There is no tenderness in the calf. The thigh is also larger than on the right side and there is a little tenderness along the course of the vessels in Scarpa's triangle and below on the inner side of the thigh. The pulsation of the femoral artery in Scarpa's triangle is not to be made out on the left side, though the deep epigastric is to be felt as it emerges and passes upward. On prolonged examination, however, there is, perhaps, some suggestion of a very slight femoral pulsation. On the right side the pulsation of the external iliac artery is clearly felt above Poupart's ligament; it is not to be felt on the left."

The following measurements were taken of the two legs:

	Right.	Left.
	Cm.	Cm.
3 cm. below patellar tubercle. . . .	24	25
6 cm. below patellar tubercle. . . .	22.9	24.5
9 cm. below patellar tubercle. . . .	22.2	23.8
12 cm. below patellar tubercle. . . .	21	22.3

Measurements of the thighs were also taken.

	Right.	Left.
	Cm.	Cm.
10 cm. above middle of patella. . . .	25.7	30.5
20 cm. above middle of patella. . . .	30.6	36
30 cm. above middle of patella. . . .	33	37.9

The surface temperature, taken on the inner side of the thighs, about midway between the knees and pubis, was 78 degrees Fahrenheit on the right, 76 on the left.

On the following day the pulsations of the dorsalis pedis and the posterior tibial arteries had improved a little, as well as the pulsation of the femoral, though this was still very indistinct. There was distinct tenderness in Scarpa's triangle and along the course of the vessels in the thigh. At the latter point the pulsation was better felt than on the day before, while the swelling had somewhat diminished. There was no cord to be felt.

On the forty-fifth day Dr. Cole noted a very slight edema over the anterior surface of the foot and ankle.

Two days later the following note was made: "Pulsation of the arteries of the foot is much better, also that of the femoral, although there is still a material difference between the pulse of the two sides. The tenderness has disappeared and the swelling is no longer apparent on inspection. The vessels in the left Scarpa's triangle are not as readily felt as on the right, and one feels as if there were a thickening of the tissues about the sheath of the vessels."

On the forty-ninth day the boy began to hold his leg somewhat flexed. The whole leg became more swollen, and marked tenderness developed in the popliteal space, where there was also distinct swelling.

On the fifty-first day I found that there was evident enlargement of the lower part of the thigh and calf, while the swelling and tenderness in the popliteal space had increased. The pulsation of the posterior tibial and dorsalis pedis arteries remained about as in the last note, still considerably less than on the right side. Several large veins under the skin on the inner side of the left leg and knee had become more evident. There was tenderness on deep pressure in the calf, especially

about in the middle line. Leucocytes, 18,800 to the cubic centimeter.

On the following day the sensitiveness in the calf had increased and the leg felt hotter than the other, while the foot was rather cold and cyanotic; the thigh was considerably swollen. The arterial pulsations in the foot were barely palpable.

On the fifty-fourth day a little edema was noticed over the shin of the left leg.

On the fifty-fifth day the temperature had reached a normal point, and from this time recovery was uninterrupted. The slight edema soon disappeared and on the fifty-ninth day I made the following note: "The pulsation is returning; that in the dorsalis pedis is nearly as good on the left as on the right. The popliteal pulse is to be felt on the left side. The pulsation in the femoral artery in Scarpa's triangle is feeble, but better palpable than heretofore, though much less marked than on the right. No cord is to be felt in the region of the saphenous vein; none this afternoon in the popliteal space. There is no edema. The veins which some days ago appeared to be more prominent in the left leg have in great part disappeared or are visible only as on the other side."

From this time there was a steady improvement and the patient left the hospital well on September 18th, the seventy-ninth day after the onset of his disease. The left leg and thigh were still slightly larger than the right, but the pulsations of the vessels were almost equal on the two sides.

CASE IV. Typhoid fever—tenderness and redness over braehial artery at bend of elbow, following repeated compression (estimations of blood pressure) just above—diminution in pulsations of the vessels at the wrist—coolness of hand. Recovery.

L. G., a school teacher, aged 27, entered the Johns Hopkins Hospital on September 29, 1902, the thirteenth day of typhoid fever. On the tenth day of her disease she suffered from very profuse intestinal hemorrhage. During this day the blood pressure was taken repeatedly by Cushing's modification of the Riva-Rocci instrument, the elastic band being placed about the left arm just above the elbow. On the twenty-first day the following note was made: "The patient complains of pain in the left elbow; the entire left arm looks somewhat red; it is not tender on palpation except at the joint, and there only slightly. . . ." Twelve hours later the patient complained bitterly of this pain.

On the following morning the leucocytes were 8,500 to the cubic centimeter. Any movement of the left arm was very painful and there was tenderness at the bend of the elbow; the entire arm felt hotter than the right. Over the outer elbow region of the left arm there was a slightly reddened area with some edema; the tenderness was most marked just at the bend of the elbow. On the right anterior aspect of the left forearm, just above the wrist and extending half way up, there was a somewhat erythematous blush, and the skin was rather hot, but not tender. The pulse of the left side was smaller than on the right; the left hand was much cooler and somewhat paler than on the other side. There was no pain in the axilla. A count of the leucocytes in the evening showed 9,500 to the cubic millimeter.

On the following day the left arm, above the wrist, felt hot and burning, the corresponding part of the right arm comparatively cool; the left finger tips cool, the right warm. The pulse on the left side, however, had improved. On the twenty-fourth day the pulse was almost as good on the left as upon the right, though the hand was still a little cooler. From this time on there was steady improvement, the patient making a gradual but complete recovery.

CASE V. Typhoid fever—pain, redness, swelling and resistance over braehial artery—disappearance of pulsation in braehial and arteries at wrist—coolness, mottling and cyanosis of hand—threatened gangrene. Complete recovery, with return of pulsation in affected vessels.

Through the kindness of Dr. W. R. Steiner, of Hartford, Conn., I am able to mention briefly a case which

occurred in his practice two years ago. This case will probably be reported in full by Dr. Steiner in a subsequent publication. The patient, a boy of 8, in the fifth week of typhoid fever, complained one day of pain in two fingers of the right hand. This was followed by pain radiating up along the course of the braehial artery; the tissues over the artery became somewhat swollen and slightly reddened, and the artery could be felt as a tender pulseless cord. The hand became cool, mottled and cyanotic, and the pulse at the wrist disappeared. For a time it was thought that gangrene would surely follow, but in the course of several weeks the pulse gradually returned, the tenderness and resistance over the braehial artery disappeared and complete recovery followed.

* * *

Let us consider for a minute the manifestations of these cases:

The first was an instance of thrombosis of the middle cerebral artery coming on in a young man, 22 years of age, on the ninth day of a mild typhoid fever without premonitory symptoms. The autopsy showed that there was an extensive arteritis, not wholly limited to the occluded area.

The second case was one of occlusion, probably thrombotic, of the left femoral artery, coming on in a girl of 16 on the fourteenth day of a severe typhoid fever, with a resultant dry gangrene of the leg. The exact manner of onset of the occlusion was difficult to determine on account of the delirious condition of the patient.

In the third and fourth cases the patients, young people in the fifth and sixth weeks of typhoid fever, began to complain of pain along the course of one of the arteries of the extremities. This was associated with swelling, heat, tenderness on pressure, and finally complete or almost complete disappearance of pulsation in the arteries of the affected part, coldness, and in one instance blueness and threatened gangrene of the extremity. In each case, however, there was, in the course of three or four weeks, complete disappearance of the symptoms with the return of pulsation in the affected vessels. In Dr. Steiner's case there was a well-marked resistant sensation along the course of the braehial artery. In my own instance there was swelling, tenderness and heat along the course of the vessels in the thigh and later in the popliteal space.

The fourth case, which was similar to the third and fifth, was extremely mild and especially interesting, in that it may possibly have been due to a traceable trauma—the estimation of the blood pressure.

* * *

These clinical pictures are not new. That gangrene of the extremities might occur in the course of typhoid fever has been known for many years, having been noted as long ago as 1806 by Hildenbrand. Though in many instances due to venous thrombosis or of embolic origin, the fact that it might be due to autochthonous arterial thrombosis was recognized by Fabre in 1851.

There has, however, been considerable question as to the cause of this autochthonous throm-

basis. Fabre, to be sure, suggested that it resulted from chemical changes in the blood produced by the disease. No sufficient exciting cause, however, was apparent. Occurring for the most part in young individuals, the chronic arterial changes so frequently regarded as the primary element in gangrene of the extremities in older individuals are not likely to be present, nor have they been found, and there is no evidence in the majority of cases of general circulatory disturbances sufficient to play an important predisposing rôle. That the coagulability of the blood in typhoid fever tested by ordinary methods, is not increased is well known.

In 1863, however, Patry de Sainte-Maure pointed out the fact that the thrombosis is in a large portion of cases preceded by severe pain and tenderness along the course of the vessel, which later, becomes occluded, while the gross pathological appearances found after amputation show evidences of arteritis and periarteritis. This arteritis, according to Patry and others, is the direct causal element in the arterial thromboses. Since this time many similar cases have appeared in literature, histological examinations showing general inflammatory infiltration of the walls of the affected vessel. The few microscopical studies that have been made have, however, been limited to the plugged area, and little definite information as to the character of the early stages of the process has been obtained. The observations of Hayem (1869), Landouzy and Sireday (1885, 1887), Rattone (1887), Mollard and Regaud (1899), and others, on the changes in the smaller arteries in the heart and elsewhere in typhoid fever and other infectious diseases, cannot without further investigation, be applied to the process in the larger vessels. It must be said, moreover, that positive proof that some of these changes are not post, rather than pre-thrombotic is wanting.

Our first case, however, affords an excellent example of an acute arteritis of typhoid origin in which the vascular changes have clearly preceded the thrombosis. The early changes here, as noted by Mollard and Regaud in the small vessels of the heart muscle, would appear to chiefly affect the media; indeed, they bear a striking resemblance to the conditions described by these observers. Within the last forty years, also, there has been accumulated a mass of clinical material which leaves little room for doubt that these peripheral thromboses are preceded in many instances by acute inflammatory processes in the course of the affected vessels. Taupin (1839), Patry (1863), Potain (1878, 1890), Barié (1884), Sallès (1893), and others have shown that the initial symptoms common to these so-called peripheral arteritides, symptoms of pain, heat, tenderness, swelling and even resistance in the course of an artery, with diminution or disappearance of the pulsations and coldness or blueness of the extremity, may be followed in several weeks by complete recovery, with the disappearance of all symptoms and

return of pulsation, not only in the peripheral, but in the affected vessels.

This picture, which has been best described by Potain and Barié, will be recognized as exactly that of the last three cases which I have reported.

How are we to account for the apparent disappearance of pulsation in these cases which are followed by complete recovery? It is, it seems to me, scarcely reasonable to assume that there has been actual thrombosis; a complete return of pulsation, together with the entire disappearance of all swelling or induration over the vessel where an actual thrombosis has occurred, is hardly conceivable. What, then, causes this apparently complete occlusion? It has been suggested that the swelling of the arterial walls dependent upon the edema and infiltration may result in so great a diminution of the lumen of the vessel as to render its pulsation practically impalpable. In favor of this idea is an observation of Tuthill (1885), who states that in a leg amputated for gangrene following post-typhoid arteritis and phlebitis, "The only artery found pervious was the posterior tibial, which emitted fine, needle-like jets, showing its caliber lessened in proportion to the thickening of its walls." In other cases in which the pulse remains always somewhat diminished on the affected side, it is probable that a parietal thrombosis which has in time become organized and shrunken has been the cause of the occlusion. There are several cases in the literature in which there has also been slight persistent disability in the affected extremity—weakness and fatigue after standing or on exercise.

What is the exciting cause of these arterial changes?

With regard to this question our knowledge is as yet incomplete. From analogy, however, with what has been shown to be the case in typhoid phlebitis, it is natural to suspect that they are a result of an actual localization of the *B. typhosus*, or of some secondary infectious agent in the walls of the vessels. Rattone (1887), indeed, asserts that he has demonstrated microscopically and by culture the presence of typhoid bacilli in foci of arteritis in the smaller vessels of the heart walls.

Must we assume that an acute arteritis is always present in autochthonous arterial thrombosis in typhoid fever?

Such a conclusion would surely be unjustified. A large proportion of cases of typhoid arterial thrombosis are preceded by symptoms suggestive of arteritis, but there are many, as in our first case, in which the onset is apparently as sudden as in the embolism; and yet in that case extensive arteritis was shown postmortem. The revelations of modern researches on immunity, with regard to the relations between microorganisms, blood and tissues, may well bring us in the near future to a more satisfactory explanation, not only of the increased tendency toward thrombosis which has long been known to exist in

typhoid fever, but also perhaps of the occurrence of the vascular lesions themselves. Flexner* has already described thrombi, due apparently to bacterial agglutinines in dilated veins of the intestinal submucosa near typhoid ulcers.

Indeed, the relation of an arteritis when present, to the thrombosis may well vary. In the one instance the mechanical rôle of the anatomical changes in the vessel wall may be the determining element in the development of thrombosis. In another, however, as possibly in our first case, the thrombus may be agglutinative, owing its origin to the absorption of agglutinines arising at a local focus of infection in or near the vascular wall—independent, however, of anatomical alterations in the vessel.

But my object to-day was more particularly to call attention to certain clinical facts:

(1) That there is a well characterized complex of symptoms occurring occasionally in typhoid fever, more particularly in the later stages, indicative of inflammatory changes in the walls of one or more peripheral arteries. While the histological observations previously reported have not been very complete, yet when considered in connection with the changes found in our first case, as well as with the clinical picture, they would seem to justify the use of the term arteritis. The clinical picture consists in the appearance, usually at some period after the second week of typhoid fever, of pain and tenderness along the course of one or more large arteries, usually in the leg or thigh. This is associated with local tenderness, swelling and redness, and slight enlargement of the member, with, however, little or no edema. At first there may be an increase in the extent of the pulsations of the affected vessels (Potain, 1890); later there is disappearance or great diminution in the size of the pulse in the main artery, as well as in the peripheral vessels, together with coldness, and sometimes blueness and mottling of the extremity. These alarming symptoms may be followed by one of two results:

(a) After a few days the pulsations entirely disappear, the coldness and discoloration of the extremity increase and are followed by the development of a dry gangrene which may affect only the more peripheral parts or may extend well up to the point of arterial occlusion, or

(b) The symptoms may gradually diminish and end, in the course of several weeks, in complete recovery, without a trace of the original lesion. In some cases, however, the pulse may remain permanently less in the affected member, while some slight physical disability—undue fatigue after exercise—may persist.

(2) The histological appearances in the first case justify the assumption that acute arteritis may be an early incident, perhaps the primary

element in some of the interesting cases of aphasia and paralysis which are reported during the course of typhoid fever.

LITERATURE.

ALIBERT: *Recherches sur une occlusion peu commune des vaisseaux artériels considérée comme cause de gangrène. Par., 4^e, 1828.

ALLEN, J. A.: Gangrene of the leg following typhoid fever; amputation below the line of demarcation; recovery. Med. Rec., N. Y., 1897, LII, 918.

ANDREWS, T. H.: Gangrene of foot following typhoid fever. Proc. Path. Soc. Phila. (1860-66), 1867, ii, 177. Also: Am. J. M. Sc., Phila., 1865.

BACOLOGLU: *Le cœur dans la fièvre typhoïde. Paris, 8^e, 1901.

BARIÉ: Contribution à l'histoire de l'artérite aiguë consécutive à la fièvre typhoïde. Rev. de méd. Par., 1884, IV, 1, 124.

BEACH: Diseases of the circulatory system occurring in connection with typhoid fever. Tr. Med. Soc., N. Y., Phila., 1889, 87-90.

BEAUMANOIR: Fièvre typhoïde compliquée de gangrène des extrémités inférieures. Bull. Soc. anat. de Par., 1880, LV, 555-562. Also: Progrès méd. Par., 1881, IX, 364-366.

BENECKE: Gangræna pedis (als Folge eines nicht ausgebrochenen Nervenfiebers). Ztschr. d. Nordd. Chir.-Ver., Magdeb., 1848, II, 38.

BERTHOUD: Etude pathogénique et clinique sur l'oblitération des troncs artériels dans la fièvre typhoïde. 4^e, Par., 1881.

BÉHIER: Rapport sur une note ayant pour titre: Sur la gangrène des membres dans la fièvre typhoïde, par M. le docteur Bourgeois. Bull. Soc. méd. d. hôp. de Par. (1856-8), 1864, iii, 305-319.

BIMSENSTEIN: Observation d'un cas de gangrène sèche des membres, consécutive à la fièvre typhoïde. Gaz. méd. d'Orient, Constantinople, 1863-4, VII, 71.

BOURDEAU: Gangrène spontanée des extrémités inférieures dans le cours d'une fièvre typhoïde; guérison. Arch. méd. Belges, Brux., 1874, 3 s., vi, 73-106.

BOURDEAUX: Note complémentaire d'une observation de gangrène spontanée des extrémités inférieures dans le cours d'une fièvre typhoïde. Arch. méd. Belges, Brux., 1885, 3. s. xxviii, 5-11.

BOURGOIS: Sur la gangrène des membres dans la fièvre typhoïde. Arch. gén. de méd., Par., 1857, ii, 149.

BOURGUET: Observation de gangrène spontanée de la jambe, à forme sèche, consécutive à la fièvre typhoïde; embolie de l'artère tibiale postérieure. Gaz. hebdom. de méd., Par., 1861, viii, 350. Also: Gaz. de hôp., Par., 1861, xxxiv, 277.

BRONGNIART: Gangrène sèche dans la fièvre typhoïde. Gaz. hebdom. de méd., Par., 1878, 2 s., xv, 120.

BROUARDEL ET THOINOT: La fièvre typhoïde, 8^e, Par., 1895, Baillière, p. 110.

BURLUREAUX: Sur les gangrènes sèches observées dans le cours de la fièvre typhoïde. Gaz. hebdom. de méd., Par., 1878, 2 s., xv, 72.

CAMUS, F.: Gangrène de la jambe à la suite de la fièvre typhoïde; amputation de la cuisse; guérison. Arch. de méd. et pharm. mil., Par., 1891, xviii, 343-349.

CAUVY: Fièvre typhoïde; gangrène de la jambe gauche; amputation de la cuisse; guérison. Gaz. hebdom. de méd., Par., 1878, 2, s., xv, 151.

CHAUFFARD: Myocardite typhique. Semaine méd., 1891, xi, 397.

CHAUVEAU: *Essai critique sur la pathogénie des gangrènes en masse dans la fièvre typhoïde. 4^e, Par., 1878.

CLARKE, W. B.: Gangrene after typhoid fever. Illust. M. News, Lond., 1889, iv, 301, 1 pl.

CURSCHMANN: Typhoid fever and typhus fever. (Nothnagel's Encyclopedia of Practical Medicine). American edition, edited by W. Osler. 8^e, Phila., 1902, Saunders, pp. 107, 167.

*Remarks before the Amer. Assoc. of Pathologists and Bacteriologists at Cleveland March, 1902. Published since the reading of his paper, in Univ. of Pennsylvania Med. Bull., 1902, XV, 324.

DAVID, G.: *Quelques considérations sur la gangrène typhoïde. 4°, Paris, 1883.

DEBIERRE, C. M.: *Des oblitérations artérielles dans la fièvre typhoïde. 4°, Par., 1877.

DÉHU: *Le rôle du bacille d'Eberth dans les complications de la fièvre typhoïde. Par., 1893.

DESCHAMPS: *De l'artérite aigue dans le cours de la fièvre typhoïde (artérite pariétale). 4°, Par., 1886.

DEZANNEAU: Gangrène du membre inférieur gauche à la suite d'une fièvre typhoïde; amputation de la jambe. Arch. méd. d'Angers, 1898, ii, 23-27.

DREWITT, F. G. D.: Gangrene of the leg in typhoid fever. Lancet, Lond., 1890, ii, 1023.

DREWITT, F. G. D.: On gangrene of the limbs following typhoid fever. 12°, London, 1894.

DUCHESNE: Gangrène bilatérale des extrémités dans le cours d'une fièvre typhoïde. Méd. mod., Par., 1895, vi, 60.

DURAND: Fièvre typhoïde anormale; gangrène symétrique des membres inférieurs; amputation des deux jambes; guérison. Arch. de méd. et pharm., mil., Par., 1894, xxiv, 44-49.

FABRE: Cas de gangrène et séparation complète du pied dans le cours d'une fièvre typhoïde. Abeille méd., Par., 1880, vii, 242. Also: Gaz. méd. de Par., 1851, 3 s., vi, 539.

FACIEU: *De l'artérite des membres dans la fièvre typhoïde. 4°, Toulon, 1886.

FERRAND, J. C. V.: *Contribution à l'étude de la gangrène des membres pendant le cours de la fièvre typhoïde. 4°, Paris, 1890.

FORGUES: Note sur un cas de gangrène sèche de la jambe droite, consécutive à une oblitération de l'aorte abdominale (par embolie) chez un convalescent de fièvre typhoïde. Rec. de mém. de méd. mil., Par., 1880, 3 s., XXXVI, 386-392.

GASCON, T.: Gangrena de los pies subsiguiente a una calentura tifoidea; amputacion por la contiguidad; curacion. Bol. de med., cirug. y farm., Madrid, 1847, 3 s., ii, 285.

DE GASTEL, H.: Fièvre typhoïde; gangrène spontanée de la jambe; artérite. Bull. soc. anat. de Par., 1882, 4 s., vii, 73-75.

GIARD: Amputation des deux jambes, au lieu d'élection par les seuls efforts de la nature à la suite d'une fièvre typhoïde. Gaz. méd. de picardie, Amiens, 1893, xi, 449-451.

GIGON, C.: Note sur le sphacèle et la gangrène spontanée dans la fièvre typhoïde. Union méd., Par., 1861, 2 s., xi, 577, 611.

GOSSE, W.: Gangrene after typhoid fever. Lancet, Lond., 1890, ii, 1267.

GUILLOU: Fièvre typhoïde; phlébite de la veine fémorale; artérite due membre inférieur; gangrène; amputation; guérison. Gaz. méd. de Nantes, 1883-4, ii, 108.

GYOT: Deux cas de gangrène sèche, suivie de gangrène humide. L'union méd., Par., 1882, 3 s., xxxiv, 505.

HAUSHALTER: Phlegmasia alba dolens et bacille typhique dans la fièvre typhoïde. Mercredi méd., Par., 1893, iv, 453.

HAYEM: Recherches sur les rapports existant entre la mort subite et les altérations vasculaires du cœur dans la fièvre typhoïde. Arch. de phys. norm. et path., 1869, ii, 699.

HAYEM: Des manifestations cardiaques de la fièvre typhoïde. Le progrès méd., Par., 1875, iii, 514; 525; 571; 589; 621; 696.

HEURTAUX: Gangrène des membres inférieurs dans la fièvre typhoïde. Bull. Soc. anat. de Nantes, 1876-8, Par., 1879, I, 18.

HILDENBRAND: Uber den austeckenden Typhus, etc., 8°, Wien, 1810.

KEEN, W. W.: Gangrene as a complication and sequel of the continued fevers, especially of typhoid. Boston, M. & S. J., 1896, cxxxv, 1, 29.

KEEN, W. W.: The surgical complications and sequels of typhoid fever. 8°, Phila., 1898, Saunders.

LACOMBE: *Localizations angiocardiaques de la fièvre typhoïde. 40 Par., 1890.

LANDOUZY: La fièvre typhoïde dans ses rapports avec l'appareil vasculaire et cardiaque. Gaz. d. hôp., Par., 1886, LIX, 323.

LANDOUZY ET SIREDY: Contribution à l'histoire de l'artérite typhoïdique; de ses conséquences hâtives (mort subite) et tardive (myocardite scléreuse) du cœur; cardiopathies typhoïdiques. Rev. de méd., Par., 1885, V, 843.

LANDOUZY ET SIREDY: Etudes sur les localizations angiocardiaques prochains et éloignées. Rev. de méd., Par., 1887, VII, 804, 919.

LECLERC: De l'artérite typhoïdique oblitérante chez les enfants. Normandie méd., Rouen, 1900, XV, 445.

LEGENDRE: *Essai sur la pathogénie de la gangrène typhoïde. 4°, Par., 1885.

LEREBoullet: Observations de gangrène sèche survenue dans le cours d'une fièvre typhoïde. L'union méd., Par., 1878, 25, 353.

LEVITSKI, I.: K kasuistike oslojnenii broushnago tipha omertveniem konechnosti i mosgovimi porajenijami. (Complication with gangrene of extremities and affection of brain.) Ejened klin. gaz., St. Petersburg, 1882, ii, 313-316.

LIPSCOMB, T.: A case of typhoid fever resulting in dry gangrene of the right foot and leg; ultimately in death. South. Pract., Nashville, 1881, iii, 75-77.

LORING, R. P.: An unusual sequel of typhoid fever; gangrene of the left leg extending to upper third of thigh; amputation and recovery. Boston M. & S. J., 1889, cxx, 104.

MASSERELL: Ein Fall von spontaner Gangrän nach Abdominaltyphus. Deutsches Arch. f. klin. Med., Leipz., 1869, v, 445-449.

MATTOCKS, B.: Gangrene accompanying typhoid fever. Northwest. M. & S. J., St. Paul, Minn., 1873-4, IV, 94.

MERCIER, M.: De la gangrène sèche des membres dans la fièvre typhoïde. Arch. gén. de méd., Paris, 1878, cxlii, 402, 676.

METTLER, L. H.: Gangrene after typhoid fever. Phila. M. Times, 1886-7, xvii, 339-341.

METTLER, L. H.: Arteritis complicating typhoid fever. Phila. Med. Times, 1886-7, xvii, 467-471.

MILLARDET: *Des oblitérations des artères viscérales dans la fièvre typhoïde. Par., 8°, 1900.

MOLLARD ET REGAUD: Etat des artères du cœur dans les myocardites aiguës. Congrès Franç., de méd., 1899, v, 280.

OLLIVIER, A.: Gangrène des membres et infarctus du rein dans le cours de la fièvre typhoïde. Bull. méd., Par., 1888, ii, 231-234.

OSORIO, N.: Observaciones sobre la gangrena espontanea de los miembros inferiores, como consecuencia de la fiebre tifoidea. Gaz. med., Bogota, 1866-7, ii, 10.

PACHMAYR, O. P.: Typhus: Gangraen beider Unterschenkel; Operation; Tod. Verhandl. d. phys. med. Gesellsch. in Wurzb. (1866-8), 1869, n. F., i, 18-23.

PEÑA, E.: Contribucion al estudio de la gangrena de los miembros en la fiebre tifoidea. 8°. Buenos Aires, 1884.

PEITIT, H. L.: Sur les affections cardiaques et artérielles consécutives à la fièvre typhoïde. L'union méd., Par., 1888, xlv, 609.

PHILLIPS, S.: A case of typhoid fever with occlusion of the femoral artery during convalescence and with acute maniacal attacks. Brit. M. J., Lond., 1891, I, 1176. Also: Lancet, Lond., 1891, I, 1207.

POTAIN: De l'artérite et de la gangrène sèche dans la convalescence de la fièvre typhoïde. Gaz. d. hôp., Par., 1878, li, 537.

POTAIN: De l'artérite transitoire des membres inférieurs dans la convalescence de la fièvre typhoïde. Bull. méd., Par., 1890, iv, 845.

POTAIN: De l'aortite typhique. Semaine méd., Par., 1894, xiv, 460.

PURKHISER, W. J.: Typhoid fever; gangrene of the foot. Progress, Louisville, 1886-7, i, 362-364.

DE QUERVAÏN, F.: Ein Fall von Extremitätengangran nach Abdominaltyphus. *Centralbl. f. innere Med.*, Leipz., 1895, xvi, 793-803.

RATTONE: Dell'arterite tifosa, *Il Morgagni*, 1887, xxix, 577; 641.

RODAS, C.: Un caso de gangrena sea; complicacion de una fiebre tifoidea; intervencion quirurgica; curacion. *Bol. de san. mil.* Buenos Aires, 1891, i, 539-547.

RODDICK, T. G.: Embolism of both external iliac arteries during typhoid fever; gangrene; death. *Canada M. & S. J.*, Montreal, 1879-80, viii, 1.

ROMBERG: Über die Erkrankungen des Herzmuskels bei Typhus abdominalis, Scharlach und Diphtherie. *Deutsche Arch. f. klin. Med.* 1891, XLVIII, 369; 1892, XLIX, 413.

SALLÉS: Note sur un cas d'obstruction artérielle au cours d'un cas de fièvre typhoïde chez l'enfant. *Lyon méd.*, 1893, lxxvii, 77.

SCHON, F.: Nogle Tilfaelde af spontan gangraen i tyfoid Feber. *Hosp. Medd.*, Kjobenh., 1853, VI, 258-278.

SQUINTANI, G.: Febbre tifoidea miigliare terminata con gangrena acuta. *Gazz. med. ital. lomb.*, Milano, 1859, 4 s., iv, 362.

SUBERT, J.: *De la pathogénie des gangrènes typhiques. 8° Paris, 1899. (With extensive table of references to the literature.)

TAUPIN: Recherches cliniques sur la fièvre typhoïde, observée dans l'enfance. *J. d. conn. méd.-chir.*, Par., 1839-40, vii, pt. 1, 177; 241; pt. 2, 11.

TUTHILL, R. K.: Arteritis and phlebitis as a sequel of enteric fever. *Tr. Med. Soc.*, N. Y., Syracuse, 1885, 222.

VALETTE: De la gangrène des membres dans la fièvre typhoïde. *Ann. Soc. de méd. de Lyon*, 1875, 2, s., XXIII, 318-328. Also: *Lyon méd.*, 1876, xxi, 191-236.

VULPIAN: Note sur deux cas d'accidents survenus pendant la convalescence, de la fièvre typhoïde. *Rev. d. méd.*, Par., 1883, iij, 617.

WELCH: Thrombosis and Embolism. Reprint from Allbutt's *System of Medicine*, Lond., 8°, 1899, vol. vi, p. 155.

WORMS: Gangrène du membre supérieur par coagulation-fibreuse dans le cœur droit au début d'une fièvre typhoïde. *Gaz. d. hôp.*, Par., 1858, xxxi, 453.

THE MODERN TREATMENT OF TYPHOID FEVER.¹

BY W. GILMAN THOMPSON, M.D.,
New York City.

(A part of the symposium on typhoid fever at the meeting of the New York State Medical Association, October 22, 1902.)

THE so-called "antiseptic treatment" of typhoid fever has been advocated by many clinicians on the theory that the focus of activity of the bacilli being in the intestines, they might be there reached and destroyed or rendered innocuous by bactericides. There are several objections to this view: First, there is difficulty in administering a true antiseptic in sufficient strength to kill typhoid bacilli, which will not injure the even more sensitive epithelium of the alimentary mucosa. Secondly, there is grave doubt whether many of the alleged intestinal antiseptics may not become so altered in strength or composition by the time they reach the ileum as to have their efficiency greatly impaired by the varying chemical reactions with which they meet, and by dilution with the gastric,

intestinal and biliary secretions. Thirdly, the typhoid bacilli are entrenched in large numbers within the lymph structures of the intestinal mucosa, where antiseptics cannot reach them except through process of absorption, a process which gives further opportunities for diminution in strength and modification in composition. Finally, the typhoid bacilli have been recently shown to be much more widely distributed throughout the system than was originally supposed—witness the frequency with which, in ordinary cases, they are discovered in the blood, urine, kidneys, gall-bladder and other viscera.

Upon these theoretical grounds I have always been skeptical as to the efficacy of intestinal antiseptics in typhoid fever, although I confess having given their use fair trial with disappointing results, an experience which I believe is shared at present by a number of others. There is analogy between the failure of intestinal antiseptics, *i. e.*, true bactericides, and the failure of similar remedies to cure tuberculosis by inhalation, and the discovery of the extensive distribution of typhoid bacilli within the body has proved a serious check to the antiseptic method.

A report of E. K. Kerr and F. G. Harris, made before the Chicago Medical Society, October 1, 1902, refers to the finding of typhoid bacilli in the blood in 87.5 per cent. of 102 collected and original cases of typhoid fever, examined within the first week of the disease. H. Schottmüller, writing September 23, 1902 (in the *Münchener Med. Woch.*), states that the bacilli are found in the blood in 80 per cent. of cases of typhoid fever examined, and claims, in common with other observers, that their number bears a direct relation to the severity and the stage of the disease, and that having disappeared toward its defervescence, they are again discoverable in the blood in relapse. He therefore argues that the lymphatic lesions of typhoid fever are rather of the nature of metastases than primary lesions.

The accumulating data of this sort are rapidly leaving the intestinal antiseptic treatment of typhoid fever without either rational or empirical basis.

An initial dose of calomel is usually desirable when the typhoid fever patient is seen within the first week, but the daily exhibition of calomel throughout the disease, which was extolled by Watson ("Practice of Physic," Vol. II) more than fifty years ago, and which is often advocated in the medical press of to-day, as if it were new, accomplishes the salivation much oftener than the salvation of the patient. It is a decided misconception to regard calomel as an intestinal antiseptic in this disease. There is grave doubt whether any of it is converted into corrosive sublimate in the intestine, and even if it were all so converted, a half-grain dose of the drug mixed with a quantity of gastric and intestinal fluids and fluid food, equaling at least a quart, would mean a dilution of nearly 1 : 30,000, whereas a strength of 1 : 2,500 is required to

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

inhibit the growth of typhoid bacilli, and, according to Sternberg, a 1 per cent. solution is required if albumen be present (as would usually be the case in the intestine), owing to the formation of insoluble albuminates of mercury in a non-acid medium.

The explanation of the failure thus far to discover an antitoxic serum of potency in this disease is probably to be similarly explained on the ground that the condition present is a bacteriemia, and the problem of antagonizing it is very different from that afforded by either diphtheria, cholera or dysentery. It is, however, to be hoped that ere long some bactericide may be discovered of sufficient strength to destroy the typhoid bacilli themselves in their extensive distribution throughout the body, without injury to the blood and other tissues.

Very different from the problem of intestinal antiseptics is that of intestinal antifermentatives. Persistent tympanites, with a rigid, distended and often somewhat tender abdomen, is a condition more to be dreaded than any symptom, not even excepting intestinal hemorrhage. Extreme gaseous distention of the ileum not only stretches the ulcers to the verge of perforation or rupture of blood vessels, but it indicates abnormal fermentation processes, impaired absorption of nutriment and a parietic condition of the bowel. At the first indication of such distention, effort should be made to control it by change in diet, removal of constipation and the employment of antifermentatives. The total quantity of fluid food should be temporarily reduced to 30 or 40 ounces per diem, and for milk should be substituted broths, egg albumen mixture and such predigested proteids as peptonoids or panopeptone. Very often this simple change is efficient, and if a milk diet is resumed after a day or two the milk should be peptonized. If the bowels are persistently constipated, in an uncomplicated case, there is no objection to supplementing the daily enema with small doses of bitter water. The intestinal abnormal fermentation may be best controlled by the use of salol (gr. v every three hours), creosote in keratin-coated capsules (℥ i-ii), or acetozone (grs. vi-xii) in a quart of water, to be drunk through the day. In more serious cases the expulsion of flatus should be favored by the insertion of a rectal tube, the application of turpentine stupes to the abdomen, and the internal administration of sodium sulpho-carbolate (gr. x) or turpentine (℥ xxx in emulsion). The latter remedy still justifies the reputation it has borne for many years. Should frequent diarrhea be present instead of constipation, and the stools are foul, cleansing rectal irrigation with normal salt solution may be employed, for the risk of exciting increased peristalsis thereby, or possible hemorrhage, is less than that of persistent extreme distention and absorption of putrefactive intestinal products. Some clinicians advocate the routine employment of intestinal antifermentatives at the commencement of every case, but so many cases pursue a

mild, uniform and unprotracted course without any treatment whatsoever beyond rest, good nursing, diet and cold water that I am unaccustomed to resort to medication without positive indication for it. When the mouth is kept thoroughly clean with hydrogen peroxide solution, so long as the tongue remains moist, the abdomen undistended and soft and the bowels respond successfully to enemata, there is little need of antifermentatives or any other drugs. The patient should always be given as much water as he will take, for it not only facilitates elimination by the kidneys, but dilutes to some extent toxic products in the blood, maintains the fluidity of the normal secretions and lessens the tendency to constipation if it exists.

Of the treatment by cold tub baths there is little new to be said, but certain facts cannot be emphasized too often. The Brand method, if employed at all, should be practiced with the courage of conviction, and not, as it so often is, in a half-hearted manner, and it should be applied as a stimulus to the nervous system, rather than as a mere regulator of body temperature. There are guides more important than the thermometer in typhoid fever, for this instrument only records the average or temporary balance of heat gain and loss. Excessive heat production, if accompanied by proportionately rapid heat loss, may give a low thermometric record, and yet the obscure abnormal metabolism producing the increase in heat may be working great havoc within the body, a fact which may in some degree account for the exceptionally rapid emaciation in a certain class of cases in which the thermometric record remains low throughout, for heat production in the body is mainly due to chemical processes, its loss to physical processes.

In severe cases typhoid fever becomes almost a disease of the nervous system, so profoundly does the latter suffer, as evidenced by the early intense headache, disturbances of special sense, restlessness and insomnia, and the later prostration and lethargy or delirium, subsultus, tremor, carphologia, and profound digestive and nutritional disorder. It is this group of symptoms which are best controlled by arousing the nervous system through the sudden shock of cold and mechanical shock of friction. It has been well said that the Brand treatment might be appropriately called that by "rubbing," rather than "tubbing." Only the full bath admits of thorough friction of the skin, for in it the patient floats, and there is easy access to all surfaces of the body which cannot be obtained in like degree or facility by such compromises as the sponge bath, bed douche bath, etc. Moreover, the suddenness of the shock of cold resulting from the cold plunge is far more stimulating than the influence of the lukewarm bath gradually cooled, as first advocated by Liebermeister many years ago. If one desires a vigorous reaction against muscular fatigue after exercise in health, it is the cold plunge which best gives it, not a gradually cooled tepid bath or sponging limited por-

tions of the body at a time with alcohol and water. It is energetic friction which prevents shivering, keeps the skin in good condition, determines more blood to the peripheral vessels and helps to divert the patient's mind from discomfort. A feature of no little importance is the increased depth of respiration obtained throughout the cold plunge bath, which antagonizes the tendency to pulmonary congestion and bronchial catarrh. As a more remote, but no less important, effect the digestion improves and nutrition is maintained, so that extreme emaciation is rare, bed-sores and general furunculosis are practically unknown, the mind clears, the sensation of muscular soreness is alleviated and the entire morale of the patient is benefited. Such are the real advantages of treatment by cold tub baths, and the fact should be emphasized that they may all be obtained through the stimulation of the nervous system, even without immediate lowering of the thermometric record. In every considerable group of typhoid fever cases are a few in which the cold tub bath fails to reduce the body temperature, and I have seen it even rise a little after a bath, while the patient showed marked improvement in other respects. I have records of cases in which sponge baths produced as decided an effect upon the temperature alone as did subsequent "tubbing," but I have yet to see one in which their effect exceeded that of tubbing, and in the great majority of cases they fall far short of it in every way.

My present practice is to employ the tub bath at 75 degrees Fahrenheit for fifteen minutes whenever the patient's temperature reaches or exceeds 102.5 degrees Fahrenheit, and insist upon gentle but continuous friction of the skin by two nurses during the entire bath. When first using this treatment at the New York Hospital, some fifteen years ago, where I followed the practice of Dr. Peabody, we used water 10 or 15 degrees Fahrenheit cooler, and previously we had given several years' trial to the Liebermeister graduated bath with poor results. Experience has taught the advantage of attention to detail in the treatment, and the fallacy of rigid rules. Not a few patients do better with a bath of eight or ten minutes' duration than in one of fifteen minutes, or they may do better with water at 80 degrees Fahrenheit than at 75 degrees Fahrenheit. Alcoholic stimulation should be given fully twenty minutes before the bath, to admit of its absorption before the cold is applied—a matter of no little importance. Shivering is less if the back be rubbed first, and the tub should be large enough and full enough to admit of readily floating the patient; on no account should he be left to shiver for several minutes in the tub while the nurse is preparing the bed for his return; he should be promptly and thoroughly dried when taken out of the tub and immediately left alone to sleep. These may appear trivial details, but any one who has had personal experience in the tub realizes that they are not so, and they are often overlooked by those who state that

they have applied this method of treatment, but gave it up on account of the patient's discomfort. I have met with far more complaint of the discomfort of cold sponge baths than tubbing among patients who have submitted to both.

No one claims that cold tubbing "cures" typhoid fever, or even aborts it, but it unquestionably fortifies the nervous system against the factors of the disease, and enables the patient to endure what is at best a long and tedious siege, with very much less misery. The only indications for its suspension are the occurrence of hemorrhage or pneumonia, when cold sponging should be substituted. The method most emphatically does not induce hemorrhage, or produce relapse, or cause neuritis, or any other serious complication, as has been claimed against it. Its justification is shown in the remarkable unanimity of the hospital records throughout the country which show a mortality among thousands of cases averaging from 7 to 7.5 per cent. in each institution where the treatment has been faithfully carried out for years, as against a previous death-rate of double, often treble, that figure.

Enthusiasm for hydrotherapy should not lead one to deprive the patient of sufficient rest, and except in cases of a temperature protracted in the neighborhood of 105 degrees Fahrenheit, it is best to omit at least one of the three-hourly baths at night, and if desirable to give a mild hypnotic. Of these the bromides, trional and codein are the best. Trional is a perfectly safe, non-depressing drug which either alone or in combination with codein works admirably in typhoid fever, insuring rest and controlling mild delirium, without the disagreeable features which attend the use of opium.

The occurrence of hemorrhage from the intestine we seem as powerless to prevent as to foresee. One great difficulty in drawing conclusions as to the influence of treatment is the length of time which may elapse between the bleeding and the appearance of blood in the stools; thus the bleeding may have ceased spontaneously a dozen hours or more before the evacuation of the blood, or possibly blood may be voided long after a hemostatic has been given, the blood having lain in the colon or rectum. On the occurrence of hemorrhage, food should be withheld from the stomach, but if the hemorrhage is repeated at intervals for several days, as it often is, it is unwise to continue starvation, and one of the numerous predigested meat or peptone solutions should be given per os with egg albumen in small quantities, and rectal feeding may be resorted to. If not more than two or three ounces of a nutrient enema be given at once, it is not likely to excite peristalsis, and there is a chance that it may be absorbed, in part at least, although for fear of disturbing the bowel it may be unwise to attempt previous cleansing of the rectum. To secure rest of the intestine and lessen peristalsis it is best to keep the patient well under the influence of opium, and for this purpose the drug is

more reliable when administered in the form of the tincture by the mouth than hypodermically. Ergot is of no value, nor have any of the so-called astringents or hemostatics proved infallible. It may be several hours before they enter the intestine, and it is difficult to administer them in sufficient strength. Turpentine has acquired some reputation as an intestinal hemostatic, and it may be of service, especially in cases accompanied by much tympanites and fermentation, as previously mentioned. I had hoped much from the use of the suprarenal extract, and have seen cases in which it exercised apparent control, especially in the early hemorrhages, due rather to congestion than to the more serious later lesions of extensive ulceration, but in other cases it has signally failed, and, for reasons stated above, its apparent benefit may have been a coincidence. I have abandoned the common practice of applying cold locally to the abdominal wall. It is impossible for the cold to materially lessen peristalsis, and if it merely empties the superficial blood vessels, and by reflex effect raises the deep-seated blood pressure, it is distinctly undesirable. It is, however, doubtful whether it has anything more than negative effect. Within the past few years I have seen a considerable number of cases in which either transfusion or hypodermoclysis of normal salt solution was of marked value, and not a few in which it undoubtedly saved the life of patients *in extremis* from loss of blood. As in hemorrhage from other sources, the beneficial effect upon the heart action and pulse is immediate, whether it controls at once the bleeding or not. About 1,000 cc. should be given in any case in which the loss of blood produces marked constitutional symptoms of collapse, and repeated several times if necessary. At the Presbyterian Hospital we keep a supply of normal salt solution constantly warmed by a thermostatic burner ready for immediate use during the typhoid season.

The dietetic treatment of typhoid fever is always a fruitful topic of discussion and is one which can only briefly be summarized within the limits of this paper. It is, I think, generally conceded that a plain milk diet is sufficient and best for the majority of uncomplicated cases. The quantity given should depend upon the physique of the patient as well as the condition of his digestive organs. The robust laboring men who constitute a large proportion of the typhoid fever patients seen in the hospitals of this city do very well with 60 or 70 ounces per diem, so long as the tongue remains moist and the excretions are normal. With less than this there may be too rapid loss of weight. The indications for reducing the amount have been mentioned above. Less vigorous patients may be given 40 or 50 ounces. Those who object to milk on the score of its taste often cease to do so after the first two or three days, or the taste may be modified by a very little coffee or caramel or by dilution with vichy. In some cases it is desirable to effect a compromise by giving in alternation with the

milk, beef, mutton or chicken broth, egg albumen, beef juice or a little simple farinaceous food, such as arrowroot gruel, and orange juice may be allowed daily. As a hospital interne I was brought up to give nothing but milk to typhoid fever patients (whether they digested it or not) and to continue the exclusive milk diet for a week, or, in some cases, ten days, after the temperature became permanently normal, but in the light of wider experience I am convinced that such treatment unduly protracts convalescence. There can be no greater mistake than to treat all cases of typhoid fever by one dietetic rule, and a far better guide than the patient's temperature is his general condition. With a clean, moist tongue, a soft abdomen, normal stools, persistent hunger and the facies of convalescence, it is not only safe, but eminently desirable, to increase the diet so soon as the temperature reaches the normal or even when it reaches 100 degrees Fahrenheit. This applies particularly to defervescing cases in which the temperature tends to oscillate daily for a week or more between one or two degrees below and a degree above the normal line. Such food may then be given as soft-cooked eggs, cream toast, junket, boiled rice, and in a day or two scraped beef. There is doubt whether a change in diet, properly supervised by the physician, is ever a cause of relapse. I would not deny that coarse food, such as may be surreptitiously offered by well-intentioned but ignorant friends, may give rise to relapse, but it does not invariably do so, and, on the other hand, I have seen many relapses occur while the diet was still confined to milk. Milk is no longer fluid food on reaching the stomach, and undigested milk curds are as irritating to the intestine as almost any form of solid food, hence the frequent examination of the stools to detect their presence is most essential. Even should a relapse follow, it may be better for the patient to have had the benefit of increased nutriment for a few days, to better prepare him for it. The mistake is sometimes made of not recognizing the influence of complications or sequelæ in greatly prolonging temperature. I refer to cases in which fever continues for forty, or perhaps fifty or more, days, and a phlebitis or furunculosis or some other complication is present. There are also exceptional cases in which a moderately elevated temperature is protracted by starvation—I have sometimes seen genuine scurvy in such cases—and the temperature promptly regains the normal after increasing the dietary. The best principle for the dietetic treatment of this disease is to exercise alert observation of the changing conditions from day to day and be guided by the whole physiognomy of the case rather than by the thermometric record alone.

Many details of treatment of exceptional cases are necessarily omitted in this brief summary. I have purposely omitted the discussion of prophylaxis, prophylactic serum, of perforation, the treatment of which is purely surgical, and of

the treatment of complications such as pneumonia, thrombophlebitis, neuritis, the typhoid spine, etc. I am aware that I have stated no doctrines which are new to any of this audience, but with so important a malady an occasional review and summary of general principles may serve as a basis for renewed effort to seek more definite advancement in treatment. I have therefore advocated as such foundation principles: The use of intestinal anti-ferments rather than antiseptics; plentiful application of cold water, within and without; a milk diet, not too rigidly enforced or too long continued, and the possession of a mind open to conviction as to new methods, but meanwhile not misled by enthusiasm over alleged "specifics" for a disease from which fully 93 per cent. of patients recover with careful nursing, dieting and hydrotherapy.

DISCUSSION.

Dr. S. J. Meltzer, of New York, said that Dr. Brill had been kind enough to credit him with a share of the responsibility in introducing the term paratyphoid, which he found to be incorrect. The term pseudo-typhoid, Dr. Brill thought, would be more nearly correct. The speaker said that Dr. Brill had been the first to report a large series of cases resembling typhoid, but not presenting the Widal reaction. He did not think Dr. Brill would be willing to say they were false typhoid, but rather that they were "typhoid-like," "next to typhoid," and that was what Dr. Meltzer had meant by the term "paratyphoid." Besides, Dr. Brill's preference for the term paracolons is exposed to the same etymological reproach. In discussing this question about one year ago he had only reported twelve cases; Dr. Brill was now in a position to speak of thirty-eight cases. It was interesting to note that in all of these cases the Widal reaction was absent, and paratyphoid bacillus was found. He did not think there was at present a single case on record in which the Widal reaction was absent and a paratyphoid was not found. Dr. Brill could correct him if in error on this point. When speaking a year ago about the Johns Hopkins Hospital Reports, which contain the statement that they had there 99.6 per cent. of typhoid in which the Widal reaction was found, it seemed to him to be an exaggerated statement; he was glad to see that Johnston within a few months was able to find in Osler's wards three paratyphoid cases, or about 6 per cent. of their cases. The laboratories of most Boards of Health made their Widal reaction with a dilution of only 1 in 20. This was too low a dilution for the agglutination on reaction and might include cases of mixed infection in which the typhoid was only superimposed, as he had previously suggested. He would make still another suggestion. The blood of the sheep and of the goat, as it was shown by Ehrlich, has some lysis in common. Furthermore, if a rabbit is immunized with human blood, this blood would cause the formation of precipitins in the blood of a monkey. This applies not only to lysins and to precipitins, but also to agglutinins. It was quite possible that a case of so-called typhoid might be caused by a paratyphoid bacillus, and yet may give an agglutination reaction for typhoid bacillus in a dilution of 1 to 20.

With regard to the cases of typhoid with arterial thrombosis the speaker said he would like to ask Dr. Thayer if any note had been taken of the relation of the agglutination reaction and the formation of thrombosis. It is a new idea, which was brought forward by Dr. S. Flexner, that thrombus could be caused by increased agglutination.

Dr. E. Libman, of New York, said with reference

to paratyphoid infections that this was at present a much confused subject in the minds of most practitioners.

It was important to know that the colon bacillus, the typhoid bacillus and the paratyphoid (or paracolons) bacilli could be readily distinguished from each other in culture. The colon bacillus differed from the other organisms in its power of fermenting lactose and coagulating milk. The paratyphoid organisms produced visible gas in glucose, a property belonging to the colon bacillus, but never present with paracolons bacilli. There were other distinguishing features, but those mentioned were enough to indicate the ease of identification.

Some writers had attempted to classify the paracolons bacilli according to whether they produced any secondary alkalinity in litmus milk or not. To Dr. Libman this seemed to be going too far, as such secondary alkalization of milk on the part of an organism not capable of fermenting lactose might be simply due to greater activity of growth. The organisms causing meat-poisoning and psittacosis were practically the same culturally as the paracolons bacilli.

As to the value of agglutination reactions in the diagnosis of paratyphoid fever, the speaker said that all paratyphoid bacilli would not react to the same serum in the same way. So that one would have to test a patient's serum against a large number of bacilli and might not then obtain a reaction in a case which later proved to be one of these under discussion. It has been found that if an animal were immunized with the colon bacillus or typhoid bacillus its blood might give a reaction with allied organisms, in lesser dilutions. So that a reaction with a paratyphoid bacillus, unless in very high dilution, might occur in a case of infection by an allied organism. In the case that the speaker had published the reaction with the typhoid bacillus had been present in a dilution of 1 to 250, and with the paracolons organism in a dilution of only 1 to 100. The paracolons bacillus was found in the gall-bladder, urine and blood. The reaction against the typhoid bacillus being present in higher dilution than that against the paracolons bacillus indicated that there was an infection also present by the typhoid bacillus.

Dr. Libman drew attention to the necessity of examination for "thread" reactions as well as clump reaction (*Journal of Medical Research*, vol. viii, p. 192). In his case the reaction with the paracolons bacillus took the form of a thread reaction. In brief, this consisted of the following: When the serum tests were made they were allowed to stand for a number of hours; no clumping occurred, but the bacilli were found after a while to have grown in chain form and looked like streptococci.

The term "paratyphoid" was not a good one. Bacteriologically, there was an objection to its use for the bacilli under discussion. There had been described a number of organisms resembling the typhoid bacillus accurately in cultural characteristics, but differing in reactions with immune sera. If any organisms were called "paratyphoid," certainly these should be and not those found in so-called paratyphoid fever. As far as the practitioner was concerned the disease was typhoid fever.

Dr. C. N. B. Camac, of New York, spoke of the method of collecting and examining the blood for the Widal reaction by laboratories. The method had been originally adopted by the Board of Health of New York City, and the tubes were so small that they could be mailed in a small wooden box.

Dr. Brill, of New York, said that it was impossible to answer the question of Dr. Meltzer as to the number of cases not giving the Widal reaction.

Dr. Thayer, of Baltimore, said that the first case in which thrombosis occurred was before the days of the Widal reaction. He could not recall exactly what was the dilution in the second case, but no special observations were made on this point. There was reason to hope that we might soon learn something of the

relations between the bacteria and the different body elements bearing upon the subject of thrombosis in typhoid fever. With regard to the high percentage of Widal reactions in the first report from the Johns Hopkins Hospital, he said that this included only 165 cases, a rather small number. The observations were, however, made with great care.

REPORT AND PRESENTATION OF A CASE OF IDIOPATHIC ATROPHY OF THE SKIN.¹

BY WILLIAM S. GOTTHEIL, M.D., AND ROBERT ABRAHAMS, M.D.,
New York City.

THE salient points of interest in the case which we take pleasure in presenting to you to-night are as follows:

First. The extreme rarity of the occurrence of a true or essential atrophic skin disease as contrasting with and differing from a symptomatic atrophy of the skin. Unna, in his great work on the "Histopathology of the Diseases of the Skin," published in 1896, was able to refer to three cases only of the disease under consideration, reported by three observers. Since then a few more reports appeared in medical journals of different countries, thus making a total of authentic cases of probably no more than a dozen.

The second point of interest about the case is the slow, yet progressive, diffusion of the pathological process.

Third. The total darkness which covers the etiology of the affection. The pathology, though a mooted question till recently, is beginning to be solved now, and my friend and collaborator, Dr. William S. Gottheil, will, in his report, further elucidate the pathological factors underlying this degenerative process.

Fourth, and last, the absolute failure of all remedial agents to effect a cure or to arrest the progress of this atrophic malady.

The man is 58 years old. His family history is negative. His personal history is as follows: He never had any specific trouble. At the age of 13 he had "eczema" in the left popliteal space. This lasted two years. At that time several small ulcers formed on the upper and lower parts of both legs. When these were cured a new feature turned up, namely, marked hyperemia of the toes and back of the left foot, allowed shortly by a similar condition on the right. This redness, which was unattended by pain or itching, disappeared, leaving but a red margin around the skin of both ankle joints. The hyperemic skin first turned pale white, then dusky brown, eventually becoming dry, shriveled and covered with dark-gray scales.

The patient to-day, notwithstanding his long, annoying and distressing affection, enjoys perfect health. All the internal organs, including the glandular system, are in a normal condition. Inspection of his body, however, reveals the following state: (1) There is a decided difference in the circumference of the legs, the left is thinner than the right. This difference is due to the

greater changes in the skin of the left than in the right leg. (2) The veins of both extremities form a complete network, and being prominent and dilated, impart a violaceous color to the limbs. (3) Large and painful ulcers exist around the ankle joints and heels. (4) The skin of the dorsum of both feet is remarkably indurated, giving one the impression of scleroderma instead of atrophy; this condition, however, resulted from cicatrization of old ulcers. (5) From the middle of the left thigh and extending upward toward the inguinal and gluteal regions the color is dark red and has a velvety feel. The same condition is noticeable on the right thigh, but to a somewhat lesser degree. This hyperemia precedes every new area of skin, which eventually becomes atrophic. (6) The skin of nearly the entire lower half of the body, particularly the extremities, has undergone marked atrophic changes. It is soft, wrinkled and easily thrown into folds. All through it has the feel of tissue paper, or, as one observer compared it, to "crumpled-up cigarette paper." The whole surface is covered with easily detachable grayish scales.

REPORT OF THE MICROSCOPIC EXAMINATION.

BY WILLIAM S. GOTTHEIL, M.D.

A BRIEF summary only of the results of the microscopic examination is here presented without going into detail. A portion of skin at the advancing margin of the disease upon the buttock was excised, that location being selected for two reasons. In the first place the chief interest in the pathological examination lay in the question as to the mode of origin of the atrophic process, and this could be better ascertained at a point where it was in its earlier and advancing stage than at one at which the retrogressive changes were already complete; and in the second place it was questionable whether an artificial lesion in the atrophied and badly nourished skin would heal at all, and would not be followed by a chronic spreading inflammatory process similar to that already existent upon the legs. Even in the location selected, however, the thinned and parchment-like condition of the integument was evident; the tissue was certainly not more than half its normal thickness.

Serial paraffin sections of the excised tissue, stained in various ways to demonstrate the different dermic elements, showed a general atrophy of them all. The subcutaneous fat was entirely absent, and the glandular structures of the skin were greatly diminished in size and number. In all the 500 sections only a few small sweat and sebaceous glands and some atrophied hair follicles were found.

All the various layers of the epidermis were thinned and composed of one-third to one-half the normal number of epithelial strata. This was especially the case with the lower granular layers and the rete, the corneous layer being less

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

affected. The change in the papillary layer was marked. Where the papillæ were present at all they were flattened, thickened and clubbed, as if fused together; but where the atrophy was at all advanced they were entirely absent, the lower layer of the epidermis forming a straight line in which no trace of the normal papillary undulations could be found. Numerous heaps of pigment occurred in various portions of the rete.

The corium was thinned, showing especial decrease in the number of elastic fibers. The blood and lymphatic vessels were, if anything, enlarged in size, and around them and in their neighborhood the most interesting of the pathological changes were found. These consisted of small masses of cell infiltration, mostly of plasma cells, with a small number of leucocytes. They were grouped mostly around the vessels, but some isolated masses were found in other locations. The entire appearance of the sections showed all the phenomena of inflammatory action.

To sum up, then, the microscopical examination showed a general atrophy of all the elements of the skin, following upon and consequent to a chronic inflammatory process. It is upon this point that the testimony of the Continental and English observers of some eleven recorded cases of the disease are most at variance. While some of them hold that their investigations show the condition to be the results of a chronic inflammation, the majority believe it to be idiopathic and of unknown origin. The results of this examination enable us to confirm the former view; and we would suggest the term "Dermatitis Atrophicans" as more appropriately descriptive of the affection than the unsatisfactory one of Idiopathic Atrophy of the Skin.

HEALTH RULES FROM AN OLD BIBLE.

In the family Bible of a Roxborough man there are a number of medical rules, written over seventy years ago by the great-grandmother of the Bible's present owner. Among the rules are the following:

"A stick of brimstone worn in the pocket is good for them as has cramps.

"A loadstoan put in the place ware the pane is beautiful for the Rheumatiz.

"A basin of water gruel, with haff a quart of old rum in it, with lots of brown sugar is good for Cold in Head.

"If you have hiccups, pinch one of your wrists wile you count sixty, or get somcbody to skare you and make you jumpe.

"The earache—Put onion in ear after it is well roasted.

"The consumption—Eat as many peanuts as possible before going to bed."—*Philadelphia Record*.

Binding of the "Journal."—Subscribers to the JOURNAL may have their numbers bound by sending them to the office of the New York State Medical Association, 64 Madison avenue, New York City, together with \$1 to defray the cost of binding and return expressage. Missing numbers will be replaced without extra cost.

CONSTITUTION AND BY-LAWS OF THE AMERICAN MEDICAL ASSOCIATION, 1902.

CONSTITUTION, OR ARTICLES OF INCORPORATION.

ARTICLE I.—TITLE OF THE ASSOCIATION, OR CORPORATION.

The name and title of this organization shall be THE American Medical Association.

ARTICLE II.—OBJECT OF THE ASSOCIATION, OR CORPORATION.

The object of this Association shall be to federate into one compact organization the medical profession of the United States, for the purpose of fostering the growth and diffusion of medical knowledge, of promoting friendly intercourse among American physicians, of safeguarding the material interests of the medical profession, of elevating the standard of medical education, of securing the enactment and enforcement of medical laws, of enlightening and directing public opinion in regard to the broad problems of state medicine, and of representing to the world the practical accomplishments of scientific medicine, with power to acquire and hold property, publish journals, etc.

ARTICLE III.—COMPOSITION OF THE ASSOCIATION, OR CORPORATION.

SECTION 1.—This Association shall consist of Members, Members by Invitation, Honorary Members, Associate Members and Delegates.

SEC. 2. *Members.*—Members shall consist of such members of the state societies, together with their affiliated local societies, entitled to representation in this Association as shall make application for admission, in writing to the Treasurer, and accompany said application with a certificate of good standing signed by the president and secretary of the society of which they are members, and the annual fee.

SEC. 3. *Members by Invitation.*—Members by Invitation shall consist of distinguished physicians of foreign countries who may be invited by the officers of Sections or of the Association. They shall hold their connection with this Association until the close of the annual session to which they are invited, and shall be entitled to participate in all of its affairs, as in the case of members, but they shall not be assessed the annual dues.

SEC. 4. *Honorary Members.*—Honorary Members shall be physicians of foreign countries who have risen to pre-eminence in the profession of medicine.

SEC. 5. *Associate Members.*—Representative teachers and students of the allied sciences, not physicians, may become Associate Members by the vote of the House of Delegates.

SEC. 6. *Delegates.*—Delegates shall consist of such members of the affiliated state and territorial medical societies and of the medical service of the United States Army, of the United States Navy, and of the United States Marine-Hospital Service as shall be chosen in accordance with the provisions of the Constitution, or Articles of Incorporation, and By-Laws of the AMERICAN MEDICAL ASSOCIATION.

ARTICLE IV.—HOUSE OF DELEGATES.

SECTION 1.—There shall be a House of Delegates which shall consist of (1) delegates elected by the permanently organized state and territorial medical societies in affiliation with this Association; (2) delegates elected by each of the component scientific Sections of this Association; (3) one delegate each from the medical departments of the United States Army and United States Navy, and one from the United States Marine-Hospital Service.

SEC. 2.—The total membership of the House of Delegates shall not exceed 150, and the delegates representing the affiliated state and territorial medical societies shall be apportioned among the several affiliated state and territorial medical organizations in direct ratio to their true membership.

ARTICLE V.—SECTIONS.

In order that its appropriate scientific work may be expeditiously and systematically performed this Association shall be divided into Sections, each of which shall

be devoted to the encouragement and pursuit of knowledge in one of the recognized branches into which the science and art of medicine are for convenience divided. New Sections may be organized or existing Sections discontinued from time to time as necessity arises and when authorized by the House of Delegates.

ARTICLE VI.—BRANCHES.

The House of Delegates shall have authority to provide for and to create such branch organizations as may be deemed essential to the promotion of the welfare of the medical profession.

ARTICLE VII.—SESSIONS AND MEETINGS.

The Association shall hold an Annual Session, during which there shall be held daily a General Meeting, which shall be open to all registered members and delegates. The place and time for holding each Annual Session shall be determined for each next succeeding year by the House of Delegates.

ARTICLE VIII.—OFFICERS.

SECTION 1.—The officers of this Association shall be a President, four Vice-Presidents, a Secretary, a Treasurer, and nine Trustees.

SEC. 2.—The officers of this Association shall be elected by the House of Delegates.

SEC. 3.—Each officer, with the exception of the Trustees, shall hold office for one year, or until his successor is elected and installed. Three Trustees shall be elected annually by the House of Delegates for a term of three years.

SEC. 4.—No member of the House of Delegates shall be eligible to any of the offices mentioned in the foregoing sections of this article.

ARTICLE IX.—FUNDS AND APPROPRIATIONS.

Funds for meeting its current expenses and awards from year to year shall be raised by the Association by an equal assessment of not more than ten dollars annually on each of the members; by voluntary contributions for specific objects; and from the profits of its publications. Funds may be appropriated by the House of Delegates in accordance with the articles of incorporation for defraying the expenses of its annual meetings; for publication; for enabling standing committees to fulfill their respective duties, conduct their correspondence, and procure materials necessary for the completion of their stated annual reports; for the encouragement of scientific investigation by prizes and awards of merit; and for defraying the expenses incidental to specific investigation.

ARTICLE X.—REFERENDUM.

SECTION 1.—The General Session shall have the right to discuss questions referred to it by the House of Delegates, and it may, by a two-thirds vote, order a general referendum on any question pending before the House of Delegates.

SEC. 2.—The House of Delegates shall, upon a two-thirds vote of its own members or upon a two-thirds vote of the General Meeting, submit any question, either through THE JOURNAL or by mail, to the general membership for final vote; and if the persons voting shall comprise a majority of the members, the majority of such votes cast shall determine the question, and this vote shall be binding upon the House of Delegates.

ARTICLE XI.—AMENDMENTS.

The House of Delegates shall have authority to amend any article of this Constitution, or Articles of Incorporation, by a three-fourths vote of all the members composing the House of Delegates.

BY-LAWS.

CHAPTER I.

MEMBERSHIP.

SECTION 1.—No member shall take part in the proceedings of the Association, or of any of its Sections, until he has exhibited his credentials to the proper officer or committee, entered his name and address in full on the registration book, and paid his annual dues. He

shall also indicate the Section to which he will officially attach himself.

SEC. 2.—Members who have complied with the foregoing regulations shall at all times be entitled to attend the General Meetings and sections, and to participate in the affairs of the Association, so long as they continue to conform to its regulations.

SEC. 3.—No individual who shall be under sentence of expulsion or suspension from an affiliated society (whether a directly affiliated state or territorial society or an indirectly affiliated local society) of which he may have been a member, or whose name shall have been dropped from the rolls of the same, shall be received as a member or shall be allowed to continue as a member of this Association, until he shall have been relieved from said sentence or disability by such society; nor shall any person not a member of his local affiliated medical society, provided there be such a one, be eligible to membership or be allowed to continue as a member in the AMERICAN MEDICAL ASSOCIATION.

SEC. 4.—Members may vote for Section officers only in that Section with which, upon registration, they have declared their intention of uniting.

SEC. 5.—Any member who shall fail to pay his annual dues for one year, unless absent from the country, shall be dropped from the roll of members, after having been notified by the Secretary of the forfeiture of his membership.

SEC. 6.—Honorary Members may be elected by the House of Delegates on the nomination of a Section, but not more than three Honorary Members shall be elected in any one year.

SEC. 7.—Honorary and Associate Members shall have all the rights of membership except those of voting and holding office. They shall not be assessed for dues, nor shall they be entitled to receive THE JOURNAL free.

SEC. 8.—The House of Delegates shall have authority to provide for membership under proper restriction from among the members of recognized medical societies of neighboring countries, provided that the right of representation in the House of Delegates shall be restricted to affiliated state and territorial medical societies in the United States.

CHAPTER II.

GENERAL MEETINGS.

The General Meetings shall include all registered members and delegates, who shall have equal rights to participate in discussions and to vote upon pending questions. Each General Meeting shall be presided over by the President, or, in his absence or disability, by one of the Vice-Presidents. Before it there shall be delivered upon the opening day of each annual meeting, the address by the President, whose recommendations shall thereupon go to the House of Delegates for action, and on each following meeting such addresses on scientific subjects as may be assigned to orators selected for the purpose. It shall have power to create committees or commissions for scientific work of special interest or importance, and to receive reports of the same, provided that any expense incurred in connection therewith by the Association must first be authorized by concurrent action of the House of Delegates and the Board of Trustees.

CHAPTER III.

HOUSE OF DELEGATES.

SECTION 1.—The House of Delegates, as far as may be consistent with the Articles of Incorporation, shall be the legislative and fiscal body of the Association. Its sessions shall be open to the members of the Association, but, except upon invitation of the House of Delegates, they shall have no right to participate in its proceedings.

SEC. 2.—Each state and territorial society entitled to representation shall have the privilege of sending to the House of Delegates one delegate for every 500 of its resident regular members, and one for any additional fraction of that number; but each affiliated state and territorial society shall be entitled to at least one delegate.

SEC. 3.—The House of Delegates, once in every three years, shall appoint a committee of five on reapportionment, of which the President and Secretary shall be members. It shall be the duty of this committee to examine the membership lists of all the affiliated state and territorial medical societies, and to determine therefrom the number of delegates to the Association to which each state or territory shall be entitled for the ensuing three years, beginning with the annual meeting next succeeding that at which the reapportionment is approved by the House of Delegates.

SEC. 4.—Members of the House of Delegates shall be elected for a term of two years, and those state and territorial societies entitled to more than one representative are requested so to arrange such election that one-half of their delegates, as near as may be, shall be elected each year.

SEC. 5.—In order that each state and territorial medical society may properly provide for a full delegate representation at each Annual Session of the Association, it shall have the authority to elect alternates, who, upon presentation of the proper credentials, shall be empowered to serve as delegates in the absence of the regularly elected delegates. *Provided*, That in case of the absence of the regularly appointed delegate or alternate, the members from that affiliated society who are present at that meeting may select one of their number, who shall represent that society, and, provided further, that when only one member is present from any affiliated society, that member may represent that society in case he is in other respects eligible to the office of delegate.

SEC. 6.—No one shall serve as a member of the House of Delegates who has not been a member of the AMERICAN MEDICAL ASSOCIATION for at least two years.

SEC. 7.—Every Delegate from an affiliated state or territorial society, before being permitted to take part in the proceedings of the House of Delegates, must deposit with the Secretary, or other designated officer or committee, a certificate signed by the President and Secretary of the Society from which he receives his authority, stating that he has been regularly and legally elected a Delegate to the AMERICAN MEDICAL ASSOCIATION for a definitely stated term; and the delegates from the Sections shall present credentials signed by the Chairman and Secretary of the Section they represent. This certificate shall be subjected to review by the Judicial Council, and all disputes as to credentials shall be investigated by the Judicial Council and determined by vote of the House of Delegates.

SEC. 8.—The House of Delegates shall approve all memorials and resolutions of whatever character issued in the name of the AMERICAN MEDICAL ASSOCIATION before the same shall become effective.

SEC. 9.—The House of Delegates shall present a summary of its proceedings to the last General Meeting of each annual session of the Association, or it shall publish the same in a bulletin to be issued each day during the annual session.

SEC. 10.—A majority of the members composing the House of Delegates shall constitute a quorum for the transaction of business; provided that at any adjourned session of any Annual Meeting ten members shall constitute a quorum.

CHAPTER IV.

ELECTION AND INSTALLATION OF OFFICERS.

SECTION 1.—All elections shall be by ballot, and a majority of all votes cast shall be necessary for an election.

SEC. 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the annual session. Only those in attendance at the annual session at which the election occurs shall be eligible for election.

SEC. 3.—The officers elected at each annual session of the Association shall be installed at the closing General Meeting.

CHAPTER V.

DUTIES OF OFFICERS.

SECTION 1. *President*.—The President shall preside at the General Meetings and over the House of Delegates and at meetings of the Board of Trustees, if present, preserve order and decorum in debate, give a casting vote when necessary, and perform all the other duties that custom and parliamentary usage may require. In addition to these duties the President, on the morning of the first day of the annual session following his election, shall deliver before the General Meeting an address, not exceeding forty minutes in length, upon such matters as he may deem of importance to the Association. He may at any time make such suggestions as he may deem for the best interests of the Association, either to the General Meeting or to the House of Delegates, or to any standing or special committee of the Association, provided that said suggestions are submitted in writing. He shall not be eligible for reelection. He shall, also, perform such other duties as may, from time to time, be required of him by the Association or its Board of Trustees.

SEC. 2. *Vice-Presidents*.—The Vice-Presidents, when called upon, shall assist the President in the performance of his duties, and during his absence, or at the request of the President, one of them shall officiate in his place. In case of the death, resignation, or removal of the President, the vacancy shall be filled by the senior Vice-President, beginning with the first. They shall perform all other duties prescribed for that office.

SEC. 3. *Secretary*.—The Secretary shall keep a record of the proceedings of, and conduct the correspondence for, the Board of Trustees; he shall, also, keep in separate books the minutes of each day's proceedings of the General Meeting and of the House of Delegates, which minutes shall be read and presented for adoption by the respective bodies. He shall give due notice of the time and place of each next ensuing annual session; notify all members of committees of their appointment, and of the duties assigned to them; hold correspondence with other permanently organized medical societies, both domestic and foreign; and carefully preserve the archives and unpublished transactions of the Association. It shall be his duty to verify the credentials of members, to receive and announce all essays and memoirs voluntarily contributed, to determine the order in which such papers are to be read and considered, and to fix a definite hour each day for the general addresses before the Association. He shall prepare for publication the official program of each meeting. It shall be the duty of the Secretary to provide a special registration book for members of the House of Delegates, in which shall be recorded the name of every delegate in attendance at each meeting, together with that of the society which he represents. It shall also be his duty to prepare a roll of the delegates attending each annual session, to facilitate voting by roll-call.

The Editor of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION may be the Secretary of this Association.

SEC. 4. *Treasurer*.—The Treasurer shall have charge of the funds and property of the Association, and shall disburse its funds only on the order of the Board of Trustees, or House of Delegates, when approved by the Board of Trustees, properly attested by their respective officers. He shall give to the Board of Trustees bond for the safe keeping and proper use and disposal of his trust, and he shall make such reports to the Board as it may require of him, and through the same Board he shall present his accounts, duly authenticated, at every annual session of the House of Delegates.

SEC. 5. *Board of Trustees*.—The Board of Trustees shall consist of nine members, together with the President, who shall be a member *ex officio*, three of whom shall be elected annually by the House of Delegates to serve for three years. It shall be the duty of this Board to provide and superintend the publication and distribution of all such proceedings, transactions, and memoirs of the Association as may be ordered to be published, in such a manner as may be directed; and in

doing this it shall have authority to appoint an editor and such assistants as it deems necessary, determine their salaries, and procure and control such materials as may be necessary for the accomplishment of the work assigned to it. Further, to facilitate its work, it shall be the duty of the secretaries of the Association and of the several Sections, during each annual session or as soon thereafter as practicable, to deliver to the Board, or such editor or agent as it shall appoint, all such records of proceedings, reports, addresses, papers, and other documents as may have been ordered for publication either by the General Meetings, by the House of Delegates, or by the Sections. All money received by the Board of Trustees, or its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Association, and all orders on the Treasurer for disbursements of money in any way connected with the work of publication must be endorsed by the Chairman of the Board of Trustees, and countersigned by the Secretary. All matters of the Association pertaining to the expenditure of money for other purposes shall be referred, during the annual session, to the Board of Trustees, who shall make a report on the same within twenty-four hours after the same are referred to it, and if the House of Delegates orders the expenditure of money in connection with said report, and the same is approved by the Board of Trustees, the payment shall be made by the Treasurer as provided above. It shall be the further duty of the said Board of Trustees to hold the official bond of the Treasurer for the faithful execution of his office, to annually audit and authenticate his accounts, and to present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Association during the year, and the amount of all other property belonging to the Association, under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of Treasurer, by death or otherwise, the Board of Trustees shall fill the vacancy *ad interim*.

It shall be the duty of this Board, at its first meeting after the Annual Meeting of the Association, to elect a Chairman of the Board, who shall, in the absence of the President, preside at all meetings of the Board, and perform such duties as may devolve upon him under these By-Laws, or by resolutions of the Board. This Chairman shall at the first meeting of the Board after the Annual Meeting of the Association appoint two Standing Committees of said Board, each consisting of three members.

1. A Finance Committee, which shall audit and have general supervision of the Treasurer's accounts, and shall make a report thereon at the annual meeting of the Board.

2. A Publication Committee, which shall have supervision of the publication of THE JOURNAL, and shall aid and advise with the Editor respecting measures and methods for conducting and developing it.

The Board shall determine the compensation of the Treasurer and Secretary, respectively; it shall employ the Editor of THE JOURNAL, who shall, under its direction, have the management of THE JOURNAL of the AMERICAN MEDICAL ASSOCIATION; and who shall give such bond as the Board may, from time to time, require of him; the Board shall fix the terms and conditions of his employment, and that of all other employees of the Association. Regular meetings of the Board shall be held immediately after the Annual Session of the Association and on the third Friday in the month of February of each year. Special meetings of the Board may be called at any time by the President, or by five members of the Board, by mailing a written or printed notice to the last known address of each Trustee, at least five days before such meeting is to be held, in which shall be specified, in general terms, the object of such special meeting, and no other business shall be transacted thereat: *Provided*, That if at any time a meeting of the Board be held at which all the Trustees are present, or the proceedings of which are approved in

writing by every member of the Board, said meeting and proceedings shall be valid, without any previous notice having been given. Five members of the Board shall constitute a quorum. Special sessions of the Association may be called at any time by the President upon written request of one hundred members of the Association, by mailing a written or printed notice to the last known address of each member, at least twenty days before such special session is to be held, in which shall be specified, in general terms, the objects of such special session, and no other business shall be transacted thereat. One hundred members or more shall constitute a quorum for the transaction of business at any general or special session and ten members shall constitute a quorum at any adjourned session thereof.

SEC. 6.—All business of each annual session shall be completed by the officers who have served through the session.

CHAPTER VI.

STANDING COMMITTEES.

The Standing Committees shall be the following:

1. A Committee of Arrangements.
2. A Judicial Council.
3. A Committee on Medical Legislation.
4. A Committee on Nominations.
5. A Committee on Transportation.

And such other Committees as the House of Delegates from time to time may create.

CHAPTER VII.

DUTIES OF COMMITTEES.

SECTION 1. *Committee of Arrangements*.—The Committee of Arrangements shall be appointed by the President, and shall be composed of seven members residing in the place at which the Association is to hold its next annual session. It shall be required to provide: 1. A hall for the General Meetings. 2. Hall for the House of Delegates. 3. Halls for Sections. 4. Rooms for Committees. 5. Rooms for post-office and the force thereof. 6. Rooms for registration and the force thereof. To meet these expenses the Committee of Arrangements shall have the proceeds of the exhibition hall. This arrangement must be agreed to by the representative of the local committee inviting the Association, before a place for the meeting of the Association is selected by the House of Delegates.

SEC. 2. *Judicial Council*.—The Judicial Council shall be composed of nine members, three of whom shall be chosen annually by the House of Delegates to serve for three years. All questions of a personal character, including complaints, protests, and credentials, shall be referred at once, after the report of the Committee of Arrangements or other presentation, to the Judicial Council without discussion.

The said Council shall organize by choosing a Chairman and Secretary, shall keep a permanent record of its proceedings, and shall report its findings to the House of Delegates at the earliest practicable moment.

SEC. 3. The Committee on Legislation shall report to the House of Delegates at each annual session its proceedings during the previous year, and shall recommend such action in respect to pending legislation as it shall deem proper.

SEC. 4. *Committee on Nominations*.—The Committee on Nominations shall consist of nine members of the House of Delegates, not more than one from one state or territory, selected annually by the House of Delegates. It shall be the duty of this Committee, after consultations with the members of the Association, to hold one or more meetings at which the assignment of the offices of the Association for each ensuing year shall be carefully considered. The Committee shall then, on the morning of the third day of the annual session, report the result of its deliberations to the House of Delegates in the shape of a ticket providing one, two, or three names for each office, but not more than one candidate for each office shall be named from any one state or territory. Nothing in this section shall be construed

to prevent additional nominations being made by the members of the House of Delegates.

SEC. 5. *Transportation Committee.*—The House of Delegates shall appoint a Committee on Transportation, which Committee shall secure railroad rates for the annual session and publish the same in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION sufficiently early to enable all who desire to attend the annual session to obtain necessary information.

SEC. 6. The Standing Committees shall discharge all the duties imposed on them by the By-Laws and such other duties as the Association may from time to time direct.

SEC. 7. The members of the Standing Committees whose appointments are not otherwise provided for shall be selected and appointed by the President of the Association before the adjournment of the annual session.

SEC. 8. The Special Committees shall perform the duties for which they are created, and when the report of a special committee is received and acted on said committee shall cease to exist.

SEC. 9. All Special Committees shall be appointed by the officer presiding over the meeting at the time the special committee is directed to be constituted. No one appointed on a special committee who fails to report at the meeting next succeeding the one at which he is appointed shall be continued on such committee, unless a satisfactory excuse is offered.

SEC. 10. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such Committees shall have the right to report to the House of Delegates in person, and to participate in the debate thereon pending the adoption of such report; but they shall not have the right to vote.

CHAPTER VIII. TIME OF MEETINGS.

SECTION 1. The General Meetings of the AMERICAN MEDICAL ASSOCIATION shall be held at 11 a. m. and 7:30 p. m. of the first day of the annual session, at 7:30 p. m. of the two subsequent days, and at 12 noon of the concluding day.

SEC. 2. The various Sections of the Association shall hold their first meeting of each annual session at 2 p. m. of the first day, and on subsequent days of the annual session they shall meet from 9 a. m. to 12 noon and from 2:30 p. m. to 6 p. m. until their respective programs are completed, or as the Sections themselves may otherwise order; *provided*, that no Section meeting shall be appointed in conflict with the General Meetings.

SEC. 3. The House of Delegates shall hold its first meeting of each annual session at 2 p. m. of the first day, and on subsequent days at such time as may be necessary to complete its business, provided that it shall not meet at hours that will conflict with the General Meetings of the Association.

CHAPTER IX. SECTIONS.

SECTION 1. The AMERICAN MEDICAL ASSOCIATION shall be divided into the following Sections:

1. Practice of Medicine.
2. Surgery and Anatomy.
3. Obstetrics and Gynecology.
4. Ophthalmology.
5. Laryngology, Otology and Rhinology.
6. Diseases of Children.
7. Materia Medica, Pharmacy and Therapeutics.
8. Pathology and Physiology.
9. Stomatology.
10. Nervous and Mental Diseases.
11. Citaneous Medicine and Surgery.
12. Hygiene and Sanitary Science.

SEC. 2. Each Section shall be composed only of such members as have complied with Sections 1, 2, 3 and 4 of Chapter I of these By-Laws, and Section 3 of Article III of the Constitution.

SEC. 3. *Officers of Sections.*—The officers of each Section shall be a Chairman, a Secretary, and an Executive Committee. The latter shall consist of the last three retiring chairmen. At the commencement of the afternoon meeting of the third day of each annual session, each Section shall elect its own officers to serve for the ensuing year, their duties to commence with the close of the annual session at which they are elected and to continue until their successors are elected and qualify. Each Section shall elect annually two representatives to the House of Delegates. In each Section a nominating committee of three members shall be elected by open ballot on the first day to make nominations for section officers.

SEC. 4. *Addresses in Sections.*—The Chairman of each Section shall prepare an address on recent advances in the branches belonging to his Section, including such suggestions in regard to improvements or methods of work as he may deem important, and present the same to the Section over which he presides on the first day of its annual session. The reading of such addresses shall occupy not more than twenty minutes.

SEC. 5. *Papers Before Sections.*—It shall be the duty of every member of the Association who proposes to present a paper or report before a Section to forward either the paper or an abstract indicative of its contents, and its *length*, to the Secretary of such Section at least one month before the annual session at which the paper or report is to be presented. This abstract shall contain not less than fifty nor more than two hundred words.

It shall also be the duty of the Secretary of each Section to arrange such papers in the order in which they shall be read, after which he shall send such information to the Secretary of the Association at least twenty-eight days before the annual session for publication in the official program for the use of all members attending the annual session.

SEC. 6. *Length of Papers and Discussions.*—No paper, the reading of which occupies more than twenty minutes, shall be read before any Section. Authors of longer papers, however, may read abstracts before a Section within the allotted twenty minutes. Such papers shall be referred by the Section to the Executive Committee of the Section or to a subcommittee specially appointed for their examination. Such committee shall be allowed twenty days for such examination; at the end of which time they shall forward the papers to the Board of Trustees or to the Editor, with such recommendations as they may deem proper. No member shall address a Section more than once upon the same subject, nor speak longer than five minutes without the approval of the Section.

All the papers presented directly to the Association, and other matters, may, at the discretion of the Association, be referred to the various Sections for their consideration and report.

SEC. 7. *Publication of Papers and Reports.*—No report or other paper shall be entitled to publication in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, unless it be approved by each member of the Executive Committee of the Section before which it is read.

Authors of papers are required to return their proofs within two weeks after their reception.

Every paper received by the Association and ordered to be published, and all plates or other means of illustration, shall be considered the exclusive property of the Association, and shall be published and sold for the exclusive benefit of the Association.

The Board of Trustees shall have full discretionary power to omit from THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, in part or in whole, any paper that may be referred to it by any of the Sections, unless specially instructed to the contrary by vote of the House of Delegates.

No report or other paper shall be presented to this Association, or any one of its Sections, unless it be so prepared that it can be put at once into the hands of the

Secretary to be transmitted to the Board of Trustees.

No paper shall be printed as having been read before this Association unless it has actually been read by its author, or unless for special reasons when the author has been present and prepared to read the paper, the Association or Section to which it is presented shall unanimously vote to have it read by title. All other papers shall be treated by the Board of Trustees and Editor as volunteer papers.

CHAPTER X.

ADDRESSES.

The House of Delegates shall elect annually three members to deliver addresses in the General Meetings of the next ensuing annual session—one on some topic or topics relating to general medicine, one relating to general surgery, and one relating to state medicine. None of these addresses shall exceed thirty minutes in its delivery.

CHAPTER XI.

DELEGATES TO FOREIGN MEDICAL SOCIETIES.

The President shall be authorized to appoint annually delegates to represent this Association at the meetings of such scientific bodies in foreign countries as are in affiliation with this Association, whose appointment is not otherwise provided for.

CHAPTER XII.

RULES OF ORDER.

SECTION 1.—This Association shall be governed by the rules prescribed in "Roberts' Rules of Order."

SEC. 2. *The Previous Question.*—When the previous question is demanded, it shall take at least ten members to second it; and when the main question is put under force of the previous question and negatived, the question shall remain under consideration as if the previous question had not been enforced.

SEC. 3.—No one shall be permitted to address the Association until he shall have announced his name and residence, which shall be distinctly repeated by the chair; but no member, except an officer of the Association, or an appointed orator, or an officer of a committee presenting a report, shall be permitted to address the General Meetings from the platform. Remarks shall be limited to five minutes.

SEC. 4.—No new business shall be introduced at the General Meeting of the Association on the last day of the annual session except by unanimous consent.

CHAPTER XIII.

ORDER OF BUSINESS.

SECTION 1. *General Meetings.*—The order of business of the General Meetings at the annual sessions of the AMERICAN MEDICAL ASSOCIATION shall at all times be subject to the vote of three-fourths of all the members in attendance; and, until permanently altered, except when for a time suspended, it shall be as follows:

1. The calling of the meeting to order by the President elected the preceding year, or, in his absence, by one of the Vice-Presidents.
2. Reading and adopting the minutes.
3. The report of the Committee of Arrangements.
4. The reception of "members by invitation."
5. Reports of standing committees in the order named in the By-Laws.
6. The annual address of the President.
7. The reception of the reports of all special committees and voluntary communications, and their reference to the appropriate Sections or committees.
8. The reading and consideration of the reports of the Committees on Prize Essays, and of the Chairmen of Sections.
9. Resolutions introducing new business.
10. Reports from the several Sections.
11. Unfinished and miscellaneous business.
12. Report of the House of Delegates.
13. Adjournment.

SEC. 2. *The Opening General Meeting.*—The opening meeting shall be for the addresses of welcome, and the responses thereto, for the report of the Committee of

Arrangements, and other exercises pertaining to the opening of the General Meeting, and for such other business as may be provided. At this Meeting the President shall deliver his annual address, which shall be referred to the House of Delegates for action.

SEC. 3. *The Closing General Meeting.*—The closing meeting shall be devoted to such exercises as may be provided, to the report of the House of Delegates, to the announcement of the election of officers, and to their installation.

SEC. 4. *House of Delegates.*—

1. Call to order by the President.
2. Reading and adopting the minutes.
3. Reports of officers.
4. Reports of committees.
5. Consideration of the recommendations contained in the President's address.
6. Consideration of memorials, resolutions or other business referred from the General Meetings.
7. Consideration of memorials, resolutions or other business referred from the Sections.
8. Consideration of memorials, resolutions or other business referred from the State Societies.
9. Unfinished business.
10. New business.

SEC. 5. *Sections.*—Each Section shall have authority to arrange its own order of business.

CHAPTER XIV.

AMENDMENTS.

The House of Delegates shall have power to frame rules for its own government and for the government of the Association; it shall, also, have power to amend the By-Laws of the Association at any annual meeting, by a three-fourths vote of its members.

Book Reviews.

BACTERIOLOGICAL TECHNIQUE. A Laboratory Guide for the Medical, Dental and Technical Student. By J. W. H. Eyre, M.D., F.R.S., Edin., Bacteriologist to Guy's Hospital and Lecturer on Bacteriology at the Medical and Dental Schools, etc. Octavo of 375 pages, with 170 illustrations. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$2.50 net.

Eyre's book is a notable addition to our bacteriologic literature. With the exception of one chapter (that on the pathogenic bacteria), it is written in such a manner as to be available for the use of those engaged in the study of brewing, dairying and agriculture, as well as medical and dental students.

The volume is an elaboration of the notes given by the author to his classes. It is, therefore, full of details which are of great value to the beginner. At the same time the experienced bacteriologist will find numerous valuable hints. The book is concisely and very lucidly written.

Some of the subjects discussed are: Apparatus, methods of sterilization, the use of the microscope, staining methods, media, anaerobic cultivations and the methods of identification of bacteria. In the subdivision devoted to the last topic, Chester's terminology is adopted. Appended are several complete articles on the bacteriologic examination of water, air, soil, milk, butter and meats.

Particularly praiseworthy are the chapters on the making of media, staining methods and the methods of experimental inoculation. In the first-named, however, we should like to have seen Theobald Smith's method of rendering media sugar free, as it is much simpler than the method mentioned. The medium for cultivating the gonococcus, given on page 157, should have been ascribed to Libman. The description of the methods of anaerobic cultivation is very complete. It would have been advantageous to point out which are the more reliable.

The book will certainly meet with a hearty welcome.

It should be owned by every one engaged in the study of bacteriology.

HOW TO SUCCEED IN THE PRACTICE OF MEDICINE. By Joseph McDowell Mathews, M.D., LL.D., President of the American Medical Association, 1898-1899; Ex-President Mississippi Valley Medical Association, Ex-President Kentucky State Medical Society, Professor of Surgery, Hospital Medical College; late Professor of Surgery, Kentucky School of Medicine, Louisville, Ky. John P. Morton & Co.

When a man has been President of the American Medical Association, the editor of a successful medical journal, professor of surgery for a number of years, and possessed of a large practice, he is indeed fitted to write a book on "How to Succeed in the Practice of Medicine."

In the book before us the writer essays to answer this question so important to the graduate in medicine. One is struck at once by the author's dedication, which is brief and reads as follows: "This book is affectionately dedicated to my wife; for twenty-five years she has been my partner in love and affection, and to her rare good judgment, excellent advice and steadfastness I owe much of whatever success may have come to me in the medical profession." This dedication is but the keynote to what the writer has to say in his loving tribute to women, to American women, and the wives and mothers of doctors in particular. He preaches the text, "A good man is what unpervverted womanhood demands that he should be." He calls to mind memories of mothers beloved, of their watchful care over us in days of yore, of their pride in every little fancied achievement, and their constant hope and wish for our success.

To the doctors' wives who pin their faith upon their particular doctor's ability, who encourage him in the days that are dark, who constantly seek to do that which will tend to his success—self-denying, faithful and considerate, their abiding faith in him never ceasing—the writer gives but a just tribute.

He dwells with much force and emphasis upon the happy life that a right woman makes, and is sympathetic to the unfortunate who has made a mistake. To these happy ones we can recommend this book most highly and advise them when sitting by their cozy firesides to read it to the partners of their joys and sorrows. It will save them much reiteration and enable them to say, "Them's my sentiments."

It goes without saying that there must be some character in the man to enable these mothers and wives to have that abiding faith, and they, on their part, will have something very pleasant to say of him. We can readily imagine the author's wife saying, "From the days of our earliest acquaintance, throughout our courtship and subsequent married life, my husband has been all the world to me. Patient and gentle, he has never been fretted by the small whims of womankind, but has always been the strong, gallant, considerate and faithful husband. If every woman could meet and know and love such a man, marital troubles would be unknown, and life would be, as it has been with us, 'one grand, sweet song.'"

There are many valuable hints and suggestions in this book and we commend it especially to the young medical man just reaching out to begin practice, and thank the author on behalf of the men and women of the medical profession.

THE AMERICAN TEXT-BOOK OF OBSTETRICS. In two volumes. Edited by Richard C. Norris, M.D. Art Editor, Robert L. Dickinson, M.D. Second edition, thoroughly revised and enlarged. Two handsome imperial octavo volumes of about 600 pages each; nearly 600 text illustrations and 49 colored and half-tone plates. London and Philadelphia: W. B. Saunders & Co. Per set, cloth, \$3.50 net; sheep or half-morocco, \$4 net.

These exceedingly attractive volumes on obstetrics commend themselves at once to both the student and the practitioner. The change from one large cumbersome volume to two has been a good one. On glancing

through the volumes one is impressed at once with the wealth of excellent illustrations which so materially aid in explaining the text.

Dr. Piersol, in his lucid style which appeals so strongly to the eager student, has contributed the admirable chapters on the anatomy of the pelvis and its contents, and the physiology of pregnancy.

In the chapter on the hygiene and the management of pregnancy Dr. Palmer strikes the right note when he calls attention to the fact that every woman needs the judicious advice of an intelligent obstetrician as to the mode and method of the management of her condition until parturition commences.

In the chapters on the pathology of pregnancy it is stated that all ovarian and other tumors which may complicate parturition should be removed when discovered. This is supported by numerous cases in which excellent recoveries resulted and where the pregnancy went to term without complications.

The warning for eclampsia is given in the paragraph on toxemia. Obstetricians have long since learned that a superficial examination of the urine for the detection of the presence of albumen only, is not the sole indication of threatening eclampsia. It is the retention in the blood of certain toxic agents, the precise nature of which is not yet known. This condition is revealed by the toxicity of the urine. Dr. Davis does not ascribe the causal rôle in toxemia to retained urea, but he regards it as a valuable index in estimating the excretory activity of the patient.

Dr. Jewett's deductions from insurance reports show that from 65 to 75 per cent. of puerperal deaths are attributable to sepsis, that this 65 to 75 per cent. is in those delivered outside of hospitals—showing that an "aseptic instinct" or "conscience" is not yet possessed by the physician in general.

The mechanics of normal and abnormal labor are given in great detail in a clear and scholarly manner and are finely illustrated. Space forbids a detailed review of the separate chapters on dystocia and the puerperium; they are very instructive. There is but one line to mar the excellence of these articles, a seeming advertisement on page 240, Volume II, which detracts from the dignity of a work of this kind.

Chapters on the physiology and pathology of the new-born infant are very brief, but cover the ground well. Obstetric surgery, including the instrumental and manual operations and cœliotomy for sepsis, concludes the second volume.

Both for the student and the physician the work is obviously indispensable.

ATLAS AND EPITOME OF TRAUMATIC FRACTURES AND DISLOCATIONS. By Prof. Dr. H. Helferich, Professor of Surgery at the Royal University, Greifswald, Prussia. Edited, with additions, by Joseph C. Bloodgood, M.D., Associate in Surgery, Johns Hopkins University, Baltimore. From the fifth revised and enlarged German edition. With 216 colored illustrations on 64 lithographic plates, 190 text-cuts, and 353 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3 net.

The enlarged and improved edition of Professor Helferich's valuable and most explicit work brings the subject of fractures and dislocations thoroughly up to date, and in its translation Dr. Bloodgood has done the profession a great service. His demonstration of the visible external deformity, the anatomic preparation and the X-ray shadow presents the subject so plainly to the mind that it may be grasped instantaneously. The illustrations are numerous and the colored plates are especially noteworthy, being beautiful examples of the present-day lithographic art; they are as true to nature as it is possible to produce them.

The explanation of the plates, to which the author has called attention in his preface, is clear and concise, while the text abounds in good surgical teachings.

The brevity of the work recommends it strongly to the busy practitioner as well as to the medical student, and it should be consulted by both with pleasure and profit.

ATLAS AND EPITOME OF OPERATIVE SURGERY. By Dr. Otto Zuckerkandl, Privat-docent in the University of Vienna. Second edition, revised and enlarged, authorized translation from the German; edited by J. Chalmers Da Costa, M.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College; Surgeon to the Philadelphia Hospital; with 40 colored plates and 278 illustrations in the text. Philadelphia: W. B. Saunders & Co., 1902.

This atlas, with its descriptive pages, was intended originally as an elementary work for students, and it continues to serve most admirably that important function. Its usefulness, however, is not limited to this sphere. The practitioner who is called upon from time to time to do minor or even major surgery will find the anatomical relations so admirably pictured and the technique of many procedures so accurately described and illustrated that a hasty glance tells the whole story. It is an excellent hand-book for such purposes. Those who are familiar with the work in its original form will be pleased to know that it has been put abreast of the times by the addition both by word and illustration of all the newer operations that have seemed to the author to have special or permanent value. There have been added 16 lithographic plates in colors and 61 figures in the text.

DISEASES OF THE PANCREAS AND THEIR SURGICAL TREATMENT. By A. W. Mayo Robson, F.R.C.S., Senior Surgeon, Leeds General Infirmary; Emeritus Professor of Surgery, Yorkshire College, Victoria University, England, and B. G. A. Moynihan, M.S. (London), F.R.C.S., Assistant Surgeon, Leeds General Infirmary; Consulting Surgeon to the Skipton and to the Mirfield Memorial Hospitals, England. Pp. 293, illustrated. Philadelphia and London: W. B. Saunders & Co., 1902.

At the present time, when attention is being directed on many sides to the diseases of the pancreas, the appearance of a volume by two surgeons of the standing of Mayo Robson and Moynihan cannot fail to be opportune. The authors' object has been to record and review the work done in the past, and to indicate, as far as possible, the scope and trend of future research. In a short monograph of 260 pages they have given practically everything of importance that is known concerning the diseases of the pancreas.

The first chapter gives a rather meager account of the anatomy, development and structure of the pancreas, and the methods of obtaining access to the organ for the purposes of operation. Then follows an excellent description of the experimental work that has been done on the pancreas, from the earlier experiments of Martinotti, von Mering and Minkowski, to the recent investigations of Opie. After a short discussion of prolapse and injuries of the pancreas, the authors devote four chapters to the subject of pancreatitis. For purposes of classification they divide inflammations of the pancreas into the acute, subacute and chronic forms.

Robson and Moynihan believe that there is much less danger of serious hemorrhage in patients jaundiced from gall-stones than in those where the jaundice depends on pancreatic disease. They accept the conclusions of Opie, that the occurrence of glycosuria in pancreatic disease is due to a diffuse interacinar inflammatory process which early invades the islands of Langerhaus.

Cholecystotomy and drainage of the gall-bladder, as a method of treatment of chronic pancreatitis, has yielded very encouraging results in the hands of Robson and Moynihan, they having succeeded in curing six out of seven cases.

Other chapters of the book treat of cysts, calculi and new growths of the pancreas. The first are classified as 1, retention cysts; 2, proliferation cysts; 3, hydatid cysts; 4, congenital cysts; 5, hemorrhagic cysts; 6, pseudo-cysts. Especial attention is drawn to the frequency of confusion between true pancreatic cysts and effusions into the lesser peritoneal cavity.

To those who desire to obtain a practical working

knowledge of the diseases of the pancreas we can recommend this book most highly. It is remarkable not only for clearness of style and accuracy of observation, but also for the masterful fashion in which the authors have succeeded in compressing a large amount of information into a small space. The volume is dedicated "to the surgeons of America in cordial recognition of their work," but we feel certain that American physicians will not be alone in giving to Robson and Moynihan's monograph their high commendation.

CELLULAR TOXINS OR THE CHEMICAL FACTORS IN THE CAUSATION OF DISEASE. By Victor C. Vaughan, M.D., LL.D., Professor of Hygiene and Physiological Chemistry and Director of the Hygienic Laboratory in the University of Michigan, and Frederick G. Novy, M.D., Sc.D., Junior Professor of Hygiene and Physiological Chemistry in the University of Michigan. Fourth edition, revised and enlarged. Philadelphia and New York: Lea Bros. & Co., 1902.

To one who desires to keep himself *en rapport* with the latest discoveries in the causation of disease—and who does not?—this work will prove invaluable, as it presents the subject in the most concise, intelligent and satisfactory form. We are all conscious in a general way of the giant strides that medicine is making, still it is somewhat startling to read in the preface of this book that the advance in the knowledge of the causation factors of disease, since the first edition appeared, fourteen years ago, has rendered it necessary not only to discard many chapters and rewrite others, but to absolutely change the chief title of the book. Several new chapters have been added, bringing into the volume subjects that were wholly unknown at the writing of the third edition. It has been the effort of the writers to present everything of importance done in the lines treated of down to the close of the year 1901. The book is in confirmation of the truism that clear thinking begets clear speaking. Some of the chapters are simply captivating—chapter one, on the etiology of the bacterial diseases, and chapter nine, on immunity, contain the key to the modern interpretation of disease, recovery and health. The man who reads and rereads these two chapters till they become a constituent part of his mental fiber will have his vision so illuminated that disease will become a fascination and its treatment a joy. This does not imply that final knowledge in these subjects has been attained. On the contrary, the charm of the subject lies as much in what is not known as in what is understood, for enough is established to indicate how big the future is with possibilities, possibilities that lie within the reach of the humblest investigator when once he has caught the scientific spirit and method. Specific diseases are classified according to the bacteriological or cellular toxins, and are discussed in succession from ptomain poisoning down through the list of infectious diseases, as anthrax, cholera, tetanus, diphtheria, tuberculosis, gonorrhoea, diarrhoea of infancy, and so on to food poisoning and the autogenous diseases. This is groundwork for the medical student and it is equally valuable for the scientific practitioner.

DISEASES OF THE EYE. A Hand-book of Ophthalmic Practice for Students and Practitioners. By G. E. De Schweinitz, A.M., M.D., Professor of Ophthalmology in the University of Pennsylvania. Fourth edition, revised, enlarged and entirely reset. Philadelphia and London: W. B. Saunders & Co., 1902.

This book, the fourth edition in ten years, speaks well for its popularity. It is well written, to meet the needs of the students and practitioners. The subject matter is not given in great detail, but is simple, and in connection with the large number of illustrations with text explanations, makes a valuable book. The author's details of general optical principles give the knowledge necessary for the successful practice of ophthalmic science. The latest methods for examination have been added, and many therapeutic agents are given in connection with the diseases in which they are indicated. He does not, however, present sufficient therapeutic

data; merely says such and such can be used, without stating the first value of one. In the chapter on operations, credit is given, and full detail of operations of which the author has had no experience. This is creditable to the author and does not detract from the value of the book. There are many points of technical detail that have arisen in the writer's experience as a teacher and operator. The illustrative feature of the work has been greatly enhanced by the addition of many new cuts and six full-page chromolithographic plates, portraying the pathologic conditions. This edition deserves the same popularity as did its predecessors.

TRANSACTIONS IOWA STATE MEDICAL SOCIETY, DES MOINES, 1902.

This volume contains thirty-six original articles, together with a list of names of the 900 members of the State Society. One hundred and seventeen new members were added during the year, which bespeaks a vigorous administration. The papers are of unusual merit and would do credit to many an Eastern center. These are distributed among six sections, namely, Otolaryngology, Ophthalmology, Obstetrics and Gynecology, State Medicine, Surgery Medicine and Materia Medica.

TRANSACTIONS OF NEW HAMPSHIRE STATE MEDICAL SOCIETY, 1902.

This neat little volume of 330 pages contains the proceedings of the 111th annual meeting of the organization, together with twenty papers and their discussions. The greater number of papers consist of reports of interesting cases. It is probably true that to the average physician reports of cases are of more interest and provoke more lively discussion than do the statements of general principles and theories so much in vogue at present in the medical societies of the larger cities.

The Family Physician and the Children.—

Physicians often ask themselves and each other, and justly, too, why the generality of people are so prone to patronize the "irregulars" or advertising quacks for certain conditions, and pay them exorbitant fees for their services, when their own family physician would render them the same service for a much smaller fee. This question is not always an easy one to answer, and yet in most instances the answer is self-evident when all the facts in the case are known. The erroneous notion, so prevalent at one time among the fraternity, that the practice of medicine is a calling in which ordinary business methods cannot be employed has, perhaps, done more to bring about this state of affairs among the laity than would usually be admitted.

At one time in the history of our profession the art of medicine was deemed all important, but this is an age of science. The scientific in medicine and surgery has been in the ascendancy for decades in the regular profession. It has received all the attention in medical societies, while the art has gone begging. The astute irregulars have recognized this weakness in our ranks, and have reaped a rich financial reward at our expense. While I do not wish to be understood as advocating the adoption by the regular profession of the methods of the advertisers, yet there are many things we may learn from them that would be a benefit to our patients and a source of revenue to ourselves. Art is just as essential to

success in medicine as it is in business. This is particularly true of the family physician. On him depends, in a large degree at least, the favor or disfavor of a community toward our fraternity; and on him rests also largely the responsibility of turning the tide of public sentiment from the advertisers to the reputable, regular specialists.

It has often been remarked that a community that would support one physician twenty years ago will support three at the present time, with the same population. This, to my mind, is not due to increased sickness, but because physicians now see and treat successfully many conditions to which they gave little or no attention in former years. I fear that the regular profession does not deserve as much credit for this condition of things as it might. It is largely due to force of circumstances. The advertising quacks have educated the public to such an extent that we are often asked concerning certain conditions which, if we had been awake to our privileges, would have been removed by us long before. The average family physician fails to interest himself sufficiently in the welfare of his families. He fails to direct their attention to the importance of remedying certain trivial conditions before they become serious. He hesitates to inform his clientèle that certain lesions or malformations can be successfully treated by him, and, of course, is surprised when he learns that some newspaper advertisement has caught his patient. In the majority of these instances he has no one but himself to blame for the loss of his patient, because he had the first chance. These object lessons will not be in vain to him if he will heed them. They will compel him to see things that he formerly neglected because he thought he was not expected to see them or to advise concerning them. That these advertisers often do injustice to the regular profession by promising impossibilities cannot be successfully gainsaid, but the best way to demonstrate this to the public is to let them have nothing but the impossibilities. This would soon stop the advertisements. If the regular profession would make the same diligent effort to cure all curable cases coming under their observation that the irregulars make to get them, the shameful advertisements in our secular and even religious press would soon disappear.—G. A. HEIDNER, M.D., *West Bend, in Transactions of State Medical Society of Wisconsin, 1902.*

Dr. William M. Leszynsky has been appointed Neurologist to the Lebanon Hospital.

* * *

Dr. Frank Billings, president of the American Medical Association, was in the city of New York from December 19th to 22d and did us the honor of paying a visit to this office. He was particularly interested in the publications of this Association, notably the exhaustive and thorough card system used for the Directory.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:
EMIL MAYER, M.D., Chairman, New York.
Chas. E. Denison, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.

PUBLICATIONS:
THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 2.

FEBRUARY, 1903.

\$1.00 PER ANNUM

THE NEED OF A CODE OF ETHICS.

We print elsewhere in the JOURNAL a letter from the *Journal of the American Medical Association* for January 3d, by Dr. Gilmore, and in other portions of our news columns will be found indications that there is a growing demand for the need of a code of ethics. This growing demand is, perhaps, best exemplified by the following, which we reproduce from the *Boston Medical and Surgical Journal* for January 1, 1903:

We have already called attention to the fact that the students of the Harvard Medical School have, on their own initiative, arranged for a series of evening lectures to be given by prominent men, not necessarily physicians, on the general topic of the relation of the physician to the community. This action is noteworthy from several points of view. It shows, in the first place, a growing interest among students of medicine in the broader aspects of their professional work and in the responsibilities which it is sure to entail. Such a movement on the part of medical students, popularly supposed already to be overburdened with lectures, could hardly have occurred ten years ago. To those who have watched the development of the last few years, however, it comes as no great surprise. The students are certainly becoming more and more independent in thought, and are standing more in judgment upon the work which they are called upon to do and upon the teachers who direct it. The results have been in every way salutary both as regards teachers and students.

The desire of a large body of students to provide certain lectures for themselves furthermore points toward a definite need, which they are feeling is not supplied them in the regular course. They want, broadly speaking, to learn from men of experience of their future social and ethical relations to the communities in which they may happen to be placed. This is evidence that they

receive no such instruction in their ordinary undergraduate work, which, we believe, is the fact. This leads us to speak of a distinct lack in medical education, and that is, the direction of students in their relation to patients and others whom they must later come in contact with in their professional work. No attempt is made to teach the ethics of medicine except by precept and example, a good but not a sufficient method. Students of medicine certainly need instruction in this subject, a fact which the Harvard students have appreciated and have taken measures to accomplish by the establishment of these evening lectureships.

CALIFORNIA IN LINE.

The medical society of the State of California has done away with the Annual Volume of Transactions and now publishes its proceedings in the form of a journal, under the name of the *California State Journal of Medicine*. The first number was issued in November and is ideal in appearance. The editor recognizes the fact that it is not the office of a State medical journal to make money, but rather that it is a means for the dissemination of knowledge in the interest of humanity. Very few advertisements are found on the pages of the first issue, and not many are to be expected if the editor's promises are fulfilled. He says:

"The advertising pages of the *Journal* will be limited in number and will be open only to advertising matter which complies with the strictly ethical standard that is so well understood by all, yet so frequently forgotten—when there is a financial reason to forget."

In another editorial, setting forth the character of advertising matter which will be accepted, he concludes:

"The editor, who is under bonds to publish the *Journal* monthly, and is personally responsible for all financial obligations connected with its

publication, has been advised that he will secure little or no advertising on the basis outlined. This may or may not be true, but he is going to try it, even if he 'goes broke.' If the regular practitioners of this coast and country desire to see one journal in the United States conducted on such a policy, then there is no danger of the *Journal* not paying its own expenses."

Management of Dry Labor.—Put the patient in a hot bath and administer an enema. I need say nothing special as to these procedures because they should be carried out as a matter of routine in all cases of labor.

Keep the patient quiet in bed. While it is not necessary to consider this an absolute rule, I think it well for you to bear in mind the fact that excessive fatigue, or even a slight amount of weariness, may do considerable harm in all cases of dry labor.

Give chloral in all cases of dry labor, as soon as the pains commence. In those cases where the membranes rupture days before the onset of labor it may be well to give two or three doses of chloral about bedtime; give fifteen grains every fifteen or twenty minutes for three doses.

Give chloroform to the obstetrical degree when the pains become very severe. It is not easy to give any definite rule as to how much chloroform should be administered in such cases. We must always bear in mind the fact that the administration of large quantities of chloroform may be followed by very serious results, especially by postpartum hemorrhage. Having this in view we ought to be exceedingly careful about the administration of chloroform early in the first stage or perhaps at any time in the first stage.

I have already referred to certain cases in which the dilatation could be very much hastened by manual interference while the patient was fully under the influence of the anesthetic, but one does not like to give much chloroform when the os is very slightly, or not at all, dilated.

If it happens, however, that you see a patient who has been in dry labor for many hours, and find that she is considerably exhausted, and that there is, at the same time, spasm of the cervix or Bandle's ring, or of the whole body of the uterus, chloroform may be administered as follows: Administer chloroform to the surgical degree perhaps for twenty minutes. The patient may shortly afterward waken, feel much refreshed, and the spasm may be greatly or wholly relieved. In other cases it may be well to give chloroform for a short time, followed by hypodermic injection of morphine, allowing the patient to have a comfortable sleep, after which the condition will be found to be greatly improved.

Make it a rule always to terminate labor as soon as possible, even when there is considerable rigidity of the perineum, vagina and cervix. Remember, as I have before told you, the administration of chloroform nearly always makes a vast difference; the parts become, if not dilated, much

more dilatable or stretchable than they were. After the patient is completely anesthetized introduce, first, fingers, then hand slowly into the vagina. Dilate as rapidly as you can without using any force which is apt to injure the parts. Then dilate the cervix sufficiently to allow the hand to pass into the uterine cavity.

Manual Rotation.—Seize the head between the thumb and the one side and the fingers on the other, and rotate the occiput to the front; at the same time, with the external hand push the shoulder in the same direction in which you have rotated the occiput. When, as is most commonly the case, the occiput is turned to the right rear, the back of the shoulder will be found above the pubes; with the external hand push the shoulder toward the mother's left side. If you succeed in pushing the shoulder over, the occiput will not slip back; if you do not succeed in moving the shoulder, the occiput will very readily, as a rule, slip to the rear. If you are not able to push the shoulder with the external hand, it is sometimes a comparatively simple matter to push the internal hand on past the head and rotate the body of the child in such a way as to bring the shoulder in its right position, with the back of the child toward the mother's front, instead of toward the right side. If you are not quite certain that you have got the body of the child in the right position, and especially if you find the slightest tendency in the occiput to slip backward, try to hold it in position until you have introduced one blade of your forceps. This will generally keep the occiput to the front until you have applied the second blade.

If you have applied the forceps, deliver in the ordinary way, not too rapidly—at the same time without losing any unnecessary time.—*Adam Wright, Canadian Practitioner, December, 1902.*

* * *

Medical Journals.—At present there are 266 medical journals published in the United States. 11 weekly and 209 monthly. Of these, 45 are published in New York, 21 in Chicago, 21 in St. Louis and 19 in Philadelphia.

THE DIRECTORY.

The following from *The Homœopathic Eye, Ear and Throat Journal*, the official organ of the American Homœopathic, Ophthalmological, Otolaryngological and Laryngological Society, for January, 1903, will be of interest to our readers:

The Medical Directory of New York, New Jersey and Connecticut is before us in its fourth edition, and is a credit to the gentlemen who have brought it out. One of the conveniences of the directory is the "street directory," giving the names and locations of the physicians in regular order by streets. The use of tinted paper of different colors for the States represented makes it easy to turn directly to the place desired. We also find given the names of and information concerning all the various medical societies in the State (homeopathic excepted), and the hospitals, including those that are under homeopathic management. Taken altogether, it will prove to be of daily value to the physician who owns a copy.

The Association.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION, AT NEW ORLEANS, MAY 5 to 8, 1903.

Dr. H. L. E. Johnson, chairman of the Transportation Committee of the Board of Trustees of the American Medical Association at Washington, D. C., has been able to secure special rates for the next meeting of the American Medical Association. He states that the Southern Railway has authorized a rate of one fare for the round trip, from Washington and all prominent points on the entire system of roads throughout the entire South. Dates of sale May 1st, 2d, 3d and 4th, good for continuous passage in each direction, with final limit of ten days from date of sale. Tickets can be extended for longer period, however, provided they are deposited in person by the original purchaser with special agent at New Orleans, not later than May 12, 1903, and fee of 50 cents is paid at time of deposit, when final limit will be extended to a date not later than May 30, 1903.

The Southern Railway operates double daily fast limited trains with Pullman sleeping, compartment, club, observation and dining cars, Washington to New Orleans, by way of Charlotte, Atlanta and Montgomery, and also by other routes.

* * *

Cortland County Association.—The annual meeting of the Cortland County Association was held in the Y. M. C. A. parlors in Cortland on January 2d.

The meeting was called to order by the president, Dr. F. D. Reese, at 8 p. m. The meeting, which was largely attended, was the most successful one in the history of the Association from both a scientific and a social point of view.

In the symposium on acute Bright's disease every member on the program responded when his name was called. Following the papers a very interesting discussion took place.

Election of officers for the coming year resulted as follows:

President, Dr. S. J. Sornberger.
 Vice-president, Dr. F. S. Jennings.
 Secretary, Dr. H. S. Braman.
 Treasurer, Dr. E. A. Didama.
 Executive Member, Dr. P. M. Neary.
 Fellow, Dr. H. C. Hendrick.
 Alternate, Dr. F. D. Reese.

Following the election a collation was served.

A vote of thanks was tendered the Y. M. C. A. for their kindness in throwing open their parlors to the Association.

While the Association is young, it is also vigorous and growing in both enthusiasm and membership.

Kings County Association.—The fifteenth annual meeting was held at 315 Washington street, Brooklyn, on Tuesday, January 13th, at 8.30 p. m.

The evening was devoted entirely to the executive business of the Association. Dr. Ira Otis Tracy, of the Long Island State Hospital, was elected to membership. The list of the nominees published in the January JOURNAL was declared elected.

After transaction of the routine business, the retiring president, Dr. Hubert Arrowsmith, read an address, which will appear subsequently in the JOURNAL.

After adjournment a collation was served.

* * *

New York County Association.—The stated meeting of January 19th was attended by an unusually large number, probably 150 being present. Many were attracted by the announcement on the program that Dr. C. C. Barrows would report upon the case in which he had first tried his new treatment of septicemia by the intravenous injection of a solution of formalin. The reading of this paper brought out reports of cases similarly treated within the past few days by Dr. Edward Waitzfelder and Dr. W. L. Baner, and the discussion was participated in by Dr. W. R. Pryor, Dr. W. M. Polk and Dr. J. Whitridge Williams, of the Johns Hopkins Hospital.

Dr. J. Riddle Goffe presented specimens of fibrous tumors and of a dermoid cyst, and Dr. Parker Syms exhibited a hydrocele which had been removed intact without opening the sac.

The remainder of the evening was devoted to a discussion on the urine. The first paper, on "The Significance of Oxaluria," was by Dr. J. Bergen Ogden; the second, on "Hyperacidity of the Urine," was by Dr. Thomas W. Hastings; the third paper, on "The Prognostic Value of the Diazo Reaction in Tuberculosis," was by Dr. F. C. Wood, while Dr. Edward W. Lambert presented the final paper, taking for his theme "The Prognostic Significance of Albumin in the Urine." Drs. S. Oakley Vanderpoel, Brandreth Symonds and W. Evelyn Porter discussed the subject from their standpoint as life-insurance examiners.

Drs. Albert C. Geysler, Dennis A. McAuliffe, Charles H. Peck, J. George Sauer, Henry A. Siebenborn and Ernst A. W. Wilkens were elected to membership in the Association.

* * *

Rockland County.—The annual meeting was held at Hotel St. George, Nyack, on Wednesday, January 21, 1903, at 2.30 p. m. Dr. S. W. S. Toms, of Nyack, read an able and instructive paper on "Hernia." The discussion was opened by Dr. Parker Syms, of New York, followed by Dr. F. H. Wiggin.

The Association went into executive session. The minutes of the last meeting and the report

of the secretary-treasurer were read and approved. The amendments to the by-laws to bring them into harmony with the by-laws of the State Association were read and adopted. At the annual election Dr. D. Burr Van Wageningen, of Suffern, was elected president; Dr. Geo. A. Leitner, of Piermont, vice-president; Dr. N. B. Bayley, of Haverstraw, secretary-treasurer; Dr. J. H. Crosby, of Haverstraw, member of the Nominating Committee of the Fifth District Branch; fellow to the State Association, Dr. C. D. Kline, of Nyack; alternate, Dr. J. A. Dingman. Dr. Syms, president of Fifth District Branch, addressed the Association, congratulating it on its prosperity. Dr. F. H. Wiggin addressed the Association upon the work, progress and ideals of the New York State Medical Association, considering its origin and progress and of the proposition for the amalgamation of the two State societies.

* * *

Wyoming County Association.—There was held at Perry, N. Y., January 6, 1903, the quarterly meeting of the Wyoming County Association. Much interest and enthusiasm were apparent.

Dr. Grover W. Wende, of Buffalo, read a paper on "Eczema," and Dr. Floyd S. Crego read one upon "Syphilis of the Nervous System."

There was a total attendance of twenty-two, and two new members were elected.

Treatment of Acute Colitis.—This must proceed along the lines usually adopted for this complaint, but the rheumatic element in many of these cases must not be neglected. With regard to the treatment of the less acute forms of catarrh as here described, the amount that has been written upon the treatment of membranous colitis and the number of remedies suggested in the text-books are a sure proof that it is apt to be extremely intractable, and this is certainly so as far as the severe chronic cases are concerned. In the majority of cases, however, the disease is eminently curable if suitable means be adopted before the disease has advanced too far. The key to the treatment of this disease is, in my opinion, the recognition of its relation to gout and the "uric acid" diathesis, and also the recognition of the fact that it is a catarrh of the colon.

The first indication is met by the exhibition of the salicylates, in the form of sodium salicylate or salicine in the acuter cases. These sometimes have a remarkable effect upon those cases of cecal catarrh or typhlitis which so closely resemble appendicitis, and the rapid disappearance of symptoms under this treatment often confirms the diagnosis of cecal catarrh in a doubtful case.

In more chronic cases one of the combinations of salicylates with carbolic acid of the salol type seems to be the most effective, and this last-named drug has in my hands proved of extreme value in the treatment of colon catarrh,

even when it has reached the stage described as chronic membranous colitis. Another very effective treatment is by means of the combination of the perchlorides of mercury and iron which is so useful in enteric fever.

The second point of prime importance to be remembered in the treatment of these cases is the fact of the undue irritability of the colon, both secretory and motor. Therefore, the second main indication for treatment is the elimination from the dietary of all articles of food liable to leave an indigestible solid residue which might irritate the colon. The treatment must, therefore, take a line the exact opposite of that usually adopted for simple constipation.

Brown bread, porridge, figs, etc., which relieve ordinary constipation, are most potent in producing pains and excess of mucus in cases of colon catarrh, and in aggravating the irregular muscular action, which is one of the causes of constipation in this disease. In fact, any vegetable food containing much woody fiber must not be admitted to the dietary; even bananas often disagree; also the skins and seeds of fruits, and all fruits such as pears, with a gritty pulp. In taking meat care must be taken to remove the skin, gristle and more fibrous parts. All indigestible solids should be removed from the dietary. These dietetic precautions, combined with the use of salol (20 gr. to 30 gr. per diem), will be found to produce great amelioration in the majority of the milder cases and in some of the severer ones. Where nervous symptoms have become prominent the treatment of these also constitutes an important part of the work of the physician, and the cure will be hastened by attention to hygienic, climatic and social treatment, as well as to the medicinal and dietetic.

In cases of long standing, where considerable damage has been occasioned to the mucous membrane, treatment by enemata of simple saline solution, or with boracic acid, sometimes proves of value. In extreme cases it may be necessary to give the colon complete rest for some months by performing the operation of right inguinal colotomy, allowing no feces to pass along it. Several successful cases of this have been put on record in recent years.

The intractable nature of these chronic cases and the ease with which an early case can be cured emphasize the importance of early recognition of catarrh of the colon. Not only is early diagnosis necessary on these grounds, but also because, when not recognized and properly treated, catarrh of the colon, even in the less severe cases, is apt to cause very considerable suffering, both physical and mental, to those afflicted by it; and no small part of their suffering may sometimes be due to the fact that they have constant and annoying pain, while retaining every appearance of health, and consequently are considered to be hysterical and making much of a little. The deceptive character of the early symptoms renders the early recognition of this con-

dition far from easy, because they suggest to both patient and doctor the presence of a gastric rather than of intestinal ailment.—*Stacey Wilson, in British Medical Journal, December 6, 1902.*

THE X-RAYS FOR MALIGNANT DISEASE.

The *Medical News* for January 3, 1903, says the following editorially: "The recent discussion of the therapeutics of the X-rays in malignant disease, at the meeting of the New York State Medical Association, presents some of the limitations of their use as well as the helpful suggestions that experience has brought with it. It is clear that in the present state of our knowledge the only affections for which there is proper justification for the employment of the X-rays are superficial cutaneous cancer and inoperable tumors or recurrences. To suggest the use of the X-rays for primary cancer of the breast, for instance, as a method of treatment advisable early in the case is to expose the patient to serious risk without adequate hope of securing a cessation or retrogression in the growth of the tumor, which may, and in all probability will, proceed to give lymphatic metastases during the precious time expended on this method of treatment. These will surely complicate the further course of the case and may make radical operation by the knife ineffective.

"There seems undoubtedly to be a good field for the employment of the X-rays as a prophylactic measure after surgery has accomplished all it can. Frequent exposures to the X-rays will cause retrogression of many recurrent cancer nodules, such as make their appearance along the line of scars or even in more or less distinct, if only superficial, lymphatic glands. If in anticipation of such recurrences and metastases, X-ray treatment be instituted, there is good reason to think that deep tissue involvements may be prevented and lives saved. For while recurrences usually take place in the superficial parts they may be much deeper and spread beyond effective treatment before suspicion of their presence is aroused. This method of treatment may also be made to apply to uterine cancers after panhysterectomy, for by specially constructed tubes exposures may be made by which the X-rays are allowed to act only upon pathological tissues. This latter suggestion has as yet been very little tried, but it presents elements of hope in what are so often practically hopeless cases that it seems well worth putting to the test of extensive experience.

"As for cutaneous cancer and especially the form known as rodent ulcer the X-ray seems the best, easiest and most effective method of treatment yet introduced. This is saying much for the systematization of the employment of arsenic pastes and has given excellent results. The cosmetic results of X-ray cures are especially satisfactory. It has been suggested that certain

combinations of remedies may prove more effective than any single one in some of the more obstinate of these cases. For rodent ulcers with rolled-up, thickened, indurated edges, Dr. Kinnicut said that English authorities have found an alternation of treatment by Finsen rays and X-rays more effective than the use of either agent alone. Very strong light must be employed and the parts on which it is expected to act must be rendered bloodless by firm pressure against the lens of the Finsen lamp.

"As might be expected, the technic of the use of X-rays is not yet perfected. One of the most serious difficulties results from changes in the vacuum of tubes that sometimes give the rays increased burning power. The X-rays are not well understood, but it is generally held that they are not a form of electricity, but are more closely related to light. Electrical energy is the most available means for their production.

"It must be borne in mind that the results obtained by the use of the X-rays for malignant disease have not endured sufficiently long to give any assurance of permanency of cure. In a certain number of cases the disappearance of tumors, especially of secondary recurrent nodules of carcinoma of the breast, has been followed by subsequent symptoms from internal metastases and even by recurrences in the scar. A certain number of patients, with regard to whose definite cure there are notices in literature, are now dead from such recurrences. With regard to rapidly growing sarcomata the X-rays are especially ineffective, yet they may at times retard very much the progress of the case. For the slower varieties they seem to encourage breaking down, and this is apt to be followed by decided improvement, or even what appears to be radical cure.

"Evidently much remains to be learned about methods of application and ultimate results of X-ray treatment, yet the prospect is most encouraging. When it is realized that a symposium, such as that presented by the New York State Medical Association, on X-rays in cancer would have been absolutely impossible only a year ago because of lack of experience, it can be seen how much has been accomplished in a few months. Overenthusiasm in the reporting of results is especially to be deprecated at this stage in the evolution of our knowledge of the subject. Obstinate cases and failures must be included in reports or there will eventually be as sad disappointment in this matter, perhaps, as in the use of certain forms of electricity. In at least one reported case, a malignant neoplasm developed with fatal results in the scar of an X-ray burn. There is need, therefore, of extreme care in the use of the new method, and only the control experiences of many conservative observers will supply us with suitable data for an exact definition of the indications and limitations of X-ray treatment."

Original Articles.

WHAT ADVICE SHOULD BE GIVEN TO A WOMAN SUFFERING FROM FIBROID TUMOR OF THE UTERUS?¹

BY J. RIDDLE GOFFE, M.D.,

Professor of Gynecology in the New York Polyclinic Medical School and Hospital; Visiting Gynecologist to the New York City Hospital, Etc., Etc.

IT may be open to question whether fibroid or myomatous tumor of the uterus, as a disease, is increasing or not. Certain it is that many more of them are observed at the present time than formerly and vastly more cases are presenting themselves for treatment and operation. The multiplicity of cases has attracted increased attention to the condition, with the result that greater accuracy has been infused into statistics, and keener observation into the nature of the growths, their life history and ultimate termination.

According to Bayle, quoted by Bishop, 20 per cent. of all women, after the 25th year of age, suffer from fibroid, and, according to Klob, 40 per cent. of all women over 50 years of age.

Formerly, fibroids were classed among the harmless growths, and we were taught that, exclusive of polypoid tumors, they were never fatal; that their characteristic symptoms were pain and hemorrhage, and those due to mechanical pressure from their size. Indeed, the first patient upon whom I performed hysterectomy for fibroid tumor (it was a large tumor) had been counseled by one of the most prominent gynecologists of New York, at that time, not to allow any one to operate upon her, for, if she did, she would probably die; but to go to a dentist, have her teeth put in order, so that she could masticate her food and improve her digestion, and then she would live to as ripe an age as anybody. It so happened that the woman, although well past her 40th year, was a maid, and her hand was being sought in marriage. She felt it necessary to get rid of her protruding abdomen, and hence the application to me for relief. Supravaginal hysterectomy was done, and recovery followed in due time, and marriage as well. I mention this case not to reflect upon the eminent man who gave the advice, but to illustrate the attitude of the Nestors of the profession twenty years ago toward this condition.

We now know that fibroid tumors of the uterus constitute a serious affliction; that they are a frequent cause of sterility; that in many instances they cause miscarriage; that they seriously complicate pregnancy and parturition; that they cause obstruction of the bowel, even producing

strangulation; that they are a frequent source of inflammation; that the tumors themselves undergo all forms of degenerative processes, such as calcareous degeneration, necrosis, edematous infiltration, resulting in general sepsis in some instances and sometimes death. The last is, however, confined quite exclusively to submucous fibroids and usually of the polypoid variety.

M. A. Tate, Cincinnati, O., has collected 39 cases of fibroids complicated by pregnancy, from the literature, and reported 2 which had occurred in his own practice. Analyzing these 41 cases: In 6 the tumor became gangrenous; hemorrhage was a prominent symptom, in that it occurred in 18 cases; 3 polyps were expelled spontaneously; 7 polyps were removed; in 3 cases the polyp was not removed; in 10 cases the labor was normal; in 4 cases labor was difficult; in 2 cases the child had to be destroyed, 1 was a case of turning and the other a breech; in 4 cases the tumor was discovered before, in all of the rest after, labor; 4 cases were reported in which labor set in before time; 2 were at the fifth and 2 at the seventh month. The following were the complications reported: Septicemia, 8; measles, 1; puerperal mania, 1; retained placenta, 4 cases. Treatment mentioned: Cold applications, ergot, iodids, whisky, vinegar, cloths in the uterus, packing of uterus with gauze and removal of tumor. Causes of death: Sepsis, 3; hemorrhage, 3; peritonitis, 1, and collapse, 1, making in all 8 cases. If all of the other cases, including 9 without histories, recovered, there would be 33 recoveries and 8 deaths, a mortality of 19.5 per cent.

While drawing this somewhat melancholy picture of this affliction I am not unmindful of the fact that occasionally fibrous tumors cease to grow and remain stationary for months and years, and even sometimes without any obvious cause decrease in size and even entirely disappear. Such a favorable termination is the rare exception, amounting, as Penrose says, to a medical curiosity.

In addition to the degenerative changes that are likely to occur, frequent and most serious complications of fibroid tumor of the uterus are pyosalpinx and ovarian abscess. The etiological relation between the tumor and the pus formation is not very clear, but the frequency with which this complication occurs in connection with fibroids points to some septic infection from some degenerative process and usually of that part of the tumor lying directly in contact with the lining membrane of the uterus.

Another most annoying and serious symptom or complication of fibroid tumors of the uterus is the frequent menorrhagia or metrorrhagia which not only continues during the years of a woman's life that should be most active and useful, but delays the menopause from five to twenty years, the health meantime being not only impaired but in many instances completely wrecked.

With such dangers more or less imminent in all cases of advanced or large tumors, and with the

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

knowledge that such conditions, with rare exceptions, are destined sooner or later to develop, what should be the attitude of the profession toward this condition, and what advice should we, as doctors or surgeons, give to a woman who presents herself afflicted with one of these growths?

Electricity as an agent for the eradication of the neoplasm or as a factor in retarding the growth of these tumors has proved a disappointment, and the very small percentage of cases in which the tumor has disappeared after the application of electricity would lead us to class them among those rare instances in which spontaneous disappearance occurs. Moreover, the serious complications found at operation in cases previously treated by electricity, such as firm adhesions and disseminated pus pockets, rendering relief by operation increasingly difficult and dangerous, as attested by every operator of much experience in this field, condemns electricity as a harmful agent in the treatment of fibroid tumors of the uterus.

Curetage as a relief from intra-uterine hemorrhage occasionally is successful, but, as a rule, it requires frequent repetition, and in many instances becomes a dangerous procedure from injury done to the tumor encroaching upon the uterine cavity, thus opening a way for infection and degeneration, and leading in some instances to general sepsis and death.

Perhaps the general question involved in the interrogatory of my paper can be best answered by taking up *seriatim* the various classes of cases as they present themselves. And in this consideration let us not forget that there are immediate symptoms to be relieved as well as the saving of the patient from the possible dire experiences that, if left alone, await her.

Probably we are all agreed at the present time that a woman suffering from a fibroid tumor whose size is sufficient to exaggerate her figure and cause discomfort should be relieved of the neoplasm, and that promptly. Whether this operation should sacrifice the uterus or conserve it would depend somewhat upon the age of the patient and the location and character of the tumor. If the patient has reached or passed the menopause, little consideration need be given to the preservation of her generative organs, and a supravaginal hysterectomy being the simpler procedure, or a panhysterectomy, except in case of pedunculated fibroids, is the operation of choice. But in a woman still in the child-bearing period, especially if she has desire for offspring, the operation of choice is myomectomy, even at the expense of greater risk to the patient and in the face of prolonged and tedious operation.

In the second class of cases let us consider a woman ranging from 25 to 40 years of age with a small tumor or tumors varying in size from a hen's egg to a cocoon. What shall we say to her? If she be married, the tumors may be causing sterility; or, if by chance that disability has

been overcome, the increased blood supply to the uterus will nourish the tumors and cause them to grow to a size productive of serious complication at parturition. Shall we, therefore, allow this woman to subject herself to such risks, or shall we, by removal of the tumors, anticipate pregnancy and save her from this calamity?

The answer is obvious and the operation should invariably be myomectomy wherever possible.

The indications for myomectomy increase with experience in dealing with these conditions, and growths that seemed on superficial inspection to be coextensive with the uterus are found in many instances to be limited and suitable for removal without ablating the uterus itself.

In this class we have been considering the young married women. Let us take the unmarried women who have hemorrhage or leucorrhea or dysmenorrhea or intermenstrual pain, and in whom examination reveals the presence of a small fibroid in the uterine wall. The course formerly pursued was to meet the symptoms as best might be, and the advice was to wait and see whether the tumor had a tendency to increase, but under no circumstances was the patient to marry. Within the past year a prominent gynecologist has insisted, before a medical society in this city, that the only course to pursue is the waiting policy, and the only advice to give such a woman is to avoid the married state.

To my mind, such advice is not consonant with the present status of surgical progress. To compel a woman, for the simple reason that she has a fibroid tumor of the uterus, by picturing to her the terrors of what might follow, to give up all the sweet companionship of life that comes from the married state, and condemn her to a life of celibacy, when, perchance, the opportunities for home and family and motherhood might otherwise be hers, is a cruelty for which there is no justification. Myomectomy offers such simple and such perfect relief in the hands of the skilful operator that the manly and only true scientific course to pursue is to advise that woman to submit at once to operation. Many of these tumors can be removed per vaginam, thus avoiding the risks of laparotomy and the unsightly scar, and the subsequent hernia.

Within the past three years I have performed myomectomy per vaginam in four cases, three of which have been reported and published. Of these cases, one had a single fibroid the size of a small orange situated in the posterior wall of the uterus just above the internal os. This was complicated by retrodisplacement of the uterus and extensive adhesions. After making an incision into Douglas' pouch and freeing the adhesions as far as they could be reached, the anterior fornix was opened, the remaining adhesions broken up and the uterus, with tumor, delivered into the vagina. Myomectomy was done, the round ligaments shortened to cure the displacement and the uterus restored to the

pelvis. This operation was done in October, 1899. The symptoms previous to operation had been annoying in the extreme. The patient had been married ten years, one miscarriage nine years ago, no children, painful menstruation twice each month, lasting seven days; constant backache, nervous, irritable and anemic. She was completely relieved by the operation; she is experiencing normal menstruation and considers herself in perfect health. The second case was the wife of a physician and a physical wreck. In this case I removed seven subserous fibroids per vaginam, curetted the uterus, repaired an extensively diseased cervix uteri due to bilateral laceration, shortened the round ligaments to cure retrodisplacement, and restored a lacerated perineum. One advantage of myomectomy per vaginam is the facility offered at the same sitting for multiple operations, as were done in this case. The patient had a smooth and comfortable convalescence, and left the sanatorium for her home, 300 miles from New York, on the nineteenth day after the operation. The third case had three small mural fibroids situated in the anterior wall of the uterus, the latter being in a position of extreme retrodisplacement. The tumors were removed through the anterior vaginal incision and the round ligaments shortened as in the previous cases. The fourth case was a counterpart of the first, the tumor being situated in the posterior wall of the uterus and the uterus retroverted and adherent. The same operation was repeated in this case and the result was satisfactory. From a thin, anemic, neurotic young woman afflicted with indigestion and insomnia the patient became a picture of health.

No doubt all of these myomectomies could have been done by laparotomy, but they could not have been done with so great safety to the patients, both immediate and remote, nor could the attendant complications have been dealt with so easily. In young women, especially unmarried women, for obvious reasons, the vaginal method is greatly to be preferred.

But if the tumors are too large to be handled even by morcellation through the vagina, laparotomy will afford facilities for their enucleation, leaving a functioning uterus, and a mind unclouded by a consciousness of mutilation.

The fourth class is one which requires perhaps the nicest judgment of all the conditions with which the surgeon is called upon to meet, viz.—cases of fibroid tumor of the uterus complicated by pregnancy. Here several courses are open to the operator. First, if the case is not too far advanced he can bring on a miscarriage and relieve the uterus of its contents, thus removing the complication and preparing the field for such treatment as might then be indicated. Secondly, the immediate operation of myomectomy is open for performance, leaving the uterus and its contents intact. Many instances have been reported where the patient has gone to full term and

been delivered of a living child. But the woman who submits to this procedure has to face the danger of subsequent miscarriage. The third course is to allow the patient to go to full term, with the understanding that if dystocia occurs Cesarean section may be performed and a living child secured.

To my mind, the dangers of this condition have been somewhat exaggerated. In my early experience as a physician I attended in confinement many colored women who harbored fibroid tumors, and in no one of them did anything more serious occur during delivery than a delayed expression of the placenta.

Within the past year I have had a patient under my care who had formerly had a fibroid tumor of the uterus complicated by pregnancy. She was advised to go to full term and submit to a Cesarean section, which she did and secured a living child. Myomectomy was performed at the same time and she still retains her uterus. While this patient was under my observation for other cause than that under discussion, a patient was referred to me who was suffering from a fibroid tumor complicated by pregnancy, advanced to about the fourth month. While the main body of the uterus had risen above the rim of the pelvis, the tumor itself was caught under the promontory of the sacrum and resisted all effort to elevate it into the abdominal cavity. The desire for offspring was so strong in both the woman and her husband that they were ready to take any risk to secure a living child, but wanted to do it in the least dangerous and most certain way. After considering all the consequences in the case, my advice was to allow pregnancy to go to full term, and to prepare for the probable performance of Cesarean section. To this they finally consented, but when the allotted time had expired labor pains came on and the child was delivered naturally.

To sum up the situation, then, the proper treatment for fibroid tumor of the uterus, speaking in a broad way, is removal by operation, and that, too, immediately, whether the tumor be large or whether it be small, whether it be in a married woman or in a single woman, excepting from this rule only women of very advanced years, and those in which the tumor is complicated by pregnancy. In the last the course to pursue will depend largely upon the circumstances and conditions of the individual patient. As a rule, however, I believe that the majority of cases of fibroid tumor of the uterus complicated by pregnancy will go to full term and be delivered normally. In the hands of an expert Cesarean section at full term is safer for mother and child than myomectomy during gestation in the rare instances in which such an extremity is required. I mean that it is better to take the risk of such a procedure, the necessity of which is very remote, than to destroy the child by inducing miscarriage or taking the risks of myomectomy.

DISCUSSION.

Dr. E. D. Ferguson, of Troy, said he had nothing to say except in the way of commendation of the advice given in the paper as to the course which should be followed in case of fibroids. There was still room for an honest difference of opinion with regard to the extent to which myomectomy was to be applied. No doubt in those patients who were extremely desirous of having children, and in those in whom the tumors could be readily enucleated, the operation was appropriate, nevertheless those who had seen these operations and had noted the difficulty of enucleating all the tumors, would be inclined to hesitate to decide in favor of myomectomy. He would admit also that fibroids do disappear. Only two or three years ago he had been called to see a pregnant woman, who had miscarried because of the presence of a fibroid tumor in the anterior wall of the uterus. The question arose as to whether operative interference should be instituted at that time—either the induction of premature labor or any other operation. He had been thoroughly convinced of the wisdom of waiting in such cases, because he had noted natural delivery in too many cases of large fibroid tumors. In this case he favored postponing operation until after delivery. The tumor absolutely disappeared. It should not be inferred, however, that this was the rule. Ordinarily the operation should be done rather than wait for such an unusual result.

Dr. Frederick Holme Wiggin, of New York, said he would like to emphasize the last part of Dr. Ferguson's remarks as to the necessity for operating even when these tumors were causing no great discomfort. In his own experience he had met with several cases in which apparently fibroid tumors which had been allowed to remain had resulted in carcinoma of the ovary and of the whole omentum. He agreed with the views of the reader of the paper almost entirely. He was of the opinion that the mechanical injury arising from a tumor of considerable size, when allowed to remain, may lead to malignant disease. As the patient grew older these tumors became hard from calcification. He had found it possible to remove even very large fibroid tumors—one of twenty pounds and one of sixteen pounds—by myomectomy. In these cases this form of operation had been selected because of the feeble condition of the patients. A large incision had been made and the tumor rapidly shelled out and the vessels clamped and cut, and ligated after the removal of the tumor. Only a few deep sutures were required to close the wound in the uterus after which the peritoneum was brought together over the line of the incision.

Dr. R. H. Gibbons said that whether one should operate during pregnancy depended largely upon the location of the growth. If it were situated low down in the uterus and was liable to interfere with the birth of the child, of course operation should be done at once. On the other hand, if a tumor in any situation was not likely to interfere with birth the operation should not be done. A case had been reported a few years ago by Dr. J. Duncan Emmet, from the Woman's Hospital. He had seen at least a dozen cases in which malignant degeneration had occurred, as referred to by Dr. Wiggin.

Dr. Goffe, in closing the discussion, said that no one could tell with certainty in a given case how many nuclei were present. Dr. McCosh had reported a case in which he had removed about thirty tumors, large and small, and had secured an excellent result. Therefore, we should not hesitate to do myomectomy because of uncertainty that every focus could be removed. If it is possible to remove all the palpable tumors and still retain a respectable semblance of a uterus, this should be done, even if some nuclei are left behind. If they develop subsequently, remove them.

URETHRAL STRICTURE—REMARKS INTRODUCTORY TO A DISCUSSION ON ITS MODERN TREATMENT.¹

BY J. W. S. GOULEY, M.D.

THE following remarks may well be premised by the statement that urethral strictures are now of less frequent occurrence than they were thirty years ago. This utterance will not seem strange if the modes of treatment of urethritis employed up to forty years ago and the improved methods of the last twenty years be contrasted. The so-called abortive treatment of acute urethritis by the injection of 6 or 8 per cent. solutions of silver nitrate was a prolific cause of stricture, as was also the use, or, rather, abuse, of other caustic injections, such as strong solutions of mercuric chloride or of zinc chloride, which excited a superabundant epithelial exfoliation and increased the extent of the acute phlegmasia even to the spongy substance of the canal. Realization of the evils of these rash procedures brought about a radical change in treatment. Injections were given up for the adoption of the oral administration, in very large doses, of *copaiba* or of *cubeb*s, designed to act through the urine. This large dosage was often detrimental to the kidneys and generally failed to fulfil the promise of rapid relief; the urethritis becoming chronic and confirmed stricture ensuing. All that need be said of the more modern treatment of urethritis is that it has insured a quicker cure without doing violence to the mucous membrane or to its underlying tissues, and therefore has been, in great measure, preventive of stricture. However, there are still very many cases of obstructed urination, due to neglect or to the heroic treatment of urethritis (the patients often treating their own cases), to occupy much of the time and attention of the physician and to demand of him an abundant supply of bougies and other needful instruments.

Very narrow strictures—the so-called impassable—also are of less frequent occurrence than formerly, and rupture of the urethra, behind a stricture, followed by infiltration of urine in the ambient connective tissue, is rarely met with in our days. The comparative rarity of these grave conditions is accounted for by the fact that, for some years past, strictures have been more commonly treated during their formative stage. The value of early prophylactic treatment needs no further comment.

The rational treatment of urethral stricture must be based upon a correct appreciation of the general physical condition of the patient, of the cause, duration and nature of the disease, of the form, site and degree of the constriction, and of existing complications, besides a thorough familiarity with the mechanism and care of the necessary instruments. Therefore, the physician should lay no absolute rule for the management of his cases, but be guided by the knowledge he

¹Read before a meeting of the New York County Medical Association, December 15, 1902.

has acquired in the observation of the phases of the complaint. This surely will lead him to a proper discrimination in his choice of treatment in the difficult cases, while in the ordinary cases he will find dilatation to be a safe and certain measure. The main objects, then, of these remarks are to recall attention to the well-tested methods of dilatation employed so successfully in the relief of sufferers from urethral stricture, and to the indication of other modes of treatment when dilatation is not practicable.

The many monographs on stricture, published from 1840 to 1870, particularly those of the great Scotch surgeon, James Syme, seem to have given rise, among young operators, to the stricture-cutting mania, with attendant delirium of numbers, which was so prevalent for about twenty years, but which, fortunately, lessened in intensity, until even the tyros in surgery ceased boasting of their annual hundred urethrotomies. This urethra-cutting madness had led also to division of the meatus to the point of hypospadias for the purpose of frequently and excessively distending, with enormous steel sounds, the whole urethra, which soon lost its suppleness and at length became indurated and leathery, subserving no better purpose than that of an unyielding canal reminding of a decayed India-rubber tube. These extreme measures were at last forsworn because experience proved them to be worse than useless and also because of a better knowledge of the minute anatomy of the urethra and of the nature of its morbid states. It was the apparently slow process of dilatation as well as the common reports of failure of other modes of treatment that had led heroic beginners to indiscriminate and unduly frequent urethra-cutting, and it was not until they had learned how little, if any, time was to be gained through a bloody procedure, and had felt the absolute necessity of using dilators, as the after-treatment, for many months following the incisive operation, that they strove to re-instate the too much neglected simple process of dilatation so well suited to the majority of cases. They had then realized that no single method of treatment was applicable to all cases, and, furthermore, that the decision of the important question of indication of a particular method must be based upon mature experience and sound judgment.

A short rehearsal of the adaptation of special modes of treatment in different varieties of strictures seated in the balanic, phallic, scrotal and perineal regions of the urethra will suffice for the purposes of these remarks.

1. Strictures at the meatus and in the balanic region, being ordinarily dense and refractory to dilatation, require incision.

2. Strictures in the phallic region that are of long standing, indurated, resilient, refractory to dilatation require internal incision.

3. Strictures in the scrotal region that are narrow, indurated, resilient and refractory to dilatation require internal incision.

4. Strictures complicated with false routes that render catheterism difficult and dangerous ordinarily require internal incision when seated in the phallic or in the scrotal region, and external incision when in the perineal region.

5. Strictures in the perineal region that are narrow, indurated, resilient and refractory to dilatation or to divulsion require external incision.

6. Strictures in the perineal region that are narrow, and complicated with fistulæ and extra urethral inodular masses, require external incision.

7. Strictures in the perineal region, complicated with abscess formation or with extravasation of urine, require immediate external incision.

8. Traumatic strictures in the perineal region require early external incision.

9. Laceration of the urethra from perineal injury, being a stricture in embryo, requires immediate external incision.

10. All other urethral strictures are generally amenable to dilatation or, at least, to divulsion.

Strictures in regions of the urethra heretofore exempt from this affection are likely to occur with more or less frequency, now that enucleating and cauterizing operations upon the prostate are so commonly performed. The site of constriction in the one case will then be the membrano-prostatic junction, and its cause the severance of the membranous urethra from the prostate when undue force is used in enucleating masses of diseased prostatic glands. In the other case the site of the stricture may be at the urethro-vesical junction or wherever else in the urethra electro-cauterization may destroy enough tissue to leave a progressively contracting scar.

The great majority of strictures being amenable to the milder measures of treatment, it may be well now to summarize the principal modes of dilatation, to wit: 1, gradual; 2, continuous, and 3, rapid dilatation.

1. *Gradual dilatation* is indicated in the formative stage of strictures due to urethral phlegmasia (which is rightly regarded as a stricture *in posse*); in fully formed strictures that bear the expansion made with the aid of an olivary bougie or a conical sound introduced slowly and gently by a light hand; in those that have been rapidly dilated or divulsed to a certain, but not sufficient, extent, this gradual expansion serving as after-treatment to these processes when it is not judged wise to carry them beyond safe limits; and, it may be added, in long-neglected cases with involvement of the upper urinary passages when a bloody operation would be likely to prove fatal. In such cases the object of the dilatation is only to relieve suffering or prolong life.

This dilatation is ordinarily effected by the cautious introduction of duly sterilized soft olivary bougies, and later of conical steel sounds. The seat and caliber of the stricture having been

ascertained by the use of an acorn-tipped soft explorer, a flexible olivary bougie, one size larger in its shaft than the base of the explorer's acorn, is well lubricated and slowly introduced, until it reaches the bladder, and at once withdrawn. In two days the operation is repeated with a bougie one size larger, and so every second day the process of dilatation is renewed until No. 12 or 13 (English scale) is reached; after this it is best to use conical steel sounds whose introduction, by a skilled operator, gives less pain than that of the larger-sized soft bougies.

When it is desirable to overdilate the strictured part of the urethra, the extent of such distension is determined by the ascertained caliber of the normal parts of the canal in each case, for the urethral caliber is as variable in different individuals as are the form and dimensions of the other organs of man's body. If the normal diameter of a urethra be eight millimeters, the strictured part may be safely distended to ten millimeters and a half, and if, in another case, this diameter be six millimeters and a half, then the distension of the strictured part need not exceed eight millimeters. It should be remembered that the restoration, as nearly as possible, of the urethral suppleness is as essential as the dilatation of the diseased part. Extreme overdilatation and unduly frequent catheterism with very large instruments not only defeat the precious object of restoring the wonted suppleness, but cause a sclerotic change in the urethral structure destructive of its elasticity. This extreme overdilatation, so often practiced of late years, cannot be too strongly condemned.

In its early stages, stricture due to urethritis may be cured permanently in a few months by the simple process of gradual dilatation, but in the case of a confirmed, callous stricture many months, or even years, of the persistent use of dilating instruments will be required to maintain the effected calibration, no matter what may have been the nature of the treatment employed to secure the needed calibration of the canal. Such has been the experience of many physicians who have had much to do with sufferers from stricture of the urethra.

2. *Continuous dilatation* is indicated in cases of narrow strictures that are unyielding to ordinary dilators and threaten retention of urine. The term continuous dilatation is used partly to express the idea of the action of a soft bougie or catheter retained in the urethra, the presence of the instrument for from a few hours to one or two days having the effect of softening the stricture and of rendering it sufficiently expansible to permit its further dilatation with ordinary bougies, or to admit the shaft of a divulsor or the concealed blade of a urethrotome, and so facilitate its divulsion or its incision. This process is, therefore, only a preparatory step to gradual dilatation, to rapid dilatation, to divulsion or to urethrotomy, and should not be employed longer than two or three days, otherwise urethral ulcer-

ations and other untoward effects may be expected. The continuous dilatation of narrow strictures is ordinarily effected with safety by observing the following directions: A bougie or catheter only a little smaller than the lumen of the stricture is passed and retained in position six or eight hours. It is then withdrawn and another slightly larger substituted and retained six or eight hours, and so until three or four such changes have been made. The moment the stricture begins to yield, the operator proceeds with further dilatation, or with whatever other mode of relief his judgment may dictate. In case, however, the stricture is refractory to this continuous dilatation in the first twenty-four hours, a gum catheter is passed and retained undisturbed for forty-eight hours, at the end of which time, as a general rule, the obstruction will be permeable to such instruments as may be required.

3. *Rapid dilatation* is indicated in those narrow strictures that threaten to cause retention of urine. By rapid dilatation of a stricture the writer means the expansion of the constricted part of the urethra to two, three or four numbers of the catheter scale at one sitting. For instance, if the stricture first admit a No. 1 bougie, this is succeeded by Nos. 2, 3, 4, and at the next sitting, in two days, Nos. 6, 7, 8, and so at each subsequent sitting Nos. 9, 10, then 11 and 12, when the after-treatment begins with the process of gradual further expansion to the end of restoring the right caliber and the wonted suppleness of the urethra. There are, however, cases whose urgency demands still more rapid dilatation during the first sitting. They are those in which retention of the urine already exists and requires immediate relief. It is then necessary to dilate or, perhaps, divulse* the stricture to No. 10 or 12, so as to enable the operator to introduce a catheter of sufficient size to drain (slowly) and cleanse the bladder. Some of those strictures are so narrow as to admit a bougie of only a millimeter or of even less than a millimeter in diameter. In such cases a safe method of dilatation is by means of the tunneled sound for which the bougie (of whalebone) serves as a guide threaded through the short canal at the extremity of the sound. This mode of catheterism upon a conductor, devised in 1864 by the writer, is often the only procedure that can be safely employed for passing eccentric strictures or those complicated with false routes.

A method of rapid dilatation of strictures that are not extremely narrow, but that resist the expansive action of bougies or sounds, was sug-

*The writer has said next to nothing of divulsion as a primary operation because he has long believed that this divulsing of strictures is, and should be, only the extension of the process of dilatation of dense constrictions which are split longitudinally when a conical sound is wedged in their tract. When bleeding follows the process of rapid dilatation, by a skilled operator, the presumption is strong that longitudinal divulsion has occurred, and the easy passage of a larger instrument may be expected. The writer does not favor the violent modes of divulsion such as those effected by means of the instruments of Holt and others.

gested by Mercier, and consists in the wedging of an olivary bougie or a conical sound as far as possible in the tract of the constriction, then of passing a slightly smaller bougie or sound to be followed by a third two sizes larger, and this to be succeeded by a fourth one size smaller than the last, and continuing the process until the stricture is fairly dilated. The passage of six or eight instruments in rapid succession is often necessary to effect the desired dilatation at the one sitting. Every two or three days thereafter this dilating process is repeated until the constriction becomes tolerant and yields to the action of ordinary dilators. This truly conservative method of treatment has often been the means of avoiding bloody operations. It should, of course, be followed by the periodical use of dilating instruments with the intent of maintaining the established calibration of the urethral canal. It is almost needless to say that an appropriate medical treatment of sufferers from urethral stricture should accompany the surgical treatment. Periodical dilating catheterism is essential to the maintenance of the restored urethral caliber not only after gradual dilatation, but after divulsion and urethrotomy; at first, once a week, then every two weeks, and, finally, every four weeks, for many months or years, according to the character of the original lesion. Those who have studied the Celsian rules, reiterated by teachers down to our time, for the introduction of the catheter, know how easy the operation is in simple cases, how extremely difficult in other cases and what serious injury is done to the urethra when these rules are violated.

The late Prof. S. D. Gross was among those great teachers who regarded urethral catheterism as "one of the nicest and most delicate processes in surgery." . . . "It is true," he said, "the most untutored and awkward surgeon may occasionally, nay, perhaps not unfrequently, reach the bladder without difficulty; but let such an individual attempt the passage of the instrument when there is some mechanical obstacle, as a stricture or an enlarged prostate, and he will be sure to be foiled. The moment the catheter is arrested, he becomes bewildered; his hand trembles, dismay is depicted in every feature, large drops of sweat stand upon his brow and his whole frame is paralyzed. If, under these circumstances, he proceed, he will inflict severe suffering upon his patient, if not actually endanger his life."

Dr. Marcus K. Goldsmith, a member of the New York State Medical Association, died at his home, 1704 Lexington avenue, on January 16, 1903. Dr. Goldsmith was born in Frankfort, Germany, March 19, 1847. He graduated in medicine from the medical department of the New York University in the year 1885. The cause of Dr. Goldsmith's death was the result of an infection received while dressing a surgical case.

EXTERNAL PERINEAL URETHROTOMY.¹

BY DR. PARKER SYMS.

I FEEL it a great honor to be permitted to take part in this discussion which has been introduced by my distinguished friend and teacher, for it is eminently to Dr. Gouley that surgery is indebted for the modern treatment of urethral stricture.

Perineal urethrotomy should always be done by the open or external method, this being the safest mode of procedure because the open wound affords the needed drainage and makes it possible to control hemorrhage and to avoid urinary infiltration and infection.

This operation should be employed for the following conditions:

- (1) Rupture of the urethra.
- (2) Intractable stricture.
- (3) Impassable stricture with retention of urine.
- (4) Stricture with false passages.
- (5) Strictures with urinary extravasation.
- (6) Strictures with abscesses or fistulæ.

And it may be the operation of choice in milder cases of deep-seated strictures, for permanent cure may result from urethrotomy, but not from dilatation.

In case of rupture of the urethra, as soon as diagnosis is made external perineal urethrotomy should be performed.

If possible this should be done before the patient has attempted to urinate, and no catheterism or instrumentation should be employed except as a part of the operation. The act of urinating through a torn urethra is very liable to result in urinary extravasation; and the attempt to pass an instrument through a ruptured urethra is liable to produce further laceration and false passages. Even should it be possible for the patient to voluntarily void urine through a ruptured urethra or for a surgeon to pass a catheter through the same, an external incision should at once be made for the purpose of repairing the injury and of draining the bladder and the wound.

In cases of intractable or complicated stricture, as enumerated above, this operation should be performed because it is the most reliable and the safest method of treatment. In cases of impassable stricture with retention of urine, it is safer than aspiration or puncture of the bladder, and, of course, it is radical and curative.

External perineal urethrotomy with a guide is a very easy operation, but when a guide cannot be passed it is often a most tedious and most difficult one.

The operation.—Shave the pubic region and perineum and thoroughly scrub and disinfect the entire region. Irrigate the urethra with boric acid solution. Use a watery solution of green

¹Read before the New York County Medical Association, December 15, 1902.

soap as the only lubricant. Make careful attempt to introduce a Gouley whalebone bougie into the bladder, and, if successful, introduce on it a Gouley tunneled-grooved catheter. Place the patient in the lithotomy position, with the catheter or staff held firmly in the median line by the assistant who holds up the scrotum. Make a free incision in the median line of the perineum from the base of the scrotum to within half an inch of the anus. This incision should go through the skin and superficial fascia. Carefully locate the guide and continue the dissection with clean sweeps of the knife, always in the median line, until the urethra is reached and recognized. Open the urethra just in front of the stricture, introduce a narrow bistoury on the guide and thoroughly divide the stricture and a short portion of the urethra behind the stricture. Now introduce a large catheter through the wound into the bladder, which should now be emptied and irrigated.

Divide the meatus to the full size, and with a urethrotome cut all anterior strictures. Pass a full-sized sound through the entire urethra into the bladder and be sure that its passage is easy and unobstructed. Thoroughly irrigate the urethra, bladder and wound. Fasten a full-sized rubber perineal drainage tube in the bladder, passed through the wound. Thoroughly pack the wound around the catheter with iodoform gauze. Cover the whole with an ample sterile gauze dressing secured in place by means of a T bandage.

If a guide cannot be passed, introduce a staff or sound to the stricture, and on it open the urethra in front of the stricture. Put a silk loop suture on each side of the urethra for retractors and guides. With wound and urethra held well open, search for the opening through the stricture with a small probe or filamore bougie. The opening is always there, but it may take great patience and skill to find it. When found, introduce a tunneled catheter or grooved director into the bladder and then divide the stricture and complete the operation as described above.

These wounds should never be closed by suture; the only instances in which any sewing should be done are cases of complete rupture of the urethra, and in those instances it is safer to close but the upper part of the urethral wound and to drain the bladder and the perineal wound as in other cases.

After-treatment.—When the patient is in bed again, thoroughly wash the bladder with boric solution through the perineal tube. To this drain attach a long rubber tube, the end of which must be kept submerged in a disinfectant solution, and continuous drainage should be kept up by this means for three to five days. Remove the gauze packing at the end of twenty-four hours and repack the wound very lightly. Remove the perineal drain at the latest on the fifth day and at that time pass a full-sized sound through the entire urethra. During the healing of the wound

a sound should be passed at regular intervals, at first every third day; finally, the interval may be lengthened to once a month. When the tube is first removed from the bladder the patient may not urinate voluntarily, and it may be necessary to catheterize him a few times. This should be done through the perineal wound. During the healing the wound should be packed very lightly, only so much as to provide against pocketing or retention of discharge. The patient may safely be allowed to sit up as soon as the perineal drain is removed. Healing of the wound should take place in from two to four weeks.

There has been much discussion as to whether permanent cure ensues from urethrotomy. The experience of the author has been that it is to be expected, many cases showing no recontraction after long intervals. The author confidently asserts that contraction will never take place as a result of the operation, for not one of his cases of perineal prostatectomy has shown the slightest tendency to contraction. That operation as done by him is practically a classic perineal external urethrotomy, but in many of the cases there is very extensive incision or laceration of the floor of the urethra, sometimes extending throughout its membranous and prostatic portions.

It is for this reason that the author asserts that this operation may be the treatment of choice in cases of deep-seated stricture, even though they might be amenable to gradual dilatation, for it must be borne in mind that dilatation of strictures never results in a permanent cure, but must be continued at longer or shorter intervals throughout the remainder of the patient's life.

Perineal external urethrotomy is to-day a very safe procedure. It should and may be done antiseptically, but it cannot be done aseptically, for the urethra can never be disinfected. Like all operations in such regions, the open wound properly treated is the great safeguard as far as infection is concerned. There are many cases in very susceptible individuals where every attempt at catheterism or dilatation will result in more or less infection, as evidenced by chill and fever. In these cases it is far safer to perform external urethrotomy than it is to persist in attempts at instrumentation.

In closing, the author would like to mention one other condition in which external perineal urethrotomy is the proper and safest procedure. He refers to those emergency cases of sudden, complete retention due to prostatic obstruction in which unwise instrumentation has been attempted and has resulted in laceration of the urethra with false passage, as evidenced by hemorrhage from the urethra, and in which the surgeon finds it impossible to readily pass the catheter into the bladder. In such cases do not puncture the bladder as a means of temporary relief, but perform your perineal external urethrotomy as a preliminary operation and do the perineal prostatectomy as soon as the patient has acquired sufficient rest and strength.

INTERNAL URETHROTOMY.¹

BY LUCIUS W. HOTCHKISS, M.D.,

New York.

WITH a clearer understanding of the pathology of urethral stricture there comes a sharper differentiation between the inflammatory and the organic variety, and a consequent diminution in the number of cases considered as suitable for the operation of internal urethrotomy. Under these conditions one ought, perhaps, to be better able to estimate the true value of the operation, and recognize more clearly the indications for its performance.

Since organic stricture may be found in any part of the urethra, it is clear that the operation in each case should depend upon its location, as well as upon its character, extent and caliber; so that an operation appropriate in one case might be a highly inappropriate procedure in another.

Strictures at or near the meatus are best divided upon the floor of the canal by means of a long-bladed, blunt-pointed, straight bistoury, and under the guidance of the sight as well as of the sense of touch.

The deeper strictures in the penile portion require a much more elaborate instrument for their division, and the needs of these cases have led to the production of the various forms of internal urethrotomes. The instruments which are best known and most used are those of Maissonneuve and Otis, and most of the others in use are modifications of these.

Theoretically at least, a stricture should be most accurately and completely divided when, after careful location, it is put upon the stretch and its fibers severed by a keen blade. Practically this has been sufficiently well demonstrated in the case of the Otis instrument. The Maissonneuve urethrotome is suitable for cutting the tighter strictures which will admit only of the passage of an instrument the size of its long filiform guide. The dilating urethrotome of Otis, however, which, when closed, has the circumference of a 20 French sound, finds its field in strictures of somewhat larger caliber, and in the hands of many surgeons serves also as a proper instrument to complete an operation begun by the Maissonneuve.

In the Maissonneuve urethrotome the blade is pushed along the groove in the upper surface of the guide from before backward in such manner as to divide along the roof of the urethra any obstructions which may impede its passage. The Otis dilating urethrotome, on the other hand, is first introduced after carefully locating the points of stricture and, dealing with these separately, the blade concealed near the tip is pulled from behind forward through the stricture, held tense by the dilating arms of the instrument. The French urethrotome serves to open a passage through a

much contracted urethra, but cannot be relied upon always to more than partially divide the strictures. The Otis instrument, on the other hand, when properly used, is an instrument of precision, and one which will cut through strictures at definite points previously located, accurately and completely.

In this brief discussion of the subject of internal urethrotomy the writer assumes that he is dealing with cases of true fibrous stricture, which, for various reasons, are deemed unsuitable for dilatation. Such cases present themselves constantly in our hospital wards and are familiar to every surgeon. In these the passage of the sound may be followed by an intense reaction, retention, chills, fever and great depression, or may even prove fatal. The operation of dilating internal urethrotomy, as perfected by the late Fessenden N. Otis, rests upon the ability of the surgeon to definitely locate the stricture or strictures by means of a bulbous bougie or urethrometer, and, having clearly defined and noted their position, number and size, to completely divide them by means of the Otis dilating urethrotome. This instrument is too well known to need a detailed description, and is regarded by those who have used it most as entirely reliable and fully capable in skilled hands of accomplishing the purpose for which it was designed.

Whatever opinion we may now hold as to the existence of any definite relationship between the circumference of the penis and the caliber of the urethra, the fact remains that the claims of Otis in this regard have pretty clearly demonstrated that the size of the normal, healthy male urethra is considerably larger than was generally admitted or believed.

It has been claimed, and very properly, too, that the urethrotome is a dangerous instrument. This is equally true of the steel sound or any rigid instrument in careless hands.

The operation of internal urethrotomy, however, presupposes a moderate intelligence on the part of the operator, good judgment, and a reasonably well-trained touch. Under these conditions it may easily be performed by any one who can appreciate its uses, its limitations, its dangers and its results, and who will take the pains to make it what it should be, viz., an operation of precision.

It has always been the practice of the writer to exercise the greatest care in the definite location of the strictures to be dealt with, and then to cut each one as completely as possible with the Otis dilating urethrotome. In this operation, care, patience and accuracy make for the good of the patient and the ultimate success of the case. When the stricture is located at a point beyond four and a half or five inches from the meatus—that is, in the region of the bulb—it is his almost invariable practice to add as a measure of precaution the operation of perineal cystotomy, which can be quickly and easily performed. In deep strictures, also, it has been found practica-

¹Read before the New York County Medical Association, December 15, 1902.

ble, with the aid of the perineal cystotomy opening, to divide all or a greater part of the strictures from within and upon the roof of the urethra by means of an Otis urethrotome introduced through the meatus and out of the perineal opening.

When a stricture is too small to admit the Otis instrument the guide of a Maissonneuve is first passed through the stricture and then screwed on to the urethrotome which follows it into the bladder, and the passage is further widened by pushing the smaller blade of the instrument along the groove in its upper surface. After this, the partially divided strictures which have been previously located are completely divided by the Otis urethrotome, and, as far as possible, the full caliber of the urethra is restored.

It may be argued by some of you that the addition of a perineal cystotomy wound in the class of cases to which I have alluded is unnecessary and dangerous, but to one who has seen a fatal result follow so simple an operation as internal urethrotomy, its usefulness and necessity will be obvious.

Although fully aware that in the practice of the modern French school, bladder drainage by means of the tied-in catheter seems efficient, it represents simply a different means to the same end, and the question then arises as to the relative value of the two procedures.

The bulbo-membranous portion of the urethra may well be considered a dangerous area, in that it occupies a dead point as regards natural drainage, under the conditions involved in the internal division of strictures in this region.

When strictures lying within this area are treated by internal urethrotomy the same conditions which are present in any undrained and infected dead space may obtain and disastrous results follow. Upon general surgical principles, all dead spaces which cannot be obliterated or safely allowed to fill with the aseptic blood clot had best be drained.

Aseptic healing under the blood clot is manifestly impossible, in most internal urethrotomy wounds involving the deeper parts of the urethra; inasmuch as in most of these cases the surgeon has also to deal with an infected bladder. The rational alternative, then, when deliberate external urethrotomy is not done, is to make a perineal cystotomy, drain the bladder with a tube for a few days and then allow this wound to heal. When granulation shall have been well established, or about the fifth day, a sound may be passed through the anterior urethra down to the tube, the urethra washed out, and the bladder drainage tube withdrawn, unless special indications exist for its longer maintenance.

By means also of the perineal wound, frequent irrigations through the anterior urethra may be practiced when this seems necessary. After the first passage of a large sound, the operation is repeated every third day until all bleeding ceases

and the urethral wounds are covered in by a new epithelium.

It has been the writer's privilege to examine a few of his cases treated by this method, after a lapse of several years, and it has been gratifying to note, in some of them at least, no recontraction of the stricture. The results indeed are often astonishingly good in the class of cases where radical cure is believed by many to be unattainable.

Various complications may arise after internal urethrotomy. The principal ones are hemorrhage, sepsis, reflex urinary suppression, and, later, distortions of the penis, due to infiltration about the seat of operation. Hemorrhage is liable to occur in any case, and may be serious or not. It can generally be easily controlled by pressure, and when the blood does not force its way back into the bladder and distend that viscus with clots, it may not call for very radical measures. In the last event, however, prompt perineal cystotomy may be necessary to save life. Most of the distortions disappear within a few weeks or a few months; some are avoidable and some are not, though it is probable that too extensive cutting through and beyond the stricture may be responsible for many of them.

Although the field of operation in these cases is not aseptic, every effort should be made to work with sterile instruments and clean hands; and, recognizing the possible danger from hemorrhage in the deeper operations, no hesitancy should be felt in performing primary perineal cystotomy as a precautionary measure in all cases where the dangerous area of the urethra is invaded.

It may be claimed that this operation adds the danger of a possible perineal fistula. To this, reply might be made that where the caliber of anterior urethra has been thoroughly restored, by complete division of its strictures, this is a negligible factor. If the bladder drainage tube is not left in too long, the perineal wound heals, as a rule, with the greatest promptness, it being difficult sometimes to keep it open as long as one would wish.

To those who look upon internal urethrotomy merely as a means to a later and continued dilatation of partially divided strictures, the claim that the operation may in any case be curative sounds preposterous, and to these the writer can only recommend a careful study of the work and results of the elder Otis and his followers.

Inasmuch as one is apt to be guided by one's own experience, the writer feels no hesitancy in maintaining that a well-planned and well-executed dilating internal urethrotomy is often followed by permanent results as regards recontraction, and that many even of the deeper urethral strictures which are ordinarily treated by external urethrotomy may be well and safely treated by the method of dilating internal urethrotomy combined with perineal cystotomy for drainage.

DISCUSSION.

Dr. Joseph D. Bryant said that urethral stricture seems to be a much less frequent sequel of specific urethral inflammation than formerly; also other common sequels of this form of disease appear less often and are obviously less severe than during a comparatively recent period. And, too, it sometimes seems as though they yielded to treatment more readily than they did fifteen and twenty years ago. He believes that it will be admitted without much cavil that the causal differences of this distress, especially relating to both inclination and opportunity, cannot be regarded as exercising any practical influence in securing these changes for the better. It is much the wiser to regard these improvements as the outcome of the prompter, more vigorous and better therapeutics of recent times than to any other definite cause. It has not been his practice to divide the meatus except when required for the purpose of the better introduction of suitable-sized instruments for dilatation or for localized medication. Quite early in the beginning of the period of too indiscriminate and free internal urethrotomy for cure of stricture. He experienced in a simple case severe and troublesome hemorrhage, the control of which invested the case with a far greater degree of danger to the patient and embarrassment to the surgeon than many such of an apparently similar nature had done in the past, when treated by the simpler method. In still later time he had been thankful for this case of so suggestive experience. It should be kept clearly in view, however, that aseptic internal division is safer in obstinate stricture than the treatment by dilatation as ordinarily practiced, for the latter, unless employed with scrupulous aseptic care by the physician himself, is soon followed by infectious cystitis. The plan of instructing the patients in the use of the sound for occasional introduction to maintain the completed dilatation gained by the surgeon is fraught with much danger, no matter how intelligent and trustworthy the patient may be.

Dr. John F. Erdmann thought the Oberlaender and Kohlman instruments afforded a more convenient and less painful method of dilating strictures than the use of sounds or bougies. Where difficulty was encountered in passing a stricture, it was exceedingly useful to give a patient a hot bath for fifteen to thirty minutes before. In the operation of external perineal urethrotomy without a guide he advised the use of the wide dissection recommended by Dr. Bolton, in which the patient is placed in the reversed Trendelenberg position and then the incision of Zuckerkandel is made.

Dr. E. L. Keyes, Jr., said that in the few cases in which he had been compelled to do external perineal urethrotomy without a guide he had found it very important to make use of a wide incision. By making a large external incision and cutting down upon the urethra external to the stricture, fastening two stout silk threads on either side, and splitting it up until the face of the stricture was reached, it was comparatively easy to find the opening and complete the operation. The free incision recommended by the last speaker most certainly proved useful, yet it seemed to him an unnecessarily free dissection. The use of urotropin seemed to him exceedingly valuable in these cases.

Dr. Ferd. C. Valentine said that we have heard a truly scientific symposium on the various treatments of urethral stricture. It was by men of justly acknowledged eminence in the profession. He could therefore but hope to add emphasis to the value of the non-operative treatment of stricture. This was done, not theoretically, but upon experience, which it would be false modesty to call small.

However, before offering his views upon the non-operative treatment, he asked indulgence for a brief consideration of the conditions which imperatively require operative intervention.

These are traumatic strictures in which the urethra has been crushed, resulting in masses of cicatricial tissue, with vesical infection, that demand prompt treatment; also when there are growths or foreign

bodies in the bladder which require care at once. In addition to these there are the urethral and renal causes (among them growths, foreign bodies) which cannot wait until the urethra is sufficiently dilated to permit cystoscopic treatment. In this connection, too, we must keep in mind prostatic involvements when they have become too urgent to brook delay. In these it must be conceded that internal or external urethrotomy, or both, may become an inevitable procedure.

But these are the minority of the cases. The majority, in the light of his experience, are amenable to the non-operative, or, to be in fashion now, the bloodless treatment.

Least the very many cases which he cut, up to about eighteen years ago, be pointed out to contravene his statements, he would say that since then he had subjected but very few men to the operation. Among these one case is as recent as four years ago. The patient was a busy surgeon residing in another city, whose large number of capital operations prevented his devoting time to the dilations his urethra required. The day was set for his marriage and the presence of a stricture in the posterior third of his pendulous portion grew to be an obsession to him. He insisted upon internal urethrotomy, which was done by the speaker with the agreement that he was to continue dilatations thereafter until cured.

With the exceptions mentioned, he insisted that only the minority of strictures demand urethrotomy. He had been at first, and for years, a devout follower of the revered Otis; a friend and admirer of the skill of his son. He did not now agree with the attractive theory that by incision the contracted urethra is "spliced" to attain a wider caliber. True, the result of the operation is immediate; the patient who could but painfully and laboriously urinate before, at once can pass a free stream. But, safe as the cut is in the hands of skilled operators, it still has a mortality of 2 per cent. Moreover, it is dangerous, in that the patient being able now to urinate is not likely to heed the reconstrictions which occur so slowly as to be unobserved. In the course of variable time the patient, unless persistently dilated, is more heavily strictured than he was before.

No one can be more fully appreciative of the fact that in hospitals, where beds are needed for the more acute cases, the surgeon is compelled to cut strictures he would otherwise dilate. This is a misfortune that will remain until separate institutions exist for genito-urinary diseases.

This is not the time or place for elementary discussion of the steps of urethral dilations, further than that the technique thereof can be as easy and effective in the hands of the general physician as it is in those of the specialist.

It will suffice to offer a few points of importance in connection therewith. Posner (*Therapeutik der Harnkrankheiten*) says that an impermeable stricture is a reflection upon the skill of the operator and not a reflection upon the tightness of the urethra, and the speaker added thereto that the patience and gentleness of the operator are not minor elements in the matter of conquering strictures. Once the finest filiform passed, the battle is won. It was not his experience, like that of our own master, Gouley, who told us this evening that after having such a filiform *in situ* for six or eight hours, a larger one could be inserted. He keeps the filiform in the urethra for twenty-four or even forty-eight hours. Guyon says that it there exercises a dynamic influence upon the stricture; Oberlaender asserts that its pressure causes a retrograde metamorphosis of the fibrillary tissue into parvicellular structure, enabling its absorption. The fact remains, however, that soon after insertion of a filiform bougie, urine begins to dribble along its sides, and on the morrow after insertion of the instrument it lies quite loosely in the urethra. Then, progressively larger instruments can be passed until a urethral caliber of about 15 French is attained. Thenceforward dilatations with the Oberlaender dilator can be performed, to be followed

later with equally gradual dilatations with the Kohlman dilator. These, however, have been mentioned by Dr. Erdmann. To again emphasize what has been written on the subject, he called attention only to their superiority over sounds, in that the work of the dilator is centrifugal. Dilators do not drag upon the mucosa as sounds must, but press and make a species of massage from within outward.

In urethrotomy the work is but begun. It must be followed by dilatations to overcome not only the stricture, but also the additional scar of the cut. In dilatations, gradual, slow, methodical, and especially when associated with irrigations, the end is reached more surely than after incision.

Dr. Robert Newman said that his experience with the treatment of urethral strictures by electrolysis now embraced upward of 2,500 strictures, and the permanency of the results was attested by many patients in this city who had been cured a great many years ago. He was glad to see that certain authorities in this field were declaring against internal urethrotomy. This operation had never seemed to him to be a rational method for the treatment of most urethral strictures, for if the incisions were allowed to heal by first intention they could not increase the caliber of the urethra, whereas if they were kept open and the gaps allowed to fill by granulation, the resulting cicatrices could but aggravate the original pathological condition.

THE SURGICAL DISEASES OF THE KIDNEY FROM THE STANDPOINT OF THE COUNTRY PHYSICIAN.¹

BY GEORGE A. LEITNER, M.D.,
Piermont, N. Y.

IN assuming the title of this paper it was neither my intention nor my purpose to enter into and dilate upon the profound and almost inexhaustible subject of the surgery of the kidneys, but simply to present to your attention some of the more serious forms of surgical diseases as encountered in the usual routine work of the general country physician.

In order to gain your attention I will not go into the pathology nor waste your valuable time with a long-drawn-out history of the origin and progress of this branch of surgery, but will at once place before you two specimens, which embrace three of the most important surgical conditions with which we have to contend, viz.—stone abscess and carcinoma of this organ.

Specimen number one is of the type of adenocarcinoma, involving the entire parenchyma of the kidney. The patient from whom it was removed will shortly be presented to you.

The clinical history of this case is as follows: Larry ——. Age at the time of operation, 47 years. Weight, 124 pounds. By occupation a hotel-keeper and farmer. Single. Habits decidedly temperate and gives negative history of any specific trouble.

His family history shows an absence of any malignant disease; his father died in early life of pneumonia; mother died at the age of 78 years of what was called senile marasmus. He is positive in his declaration that she was not afflicted with cancer and that no other member of the family had died of malignant disease.

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

The patient's trouble dates back to eight years ago (six years previous to the time of operation); he had retired to his bed in the usual good health when he suddenly awoke with an excruciating pain in the region of his bladder, accompanied with an uncontrollable desire to urinate; for at least a half an hour his efforts were useless, then suddenly there was a gush, and he claims that in the next two hours he passed at least two quarts of blood and urine; he again retired and slept until morning; he did not consult his family physician, although for the next four days the urine contained a large quantity of blood. This symptom eventually disappeared, and for a period of four years he enjoyed good health and attended to his usual duties.

On September 9, 1899, he awoke about 2 A. M. with severe pain in the region of his bladder and with the same uncontrollable desire to urinate, and during the next two hours there occurred complete retention; then he voided in the next hour two quarts of blood and urine. The following morning he consulted his physician, who ordered him to bed and under medical treatment until the urine was entirely cleared of blood. The chemical examination of the urine after it was freed of blood showed a very high percentage of albumen; the microscopical examination revealed the presence of numerous granular and epithelial casts.

The patient was placed upon alkaline and tonic treatment, and, about two weeks later, his physician was called away and he came under my charge. I continued without change the treatment pursued by his physician, and repeated examinations of his urine for the next few months showed little or no improvement.

In May, 1900, upon my advice, he decided to visit the baths in Europe. He selected those at Baden-Baden and there remained for three months under the care of a physician. He physically failed to improve, although assured that his kidney disease had entirely disappeared. He returned to America on August 22d, and again came under my care. The examination of his urine again revealed the evidences of a large quantity of albumen and the presence of numerous casts. I made a physical examination of the patient on September 5th, and then, although previous examinations had failed to show any abnormal conditions, I could easily locate a rather large, movable mass in the right lumbar region, which anteriorly extended from the free border of the liver downward to within three inches of Poupert's ligament. With this unmistakable evidence of enlargement, together with the past history of sudden hemorrhages, the constant presence of large quantities of albumen and casts, the continuous loss of weight and the characteristic cachectic appearance of the patient, a diagnosis of malignant disease of the right kidney was arrived at and an immediate operation for removal of the kidney was advised. The patient cheerfully consented and entered the

Nyack Hospital, on my service, September 8th.

On the morning of September 11, 1900, the patient having been thoroughly prepared, the operation was begun with the assistance of Drs. Blauvelt, Kline and Maynard. The incision was made at a point about one inch to the outer border of the right rectus muscle, half an inch below the edge of the ninth rib, and extending downward over the long axis of the tumor to within two inches of Poupart's ligament. The peritoneal cavity was opened to the full extent of the skin wound and the growth brought into view (examination of the left kidney showed it to be normal in size and appearance). The intestines were carefully drawn to the left side and safely protected; an incision through the peritoneal covering, extending along the long axis of the mass, was made, and the serous membrane dissected off; the renal vessels and the ureter separately secured and each ligated with two sets of Chromized catgut ligatures about one inch apart; they were then divided between the ligatures and the enucleation of the kidney accomplished. The ureter was then followed downward along a part of its course to healthy tissue, again ligated and the stump cauterized with the Pacquelin cautery; the retro-peritoneal space was carefully mopped and the edges of the posterior peritoneum were adjusted, but not sutured. The anterior peritoneal surfaces were closed with continuous catgut suture, each layer of the abdominal wall separately sutured and the patient returned to his bed. The following morning the temperature and pulse were normal; so they continued, and on the seventh day the dressings were changed. We were gratified to find that the wound had healed by first intention. His recovery from this time on has been uneventful. The fourth day after operation, chemical examination of the urine showed that the albumen had disappeared, and up to the present time there has been no further trouble. The patient left the hospital on the thirty-fifth day; his weight has gradually increased and he now, after two years, presents all the appearance of perfect health.

The second specimen is one which carries with it more decided interest, inasmuch as it presents three important pathological conditions, viz.—stone abscess and carcinoma. This specimen was removed from a patient who gave the following history: George R.—. Age, 37. By occupation, a laborer. No specific history. Habits, temperate. Family history is entirely negative. Causes of death of father and mother unknown. From his 17th year has had severe attacks of renal colic, always on the right side, followed by expulsion of numerous small calculi from the bladder. For the past two years his attacks have become more frequent and decidedly more painful, occurring often twice or three times within the week, followed by severe pains in the lumbar region; has never had any hemorrhages, although for the past six months there

has been a large quantity of pus in the urine. The loss of weight has not been remarkable and he has continued almost uninterruptedly at his occupation, to within three days of his operation. Two days before his admission to the hospital I was called, for the first time, to see him at his house. On examination of the right side, by palpation, I easily detected this large mass almost filling up the entire right half of the abdomen. A diagnosis of malignant disease of the kidney was made, and an operation advised for its removal. The patient consented and he entered the Nyack Hospital, June 22d, and on June 24th the operation was performed. The same incision and technique were followed as in the previous case. After the dissection of the kidney had well advanced we found a distinct bridge of carcinomatous material extending across and attached to the head of the pancreas, which was also infiltrated. The entire mass was removed, including its attachment to the pancreas; the cavity was cleaned and dried; the abdominal wound was closed with interrupted silk worm gut sutures, wound dressed and the patient returned to his bed. The symptoms of severe shock almost immediately developed; temperature, 97.6; pulse, 134; respiration, 34; extremities cold; skin clammy; salt solutions subcutaneously and by rectum administered; hot applications to the extremities; the foot of the bed elevated; hypodermics of morphia and atropia, together with strychnia and caffeine, were subcutaneously injected, but the patient failed to rally and died the following morning.

This specimen is decidedly interesting because it exhibits in the one kidney the evidences of malignant disease, stone and pus cavities, containing practically the three most frequent diseases with which the surgeon has to contend. It also shows from the history that the calculi, present in such large size and numbers, both in the pelvis and in the parenchyma of the kidney, were unquestionably the exciting causes of the carcinoma and the pus cavities, and that a much earlier operation, that of nephrolithotomy, would undoubtedly have prolonged his life and would have prevented the progressive formations of pus cavities and the more serious condition of carcinoma.

The Importance of Hyaline Casts in the Urine.
—Purely hyaline casts have been found in a large percentage of individuals who are apparently healthy and without other evidence of kidney disorder. These percentages increase with the advance of age. This, in the absence of post-mortem observations, has led to a more or less general belief that hyaline casts in urine of individuals past 50 are without significance.

A series of forty-eight autopsies in which urine examinations had been made some time previous to death, shows that casts were present in forty-one cases and chronic nephritis in forty-seven

cases, permitting the inference that hyaline casts in these cases were distinctly an indication of an organic disease of the kidneys.

The five disease conditions in which hyaline casts exist alone or with finely granular casts are: The atrophic stage of chronic parenchymatous nephritis, chronic intestinal nephritis, chronic diffuse nephritis, senile intestinal nephritis and chronic passive congestion of the kidneys.

The prognosis of these conditions, with the exception of passive congestion, depends as much upon the general clinical condition of the patient, especially in reference to cardiac and vascular disease, as upon the character of the kidney lesion.—*Defendorf, Yale Medical Journal, December.*

FACTS, FANCIES AND FALLACIES IN THE TREATMENT OF CONSUMPTION.¹

BY M. J. BROOKS, M.D.,
New Canaan, Conn.,

Physician-in-charge New Canaan Pulmonary Sanatorium; Member Connecticut State Medical Society, Etc.

THERE is no specific in the treatment of phthisis. Nor is there likely to be one; for phthisis is a degenerative process etiologically dependent upon too many factors, both predisposing and direct.

Predisposing.—Vulnerability, or susceptibility in the sense merely of cell debility—hereditary, or acquired—that is the soil, and then, a decided deviation from the conditions essential to a healthy animal life.

The direct cause of phthisis is a symbiosis of pathogenic organisms, two or more acting in unison. Not the tubercle bacillus alone, but also pyogenic organisms, and these latter are, in fact, far the more important.

Lung destruction, with all its concomitant manifestations, is due solely to this pyogenic superinfection.

The implantation of the tubercle bacillus *per se* is not necessarily pernicious.

The tubercle itself is a conservative process. It is not the product of the bacillus or organism, but of the organ. It is built up of cells in the immediate juxtaposition to the parasite. The tubercle sequesters the bacillus and naturally is a protection from further invasion.

It is composed, as you know, primarily of connective tissue cells which tend to fibrosis with ensuing cicatrization and contraction. That is to say, pure tuberculosis has the greatest tendency to spontaneous recovery.

The general recognition of the disease at this period is tantamount to a solution of the problem of eradication.

That the diagnostication of pure tuberculosis clinically is not difficult, I have elsewhere attempted to demonstrate. (1)

En passant, it would seem that the Germans lead us somewhat in this matter of early diag-

nosis, if we may judge from the late reports of their Central Sanatoria Committee.

Pure tuberculosis is, of course, eminently curable. Likewise phthisis in the great majority of cases, but restorative measures must ever be dependent upon the extent of pulmonary involvement and destruction.

We are upon the threshold of a new era in the practical therapeutics of phthisis. The present is but formative, however, and the medical profession in general has scarcely, as yet, emerged from the gloom of empiricism in the treatment of this disease.

We still hear of advocates of culture products in the treatment of consumption, of Koch's Tuberculin, of Maragliano's Serum, of Von Ruck's Extract of Tubercle Bacilli, etc., but it is obvious that a specific culture product or a serum cannot meet the indications furnished by a mixed infection.

It has been repeatedly noted that in the contest between the system and the organisms associated with phthisis, the leucocytes and their alexins play a lesser part than in any other infectious disease.

And there are those that still pin their faith to drugs.

Yet centuries of experimentation, again and again, with every ingredient mentioned in the pharmacopœia have given us not a single one that has the slightest favorable action on the progress of this disease. And these remarks apply equally as well to the much-vaunted creosotes, guiacols and glycerophosphates of the present time.

And climate. Who of us has not at some time fancied that somewhere there existed a specially favored climate?

Science is somewhat of an iconoclast.

Under the searchlight of close investigation, the specific virtues of climate have vanished like the mist of the morning.

The old theory of immune zones is no longer tenable. The bacillus is found regardless of temperature, of elevation, of moisture or prevailing winds. The disease prevails regardless of demographic conditions or geographic positions.

Thus we find Crowley and Duckman and the California State Board of Health Reports (2) inveighing against the practice of sending consumptives to their State; the Honolulu Health Reports showing progressive increase of the disease among the natives; Girdner, in the *Medical Record* (3), affirming the percentage among the citizens of Asheville, N. C., to be the same as New York; Newton (4) assuring us of its prevalence among the natives in the Adirondacks; Davies (5), in the *British Medical Journal*, demonstrating consumption rampant even upon the Isle of Man, "where the temperature is equable, abundant sunshine and fogs unknown." Yet the climate of these places has frequently been lauded as a specific in consumption.

¹Read at the meeting of the Kings County Medical Association, November 11, 1902.

The editor of the *Philadelphia Medical Journal* seems somewhat amazed at the large number of deaths from consumption in Porto Rico. It strikes him as peculiar. He adds (6), "One would think that it would be to escape the ravages of the disease that invalids would seek the climate of Porto Rico. But the fact that this glorious island is infected with consumption only proves that it is not a matter of climate."

The well-known Dr. Dettweiler, of Falkenstein, maintained a quarter of a century ago that climate should not be taken in consideration in the treatment of consumption.

You remember the Naples Congress of Tuberculosis. Lannelangue, Archard and Guillard there reported the result of their studies on the influence of climate upon the evolution of tuberculosis. Their conclusions were as follows: "In certain regions the disease is rare, and its relative infrequency is attributable solely to the mode of life of the inhabitants. The improvement which has been noted in patients at health resorts which have a reputation for the cure of phthisis is due alone to the different methods of treatment adopted, and cannot be attributed to the region or place." This, in fact, was the deduction of all the several congresses.

Dr. William W. Betts, of Los Angeles, Cal., says that there is no greater fallacy in medicine than climate, and perhaps he should know.

Dr. Albert Abrams, of San Francisco, puts it somewhat more forcibly: "We will no longer regard climate as that indefinite, mysterious and subtle factor which is too often an accommodating haven for the physician's delinquencies when he wishes to transfer his proprietorship of the patient to death."

And elevation! How many physicians still have faith in altitude as a remedy for consumption? Some have imagined an antiseptic quality in the air of mountain tops, a peculiar dryness inimical to the growth of bacteria, but this is only another idle fancy. Lancereaux (7) not only found that the tubercle bacillus and other germs grew well, but existed in a virulent condition upon the summit of Mt. San Luis Potosi, 16,000 feet above sea level.

No, gentlemen; elevation, far from being favorable to the treatment of consumption, is absolutely contraindicated.

Rarification of atmosphere is but an attenuation, a deficiency of volume. It is not a question in the treatment of consumption how little air may suffice, but how much can be obtained.

The last issue of the *Journal of Tuberculosis* has an article by Dr. Von Ruck, its editor. Dr. Von Ruck, it will be remembered, has a sanatorium at Asheville, N. C., which is at quite an elevation.

He states that altitude has proved absolutely detrimental in even the earliest stages of phthisis; that it favors increased lymphatic absorption and thereby greater degrees of fever and more rapid decline; that the effect upon the circulation has

proved likewise undesirable, preventing even in non-febrile cases the taking of sufficient outdoor exercise on account of local congestions and hemorrhages induced. He states that pneumonia appears to be more frequent than at lower elevations.

As for that increase of red-blood cells which Solly and other Westerners have claimed for elevation, he quotes the investigations of Schroeder, Gottstein and Meissen, which are somewhat amusing in that they show that this apparent increase in red corpuscles is but due to diminished air pressure upon the cover-glass of the blood chamber in which the count is made.

Prof. Albert Rosenberg, of Berlin, observed some time since that while visiting Leysin he first convinced himself that the widely accepted view in regard to altitude in the treatment of tuberculosis was a prejudicial one, and on the whole patients were better provided for at lower levels.

Dr. Theo. J. Jaquenin, in a recent letter to the editor of *American Medicine*, and which, in a footnote, has the editor's concurrence, sums up the "contraindications to treatment by altitude" as follows:

Firstly. Nervous temperament and erethism.

Secondly. Disease of the heart and blood-vessels.

Thirdly. Pulmonary emphysema or asthma.

Fourthly. That form of tuberculosis known as the pneumonic form.

Fifthly. All cases of continuous fever and those of a remittent type.

Sixthly. Extensive pulmonary lesions, whether they be monolateral or bilateral.

Finally. The so-called consumptive stage of the malady. Whether this stage sets in early or late is a matter of small importance; it is always prohibitive of residence in altitude.

But all this is but a reiteration of the consensus of opinion of the phthisiologists that assembled at the Moscow, the Berlin, the Paris, the Naples and the other congresses.

It seems an odd coincidence that the two Berminghams, Braine-Hartwell (8) in England and J. E. Bermingham (9) here should have at approximately the same time protested against sending consumptives to altitudes.

Atmospheric conditions are unimportant. Barometric pressure, as Ruhemann (10) has well said, does not hold the slightest causative relationship to any disease. On the contrary, we now find in a recent issue of the *London Lancet* an article on the salutary virtues of rainstorms, considered from a physical, mechanical and chemical standpoint.

Prof. Sir Granger Stewart, in his address before the International Congress, showed that the results of treatment obtained in Edinburgh, with its "rain and mist and east winds," were equal to the most favorable obtained anywhere.

It is hardly necessary to dwell further on this point.

Von Schrotter (11), Walker (12), Burton-Fanning (13), Otis (14), Knight (15), Shaper (16), Girder (17), Tew (18), Roane (19), Brunnon (20), Hillier (21) and others are all in the same ranks.

Ocean voyages have been recommended as a remedy for consumption, but in the light of present knowledge are hardly available. The argument is briefly as follows: In sea voyages passengers are greatly at the mercy of the weather. The average stateroom is too small and ill-ventilated to be suitable for a consumptive patient. There is too great a change from the cabin to the deck. While the fare on board ship may be all-sufficient for a healthy individual, it is by no means suitable for an invalid. Systematic medical supervision, the *sine qua non* to successful treatment, is precluded.

I would here, parenthetically, call your attention to the fact that consumptives, even of the better class, may re-infect themselves. Autoinfection is not uncommon with them. That he may inadvertently infect others is likewise obvious. I have been told that the eldest son of one of the founders of the Long Island College was thus infected by occupying the same stateroom with a consumptive. This may or may not be true, but it is nevertheless certain that the staterooms aboard some of the ocean-going vessels are not always periodically and properly disinfected.

As for surgical measures. Pneumonotomy has from time to time been advocated upon purely theoretical grounds, with a view of obtaining adequate drainage of a cavity. But this is totally impractical, since with cavity formation there is always an extensive dissemination of foci, and hence complete removal of the disease process is out of the question.

Murphy, Loomis and others, as you no doubt remember, have advocated the compression of the lungs by means of filling the pleural cavity with nitrogen gas. We have, however, yet to see a case of consumption wherein it is possible to inject sufficient gas to collapse the lung, but even if this were possible such a procedure would not cure consumption. Thoracoplasty has the same object in view, and is manifestly as impractical.

The sum and substance of successful treatment is what is known as the Brehmer-Dettweiler system or sanatorium treatment, incorporating modern and effectual adjuvants.

The sanatorium should be situated most favorably in a quiet space of open country with relatively pure air—that is to say, air uncontaminated by smoke and soot of factories and thickly settled habitations. Such an institution should be properly and specially equipped, with modern sanitary arrangements, with due attention to prophylaxis and with an adequate staff of assistants.

The patients should be under the strictest hygienic regimen, with constant, sincere and pains-

taking medical supervision and efficient nursing.

This is the modern and effectual treatment of consumption. All else is but a makeshift in the light of present knowledge and experience.

Please remember that a sanitarium, where the patients take their own temperature, keep their own records, sleep in wards and see their physicians at stated intervals, is but a substitute for the sanatorium.

The ward system of the general hospital is not applicable to the treatment of this disease. An almost constant symptom, as you know, is the cough, and as this is largely a matter of habit, the mere suggestion of a cough frequently spreads the same throughout the ward, thus precluding the sleep that otherwise might be obtained in individual chambers.

Again, the Swiss chalet or cottage system has been found vastly inferior to institutions under one roof. Constant guidance, medical supervision and advice, hydrotherapeutic measures, proper nursing and watching in order to eradicate careless habits and inculcate good ones, attention to hygiene and disposition of sputa, disinfection and prophylaxis, enforcement of strict routine and individual symptomatic treatment at the proper time, all of which are of paramount importance, cannot be carried out to the best advantage under the cottage system.

The fundamental basis of the armamentarium of the sanatorium treatment is the open air, hygienic, dietetic trinity, but this is but the basis, not all of the treatment. Consumptives are truly invalids, and if there is a disease in the whole nosology and category of medicine that demands constant and best skill of the profession, it is consumption. It is not a self-limited disease, and recovery rarely takes place without the aid of competent and conscientious medical treatment.

Yet there are physicians who believe that air and exercise alone will cure consumption, and will send their patients to the forest preserves, peradventure, or elsewhere, regardless of the season. Such physicians will probably order the patient to "rough it," "take plenty of exercise," "eat heartily," and with a bottle of their favorite tonic ship him off with a high temperature and a rapid pulse.

A writer in the *Journal of Tuberculosis* protests against this indiscriminate shipping of consumptives to localities beyond the reach of trained medical advisers, as follows: "The poor patient is unsuitably clad and physically unable to contend with the altered condition of existence. Like a waif in the tide, he is left to sink or swim by his own reserve of recuperative power, and how often he sinks can only be appreciated by a study of the mortuary records of these resorts."

Such a course, gentlemen, is an egregious fallacy. It is more—it is cruelty.

On the outskirts of the city of Boston, what they call the "Back Bay," consumptives, it is said, will be placed in open tents and especially constructed shacks. Aerotherapy and exposure

are not synonymous. Fancy a poor consumptive with high fever and night sweats arising in order to change his damp garments in the bitter cold of a winter's night. Perhaps midst a raging storm, in addition. Another fallacy. It would indeed be providential if a typical bronchopneumonia would not speedily terminate the case under such conditions.

Surely it cannot be that this is the result desired.

A writer in a recent issue of the *London Lancet* speaks of the "beautiful and equable climate of Colorado." Verily, "distance lends enchantment to the view."

The annual range of temperature last year at Denver was 122. That is from 100 above to 22 below zero. This is hardly equable.

Another erroneous impression prevails among some that our own Adirondacks are particularly equable and agreeable, but on investigation we find the annual range of temperature is decidedly greater than here in Brooklyn, and as far as its dryness is concerned, permit me to quote from a personal letter from my friend, Dr. Corwin, of Bayonne, N. J., who spent last winter in the Adirondacks with his wife. "Saranac may be dry some days, but there are mighty few other dry days, and we have more sunshine in Bayonne in a week than they do in a month."

Wherever consumptives congregate, not under constant and efficient supervision, such places are only too apt to be centers of infection.

This, it is claimed, is the cause of the increase in the deaths from consumption amongst the native inhabitants at the beautiful Riviera, but in this I cannot wholly concur.

However, we know that many consumptives find quarters at the various hotels and boarding-houses in the vicinity of such resorts, and it may with reason be doubted whether their rooms are properly disinfected and sufficient attention paid to prophylaxis.

Some of these hotels advertise that they do not receive consumptives, but we have ample evidence to the contrary. (22)

In conclusion, permit me to say that favorable conditions for the treatment of consumption obtain anywhere in a space of open country, and when a number of properly equipped and supervised sanatoria have been erected in the neighborhood of our larger cities, and last, but not least, seaside institutions for tubercular children, then will a considerable step forward be made in the crusade against the "great white plague."

REFERENCES.

1. Journal of Tuberculosis, July, 1902.
2. June and July, 1900.
3. J. H. Girdner, May 14, 1898.
4. Richard Newton, June 23, 1900.
5. Charles Davies, August 3, 1900.
6. September 6, 1902.
7. Gaz. des Hopitaux, April 4, 1901.
8. Medical Review, July, 1899.
9. Phila. Med. Journal, March 18, 1899.
10. Zeitsch. fur Diatet. und Physik. Vol. 4, No. 4, 1900.
11. Zeit. fur Tuber. Vol. 1, 1900.
12. British Med. Journal, August 7, 1900.
13. Supra.
14. Boston Med. and Surg. Journal, February 8, 1900.
15. Supra.
16. Berlin Klin. Woch., April 3, 1899.
17. Loc. cit.
18. British Med. Journal, August 18, 1900.
19. Revue de Medicine, July, 1900.
20. Loc. cit.
21. Recent work.
22. F. M. Corwin, Bayonne, N. J.

DISCUSSION.

Dr. Frank West opened the discussion by saying that the writer's epigram, that there is no specific for the treatment of phthisis, is only too true. The old-fashioned routine treatment with cod liver oil, creosote, guaiacol, ichthyol or some other "ol" is useless. Each case must be treated individually, and symptoms must be met as they occur. He did not think by any means that medication was useless, but the utmost skill and judgment are required in selecting remedies to meet the individual case. The practice of loading up an already weak stomach with nauseating medicine is not only useless, but harmful. That climate accomplished nothing in the treatment of these cases was not by any means his opinion, although many cases were injured by being shipped off indiscriminately to some "better climate." The selection of the climate requires as much care and as much individualizing as the selection of drugs.

Theoretically, sanatorium treatment is best for consumptive patients, but the general practitioner has to deal with facts, and the facts are that a majority of the cases that he meets will not or cannot go to a sanatorium. For such patients the physician must use all his resources, hygienic and medicinal, and never settle down to routine treatment.

Dr. Nathan Belcher said that cases of consumption in his experience were divided into two classes—those that we can help, and those that we cannot. Unfortunately, most belong to the second class. If we could only see these cases earlier much might be done for them, but most are too far advanced to be benefited, or at least to be cured. He agreed with Dr. West on the impossibility of getting many cases into the sanatorium.

Dr. T. M. Lloyd said that physicians must not be too ready to relegate patients to the incurable class. Although consumption is a discouraging disease to combat, there are apparently hopeless cases that will recover. He gave the history of a case complicated with an ischio-rectal abscess that finally recovered after rest in bed and later a stay in the Adirondacks.

Dr. Bierwirth also spoke of the utter worthlessness of specific treatment. He said that the conscientious practitioner was handicapped by the prejudice and ignorance of the public, which prevented the satisfactory application of rational hygienic principles. In his experience, phthisis was almost a hopeless disease to deal with in city practice.

Dr. Prendergast also spoke of the hopelessness of treatment in most cases, and mentioned the importance of sputum examination.

Dr. Sherwell agreed with Dr. Brooks, that recovery occurred in large numbers of cases of pure tuberculosis, but he also thought that phthisis in the hollow-chested, spare type of people was hopeless.

Dr. Sullivan thought that there was much for the physician to do in the way of educating the public and in cooperating with the Health Department to check infection.

Dr. Arrowsmith said that the feeling of hopelessness was due largely to the apathy of the attending physician. We are not doing our duty by the patient in following

a routine treatment and advising travel. He agreed with Dr. Sullivan in the importance of educating the patient and the public.

Dr. Brooks, in closing the discussion, said that he had been much interested in the discussion. He had not meant to say that change of climate was not beneficial in phthisis, as in other diseases, but he did claim that there was no climate or place that was a specific for tuberculosis. There ought to be everywhere suburban sanatoria for the treatment of this disease. The human animal is peculiarly susceptible to tuberculosis, but the tubercle bacillus itself is not virulent, and there is a marked tendency to spontaneous recovery. The danger is not from hereditary susceptibility but from cell debility from various causes. It is important to recognize the difference between pure tuberculosis, with its tendency to recovery, and phthisis or consumption, which is a mixed infection with rapid destruction of tissue. Pure tuberculosis cannot be diagnosed from the examination of the sputum, because there is no sputum, no bronchitis, no cough; merely a roughened breathing. There is a difference of opinion as to whether the mixed infection with the staphylococci or with the streptococci is the more dangerous. From his personal experience he would make two suggestions: Do not take a hopeless view of phthisis and never give up a case. It is remarkable how far gone a patient might be and recover. In private practice put the patient to bed and treat as pneumonia. He believed that in the cases of tuberculosis, reported as following the acute infectious diseases, the tubercular condition had preexisted and that a mixed infection had been set up by the acute disease.

OBITUARY.

John Byrne, M.D., LL.D., F.R.C.S.E., died at Montreux, Switzerland, on December 2, 1902, at the age of 77.

Dr. Byrne was born in Kilkeel, Ireland, and studied medicine in Belfast, Dublin, Glasgow and Edinburgh, graduating from the last in 1846.

After two years' hospital service he came to America, settling in Brooklyn, L. I. In 1856 he was one of the originators of the Long Island College Hospital. He was especially interested in gynecology and was clinical professor of gynecology in the Long Island College Hospital and Surgeon-in-Chief to St. Mary's Maternity of Brooklyn. He was also a founder of St. Mary's Surgical Hospital.

He was an active member of many medical societies. He was a member of the New York State Medical Association, Kings County; the American Medical Association, a fellow of the New York Academy of Medicine, ex-president of the New York Obstetrical Society and of the American Gynecological Association.

As late as September 15, 1902, Dr. Byrne read a paper on Cancer of the Uterus, and his special method of treatment, at the International Congress of Obstetricians at Rome, Italy.

Dr. Byrne was a hard worker, a deep thinker, a forcible speaker and had the courage of his convictions. If he believed a statement to be correct, he stood by it, even if he stood alone.

About a year ago he announced that he would be compelled to rest from his life work, because of his physical inability to continue, and that it was his intention to go abroad to recuperate. Before his departure a large number of his

friends presented him with a memorial, as they gathered about him to wish him many years more of life, expressing the hope that in his retirement he would gain strength and return to them ere long, refreshed and invigorated. Unfortunately, this was not to be.

Dr. Byrne died full of years and leaves behind him a reputation such as any honorable physician might well envy.

He was a man of noble character, genial in disposition, devout and with a large amount of love for his fellowmen and for his chosen profession. To his patients he was a tower of strength, always cheery and encouraging, his witty conversation brightening many a weary hour.

His deeds of kindness were many, and for all his great goodness, his humanity, his sterling character, it may truly be said of him: "Well done thou good and faithful servant."

* * *

Susan R. Pray, M.D., died on January 14, 1903, in the city of Brooklyn, of Bright's disease, at the age of 45.

Dr. Pray was born in Brooklyn and graduated at the Woman's Medical College of the New York Infirmary in 1882.

After being connected with several clinics in New York City, practicing meanwhile in Brooklyn, she concluded to devote her life to the service of the Foreign Missionary Board of the M. E. Church. She went as medical missionary to Foo Chow, China, where she rendered most efficient service and made many friends who have been ever faithful to her.

At the expiration of two and a half years an attack of sunstroke so incapacitated her that she was compelled to return home, resuming practice in the city of Brooklyn.

She was one of the first women to pass the examination for the position of inspector to the Board of Health, and she held that position continuously for thirteen years, until her death. In the department she was a most faithful and conscientious worker and entered fearlessly upon her duties.

She was one of the founders of the New York State Medical Association, attending the meetings of the County, District Branch and State organization. She was also a member of the American Medical Association and attended its meetings whenever possible.

With her work in the department and her private practice she was kept quite busy and made many warm friends.

The last illness of Dr. Pray was the culmination of a whole chapter of serious disturbances and accidents, and it was wonderful to note how cheerfully she bore the most distressing conditions. Those who knew Dr. Pray in years gone by remember her as a woman, large hearted, honest, sincere to her friends and of a most charming and sunny disposition, and it was with infinite pain that they saw her tortured with

disease and suffering, dying an untimely death.

In addition to her love for mankind she had a great love for dumb animals. She always went to their relief, even at the risk of personal annoyance. This lack of consideration of herself, as exemplified by the above statements, had much to do with hastening her end.

She died at the residence of her friend and college classmate, Dr. Augusta F. Holmes.

* * *

William C. Gallagher.—We regret to note the death of Dr. William C. Gallagher, on January 5, 1903, a fellow-member of the New York State Medical Association, New York County. Dr. Gallagher lived at 302 West Twelfth street, and was 40 years of age. He was born in the city of New York and was a graduate of the Bellevue Hospital Medical College, class of 1886. Dr. Gallagher served the regular term of interne to the St. Francis Hospital of New York City, beginning with October, 1888. He died at the New York Hospital, of typhoid fever, after an illness of fifty-nine days. It is believed that he contracted the disease from a patient whom he was attending. Dr. Gallagher was in general practice and he had many friends both in the profession and among the laity. He was unmarried and was associated with his brother, Dr. Edward J. Gallagher, to whom we extend our most respectful condolences.

* * *

Dr. Jacob M. Kraus, a member of the New York State Medical Association, Erie County, died at his home in Buffalo, on December 19, 1902, after a long illness, aged 36 years. Dr. Kraus was a graduate of the University of Buffalo, 1889. He was a physician of marked ability, and at the time of his death was dermatologist to the German Hospital and physician to the Erie County Penitentiary. Resolutions expressive of sorrow and respect were passed by the hospital staffs and societies with which he was affiliated.

ADDITIONAL LIST OF MEMBERS IN THE NEW YORK STATE MEDICAL ASSOCIATION.

- Allen, Charles Warrenne, 30 East 33d street, New York City.
 Besemer, Howard B., Ithaca, N. Y.
 Braman, Harry S., Homer, N. Y.
 Cheney, Lyman A., 70 Rivington street, New York city.
 Clark, George W., Waterloo, N. Y.
 Curran, Martin W., 154 East 72d street, New York City.
 Cutler, Colman Ward, 36 East 33d street, New York City.
 Dearden, John E., 1368 Lexington avenue, New York City.
 Deary, Louis E., 321 East 20th street, New York City.
 Donlon, Edward J., 129 West Houston street, New York City.
 Douglass, William C., Ithaca, N. Y.
 Dumond, M. A., Ithaca, N. Y.
 Egan, Joseph M. F., 46 West 120th street, New York City.
 Earl, William P., Little Falls, N. Y.
 Eynon, W. G., 184 Willis avenue, New York City.
 Fitz Gerald, John F., Rome, N. Y.
 Getty, Andrew H., Athens, N. Y.
 Geysler, Albert C., 352 Willis avenue, New York City.
 Gilchrist, George M., Groton, N. Y.
 Goodwin, Phillip S., Perry, N. Y.
 Goodyear, Miles D., Groton, N. Y.
 Gottlieb, J. Adelphi, 43 West 131st street, New York City.
 Greeff, J. G. William, 24 West 91st street, New York City.
 Greene, Cordelia, Castile, N. Y.
 Greene, Mary T. Castile, N. Y.
 Humphrey, L. Hayden, Silver Springs, N. Y.
 Kamp, John C., 248 Amherst street, Buffalo, N. Y.
 Kenerson, Vertner, 186 Allen street, Buffalo, N. Y.
 King, Willis E., Newfield, N. Y.
 King, James E., 93 Niagara street, Buffalo, N. Y.
 Knight, Archibald S., Enfield, N. Y.
 Kopetzky, Samuel J., 290 West 137th street, New York City.
 Leister, Oscar M., 227 West 44th street, New York City.
 Leonard, Theodore Miller, 155 Allen street, Buffalo.
 Lusk, Zera J., Warsaw, N. Y.
 McAuliffe, Dennis A., 310 East 57th street, New York City.
 Macy, William Austin, Willard, N. Y.
 Merrigan, Thomas D., 167th street and Kingsbridge Road, New York City.
 Munger, Charles, Knoxboro, N. Y.
 Myers, John Franklin, Sodus, N. Y.
 O'Neill, Rodger Power, 910 St. Nicholas avenue, New York City.
 Paine, Ridley C., Bethel, N. Y.
 Page, Emmett D., 304 Washington avenue, Brooklyn.
 Palmer, Floyd, East Meredith, N. Y.
 Peck, Charles H., 37 West 48th street, New York City.
 Peddle, George H., Perry, N. Y.
 Peiser, Louis, 52 East 80th street, New York City.
 Post, Albert Todd, Erie County Savings Bank Building, Buffalo, N. Y.
 Sage, Arthur G., 12 Parker avenue, Buffalo, N. Y.
 Sauer, J. George, 250 Willis avenue, New York City.
 Schroeter, Ludwig, 798 Fillmore avenue, Buffalo, N. Y.
 Siebenhorn, Henry A., 322 West 31st street, New York City.
 Siefert, Carl F., 97 Second avenue, New York City.
 Simmons, Charles E., 762 Madison avenue, New York City.
 Skiff, George S., Gainesville, N. Y.
 Slade, Mary, Castile, N. Y.
 Steele, Wellington G., Mongaup Valley, N. Y.
 Stevens, Charles W., 22 East 46th street, New York City.
 Stern, Abram R., 113 West 85th street, New York City.
 Stubbett, J. Edward, 25 East 45th street, New York City.
 Tracy, Ira Otis, Long Island State Hospital, Brooklyn, N. Y.
 Tuttle, George A., 237 West 44th street, New York City.
 Urban, Adolph Hermann, 523 Franklin street, Buffalo, N. Y.
 Wackerbarth, Henry J., 183 Second avenue, New York City.
 Waldron, Henry A., 206 Grand street, Newburgh, N. Y.
 White, Arthur D., Ithaca, N. Y.
 Wilkens, Ernst A. W., 284 Alexander avenue, New York City.
 Wilson, M. Jean, Warsaw, N. Y.
 Wilzen, Isaac M., 2412 Seventh avenue, New York City.
 Wolper, Max, 217 East Broadway, New York City.
 Zitz, Frank H., 1087 Lexington avenue, New York City.

Book Reviews.

DEVELOPMENT AND EVOLUTION, INCLUDING PSYCHOPHYSICAL EVOLUTION, EVOLUTION BY ORTHOPLASY, AND THE THEORY OF GENETIC MODES. By James Mark Baldwin Stuart, Professor in Princeton University. New York: The Macmillan Company. Pp. 395. \$2.60.

This book is the third in the series of which "Mental Development in the Child and the Race" and "Social and Ethical Interpretations" are the previous volumes. This series of papers, however, does not deal exclusively with evolutionary psychology, but is rather an attempt "to determine what sort of a theory of biological evolution is rendered the more probable when we recognize, together with all the established biological facts and principles, also the facts and principles of the mental life." The main title of the book is more fully explained on page 3, as contrasting *individual* development with *racial* evolution; in other words, it is a simultaneous study of ontogeny and phylogeny, or, rather, a study "of the interrelation or correlation of these two great spheres."

A large part of the volume is devoted to an explanation of the theory of "orthoplasy," to use the word coined by the author. This is a theory of evolution arrived at independently by three students, Profs. H. F. Osborn, Lloyd Morgan and the author. It is defined as "the theory of evolution which makes essential use of organic selection." Later, however, we find that the term "organic selection" is here used to imply selection by the organism itself, in contradistinction to the Darwinian term, "natural selection," which ignored the personal equation, so to speak, in the evolutionary process. That this factor of individual intelligence must count for much in the "survival of the fittest" seems to be a self-evident fact when probed out, but it is, after all, only a fuller development of the fact recognized by the father of evolution, that intellectual superiority counted for more in the struggle for existence than mere physical strength.

The great value of orthoplasy as a working hypothesis, however, lies in the fact that it presents a method of indirect transmission of acquired characteristics. If, therefore, it is generally accepted as satisfactory, it relegates to the merely historical the bitter war that has but just closed between "Weismannism" and "Lamarckianism." In the past the merely theological opponents of "evolution"—as meaning the descent of man from monkeys—looked upon Weismann's complete overthrow of the theory of the hereditary transmission of acquired characteristics as an overthrow of "Darwinism." Orthoplasy, to explain it in a very general way, points out that the individual organism—and it is here that the principles of ontogeny are made use of—assumes the acquired characteristics of its parents by reaction with its environment. In other words, each individual adopts by conscious or unconscious imitation or by force of circumstances the advantageous acquired characteristics of its older associates.

In the appendices the original statements of the three authors of the theory of "organic selection" are given in full for the sake of reference and comparison. To the busy practitioner of medicine this will not seem like a readable book, but to the student who is interested in the various phases of the doctrines of evolution it will be of great interest. It is essentially a work for the specialist and takes for granted throughout a pretty accurate knowledge of the theories of Lamarck, Weismann, Romanes and the others who have worked out the present general beliefs in regard to the processes of evolution. To the psychologist as well as the biologist this volume will be of great interest, and to the physician who takes the time to keep up with current thought it will be of much value.

A TEXT-BOOK OF THE SCIENCE AND ART OF OBSTETRICS. By Henry J. Garrigues, A.M., M.D., Consulting Obstetric Surgeon to the New York Maternity Hospital; Gynecologist to St. Mark's Hospital; Honorary Fellow of the Obstetrical Society of Edinburgh; ex-President of the German Medical Society, etc. With 504 illustrations. Pp. 844. Philadelphia and London: J. B. Lippincott Company, 1902.

Dr. Garrigues is so well known as an author, teacher and original worker in this important branch of medico-surgical science that a text-book from his pen at once commands attention. During the past year this is the only complete text-book on obstetrics written by one man, and of that man's experience, that has graced our literature.

The book is most comprehensive and embraces in a detailed manner the entire field of obstetrics. The illustrations are practical and helpful to the student and practitioner, in that they graphically carry to the mind, through the eye, detail in technique that is impossible to understand and appreciate from the text alone. Many of the illustrations are drawn or photographed from nature.

The volume is divided broadly into two sections, with a chapter added on diseases of the new-born.

The physiology of pregnancy is discussed in a thorough manner, the development of the fetus, membranes and placenta being particularly well illustrated.

There is a short chapter devoted to the theories of the cause of sex. The author questions the accuracy of any of them. He does not believe in Professor Schenk's ability to influence sex in any manner.

Asepsis and its offspring, antisepsis, receive their proper attention. This chapter can be read with profit by any physician doing obstetrical work.

There is a brief but admirable section devoted to ectopic pregnancy. The author's theories are very plausible.

The subject of intraspinal cocainization receives attention. The author states that he has never used it, and never intends to; he is sure that it is more dangerous and less reliable than chloroform or ether.

The manifold advantages of the axis-traction forceps are well emphasized. He claims that they substitute mechanism for judgment, dexterity and experience, which in the nature of things can only be in the possession of a few favored ones, and that the forceps are in a wonderful degree a labor-saving device. The author considers a high application no more difficult with the axis-traction forceps than with ordinary forceps, even in the hands of a tyro—rather dangerous teaching.

Symphiseotomy and the Cesarean operation are taken up in detail; various published views, their discussions and their references are given.

One of the most valuable chapters in the book is the one on puerperal infection. Its prophylaxis, etiology and the classification of the different varieties, with the appropriate treatment, are thoroughly considered.

The chapters on midwives and lying-in institutions are timely.

DISEASES OF THE BRONCHI, LUNGS AND PLEURA. Nothnagel's Encyclopedia of Practical Medicine, American Edition. By Prof. Dr. Friedrich A. Hoffman, Professor of Medicine in the University of Leipsic; Prof. Dr. O. Rosenbach, of the University of Breslau; Dr. E. Aufrecht, Chief of Clinical Medicine in the Magdeburg-Altstadt City Hospital. Edited, with additions, by John H. Musser, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Authorized translation from the German, under the editorial supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia and London: W. B. Saunders & Co., 1902.

This volume is truly an encyclopedia of our knowl-

edge of these diseases, for it is a storehouse of knowledge. Dr. Musser is to be congratulated on his editing and additions. The anatomy of the bronchi is clearly described, and the study of this article will add greatly to the knowledge of the meaning of the physical signs encountered in various pulmonary conditions. The full report of the various foreign bodies that have been found in the bronchi, with the symptoms produced, treatment and result, forms a table that is interesting reading to those who are looking for the curiosities of medicine and is instructive to every practitioner. Aufrecht, the author of the article on pneumonia, holds that the infection takes place through the air passages and that "the further distribution of the pneumonia cocci from the diseased lung very likely takes place principally by means of the circulation." The editor, on the other hand, believes "that a clearer conception of pneumonia would be had if the lung process were considered to be one of many manifestations of a pneumococcus infection." The fact and argument seem to be strongly in favor of the author. It is unfortunate that the editor uses the word *toxemia* as synonymous with *septicemia*. It would seem wise to use some equivalent of septic intoxication in those diseases in which the bacteria do not circulate in the blood, or circulate but rarely, and to use septicemia when the bacteria are to be found in the circulation. The bacterial poisons are generally called toxins, and toxemia gives one the idea of the circulation of soluble toxins rather than the bacteria. It is well to keep clearly in mind that probably in the majority of cases of pneumonia there is a true pneumococcus septicemia. Any careless use of words only confuses those who have not had the advantage of a special bacteriologic or pathologic training.

The treatment of pneumonia as advised by the author is interesting, differing as it does from that in general use in this country. For the pleuritic pain an ice-bag and morphine are used, and for too rapid heart action or irregularity in the pulse, 4 grains of the powdered digitalis leaves, every few hours is deemed sufficient. In mild cases with no severe symptoms, a special neutral tannate of quinia and Ferrum oxydatum of the German pharmacopœia, 15 grains each, three times a day is all that seems necessary. Except in patients addicted to alcohol and for patients in collapse, the use of alcohol is distinctly not recommended. In severe cases, on the fifth or sixth day, or even earlier, the hypodermic use of the hydrochlorate of quinine is recommended. This should be given in doses of 7½ grains in a half ounce of water and injected into the side of the abdomen. The author has obtained favorable results with two injections upon successive days, or with an interval of forty-eight hours between injections. Frequently one injection was sufficient. Up to the present time three injections have been required but twice. The author illustrates the value of these quinine injections by stating that in the fifteen years previous to their use, his mortality averaged 16 per cent.; in the 121 cases in which they were used, his mortality has been 7.4 per cent. While the type of pneumonia varies from year to year in its virulence, and the mortality rate does not necessarily show the value of any treatment, these results are certainly striking.

The various inflammations of the lungs and pneumonokiosis, carcinoma, embolism, thrombosis and infarct, abscess and gangrene of the lung are dealt with exhaustively and with a full bibliography. This is also true of bronchitis, emphysema, atelectasis and the various diseases of the pleura and subphrenic-pyopneumothorax.

The work is an excellent example of the careful compilation and thorough exposition of all the scientific facts that are known concerning the diseases in question, and represents the best scientific work produced by our German confrères. The additions by Dr. Musser have certainly improved it for the use of English-speaking physicians.

A SIDE LIGHT ON ETHICS.

To the Editor of the JOURNAL:

Apropos of the Code of Medical Ethics, recently published in the JOURNAL, it has occurred to me that we are very foolishly shutting our eyes and closing our ears to the low standard of ethics practiced by the medical profession in America to-day. This is an age of commercialism. It has planted itself as firmly in the profession of medicine as in the department stores. This commercialism is a menace to the high standard of our medical men; it handicaps the good we might do for humanity; the reform we might accomplish; the respect we might command. Year by year the standard of ethics and ideals is lowered. At present we stand almost at the head of the list, in the eyes of the world, of professional jealousies. The musician and the medical man rank side by side in their bickering and in their enviousness. Newspaper men and the laity in general recognize it and laugh good-naturedly at our expense.

The public know in a vague way that there is an indefinable thing called medical ethics. They envelope it with the mysticism that the uninitiated envelope the masonic rite. They know that the profession regards the physician who advertises in the advertising columns of the daily papers as a quack, but that if a man have sufficient reputation he may insinuate his name with impunity in the main body of the newspaper—this they understand is immeasurably more delicate, and certainly tells in a more clever fashion, while the "small fry" dare not be so bold as to resort to either of these methods. The laity accordingly are fairly settled in the belief that the unpardonable sin is for the professional man to insert his ad. among the advertisements, and they thus differentiate between the man of reputation and the quack by the part of the paper in which his name appears. When the public comes in personal contact with many of our profession who are in good standing and with the successful "smooth quack" they are too frequently unable to detect any difference in their conduct.

I think I express the sentiments of the average, medical man when I say that the recent graduate very soon takes on one of the characteristics of an animal called a bulldog. When that animal gets a bone, by chance or otherwise, if there is good meat on it he shows his teeth at the approach of another dog, and stands ready to fight for his rights. I am not a pessimist. It is my good fortune to have been associated in consultation, with few exceptions, with men who were ethical to a degree. I may add that when I have the privilege, I choose my consultant with as much care as though I were selecting a lawyer to defend me against a charge of murder in the first degree.

It is easy enough for the man of means and of some social prestige to adhere to most of the Code of Ethics. But what of the man who starts his professional life with a wife, perhaps a young family, and a small bank account? Can he afford to be ethical in the face of an empty pantry, and scanty clothing? How many of us are strong enough to do unto others as we would be done by, when, as David Harum says, the other fellows are doing us and doing us first? What incentive is there for the young specialist to keep faith with his Code, when men who have risen to the very top of the ladder in their respective lines are flagrant violators of the essentials of medical ethics?

May I illustrate a case in point? For the past few years I have been the family physician in a certain household. After urgent persuasion I gained the mother's consent to make a local examination for a persistent and suspicious hemorrhage from the uterus, with the result that I unhesitatingly declared she be sent to the hospital, and after more thorough investigation, probably submit to a hysterectomy for cancer. The family were quite satisfied until a near relative insisted on consultation with a noted surgeon who performed an operation on a sister. The surgeon in question stands in the very front rank of our profession. I called him up by telephone and explained the situation. I agreed to have him see my patient at

the hospital he desired, and at a time to suit his convenience. After we had finished our consultation, my consultant, without asking my permission, called the family together, gave his diagnosis, his treatment, and his prognosis. He then proceeded to set the time for operation, and graciously invited me to be present as an on-looker, if I so chose. However, as the invitation was suggestive of my being asked to officiate at my own funeral, I did not go. Previous to the consultation, the husband of my patient had asked what my charges would be if I did the operation. He was worth from \$25,000 to \$50,000, but knowing the family's tendency to "nearness," I felt I must be moderate if I were able to keep my bone. I answered, "One hundred dollars!" The husband shook his head. "This big surgeon my sister wants us to call in would not charge me as much as that." I learned afterwards that my consultant of large fame actually did the operation—hysterectomy—for \$40.

I mention this case because it is typical of the point I wish to bring out. My consultant is a good man. His alma mater is proud of him, so is his State, so is his country—so am I for the advances he has made in surgery. He is an honor to his profession. He is one of the men whom an esteemed French confrère had in mind when he wrote me enthusiastically: "I have visited every great medical center in the world, and I have never yet seen the equal of your surgical clinics in Chicago. It is magnificent—the material, and the men you have to operate on it." My consultant is an overworked man; he has more operations than he can do. Patients wait their turn for him. He was not tempted to take my case away from me, nor unwilling to share the honors, if there were to be any, of the result of the operation, because he was in need of money. He is not a grasping man; his fee of \$40 would give the lie to such an accusation. It is said he stood at the head of his class in the average of his studies, but he certainly was never compelled to take an examination in medical ethics. He is too busy now to think about such a trifling thing as ethics. He may have seen the word written somewhere. He may possibly glance over the Association's revision of the Code, but it will never occur to him during his eminently successful and busy career to drink of the spirit of these rules and regulations. He is too old to learn. Hundreds of men will continue to witness his operations and to learn what they may from him, but if they have good sense, they will avoid him assiduously as a consultant. Meanwhile he will unconsciously continue, day after day, to go on with the gentle art of dampening the youthful ardor of the enthusiast who leaves his alma mater with high ideals and ethical aspirations. He will make these men smile at the mention of Flint on Ethics, and have thoughts unfit for publication when he reads, "Of the duties of the physician in regard to consultations."

In Article 1, Section 2, the revision of the Code admonishes the physician "to entertain a due respect for those seniors who, by their labors, have contributed to its advancement." Be assured the younger man will never fail in veneration for his senior, if the latter is worthy of it. The ethical man of reputation will ever have bestowed on him his due—and more.

The discourtesy existing in many of our medical societies in America is proverbial, and so rough is the abuse at times, and so unwarrantable the insults, that many a man who would gladly give his little to "enrich the science" with some new thought or experience, shrinks from a public encounter with his medical associates. Allow me to detail another personal experience. At the suggestion and invitation of a most ethical consultant, I presented, a few months ago at one of the medical societies, a simple apparatus for the convenience of putting up, at right angles, a fractured leg of an infant. The history of my case in brief was this: After a difficult and tedious labor in a primipara, aggravated by a breech presentation, I delivered my patient of a living eight-pound child. As a last resort, when the anesthetic had to be stopped on account of a very rapid pulse, and a threatened cessation of respiration, I used

the blunt hook. Stimulants were given hypodermatically, and artificial respiration was being performed while I made one last attempt to deliver the child with the aid of that instrument. I succeeded, and at the same time fractured the upper third of the thigh during the process. Fortunately, the mother and child made a good recovery. At my request the parents consented to bring their babe to the medical society on the evening that I was to exhibit my apparatus. I gave a brief outline of the case from the *time of fracture*, merely mentioning that the accident had occurred from the use of the blunt hook during delivery. I exhibited the X-ray photograph of the broken fragments of the femur, the little apparatus that had served its purpose so well, the various photographs of the infant while in the fracture bed, and the undeformed child. As soon as I had finished my remarks, and while the baby, held in the mother's arms, was being exhibited, one of the most noted members of the society sprang to his feet and began to denounce, in very scathing terms, my use of the blunt hook. Under the most favorable circumstances the discussion of the use of the blunt hook was hardly in order. The man criticizing me knew nothing of the emergency of the obstetrical case. Moreover, I came there solely for the purpose of presenting a simple and effectual means of suspending the fractured leg at right angles, and in the hope that even the little I had to offer might serve its purpose of "enriching the science," no matter how insignificant that enrichment might be. No words can express my consternation at the sudden turn of events, especially when the tirade of criticism directed against me was made in the presence of my small patient's mother and father. Up to this time the family had considered me, like Tommy Sandys, "a wonder!" But here was a revelation for them. I was caught red-handed in an unscientific and unpardonable error—had I conducted my case properly I would not have broken their baby's leg. It is hardly necessary to add, that I am not, at present writing, their family physician. The episode in the medical society may or may not be entirely responsible for their change of doctors. Be that as it may, I should certainly feel much easier if I were ever to exhibit another patient before the same society, if the individual were deaf, dumb and blind.

The point I wish to emphasize is this: The doctor who "called me down" before my patient was a thoughtless man. If he reads this article he will probably not remember the incident. He had never met me personally before, nor has he since. There was no malice, no evil intent, and I doubt if the majority of men present at that meeting gave the incident even a passing thought, so little would such a gross breach of ethics attract attention at the present time. But I ask in the name of all that is lofty in medicine, what an effect such an affair would have on a young fellow who had just started out in his practice, and who could not see how he was going to get money enough together to buy a winter overcoat. A young fellow, by the loss of that one family and the everlasting harm they could do him—if they so had a mind—might be compelled to give up the weary fight, and perhaps accept a position offered him by a chemical house as traveling salesman. I ask in all fairness why there should not be adequate punishment meted out to such men—no matter whether the blunder be of thoughtlessness or malice. Younger men must have protection from these onslaughts if it is expected of them to "entertain a due respect for those seniors, who by their labors, have contributed to its advancement."

Article IV, Section 4, says that "Consultations should be promoted in difficult cases, as they give rise to confidence and more enlarged views in practice." Theoretically, this is a fact. But I speak for the younger, struggling practitioner when I say I know in a great number of cases that if the physician in charge be in any degree a sensitive man, he is a moral coward when it comes to consultations. This is especially so if he is not personally acquainted with his consultant. Too often, on his senior's arrival, he waits breathlessly for—whatever damage this man who has made his mark in

the world, may see fit to deal him. We all realize the fact that it is not the rule for the consultant to be careful not to walk into the sick-room first. He frequently begins to examine the patient at once. He practically ignores the attending man, proceeds to interview the family, gives his diagnosis, prognosis and treatment, and finally leaves behind him doubts in the family, and a lack of confidence in their attending man. He not rarely does more harm than good.

Before we attain as high a regard in the eyes of the public as we have ambition for, we must set about casting these notes from our eyes. The older and more experienced man must never withhold a helping hand to the beginner. He must guide, protect, advise him, as he would his own son. He who reaches the summit of his profession must step on the center of the platform, with the lime-light full on him. He may err with impunity, he may have his weaknesses, his foibles as before he gained his fame, but he must never be found wanting in that sentiment which underlies and permeates the Golden Rule. Medical ethics after all, are simply the embodiment of that rule, and it must be the religion of the medical man. Not until our profession has been delivered from the chaotic state of its present ethics can we hope to stand together in a body for the good of present and future humanity. And until then it is a waste of space to insert Article II on the "Obligations of the Public to the Physician." We have no right to ask the public to respect us when we do not respect each other. We must turn out from our colleges as indispensable qualifications, men who are ethical to a degree. A majority of us to-day must turn over a new leaf in our attitude toward each other. We must pull up the commercialism, root and branch, that is eating into our vitals like a cancer. We must never be too busy, too overworked, too successful, to do unto others as we would wish them to do unto us.

Granted that the public should be enlightened so that they may more truly appreciate the difference between the spurious and the trustworthy qualifications of the medical man, be it also demanded that they be taught the laws of medical ethics. They should be able to detect the unethical consultant as quickly as the physician in charge. They should be taught to respect these ethics. And they should also be taught that the consultant who transgresses upon this Code is not the man to whom they owe obligations, consideration, or respect.

As an ethical body, in spite of our multitudinous differences, we can join hands. We can aid in repressing wrongs, physical and moral. We can successfully establish reformations. Isms, false sciences, charlatanism, will gradually die out from lack of patronage. There will be no limit to our potency for good.

I venture the statement that I can send one of my patients on whom I have recently performed an abdominal section, the rounds, in alphabetical order, to the physicians whose names appear in the Blue-Book, or official directory, that she can go to each one of these men with a like tale—e. g., that she has recently undergone an operation by me, that she is no better, that she doubts as to whether I was honest with her in what I said and did, that she would like to be examined and have them give her their opinions as to the nature of the operation I performed. Barring some of the men who know me personally, I think I do not exaggerate when I say that 3 per cent. only might ask if I had been paid and discharged from the case. I doubt if it would occur to 2 per cent. to find out if I were a physician in good standing, or if they had a telephone in their office, take the trouble to call me up before proceeding to grab my bone because I was not looking—especially if there were any meat on it in the shape of currency.

When such a state of affairs exists, I can readily believe that many of the men who read our revised Code, may think it worthy of emanating from the pen of our Mark Twain, and consider its fitness to be entered for a prize in the contest of the "Funniest thing I have ever read."

This is a busy, busy world, and so long as we, as a

body, adopt the present method of business for personal gain, no matter at whose cost, let us not be so cowardly as to ask the public for any more consideration than they give to other business men. We are neither better nor worse than the rest of tradesmen. Our religion is his religion: "Every man for himself and the devil for us all."

If we are not content with the present condition of affairs, we must begin at the very beginning. We must impress on the applicant for admission to our medical schools, that something more is required of him than his fee, and satisfactory credentials as to his literary attainments. He must be capable of comprehending and appreciating the sentiments and essentials of the Golden Rule. As a freshman, while vivid conceptions are made on his mind, he should receive a short but impressive course of lectures on medical ethics, and he should be examined on these lectures at the close of his freshman year, and he should not be allowed to continue with the remainder of his studies until he had passed a high per cent. in ethics. This should be continued during the remainder of the prescribed years of his college course. The strictest ethical conduct should be observed between professors and instructors. When a patient is sent from one department to another, or from one clinic to another, or from one college to another, the ethics of the man or men in charge, should be above reproach and of such a nature as to impress every student present. If there is the slightest chance of the patient having been attended by some physician and a previous diagnosis having been made, the last man whom the patient appeals to must withhold his opinion entirely, or at least he must give it in such a manner that the patient cannot interpret that there has been a criticism of his previous medical attendant or attendants.

There is a way in which one professional gentleman can disagree with another professional gentleman, or take serious issue with him, which is a source of inspiration to the student, and stimulates him with a healthy desire to hear both sides of the question, and no matter which view appeals strongest to the student's mind, he has a profound respect for both gentlemen. There is a broad-minded, courteous, refined way of differing from another, and there is a sneering, narrow-minded way not unlike the manner in which one butcher runs down another butcher's grade of meat, or his methods of business. We would be more honest with ourselves if we either entirely did away with a Code of Ethics and made no pretense of being ethical, or obeyed it to the letter. We must be a body of professional men with high aims and lofty principle, or we must be a body of first-class, shrewd business men.

We can accomplish the former much-to-be-desired condition of affairs only by educating our men while they are in college, and thus giving them an ethical conscience, as the up-to-date medical man acquires the "aseptic conscience." You can mark the man who has recently taken up the aseptic theory, and the man who has had it drilled into him from the time he was a freshman. It is second nature for the drilled man to hold his clean hands in the air until he is ready to touch the field of operation. He never forgets. He never touches anything that is not sterile. When his hands are cleaned they go as automatically as a soldier salutes when his superior officer passes him. If we would turn out ethical men from our schools we must train them with as much care as we drill them in their technic of asepsis. His ethics must become a part of him—second nature.

The consultant must fully understand that his influence is incalculable either for good or for evil. He must appreciate the fact that he often has it in his power to turn the tide of a young fellow's career. That he is responsible for the bulldog tendency of to-day. It is he who is capable, in a great measure, of inspiring the younger men to live up to the high ideals of their profession, and to be a worthy part of a body of men who can if they will, accomplish more good for humanity than any other profession or factor. On the contrary, he does his part in damning the hard-pushed, recent

graduate, until he finally gives up the fight and goes into another business, or worse yet, joins the ever-increasing army of men who have graduated from medical schools in good standing, and who become a menace to society by inserting medical advertisements in which they assure the public of "guarantees" and "sure prevention."

The alumni from every reputable medical college must remember their alma mater with affectionate regard, and they must be made to feel that the men connected with their alma mater are their foster fathers, and if they are deserving, they can depend on them always for encouragement, professional assistance, protection and for ideal consultation. We must add another chair to our medical course, and the man who is at the head of that chair must be possessed of an "ethical conscience."

ROBT. T. GILMORE, Chicago.

THE NEW YORK STATE MEDICAL ASSOCIATION.

By-Laws, as Amended, October, 1902.

Article I.—Organization.

Composition.—Sec. 1. The New York State Medical Association shall be composed of resident, non-resident, corresponding and honorary members.

Organization.—Sec. 2. The resident members shall constitute the active membership, and shall be organized into five (5) district branches and sixty-one (61) county associations.

Council.—Sec. 3. The Council shall consist of the officers of the Association.

Fellows.—Sec. 4. The Fellows shall be members specially chosen by the several county associations, to the number of one for every ten of this membership, to hold office for one year from the date of their election.

Officers.—Sec. 5. The Officers shall be a President, a Vice-President, five (5) Vice-Presidents ex-officio, a Secretary, a Treasurer and the Chairmen of the Standing Committees.

Committees.—Sec. 6. There shall be six (6) Standing Committees—namely, a Committee on Arrangements, a Committee on Legislation, a Committee on the Library, a Committee on Public Health, a Committee on Publication and a Committee on Nominations.

Term of Office.—Sec. 7. All officers, Fellows and members of Standing Committees shall hold office for one year from the date of their election or appointment or until their successors have qualified. No member shall hold more than one office entitled to representation on the Council.

Article II.—Duties of the Council.

Executive Board.—Sec. 1. The Council shall be the Executive Board of the Council and Fellows, with full power and authority to put into effect the purposes of the Association as expressed in its Charter, By-Laws and Resolutions.

Meetings.—Sec. 2. The Council shall meet annually in the City of New York, on the third Monday in October, and immediately after the adjournment of each annual meeting of the Association, and at such other times and places as the President may direct; and the President shall call special meetings at the written request of five (5) members.

Quorum.—Sec. 3. Seven (7) members shall constitute a quorum.

Order of Business.—Sec. 4. The order of business at all meetings of the Council shall be:

1. Roll-call by the Secretary.
2. Reading of the Minutes.
3. Communications from the Secretary.
4. Communications from the Treasurer.
5. Communications from the Chairmen of Standing Committees.
6. Unfinished Business.
7. New Business.
8. Adjournment.

Vacancies in Elective Offices. Delegates.—Sec. 5.

The Council shall fill vacancies in elective offices for unexpired terms, and shall appoint all delegates to the Societies of other States, and of foreign countries.

Prosecution of Violators of Medical Laws.—Sec. 6. The Council shall have authority to take action in all cases of violation of the laws relating to medical practice or public health, and may prosecute alleged violators of these laws. It shall be the duty of the Council, when necessary, to employ an attorney or counsellor at law who shall appear in all legal matters for and on behalf of The New York State Medical Association.

Defense of Suits of Alleged Malpractice.—Sec. 7. The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the Secretary, shall sign a contract renouncing his own and vesting in the Council sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused, but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise.

Death-benefit Fund.—Sec. 8. It shall be the duty of the Council to formulate a plan for a death-benefit fund when conditions seem favorable for action thereon and to submit the plan to an annual meeting of the Council and Fellows.

Board of Appeals.—Sec. 9. All appeals from decisions of District Branch Associations on questions of ethics and discipline shall be referred to and be adjudicated by the Council.

Poll of Council.—Sec. 10. The President shall have power, in the interim of meetings, to order a poll of the Council by letter. Upon such order the Secretary shall transmit to each member of the Council a copy of the question to be decided as formulated by the President, and shall call for a vote before a stated day. Votes received in conformity with this call shall be counted by the Secretary and a member of the Council designated by the President and the result recorded in the minutes of the Council.

Report.—Sec. 11. The Council, through its Secretary, shall present at the annual meeting of the Council and Fellows an annual report which shall include a statement of the investments, the condition of the funds of the Association, the disbursements for the current year and a record of all changes in membership.

Article III.—Duties of the Council and Fellows.

Meetings.—Sec. 1. There shall be an annual meeting of the Council and Fellows in the City of New York, on the third Monday in October, following the meeting of the Council; and special meetings at such other times and places as may be determined by the Council.

Quorum.—Sec. 2. Thirty-five (35) members shall constitute a quorum.

Rules of Procedure.—Sec. 3. All questions of order shall be determined in accordance with the rules of order and procedure laid down in "Roberts' Rules of Order."

Order of Business.—Sec. 4. The order of business at the annual meeting of the Council and Fellows shall be as follows:

1. Calling the meeting to order.
2. Roll-call by the Secretary.
3. President's report on the needs of the Association.
4. Annual report of the Council.
5. Report of the Treasurer.
6. Reports of the Standing Committees.
7. Reports of Special Committees.

8. Unfinished business.
9. New business.
10. Report of the Nominating Committee.
11. Election of Officers.
12. Reading of the minutes of the meeting and action thereon.

Article IV.—Duties of Officers.

President.—Sec. 1. The President shall preside at all meetings of the Council and of the Council and Fellows and of the Association. He shall appoint all committees or members of committees not otherwise provided for. At the annual meeting of the Council and Fellows he shall report the condition and needs of the Association, and shall deliver before the Association at its annual meeting an address upon some scientific subject at such time as may be determined by the Committee on Arrangements.

Vice-President.—Sec. 2. The Vice-President, at the request or in the absence of the President, shall temporarily perform the duties of President. In case of resignation, disability or death of the President, the Vice-President shall act as President until the next annual election of officers.

Vice-Presidents Ex-Officiis.—Sec. 3. In the absence or disability of the Vice-President, the Vice-Presidents ex-officiis shall take office in the numerical order of their district branch associations.

Secretary.—Sec. 4. The Secretary shall make and preserve accurate minutes of the meetings of the Council and Fellows, and of the general and special meetings of the Association. He shall conduct the official correspondence of the Association, shall preserve all such correspondence, including copies of official letters written by him. The Secretary may nominate to the Council, for its action, an Assistant Secretary who shall be under his direction and perform such secretarial and recording duties as may be prescribed by the Secretary. The Council shall decide upon the compensation of the Assistant Secretary, who may be required to be present at meetings of the Council.

Treasurer.—Sec. 5. The Treasurer shall receive and disburse all funds of the Association under the direction of the Council and Fellows. He shall make an annual report to the Council and Fellows on the finances of the Association and on the names of delinquent members. He shall collect the dues of non-resident members.

Bond.—Sec. 6. The Treasurer shall be under bond to an amount fixed by the Council and Fellows.

Article V.—Composition and Duties of Committees.

Chairmen.—Sec. 1. The Chairmen of all Standing Committees shall be elective officers, and the other members, with the exception of the Committee on Nominations, shall be appointed by the Council.

Sec. 2. The Chairmen of Standing Committees shall make full reports at the annual meeting of the Council and Fellows of the work done by their respective committees during the year.

Meetings.—Sec. 3. Each committee shall hold at least one meeting annually, at which a majority of its members shall constitute a quorum, and shall make and preserve accurate minutes of all its proceedings.

Committee on Arrangements.—Sec. 4. The Committee on Arrangements shall consist of thirteen (13) members, including the Chairman and the President, Vice-President and Secretary, who shall be members ex-officiis.

Sec. 5. It shall be the duty of this committee to take entire charge of and to make all necessary arrangements for each annual meeting of the Association.

Committee on Legislation.—Sec. 6. The Committee on Legislation shall consist of five (5) members exclusive of the Chairman, one from each of the District Branches. It shall be the duty of this committee to inform itself of all proposed legislation in the Legislature of the State bearing on medical subjects, and to organize and carry into effect, subject to the approval of the Council, such plans intended to influence legis-

lative enactment as it may deem for the best interests of the public.

Committee on the Library.—Sec. 7. The Committee on the Library shall consist of three (3) members, including the Chairman, who shall be designated as the "Director of the Library." This committee shall have charge of the Library and of the contained property. The Chairman of this committee may appoint, as required, a Librarian, subject to the approval of the Council, at such salary as may be determined by the Council and Fellows.

Committee on Public Health.—Sec. 8. The Committee on Public Health shall consist of five (5) members exclusive of the Chairman, one from each District Branch. This committee shall be charged with the duty of investigating all questions relating to public health and of presenting to the Council and Fellows recommendations as to action to be taken.

Committee on Nominations.—Sec. 9. The Committee on Nominations shall consist of a Chairman and two (2) Fellows elected by each District Branch. It shall be the duty of this committee to present nominees for all elective offices at the annual meeting of the Council and Fellows until such offices shall be filled, and to present, as occasion requires, nominees for appointment by the President, to serve for the unexpired term for any office made vacant by resignation or death.

Committee on Publication.—Sec. 10. The Committee on Publication shall consist of a Chairman and four (4) members to be appointed by the Council. This committee shall have full charge of all publications of the Association, with power to determine what papers shall appear in the printed "Transactions" of the Association. No paper that has appeared in print or that has been read before any medical society previous to its presentation before the Association shall be published in the "Transactions."

Article VI.—Meetings of the Association.

Annual.—Sec. 1. The Association shall hold an annual meeting in the City of New York, beginning on the Tuesday following the third Monday of October, and special meetings at such times and places as may be determined by the Council.

Special.—Sec. 2. Special meetings shall be called by the President on the written request of twenty-five (25) Fellows.

Order of Business.—Sec. 3. The order of business at the annual meeting of the Association shall be as follows:

1. Calling the Association to order.
2. Address of welcome by the Chairman of the Committee on Arrangements.
3. Reports of Special Committees.
4. Special addresses.
5. President's address.
6. Reading and discussion of papers.
7. Installation of officers.
8. Adjournment.

Article VII.—District Branches.

Sec. 1. The sixty-one (61) counties of the State shall be grouped in five (5) districts, to be constituted and designated as follows:

Territorial Divisions.—The First or Northern District shall embrace the counties of Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Oswego and St. Lawrence. The Second or Eastern District shall embrace the counties of Albany, Clinton, Columbia, Essex, Greene, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington. The Third or Central District shall embrace the counties of Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Madison, Onondaga, Otsego, Schuyler, Seneca, Tioga and Tompkins. The Fourth or Western District shall embrace the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Steuben, Wayne, Wyoming and Yates. The Fifth and Southern District shall embrace the counties of Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Rich-

mond, Rockland, Suffolk, Sullivan, Ulster and Westchester.

Organization.—Sec. 2. In each of these districts there shall be organized a District Branch Association of The New York State Medical Association, to be composed of the several County Associations and members residing in counties temporarily having no County Association.

Officers.—Sec. 3. The officers of each District Branch Association shall be a President, who shall be ex-officio, a Vice-President of the State Association, a Vice-President, a Secretary and a Treasurer.

Committees.—Sec. 4. There shall be an Executive Committee in each District Branch Association composed of its officers and of the several Presidents of the component County Associations, a committee on Legislation and a committee on Public Health, each consisting of five members to be appointed by the President, and a Nominating Committee composed of one member chosen from and by each of the component County Associations.

Duties of Officers

President.—Sec. 5. The duties of the President and the Vice-President shall be such as commonly pertain to those offices. In addition thereto the President shall assist in providing scientific material for the meetings of the County Associations in his jurisdiction, shall make state visitations to such County Associations during the year, shall make himself familiar with the character and quality of the work performed by those County Associations and shall report upon the condition of each Association to the District Branch at its annual meeting. Whenever he deems it necessary the President may invoke the aid of the Vice-President and Secretary.

Secretary.—Sec. 6. The Secretary shall perform the usual duties pertaining to that office and shall present an annual report of the proceedings of the District Branch Association to the Secretary of the State Association, and shall give therein the names of the Fellows and their Alternates and the members of the Nominating Committee of the State Association for his District Branch Association.

Treasurer.—Sec. 7. The Treasurer shall receive and disburse the funds of the Association (as hereinafter prescribed) under the laws regulating the distribution of dues.

Duties of Committees.—Sec. 8. The Executive Committee shall be charged with the general management of the affairs of the District Branch Association, and shall hold at least one meeting annually, at which five (5) members shall constitute a quorum.

Committee on Legislation and Public Health.—Sec. 9. The Committees on Legislation and Public Health shall be associate committees of the corresponding committees of the State Association and shall present a report at the annual meeting.

Sec. 10. The Nominating Committee shall present at the annual meeting a list of nominees for the several elective offices.

Annual Meeting.—Sec. 11. Each District Branch Association shall hold an annual meeting during the month of May, June or July, at which shall be chosen by ballot two Fellows to serve as members of the Committee on Nominations of the State Association.

By-Laws.—Sec. 12. Each District Branch Association shall make its own by-laws in conformity with the charter and by-laws of The New York State Medical Association, and subject to the approval of the Council.

Article VIII.—County Medical Associations.

Charter Associations.—Sec. 1. All such County Medical Associations as shall have accepted the invitation of The New York State Medical Association to become its subordinate associations at the time these by-laws are ratified by the Council and Fellows of the State Association shall thereafter be the County Medical Association contemplated in the charter for their respective counties.

Formation.—Sec. 2. When the members of any Dis-

trict Branch Association residing in any county are ten in number they shall forthwith be organized as the County Association of The New York State Medical Association for that County by the President of the District Branch. But any independent medical society in a county having no organized branch of this Association may, upon formal application after the adoption of the required by-laws, be accepted by the Council as the Branch of this Association for that county upon the payment of the required dues. Upon such acceptance by the Council members of this Association resident in that county shall become members of such County Medical Association.

Officers.—Sec. 3. The officers of each County Association shall be a President, Vice-President, Secretary and Treasurer, and any Association may have a Second Vice-President and a Corresponding Secretary.

Committees on Legislation and Public Health.—Sec. 4. All Committees on Legislation or Public Health of County Associations shall be associate committees of the corresponding committee of The New York State Medical Association.

Secretary.—Sec. 5. The Secretary of each County Association shall make an annual report to the Secretary of his District Branch Association, which shall contain the names of the Fellows and their Alternates and the member of the Nominating Committee of such Branch Association for his County Association.

Treasurer.—Sec. 6. The Treasurer shall receive and disburse the funds of the Association as hereinafter prescribed under the laws regulating the distribution of dues.

Annual Meeting.—Sec. 7. Each County Association shall hold an annual meeting during the month of January, February, March or April, at which shall be chosen Fellows of the State Association to the number of one for every ten of the County Association membership, a corresponding number of Alternates, and one member of the Nominating Committee of the District Branch Association.

By-Laws. Sec. 8. Each County Association shall make its own by-laws, which shall be in conformity with the charter and by-laws of The New York State Medical Association and subject to the approval of the Council.

Article IX.—Membership.

Eligibility.—Sec. 1. Physicians in good standing, resident in the State of New York, and duly licensed and recorded in the office of the County Clerk of their respective counties, shall be eligible for active resident membership in The New York State Medical Association. Physicians in good standing, members of other State Associations, shall be eligible for non-resident membership. Physicians of eminence, members of other State Associations shall be eligible for corresponding membership, and in other countries for honorary membership.

Application and Election.—Sec. 2. Application for resident active membership shall be made in prescribed form to the County Association in the county in which the applicant resides, or, when no such County Association exists, to the District Branch Association. The Council may elect members at any regular meeting when the application is approved by three (3) members of the Executive Committee of his District Branch Association, provided there is no County Association in the county in which the applicant resides.

Non-Resident, Corresponding and Honorary Members.—Sec. 3. Upon nomination by two Fellows, non-resident members may be appointed by the Council. Corresponding and honorary members, not to exceed two each during any one year, may be appointed by the Council at its annual meeting after nomination by three Fellows in writing at the preceding annual meeting.

Privileges of Members.—Sec. 4. Resident members shall have all the rights and privileges conferred by their respective County Associations and District Branch Associations. They shall be eligible to any office in the gift of the Association; shall be entitled to attend all meetings of the Council and Fellows, and

shall receive all the protection, benefits and support conferred by the Association; but if a member's dues be unpaid at the time of the annual elections of his County Association or District Branch Association he shall not be counted as a basis of representation in this Association; shall not be eligible for election as a Fellow, shall not receive the publications of the Association or be included in its published list of members for that year, nor thereafter until he has discharged his indebtedness in full.

Sec. 5. Non-resident, honorary and corresponding members shall be privileged only to take part in the scientific meetings, programmes of which shall be sent to them, and they shall receive the "Transactions" of the Association.

Removal.—Sec. 6. When a member in good standing of a County Association removes to another county his name shall be transferred to the roll of members of the Association in the county of his new residence.

Sec. 7. When a member removes from the State of New York permanently he shall cease to be a member of The New York State Medical Association, and shall forfeit all right and title to any share in the privileges and property of the Association. If he shall send a written notice of his removal to the Secretary of his County Association (or District Branch Association) within thirty (30) days of such removal he may make application to the Council for non-resident membership.

Resignation of Members.—Sec. 8. When a member shall resign his membership he shall thereby forfeit all right and title to any share in the privileges and property of "The New York State Medical Association" or its subordinate divisions.

Sec. 9. No member shall be permitted to resign while owing dues or assessments or while he is under charges which may lead to his expulsion.

Expulsion of Members.—Sec. 10. When a member is expelled he shall thereby be deprived of all rights and title to any share in the privileges and property of The New York State Medical Association.

Reinstatement of Members.—Sec. 11. When a former member applies for reinstatement he may be admitted to membership, provided that, if expelled for non-payment of dues, he makes good his indebtedness before he makes application for reinstatement.

Article X.—Dues.

Applications for Membership.—Sec. 1. All applications for membership shall be accompanied by five (5) dollars annual dues for the current year, but if the application be made on or after the first day of October such dues will be credited as of the next year.

Dues.—Sec. 2. The annual dues of resident and non-resident members shall be six (6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (1) dollar may be deducted. Corresponding and honorary members shall be exempt from the payment of dues.

Payment of Dues.—Sec. 3. All dues shall be payable on the first day of January of each year. Resident members shall transmit their dues to the Treasurer of their County Association or of their District Branch Association where no County Association exists. Non-resident members shall transmit their dues to the Treasurer of the State Association.

Collection of Dues.—Sec. 4. On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year, and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be dropped from the official roll of members.

Sec. 5. On every bill for dues sent to members, the Treasurer shall cause to be printed Sections 1, 2, 3 and 4 of this article.

Distribution of Dues.—Sec. 6. The Treasurer of each County Association and District Branch Association

shall pay to the Treasurer of the State Association the sum of \$5 or \$6 (in accordance with paragraph 2 of this article) for each and every member who has paid his dues for the year. Remittances should pass to the State Treasurer at such intervals as may be determined by the amount of accumulated collections on hand, but by the first day of October in each year all the funds properly coming to the State Association shall be in the State Treasurer's hands, to be included in his forthcoming annual statement

Article XI.—Ethics and Discipline.

Ethics.—Sec. 1. The Code of Ethics of the American Medical Association shall be the Code of Ethics of The New York State Medical Association and of its subordinate divisions, and shall form an integral part of the by-laws.

Discipline.—Sec. 2. The adjudication of all questions of ethics and the administration of discipline shall be vested in the County Association and the District Branch Associations, but any member under sentence of expulsion for any cause other than non-payment of dues shall have the right to appeal to the Council.

Article XII.—Delegates.

Election.—Sec. 1. Delegates and their alternates from this Association to the American Medical Association shall be chosen in the same manner as are the elective officers of the Association, and vacancies in their number may be filled by the Council. Credentials shall be furnished by the Secretary to said Delegates and their Alternates signed by the President and Secretary of the Association.

Reception of Delegates.—Sec. 2. At any annual meeting of The New York State Medical Association, duly authenticated delegates from societies of other States or from foreign societies shall be received, and such delegates may be invited to read papers and participate in the scientific proceedings of such annual meeting.

Guests.—Sec. 3. Invited guests, members of the medical and other professions may be accorded the same privileges as delegates from other States and foreign medical societies.

Article XIII.—Seals.

State Medical Association.—Sec. 1. The Seal of The New York State Medical Association shall be of the same size and design as that of the New York State Medical Association founded in 1884, but the marginal inscription shall be, in the upper segment, The New York State Medical Association, and in the lower segment, 1884-1900.

District Branch Associations.—Sec. 2. The Seal of each District Branch Association shall be identical in size and design with the Seal of the State Association, but the marginal inscription shall be, in the upper segment, 1884—The N. Y. S. M. A.—1900, and, in the lower segment, the number of the District Branch Association.

County Association.—Sec. 3. The Seal of all County Associations shall be identical in size and design with that of the State Association, but the marginal inscription shall be, in the upper segment, 1884—The N. Y. S. M. A.—1900, and, in the lower segment, the name of the county.

Article XIV.—Transfer of Property.

Transfer of Property.—Sec. 1. At the expiration of his term of service each and every officer of The New York State Medical Association and of its District Branch and County Associations shall transfer to the new incumbent such of the Association's property as may be in his charge, and the new incumbent shall give him a receipt therefor in which the nature of the property shall be specified.

Article XV.—Amendments.

Amendments.—Sec. 1. Amendments to these by-laws may be made by a three-fourths affirmative vote of the Council and Fellows present and voting at any regular meeting; provided that notice of such amendment shall have been presented in writing at the previous annual meeting.

News Items.

[All matter intended for this column should be in this office before the 22d of the current month, and should be addressed to Dr. L. C. Ager, corner Third avenue and Silliman Place, Brooklyn, N. Y.]

Orange County Association.—The annual meeting of this association was held at the office of Dr. M. C. Conner, Middletown, N. Y., on January 21, 1903. The following officers were elected for the ensuing year:

President, Dr. W. F. Purdy, Middletown, N. Y.; vice-president, Dr. W. E. Douglas, Middletown, N. Y.; secretary and treasurer, C. F. Redfield, Middletown, N. Y.; fellow New York State Medical Association, Dr. A. W. Preston, Middletown, N. Y.; alternate, Dr. L. G. Distler, Westtown, N. Y.

The amendments to the by-laws presented at the annual meeting of the New York State Medical Association were ordered to be printed.

A vote of thanks was tendered to the retiring president, Dr. M. C. Conner, for his unselfish work in behalf of the association and for the use of his office as a place of meeting.

Dr. W. S. Gotthiel, of New York, presented a very instructive address on some of the common and a few of the rarer forms of "Skin Diseases." The address was illustrated by some excellent photographs of the various skin diseases mentioned.

Dr. M. A. Stivers, of Middletown, presented a rare human monstrosity of the heart, liver, intestines and spleen. There was also a moderate hydrocephalus and a double talipes equinovarus with a peculiar deformity of the left hand, which was bent upward obliquely on a shortened forearm. The meeting then adjourned.

* * *

Chautauqua County Association.—The annual meeting of this association was held at the Jamestown Club House, Jamestown, N. Y., on January 20th.

Thirty members were present, and after the scientific program seven new members were elected to membership, as follows:

Dr. H. R. Willsie, Westfield, N. Y.; Dr. W. O. Smith, Falconer, N. Y.; Dr. A. F. Soch, Fredonia, N. Y.; Dr. A. C. Kingsley, Ripley, N. Y.; Dr. B. S. Swetland, Brocton, N. Y.; Dr. W. D. Wellman, Jamestown, N. Y.; Dr. B. S. Illston, Jamestown, N. Y.

In addition to the election of officers for the ensuing year, whose names will be found in the list of State officers printed elsewhere in the JOURNAL, Dr. M. N. Bemus, of Jamestown, was elected member of the Executive Committee; Dr. T. D. Strong, of Westfield, member of the Nominating Committee of the Fourth District Branch, and Dr. V. D. Bozovsky, of Dunkirk, an alternate. The next meeting will be held at Dunkirk the last Tuesday in May.

Dr. Alfred Austin Becker, of Jamestown, N. Y., was married on Wednesday, December 24th, to Miss Maud Jane Burch, daughter of Mrs. Carrie Burch Johnson, at New Richmond, Pa. Dr. and Mrs. Becker will be at home in Jamestown, N. Y., after February 1st.

* * *

Dr. Frank C. Raynor, recording secretary of the Kings County Association, was married on Monday evening, January 12th, to Mrs. Deichman, at the home of the bride, 54 Livingston street, Brooklyn. The couple have gone on an extended trip through the South.

INDEX MEDICUS.

The Carnegie Institution of Washington, D. C., will publish hereafter an Index Medicus, which is to be, as heretofore, a monthly classified record of the current medical literature of the world. The editors are Dr. Robert Fletcher and Dr. Fielding H. Garrison.

The subscription price (to be paid in advance) is \$5 per annum in the United States and Canada; in foreign countries, 25 shillings or marks, 30 francs or lire. All communications relating to subscriptions must be addressed: Carnegie Institution, Washington, D. C. Letters relating to the editorial department should be addressed: Editors Index Medicus, Washington, D. C.

OFFICERS OF THE NEW YORK STATE MEDICAL ASSOCIATION (Continued).

First or Northern District Branch.

PRESIDENT—Jeremiah R. Sturtevant, Theresa.
TREASURER—Edgar H. Douglas, Little Falls.

ONEIDA COUNTY MEDICAL ASSOCIATION.

VICE-PRESIDENT—James W. Douglass.
SECRETARY—J. Orley Stranahan.
TREASURER—John Groman.

Second or Eastern District Branch.

PRESIDENT—Everard D. Ferguson, 1 Union pl., Troy.
VICE-PRESIDENT—Pierson C. Curtis, Round Lake.
SECRETARY AND TREASURER—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

PRESIDENT—William E. Lothridge.
SECRETARY AND TREASURER—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Thomas Wilson.
VICE-PRESIDENT—H. Lyle Smith.
SECRETARY AND TREASURER—Otis H. Bradley.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Charles S. Allen.
VICE-PRESIDENT—Matthew B. Hutton.
SECRETARY AND TREASURER—Frederick A. Smith.
COMMITTEE ON LEGISLATION—E. D. Ferguson, chairman; William Finder, Jr.; William L. Allen.
COMMITTEE ON PUBLIC HEALTH—J. B. Harvie, chairman; D. W. Houston; W. L. Hogeboom.
COMMITTEE ON ETHICS AND DISCIPLINE—J. P. Marsh, chairman; H. C. Gordinier; George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Frank A. Palmer.
VICE-PRESIDENT—Henry J. Allen.
SECRETARY—James T. Sweetman, Jr.
TREASURER—William E. Swan.
EXECUTIVE COMMITTEE—G. T. Church (2 years); Francis W. St. John (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—David J. Fitzgerald.
VICE-PRESIDENT—Daniel B. Howard.
SECRETARY AND TREASURER—Frederick G. Fielding.

Third or Central District Branch.

PRESIDENT—Chauncey P. Biggs, Ithaca.
 SECRETARY—Franklin J. Kaufmann, 311 W. Genesee street, Syracuse.
 TREASURER—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

PRESIDENT—LeRoy D. Farnham.
 VICE-PRESIDENT—William A. White.
 SECRETARY—Clark W. Greene.
 TREASURER—William H. Knapp.

CORTLAND COUNTY MEDICAL ASSOCIATION.

PRESIDENT—S. J. Sornberger.
 VICE-PRESIDENT—Frank S. Jennings.
 SECRETARY—H. S. Braman.
 TREASURER—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Franklin J. Kaufmann.
 VICE-PRESIDENT—Bernard S. Moore.
 SECRETARY—Charles B. Gay.
 TREASURER—Alexander J. Campbell.

OTSEGO COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Julian C. Smith.
 VICE-PRESIDENT—Sylvester G. Pomeroy.
 SECRETARY—Arthur H. Brownell.
 TREASURER—Frank L. Winsor.

Fourth or Western District Branch.

PRESIDENT—J. William Morris, Jamestown.
 VICE-PRESIDENT—Bernard Cohen, 497 Niagara street, Buffalo.
 SECRETARY—William Irving Thornton, 152 Jersey street, Buffalo.
 TREASURER—Joseph Burke, 388 Franklin street, Buffalo.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Orrin C. Shaw.
 FIRST VICE-PRESIDENT—Era M. Scofield.
 SECOND VICE-PRESIDENT—Vacil D. Bozovsky.
 SECRETARY AND TREASURER—Henry A. Eastman.
 COMMITTEE ON LEGISLATION—Laban Hazeltine, George F. Smith, Herbert W. Davis.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.

COMMITTEE ON ETHICS AND DISCIPLINE—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Joseph W. Grosvenor.
 VICE-PRESIDENT—Howard L. Hunt.
 SECRETARY—Jacob S. Otto.
 TREASURER—William I. Thornton.
 COMMITTEE ON ETHICS, DISCIPLINE AND MEMBERSHIP—Charles G. Stockton, chairman; J. H. Potter, Grover W. Wende.
 COMMITTEE ON LEGISLATION—Herman E. Hayd, chairman; Edward E. Blaauw.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—Julius Ullman, chairman; Charles S. Jewett, De Lancey Rochester.

STEBUEN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—John G. Kelly.
 FIRST VICE-PRESIDENT—Charles O. Green.
 SECOND VICE-PRESIDENT—George C. McNett.
 THIRD VICE-PRESIDENT—Herbert B. Smith.
 SECRETARY AND TREASURER—Charles R. Phillips.

Fifth or Southern District Branch.

PRESIDENT—Parker Syms, 50 West 47th street, New York.
 VICE-PRESIDENT—Charles E. Townsend, 231 Liberty street, Newburg.
 SECRETARY—Charles S. Payne, Liberty.
 TREASURER—Edmund L. Cocks, 156 West 119th street, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Irving D. LeRoy.
 VICE-PRESIDENT—Edwin Barnes.
 SECRETARY—John W. Atwood.
 TREASURER—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.
 Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

PRESIDENT—George H. Treadwell, 64 South Portland avenue, Brooklyn.
 VICE-PRESIDENT—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
 RECORDING SECRETARY—Frank C. Raynor, 54 Livingston street, Brooklyn.
 CORRESPONDING SECRETARY—George F. Maddock, 80 McDonough street, Brooklyn.
 TREASURER—Edward H. Squibb, P. O. Box 760, Brooklyn.
 EXECUTIVE COMMITTEE—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.

COMMITTEE ON ETHICS AND DISCIPLINE—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.

COMMITTEE ON LEGISLATION—Charles P. Gildersleeve, chairman, 18 Schermcrhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Harry W. Skerry, William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month, except July, August and September.

PRESIDENT—Alexander Lambert, 125 East 36th street, New York.

FIRST VICE-PRESIDENT—Wilbur B. Marple, 35 West 53d street, New York.

SECOND VICE-PRESIDENT—Frederick P. Hammond, 129 East 116th street, New York.

SECRETARY—Ogden C. Ludlow, 234 West 135th street, New York.

CORRESPONDING SECRETARY—Frederic W. Loughran, 744 Prospect avenue, New York.

EXECUTIVE COMMITTEE—Frederick Holme Wiggin (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).

COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.

COMMITTEE ON ETHICS AND DISCIPLINE—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutilier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.

COMMITTEE ON LEGISLATION—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORANGE COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Willis I. Purdy.
 VICE-PRESIDENT—William E. Douglas.
 SECRETARY AND TREASURER—Charles I. Redfield.
 COMMITTEE ON LEGISLATION—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
 COMMITTEE ON PUBLIC HEALTH—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
 COMMITTEE ON MEDICAL CHARITIES—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
 COMMITTEE ON BY-LAWS—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Daniel Burr Van Wagenen.
 VICE-PRESIDENT—George A. Leitner.
 SECRETARY AND TREASURER—Norman B. Bayley.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.

COMMITTEE ON LEGISLATION—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Charles S. Payne.
 FIRST VICE-PRESIDENT—Howard P. Deady.
 SECOND VICE-PRESIDENT—George R. Bull.
 SECRETARY—John L. C. Whitcomb.
 TREASURER—Charles W. Piper.
 COMMITTEE ON LEGISLATION—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—A. B. Sullivan, chairman; Sherman D. Maynard.

COMMITTEE ON ETHICS AND DISCIPLINE—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—James L. Preston.
 VICE-PRESIDENT—Albert Reed.
 SECRETARY—Alice Divine.
 TREASURER—Alexander A. Stern.
 COMMITTEE ON LEGISLATION—Mary Gage-Day, chairman; E. Osterhout.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—Alexander A. Stern, chairman; George S. LaMoree, Alexander Stilwell.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Norton J. Sands.
 VICE-PRESIDENT—J. Lindsay Porteous.
 SECRETARY AND TREASURER—Donald T. McPhail.
 EXECUTIVE COMMITTEE—Benjamin Jerome Sands (1903), H. Ernest Schmid (1902).

COMMITTEE ON LEGISLATION—H. Ernest Schmid, chairman; William L. Wells, Edward F. Brush.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL CHARITIES—William D. Granger, chairman; Walton J. Carpenter, John W. Small.

COMMITTEE ON ETHICS AND DISCIPLINE—Richard B. Coutant, chairman; Thomas J. Acker, H. Eugene Smith.

The New York State Journal of Medicine.

Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.



PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 3.

MARCH, 1903.

\$1.00 PER ANNUM

PROPRIETARY REMEDIES.

Undoubtedly much of the popularity which proprietary remedies have received among some members of the profession has been entirely due to the ignorance of those physicians of the subject of pharmacology. This deplorable condition of affairs may be righted in the future by the colleges giving more careful and thorough instructions in materia medica and in the compounding of drugs, but that does not offer a means of doing away at once with these undignified and unscientific means of prescribing medicine. Prating of their compounds being ethical, of their frankly publishing the formulæ, of their catering only to the profession, the next breath may assure you that the druggist will dispense in such a way that the patient will not know that he is not receiving a combination of drugs and which is especially compounded for his own personal use. The insult is increased a thousandfold when those manufacturers assume to tell us the correct doses, and the diseases in which the remedies will work wonderful cures.

The space devoted in our journals to therapeutics could well be studied by those who feel themselves so incompetent as to be forced to use proprietary medicines. Would it not be well for our postgraduate schools to offer greater facilities for learning the art and science of medication and of proper prescription writing?

In an editorial of the *Journal* of the American Medical Association of February 7th the following remark is made and may well be taken to heart by those who have been drifting into unprofessional channels:

"It looks as though we were to have a reaction in the medical profession from the use of proprietary remedies and polysyllabic compounds to the employment of the simple but official drugs and compounds of the United States 'Pharmacopœia.' It cannot be denied that too many physicians are unfamiliar with that valuable work. Created by the medical and pharmaceutical profession, it has always been recognized by the pharmacist as a reliable and official guide, but

to the physician it has been too often an unknown work and one seldom found on his bookshelves."

REASONS FOR JOINING THE MEDICAL ASSOCIATION.

To be identified with the county, State and national organizations, just as every patriotic citizen exercises his rights of suffrage in local, State and national affairs.

To assist in raising the political and social standing of the profession to a higher plane.

To show interest in all matters medical which should demand the attention of any legislative body.

To assist in demonstrating that the medical profession is not less noble to-day than hitherto; that its members have not grown so "commercial" as to consider their skill as simply a "stock-in-trade" for sale to the highest bidder, but that love and sympathy for the human race are the prime instigators of their every action.

To assist in unifying the opinions of the best professional conduct, and in supporting such a code of ethics that the members may not be constantly harassed by temptations and uncertainties as to how to proceed.

Although a large proportion of the members of our Association are already members of the American Medical Association, still there are many of the members who have not realized their full privilege as members of our State Association by joining the national organization. It is hoped that these members will in the near future notify F. H. Wiggin, President of the State Association, of their intention to become members of the American Medical Association.

This is particularly important at the present time in view of the fact that the names of a large number of the physicians have been dropped from the rolls of the American Medical Association. These names have been carried without authority for some years and we should strive to make up the deficiency.

National Incorporation.—Our readers will be especially interested in a letter on another page, by the president of the New York State Medical Association, relative to a national incorporation for the American Medical Association. We urge every member throughout the State to give it his careful attention.

MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

The *Journal of the American Medical Association*, on January 31st, published an editorial entitled "Membership in the American Medical Association." We consider this very important and have printed it in full. We also publish the letter of Dr. Billings, president of the American Medical Association, and the letter sent out by Dr. Simmons, secretary, to members of the Association who were not affiliated with the State Association.

MALPRACTICE SUITS.

Three members of the Association have had the misfortune in being attacked by the blackmailing litigant, which in two of the cases immediately followed attempts to compel payment of bills.

It is with great interest that we are able to note that in every case the doctor has had the courage of his conviction and will compel these libelers to pay in the end. In one case the attorney for the plaintiff was called upon to pay \$20 costs of a motion and he has not made a move since.

The counsel for the Association has been somewhat hampered by members coming after having other counsel in the case. There can be but one "attorney of record" and he is apt to demur to Mr. Lewis coming into the case after the case is well started, and our counsel cannot take part unless asked to do so. It is far better if the member go direct to the president of the Association and thereby save himself the expense of an attorney.

It will take a little time for the lay public to learn that members of the New York State Association are poor subjects to attempt to frighten, as their legal defense is furnished gratis, but as soon as they learn it through the publicity given to a suit or two, the blackmailing variety of malpractice suits will cease. This class constitutes 97 per cent. of all of such suits brought.

It seems almost incredible that after all has been said and done, many of the members of the Association are not aware of this medical defense. If it were thoroughly known the membership would double within the year.

The attention of the officers of the County and District Branch Associations throughout the State is called to the very full report of the New York County Association in this issue. It should be possible for all of the secretaries of these associations to furnish similar reports of each meeting. Copies of all programs should be sent to

this office at the time that they are mailed to members.

ASSOCIATION DUES.

The attention of members who have not paid their dues is called to the by-law of the State Association relating to the payment of dues. See Article 10, Section 2, in the February number of the *JOURNAL OF MEDICINE*, on page 74. Members will receive a rebate of \$1 when dues are paid before April 1st. This rebate can be deducted on sending the amount of dues to the local treasurer.

Article IX.

Privileges of Members.—Sec. 4. Resident members shall have all the rights and privileges conferred by their respective County Associations and District Branch Associations. They shall be eligible to any office in the gift of the Association; shall be entitled to attend all meetings of the Council and Fellows, and shall receive all the protection, benefits and support conferred by the Association; but if a member's dues be unpaid at the time of the annual elections of his County Association or District Branch Association he shall not be counted as a basis of representation in this Association, shall not be eligible for election as a Fellow, shall not receive the publications of the Association or be included in its published list of members for that year, nor thereafter until he has discharged his indebtedness in full.

Sec. 9. No member shall be permitted to resign while owing dues or assessments or while he is under charges which may lead to his expulsion.

Article X.

Sec. 2. The annual dues of resident and non-resident members shall be six (6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (1) dollar may be deducted.

Sec. 3. All dues shall be payable on the first day of January of each year.

Sec. 4. On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year, and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be dropped from the official roll of members.

The Library of the New York State Medical Association is being constantly increased from time to time by contributions from members of the Association, as well as books sent for review, being returned to the library by the reviewer. While the number of new books is not large at the present writing, yet a beginning has been made and we hope soon to open a department for lending books to members. Before long we intend to issue a list of new books, showing the books that can be obtained. Members of the Association willing to offer their services to review medical books will kindly send their names to the chairman of the Committee on Publication.

MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

We print in this issue a communication and an official announcement, each of which is of importance at the present time. The communication is a letter from the president of the American Medical Association to a New York physician and bears directly on the present condition of affairs in that State, and indirectly on membership in the American Medical Association throughout the United States.

As stated by Dr. Billings, a committee was appointed by each of the New York State bodies for the purpose of considering the possibility of uniting the two into one organization. For a time it seemed that the efforts of the committees would result satisfactorily and a union be consummated. Then matters came to a standstill and the prospect for a settlement was as far off as ever. At this point President Billings, hoping against hope, asked for a conference with the two committees. The result of the conference is to be found in his communication. In brief, it appears that the proposition of the committee representing the New York State Medical Association was at first accepted, but later refused by the committee representing the society, viz., that the Medical Society of the State of New York should be the name of the reorganized body, that the general plan of organization of the New York State Medical Association should be adopted, that the New York State Medical Association should cease to exist, and that a committee representing both should go before the Legislature for a new charter.

While at the recent conference objections were made by the society committee to certain business and legal obstacles, the code, without doubt, was the one thing that blocked the efforts for union. Considering that a revised code had already been introduced and is in the hands of a committee to report at New Orleans, that an informal agreement relative to certain changes in the code was made at Saratoga between men representing the society, the association and the American Medical Association, and that affiliated societies are not now required to formally adopt the code, it does seem that the committee representing the society was not governed in its action by a too great amount of liberality.

The official notice regarding membership needs no further comment or explanation than is contained in the circular letter signed by the secretary and the preamble, with its decisions, signed by the president and the secretary. The medical profession is being organized on a definite and systematic principle, a principle which is the basis of all organizations, viz., that membership in the lower is necessary for membership in the higher body. This principle has always been the one governing membership in the American Medical Association, although it has not heretofore been enforced.—*Journal American Medical Association.*

Association News.

All matter intended for this column, unless received by the 20th of the current month, cannot be printed until the following month. All such matter should be addressed to Dr. Louis C. Ager, corner Third avenue and Silliman place, Brooklyn, N. Y.

COUNTY ASSOCIATION MEETINGS FOR MARCH.

Erie County, Monday, March 9th.
Kings County, Tuesday, March 10th.
New York County, Monday, March 16th.
Orange County, Wednesday, March 18th.
Cortland County, Friday, March 20th.
Westchester County, Thursday, March 26th.
Saratoga County, Last week in March.

Broome County Association.—The stated meeting of the Broome County Association was held on January 8th, at the office of Dr. Orton, in Binghamton. Seven members were present. A letter from Dr. C. P. Biggs, president Third District Branch Association, stating that the physicians of Tompkins County desired to form a county association, was read by the secretary and approved by the Nominating Committee.

Dr. J. H. Martin, of Binghamton, read a report of a case of confinement accompanied by fever, not septic. Dr. J. M. Farrington presented an elaborate paper upon the subject of a "National Code of Medical Ethics." The paper was discussed by nearly all the members present.

* * *

Kings County Association.—The regular monthly meeting was held at 315 Washington street, Brooklyn, on February 10th, at 8.30 p. m., the president, Dr. Treadwell, in the chair.

Dr. Henry H. Morton showed specimens of prostatic tumors and read a brief paper on the subject.

Dr. Arthur C. Brush read the regular paper of the evening on "The Etiology of Tabes Dorsales." The paper was discussed by Drs. B. Onuf, Wm. Browning, Cecil MacCoy and others.

In executive session the following were elected to membership in the Association:

Dr. Albert H. Brundage, Dr. Jas. C. Kennedy, Dr. Cecil MacCoy, Dr. Earl H. Mayne, Dr. Charles Waldo Stickle.

The Committee on Public Health and Medical Charities presented a preliminary report containing the following resolution for adoption by the Association:

WHEREAS, For the past ten years the summer infant mortality has been very appreciably higher in Brooklyn than in Manhattan; and,

WHEREAS, Such a condition must be largely preventable;

The Committee on Public Health and Medical Charities is instructed to bring the facts to the attention of the profession and the public, and to cooperate with similar committees from other organizations, with the Health Department and with various charitable organizations in their ef-

forts to prevent the occurrence of similar conditions during the coming summer.

The Committee also called attention to the resolutions adopted by the New York Academy of Medicine in regard to free sanatoria for consumptives and asked authority to take the initiative in bringing about a simultaneous effort on the part of every medical organization in the State for the enactment of suitable legislation and for the appropriation of funds to begin the erection of local sanatoria as they may be needed.

The report was adopted in full and was reported back to the Committee with power to carry out its provisions and instructions to report from time to time to the Executive Committee.

After the Association adjourned the usual collation was served.

* * *

New York County Association.—The stated meeting of the New York County Association was held February 16th, the President, Dr. Alexander Lambert, in the chair. The Committee on Public Health reported the following:

WHEREAS, The public health and comfort are sacrificed continually by the failure of the street railway companies to adequately heat their cars during the cold season; and,

WHEREAS, There is abundant evidence that it is perfectly feasible, without any change in the present equipment, to keep all of the cars comfortably warm and obviate the present dangers and discomforts connected with changing from warm to cold ones;

Resolved, That the New York County Medical Association emphatically protest against this long-standing and persistent disregard of the public health, and earnestly request the Health Department of the City of New York to immediately take such action as will most promptly and effectively remedy this evil.

Your Committee on Public Health report in regard to the resolution referred to said Committee at the stated meeting of the Association held December 15, 1902, that, as the State Railroad Commission, acting upon the letter of the Merchants' Association, is now considering the general regulation of street railroad traffic, including the heating of the cars, we suggest that the Association indorse the recommendations of the Merchants' Association and forward the indorsement to the State Railroad Commission and the Merchants' Association.

The Committee appointed to confer with other medical societies in regard to the abolition of the office of Coroner read its report.

Dr. Lambert offered the resolution as follows:

WHEREAS, Certain bills have been introduced in the Legislature to amend the present laws controlling the building and sanitation of tenement houses;

WHEREAS, These amendments, if passed, will utterly abolish the great advances made in recent years in tenement-house reform and sanitation bill, therefore

Resolved, That the New York County Medical

Association do most earnestly protest against these amendments as against the public health of this community.

The following new members were elected: Drs. Walter Brooks Brouner, Edgar Dinkelspiel, Victor Hugo Jackson, Libman Miller Kahn, Charles G. Kirchhof, John Lo Pinto and George Gibier Rambaud.

In the scientific session Dr. George Tucker Harrison presented a specimen of ectopic gestation with a beginning hematocele. He considered the specimen interesting from the fact that the tube was ruptured, whereas in most cases of ectopic gestation a tubal abortion occurred without rupture.

Dr. W. Gill Wylie read a paper entitled, "A New Method of Fixation of the Movable Kidney." He said that an abnormally movable kidney in women was very common. This is largely due to imperfect development, caused by insufficient exercise, especially among the well-to-do classes, and by tight corsets and waistbands which press upon the lower ribs and prevent proper use of the abdominal muscles.

Many of these women present also a relaxed condition of the stomach, intestines and omentum and a relaxed and congested condition of the generative organs. These cases are usually treated for "chronic dyspepsia," but if a careful search be made a diseased appendix may frequently be found. The displaced kidney probably does not cause the inflammation of the appendix, but if it descend low enough to press upon it, will cause pain.

In many of these cases removal of the appendix, even if the kidney be not replaced by operation, will relieve the pain and dragging sensation, the patient regaining flesh and strength. Before the surgeon operates to restore the kidney to its normal position he should make sure that *it* is causing the pain and not the appendix or some other abdominal or pelvic organ.

Dr. Wylie considers the efforts of many surgeons actually to "fix" the kidney at the level of or just below the twelfth rib as wrong, for the kidney is normally somewhat movable. Besides which, if fixed at this level, the tight corsets and bands press on the kidneys, causing pain and discomfort.

His aim is to replace the kidney in its proper position and then suspend it in such a way that it moves slightly with respiration as it should in health. This is accomplished in the following way: The incision is made just below the twelfth rib; the kidney is replaced; then the fatty, fibrous capsule is pulled out with forceps until the tension holds the kidney just above the twelfth rib, but allowing it to move slightly with respiration; the surplus capsule is cut and the ends sutured to the fascial lining of the muscles about the opening with silk; the muscles are closed with catgut. After this operation the kidney is usually in its normal position and also possesses its normal mobility.

Dr. Alex. B. Johnson read a paper on "Re-

sults Obtained by Fixation of the Kidney by Present Methods."

Dr. Johnson stated that the object to be obtained was the replacement of the kidney without interference with the functions of the ureter or disturbance of the colon. He gave details of the methods adopted by the different surgeons to obtain this result. He considers Riddell's (?) method of operation good and prefers catgut for sutures.

DISCUSSION OF PAPERS.

Dr. Blake considered the failure to fix the kidney under the diaphragm due to its rotating on its upper pole and thus coming to lie horizontally. In suturing, the stitches may be passed either through the fatty or fibrous capsule, as their support is useful only till the granulations form. Catgut is the best material.

Dr. Erdman discussed the frequency of appendicitis occurring with displaced kidney. Fixing the kidney does not relieve the symptoms in these cases or if splanchnoptosis be present. As the rapid healing of the kidney wound is the important point, the matter of suture is secondary. In fact, if the patient could be kept quiet enough, suture might be dispensed with. Kangaroo tendon is the material he uses.

Dr. Goelet said that the danger in movable kidney was not its mobility, but in its too low displacement. The unsuccessful operations are often due to lack of proper care before operation and imperfect freeing of the capsule, during operation, of the adhesions with the intestines. He condemns catgut as too liable to stretch and prefers silk.

Dr. E. W. Lee splits the capsule and rolls it back on each side until a scroll is formed, and sutures through this thick roll, as the stitches hold better. He thinks catgut treated with silver salts in the Crèdè method a strong and non-stretchable material.

Dr. Wylie, in closing the discussion, repeated his conviction that in replacing a kidney it should be suspended and not fixed, but added that he had come to operate less and less, as he thought more good was accomplished by attending to the complicating abdominal and pelvic troubles and to the general health.

Ulster County Association.—The annual meeting of the Ulster County Association was held at the Kingston City Hospital, February 16th, at 2 P. M. The president, Dr. J. L. Preston, occupied the chair.

After the auditing of the treasurer's accounts and the reading of the secretary's report for the past year, the following officers were elected for the coming year:

President, Dr. Henry Van Hoevenberg, Kingston.
Vice-president, Dr. George S. LaMoree, Highland.
Secretary, Dr. Mary Gage-Day, Kingston.
Treasurer, Dr. Alice Divine, Ellenville.

Fellow, Dr. Alexander A. Stern, Rondout.

Alternate, Dr. Mary Gage-Day, Kingston.

The newly elected president appointed the following standing committees:

Committee on Legislation—Drs. Alexander A. Stern, Frederick A. Hunt and Elijah Osterhout.

Committee on Public Health—Drs. James L. Preston, Benjamin Neal and Elbert Reed.

Committee on Ethics—Drs. Frederick Huhne, Alexander Stilwell and Arthur J. Benedict.

After the business session the retiring president, Dr. J. L. Preston, gave an address on "Neurasthenia." This subject was of practical importance to all the physicians present, and in the discussion they agreed with the writer as to the limited use of drugs in the treatment and the importance of hygiene.

* * *

ADDITIONAL LIST OF MEMBERS IN THE NEW YORK STATE MEDICAL ASSOCIATION.

Ayling, William J., 606 East Fayette street, Syracuse, N. Y.

Bacon, Carroll B., Waterloo, N. Y.

Baldwin, Edward R., Saranac Lake, N. Y.

Beers, Nathan T., Jr., 1265 Bedford avenue, Brooklyn, N. Y.

Benedict, Arthur Judson, Phoenicia, N. Y.

Broughton, Lyman C., Castile, N. Y.

Brouner, Walter Brooks, 256 West Twelfth street, New York City.

Brundage, Albert H., 1073 Bushwick avenue, Brooklyn, N. Y.

Callan, Peter A., Yonkers, N. Y.

Cornell, Bora Bell, Warsaw, N. Y.

Dennis, Charles W., Goshen, N. Y.

Dinkelspiel, Edgar, 210 West 44th street, New York City.

Fuller, Nathaniel Hall, Friendship, N. Y.

Graber, Sidney S., 185 East 71st street, New York City.

Harnden, Rufus S., Waverley, N. Y.

Illston, Bergen F., Jamestown, N. Y.

Jackson, Victor Hugo, 240 Lenox avenue, New York City.

Jones, Edward W., 791 Michigan avenue, Buffalo, N. Y.

Kahn, Libman Miller, Lebanon Hospital, New York City.

Kennedy, James C., 762 Willoughby avenue, Brooklyn, N. Y.

Kingsley, Alfred C., Ripley, N. Y.

Kirchhof, Charles G., 527 St. Ann's avenue, New York City.

Lewis, Maurice T., 414 55th street, Brooklyn, N. Y.

Lo Pinto, John, 205 Grant street, New York City.

MacCoy, Cecil, 151 Clinton street, Brooklyn, N. Y.

Mayne, Earl H., Bath and 18th avenues, Brooklyn, N. Y.

Noonan, Cornelius J., 554 Henry street, Brooklyn, N. Y.

Nour, George Elias, Niagara Falls, N. Y.

Payne, Dorethea, Warsaw, N. Y.

Hubbard, Edward Quinn, 108 West 71st street, New York City.

Rambaud, George Gibier, 313 West 23d street, New York City.

Smith, William O., Falconer, N. Y.

Soch, Albert Ferdinand, Fredonia, N. Y.

Stickle, Charles Waldo, 1315 52d street, Brooklyn, N. Y.

Swetland, Benjamin S., Brockton, N. Y.

Tremaine, Annie M., Sonyea, N. Y.

Wellman, Warren D., Jamestown, N. Y.

Willse, H. R., Westfield, N. Y.

Wright, Albert B., 22 Park street, Buffalo, N. Y.

Original Articles.

HERNIA.¹

BY S. W. S. TOMS, M.D.,
Nyack, N. Y.,

Instructor in Surgery, New York Post-graduate Medical School and Hospital; Member of Visiting Staff, Nyack Hospital.

HERNIA being synonymous with rupture is applied in general terms to the escape of any viscus through a congenital or pathological opening from the abdominal cavity where it is naturally contained.

Some herniæ are rare and will not be considered in this paper—only inguinal, femoral and umbilical are under discussion, because of their pathological importance, the frequency of occurrence and their amenability to treatment.

The inguinal herniæ are of two varieties—oblique and direct.

The oblique or external may be congenital or acquired, and are due to a predisposing weakness or imperfection in the tissues comprising the inguinal canal, *i. e.*, such as the non-closure of the vaginal process of the peritoneum following the prenatal descent of the testicle, and such herniæ are a frequent accompaniment of cryptorchism; another cause being the possible adhesion of a viscus to the peritoneal covering of the testicle within the abdomen, the descent of which causes a hernia to be drawn down with it (Sultan).

There are a number of anatomic peculiarities of congenital inguinal hernia recently described by Bayer which I need not enter into here (*loc. cit.*).

The acquired oblique hernia always follows the course of the inguinal canal with the spermatic cord and its vessels, and may stop at any point in its descent. When it does not appear at the external orifice it is termed incomplete and called a bubonocoele. If, however, it passes through the external ring, it becomes *complete* and usually descends into the scrotum.

The fine anatomic distinctions of herniæ serve but to confuse, and need not occupy our attention, as they possess no particular consideration of a practical bearing upon treatment.

The direct or internal inguinal hernia protrudes directly through the internal inguinal fossa, being the space at the outer side of the rectus, which has no muscular covering, so that, in advancing years and relaxation of the abdominal parietes, a hernia can easily protrude which appears at the external abdominal ring.

There is no pre-existing canal here, hence this variety of hernia is never congenital and occurs only in adult or advanced life, being usually acquired as a result of chronic bronchitis or some other cause increasing intra-abdominal pressure. They are globular in shape, frequently bi-lateral and seldom scrotal.

THE IMPORTANCE OF HERNIA.

The inguinal and femoral are the most common

types, and their frequency depends upon sex, age, occupation and locality. Without going into elaborate and detailed statistics quoted by various authorities, the ratio of ruptured persons is about 1 to 15 in men and 1 to 40 in women (Agnew). More recent European statistics give 4.4%, ranging from 19.6% in first year to 1.14% at the fifteenth year (Berger). As this affliction is responsible for the lessening of the earning power of the individual by 10% with a reducible hernia perfectly retained, it can be somewhat appreciated what the large number of affected cases means in the unequal struggle for maintenance, to the sufferer and his family, and to the industrial economy of the State; and correspondingly greater if the hernia is retained with difficulty, is irreducible or of large dimensions (*loc. cit.*).

ETIOLOGY.

Predisposing factors are seldom if ever wanting, such as anatomical weakness and defects of a congenital nature. Malformations, as a sub-peritoneal lipoma acting as a wedge and making traction on the peritoneum, producing a true hernial sac.

An ectopic testis is usually accompanied by a hernia. Other causes I have previously referred to.

Heredity is certainly a remarkable element and frequently observed in the hospital clinics, where several members of the same family are subjects of hernia.

Exciting Causes.—Chief of these is increase of intra-abdominal tension, coupled with a congenital predisposition; straining at stool; sneezing; lifting; blowing wind instruments; logging; long and exhaustive marches; tight belts, *especially in infancy*; the sitting posture, favoring weakening the abdominal muscles. Phimosis in infants, causing reflex irritation of the vesicle neck in straining to micturate. The development of the hernial sacs is favored by rapid emaciation, and also by the accumulation of fat and excessive length of mesentery. Traumatic herniæ are infrequent because there must have already existed a congenital sac.

SYMPTOMS.

Many cases of acquired hernia, of the inguinal, oblique and femoral varieties, are unable to give a definite history of onset, while others can define the sensations occurring subjectively when the hernia is produced by some physical exertion. There is usually a feeling of something having suddenly given way, a stinging or burning sensation in the locality, while the pain may be referred to some distant part, as, for instance, to the umbilical region. There may be nausea and a feeling of faintness.

The objective symptoms may be wanting, but cases have been reported where a viscus has been protruded, and produced immediate strangulation.

All herniæ produce discomfort, with frequently more or less local and reflected pain and colic; dyspeptic symptoms; a sensation of weakness and

¹Paper read at the annual meeting of the Rockland County Medical Association January 21, 1903.

insecurity upon exertion; difficulty in rising from sitting posture, and maintaining an erect position; inability to endure enforced or prolonged fatigue; an altered sensation down the legs, due to the pressure of the hernia or a truss pad on the ilio inguinal nerve; often a clodness; sometimes partial anesthesia; the bowels are frequently constipated and irregular, and pain experienced at stool. Bladder symptoms usually exist in old and neglected cases, and the mental condition of the patient is often one of depression, introspection and self-consciousness. The symptoms of an irreducible or incarcerated hernia may be all those enumerated above and frequently exaggerated. In cases of strangulation all degrees of intestinal obstruction, from those of a mild type (where only omentum may be strangulated) to the more profound, with shock, rapid pulse, sub-normal temperature, vomiting, obstipation and abdominal pain, are present.

DIAGNOSIS.

The first point in diagnosis of inguinal hernia in the male is to ascertain if the testicle and cord are in the scrotum. If in the inguinal canal, whether they can be brought down into the natural repository or reduced into the abdomen. If the latter, by invaginating the scrotum with the finger (or the loose tissue of the mons in the female), to ascertain whether the orifice is above or below Poupart's ligament. If below, it is femoral; if above, an inguinal oblique. Should it be internal to the inguinal canal in an elderly person, with a history of acquiring it after middle life, in shape oblong or globular, and not scrotal, it belongs to the direct variety.

If a moderate-sized hernia, located in the groin, what other affections may it be confounded with? If the tumor is in a male and reducible, it is most likely an inguinal hernia, as the hernial orifice can easily be determined, as indicated, in most subjects; yet in a very fat woman it is often difficult to determine whether the orifice is above or below Poupart's ligament.

Again, in very large scrotal herniæ, to which side does the hernia belong? When reducible the side to which the hernia can be made to return and the location of the testicles will serve as reliable guides, as the testicle of the healthy side remains in the proper position, while the other is posterior and pushed downward.

Nearly all scrotal herniæ in infants and children, of recent origin, are congenital, appearing soon after birth.

An existing hernia, reduced through the internal inguinal ring, the canal being empty at time of examination, can be diagnosed by a slight amount of abdominal fluid perceptible in the hernial sac, felt in the course of the canal, the patient being in the upright position.

In adults the increasing size of a hernia gradually dilates the inguinal canal and finally causes it to lose its oblique direction, often making it difficult to determine an oblique from a direct

hernia. The latter, however, usually stops at the root of the penis and rarely descends into the scrotum.

As an inguinal hernia can be mistaken for a retained or dislocated testis, swollen lymphatic glands, psoas abscess, a sub-peritoneal lipoma, and frequently for a hydrocele of the cord, it is important to be able to differentiate these conditions.

We should commence with inspection by systematically examining the patient after a careful history and cross-questioning which will furnish subjective information. Does the tumor correspond to one of the hernial openings, and has it a pedicle attached within the abdomen? Does it change with the position of the patient, and is the impulse exaggerated by coughing?

In palpating the tumor, does its base enter the orifice within the abdomen, or can it be separated by the thumb and finger?

One of the surest signs of hernia is its reducibility, tympanitic sound, and gurgling on manipulation when bowel is involved. If omentum, it has a doughy feel, lumpy, and reduction more difficult, with absence of gurgling. When incarcerated, the diagnosis is more difficult, yet the history of the case helps to confirm the diagnosis.

As all abdominal herniæ are subject to the same general laws it does not seem necessary to go into details regarding the recognition of the others, as anatomical landmarks serve to give them a name. The following are the main features of

INGUINAL HERNIA AND HYDROCELE TESTIS.

Anamnesis.

The tumor appears suddenly during an augmentation of the intra-abdominal pressure; or gradually, in which case the swelling is first noticed in the abdominal wall and the enlargement is toward the testicle.

The swelling develops more slowly, not rarely after a contusion of the scrotum or inflammatory changes in the epididymis.

The swelling commences in the bottom of the scrotum and gradually spreads toward the abdomen.

With a single exception—hydrocele communicans—they do not suddenly change in size.

Inspection.

The swelling seems to be directly continuous with the tissues of the abdomen.

The swelling is not translucent; in rare cases in very young children it may be translucent.

The swelling is usually sharply circumscribed from the abdomen.

The swelling is translucent; if the walls are very thick, or if spermatic fluid or blood is present, it may not be translucent.

Palpation.

If an attempt is made to draw the tumor away from the abdominal wall between the thumb and index finger, a portion of the tumor is felt passing into the abdominal cavity.

The tumor may be replaced.

If the same attempt is made, nothing is felt between the tumor and the abdominal wall but the constituents of the spermatic cord.

The volume of the tumor remains unchanged upon pressure (with the exception of a hydrocele communicans).

Percussion.

Under certain circumstances a tympanitic note is obtained. Always dull upon percussion (*loc. cit.*).

The common forms of all abdominal herniæ tend to recovery by mechanical means during the first two years of infancy.

After the child is able to run about in the erect posture, mechanical treatment becomes less efficient and cures are the exception instead of the rule. There are many reasons for this. An active child rebels against the irksome restraint of even the best-fitting truss; carelessness upon the part of parents, in their attentions, and often an improper appliance is worn.

Prognosis in the operated cases depends upon the conditions, the kind of hernia, age, etc.

Operations of election by the Bassini method in inguinal hernia are seldom failures, and a death in 1 to 300 to 500 is quite a high rate of mortality. Recurrences in femoral are occasionally seen. Umbilical will furnish the highest death rate because of the class of subjects afflicted, corpulent, full habit, with poor hearts and kidneys. The mortality in strangulated cases depends, like appendicitis, on the time of operation.

TREATMENT—MEDICAL AND SURGICAL.

The management of hernia to-day is tending more toward the radical than ever before, because of the safety of operation, in a death rate of infinitesimal proportions, the decreased likelihood of relapse since the newer methods have devised a secure operative procedure, and the short time spent in confinement to bed (being about ten days), the percentage of cures being 100 in those cases of primary union in healthy subjects.

Yet no matter how much advance there may be in the art of surgery, the mechanical treatment of this affliction must always remain the chief source of relief to the vast majority of sufferers. The reasons for this are so obvious to us all when a patient consults us that to give them, to emphasize the statement recorded, would be superfluous.

To all infants with uncomplicated conditions the application of a properly selected and well-fitting truss, coupled with a reasonable intelligence of the mother or nurse, will effect a cure within a year or eighteen months in 90% of all cases, under safeguarding observation by the medical attendant. This is because the inguinal and umbilical herniæ are most amenable to such treatment, and usually are the only varieties met with in this period of life.

Recumbency of the little patients prevents the hernia descending through the patulous orifice except in straining, when the pressure of a truss *over the ring* affords necessary protection. Recovery takes place not by any occlusion of the sac or by adhesive inflammation, as has been generally concluded, but by a true retraction of the sac within the abdomen.

I will not enter into the history of trusses,

which is very interesting, as space does not permit, but state my reasons for the rejection of the ordinary forms on the market, and the ones usually sold by the dealer or selected by the wearer.

The German and English patterns are mostly used, and I cannot express my condemnation of them in sufficiently strong terms, because the pad, resting as it does on the pubic bone, allows the hernia to protrude through the internal inguinal ring, acting constantly as a dilating wedge in the whole course of the inguinal canal. Its prolonged use tends to enlarge the opening and eventually causes the internal ring to widen down into the external, until it becomes one immense aperture into the abdominal cavity. Therefore, all possibility of a cure resulting spontaneously from a proper retention of the hernia is absolutely removed, and the condition made worse.

This objection applies to most of the different forms of continuous spring trusses where the pads are placed upon descending arms and exert the pressure in a direction that invariably enlarges the hernial openings and canal.

Sir Astley Cooper, in the early part of the last century, appreciated these defects. He stated: "The object in applying a truss is to close the mouth of the hernial sac, and destroy its communication with the abdomen, and this object can never be perfectly fulfilled by any truss which is applied upon the external abdominal ring."

"The essential requisites of a good truss," says Holmes (*Syst. Surg.*), "are these, that it should fit easily, should not shift by any movement of the patient's body, not gall the skin, or any part project against the abdominal wall; its pad should cover the hernial aperture and its pressure should be directed properly, and should be great enough to prevent the descent of the hernia in any position or exertion which the patient may make; but it should not be so severe as to cause enlargement of the opening; the pads should be supported with the least possible force or the application will become irksome. Variations in pressure are very essential in order to adapt it to different circumstances; finally, the direction in which the pressure is made must correspond to that of the inguinal canal."

The cross-body or Marsh truss and the Hood pattern meet these requirements admirably. The former includes fully two-thirds of the body, and is applied from the opposite side, the points of pressure being over the internal inguinal ring and the gluteal muscles of the affected side by a counter pressure pad on the distal end of the spring. When shaped to the individual form it is worn with comparative comfort and security. The pad and pressure should be suitable to the case under treatment. This truss is best suited for femoral hernia as well as inguinal oblique.

The Hood truss is an encircling spring with solid front, carrying one or two hernial pads, and open at the back, being fastened by a short connecting strap. The spring being of German silver is readily malleable, and when these

trusses are covered with an impervious material they are cleanly and comfortable. This truss is so shaped that it passes about the pelvis at the most immovable point, and is, like the cross-body, entirely out of the way of the muscles of locomotion, allowing perfect freedom in all movements of the body.

These two forms of trusses are efficient, and combine security with ease of wearing when properly fitted, being suited to all ages and conditions that admit of a hernia being retained by mechanical means.

Belt trusses are only mentioned to condemn, as they constrict the hips, giving very little pressure over the inguinal region where it is most needed. They have a place as a night truss, when it becomes necessary to employ one where a persistent cough is present. That patients afflicted with hernia who consult the average physician are not advised and treated as other medical cases are is manifestly true, the usual advice being, "Go to the druggist and get a truss." This vague prescription is chargeable, to say the least, to listlessness of physicians, who thereby forfeit a kind of professional service, through inability to apply mechanical therapeutics for which they could justly claim compensation. By proper forethought the profession could instead reserve to its own members a professional duty which now goes by default to druggists, who are seldom more qualified, and should be considered less so than the physician, to perform it. Infinitely more satisfactory for both patient and physician would it be if professional selection and guidance were exercised for the sufferer's benefit in the proper adjustment of a suitable appliance. The whims and prejudices of patients, and their crude ideas formulated from the continual failures and discomforts of badly fitting trusses, as to what is needed for their cases, are seldom reliable guides in the selection of a suitable appliance.

In an address to the New York Medical Association meeting in 1889, Dr. Jos. D. Bryant says:

"The greater number of medical men of the present day are blissfully ignorant of the truss armamentarium now in the market, also of the measurement, means and method of fitting them properly to patients. The patients thus afflicted are relegated to the 'instrument makers,' or to other mechanical agents for the proper (?) truss or appliance, and the application of it. In a large number of cases, no doubt, this course on the part of the medical man is actuated by the sense of his own inability to meet the demands of the case; when this is the true cause, while we may commend him for his sincerity, still we must respectfully submit that he is a much too willing exponent of the sentiment that teaches 'where ignorance is bliss 'tis folly to be wise.'

COOPER'S DIRECTIONS FOR FITTING A TRUSS.

"Therefore, when a hernia has been returned by the surgeon into the abdomen, he should lay his fingers obliquely above and to the iliac side of

the ring and direct his patient to cough; and the farthest part from the ring toward the spine of the ilium where the internal sac is felt to protrude is the point which should be noted for the application of pad of the truss and the instrument made accordingly."

FITTING TRUSSES.

I should not feel justified in occupying more of your time in speaking of trusses or enlarging my plea for a better understanding of the subject and the therapeutics of hernia generally, but will direct your attention to the practical side of the question of fitting them. I cannot do better than quote Prof. W. B. DeGarmo's rules for measurement and method of fitting as given in a lecture delivered at the Post-Graduate Medical School:

"After getting the measures, which should be taken by passing the tape-line around the pelvis, about two inches below the crest of the ilium, and over the internal ring, we should next secure the shape of the hips and place it upon paper, where it will be of real practical use in molding the spring for the patient.

"This is done by the aid of a strip of sheet lead, half an inch wide and one-sixteenth of an inch thick, by about twenty inches long. I place this across the front of the abdomen with one end resting over the internal ring, we will say, of the right side. The lead is now molded to the shape of the front of the abdomen, and around the left hip to the center of the back or a little beyond. Having been pressed to the exact shape of the surface of the body, it is now carefully slipped off from the left side and placed edgewise upon a sheet of paper of suitable size. Its inner surface is traced around by a lead-pencil, and the process is either repeated for the opposite side, or you may simply turn the lead over, thereby completing a tracing of the circumference of the pelvis.

"You should now select the size and style of spring which you desire to use, and shape it to fit this tracing. If you select a cross-body spring, begin by shaping that portion which passes over the front of the abdomen to correspond to the diagram on the paper, and so follow around, of course allowing for compression. This method so far simplifies truss-fitting as to place it within the reach of every practitioner who is willing to devote the required time to the interest of his patient.

"Springs covered with hard rubber must be warmed before bending. When you have supplied your patient with a good-fitting truss, you have not fulfilled your entire duty. The subsequent care of the case is of equal importance. I keep all children under care, having them come back at stated intervals until they are cured. Usually I see them not less than once a month. Do not allow the parents to decide whether attention is needed or not, but have them bring the child back, that you may correct errors in the fitting of the truss which they would never see. Adults should be impressed with the importance

of reporting three or four times every year, even after perfect fitting is secured, that you may decide whether they are wearing their trusses right, and that their herniæ are being securely held.

"In the care of the skin, to prevent excoriation, cleanliness is of the utmost importance. The truss as well as the person must be kept clean, and, as far as practicable, dry."

Before describing the surgical treatment of hernia, it might be considered in keeping with the scope of this paper to describe the methods best suited in using taxis for *recent* cases of strangulation.

Taxis, or restoration of the hernial viscus to the normal position by mechanical manipulation, is termed reduction of taxis.

First, Position.—Body should be recumbent, the knees flexed, if necessary, or such attitude as to relax muscles of part. In femoral hernia the knee of affected side should be flexed obliquely, inclining to opposite side. In scrotal, raise, place the thumb and finger of left hand at the neck of tumor to prevent invagination of intestine and overlapping at the orifice and guide its course through internal inguinal ring. Grasp body of hernia with right hand, draw carefully downward and outward, then gently compress tumor, equalizing pressure as much as possible, except that it should be greatest at bottom. Gurgling often manifests the fact that the hernia has receded. Care should be taken not to reduce the testicle with the hernia, if adhesions connect the two together.*

The application of ice-bags or hot fomentations of hops often assist in the taxis of recently strangulated hernia, also the hypodermic injection of atropin sulph., gr. 1-25, into the constricted ring relaxes spasm of circular muscular fiber.

In femoral hernia the pressure on the hernial tumor must be made downward, to saphenous opening, and then upward. Long-continued and too-often-repeated efforts at reduction are frequently followed by inflammation, particularly so in this form of hernia.

The difficulty in exerting taxis on large umbilical herniæ in fat people is the tendency for the hernial viscus to slip between the fat and the skin or muscles; in most of these cases the sac is adherent. Sometimes there is more than one opening, and this impression may be often formed from another condition of the "pocketing" of the hernia. In all cases, to one side or other of the hernial orifice in the fascia or adipose tissue. Both hands should be used and placed around it, the manipulation being chiefly conducted by the thumbs and fingers in a rolling or kneading motion.

SURGICAL TREATMENT.

It is not my purpose to describe the various

methods of operating for the relief and cure of hernia, as my paper is already too long. The great names in the history of surgery are attached to some personal technique for its treatment. The object formerly sought by a radical cure was the obliteration of the sac by some means; for it was firmly rooted as an established fact that this was the primary cause of hernia. The prejudices of the medical profession die hard, and it was not until Bassini, of Padua, read his paper before the Italian Congress of Surgeons in 1888, relating his 102 cases (seven of which were strangulated) without a failure and with no mortality, at the same time stating it was his belief that it was the anatomical defects in the inguinal canal and *not* the sac *per se* which were responsible for hernia; in obliterating the canal as well as the sac and establishing a new posterior wall and a new path for the cord lay the secret of radical cure. Since then this operation has been accepted by the profession generally. Only about a month later Halstead, of Baltimore, published a new operation almost identical to that of Bassini, excepting that in his treatment the cord is external instead of below the sutured aponeurosis.

"Bassini aims, by his operation, to completely close the hernial canal within the abdominal wall, and to form a new canal for the cord which shall correspond as much as possible to physiologic conditions. His radical operation is composed of three steps:

"First step: The pillars of the external abdominal ring and the aponeurosis of the external oblique muscles are exposed by an oblique incision corresponding to the course of the spermatic cord. The aponeurosis of the external oblique muscle is now incised up to a point above the location of the internal abdominal ring, separated from the underlying tissues, and the two flaps turned back to either side. The hernial sac is now separated from the spermatic cord by blunt dissection and completely isolated from the surrounding tissues, particularly in the vicinity of the neck of the sac, so that every trace of a funnel-like diverticulum disappears. After the hernial contents have been reduced, the sac is opened at some distance from the neck, and adhesions between the sac and contents separated, the protruding portions of omentum ligated in sections and extirpated, and the hernial sac ligated as high up as possible.

"The sac is then cut off one centimeter below the ligature and the stump is buried in the abdominal cavity.

"Second step: The isolated spermatic cord is lifted up and held to one side. The two flaps of the aponeurosis of the external oblique muscle are held back by retractors, and the whole mass of muscle situated internally—the larger upper portion, composed of the internal oblique and transversalis muscles; the smaller lower portion, composed of the rectus muscle—is united throughout its entire extent with Poupart's ligament by four or five interrupted sutures or mat-

*"The dangers of indiscriminate attempts at reduction of strangulated hernia by manipulation" is elaborately discussed in a paper by W. H. Bennett, F.R.C.S., in *The Lancet* of August 20, 1892, where all imaginable accidents followed taxis, in some only a few hours strangulated.

tress sutures of kangaroo tendon so that only a sufficient opening for the spermatic cord is left in the upper and outer angles of the wound.

"Third step: The spermatic cord is laid upon the newly formed posterior wall of the inguinal canal, and the two flaps of the aponeurosis of the external oblique muscle are sutured over it, thus forming the anterior wall of the new inguinal canal.

"The operation is concluded by the suture of the cutaneous wound."*

When dealing with an ectopic testicle where a short cord prevents its descent into the scrotum, a pocket can be made in the sub-peritoneal space posterior to the lower portion of the rectus, and the testicle placed there, where it has the protection of the lower abdominal wall.

The after care of these cases is ten days in bed, allowing them to return home in two weeks, the wearing of a snug abdominal band of Canton flannel with perineal straps for six weeks.

In operating on femoral herniæ the incision is made over the tumor longitudinally, exposing the hernial sac, reducing its contents, ligating it as high as possible and excising it.

The closure of the ring is best accomplished by passing the sutures through Poupart's ligament, the pectineal fascia, and the periostum of horizontal ramus of the pubis.

UMBILICAL HERNIA.

The tendency to this form of hernia in young children and infants to spontaneous cure when appropriately treated makes the surgical treatment rarely necessary. A gauze pad fastened by a strip of adhesive plaster encircling the abdomen and changed as required usually effects a cure. The parts should receive proper antiseptic cleaning, the gauze sterile and some non-irritating and slightly antiseptic powder applied.

The surgical treatment is reserved to the strangulated, incarcerated, and large herniæ of adult life.

"A marked advance was made by Gersuny, who suggested opening the sheaths of the recti, and uniting the internal borders of these muscles as well as the usual sutures of the herniæ orifice. It is always well to perform omphalectomy, and the overlapping of the muscles as recommended by Blake, of New York, give the best results" (*loc. cit.*).

In concluding, I wish to acknowledge the assistance derived from consulting the works of Cooper, Heaton, Holmes, DeGarmo, Agnew, Gross and Sultan (Cooly's translation) in the preparation of this paper. In some instances I have freely quoted from these authors.

Dr. Alva H. Doty has been appointed by Governor Odell Health Officer of the Port of New York for the term of four years.

*This concise description is given by Sultan.

PROPRIETARY REMEDIES.

BY N. B. BAYLEY, M.D.,
Haverstraw, N. Y.

PROPRIETARY remedies form a considerable proportion of the pharmaceutical and drug trade, they enter largely into physicians' prescriptions, as a cursory examination of the prescription books of any drug store will show, and, in addition, an extensive distribution of literature highly commending these agents persistently claims the physician's attention. The definition of proprietary remedies includes, first, the so-called "patent medicines" for popular use, in which the proprietary right is confined to the label or to some distinctive device that is copyrighted, the sole object being to secure the monopoly of the article by the secrecy of composition. If the composition was patented and not copyrighted every pharmacist could obtain the formula, and prepare and sell a similar compound; second, proprietary remedies and pharmaceutical specialties which have formulæ more or less secret, with usually copyrighted labels that depend upon the secrecy of the formulæ for the control of the monopoly of the trade. These formulæ and labels may give some clue to the contents of the packages, but, even when they are expressed with some degree of fulness, there is omitted, or stated imperfectly, some peculiarity of the composition that is designed to impress the prescriber with the idea that a preparation of superior quality and of wonderful medicinal properties has been placed in his hands. If chemical symbols are given they are frequently arranged in a meaningless form.

Another class of pharmaceutical preparations is prepared according to officinal formulæ, or from formulæ which have received the sanction of the profession and are standard remedies. This class of preparations contains upon its labels the full composition of the compound, for which no greater claims are made than the care exercised in the purity of the constituents and the skill in compounding. This last class of remedies is worthy of acceptance and fills a reputable position in the *materia medica*. There are no hard and fast lines which separate patent and proprietary remedies. In their secrecy of composition and method of exploitation they are comparable. The "patent medicines" are more particularly directed to the lay public, and therefore use the public press as the medium of advertising, while the proprietary literature is addressed more particularly to the medical public through the advertising pages of the reputable medical journals, as well as those journals published apparently for this special purpose, and through circulars, attractive reading notices and physicians' testimonials. Samples and traveling agents also impress the wondrous virtue of this class of remedies upon the too receptive physician.

It is unnecessary to collect statistics of the proprietary medicine business to prove the fre-

quency and quantity of this class of remedies in daily use. The loaded shelves of drug stores, their prescription books which contain too large a proportion of advertised proprietary drugs prescribed by physicians, and the quantity of advertisements, literature and samples that fill a conspicuous place in the daily mail of every physician in the land, all give evidence of the extent of the business. Dr. Swain,* of New Haven, relates that a professor in one of the larger universities collected the pieces of such literature received during one year and that they amounted to 424 separate items. Of this number only 54 could be classed as respectable, while the remaining 370 pieces related to remedies more or less secret in preparation, supported by weak journal articles, physicians' testimonials and commendations by the makers. This last class was supported by the testimonials of 1,780 physicians, 56 editors of 10-cent medical journals and 119 professors in mushroom medical schools. The practice of writing testimonials in support of these proprietary preparations is one that no reputable physician can indorse, and I am glad to say their names are seldom found in this connection. That many of the testimonials attached to proprietary medicine circulars are of little consequence is evident from a cursory examination of a few of them. Only the other day the writer noticed among the testimonials in the circular of a popular proprietary medicine, six purporting to have been written by physicians residing in the State of New York; of this number the names of five could not be found in the last volume of the Medical Directory, and the sixth thought too little of his profession to connect himself with a medical society.

In defense of the charge that the use of proprietary specialties and remedies of more or less secret composition is an evil, the assertion is made that the uniformity of composition, pleasant appearance and taste, the care and skill exercised in their preparation, and the commendations by which they are placed before the public indicate some merit that entitles them to a trial. The claims are also made that many physicians are not sufficiently familiar with pharmacy to write tasteful mixtures and to avoid incompatibles in their prescriptions, and that many pharmacists are so in name only, and charge exorbitant prices for inferior drugs. In answer it can be truthfully said that to-day pharmacists exist in every town of any size who are competent to fill prescriptions correctly, and at a cost usually less than that of the proprietary remedy. There are wholesale druggists and chemists who place in the hands of the pharmacists and physicians who dispense their own remedies all officinal reputable preparations, accurately prepared and correctly labeled. Synthetic compounds, sera and antitoxins, when correctly represented and subjected to the scrutiny of competent clinicians, do not come within the

category of proprietary remedies. To the statement that many of these proprietary remedies are new discoveries, or contain wonderful properties, owing to the skill, care and scientific knowledge exhibited in their preparation, a denial can be safely made, as there is no evidence that this class of agents have advanced therapeutics one step, but, on the contrary, a careful examination will demonstrate oftentimes a wide departure between the published statements and the actual chemical composition or clinical results (*His. Thesaurus, Chicago, 1898*).

The habit of prescribing the class of remedies under consideration must result in a slothful and unscientific method in practice, damaging to both physician and patient. In ethics and in law the patient is entitled to careful examination and treatment; the implied contract between the patient and his physician presupposes that the latter will exercise care and skill in his examination, and be cognizant of the properties of the remedy which he prescribes.

The practice of prescribing proprietary remedies by their trade name is not to be commended. The writer is cognizant of two patients for whom their physician prescribed a popular proprietary remedy by its trade name, with the result that both patients purchased the remedy of their own accord, omitted to consult their physician, used it with the usual indiscretion in such cases, and fell victims to its effects; in the one case it was the active agent in inducing melancholia that ended in suicide, and in the other it was a factor in producing general paresis with its physical and mental degradations.

This class of remedies is put forth with overpowering emphasis as to potency for cure or relief; in their application there is no hint of failure, the directions are positive, the results must be equally certain. They utterly disregard the thousand and one complicating factors that make the practice of medicine one requiring a large amount of individualizing acumen in both diagnosing and the adaptation of methods of treatment. Here, we are told, we have analgesics and antipyretics, safe, sure and free from heart depression, or cardiac remedies which act as un-failing regulators of the whole circulation. All disorders of the nervous system, all derangements of digestion and assimilation, are quickly and speedily relieved and cured. Infections are repulsed and tuberculosis patients find in some newly concocted agent a new pabulum of life. Tiresome testimonials recite the cases of restoration in impaired virility in the young and old, no matter from what cause. Not only cure, but prevention of pathological and, it is even hinted, physiological, processes are guaranteed by implication.

Under the head of proprietary specialties must be included the artificial foods. The advertisements and directions state that these contain the nutritive forces in the proper proportion for assimilation in every condition of life. The fat,

*Yale Medical Journal, December, 1901.

proteid, carbohydrate, sugar and salt are in mathematically correct percentages, ready for absorption; the chemistry of assimilation, hemo-genesis and metabolism have been fully worked out! That some of these foods are honestly prepared and represented is not doubted, and, when intelligently used, may be of assistance. Infant and invalid dietetics has been a large field for the exploitation of foods of which the practitioner has often but little knowledge beyond the literature furnished by the manufacturers.

The use of agents that clinicians are warranted in prescribing with confidence frequently results in disappointment when administered in the form of a proprietary remedy, as in the following instance: Mrs. R. consulted a physician for incipient tuberculosis, and a certain remedy of good repute in the treatment of this disease was prescribed in the form of a proprietary remedy. By its use both patient and physician were lulled into a sense of security, until the progress of the disease warned the patient that the treatment was ineffectual; inquiry disclosed that the remedy was prescribed according to the directions of the manufacturers, rather than by a knowledge of its real properties, and therefore was not or could not be adjusted to meet the objects in view. Another instance is that of a patient suffering from cholelithiasis and gastritis with cardiac disturbances, who had had prescribed for him for some length of time a secret proprietary remedy made by a well-known firm, without any relief. The efficiency resulting from a change of medication, from the proprietary article to a prescription containing the same active ingredient, became a convincing argument in this case. And these are only samples of every-day occurrences. The unknown and uncertain composition of both proprietary remedies and foods is a sufficient reason for the physician to firmly reject the use of all such agents in his prescriptions and advice.

In the production and preparation of drugs, chemicals, animal extracts and all agents entering into the *materia medica*, a highly specialized knowledge is called for. The reports and papers of chemists, physiologists and pharmacists form a trustworthy foundation for the clinician's consideration and employment in his study of therapeutics. The work of these scientists is open to all, and is subjected to the keen scrutiny of trained workers, and frequently of competitors. In patent medicines, proprietary remedies and articles and specialties protected by secrecy of composition, trademark, copyrighted labels or other devices, all these safeguards are eliminated, so that the practitioner has no other information concerning these remedies than what the manufacturer is pleased to give to the public. This is clearly illustrated by an episode of the writer's: A traveling agent representing a well-known firm that manufactures a class of remedies of considerable merit, many of them with complete formulæ attached thereto, presented a compound of which he was unable to state the proportion of

drugs entering into its composition. A note addressed to the firm elicited the following reply: "Our preparation contains as large a proportion of the drug as any other on the market."

If there is any apology for the use of proprietary medicines it must be due to some deficiency in the physician himself, either to his lack of knowledge of chemistry and pharmacology and of physiological and clinical therapeutics, or to his inertia. A large number of reputable pharmacists and drug firms and chemists show a creditable enthusiasm in supplying the needs of the physician with every agent that enters into the medical armamentarium, with skill and intelligence and in accordance with professional ethics.

ON UNSCIENTIFIC AND CARELESS PRESCRIBING,
SECRET AND PROPRIETARY REMEDIES.¹

BY HARRY R. PURDY, M.D.,
New York, N. Y.

WHEN one assumes the rôle of critic he must in turn expect to be criticized. I am quite willing to accept this condition, especially if what I have to say shall provoke a discussion that will ultimately result in bringing about a much-needed reform.

Many times since entering upon the practice of medicine have I had occasion to ask myself the question, Has prescription writing become a lost art?

I have been surprised to learn that some physicians habitually recommend patent and proprietary remedies, and that others depend almost entirely upon the ready-made prescriptions of the tablet manufacturers. Again I have been astonished at the original prescriptions of men who, in all branches of their profession except therapeutics, were quite capable. They seemed to have no knowledge of the incompatibility of drugs. A few instances may suffice to illustrate this: Cocaine and borax are often ordered in the same mixture, with the result of forming an insoluble precipitate of cocaine borate; ammonium carbonate is frequently ordered by physicians in the same cough mixture with syrup of squills which contains acetic acid, with the result that a chemical reaction takes place liberating carbon dioxide, and the gas given off startles the patient by forcibly expelling the cork or even bursting the bottle; an acid and an alkali should only be mixed when a new product is desired. How frequently iron is ordered mixed with substances containing tannic acid, with the result of forming iron tannate or ink.

I have known such a prescription as this to be written:

R
Potassii Iodidi ℥ii
Acid-muriatic, dil. fl. ℥ii
Tinc. Cinchonæ, co. ad. fl. ℥iij

In this prescription, of course, the acid is incom-

¹Read at a meeting of the New York State Medical Association, New York County Branch, November, 1902.

patible with the potassium iodide, easily decomposing it and liberating iodine.

Sometimes a mixture containing an alkali and an alkaloid is ordered, as potassium iodide with strychnine sulphate, with the result that nearly all the strychnine is precipitated by the potassium salt in the form of insoluble hydroiodide and is contained in the last dose. Death has been caused by a prescription like this.

Corrosive sublimate is incompatible with almost everything, even the compound syrup of sarsaparilla is said to decompose it, yet how often do we find it prescribed with other drugs. In the catalogues and price-lists of prominent tablet manufacturers it may be found in a number of formulæ in which it is incompatible. Here is one: Corrosive sublimate, ammonium muriate, cinchonidine sulphate and quinine sulphate. In this combination we have not only incompatibility, but a violation of the wise rule that an active poison should always be given dissolved in a liquid. It should be said that many of the pompous prescriptions to be found in these price-lists and catalogues were written by physicians whose names are printed under them, and very few of these physicians have reason to take pride in their authorship. It is opposed to sound policy and good taste, to say the least, for these men to allow their treatment of disease and their names to be thus advertised; besides, the popularization of medicines which frequently contain narcotics and poisons, and which the laity can too easily procure, is a wrong and a danger that it is the duty of physicians to do all in their power to suppress. Those physicians who stock their offices with these ready-made, and often stale, incompatible, insoluble and inert tablets, and try to fit the disease to the remedy, rather than the remedy to the disease, in my opinion make a mistake. There is scarcely a prescription that would not be better if freshly compounded; besides, the doling out of tablets seems to many patients, both rich and poor, but a cheap and undignified way of practicing medicine. The patient should have some stronger motive to return to the physician than merely to get a new supply of tablets.

The prescribing of tablets by the numbers used by manufacturers in their price-lists to designate the various combinations is on a par with the dosing carried out on certain vessels of the merchant marine, which carry a medicine chest, but have no doctor on board. The bottles of medicine in the chest are duly numbered and with them is a book describing the symptoms which require a dose of such-and-such a numbered mixture.

Many of you may remember the old story of the ship's mate who went to the captain stating that a sailor had symptoms which, according to the book, required a dose of No. 9 mixture, but that No. 9 bottle was empty. "That does not matter," said the captain, who in the emergency rose almost to the level of certain modern prescribers, "give him equal parts of No. 4 and No. 5."

Before leaving the subject of tablets I wish to say that very recently an agent came into my office and urged me to take some stock in a company that manufactures a laxative tablet, offering as an inducement 20% on all moneys received from the sale of tablets I might prescribe. When I refused on ethical grounds, he said I was more old-fashioned than many doctors he had seen. Here is commercialism in medicine of the rankiest kind. When the agent called me "old-fashioned" I considered that he, unintentionally, paid me a great compliment. The old-fashioned physicians would not be guilty of the irregularities mentioned in this paper. They belonged to that class, and even to-day it is a large one, of which the late Drs. Flint, Barker and Draper were grand types.

Clinical experience has ever taught that it is wise to prescribe as few remedies as possible and to use no powerful drug without a distinct idea of what it is intended to do, and that to get the best effects from such a drug it should usually be given by itself.

There is good reason to fear that to-day there is too frequent violation of this rule—due, perhaps, as much to carelessness as to lack of knowledge. The very ablest physicians have been successful and gained renown by using only simples, yet it is not to be denied that good results are sometimes obtained by the scientific combination of drugs for joint effect. Thus atropine increases the good effects of morphine and prevents its bad effects. The same may be said of morphine and chloral, and in a cough mixture it is often wise to add a sedative to quiet the cough and an expectorant to affect the mucous membranes; and purgatives seem to act better when several of them are united. When a new product or remedy is desired this may be obtained by combining certain chemicals, as potassium iodide with mercuric chloride, when we get the valuable double salt, potassio-mercuric iodide. Skill in the combination of drugs, not only to increase the physiological action of each, but to make the medicine pleasant of administration, is greatly to be desired, and has made the reputation of many a man. But to attempt to prescribe for every symptom of a disease, by throwing unskilfully together eight or ten drugs, as is too often done, is unscientific, dangerous and is that abomination of abominations—polypharmacy.

While there are men who use too many drugs there are others who do not use enough, and indeed in certain quarters it seems to be the fad to decry all drugs. It is probable that the men who seldom prescribe have had bad results through overdosing, and have become as afraid of drugs as the reformed drunkard is of liquor, or they may have used medicines ignorantly and consequently without success, or it may be with some men pure affectation. I believe this last remark applies to certain surgeons as well as to a few pathologists. These surgeons (I hope there are not many) seem proud to say that they do not write one prescription a month. They speak

sneeringly of the backwardness of medicine, and point with pride to the rapid strides which surgery has made in the last half century. Why, do they not know that they owe more of their success to therapeutics than they do to their skill with the knife? For hundreds of years there have been almost as skilful operators as we have to-day. The discovery of anesthetics and antiseptics is what has revolutionized surgery. Be the surgeon ever so great, what would he do following certain operations, and sometimes during, or even preceding them, did he not resort to medication? What would he do without strychnine and digitalis; morphine and atropine; nitroglycerine and caffeine, and last but not least, common salt? Why, he would sign so many death certificates that his reputation would soon be gone.

To those pathologists who profess to feel sorry that therapeutics cannot keep up with them, and who laugh at empiricism, let it be said that while we thank them for what they have done, and the world is greatly indebted to them, diseases were treated successfully before they crowded the stage, and neither was it always necessary to wait until a man died before a diagnosis could be made. Let them tell the nature of certain diseases—cancer and rheumatism, for instance—and therapeutics will find the remedy. After we learned what that dread disease diphtheria really was, it was not long before we had antitoxin, which, next to vaccination, is probably the greatest discovery of this or of any age. It has been well said "that the man who does not believe in the proper use of drugs for the cure of disease must lack the keystone of the arch upon which all medical knowledge rests." More to be condemned than men who do not use any medicine whatever are those who prescribe patent* medicines, those medicines that make it so easy to commit murder. In using these secret remedies they not only confess that they are incompetent, but they also violate the code of medical ethics. The last remark will apply with particular force to those physicians who have their own secret remedies for the treatment of delirium tremens and other diseases. These charlatans are probably beyond redemption. They are not so ignorant as vicious and mercenary, and their punishment is the contempt in which they are held by their fellows.

Let me read Section 5 of the code of ethics: "Equally derogatory to professional character is it for a physician to hold a patent for any surgical instrument or medicine, or to dispense a secret nostrum, whether it be the composition or exclusive property of himself or others. For, if such nostrum be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality; and if mystery alone give it value and importance, such craft implies either disgraceful ignorance or fraudulent

avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret medicines, or in any way to promote the use of them."

Patent-medicine men, osteopaths, Christian Scientists and similar impostors prey upon a class of people who are so "wise in their own conceit" and so amazingly credulous that "it is easier to cheat them out of their lives than out of a shilling." Is the medical profession, that has unselfishly done so much to alleviate the distress and suffering of mankind, doing all it can properly do to eradicate dangerous and hurtful prejudices, and to guard the ignorant and unsuspecting against the frauds and impositions of unscrupulous quacks and pretenders? Are the physicians of to-day as public-spirited as were the illustrious fathers of medicine?

The difference between a proprietary and a patent medicine is more apparent than real. There is no good excuse for using these preparations.

In the "Pharmacopœia" or in the "National Formulary" may be found compounds that are every bit as elegant and far more reliable, and with which patients are not so familiar, as any of these widely and ingeniously advertised proprietary medicines.

Certain medical journals have been discussing of late the best method of excluding from their pages articles bearing the semblance of having been written by physicians in the interest of manufacturers and importers of proprietary medicines. These journals appeal to medical men to help them. Here is a quotation from an editorial in a recent number of the *New York Medical Journal*: "Meetings of even the most dignified of our societies have at times not wholly escaped the suspicion of having been exploited by the touters for some medicinal or dietetic preparation, and it is certain that papers are often read before them which a reputable medical journal would hesitate to publish." Truly, a deplorable state of affairs. We ought to come to the aid of these reputable journals by tabooing any of our members guilty of such unprofessional conduct as is charged, and we should help these journals still further with the kindly advice that they do not hereafter allow nearly every column of their advertising pages to be taken up with advertisements of proprietary and patent medicines. If it is not right to mention these remedies in the scientific and editorial columns, what makes it right to mention them in any other part of the journals? Can it be the same thing that induces certain hungry physicians to write articles for the wealthy manufacturers? Who are these manufacturers of proprietary remedies that they presume to burden our mails with circulars giving us instructions how to treat our patients? Do they employ a Brunton or an Osler, a Hare or a Behring?

It is hardly to be expected, with the keen competition among the makers of these petty

*The word patent is used to designate those much-advertised secret remedies that are popularly known as patent medicines, and not to definite chemical compounds.

nostrums, that they will use the carefully assayed drugs in their preparations that the conscientious pharmacist uses in the medicines he dispenses. To compel the members of our sister profession to go to the expense of keeping a large stock of these proprietary remedies is an injustice and a shame. This, together with the loss of legitimate prescriptions, forces some of them to resort to questionable business methods in order to earn a livelihood. It does not require any special training to handle these goods—a grocer could do it as well as an apothecary. Indeed, even now the large department stores have the lion's share of the trade in these "curealls."

That the members of the American Pharmaceutical Association feel the injustice done them is evidenced by this modest appeal which I find in the preface to the "National Formulary":

"The mission which this work is to fulfil can only be properly accomplished by the cooperation of the medical profession. It is, therefore, of the greatest importance that the members of this profession, throughout the country, be made acquainted with the existence, contents and objects of this book, and that, if the same be approved by them, as is confidently expected, they will consent to accept the preparations made in accordance with the formulæ contained therein, instead of designating *any special maker's product*." There is reason to fear that this appeal has fallen on deaf ears. What incentive will young men have to perfect themselves in pharmacy and to take pride in their calling if they do not receive the proper encouragement from the medical profession?

It may be asked why it is that we have among us physicians who use the character of remedies of which I have spoken. These men give as their chief reason that they cannot trust the apothecaries; that they substitute and have poor drugs. It is true that there are dishonest men among pharmacists as there are among physicians, but I believe the vast majority of both professions are honorable. It would be as absurd to condemn all pharmacists because a few are guilty of substitution as it would be to condemn all physicians because a few perform criminal operations. If one look about him he will have no difficulty in finding a reliable pharmacist who knows his *materia medica* and his chemistry, and who can not only be relied upon to put up prescriptions properly, but to stand between the physician and the patient, saving the latter from any errors that the former may at times, in the rush of practice, commit. Therefore, in my opinion, this excuse is a poor one. Is it not ridiculously inconsistent for a physician to trust some man in Kamchatka rather than his own neighbor? If the physician knew how to write a prescription, knew how it should look and taste and smell after it was prepared, he would soon catch the dishonest pharmacist and therefore could avoid him, but alas, there are only too many medical men who are unable to do this; too many who are unable to

tell morphine from potassium bromide. "Ay, there's the rub." Why do they not know? Why do they not know therapeutics, *materia medica*, pharmacy, or, to combine all these into one word—pharmacology? Because they have never been properly taught and have not taken the pains to learn. One reason, then, and in my opinion the principal reason for the state of affairs I have described, is that present graduates of medicine were taught neither pharmacy nor pharmacology; were not given the opportunity of learning how to write prescriptions by compounding them, nor of becoming acquainted with drugs by handling them.

It is true that for the last year or two a small number of our medical colleges have been giving a little attention to pharmacology. For this improvement on former methods we should be thankful, but when we consider that to learn only pharmacy a young man is required to spend three years in a drug store, and attend the College of Pharmacy two years in addition, we can readily understand how little knowledge a medical student can gain of pharmacology by one weekly exercise in the laboratory and a weekly lecture, during only half a session of his second and third years. This is about the way that chemistry was taught until the State Board of Medical Examiners, by sending many students home without the coveted certificates, compelled the colleges to be more practical in the teaching of this subject. When we consider that no matter what branch of medicine or surgery a man may take up after graduation he will have to resort to the use of drugs, is it too much to ask that as much time be given to pharmacology as to any other study? Is it too much to ask that the faculty of each medical college of this country create a chair of pharmacology equal in dignity and influence to any other chair, and fill it with an experienced, able man? When this is done, when physicians as a whole become more public-spirited, and when they give more attention to scientific prescribing and to medical ethics, then there will be for our ancient and honorable profession, and for society generally, the dawning of a better day.

Outdoor Sanatorium.—The Health Department of New York City wants to establish a colony of tents out in the country during the coming spring at a good and accessible place, pending the creation of a permanent sanatorium, and put about 100 patients into it.

* * *

Medical Inspectors Dismissed.—Seven medical school inspectors of the New York City Board of Health were recently dismissed for falsifying their vaccination reports.

* * *

Physicians who do much driving in the country will be thankful that the Legislature has passed the bill for good roads.

NEW DEVICES FOR THE TREATMENT OF STRICTURE OF THE ESOPHAGUS.¹

BY THEODORE DUNHAM.

Mr. President and Members of the New York State Medical Association:

IT is not necessary for me to occupy your time with a review of the difficulties and the dangers of dilating or cutting cicatricial strictures of the esophagus. The difficulty of passing an instrument in some cases and the impossibility heretofore of doing so with safety in others are well known. The danger of forcible dilatation or cutting of these strictures by means formerly in vogue is also well known and is evident from a glance at the vital organs which so snugly enwrap the esophagus. It was through practical encounters with these difficulties and by a realization of these dangers that I was led to devise the instruments and to invent the procedures which I present to-day.

The greatest cause of mortality has been from instruments, when under pressure, leaving the esophagus and puncturing the lung or other neighboring structure. To avoid this I use some sort of guide in all of my procedures for dilatation. The active portion of my instruments is thus held to its work upon the strictured part of the esophagus and cannot leave that canal.

My devices for the dilatation of strictures are of three kinds, and to facilitate the description of my instruments and the conditions in which the different ones find application, I will roughly divide cicatricial strictures into three classes.

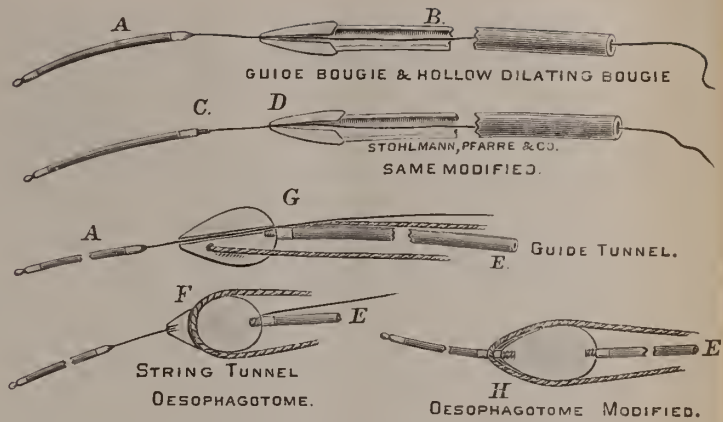
Class I. Cases where a small bougie may be passed to the stomach without force, and where the stricture offers but little resistance to dilatation.

Class II. Cases where, as in class I, a small bougie passes to the stomach without force, but where efforts at dilating the stricture are met by considerable resistance.

Class III. Cases where a bougie fails to pass by the mouth. In these cases gastrostomy must be performed. In this class I include the treatment of cases in which a bougie can be passed neither from above by the mouth, nor from below by the stomach.

Taking up these three classes of cases, I will describe the instruments applicable to each.

The cases of class I, where an instrument finds its way readily to the stomach and where the stricture offers but little resistance, I dilate by the usual principle of passing conical bougies, except that, for the sake of safety, I use a guide. The guide is a small gum-elastic bougie ending in a long wire. The gum-elastic portion is a little longer than the esophagus. It is small enough to be introduced without force, which insures its finding its way to the stomach without injuring the esophageal wall. When the proximal end of this guide is in the pharynx, its distal end will be in the stomach and its long wire will project from



the mouth. My dilating bougie differs from the usual esophageal bougie, in that it is hollow throughout. The wire of the guide is threaded through the channel of the dilating bougie and the latter is pushed along the wire until the dilating bougie and the guide lock together in the pharynx, forming virtually one instrument. This locking is accomplished by the attenuated metal end of the guide being received in the channel of the dilating bougie. The dilating bougie may now be pushed through the whole length of the esophagus, being held to that canal by the guide, which advances ahead of it and curls up in the stomach. This method is applicable to cases requiring only moderate force. If much force is found necessary to overcome the stricture, there might be danger of causing a circular laceration of the esophagus, and such cases fall into

Class II, which may be treated by my esophagotome. This instrument utilizes a principle so brilliantly employed by Dr. Robert Abbe in a case some years ago where he attempted to relieve a stricture by opening the esophagus in the neck, but found the stricture was too low to be accessible from his wound. On opening the stomach, small instruments easily found the cardiac opening and passed up and out of the esophagostomy wound; but the stricture was very resistant. Passing a cord through the strictured portion, then stretching it by a conical bougie and drawing the cord back and forth, he sawed the stricture to the desired caliber. In my esophagotome I have utilized this principle, but I have been able to do so without opening either the neck or the stomach. A guide carrying a wire, such as I have described above in connection with the hollow bougies, is first passed. The active part of the instrument consists of a whalebone staff carrying an olive-shaped piece of metal. A tunnel pierces the olive from one side of its base to its tip. Through this tunnel the wire of the guide is passed and the olive is advanced along the wire until it meets the guide in the pharynx, forming with it virtually one instrument. The olive has a second tunnel shaped like the arc of a circle which pierces the olive near its tip, the convexity of the arc being forward. This tunnel receives the bight of a silk

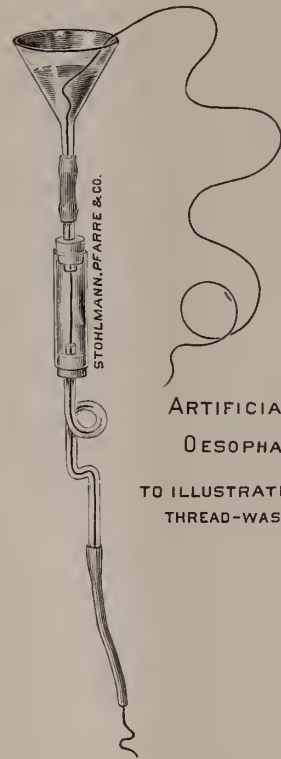
¹Read before the New York State Medical Association, October 22, 1902.

cord, the two ends of which pass over the bulge of the olive and then, together with the whalebone staff and the wire of the guide, out of the patient's mouth. When the whalebone staff is pushed upon, the olive advances, its tip engages in the stricture, but its bulge is arrested. The olive is now putting the stricture upon the stretch and the two portions of the cord lie between the bulge of the olive and the stricture. The cord is now pulled back and forth, the bight of the cord playing through the tunnel in the tip of the olive, which serves as a pulley. The cord cuts the portion of the stricture distended by the olive and the olive advances. Thus the stricture is enlarged to the caliber of the olive. The guide meanwhile is pushed ahead and curls up in the stomach. The instrument is so made that olives of various diameters may be used and the stricture dilated to any desired caliber.

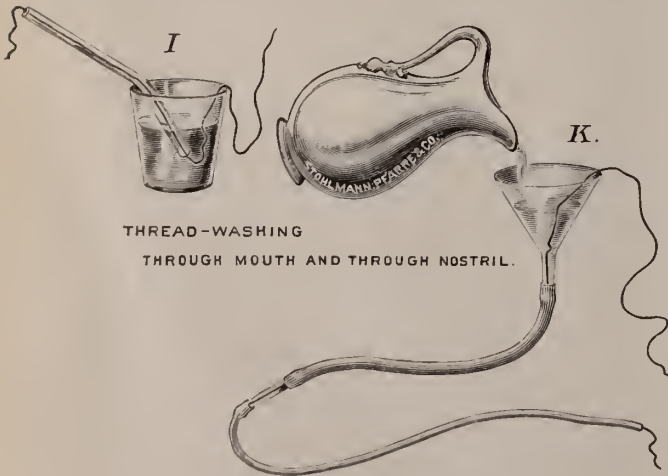
We now come to the third class of cases, those in which efforts to pass any instrument by way of the mouth fail. In such cases the stomach should be opened. The gastrostomy need be only large enough to admit an instrument a quarter of an inch in diameter. In treating such a case my first concern is to pass a thread through the esophagus, from the mouth to the gastrostomy opening. In some instances a small bougie will pass without difficulty from below up. But with a small gastrostomy there is little freedom for manipulation of an instrument, and I have found a better way of getting a thread through. It is free from all danger and is successful where no instrument can be pushed through from above or from below. I wash a thread through the esophagus by means of a current of water. To wash a thread through by way of the mouth, I use an ordinary glass drinking tube. Through its lumen I pass a rather fine silk thread, so that its tip is at the mouth end of the tube. The

glass of water. When a sufficient length of thread has been washed down, the tube is pulled from the thread, which then hangs from the patient's mouth. The stomach end of the thread may be fished out of the stomach by bending the tip of a silver probe sharply upon itself, introducing it through the gastrostomy and sweeping it about in the stomach.

This method of drinking the thread may fail from regurgitations which bring the thread up again before it has passed the stricture. A child or sensitive patient may voluntarily or involuntarily arrest the thread by the tongue. I find a more reliable method in such difficult cases is to wash the thread through a nostril. It then reaches the pharynx without the possibility of being arrested by the tongue and the water may be made to flow so gradually that no regurgitations take place. To wash a thread down



ARTIFICIAL.
DESOPHAGUS.
TO ILLUSTRATE
THREAD-WASHING.



THREAD-WASHING
THROUGH MOUTH AND THROUGH NOSTRIL.

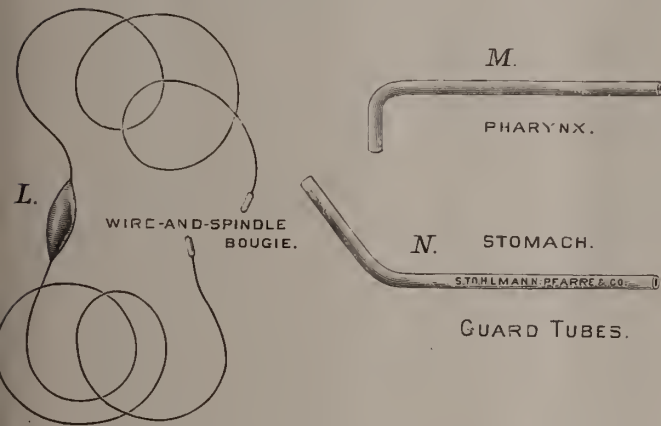
other end, from which the rest of the thread extends, is placed in a tumbler of water and the patient drinks. The thread is carried, by the current of water, up the tube, into the pharynx, down the esophagus and into the stomach. As the thread runs up the tube, more is fed into the

through a nostril, the apparatus is very simple. I use a glass funnel having a slender neck. To the neck is attached a piece of rubber tubing about two feet long. A piece of glass tubing drawn to a smaller caliber at one end connects this to a piece of soft rubber tubing small enough to pass easily through the nostril. The end of the thread is first placed in the neck of the funnel, which is then filled with water. The current carries the thread through the rubber tubing until it projects from the small rubber tube. The rubber tube is now pinched to arrest the flow. The tube is introduced into a nostril until its end hangs in the pharynx. All is now ready for the thread-washing. Thread and water are allowed to flow for a few seconds, when the

tube is again pinched and the thyroid cartilage is watched to note when the patient swallows. Then the tube is again released. Meanwhile, as the thread is carried down more is fed into the funnel. The length of time which is consumed in washing down a few feet of thread varies with different patients, being, of course, dependent on the size of the stricture. When sufficient has been washed down the small rubber tube is pulled off from the glass, the thread cut, the rubber tube pulled off from the thread, and the thread then hangs from the nostril. On looking into the throat it may be seen lying upon the posterior wall of the pharynx, whence it is readily pulled out of the mouth. The lower end is fished from the gastrostomy by a bent probe.

Having thus got a thread from the mouth to the gastrostomy, I attach a stout double thread of silk. One of these stout threads serves to pull through a strong piece of fish-line for use in sawing the stricture. The other stout thread is to pull through my device for putting the stricture upon the stretch while it is being sawed. This instrument consists of a wire some five feet long, tipped with a tiny knob at each end, so

strument lies in the fact that the spindle cannot possibly leave the esophagus, because the wire by which it is pulled is already in the esophagus. In order to protect the soft parts of the pharynx above and of the stomach below I have made what I call guard-tubes. These are metal tubes through which the wire and the fish-line are threaded. One carries them from the top of the esophagus out through the mouth, the other from the cardiac end of the esophagus out through the gastrostomy. The wire and the fish-line play easily in these tubes and they guard the soft parts from pressure of the wire or friction of the fish-line. I find it is best to pass the spindle from above downward rather than in the reverse direction, for two reasons. In the first place the mucus and blood from the esophagus are then carried down into the stomach instead of up into the pharynx, whence they might be inhaled; and in the second place, if the spindles are drawn down from the mouth and drawn back again after their way has been cut into the stomach, it is not necessary to have a gastrostomy large enough to allow the passage of the larger spindles; only so much of an opening is required as will admit the guard tube which carries the fish-line and the wire of the wire-and-spindle bougie.



that a thread may be made fast to it, and carrying at its middle a spindle-shaped piece of metal. This instrument I have called a wire-and-spindle bougie. One of the threads hanging from the mouth of the patient is made fast to an end of the wire and the latter is pulled through the esophagus and stomach until it appears upon the abdomen of the patient. Traction is then made upon the wire until its spindle is arrested by the stricture. The stricture is thus put upon the stretch and the fish-line is squeezed between the stricture and the spindle. While traction upon the wire is maintained, the fish-line is pulled back and forth. The wire is soon felt to advance and soon the fish-line has cut a way for the spindle and it enters the stomach. It is then withdrawn through the mouth, pulling up the thread by which it was introduced.

I have had wire-and-spindle bougies made of various diameters. Successively larger ones may be used and the esophagus cut to any desired caliber. A peculiar safety of this form of in-

TREATMENT OF PNEUMONIA.

BY J. W. GROSVENOR, M.D.,
Buffalo, N. Y.

IN discussing the treatment of pneumonia it is the writer's purpose to confine his thoughts to the treatment of the acute lobar pneumonia of adults. The importance of frequently investigating this subject and keeping it continually before the medical profession is seen in the fact that the mortality of this disease is estimated by competent authority to be 1 death out of every 7 to 20 of the whole number of deaths. Juergensen believes that 6.6 per cent. of the total mortality is due to pneumonia. It is the belief of some statisticians that the death rate of this disease has notably increased since the early part of the nineteenth century. In a published article Dr. N. S. Davis states that sixty years ago the mortality was 6 to 15 per cent. of the whole number of cases, and the mortality of the present day is from 20 to 30 per cent. Sears and Larabee, in an analysis of 949 cases treated in the Boston City Hospital, represent the mortality as 35.9 per cent. of all cases of the disease.

Historical.—During the nineteenth century there prevailed at different periods several distinctive methods of treatment. In the early years of the century venesection was the remedy par excellence for pneumonia, as it was for nearly all pyrexial diseases. At that period very few cases of pneumonia escaped the lancet. Statistics concerning cases of that period in which the bleedings were large and free show a mortality of about 1 in 3 out of the whole number of cases. The cases of this period in which the bleedings

were made early in the disease and were moderate in quantity, gave a mortality of 1 in from 5 to 8 out of the whole number of cases. A little later in the century, cases treated by large doses of tartar-emetic, under the care of Dietl, Grisolle and Rasori, gave a mortality of about 1 in 5 out of the whole number of cases. About the middle of the century, cases under the diet treatment, managed by Skoda and Dietl, gave a mortality of 1 in 7 to 13 out of the whole number of cases.

During the latter part of the century a mixed treatment became prevalent. This treatment was adapted to the nature of the symptoms. Huss, of Stockholm, employed bleeding and heroic remedies in the early stage of the disease, and in the later stages antimony, turpentine, morphia and quinine. Many cases were not bled. This was a modified antiphlogistic practice, in which the mortality was 1 out of 9-13 cases. Bamberger's cases, similarly treated, except that he employed no general bleeding but used leeches, fomentations and digitalis, gave a mortality of 1 out of every 9 cases. The elder Flint also used the mixed treatment, which was varied according to the case, bleeding 12 out of 133 cases. His experience gave a mortality of 1 out of every 4 cases.

Alcoholic Treatment.—Todd employed large doses of alcoholics throughout the disease. This has been called the treatment by excessive stimulation. Todd had a mortality of 1 out of every 9 cases. His treatment differed from the restorative treatment of J. Hughes Bennett only in using large and long-continued doses of alcoholics.

Restorative Treatment.—This treatment was inaugurated and earnestly advocated by Dr. J. Hughes Bennett. He believed that blood-letting and antiphlogistics were injurious; that "pus-cells are living organisms and demand an excess of blood, good nutrition and exalted vital force to hurry on their development and carry them through the natural stages of their existence."

Nutrition is the objective point of the treatment. It is not an expectant treatment, because nutrients in large amounts are given from the very beginning of the disease. Cold water was allowed as a drink, and occasionally wine as symptoms indicated. Bennett's fully tabulated 125 cases, which were treated during the period from 1848 to 1865, gave a mortality of 1 in 324 cases.

Dr. Flint, in his "Practice of Medicine," states that Dr. A. Patton treated 96 cases with carbonate or muriate of ammonia, with only 2 deaths, and Dr. J. P. Thomas treated 207 cases with the same remedies, and had only 3 deaths.

This brief historical sketch has been presented in order to set forth the influence of venesection upon this disease. Comparison would seem to show that the further the treatment recedes from the blood-letting practice the more productive is it of good results.

The writer is well aware that oftentimes statistics are discredited. Statistics, when juggled, are unworthy of consideration, but when honestly collected and correctly formulated, although they may not with certainty point out the right way, are valuable as a suggestive guide toward it.

Abortive Treatment.—The abortive treatment implies an actual beginning of the disease and only its slight advancement. A chill, fever and pain are the initial symptoms of many diseases, and hence at their onset it is difficult to determine which of several diseases is in its initial stage. If abortive treatment is successful it is far from an easy task to conclude what disease has been aborted. If an attempt has been made to abort pneumonia after crepitant râles can be heard, it is scarcely proper to call the treatment abortive. Pneumonia is a self-limited disease, by which statement is meant that it passes through a uniform course of morbid processes—congestion, exudation, solidification and resolution. It is not denied that in some cases these processes are more rapidly completed than in others. It is also probably true that remedial agents may prevent the spreading of the diseased conditions from one lobe to another or even from one lung to the other. In this sense the disease may be cut short, but such a result of treatment is not a genuine abortion. But few prominent medical authors of large experience have faith in abortive treatment. Although not doubting the possibility of its success, the writer believes that very seldom is it successful. It is pertinent to inquire whether an aborted cold is not frequently called an aborted pneumonia.

Stages of Congestion and Exudation.—Upon the appearance of the initial symptoms, as a chill, pyrexia, dyspnea, pain, the physician should recognize that the system is suffering from toxemia. The elimination of toxins is the first remedial indication. For this purpose pure air, thoroughly oxygenated, should be a prominent factor. A large, well-ventilated room, with a quiet, sanitary environment is an almost indispensable adjunct to other treatment.

The main channels for the elimination of toxic materials are the lungs, skin, kidneys and bowels: the cloaca maxima of the system.

In pneumonia the stages of congestion and exudation lessen the air cells to which the blood is exposed for decarbonization; hence an extra burden is placed upon the other organs of excretion in removing toxic substances from the system.

A sweating process will increase the activity of the sweat glands and thus aid in ridding the organism of impurities. To accomplish this object, no more prompt, safe and effective means can be used than a hot-water bath. For the same purpose, a hot poultice upon the chest, bags of hot water around the body and diaphoretic drinks are of great utility. The kidneys may be forced into unusual activity by large draughts of boiled water and normal salt solution. Mer-

curial and saline cathartics will clear the intestinal tract and hasten the removal of toxic substances. It is believed that these remedial measures vigorously applied will be sufficient to lower the temperature to a large extent, relieve the dyspnea and pain and prevent excessive engorgement.

Stage of Solidification.—History gives us no warrant in believing that any special mode of treatment will relieve the solidified lobe or lobes of their morbid material. Much can be accomplished by a continuation of the treatment indicated for the stages of congestion and exudation. Special attention should be directed to sustaining the patient by nutrients which are easily assimilated.

Should dyspnea become so oppressive as to demand immediate relief, the propriety of venesection will be presented for consideration. It is the writer's opinion that in this condition the removal of 6 or 8 ounces of blood from the general system may be of great utility. After venesection, enemata and intravenous injections of a saline solution will be helpful. As an internal remedy the writer has found none more effective than carbonate of ammonia.

Should the pyrexia rise to a high degree, the cold-water bath at a moderately low temperature will be beneficial. The cold bath and cold sponging of the surface will not only reduce the pyrexia, but will give tone to the respiratory nerve center.

Stage of Resolution.—The indication in this stage points to a removal of the exudates as rapidly as possible. If the process of resolution moves forward without any special obstacles or complications, but little medication will be required to bring the disease to a satisfactory termination. Full nutrition should be maintained, the integrity of the nervous and circulatory systems sustained by moderate doses of strychnia, and all organic functions kept in such a state of activity as to provide for the rapid elimination of all toxic materials. Should obstacles to the removal of the exudates, and complications, arise, the mode of treatment must be adapted to their effects upon the system.

In cases of cyanosis, extreme dyspnea and shallow breathing it is possible that the loss of a small quantity of blood by venesection may afford temporary relief. Strychnia, by increasing the activity of the respiratory center and deepening respiration, may be of great benefit, and diffusible stimulants will also be serviceable. Under such circumstances, perhaps no stimulant is more effective than carbonate of ammonia, given in large and oft-repeated doses. Oxygen, although it has been used for various diseases during the last 25 years, has not gained the full confidence of the medical profession. It is a rapid purifier of the blood, and, through the blood, a renovator of the whole physical organism. In the solidifying and resolving stages of pneumonia, it has been administered for the

relief of extreme dyspnea and threatening cyanosis, with marked temporary benefit. The cyanosis shows a deficient oxidation of the blood and the indication for relief is the introduction into the system of an increased supply of oxygen. This treatment may not produce a lasting effect upon the disease in many cases—may not save many lives—but it will ameliorate symptoms; diminish cyanosis, deepen respiration and strengthen the action of the heart. It will not only give comfort to the patient, but will sometimes turn the scale in favor of recovery.

³Gaertner has recommended the intravenous infusion of oxygen in cases of exigency and emergency which demand prompt assistance for the purpose of saving life, as in extensive pneumonia. He states that the infusion should be made slowly, and that it is harmless. Cardiac depression is one of the most formidable obstacles to recovery in this disease. This condition results from the poisons of microbic infection, the excessive amount of work demanded of the heart and the degeneration and weakening of its musculature. Many remedial agents have been proposed for relief of this cardiac depression, indeed, their name is legion. In days past, perhaps no remedy has been so universally prescribed by both physician and patient, as alcohol in some form of its various combinations.

Although it has lost considerable prestige, it probably holds a large place in the mind and heart of the majority of physicians and the cardiac sufferers under their care.

During recent years, experiments, conducted by scientists with scrupulous exactness, with intense persistency and with instruments of extreme delicacy and precision, have demonstrated that alcohol is a depressant, a paralyzant. These experiments declare that even in small quantities it exerts a paralyzing influence on the mental faculties and physical organs. The mention of Deladrier, Kraepelin, Ach, Schmiedeberg, Frey, Destree, Ridge, Von de Muhl, Jaquet, Kellogg, Crile, H. C. Wood, as investigators along this line is sufficient to add force to the above declarations. If a patient is suffering from depression of the heart, it is difficult to understand in what way he can be relieved of this depression by a paralyzing agent.

For energizing the heart, probably no medicine is more effective than strychnia. "Stockton recommends it in doses of 1-30 grain every 2 to 4 hours, gradually increased to 1-10 grain. It stimulates the heart muscle and increases cardiac force; muscular activity is developed; more oxygen is consumed; a larger quantity of carbon dioxide is eliminated; the blood is more fully oxygenated; the heart receives an increased amount of nourishment from the purified blood and works with greater efficiency.

Digitalis is a cardiac stimulant which has been largely used as a remedy for heart depression. The writer's experience would lead him to pre-

scribe it with very little expectation of a successful result.

Non-Alcoholic Medication.—In addition to the statements made concerning the influence of alcohol upon the heart, there are potent reasons for omitting its use in the treatment of pneumonia. ¹⁵Schafer has written as follows: "It cannot be doubted that any small production of energy resulting from the oxidization of alcohol is more than counterbalanced by its deleterious influences as a drug upon the tissue elements, and especially upon those of the nervous system."

Says ¹⁶Whyte: "Pneumonia and phthisis, for example, have been indubitably proved to occur more frequently, and to be of more serious significance in drinkers than in persons whose blood is practically free from alcohol."

Kleefield, in his recent experiments upon the nervous system of animals, has shown the injurious effects of alcohol on the neurons and protoplasmic cells. ¹⁷Kellogg writes upon Kleefield's experiments as follows: "In these observations we certainly have the most convincing evidence that alcohol is an anesthetic agent, and that its effects are always those of a depressant, resulting in displacement of the neurons, as well as other cells, of which abundant proof has been furnished, as, for example, in relation to the influence of alcohol on blood cells. In the face of these facts, it should no longer be maintained by any one who is abreast with the modern progress of medical science that alcohol is a tonic, a useful stimulant, or in any other way an aid to any nutritive or therapeutic process.

"These observations certainly have a very practical bearing upon the question of alcoholic medication. If it is true that alcohol, even in small doses, acts as an anesthetic by crippling the neurons at the centers of activity and control, it is very evident that no positive good can be expected from its use."

The author has written elsewhere: ¹⁸"Nissl and Dehio have demonstrated that under acute alcoholism degenerative changes occur in the ganglion cells of the cerebellum. Kellogg has determined that the nerve filaments are shrunken and destroyed by alcoholism.

"Other competent observers have noted the same or similar changes in the human brain through alcoholic poisoning. Jackimoff experimented with alcohol upon dogs, and found the cells of gray matter of the brain in a state of disintegration. Berkley observed in the brains of alcoholized rabbits, among other changes, an alteration of cellular protoplasm and a shrinkage in the size of the nerve cells."

In order to show the effect of alcohol upon the animal system when under the influence of infectious material, ¹⁹Laitinen, of the University of Helsingfors, experimented upon dogs, rabbits, guinea-pigs, fowls and pigeons, 342 in number. Concerning these experiments, Prof. C. Fränkel, of Halle, "according to whose sugges-

tion and scheme the experiments were carried out," has written: "Dr. Laitinen found that in all these cases, without exception, the effect of the administration of alcohol in any form whatever was to render the animal distinctly, sometimes markedly, more susceptible to infection than were the controls."

In another place the writer has thus made mention of Abbott's experiments: ²⁰"The poisoning and paralyzing influences of alcohol lead to the conclusion that the alcoholized organism presents a lessened resistance to the attacks of micro-organisms. The detailed experiments of Abbott upon lower animals lean strongly toward the same conclusion. His experiments upon rabbits showed that the normal vital resistance to some organisms was markedly diminished. In some cases alcoholized animals died after microbic infection, while the control animals lived."

Although the experiments made upon animals mentioned above may not prove absolutely that the very same effects would occur were the same experiments made upon human beings, they point very strongly to the decision that the vital resistance of the human organism to microbic infection is greatly lessened by alcohol, and that the larger the quantity of alcohol ingested the less is the vital resistance.

Some statistics may add force to the arguments already presented.

A letter addressed to the writer on this subject by Dr. N. S. Davis contains the following: "For 40 years I had almost entire charge of the medical wards of the Mercy Hospital, the oldest and one of the largest hospitals in this city" (Chicago), "during which time many cases of pneumonia were treated without alcoholic liquors, either fermented or distilled, with a mortality of less than 12 per cent. And during the same time I treated an equally large number in my round of private practice, with a ratio of mortality of less than 6 per cent., all non-alcoholic."

Dr. T. A. MacNicholl, secretary of the Red Cross Hospital, New York City, has written the author as follows: "For ten years I have treated all cases of this disease (pneumonia) without alcohol, with results that are certainly remarkable, compared with those of my medical brethren who treat such cases with alcohol. Since 1896 I have not made any study of my records along this line, but at that time I reported to my fellows on the staff of the Red Cross Hospital that for the 12 months ending May 1, 1896, I had but 1 death out of 30 consecutive cases. In this one case liquor (wine) was given against my orders. For the year ending November 1, 1897, the Red Cross Hospital reported 12 cases of pneumonia without a death."

The records of the London (England) Temperance Hospital report concerning the cases of pneumonia treated in that institution since its foundation: Whole number of cases, 163;

deaths, 41. Of the 6 cases in which spts. vini rect. was given, 2 died. It is observed that these figures give a death rate of 25 per cent.

These statistical records concerning non-alcoholic medication, are too few to point with unerring certainty to the conclusion that every case of pneumonia should be treated without alcohol; they are factors to be used in the discussion of non-alcoholic treatment, and will be helpful in determining the value of such treatment.

Serum Treatment.—Serum therapy has been used in this disease for several years without calling forth a general sentiment in its favor. ²¹F. and G. Klemperer are said to have first used the serum treatment for pneumonia in 1901, and to have met with apparent success. ²²Goldsborough reports that he treated 9 cases with antipneumococcic serum, 2 of these terminating in death. He collected 386 cases treated with the same kind of serum. These, with his own 9 cases, gave a mortality of 16½ per cent.

According to Goldsborough, Osler's investigations show that the best results of treatment in the various hospitals of America are 25 per cent., while in some the per cent. is 35.

²³Chesebro states that, "G. E. Tyler, secretary Colorado State Board of Health, in a paper read before the Denver and Arapahoe Medical Society, February 12th, of the present year, reported six cases treated by himself, and collected 130 others. The mortality was 14.18 per cent. Of the 20 fatal cases, he thinks 14 were hopeless when treatment was begun, and therefore should be excluded, leaving a mortality of only 4.7 per cent." These 130 cases were treated with antipneumococcic serum.

²⁴Floersheim reports that he used suprarenal extract in 7 cases of pneumonia. He concludes: "It had no effect on the progress of the pneumonia. * * * It is the most powerful heart stimulant known to me."

From the evidence before the medical profession to-day it is fair to draw the conclusion that serumtherapy in the treatment of pneumonia is in an experimental stage.

Hydrotherapy.—Besides the benefit resulting from the use of water, as mentioned in a previous part of this paper, it has a utility in its tonic effect on the general nervous system when used externally, and also strengthens the body's vital resistance against toxemia. The temperature of the cold bath should be moderately low, say about 75° F.; if too low the shock produced overbalances the tonic effect. Cold sponging of the body throughout the disease, is generally adequate to maintain a sufficiently low temperature. It should be remembered that the comparatively short duration of the disease prevents the serious damages from a very high temperature of long duration. Copious draughts of water internally will greatly aid in the elimination of toxins. The cold treatment, which consists in cold baths, applications of cold water to the chest and other

parts of the body, showed a mortality of 4.25 per cent. in 400 cases collected by ²⁵Mays.

For the relief of pain, opium may be used in very small doses; it should be remembered that this remedy is a depressor of vital resistance. Also for the purpose of allaying pain, both hot and cold compresses have been highly recommended. The writer prefers hot applications for this purpose. It is his belief that for the relief of pain heat in some form is at the same time one of the most harmless and most potent remedies in existence.

Pneumonia is an infectious disease. Its treatment should involve the removal of the infecting organism and its toxins, and also fortifying the system against their deleterious influences. It is doubtful if any treatment has yet been devised which will destroy the pneumococcus when once introduced into the system, without at the same time doing serious injury. It should, therefore, be the earnest and persistent aim of the physician, to remove as rapidly as is consistent with safety all accumulated and accumulating toxins, to exercise special care in forbidding remedial measures which will depress the nervous and circulatory systems and to use the most reliable means, both external and internal, which will restore to the patient his normal vital resistance.

In the production of this paper no attempt has been made to mention all the modes of treatment that have been tried and all the medicinal remedies that have been recommended for pneumonia. The favorite remedies and specifics are almost innumerable.

A few medicines not mentioned thus far in this paper, and said by the practitioners using them to be unusually effective, are as follows: Hydrogen peroxide, used by ²⁶Beshoar, with a mortality of 1 per cent.; salol, commended by ²⁷Tuthill to stop a threatening pneumonia; creosote, used by ²⁸Van Zandt since 1890, with a loss of only 1 case; atropin, recommended hypodermically by ²⁹Hare for its stimulating effect on the vaso-motor system, and caffein, commended by the same author to increase the urinary secretion; pilocarpin, antifebrin and nuclein, recommended by ³⁰von Jaksch as beneficial in increasing the number of leucocytes; iodine, highly praised by ³¹Schwartz and Orth if used early in the disease; benzoate of soda, used by ³²Cady in an epidemic with good results; nitroglycerin, useful in cyanosis, according to ³³McGee; veratrum viride, for lowering the rapidity and intensity of the circulation; large doses of quinine, recommended by ³⁴Juergensen; large doses of digitalis, given by ³⁵Petresco in 1,192 cases, with a mortality of 1.22 to 2.66 per cent.; capsicum, recommended by ³⁶Mays as a diffusible stimulant. ³⁷Borini has confirmed, by experimental research, the fact that digitalis induces intense leucocytosis in pneumonia.

Without doubt, many mild cases of pneumonia would recover without medicinal treatment. Nature is a most excellent physician, and often-

times can do her work most effectually without the assistance of human agencies.

A summary of the prominent thoughts suggested to the mind of the author on this subject is as follows:

1. The medical experience of the nineteenth century warrants the conclusion that blood-letting, as a remedial agent in pneumonia, is inadmissible except in rare cases of subjects of a robust constitution, and in conditions of cyanosis and extremely difficult breathing.

2. Success of abortive treatment is extremely rare, if not impossible.

3. At the onset of the attack, the physician should recognize that toxemia is the main factor in the causation and maintenance of the disease.

4. Toxemia is to be attacked by the elimination of toxins and the increase of vital resistance.

5. Nutrition, properly directed, should occupy a prominent place in treatment.

6. Oxygen should be more generally recognized as an efficient remedy in the last stage of the disease.

7. The danger resulting from cardiac depression should be kept in mind throughout the disease.

8. Alcohol, being a cardiac depressant, is not a useful remedy in heart failure.

9. Hydrotherapy is useful in giving tone to the general nervous system, and especially to the respiratory center.

10. Serumtherapy is still in an experimental stage.

11. Many cases will recover without any special medication.

12. Treat not only the disease, but the patient.

13. Nature is a first-class physician.

Amendments to the Public Health Law.—Senator Stewart has introduced a bill into the New York State Legislature amending the present Public Health law in the following particulars:

(1) In all buildings and institutions, owned, maintained or controlled by the State, the plans for all water supply, sewerage, sewage disposal, and garbage disposal works shall be subject to the approval of the State Commissioner of Health before being adopted or constructed.

(2) The State Commissioner of Health shall appoint for each municipality (except such municipalities as are now exempt under Section 32, Article 2, of the Public Health law) a competent physician as a member of the local board of health to be the health officer of the municipality. This health officer may be removed by the State Commissioner of Health after a hearing. He need not be a resident of the municipality for which he is chosen, but unless he is such resident he must reside in an adjoining town.

(3) Additional compensation is allowed for extra services of health officers, for extra hazardous work by reason of epidemic or otherwise. Any health board may allow traveling expenses

for delegates attending the annual sanitary conference of health officers.

(4) Local boards of health shall enforce general vaccination of all persons when required to do so by the State Commissioner of Health, who is hereby authorized to make such a requirement when in his judgment such action is necessary for the protection of the public health.

(5) For removal of nuisances health boards may use any money in the hands of the board or may call on the city council, village trustees, or town board, or may borrow the same on the credit of the municipality, to be returned when collected from the persons responsible.—*Medical Record*, February 21, 1903.

MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION AND THE NEW YORK PROFESSION.

CHICAGO, Jan. 23, 1903.

To the Editor—I send herewith, for publication in *The Journal*, a copy of my reply to a letter received from a New York physician. It explains itself. I have purposely gone into details with the intention of publishing the matter, I have done so for the reason that I feel that there is a misunderstanding on the part of some of the members of the profession, especially in New York, as to the position held by the American Medical Association in regard to the conditions in that State.

Very truly yours,

FRANK BILLINGS.

CHICAGO, Jan. 20, 1903.

Dear Doctor—Your letter of recent date to the Secretary of the American Medical Association, concerning your relations with that body, has been handed to me with the request that I reply.

In the letter you say that you wish to sever your relationship with the American Medical Association, because of the actions of the Association. You state that the conduct of the Association is narrow, that this is 1903, not 1880 or 1881, and that as long as the American Medical Association continues to make an unjust and particular target of the New York State Society, so long must you forego the pleasure of membership in it.

I am induced to make reply to this letter for the reason that you make the statement "the American Medical Association makes a target of the Medical Society of the State of New York," and that I may explain to you and to other members of the New York profession the present status of the American Medical Association and its relation to the profession of New York.

In the first place, I desire to state to you that this is 1903, and not 1880 or 1881, and I do not wish to discuss the issues of twenty-two years ago, but to take up the affairs of the American Medical Association and its objects since the plan of reorganization.

At St. Paul, in 1901, the Association adopted a plan of reorganization and a Constitution and By-laws which embodied the plan which will be pursued in the future in an attempt to organize the profession of the United States on a broader plan than has heretofore existed.

I shall not attempt to give you the Constitution and By-laws, for you may read that document. Suffice it to say that one of the principles of reorganization is the formation of a county society in each county of each State, so far as practicable, the members of which shall form a State association, and that the members of the different State associations shall constitute the membership of the American Medical Association. The county society is the initial unit, and under this plan is the portal of entry to membership in both the State and national bodies. This plan embraces, of course, the principle that there shall be but one recognized county society in a county and but one State association in a State in affiliation with the national organization.

The committee of the American Medical Association which formulated the plan of reorganization was con-

in and later formulated a "Constitution and By-laws for County Societies," and also one for State societies which agrees with the principles mentioned above and corresponds with the Constitution and By-laws of the American Medical Association.

Ten or more of the different States have since adopted the Constitution and By-laws recommended by the Committee on Reorganization, and many counties of the different States have adopted the Constitution and By-laws recommended by the committee. Reorganization is thus going on all over the country, to a greater degree than the most ardent supporter of the reorganization plan could have hoped, and the outlook now is that within a very few years the profession of the United States will be organized on the plan embodied in the Constitution and By-laws of the St. Paul meeting and we shall be a united profession.

In almost every State of the Union there are physicians who have continued to be listed as members of the American Medical Association, although they are not members of the local society or of the State society in affiliation with the American Medical Association. These physicians are therefore not legal members of the American Medical Association. Furthermore, there was no inducement for them to become members of the affiliated bodies in the State in which they lived so long as they were carried on the list of members of the American Medical Association and enjoyed all the privileges of that body.

A committee was appointed at Saratoga to look up this matter of membership, which recommended that on or about January 1, 1903, the Secretary of the American Medical Association should notify every physician in the different States who was not a legal member according to the Constitution and By-laws, that his name would be dropped from the list of members if he did not become a member of an affiliated society on or before March 1, 1903.

This action was not aimed at the physicians of the State of New York, but was intended (as indicated above) to correct an error where it existed in all of the States of the Union.

However, in New York State a worse condition prevailed than elsewhere, for the reason that two State organizations have existed there since 1884.

As you know, the Medical Society of the State of New York ceased its affiliation with the American Medical Association in 1882 because of the existence of the Code of Ethics adopted by the Association in 1847.

Although the Association adopted a new Constitution and By-laws at St. Paul in 1901, it did not in any way alter the Code of Ethics, which was continued as the ethical expression of the Association. However, the sentiment apparently of the country in reference to the code was such that at the Saratoga meeting in 1902 a draft of a revised Code of Ethics was introduced to the House of Delegates and met with much favor in that body and from the members as a whole. A committee was appointed to present a revised code at the New Orleans meeting, and that document will be acted on by the House of Delegates in May of this year.

In February, 1902, the president of the Medical Society of the State of New York wrote to the president of the New York State Medical Association, informing him that the medical society, at its meeting held the latter part of January, 1902, had adopted a resolution that a committee of five be appointed to confer with a committee representing the New York State Medical Association for the purpose of formulating a plan which should have for its object the reorganization of the regular medical profession of the State of New York into one body, which body would be in affiliation with the American Medical Association. After considerable correspondence between the presidents of the two State medical bodies of New York, a committee of five from each was formed. From the Medical Society of the State of New York the committee was Drs. Henry L. Elsner, chairman; A. Jacobi, A. Van der Veer, A. M. Phelps and George Rycerson Fowler; from the New York State Medical Association, Drs. E. Elliott Harris,

chairman; Frederick Holme Wiggin, Emil Mayer, Parker Syms and William H. Biggam.

By correspondence and by conference these committees agreed on certain propositions which were signed by the chairman of each committee.

In brief, the propositions which were adopted were as follows:

First. There is an honest desire on the part of the members of the two State organizations to unite the regular medical profession of the State.

Second. That they organize by the legal union into a single State medical body, to be known as the Medical Society of the State of New York, of which all members in good standing in both organizations should be charter members.

Third. That the reconstituted medical body should be the representative in the State of the American Medical Association by virtue of the acceptance of the Constitution and By-laws of the American Medical Association.

At a meeting of both the committees, held April 18, 1902, the question of the manner of preparing the charter of the new organization was taken up, and the preamble and proposed charter which embodied the agreements above mentioned were read and adopted and signed by the chairman of each committee. (See the *NEW YORK STATE JOURNAL OF MEDICINE*, pp. 308 to 313, inclusive, November, 1902.)

At the joint conference of the committees held at the Academy of Medicine in New York City October 3, 1902, the committee of the Medical Society of the State of New York stated that it could not recommend the acceptance by the State society of the By-laws of the American Medical Association containing Article XV. (Article XV of the Constitution and By-laws, among other things, affirmed the Code of Ethics of the American Medical Association.)

At the Saratoga meeting the Constitution and By-laws were somewhat modified, and, among other things, Article XV, was omitted.

At the meeting of the New York State Medical Association in October, 1902, the committee of the Association made its report concerning the result of its conference with the committee of the State society.

This was, in short, that the two committees had agreed that they would attempt to unite the regular profession of the State of New York into one body, to be known as the Medical Society of the State of New York, of which all members of both societies in good standing should be charter members, and the reconstituted State medical body should be the representative in New York State of the American Medical Association by virtue of its acceptance of the Constitution and By-laws of the American Medical Association. This report of the committee was accepted with the expression of the New York State Medical Association of a sincere desire for a union.

In addition to this a resolution was adopted that the committee of the Association should be continued for the purpose of cooperating with any committee from the Medical Society of the State of New York to secure a charter from the Legislature during the session of 1903.

The resolution further stated that if the Medical Society of the State of New York should fail to approve of the plan of the union agreed on between the two committees, including the adoption of the Constitution and By-laws of the American Medical Association, in such time as would enable the proper committees to obtain a charter from the Legislature in 1903, that the committee of the Association should be discharged and the proposition for the union should be withdrawn.

This action of the Association left its special committee on conference in abeyance until such time as the committee of the society or the society itself could agree in full to the proposition made in joint committee meeting.

This status of affairs has continued in New York since the date of the meeting of the joint committee on October 3, 1902, or perhaps it would be better to say since the meeting of the New York State Medical Association later in October.

The Secretary of the Association, Dr. George H. Simmons, and I had conferred concerning the effect of the notice which, as stated above, was to be sent by him to the physicians who were listed as members of the American Medical Association in the different States, but who were not legally members of the Association. As there were nearly one hundred and fifty of these in New York State, the greater number of whom were members of the Medical Society of the State of New York, it made the situation there of greater import than in any other State of the Union.

It therefore seemed wise to Dr. Simmons and to me that I, as President of the Association and as an outsider, should go to New York, and, if possible, confer with the two committees for the purpose of hastening legal union of the two bodies. If this could be accomplished before the first of March all of the listed members could then become legal members of the Association; and if it could be accomplished before the first of January none of them would receive a notice from the Secretary as mentioned above.

Accordingly, I communicated with the chairman of each committee, with the result that a meeting of a full membership of each committee with me was held at 3 o'clock on Friday, December 19th, at the Academy of Medicine in New York City.

The chairman of the committee of the New York State Medical Association stated to me that his committee was in abeyance by the action of the State association and could not discuss the question at issue, inasmuch as the propositions for a union had been made by the association, and that the most of the propositions had been accepted by the committee of the society, and at this time awaited only the acceptance by the committee of the society of a signed agreement to accept the Constitution and By-laws of the American Medical Association. That if the Medical Society of the State of New York should accept the report of its committee of its society, including the agreement to acknowledge the Constitution and By-laws of the American Medical Association at its meeting in January, 1903, then the committee of the association would become active again and be ready to cooperate with a committee of the society to secure a charter and legalize the union of the regular profession under one society as mentioned above.

In the conference I found the gentlemen of the two committees kind and courteous, and the most cordial and kind consideration was shown to me and to the members of the two committees by each individual present.

I made a preliminary statement, in which I said that the committee of the State association, through its chairman, had indicated to me that his committee could not enter into a discussion of the propositions for union because they were in abeyance and also for the reason that the propositions had been accepted by the State association and required no further discussion from them as a committee.

I also outlined the status of conditions in New York, naming step by step the propositions which had been advanced and accepted by the two committees to the time of their last joint meeting on October 3d. In addition to this, the statement was made of the acceptance by the State association of the propositions. I also stated that the object of the meeting was to confer about existing conditions in the State of New York, and that I hoped no discussion of the problems of twenty-two years ago would come up, as I felt there was nothing to be gained thereby.

Inasmuch as a discussion of the meaning of Article XV of the Constitution and By-laws had been questioned after it had been omitted from the Constitution in 1902, I made the statement that the omission of Article XV did not in any way alter the relation of the Code of 1847 to the American Medical Association. That without Article XV the code was as much a part of the Association as before.

In answer to my preliminary remarks, Dr. Henry L. Elsner, chairman of the committee of the society, made

the following statement. I do not attempt to quote his exact words, but in brief he said:

First. That since the conference of the two committees, conditions had occurred which made the committee of the Medical Society of the State of New York alter its attitude in reference to the propositions made for a union of the two organizations into one legal body.

Second. That the committee of the society could not now agree to the proposition of the union on the basis of the abandonment of the charter of the Medical Society of the State of New York; that the charter of the society, granted in 1806, contained many valuable provisions which their legal advisor had informed the committee could not be secured, at the present date, from the Legislature of the State. That the traditions of so old a society, in addition to its many privileges, should not be given up. That the society would be willing to receive the members of the association in good standing into its body in lieu of the members of the two societies becoming charter members in the proposed new society.

Third. That the society could not afford to amalgamate with the association in obtaining a new charter, for the reason that the new body would assume necessarily the debts and obligations of each of the existing State bodies. That the financial condition of the association was such that the society could not afford to assume the risk of its debts.

Fourth. That the committee of the society was not willing to accept the Constitution and By-laws of the American Medical Association or to recommend its acceptance to the Medical Society of the State of New York, with the understanding that the Code of Ethics of 1847 was still in existence.

I then made the additional statement that the status of the Code of Ethics differed only from that of twenty-one years ago in this. That at the St. Paul meeting in 1901, when the new Constitution and By-laws were adopted, the clause in the old Constitution and By-laws which made it necessary for every medical body affiliated with the Association to adopt the Code of Ethics was dropped. That since 1901, therefore, while the code existed it was not now necessary that a county or State society in affiliation with the American Medical Association should adopt the code. That such affiliated bodies could organize without a code at all or with a code differing from that of the American Medical Association. I stated that Illinois and Ohio had no code, and that Massachusetts and possibly one other State had a code of its own. That doubtless other States and county societies existed without a code or with a code differing from that of the American Medical Association. That it was, therefore, perfectly feasible for the two State medical bodies of New York to unite on the propositions made and agreed on at former conferences to secure a charter from the State Legislature and to organize a body which should be the representative in the State of the American Medical Association without a code or with a code formulated to suit themselves. That if they did so unite before the meeting of the Association in New Orleans, their delegates—who would doubtless be men now representing both the society and the association—could go to New Orleans and help in formulating and adopting a revised code.

Dr. Jacobi, a member of the committee of the society, also spoke in substance as follows:

That he, as a member of the committee, would not agree to the propositions for a union so long as the present code of the American Medical Association existed. That if a revised code, as was introduced at Saratoga, were adopted by the American Medical Association, it would be acceptable to him—as it doubtless would be to the other members of the State society—although it contained objectionable features.

But, said Dr. Jacobi, if the American Medical Association is now of the opinion that it should have a revised code, or if at the New Orleans meeting the old code is abrogated or a revised code is adopted, then the American Medical Association will confess that it was wrong and the Medical Society of the State of New York was right twenty-two years ago. That he would

not consent to a union of the two bodies or become a member of the American Medical Association so long as the old code existed. That if at New Orleans a revised code, such as was introduced at Saratoga, were adopted, that by this act the American Medical Association would confess its error in the past and could in justice do no less than invite the Medical Society of the State of New York to become again the one affiliated State medical society in New York. That the State society would then be ready and willing to receive the regular members of the profession in the State of New York, including those of the association, as members of the Medical Society of the State of New York.

The committee of the association was in abeyance and had no answer to make to the statement of the committee of the society.

There was, therefore, nothing gained by the conference excepting this: That the position of the committee of the association and its members and of the committee of the society was made distinct and plain.

Before we separated I summed up the situation by the statement that the association, through its committee, had adopted certain propositions for a union such as are outlined in this letter. That the committee was in abeyance and would become active again, provided the society would accept the propositions at a date early enough to enable the joint committee to secure a charter from the Legislature of 1903. That the association had put this time limit on the society, not to force them to action, as I understood it, but so that if it was not accepted by the society, the association could then go on at the earliest possible date and reorganize the profession of the State in the different counties as the recognized State body.

At this point a member of the committee (I think Dr. Jacobi) made the statement that the committee of the society did not desire the association to stand still, but would be pleased to have them go on and organize the profession of the State without reference whatever to the negotiations going on.

As to the society, I summed up the propositions as made above by Dr. Elsner as the status of that committee.

I also said that it seemed to me that the only hope of the union of the two State bodies this year was to be accomplished on the following plan: That the committee of the society should make its report to the Medical Society of the State of New York at its January meeting and ask for further time to consider the propositions of the association. That inasmuch as the committee had unanimously agreed not to adopt the Constitution and By-laws of the American Medical Association now or as long as the Code of Ethics existed, that if at New Orleans the revised code was adopted and was acceptable to them, that they could then adopt the Constitution and By-laws and with it the revised code. That they could perhaps make provisions at the meeting of their society in January, whereby an official body or committee could then accept, with power to act, the completed report of the committee for amalgamation of the two State bodies. That this act would make the committee of the association active, and that together with the committee of the society they could then go on and secure a charter during this year.

This is a statement of the status of affairs in New York State made by an unprejudiced outsider and by one who has been and is most anxious that the profession of the Empire State should be united in one body representing the whole profession of the State in the American Medical Association.

The American Medical Association is most anxious to have the good men of the profession everywhere in its membership. And I want to repeat that no target is made of the members of the Medical Society of the State of New York. It is simply a question of adjustment of the differences between the members of the profession in New York, and that they must themselves settle.

I am sure you and every other member of the Medical Society of the State of New York will find that the great body of members of the American Medical Association

are desirous of having you back as members, and that we are willing and desirous of helping you as far as we can. But the members of the Medical Society of the State of New York must come to the American Medical Association, and should not for a moment believe that the American Medical Association will go to them.

In conclusion it must be distinctly understood that the New York State Medical Association is the only affiliated State body in New York, and as such, the only one that the officers of the American Medical Association can recognize.

Believe me, very sincerely yours,
FRANK BILLINGS,
President of the American Medical Association.

MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

The following letter is being sent to all physicians who are listed as members of the American Medical Association and who do not belong to an affiliated society in the State in which they live. The letter is published so that those interested may be informed, as it will be impossible to reach all by the first of March, the time specified in the resolutions. To save unnecessary correspondence the following information is given:

1. To retain membership in the American Medical Association it is obligatory that a physician be a member in good standing of the State society of the State in which he resides, or in one of its recognized branches. A physician is supposed to reside in the county in which he votes.

2. For the present an individual moving from one State to another is allowed two years in which to associate himself with the society into whose jurisdiction he has moved. In this case, however, he must keep in good standing in his old society.

3. Medical officers of the Army, of the Navy and of the Public Health and Marine Hospital Service of the United States are not required to affiliate with a society to hold membership in the American Medical Association.

4. In the State of New York the New York State Medical Association and its branches are the only organizations recognized by the American Medical Association.

5. Any physician who is in doubt as to whether or not the society to which he belongs entitles him to membership in the American Medical Association may obtain the necessary information by writing to the secretary of his State (or territorial) association. If such society is affiliated with the State (or territorial) association, it is in affiliation with the American Medical Association; otherwise not.

6. The requirements for membership in the American Medical Association are the same now as they have been in the past. The basic principle regarding membership, on which the Association was founded, as outlined above, is now, for the first time in many years, being enforced, and will continue to be enforced in the future.

FRANK BILLINGS, President.

GEORGE H. SIMMONS, Secretary.

The letter referred to above is as follows:

AMERICAN MEDICAL ASSOCIATION.

OFFICE OF THE SECRETARY, 103 DEARBORN AVENUE.

CHICAGO, Jan. 3, 1903.

DEAR DOCTOR:

Since the formation of the American Medical Association the fundamental principle has been that membership should depend on membership in an affiliated State or territorial association of the State or territory in which the individual resides, or in one of its subordinate branches. In the reorganization adopted at St. Paul in 1901 this principle was emphasized, but not changed. For many years, however, this has not been enforced, for the reason that no system of reporting or verification of membership under the old conditions was possible. The result has been that an individual might become a member of the American Medical Association while a member in good standing in an affiliated society, but

later withdraw from the latter, or be dropped or expelled, and yet still remain a member of the American Medical Association. Hence, there are members of the American Medical Association from every State and territory who do not belong to their State or territorial society, or any of its branches. The plan of organization now going into effect will prevent this anomalous condition in the future.

Meanwhile it becomes necessary to ask each one who is on the membership list of the American Medical Association and who is not a member of his State association, or of one of its subordinate branches, to unite with such by March 1, 1903. This is in accordance with the following resolutions adopted by the House of Delegates of the American Medical Association, June 16, 1902:

Resolved: 1. That the Secretary of the Association shall complete the verification of the list of members on the plan already begun, and obtain, so far as possible, correct information from the members themselves and from other sources as to the qualification of every person who now claims membership in this Association.

2. That all those who now claim membership and who are not eligible according to our laws shall be notified by the Secretary of such fact, and that they must furnish satisfactory evidence of their qualification for membership as required by our laws on or before January 1, 1903.

3. That not later than March 1, 1903, the Secretary is directed, after notification, to drop from the roll of members all who are not eligible to membership in this Association.

4. That the word "local" in line 9, Section 3, Chapter I, of the By-laws, shall be construed, in this connection, to apply to the State organization, or one of its recognized branches of the State in which the person holds his legal residence.

5. That a member of this Association removing from one county or State to another may continue to hold his membership in this Association for a period not to exceed two years, without joining an affiliated society in his new place of residence; provided, however, that during this time he retains his original membership in the county or State society from which he removed.

Section 3, Chapter I, of the By-laws of the American Medical Association, referred to in Resolution 4, is as follows:

SEC. 3. No individual who shall be under sentence of expulsion or suspension from an affiliated society (whether a directly affiliated State or territorial society or an indirectly affiliated local society), of which he may have been a member, or whose name shall have been dropped from the rolls of the same, shall be received as a member or shall be allowed to continue as a member of this Association until he shall have been relieved from said sentence or disability by such society; nor shall any person not a member of his local affiliated medical society, provided there be such a one, be eligible to membership or be allowed to continue as a member in the American Medical Association.

This circular letter is sent to each member of the American Medical Association whose name is not found on the membership list of his State or territorial association, or any of its branches, and is an official notification, in accordance with the above resolutions, that such member's name will be stricken from the roll of members of the American Medical Association, March 1, 1903, unless by that time he shows that he is entitled to such membership.

GEORGE H. SIMMONS,
Secretary American Medical Association.

NATIONAL INCORPORATION FOR THE AMERICAN MEDICAL ASSOCIATION.

JANUARY 31, 1903.

DR. E. E. MONTGOMERY,

Secretary Board of Trustees, American Medical Association, 1703 Walnut Street, Philadelphia, Pa.:

DEAR DOCTOR—My attention has been called to the fact that changes were made in the Constitution or Ar-

ticles of Incorporation of our National Association at the Saratoga meeting, June 10-13, 1902.

After careful consideration of all the evidence connected with these changes (referring especially to those made in Article XI) which I have been able to obtain, it seems to me to be clear that these alterations were improperly made, although, of course, this was unintentional, inasmuch as the amendments or changes had not "been proposed in open meeting of the House of Delegates one year previous to being acted upon," nor had they "been published at least three times in *The Journal* during the interim," and a copy of the proposed changes had not "been officially transmitted to each affiliated State or territorial society for consideration at its annual meeting" in accordance with provisions made in Article XI of the Constitution or Articles of Association as adopted at the St. Paul meeting, June 5, 1901.

The Revised Statutes of Illinois (Meyers, Section 34, page 336), being as follows:

"Any such corporation, society or association may change its articles of association in the manner prescribed by their own rules; but no such change shall be of legal effect until a certified copy thereof, with the seal of such corporation, etc., etc."

The fact that by an oversight the Constitution or Articles of Incorporation adopted at St. Paul were not filed with the Secretary of State, with the seal of the Association attached, as required by the laws of Illinois to make them legal, should not have been, in my opinion, taken advantage of by the attorney employed by your Board, who should, I believe, have followed the Constitution as adopted at St. Paul, as closely as possible in drawing up the new Constitution or Articles of Incorporation, making only such changes as the laws of Illinois required.

The laws of Illinois, however, in regard to the by-laws of a corporation, such as ours, made by the trustees, directors or managers, seem to be entirely different—Revised Statutes of Illinois (Meyers), page 335, Section 31—as they allow the by-laws of such a corporation to be "modified, altered or amended at any annual meeting or at any *adjourned* session thereof."

It seems to me in connection with this matter that it would be wise for your honorable Board to procure a national incorporation for the American Medical Association rather than to continue its existence under the laws of Illinois, which seem to allow ten members of the House of Delegates at an adjourned session of any annual meeting held in the State of Illinois to make changes in the by-laws and to do other acts which might undo any work that the House of Delegates at its previous meeting might have done, as well as to place the finances of the Association at the mercy of comparatively few members of the organization.

In case a national incorporation should be procured by a special act of Congress the House of Delegates could complete its business at its annual meeting wherever it might be held. The only objection to this proposition, which has been raised after considerable correspondence with some of the officers and members of the Association, was that it would not be possible for the Association to procure such incorporation. This objection seems to be overcome by the following facts:

The case of McCulloch against the State of Maryland (4 Wheat., 316), I am informed, is the leading case on this subject and takes up and discusses the whole question and determines it finally.

I am also informed that the American Social Science Association was thus incorporated in 1899 (Vol. 30, U. S. Statutes at large, page 804, chapter 63, of the 55th Congress), Justice Simeon E. Baldwin, ex-Justice of the Supreme Court of Connecticut, having drawn up the charter for this Association, he being considered by members of the legal profession one of the best constitutional lawyers in New England. The case of the Jeanett M. Thurber Conservatory of Music might also be cited.

I have been informed by the counsel of our Association that, in his opinion, the American Medical Association might be incorporated along the same lines as the American Social Science Association, and I hope

your Board will duly consider this matter and forthwith apply to Congress for a special charter and have the American Medical Association made a national body in fact.

This, I am informed, could probably be done without much expense and with little trouble, but whatever the expense and trouble incurred it would certainly be worth all that it might cost in money and in energy so to organize the American Medical Association that its interests may be carried on in the future by medical statesmen free from any disturbance from medical politicians and others who might seek their own, rather than the interests of the organization.

I also believe that your Board has the power under the present by-laws to carry out such a plan, and that the whole matter might be accomplished before the May meeting of the Association, when the House of Delegates could ratify your action and the matter be finally settled.

All of which is respectfully submitted.

FREDERICK HOLME WIGGIN,
President the New York State Medical Association.

THE BELLEVUE ALUMNI DINNER.

The Alumni of Bellevue Hospital held their annual banquet at Delmonico's on the evening of February 4th, with an attendance of 130. It was the most successful in the history of the organization. The decorations, the music, the elaborate menu and the songs and speeches reflected much credit upon the committee in charge, of which Dr. John F. Erdmann was chairman.

At the speakers' table were seated the president, Dr. Robert Morris; Dr. J. W. S. Gouley, Dr. Charles Phelps, Dr. A. Alexander Smith, Dr. Ramon Guiteras, Dr. John W. Brannan, Dr. D. B. St. John Roosa, Mr. Homer Folks and Mr. John W. Keller. District Attorney Jerome had been invited, but was unavoidably absent.

As the occasion brought a number from out of town an informal reception was held until 8 o'clock, when the doors to the dining-room were thrown open. At the place of each one was a beautiful souvenir menu, containing an etching of Bellevue Hospital and a copy of a song. Several times the doctors, old and young, rose between courses and with the accompaniment of the orchestra sang with great pleasure:

DOCTOR GOULEY.

BY THE POET LAUREATE, DR. R. K.

Air: Mr. Dooley.

There is a man that's known to all, a man of great renown,
A man whose name is on the lips of many a man in town;
They speak about him every day, you've heard his name no doubt,
And if he ever sneezes they will get an Extra out.

CHORUS:

For Doctor Gouley, for Doctor Gouley,
The smartest surgeon this land ever knew;
Always proficient, ever efficient, is
Doctor Gouley-oo-ley-oo-ley-oo.

See him at the Hospital with bright and earnest face,
Explaining to the House Staff the aspects of each case;
His patients never can forget, nor will they ever rue,
The way he used to treat them in the wards of old Bellevue.

CHORUS:

'Twas Doctor Gouley, 'Twas Doctor Gouley, etc.

And at his operations with verbiage exact,
He lectures to the students on surgery in fact;
The way he cuts for Calculi and removes them by the score
Makes every patient wish he had at least one dozen more.

CHORUS:

For Doctor Gouley, for Doctor Gouley, etc., and repeat.

When cigars and coffee at last put in an appearance, Dr. Morris arose and with a few appropriate remarks introduced the first speaker of the evening, Dr. Charles Phelps. In commemoration of Dr. Gouley's fifty years of service as an attending surgeon to Bellevue Hospital the society presented him with a silver dish.

Dr. Phelps, in making the presentation, made the following remarks: "It is my pleasure as representative of the Associated Bellevue Alumni to present to you, Dr. Gouley, this token of their affectionate regard, and to express to you, however inadequately, their high appreciation of the service which, by your example, you have rendered to the medical profession. We are sensible of the honor which your long and distinguished professional career has conferred upon Bellevue Hospital and upon us, its Alumni. We hold you in great honor as a learned and skilful surgeon, and as a man of eminent scholarship and culture. We hold you in even higher honor as a gentleman who has always maintained the dignity of his calling, who has disdained questionable methods of personal advancement, and who has always evinced a scrupulous regard for the rights of even the humblest of his confrères.

"It has seemed to us fitting that we should give to you some tangible expression of these sentiments, and in asking your acceptance of this gift



we assure you that whatever it may be destined to hold in the future, it is full laden now with infinite and heartfelt good wishes that your life may be long and happy, and that all good fortune may attend you always."

Dr. Gouley was unmistakably surprised. He had expected to be called upon for a speech, but had no inkling of the honor he was to receive.

Dr. Gouley responded substantially as follows: "Dearly beloved Brother Alumni, you have my

warmest and most grateful thanks for to-night's delicate manifestation of your good will. This expression of your esteem will be treasured in my soul, and the beautiful token will have the highest place among my cherished household gods. Our fraternity is indeed very near, for we have long lived under the dome of old Bellevue, our dear foster-mother, who has so well nourished our minds with the precious seeds which have already germinated and borne and are still bearing the richest intellectual fruit, as evinced by the high positions now occupied by so many of our brethren as private citizens in successful medical practice, as members of the medical corps of the Army and Navy, as physicians and surgeons of the great civil hospitals, and as professors in the chief schools of medicine. Our Alumni are scattered throughout this broad land, nay, in every country in the world, and not less than 200 are here in New York, enjoying all the advantages of the great city. The proud title of *Alumnus* of Bellevue Hospital is recognized and respected as a passport wherever the modern languages are spoken. You entered the hospital after a searching competitive examination and served a year and a half, and in many cases two years, on the house staff to the satisfaction of the Medical Board whose diploma entitles you to membership in our Alumni Society, which, as the president has just said, is 'a great organization' whose influence will become stronger every new year of its existence provided each individual member continues to labor for the advancement of the Society, not only by good, scientific contributions, but in many other laudable ways little dreamed of at this time. Let, then, each labor for all, and all labor for each, and let your motto be 'each for all and all for each.' Carry out, in letter and spirit, this sound principle and each and all of you will surely prosper.

"Permit me to add that R. K., the Béranger of our Alumni, has done himself much credit by his poetic effusion so well chanted in chorus this blessed night to the delight of the fraternity and the astonishment and confusion of oo-ley-oo-ley-oo."

The Doctor then spoke of the Bellevue of his early times, from 1851 to 1858, and referred to his early friendship, which still endures, with Dr. John Moore, late Surgeon-General of the Army; Dr. Robert L. Brodie, now of Charleston, S. C.; Dr. Stephen Smith, who is now great in surgery as well as in sanitary science, always public-spirited, and with Dr. Charles Phelps, so distinguished as a surgeon and so delightful in letters, and of other members of the house staff during these years. He also spoke of the great kindness and paternal affection of his early teachers, among whom were Drs. John O. Stone, S. Conant Foster, John T. Metcalfe, Alonzo Clark, Isaac E. Taylor, and James R. Wood, his preceptor, all of whom were members of the Medical Board.

We regret that we have not all the speeches

of the evening in full, as the members of the profession throughout the State would enjoy reading them, and all would profit by many of the sentiments expressed. Dr. Smith's reminiscences of his own work at Bellevue and that of others, many of whom have departed this life, leaving most honorable names and the results of valuable services to humanity, were full of interest.

Dr. Brannan was widely quoted by the lay press the next morning. His remarks told of changes made in the insane pavilion at Bellevue, under which Bellevue patients now received the same treatment as that administered at the State hospitals; of the organization of a fire brigade, with frequent and regular drills; of changes in the house staff, and of the expectation of the board of hospital trustees to start during the present year on plans for a new building which will take five years for completion and cost some \$3,000,000. But he dwelt mainly upon the recent charges against the administration of the alcoholic ward of Bellevue.

Charges were made against pupils of the training school so infamous that they might not be recited. They were made by a patient in the alcoholic ward.

An open investigation had been determined to be best, and the trial had gone far enough for him to say that the charges were baseless.

"The charges were not proved," he said, "and I know them to be unfounded. The tale was of an orgy lasting from 10 o'clock in the evening until 5 in the morning, except when a policeman was present. How do we know that the charges were groundless? There were thirty patients in the ward at the time. We have found and examined all but four of these. Of the four, one is dead, one is in the Manhattan Hospital and two are in the workhouse. The patient making the charges is the only one who saw what he described.

"There will not be a Scotch verdict. To my mind the District Attorney will bring charges against this man who made the charges against the hospital. If he be of sound mind he will be punished; we shall insist upon it. And I think that from this time there will be no more charges against Bellevue Hospital."

The following letter needs no explanation; addressed to the chairman having the presentation to Dr. Gouley in charge and signed by a man of international reputation, it is peculiarly appropriate that it receive publication:

479 FIFTH AVENUE, Feb. 3, 1903.

DEAR DOCTOR TOWNSEND—I thank you for your thoughtfulness in notifying me of the dinner of the Society of Alumni of Bellevue Hospital and especially for mentioning the feature which shall express commemoration of Dr. Gouley's long service in Bellevue Hospital.

It is just over thirty years since I, as a subordinate interne in Bellevue Hospital, first met Dr. Gouley. Although he was not on my visiting

staff I lost no opportunity of following him in his teachings through the wards. Long experience since has confirmed my early appreciation of the soundness and wisdom of those teachings.

We all know that the severest critics of a hospital surgeon are the members of his house staff. The visiting surgeon who barely escapes the censure of their criticism may congratulate himself that he has done good work. But, think of it, at that time, thirty years ago, when there impended an upheaval in the medical board and possible changes in the personnel of the visiting staff, the *house staff petitioned the commissioners that Dr. Gouley might be retained in his position!* Surely no praise or expression of esteem could have equaled such a certificate of appreciation.

The other day, a generation after, I said to my house staff in the same hospital, "Dr. Gouley's ears must always burn, for I never tire of praising his invention of whalebone guides and tunneled instruments."

Although Dr. Gouley is no longer on the attending staff of the hospital, I know I but share the wish of all, which is, that for many years, with his eminent abilities as a surgeon and a scholar, he may by his presence give distinction to the consulting staff of Bellevue Hospital.

I am sincerely yours,

WM. F. FLUHRER.

The New York State Medical Association has every reason to feel most proud of having had as one of its founders, and still possessing as its staunchest friend, a man whom not only the Alumni of Bellevue Hospital, but the alumni of every hospital and every medical college honors and respects.

Coroners.—The matter in the bill introduced in the Senate abolishing the office of Coroner in the city of New York:

Office of Coroner Abolished; Appointment of Medical Examiners' Districts; Clerks and Stenographers.—On and after September 1, 1903, the office of Coroner in the city of New York shall be abolished and the terms of office of the Coroners shall cease and determine on that day. On or before such day the Board of Health of the city of New York shall appoint, pursuant to the civil-service law and the rules and regulations of the civil-service commission, medical examiners for such city as follows: Six for the Borough of Manhattan; four for the Borough of Brooklyn; two for the Borough of Queens; two for the Borough of the Bronx, and one for the Borough of Richmond. Such medical examiners shall be citizens of the United States and residents of the city of New York, and shall be physicians learned in pathology, duly licensed to practice medicine in the State of New York, and who have practiced their profession within the city of New York for a period of five years next preceding their appointment. Such examiners shall be appointed from the Coroner's physicians in office when the office of Coroner is abolished

as provided in this act, or from an eligible list prepared by the civil-service commission after a special civil-service examination held therefor. Each of such examiners shall receive an annual salary of \$3,500. The Board of Health may divide the Boroughs of Manhattan, Brooklyn and the Bronx into districts and may assign one of such medical examiners to each of such districts. The Board of Health may appoint clerks, stenographers and other assistants to aid the medical examiners in the performance of their duties. The Board of Health may adopt rules, not inconsistent with the provisions of this title, prescribing the duties of the medical examiners and such clerks, stenographers and assistants.

Medical Examiners to Perform Duties of Coroners.—The medical examiners appointed as provided in the preceding section shall have the powers and perform the duties of Coroners, to the extent specified in this title, in respect to the determination of the cause of sudden or suspicious deaths within the city of New York.

Section 1572. Notice of Death from Violence or Sudden Death.—Any person who shall be made aware of the death of another from criminal violence, or by a casualty, or suddenly when in apparent good health, or when unattended by a physician, or in prison, or in any suspicious or unusual manner, shall immediately notify the Department of Health, one of the medical examiners, or a police officer, whose duty it shall be to forthwith notify the Health Department or one of the medical examiners of such fact, and no person except those hereinafter specified to take the examination shall touch, remove or disturb the body or the clothing upon or near the body of such deceased person.

Sec. 1573. Duties of Medical Examiners; Autopsy; Report to Be Filed.—It shall be the duty of one of such medical examiners to forthwith proceed to the place where said body lies, and take possession and exclusive charge of the same, and he may direct the removal of said body to such place as he may select or designate. He shall also take into his custody all letters and private memoranda, and articles found about and upon said body, and shall carefully seal and preserve them, and turn them over to the District Attorney or the Court. No person except the medical examiner shall touch, remove or disturb the body or the clothing upon or near the body of any deceased person hereinafter described, unless duly authorized by said officer so to do. Such medical examiner may thereupon, in the presence of a District Attorney representative and police officer, proceed to make an autopsy, if in his opinion it is necessary, and ascertain the cause of death. Such medical examiner, after determining the cause of death of such person, shall forthwith file in the office of the Department of Health a complete report in writing of all the facts and circumstances pertaining to the cause of death of such deceased person, together with his opinion of the cause of death, all of

which shall be duly subscribed and attested by him.

Sec. 1574. Inquiry by City Magistrate.—If there is a suspicion of the commission of a crime in connection with the death of any person so examined, the District Attorney of the county where said crime is committed or any person accused or charged of having any guilty knowledge of a crime in connection with such death, may require the city magistrate of the district wherein said body was discovered to hold an inquiry into all the facts surrounding the cause of such suspicious death, and such police magistrate shall have the power to issue subpoenas and otherwise compel the attendance of witnesses before him upon any inquiry held as herein provided.

Sec. 1575. Certain Civil Duties to Be Performed by County Clerks.—All the civil and other functions not herein specifically provided for, which were heretofore exercised by Coroners located within the boundaries of the city of New York, are hereby made a part of the duties of the City Chamberlain of said city.

Sec. 1576. Disposition of Property and Money Found upon Body.—The medical examiner shall take charge of any money or property found on the body of a person, the death of whom was investigated by him as provided herein, and shall immediately deliver the same to the City Chamberlain, who shall hold the same subject to the demand of the legal representatives of such person. Unless such money or other property is called for within sixty days from such delivery, the county treasurer shall deposit such money in the manner provided by the code of civil procedure. In case of money paid into court, or in case of other property, he shall sell it at public auction upon reasonable public notice, and deposit the proceeds thereof in the same manner. The money so deposited, with interest, shall be paid to the legal representatives at any time within six years from the time of the delivery of such money or property to the county treasurer, upon an order of a justice of the Supreme Court residing within the city of New York. Nothing in this act shall affect the rights, powers and duties of the public administrator of the county of Kings or the county of New York, in respect to the property and effects of deceased persons as provided by law.

• • •

To the New York County Medical Association:

The Committee appointed to investigate the office of Coroner and to confer with Committees of other societies appointed for the same purpose respectfully submit the following report:

Your Committee immediately notified the following societies of their instructions to confer with similar Committees of other societies, viz., the County Medical Society, the Kings County Medical Association, the Society of Medical Jurisprudence and the Medico-Legal Society. Of these bodies your Committee have had an opportunity of conferring only with the Com-

mittee of the Kings County Medical Association. With that Committee we have had two sessions.

After a very full discussion of the various phases of the subject the conference unanimously concluded that it would be in the interests of a sound public policy if the office of Coroner were abolished and the duties conferred upon that official were properly adjusted among other branches of the municipal government. These duties are twofold, viz., 1. Medical, or those relating to the determination of the cause of death in cases where the cause is unknown; and 2. Legal, or those pertaining to the conduct of the proceedings in the investigation of the crime and the detection of the criminal by an inquest. 3. Judicial, or those of the court holding its inquest.

Evidently these duties belong to two entirely different professions and for their proper performance require men of learning and large experience in their respective professions. Whatever may be the merits of individual Coroners it "goes without saying" that no one has yet been elected to that office in this city who brought to the performance of these duties adequate knowledge of both professions to give the best and most reliable results. And it is doubtful if such a person ever will be or even can be elected. The Committee hold that in the very nature of these duties and of the conditions governing the selection and election of Coroners a thoroughly competent person cannot be secured for that office. We believe it is for this reason chiefly that the office of Coroner has been under condemnation in every civilized country for more than two centuries. It is the reproach of an imperial city like New York, which is so progressive in the department of its sanitary service, to longer tolerate a branch of its civil administration incapable, in the very nature of its duties, of meeting the just demands of medico-legal science. It is the more surprising that we cling to this relic of the past when we have in the organization of our municipal government all the machinery essential to the performance of these duties with that promptness and accuracy which the service requires to insure the highest degree of success. All that is now required to give us a most complete system of detecting crime as a cause of death and of discovering and arresting the criminal only awaits the plastic hand of the Legislator to place in practical form and relations conditions existing in our civil organization.

The first conclusion reached by the conference was that the medical duties, or the investigation of the cause of death, should be transferred to the Health Department, where those functions properly belong. It was held that the very foundation of an intelligent and efficient administration of laws, rules and regulations for the protection and promotion of the public health are accurate vital and mortuary investigations and registration. No health authority can exercise its functions properly which does not thoroughly

understand the causes of mortality among the people. This knowledge can only be obtained by exhaustive inquiry into the circumstances and conditions under which every death occurs by persons fully qualified and equipped to employ the latest resources of science in their methods of investigation. It is apparent, therefore, that it is not only a legitimate function of the Board of Health, but it should be its statutory duty to investigate every death in the interest of the public health. And this duty should be the more imperative in cases of deaths from violence or from sudden and unknown causes, for the latter are liable to be due to conditions which are preventable and which should, therefore, be at once taken cognizance of by the Health authority.

The plan of organizing this service which, in the opinion of the Committee, is most feasible may be stated as follows: Empower the Health Department to establish a bureau especially devoted to the verification of deaths from uncertain causes; appoint as its chief officer a physician recognized as an authority in pathological investigations; appoint a sufficient number of medical examiners (four or more for the Borough of Manhattan and a proportionate number for the other boroughs) under the civil-service rules, but having as a special qualification practical familiarity with autopsical investigations; give to this bureau the full use of chemical and biological laboratories. The practical operation of this scheme would be as follows: Every death from unascertained cause reported to the Health Department would be at once referred to this new bureau for verification. The chief officer would immediately dispatch a medical examiner to the place where the body lies, who would take possession of the body and all articles and clothing found upon it. He would have power to summon to his aid the police, or bystanders, or other Health officials, or a representative of the District Attorney's office. He would at once begin a systematic study of all conditions and circumstances attending the death, making ample notes, with the aid of a stenographer, of every fact ascertained. If to determine the cause of death autopsy is required, he may proceed to make it, and he has the power to summon to his aid another medical examiner, or bystanders, or the police. If chemical or biological tests are necessary the laboratories of the Department are at his immediate service, the examinations being by experts. Having completed his examination he submits to the chief of the bureau a full and detailed account of his findings. If this officer is satisfied that the death was due to natural causes and that there is no suspicion of crime, the usual certificate of death is made to the Bureau of Vital Statistics and the case is closed, the papers being filed in the bureau. If, however, there is evidence of crime, the chief officer reports all the facts to the District Attorney, with the recommendation that an inquest be held. This closes the first or purely medical part of the pro-

ceeding. The intrinsic merit of this method may be thus stated: 1. The investigation into the cause of death is made in a department especially interested in determining the exact circumstances under which it occurred. 2. The medical examiner is thoroughly qualified for his duties and is under the direction and supervision of an eminent pathologist. 3. In prosecuting the investigation all the resources of the Health and Police Departments and the District Attorney's office are at once available. 4. These conditions secure to the medical inquiry prompt action, precision of details, expert knowledge at every step of the inquiry, abundant laboratory facilities, accurate results and economy in the expenditure of money.

The second conclusion of the conference was that the District Attorney or his representative should conduct the legal proceedings at the inquest in a magistrate's court. With the filing of the findings of the medical examiner in the office of the District Attorney would begin the legal and judicial proceedings in the case. The inquest would be conducted by a representative of the District Attorney before a magistrate and the medical examiner, and those who aided him would appear to give testimony as to the facts discovered in the preliminary investigation. These judicial proceedings would be conducted with proper dignity and in accordance with recognized rules governing the admission of evidence. If crime is revealed and the criminal discovered the farther prosecution of the case will be directed by the District Attorney, who will be better prepared to manage the subsequent details because he may have been familiar with all the preceding stages.

The third conclusion of the conference was that all other duties pertaining to the office of Coroner than those relating to the investigation of the causes of death and the holding of inquests be transferred to the City Chamberlain.

The final action of the conference was to resolve that the Committees recommend to their respective associations such legislation as will abolish the office of Coroner and transfer the duties of that office as follows:

1. The duties of investigating the causes of death in all cases which now come under the jurisdiction of the Coroner to the Health Department, which shall be authorized to organize and equip a bureau for that purpose and appoint the necessary officers.

2. The legal duties to the District Attorney's office, and the judicial duties of the inquest to the magistrate's court.

3. The duties, other than those pertaining to the inquiry into the cause of death and inquest, to the Chamberlain.

The Eleventh International Congress of Hygiene and Demography will be held in Brussels from Sept. 2 to 8, 1903. The Secretary-General of the Congress is Dr. F. Putzeys, of Brussels.

WHAT ONE COUNTY IS DOING.

It has been said, and with some truth, that medical men are not business men. It is certainly true that in the past our medical societies and medical organizations have not been business bodies in any sense of the term, but purely scientific and educational. While this, as far as it goes, is noble and idealistic, nevertheless it is recognized that a little more business, a little more medical statesmanship and a little more attention to the materialistic side would not be out of place, and ought not to detract from the scientific and educational, but rather add thereto. In the present plan of organization the business principle, while not pushed to the front, is recognized. In this connection we can not resist the temptation to call attention to what one society has already done. The Ramsey County (Minn.) Medical Society, the county in which St. Paul is situated, four years ago began the formation of a library and at the same time founded in connection with it the *St. Paul Medical Journal*. The library has been gradually built up and at the present time has over 4,000 volumes, all catalogued and shelved in a commodious hall, which is also the meeting-room for the society. The use of the hall is given, rent free, by the management of the building, which is devoted to offices almost entirely occupied by physicians. The journal has been a financial success from the beginning and puts considerable money into the treasury of the society each year, besides being the means of placing on the shelves of the library practically all the better books that are published, several hundred volumes annually. Further, all the exchanges are placed in the library, so that practically every important journal of the country is in the reading-room of the society. The society also has a well-equipped laboratory for chemical and bacteriologic work, one of the important products of which is sterilized catgut, sold at a profit. The laboratory gives to the members of the society a place in which to work, and many avail themselves of the privilege. The society takes great pride in its journal, which is one of the best medical monthlies in the country, and which is edited on a high ethical standard. Each enterprise is separate and distinct from the other, each making a full report to the society at the end of the fiscal year. One of the members says, "Our dream is to lay by a little money every year for the establishment of a fund which will ultimately enable us to buy a piece of ground, and later to own our own home." There is no doubt that the society has been built up and strengthened very materially by these enterprises. It has now over 150 active members and the officers expect very shortly to have in the society every reputable practitioner in the county. What the Ramsey County Medical Society has done can be done by other societies similarly situated throughout the country.—*Journal American Medical Association*.

NEW YEAR GREETING, 1903.

Let us pray to be ever kind to the Fellows of our Guild. Doctors, from the nature of their calling, if they develop in the right direction or move along proper lines, become more sentimental day by day, more kindly, more full of the spirit of grace, mercy and peace. We all recall the spirit of Charity, voiced by the old family Doctor, as opposed to the severe sentiments of the village clergyman in the dear old "Autocrat of the Breakfast Table's" novel of Elsie Venner, which illustrates the thought that Doctors know so much of the ins and outs of people's lives, their inherited predispositions, idiosyncrasies, weaknesses; their acquired blemishes, due to the distorting effects of sickness, sorrows, calamities, and get so in the habit of making allowances, excusing and forgiving the errors and sins of their patients that they often become the easy mark of cold-blooded, selfish and designing men, the victims of their own altruism.

Yes, Doctors are ever and always wearing themselves out in serving, condoning and forgiving the sins of their patients, but are they as sympathetic with the frailties of their fellows as they should be? I fear that their patients draw upon them to such a degree that their supply of the milk of human kindness is often exhausted before they come to the contemplation of the foibles of their "fraters." They are surely generally too exacting of each other, too ready to criticize, question and condemn.

I often wonder whether, after all, the spirit of "knocking" in our profession is not due to the same cause that prompts it sometimes in the family, relatives being proverbially the severest critics of their own clan, and yet when trouble comes, when attacks from the outside are received, how prompt the *defense*. Yes, Doctors rally to each other when the wolves and hyenas from the outside world attack one of their number, but Oh, God, why can't they realize that there are burdens, wounds, bleeding hearts that come from the every-day battles in life, that are often more painful and grievous in their results than those produced by any or all of the hungry hyenas or venomous reptiles of the outer and uttermost parts of the earth?

Little we know, often of the carking cares, the blisters and the bruises borne by the heavy-hearted and "leg-weary" members of our profession, and may we not more and more every day strive to do our work and be kind—and be kind, and open our hearts to such thoughts as are suggested by Montgomery in the *Churchman* of a recent issue, with the title, "What Know We?" as follows?

What know we of the gnawing griefs
That dim perchance our neighbor's way,
The fretting worry, secret pain
That may be his from day to day?
Then let no idle word of ours
Sting to his heart with sore dismay.

What know we of temptations deep
 That hover round him like the night,
 What bitter struggles may be his,
 What evil influences blight?
 Then be not hasty to condemn
 If he has strayed from paths of right.
 We know so little of the hearts
 That everywhere around us beat,
 So little of the inner lives
 Of those whom day by day we greet,
 Oh, it behooves us, one and all,
 Gently to deal with those we meet.
 Gently to deal and gently judge,
 With that divinest charity
 That thinks no evil, but would seek
 The good in every soul to see,
 Measuring not by what it is,
 But by that which it strives to be.

Yes, believing, as we do, that Doctors are among the best men on earth to-day, that they do more in the way of service and kindness to the sorrowing and the grieving ones the world over than all other workers combined, let's determine to give to each other each day the loving sympathy that brothers should ever give one to another. And may God bless us every one and all that we hold dear, and give us and ours and all his people a joyous, glad New Year.—*Medical Mirror*.

Experiments with Formalin.—Drs. W. H. Park and W. A. Payne have been conducting recently a series of experiments for the purpose of testing the efficacy of formalin in septicemia. The investigations in question were made in the bacteriological laboratory of the Health Department.

The experiments were performed upon rabbits, and showed that when a formalin solution of the strength used in Dr. Barrows' case was injected into a number of rabbits inoculated previously with a streptococcus germ, the result was that these rabbits did not live so long as an equal number likewise inoculated with a streptococcus germ, but which had not been injected with formalin. With larger injections of formalin, it was found that the formalin lessened the resistance of the body to the invasion of bacteria. Dr. Park concluded, as an outcome of these and other experiments, that the amount of formalin injected by Dr. Barrows had very little effect upon bacteria, retarding for a few hours only the rapidity of the development of the germs.

The formaldehyde combines with the albuminous part of both the bacteria and the blood and is consequently injurious to both. The affected bacteria quickly reproduce, and the formalin, being already consumed by the chemical combination that has taken place, has no further effect. The injury to the blood cells, however, is not healed so quickly. In short, the experiments would seem to show that formalin is of no use in septicemia, but is a source of some danger.

The fall in temperature produced by the injection of this agent is not so much owing to its action as to the presence of the solution.—*Medical Record*, February 21, 1903.

DEPARTMENT OF PUBLIC CHARITIES,
 Commissioner's Office,
 Foot of East 26th Street.

NEW YORK, Feb. 16, 1903.

Dear Sir—You will receive under this cover a copy of the Diet List of the City Hospital, Blackwell's Island, which was adopted by the Commissioner of Public Charities, January 7, 1903, and which is now in effect at that institution.

Please notice the classification of diets which your committee approved as being applicable to diseases and conditions for treatment at the City Hospital. By observing closely this arrangement in ordering for your patients you will secure a more satisfactory service from the Dietary Department than if the arrangement is disregarded.

Your attention is particularly called to the schedule of Regular Diet designed for those patients not requiring restrictions in diet. The daily average of the week's dietary is:

Proteids.	Fats.	Carbo-hydrates.	Calories.
100 grams.	100 grams.	395 grams.	2882.

This is larger than the American standard for a man with light exercise, which is as follows:

Proteids.	Fats.	Carbo-hydrates.	Calories.
100 grams.	100 grams.	360 grams.	2518.

and it is considerably larger than the life ration as estimated by Professor Atwater, which is:

Proteids.	Fats.	Carbo-hydrates.	Calories.
75 grams.	40 grams.	325 grams.	2000.

It is Professor Atwater's opinion, as expressed in the thirteenth annual report of the State Commission in Lunacy, that his proposed physiological dietary standard of 85 grams of proteids and 2500 calories of energy is considerably in excess of the actual food consumption in the State Hospitals for the Insane, and seems to him larger than is needed. He also says: "Basing our inferences upon what would appear to be the food requirements of persons in health, and upon the actual food consumption in the hospitals for the insane, it would seem that the average hospital population would be amply nourished with a dietary furnishing 80 grams of proteids and 2400 calories of energy per day, and very likely 75 grams of proteids and 2300 calories of energy would suffice for healthful nourishment. It is, however, to err on the safe side and to feed too much rather than too little, and for general practice it might be better to consider the physiological demands as requiring 85 grams of total protein and 2500 calories of energy."

This would indicate the average of our Regular Diet to be large, and ample for the average requirements of our general hospital cases.

Under the head of Extra Diet have been grouped certain articles, somewhat expensive as compared with the other articles of diet, which may be ordered either alone or in addition to any one of the other diets for special cases when no other diet is adequate or sufficient. By carefully restricting the use of these articles of Extra Diet to those in actual need of them no one will be de-

prived of all he needs. If, through oversight, or lack of careful consideration of each patient's needs from day to day, such articles are ordered when not needed, it may be necessary to reduce the diet list for pecuniary reasons.

You are especially requested to see that those in charge of the wards, and those responsible for administering the patients' diet, understand whether articles of Extra Diet ordered for your patients are to be given alone, or in addition to Regular Diet, and to instruct those who order diet for patients as to the uses of these various diets in order that articles of Extra Diet may not be ordered when not needed. You are also asked to give particular attention to ordering all diets for your patients from day to day, that there may be no unnecessary orders or overlapping of orders, and consequent waste of food materials.

Yours very truly,

Commissioner.

DIET LIST, CITY HOSPITAL, BLACKWELL'S ISLAND.

1. Regular Diet.—As per daily schedule (over). All quantities are of the cooked food materials, ready to serve. Breakfast: Cereal, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Soup, 12 ounces; meat, 5 to 7 ounces; or fish, 8 ounces; potatoes, 8 ounces; bread, 4 ounces. Supper: Farina pudding, 6 ounces; or soup, 12 ounces; and crackers, 4 ounces; or fruit sauce, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

2. Modified Proteid Diet.—Same as Regular Diet, with the omission of meat and the addition of one quart of milk daily.

3. Light Diet.—Two eggs; 2 quarts of milk daily (milk toast); $\frac{1}{2}$ ounce of butter; 1 pint of beef tea; with any article selected from the Extra Diet list.

4. Liquid Diet.—Articles to be selected and quantities specified by physicians: Beef tea, chicken soup, rice water, toast water, albumen water, strained gruels and milk.

5. Dry Diet.—Same as Regular Diet, omitting tea, coffee, milk and soup.

6. Diabetic Diet.—Articles to be selected from—Liquids: Beef tea, beef soup, tea, coffee (without sugar); milk, 1 pint daily. Animal foods: Fish of all kinds; salt and fresh butchers' meat, excepting liver; butter, cheese and eggs. Cereals: Bran bread and gluten bread; Vegetables: Tomatoes, spinach and cucumbers. Fruits: Lemons, oranges and apples. Quantities of above same as in Regular Diet.

7. Extra Diet.—Any of the following articles to be ordered either alone or in addition to any one of the above diets: Broths, soups, clam broth, beef juice, scraped beef, steak, chops, toast, cocoa, eggs, eggnog, custard, simple puddings, jellies, junket, sugar, lemons, fresh fruits (specified).

Approved by the Medical Board, City Hospital, and adopted by the Commissioner of Public Charities on January 7, 1903.

REGULAR DIET.

All quantities are of cooked food, ready to serve.

Sunday.—Breakfast: Hominy, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Barley soup, 12 ounces; roast beef, 5 ounces; potatoes, 8 ounces; bread, 4 ounces. Supper: Stewed prunes, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

Monday.—Breakfast: Oatmeal, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Vegetable soup, 12 ounces; corned beef, 7 ounces; potatoes, 9 ounces; bread, 4 ounces. Supper: Apple saucc, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

Tuesday.—Breakfast: Rolled wheat, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner:

Fish chowder, 14 ounces; bread, 4 ounces; coffee, 16 ounces. Supper: Pea soup, 12 ounces; crackers, 4 ounces; tea, 16 ounces.

Wednesday.—Breakfast: Oatmeal, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Pot-roast beef or chopped roast beef, 5 ounces; gravy; potatoes, 8 ounces; one vegetable, 4 ounces; bread, 4 ounces. Supper: Stewed prunes, 8 ounces; bread, 8 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

Thursday.—Breakfast: Farina, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Boiled mutton, 4 ounces; with broth, 8 ounces; bean polenta, 8 ounces; bread, 4 ounces. Supper: Boiled rice, 6 ounces; with milk, 4 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

Friday.—Breakfast: Oatmeal, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Fresh fish, 6 ounces; potatoes, 8 ounces; bread, 4 ounces. Supper: Apple saucc, 8 ounces; bread, 8 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

Saturday.—Breakfast: Rolled wheat, 8 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; coffee, 16 ounces. Dinner: Beef stew (potato in stew), 16 ounces; bread, 4 ounces. Supper: Farina pudding, 6 ounces; with milk, 4 ounces; bread, 4 ounces; butter, $\frac{1}{2}$ ounce; tea, 16 ounces.

At 8 P. M. daily, milk, 8 ounces.

The *New York Medical Critic* announces that each subscriber to that journal will receive a free copy of the Medical Index next month (March, 1903).

The volume will contain names, place and date of publication, office, circulation and names of editor and publishers of over 600 of the principal medical publications in this country and abroad, and also the titles and authors of each article published during the year 1902, arranged according to subjects and alphabetically. When it is known that the list is complete up to January, 1903, it should prove especially valuable in bridging over the period which has elapsed since the Index Medicus was discontinued.

Book Reviews.

SAUNDERS' MEDICAL HAND-ATLASES—ATLAS AND EPITOME OF ABDOMINAL HERNIA. By Privatdocent Dr. George Sultan, of Gottingen. Edited, with additions, by William B. Colcy, M.D., Clinical Lecturer on Surgery, Columbia University (College of Physicians and Surgeons). With 119 illustrations, 36 of them in colors, and 277 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3 net.

The first half of this valuable little work is devoted to hernia in general. The definitions of the various parts of a hernia are followed by descriptions of their locations, relations and contents. The possible etiological factors are carefully and fully considered. The pages on the accidents of hernia and the general treatment, both palliative and radical, will be found to be of great value to surgeon and practitioner alike, although, in such a small book, the various operations cannot all be dwelt upon in detail.

The second half of this epitome takes up the subject of special herniæ. A chapter on expert opinions in reference to the loss in earning power by one possessing a hernia will be appreciated greatly by those whose opinions upon the subject are sought.

The illustrations are not only very numerous, but most of them are in colors, are very artistic and are very enlightening.

BOOKS RECEIVED

ATLAS AND EPITOME OF DISEASES OF THE MOUTH, PHARYNX AND NOSE. By Dr. L. Grunwald, of Munich. From the Second Revised and Enlarged German Edition. Edited, with additions, by James E. Newcomb, M.D., Instructor in Laryngology, Cornell University Medical School; Attending Laryngologist to the Roosevelt Hospital Out-Patient Department. With 102 illustrations on 42 colored lithographic plates, 41 text cuts and 219 pages of text. Philadelphia and London: W. B. Saunders & Co., 1903.

ATLAS AND EPITOME OF HUMAN HISTOLOGY AND MICROSCOPIC ANATOMY. By Johannes Sobotta, of the University of Würzburg, Bavaria. Edited by C. Carl Huber, Junior Professor of Anatomy and Director of the Histological Laboratory at the University of Michigan. Philadelphia and London: W. B. Saunders & Co., 1903.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Lectures and Especially Prepared Articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of John B. Murphy, M.D., Chicago; Alexander D. Blackader, M.D., Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landolt, M.D., Paris; Thomas G. Morton, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh, and John Harold, M.D., London, with regular correspondents in Montreal, London, Paris, Leipsic and Vienna. Volume IV.

Twentieth Series, 1903. Philadelphia: J. B. Lippincott Company, 1903.

QUIZ COMPENDS, No. 14. A Compend of the Diseases of Children. By Marcus P. Hatfield, A.M., M.D. Third Edition, Thoroughly Revised, with Colored Plates. Philadelphia: P. Blackiston, Son & Co., 1903.

REGIONAL MINOR SURGERY. Describing the Treatment of Those Conditions Daily Encountered by the General Practitioner. By George Gray Van Schaik, M.D., Attending Surgeon, French Hospital, New York. Published by the International Journal of Surgical Company, Medical publishers, 100 William street, New York.

TEXT-BOOK OF PHARMACOLOGY AND THERAPEUTICS ON THE ACTION OF DRUGS IN HEALTH AND DISEASE. By Arthur R. Cushny, A.M., M.D. Philadelphia and New York: Lea Bros., publishers.

A TREATISE ON MASSAGE, ITS HISTORY, MODE OF APPLICATION AND EFFECTS, INDICATIONS AND CONTRADICTIONS. By Douglas Graham, M.D., of Boston, Mass. Member of the American Association for the Advancement of Science, American Medical Association, Massachusetts Medical Society, Etc. Third Edition, Revised, Enlarged and Illustrated. Philadelphia and London: J. B. Lippincott Company, 1902.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Dr. Carl von Noorden, Senior Physician to the City Hospital in Frankfort a.-M. Authorized American edition, translated under the direction of Boardman Reed, M.D., Professor of Diseases of the Gastro-intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College, Philadelphia. Part I, Obesity, the Indications for Reduction Cures. New York: E. B. Treat & Co., 1903.

First or Northern District Branch.

PRESIDENT—Jeremiah R. Sturtevant, Theresa.
TREASURER—Edgar H. Douglas, Little Falls.

ONEIDA COUNTY MEDICAL ASSOCIATION.

VICE-PRESIDENT—James W. Douglass.
SECRETARY—J. Orley Stranahan.
TREASURER—John Groman.

HERKIMER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Charles H. Glidden.
VICE-PRESIDENT—Seymour S. Richards.
SECRETARY—Edgar H. Douglas.

Second or Eastern District Branch.

PRESIDENT—Everard D. Ferguson, 1 Union pl., Troy.
VICE-PRESIDENT—Pierson C. Curtis, Round Lake.
SECRETARY AND TREASURER—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

PRESIDENT—William E. Lothridge.
SECRETARY AND TREASURER—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Thomas Wilson.
VICE-PRESIDENT—H. Lyle Smith.
SECRETARY AND TREASURER—Otis H. Bradley.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Charles S. Allen.
VICE-PRESIDENT—Matthew B. Hutton.
SECRETARY AND TREASURER—Frederick A. Smith.

COMMITTEE ON LEGISLATION—E. D. Ferguson, chairman; William Finder, Jr.; William L. Allen.
COMMITTEE ON PUBLIC HEALTH—J. B. Harvie, chairman; D. W. Houston; W. L. Hogeboom.

COMMITTEE ON ETHICS AND DISCIPLINE—J. P. Marsh, chairman; H. C. Gordinier; George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Frank A. Palmer.
VICE-PRESIDENT—Henry J. Allen.
SECRETARY—James T. Sweetman, Jr.
TREASURER—William E. Swan.
EXECUTIVE COMMITTEE—G. T. Church (2 years); Francis W. St. John (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—David J. Fitzgerald.
VICE-PRESIDENT—Dudley M. Hall.
SECRETARY AND TREASURER—Frederick G. Fielding.

Third or Central District Branch.

PRESIDENT—Chauncey P. Biggs, Ithaca.
SECRETARY—Franklin J. Kaufmann, 311 W. Genesee street, Syracuse.
TREASURER—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

PRESIDENT—LeRoy D. Farnham.
VICE-PRESIDENT—William A. White.
SECRETARY—Clark W. Greene.
TREASURER—William H. Knapp.

CORTLAND COUNTY MEDICAL ASSOCIATION.

PRESIDENT—S. J. Sornberger.
VICE-PRESIDENT—Frank S. Jennings.
SECRETARY—H. S. Braman.
TREASURER—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Franklin J. Kaufmann.
VICE-PRESIDENT—Bernard S. Moore.
SECRETARY—Charles B. Gay.
TREASURER—Alexander J. Campbell.

OTSEGO COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Julian C. Smith.
VICE-PRESIDENT—Sylvester G. Pomeroy.
SECRETARY—Arthur H. Brownell.
TREASURER—Frank L. Winsor.

Fourth or Western District Branch.

PRESIDENT—J. William Morris, Jamestown.
 VICE-PRESIDENT—Bernard Cohen, 497 Niagara street,
 Buffalo.
 SECRETARY—William Irving Thornton, 152 Jersey
 street, Buffalo.
 TREASURER.—Joseph Burke, 388 Franklin St., Buffalo.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Orrin C. Shaw.
 FIRST VICE-PRESIDENT—Era M. Scofield.
 SECOND VICE-PRESIDENT—Vacil D. Bozovsky.
 SECRETARY AND TREASURER—Henry A. Eastman.
 COMMITTEE ON LEGISLATION—Laban Hazeltine,
 George F. Smith, Herbert W. Davis.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—Elton S. Rich, Chauncey A. Rood, A. Austin
 Becker.

COMMITTEE ON ETHICS AND DISCIPLINE—Al-
 fred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Joseph W. Grosvenor.
 VICE-PRESIDENT—Howard L. Hunt.
 SECRETARY—Jacob S. Otto.
 TREASURER—William I. Thornton.

Fifth or Southern District Branch.

PRESIDENT—Parker Syms, 50 West 47th street, New
 York.
 VICE-PRESIDENT—Charles E. Townsend, 231 Liberty
 street, Newburg.
 SECRETARY—Charles S. Payne, Liberty.
 TREASURER—Edmund L. Cocks, 156 West 119th street,
 New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Irving D. LeRoy.
 VICE-PRESIDENT—Edwin Barnes.
 SECRETARY—John W. Atwood.
 TREASURER—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.
 Meets at 315 Washington street, Brooklyn, at 8.30 P. M.,
 on the second Tuesday of each month, except July, August
 and September.

PRESIDENT—George H. Treadwell, 64 South Portland
 avenue, Brooklyn.

VICE-PRESIDENT—Arthur C. Brush, 29 South Portland
 avenue, Brooklyn.

RECORDING SECRETARY—Frank C. Raynor, 54 Liv-
 ington street, Brooklyn.

CORRESPONDING SECRETARY—George F. Maddock,
 80 McDonough street, Brooklyn.

TREASURER—Edward H. Squibb, P. O. Box 760, Brook-
 lyn.

EXECUTIVE COMMITTEE—James Cole Hancock,
 Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—Louis C. Ager, chairman, Silliman place and
 Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. Mc-
 Goldrick, William H. Shepard, Morris G. White.

COMMITTEE ON ETHICS AND DISCIPLINE—John D.
 Sullivan, chairman, 74 McDonough street, Brooklyn; William
 H. Bigham, William B. Brinsmade, Homer E. Fraser, James
 W. Ingalls.

COMMITTEE ON LEGISLATION—Charles P. Gilder-
 sleeve, chairman, 18 Schermerhorn street, Brooklyn; James H.
 McCabe, Charles D. Napier, Harry W. Skerry, William H.
 Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street,
 at 8 P. M., on third Monday of each month, except July,
 August and September.

PRESIDENT—Alexander Lambert, 125 East 36th street,
 New York.

FIRST VICE-PRESIDENT—Wilbur B. Marple, 35 West
 53d street, New York.

SECOND VICE-PRESIDENT—Frederick P. Hammond,
 129 East 116th street, New York.

SECRETARY—Ogden C. Ludlow, 234 West 135th street,
 New York.

CORRESPONDING SECRETARY—Frederic W. Lough-
 ran, 744 Prospect avenue, New York.

TREASURER—Charles Ellery Denison, 68 West 71st St.
 EXECUTIVE COMMITTEE—Frederick Holme Wiggin
 (1 year), Charles S. Benedict (2 years), Parker Syms (3
 years).

COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—Robert J. Carlisle, chairman, 44 West 48th
 street, New York; John F. Erdman, Charles G. Kerley, Joseph
 D. Nagel, Edward L. Keyes, Jr.

COMMITTEE ON ETHICS AND DISCIPLINE—
 Charles E. Quimby, chairman, 44 West 36th street, New
 York; William G. Le Boutillier, Frederick M. Townsend,
 D. Bryson Delevan, Henry A. Dodin.

COMMITTEE ON LEGISLATION—W. Travis Gibb,
 chairman, 55 West 38th street, New York; Frank S. Fielder,
 Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

COMMITTEE ON ETHICS, DISCIPLINE AND
 MEMBERSHIP—Charles G. Stockton, chairman; J. H. Pot-
 ter, Grover W. Wende.

COMMITTEE ON LEGISLATION—Herman E. Hayd,
 chairman; Edward E. Blaauw.

COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—Julius Ullman, chairman; Charles S. Jewett,
 De Lancey Rochester.

STEBUEN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—John G. Kelly.
 FIRST VICE-PRESIDENT—Charles O. Green.
 SECOND VICE-PRESIDENT—George C. McNett.
 THIRD VICE-PRESIDENT—Herbert B. Smith.
 SECRETARY AND TREASURER—Charles R. Phillips.

WYOMING COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Philip S. Goodwin.
 VICE-PRESIDENT—Lyman C. Broughton.
 SECRETARY AND TREASURER—L. Hayden Humphrey.

ORANGE COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Willis I. Purdy.
 VICE-PRESIDENT—William E. Douglas.
 SECRETARY AND TREASURER—Charles I. Redfield.
 COMMITTEE ON LEGISLATION—Charles E. Town-
 send, chairman; William E. Douglas, Frank D. Myers.
 COMMITTEE ON PUBLIC HEALTH—Worthington S.
 Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
 COMMITTEE ON MEDICAL CHARITIES—Willis I.
 Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
 COMMITTEE ON BY-LAWS—William E. Douglas,
 chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Daniel Burr Van Wagenen.
 VICE-PRESIDENT—George A. Leitner.
 SECRETARY AND TREASURER—Norman B. Bayley.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—George A. Leitner, Piermont; Daniel B. Van
 Wagenen, Suffern.
 COMMITTEE ON LEGISLATION—Edward H. May-
 nard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Charles S. Payne.
 FIRST VICE-PRESIDENT—Howard P. Deady.
 SECOND VICE-PRESIDENT—George R. Bull.
 SECRETARY—John L. C. Whitcomb.
 TREASURER—Charles W. Piper.
 COMMITTEE ON LEGISLATION—John L. C. Whit-
 comb, George R. Bull, Richard A. DeKay.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—A. B. Sullivan, chairman; Sherman D.
 Maynard.
 COMMITTEE ON ETHICS AND DISCIPLINE—
 Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Henry Van Hoevenberg.
 VICE-PRESIDENT—George S. LaMoree.
 SECRETARY—Mary Gage-Day.
 TREASURER—Alice Divine.
 COMMITTEE ON LEGISLATION—Alexander A. Stern,
 Frederick A. Hunt, Elijah Osterhout.
 COMMITTEE ON PUBLIC HEALTH—James L. Preston,
 Benjamin Neel, Albert Reed.
 COMMITTEE ON ETHICS—Frederick Huhne, Alexan-
 der Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

PRESIDENT—Norton J. Sands.
 VICE-PRESIDENT—J. Lindsay Porteous.
 SECRETARY AND TREASURER—Donald T. McPhail.
 EXECUTIVE COMMITTEE—Benjamin Jerome Sands
 (1903), H. Ernest Schmid (1902).
 COMMITTEE ON LEGISLATION—H. Ernest Schmid,
 chairman; William L. Wells, Edward F. Brush.
 COMMITTEE ON PUBLIC HEALTH AND MEDICAL
 CHARITIES—William D. Granger, chairman; Walton J.
 Carpenter, John W. Small.
 COMMITTEE ON ETHICS AND DISCIPLINE—
 Richard B. Coutant, chairman; Thomas J. Acker, H.
 Eugene Smith.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:

CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3, No. 4.

APRIL, 1903.

\$1.00 PER ANNUM

REASONS FOR JOINING THE NEW YORK STATE MEDICAL ASSOCIATION.

To be identified with the County, State and National Organizations, just as every patriotic citizen exercises his rights of suffrage in local, State and national affairs.

To assist in raising the political and social standing of the profession to a higher plane.

To show interest in all matters medical which should demand the attention of any legislative body.

To assist in demonstrating that the medical profession is not less noble to-day than hitherto; that its members have not grown so "commercial" as to consider their skill as simply a "stock-in-trade" for sale to the highest bidder, but that love and sympathy for the human race are the prime instigators of their every action.

To assist in unifying the opinions of the best professional conduct, and in supporting such a code of ethics that the members may not be constantly harassed by temptations and uncertainties as to how to proceed.

ASSOCIATED DEFENSE OF SUITS OF ALLEGED MALPRACTICE.

The following letters have recently been received by the president of the State Association, and, with their answers, are self-explanatory:

NEW YORK, March 9, 1903.

DR. FREDERICK HOLME WIGGIN,
55 West 36th street, New York:

My Dear Doctor Wiggin—Will you, as president of the New York State Medical Association, kindly let me know where I may obtain full data concerning the present status of the movement to secure protection against malpractice suits through the Association to its active members in good standing? I recall considerable agitation in this matter, but do not know any details as to the results. An early reply will be a great favor.

Yours very truly, (Signed), _____

_____, ESSEX COUNTY, March 10, 1903.

DR. F. H. WIGGIN, President the New York State Medical Association, New York:

Dear Doctor—If I understand well what was written in the NEW YORK STATE JOURNAL OF MEDICINE the members of our Association are entitled to be defended gratis in a case of malpractice suit.

I am just now a victim of the blackmailer, and it would be a great help to me if the New York State Medical Association defends its members. Hoping for a favorable answer, I remain,

Yours very respectfully,

NEW YORK, March 11, 1903.

Dear Doctor—I have received your letter of the 10th and would call your attention to Section 7 of Article II of the By-laws of the New York State Medical Association, as revised at the last annual meeting, October 20-23, 1902, and to be found on page 71 of the February number of the NEW YORK STATE JOURNAL OF MEDICINE, which relates to the defense of members in suits for alleged malpractice which may be brought against them, and which is as follows:

ARTICLE II.—Defense of Suits of Alleged Malpractice. Section 7. The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the Secretary, shall sign a contract renouncing his own and vesting in the Council sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused, but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise.

Therefore, if the cause of action in your case has not arisen prior to your election to membership in our Association, kindly send me the full details of the suit which has been brought against you and I will have it submitted to the Council; then the Association will undertake your defense, and at the same time that you write to me you should also write to Dr. Guy D. Lombard, secretary of the Association, 6 East 32d street, New York City, requesting the Council to defend your suit for malpractice and agreeing that the Council shall have the sole authority to conduct the defense of your suit.

I was in court yesterday testifying in behalf of one of the members of our Association, who was trying to collect a bill for services rendered to a patient, the defense being that the doctor was accused of malpractice and therefore not entitled to compensation. The jury decided in favor of the physician.

Besides this case we have this winter successfully defended two other members of our Association in this

city from direct suits for damages which were brought against them.

The stand which our Association has taken in this matter is going to be, I am sure, of great benefit to our members.

I hope you will *make this action of our Association known far and wide to the physicians of your neighborhood*, and that you will get them to join right away and get the benefit of this privilege.

Sincerely yours,
(Signed), F. H. WIGGIN.

MECHANICSVILLE, March 14, 1903.

COMMITTEE ON PUBLICATION,

NEW YORK STATE JOURNAL OF MEDICINE:

Dear Sirs—Noticing your editorial, "Malpractice Suits," in Volume 3, No 3, March, 1903, you say: "It seems almost incredible that after all has been said and done many members of the Association are not aware of this medical defense." That may be true, yet many are not. I had supposed this only applied to the Medical Association of the County of New York. Does it apply to *all members* of the New York State Association? If so, how would a rural member proceed in case of an action begun against him? I have practiced *twenty-four* years and no action ever threatened me, neither does any; but it might, and if assistance in such a case is one of our benefits in the Association I am sure we should all like to be aware of it, and what, in such a case, we should do?

Yours,

(Signed), W. C. CROMBIE.

16 WEST 61ST STREET, NEW YORK, March 18, 1903.

DR. FREDERICK HOLME WIGGIN,

55 West 36th Street, New York City:

My Dear Doctor Wiggin—I beg to acknowledge your letter of March 11th, which gave me fully the information I needed, and which I sought purely as a matter of general information, and not because I was in a hole. I trust that pains with my patients, professional honesty and honor, and, above all, a weather eye to protect myself, will never get me into a hole, making it necessary to call upon the Association. However, I am glad to know how to do it, because the Lord only knows when anyone may not "get it in the neck" from some ungratefully patient and rascally lawyer. Thanking you for your courtesies, I am,

Yours truly,

V. C. PEDERSON.

WHAT ARE PROPRIETARY REMEDIES, PATENT MEDICINES AND NOSTRUMS?

The confusion in the use of the terms "proprietary remedies," "patent medicines," and "nostrums," and the need of a clear definition of an ethical preparation used as an internal or external medicine, has moved the New York County Medical Association to appoint a committee of ten to investigate and report upon "proprietary medicines, their use by the medical profession, and their relation to the advertising and literary departments of medical publications." We hope that the committee will be able to report conclusions that will enable physicians to make good use of some of the legion of samples of medicines which are continually left in their offices and find their way to the trash basket or are too often recommended, as chance or fancy selects, instead of being prescribed upon a scientific basis.

A proprietary medicine, the dictionary says, is an article that a certain person or certain persons have the exclusive right to manufacture and

sell, which definition includes a medicine of known formula or process of manufacture, as well as a medicine of unknown formula or secret process of manufacture. The word "proprietary," used to qualify a medicine, should not be limited in its application, as there are many new and useful remedies that come within its meaning. Though many proprietary medicines are valuable to the physician, the mentioning of them in medical meetings, or in the literary departments of medical publications, by their proprietary or copyrighted names instead of by their chemical or pharmaceutical names, leads to such gross abuses as to become another subject worthy of special consideration in medical bodies.

A patent medicine may be defined as a new and useful chemical compound, the process of manufacture being given in the application for a patent, which, if placed in the hands of a competent pharmaceutical chemist, will reproduce the identical preparation found upon the market. Many of the most valuable remedies used by physicians to-day are patent medicines, which should be considered as preparations involving the questions—namely, monopolies in medicines and the abuses practiced in recommending them by their proprietary or copyrighted names, instead of their chemical or pharmaceutical names.

Many years ago prescriptions of mixtures could be patented, but not so in later years. The absence of all secrecy from a patent medicine to-day no doubt accounts for the changed application of the word which is now so different from its popular use. *Nostrum*, according to the dictionary, is a medicine the composition of which is kept secret; a quack medicine; any recipe of charlatan character. To avoid tautology, the word secret should not be used before the word *nostrum*.

We are glad to know that the decision of the committee will include in its classification all those proprietary medicines, used internally or externally, which have the quantity of their active ingredients published in terms used in chemistry or pharmacy, but the process of compounding, including the flavoring, is held as a commercial secret. The President of the American Medical Association has appointed a committee of five to investigate and report to the House of Delegates at New Orleans, on the question, that there be incorporated a National Bureau of Medicines and Foods, having ten directors, five being appointed by the American Medical Association and five by the American Pharmaceutical Association, for the purpose as expressed in the proposed articles of incorporation, as follows: "To determine and fix upon standards of identity, purity, quality and strength, and to secure adherence to prescribed formulas of all drugs, chemicals, foodstuffs, and of all articles intended for use in the arts and sciences or for human consumption; to diffuse accurate and reliable information as to such articles, preparations or products, and as to those making or dealing in the same: to procure uniformity and

certainty in the customs, usages and methods of manufacture of those engaged in the foregoing or allied trades; to supervise the manufacture, preparation or production and distribution of all commodities, articles or preparations mentioned; and upon sufficient evidence that the standards of identity, purity, quality and strength, as well as adherence to prescribed formulas, have been maintained; and that all requirements for manufacture, preparation or production as set forth in the by-laws, rules or regulations made and provided have been complied with by the person manufacturing, preparing, producing or distributing such commodities, articles or preparations; to issue to such person a certificate of identity, purity, quality or strength and compliance with prescribed formulas, which certificate shall be of the form and nature, and shall be used in the manner set forth in the by-laws, rules or regulations for that purpose made and provided; and to aid, stimulate and encourage research, investigation and study that will tend to enlarge, improve or increase and diffuse knowledge and information of materia medica, chemistry, pharmacy, pharmacology, pharmacognosis, pharmacodynamics, therapeutics, and all arts and sciences allied thereto."

The work of these two committees, judging from the character of the men who compose them, bids fair to be of great usefulness to the medical profession as well as the community at large.

THE DUTY OF THE HOUR.

That the enthusiasm in favor of organization is growing rapidly must be evident to all who come in contact with medical men in every section of the country. Of course there are scoffers and doubting Thomases, but all respectable members of the profession are heartily tired of the antagonistic spirit which has so influenced our personal, professional and educational affairs in the past. The spirit has so lowered us in our own and in the public estimation that many had come to believe it inseparable from our calling, but the profession as a whole is ready to give reasonable trial to any plan which promises even a hope of relief.

How to take this widespread sentiment at the tide and crystallize it into a permanent reform is the problem and duty of the hour. This is being admirably done in a few States, and in many counties in other States, and should be at once undertaken by the officials and members of existing societies everywhere. The magnitude of the work will be understood when it is authoritatively stated that there are over 70,000 licensed practitioners in this country who are not members of any kind of society, county, district, State or national.

In an experience extending into many States, and where nearly every possible condition was to be met, it has been found that the physicians of nearly every county would promptly respond to

a kind and plainly expressed invitation from any recognized outside authority to meet and organize. If the preliminary discussion was frank as to existing evils, to the difficulties of maintaining local societies, and the certain reward, scientific, social and material, which would follow success, such organizations were easily made permanent. Some counties in several States are already reporting every physician within their boundaries as already members of the county and State society and of the American Medical Association.

Such results as these have not come spontaneously or by accident, but from the patient, systematic and self-sacrificing labors of some zealous member of the Association. With similar effort they are possible in all but a few sparsely settled counties of the Union. Officers of State societies and members of the Association everywhere are earnestly requested to consider the possibilities to the profession from such missionary work, and to feel free to apply to the organization department for literature and any other assistance at its command.—*Jour. Amer. Med. Assoc.*, March 14, 1903.

STANDING COMMITTEES.

These committees are too frequently in a condition of equilibrium; they don't move; they take their designation in its literal sense. Like backward children, they are afraid of striking out without the support of their mater. Some of these committees have so long been dormant that if they were resuscitated we would consider that a miracle had been performed. Yet what an opportunity they offer for unselfish, broadminded men who desire to do something for the welfare and happiness of their fellow-creatures! The careful consideration by one of these committees of even one of the many questions which are constantly arising in its field of operation, must be felt not only in the arteriole of human activity which a county association may represent, but must be felt throughout the system of this grand organization, the American Medical Association. With the County, the State and the National organizations back of us, what a power we have for good or for evil! What a responsibility we assume when we accept the position of director, as chairman of a standing committee, of all this strength, of the district over which we have jurisdiction! The responsibility is one of omissions as well as of commissions. The representative from your county at Albany should show by his words and vote upon medical matters that he is in close touch with the Committee on Legislation; the activity of the District Attorney in conjunction with the attorney of the Association in prosecuting unlawful practitioners and otherwise protecting the public from impositions, should show the encouraging hand of the Committee on Discipline; the exertions on the part of the Board of Health to prevent the spread of disease should bear evidence of the active cooperation on the part of

the Committee on Public Health. Let each chairman turn and look at the cohorts back of him—the County, the State, the National Medical Association, and his courage cannot be wanting.

TYPHOID FEVER IN ITHACA.

The epidemic of typhoid fever in Ithaca, N. Y., has been of more than usual interest, for the reasons that it has been severe, the number of cases large, and also because Ithaca is an educational center of considerable importance.

At the time that the epidemic began there were 3,500 non-resident students in attendance at Cornell University and at the other educational institutions in the city. The number of cases that developed in the first ten days of the epidemic must have been something like 300 or 400. This number in a population of about 15,000 was large, and naturally pointed to an infection of the water supply of a large number of the inhabitants.

The location of the cases in the city drew the attention of the health authorities to the water supply furnished by the Ithaca Water Company. This company supplies water to the greater part of the city.

With the exception of small areas supplied by wells the water supply is a surface supply taken from three streams. Two of these streams furnish the water supplied by the Ithaca Water Company, and the third one furnishes water to the Cornell Campus, and a new addition to the city, known as Cornell Heights.

Early in the epidemic the health authorities observed that the area supplied by wells and the Cornell Campus and Cornell Heights were practically free from the disease. The parts of the city supplied by the wells are, as a rule, those in which the houses are cheaply built, and in which it is almost impossible for water and sewer connections to be made, and in which the general sanitary conditions are the poorest in the city. On the other hand, the Cornell Campus and Cornell Heights have the best of drainage and sanitary surroundings, and are quite remote from the parts of the city supplied by well water. The water furnished by the Ithaca Water Company for the most part is a mixed water taken from the two streams, so that the infection through the water supply could not be traced to one of them.

For a number of years Ithaca has been free from epidemics of typhoid fever, and there has been an unusually small number of well-recognized sporadic cases.

About one year ago there was quite a large number of cases of mild continued fever. The medical profession and the health authorities did not consider these cases typhoid, and many of them were diagnosticated as the "Ithaca fever." These cases ran an irregular fever, were mild in character, and no intestinal hemorrhages or deaths occurred. Whether a part or all of these cases were typhoid, and whether there was any connection between the fever occurring at that time and the present epidemic, it is impossible to

say. It certainly is unfortunate that a distinct and definite diagnosis of the cases of a year ago was not made, and the medical profession and health authorities have laid themselves open to just criticism in not facing the situation at that time. The ill effects of the lack of definite diagnosis a year ago was shown at the beginning of this epidemic, in the statement frequently heard that "we have no typhoid fever in Ithaca, and these cases are the same as those of a year ago." This, perhaps, is one reason why the reports sent out in the beginning were so contradictory. Beyond question, as much harm has been done to the city and the university by the reports that have gone out that have underestimated the gravity of the situation as by those that have exaggerated it.

One of the most unfortunate statements made was the one sent out from the office of the president of Cornell University, on February 24th, by Dr. Daniel Lewis, the State Commissioner of Health. The statement was as follows: "Dr. Daniel Lewis, the State Commissioner of Health, who is here to-day, after having studied the situation carefully from every side, makes the statement that the plans which are already in operation and which are this day being extended by the city authorities make it perfectly safe for any one to return to Ithaca who so desires." Later developments show that at that time there must have been 400 or 500 cases of typhoid fever in Ithaca, and anything like systematic disinfection by the health authorities had not been undertaken. Up to the present time about 700 cases have been reported to the health officer. Of this number 230 were students of Cornell University. The total mortality, as reported to the health authorities, is between 50 and 55, and mortality among students of Cornell University that have been treated in Ithaca is 26.

The high mortality among Cornell students, treated at the Cornell Infirmary, confirms the generally accepted opinion in the medical profession that competent nursing, proper hygienic surroundings, quiet and good ventilation, are of the greatest importance in the treatment of typhoid fever. Unfortunately, the students treated in the Cornell Infirmary had neither of these vital essentials. While there were some competent nurses, the lack of organization and medical direction made efficient work on the part of the nurses impossible. The mortality of the Cornell Infirmary has been 100 per cent. higher than in the City Hospital, that was as much overcrowded but was well organized and under different control.

The astounding lack of appreciation of responsibility and of the importance of competent medical direction on the part of the laymen composing the committee in control of the infirmary was shown; when a member of the Medical Faculty of Cornell University resigned from the committee, after two or three days' service, and gave as his reason for tendering his resignation that

the opinions of a physician were not worthy of the consideration of the laymen of the committee, and for this reason he refused to serve longer on the committee.

Another Ithaca member of the Cornell Medical Faculty was informed in writing by a member of the committee in charge of the infirmary that he had violated one of the rules of the institution by taking a member of the New York Cornell Medical Faculty to the infirmary.

The attitude of the committee, from the Board of Trustees of Cornell University, who have been in control of the Cornell Infirmary, toward their own Medical Faculty and the medical profession of Ithaca, has been well stated by J. C. Bayles, in his letter to the *New York Times*.

Mr. Bayles says: "That the university management will profit by its experience in a great many essential particulars is to be expected. In its infirmary organization it is not equipped for an emergency. It may not be to blame for this, but it will be if what the emergency of the past six weeks has taught is not applied profitably. The ostentatious exclusion of its Medical Faculty from a voice in the organization and management of its infirmary is certainly to be regretted. If these gentlemen are competent to teach the science of medicine, they may be assumed to have a larger judgment as to what the infirmary needs in the matter of equipment and internal organization than laymen. I am informed that the terms of the Sage endowment do not permit the university to conduct the medical work of the institution through its own corps of physicians, but it is scarcely to be believed that they forbid surgical cleanliness, a good organization, the prevention of dangerous overcrowding, the instruction and disciplining of nurses, safeguards against infection in superfluous carpets and hangings, and such arrangements as will insure that the instructions of visiting physicians are carried out. The mortality records of the infirmary during the present epidemic, show how far it is below the standards of a good hospital organization. To recount the facts which have come to my knowledge, and which are accessible to every one for whom they have interest, would serve no good purpose. The chief concern is with the future, and I cannot too strongly advise a radical change in the infirmary organization."

THE STATE MEDICAL ASSOCIATION IMMEDIATELY ACTS.

Under a display heading, the *New York Herald* published the following letter from the president of this organization:

"To the Editor of the *Herald*:

"I was much interested in the editorial entitled 'The Lessons of the Typhoid Epidemic at Ithaca,' contained in your journal of to-day. I have requested the chairman of our Committee on Legislation to take up at once the matter of the enactment of necessary laws covering the whole question of reporting cases of typhoid

fever to local boards of health by physicians, and the relation of such boards to the State Board of Health.

"FREDERICK HOLME WIGGIN,

"President of the New York State Medical Association.

"New York, March 3, 1903."

Four days later, on March 7th, the same paper contained the following announcement:

"Senator Stewart's bill to amend the public health law relative to the discharge of sewage and other refuse or waste matter into the waters of this State is to have the immediate help of both the State and County Associations.

"This bill is the outcome of the suggestions made by the *Herald* for the enactment of the necessary laws for the reporting of cases of typhoid fever to local boards of health by physicians and the relations of such boards to the State Board of Health.

"The Committee on Legislation of the New York State Medical Association, which consists of Drs. E. Eliot Harris, New York, chairman; Jeremiah R. Sturtevant, Theresa; E. D. Ferguson, Troy; Chauncey P. Biggs, Ithaca; J. W. Morris, Jamestown, and Frank S. Fielder, New York, representing all sections of the State, took the matter up, and the result has been Senator Stewart's bill.

"Mr. Stewart comes from Ithaca, and his wife is one of the victims of the typhoid epidemic raging there. He has, therefore, a personal interest in the success of his bill. In this it is provided that permission will hereafter have to be obtained from the State Commissioner of Health for any person, shop, factory or industrial establishment to discharge any sewage, garbage, offal or decomposable or putrescible matter of any kind into the waters of this State after the same shall have been forbidden by any local board of health or other public authority."

[Here followed a detailed explanation of the bill, with proposed method of enforcing it, and the penalties for its violations.]

"The chairman of the Legislative Committee of the State Medical Association yesterday said that he was sure the measure would meet with general approval and be productive of much good when enacted into law.

"The committee believes that typhoid fever is a preventable disease,' said he, 'and that the infection of drinking water is the most common cause of the epidemics.'

"Dr. Harris will go to Albany to appear before the Public Health Committee of the Senate in favor of the principles contained in Senator Stewart's bill.

"He said yesterday that he had had a consultation with Dr. W. Travis Gibb, chairman of the Committee on Legislation of the New York County Medical Association, and that Dr. Gibb expressed himself as heartily in favor of the measure, and will make it a special subject for his committee to consider."

Association News.

All matter intended for this column, unless received by the 20th of the current month, cannot be printed until the following month. All such matter should be addressed to Dr. Louis C. Ager, corner Third avenue and Silliman place, Brooklyn, N. Y.

NATIONAL CHARTER FOR THE AMERICAN MEDICAL ASSOCIATION.

Chairman of the Committee on Publication:

The matter of asking Congress for a charter to give the American Medical Association a real national character has been discussed from various points, and there has been presented a plan which seems to promise a fulfilment of all the requirements of such a law to meet the exigencies of the case at hand.

There are four points to be considered: First, the nationalizing of the Association; any act of Congress would, of course, do that. Secondly, the power to sue or be sued, complain or defend in any court of law or equity. Thirdly, the right to receive, hold, buy or sell real or personal property, and make by-laws. Fourthly, the privilege of holding meetings in every State, at the will of the Association.

All these requirements are met by the charters granted by Congress herewith presented, except that they do not state in so many words that the meetings can be held at the will of the Association in various States. That question is academic.

There must naturally be a locus or home for the Association, and from its national character it should be at the Capital City of the United States. Then the charter should provide in terms that the meetings may be held and business legally and finally transacted in any State, not subject to the action of a half-score, to whom shall be left the duty of reenacting all that has been done at a three-day session in a distant State, as the matter now stands. No matter how cautious, careful or conscientious the quorum of ten, meeting in the State of Illinois, may be, it certainly appears to be a very unwise policy to allow to stand, and there are many other States with far broader and better laws for the purpose. Certainly Congress would be powerful enough to grant equal rights with many of our States with reference to holding meetings. South Dakota seems to give the privilege of meeting in any State; Rhode Island, New Jersey and many others are far more liberal in terms than the State selected.

Those representing the medical profession of New York, in the National Association, should take up this matter at the meeting soon to be held at New Orleans, and secure the passage of a resolution empowering a special committee to at least make the attempt at this bid for recognition. The expense of such an effort would be small, and its success would have a far-reach-

ing effect on the future of the American Medical Association.

JAMES TAYLOR LEWIS,
Counsel the New York State Medical Association, 180 Broadway, New York City.
March 14, 1903.

Charter of the National Conservatory of Music of America, granted by the Fifty-first Congress, Second Session 1890. (See Vol. 26, United States Statutes at Large, Chap. 558, p. 1093.)

Be it enacted by the Senate and House of Representatives of the United States of America, in Congress assembled, that Jeannette M. Thurber, William G. Choate, Chauncey M. Depew, Abram S. Hewitt, Frank R. Lawrence, of the State of New York; William Pinckney Whyte, Enoch Pratt, of Maryland; Fitz Hugh Lee, William H. Payne, of Virginia; Olive Risley Seward, John Hay, S. P. Langley, Anthony Pollock, C. R. P. Rodgers, John M. Schofield, of the District of Columbia, and such others as may be associated with them, are hereby constituted a body politic and corporate by the name "National Conservatory of Music of America," with perpetual succession, with power to sue and be sued, complain and defend in any court of law or equity; to make and use a common seal and alter the same at pleasure; to acquire, take by devise, bequest or otherwise, hold, purchase and convey such real and personal estate as shall be required for the purpose of its incorporation; to appoint such officers and agents as the business of the corporation shall require, and to make by-laws not inconsistent with any law of the United States for the admission and qualification of members, the management of its property and the regulation of its affairs. Such corporation is hereby empowered to found, establish and maintain a National Conservatory of Music within the District of Columbia, for the education of citizens of the United States and such other persons as the trustee may deem proper in all the branches of music. The said corporation shall have power to grant and confer diplomas and the degree of doctor of music or other honorary degrees.

Charter or Constitution of the American Social Science Association, granted by the Fifty-fifth Congress, 1899. (See Vol. 30, United States Statutes at Large, Chap. 63, p. 804.)

1. This society shall be called the American Social Science Association.

2. Its objects shall be classified in five departments: the first, of Education and Art; the second, of Health; the third, of Trade and Finance; the fourth, of Social Economy; the fifth, of Jurisprudence.

3. It shall be administered by a president, as many vice-presidents as may be chosen, a treasurer, a secretary and a Council, charged with general supervision; five department committees, established by the Council, charged with the supervision of their respective departments; and

such local committees as may be established by the Council at different points, to serve as branch associations. The Council shall consist of president, treasurer, secretary, first and second vice-presidents, the chairman and secretary of each department, and ten directors, with power to fill vacancies and make their own by-laws. The president, vice-president, treasurer, chairman, and secretaries of departments, and directors shall be chosen annually by members of the association, and shall hold office till their successors are chosen. The president, or in his absence a director, shall be chairman of the Council. The chairmen of the local committees shall be chosen at the pleasure of their respective committees. Whenever a branch association shall be organized and recognized as such by the Council, its president shall be ex-officio one of the vice-presidents of the American Association, and, together with the secretary and treasurer, shall be entitled to all the privileges of membership in that association. And, whenever a local department shall be organized and recognized as such by the Council, its chairman shall become ex-officio a member of the parent association. The chairman and secretary of each department, with the consent of the president of the association, may appoint such special department committees as they may think best. The general secretary shall be elected for three years, unless he resigns, or is removed by a two-thirds vote of the members present and voting in a regular meeting of the Council; and out of his compensation he may pay the salary of an assistant secretary, who may also be secretary of one department.

4. Election to membership shall be made by a standing committee appointed by the Council in such a manner as Council may provide. Any person so elected, and on payment of annual membership fee of \$5, may continue a member by paying annually such further sum as may be fixed at the annual meeting of the association, not exceeding \$10. On payment of \$100 any person may become a life member, exempt from assessments. Honorary and corresponding members may be elected and exempted from the payment of assessments.

5. The Council shall have sole power to call and conduct general meetings and to publish the transactions and other documents of the association. The Department Committee shall have power to call and conduct department meetings.

6. No amendment of this constitution shall be made, except at an annual meeting, with public notice of the proposed amendment.

Charter, American Social Science Association.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

Section 1. D. G. Gilpin, O. L. Wright, Oscar Strauss, Simeon E. Baldwin, William T. Harris, and others associated with them, members of the

Voluntary Association, organized in the year one thousand eight hundred and sixty-five, and known as the American Social Science Association, and their successors, are hereby constituted a corporation by that name, in the District of Columbia, for the purpose of promoting studies and researches in social science in the various departments in which said association, or the said association may be organizing.

Section 2. This act shall take effect upon its acceptance by said Voluntary Association.

Section 3. The right to alter and amend is reserved.

DISTRICT BRANCH NEWS.

The First District Branch will hold its annual meeting at Watertown, May 26th. The president, Dr. J. R. Sturtevant, of Theresa, is making great efforts to make this one of the best meetings ever held in northern New York.

Second District.

Troy, N. Y., March 20, 1903.

Dear Doctor—During the past year it has been my hope that the medical profession of the State would be united into one State organization, and for that object earnest and active work has been done by the members of our State Association.

It seemed that success was assured, for we offered to concede the name, and in every way tried to facilitate the union, only insisting that the united bodies should have an organization that complied with the conditions prescribed by the American Medical Association.

The details were worked out and agreed to in writing by the two committees, assurance was given to me by prominent and active members of the State Society that they would carry out the plan, and our Association at its October meeting accepted and indorsed the action of our committee, but the State Society at its meeting in January withdrew from every feature of the agreement made by its committee.

As our Association has for one of its main objects the bringing the profession of the State into the American Medical Association, that the manifest advantages of a strong national body may be open to all who are qualified, it is now incumbent upon us to renew the work of organization that has been allowed to bide the results of the negotiations for union.

This should embrace the creation of the County associations where none exist, a diligent effort to increase the membership of existing County associations, the prompt payment of dues and an active interest in the scientific work of our meetings.

This communication is sent to our members in the Second District Branch, with the hope that each one will interest himself in thus promoting the growth and success of our Association, and any information or other aid that I can give will be gladly furnished.

My personal wish in all these years of work for the Association has been only to promote the honor and usefulness of our profession, and such only is the motive of this letter.

I feel that you will realize the position of responsibility placed upon us as the representatives of the American Medical Association in this State, and will take an active part in discharging our renewed, almost enlarged, duties.

Sincerely,

E. D. FERGUSON,
President Second District Branch, New York State
Medical Association.

Fifth District.

NEW YORK, March 24, 1903.

My Dear Doctor—I wish to enlist your cooperation in an earnest effort to promote the growth of the Fifth District Branch of the New York State Medical Association.

The welfare of the public and the interests of the medical profession demand a union of the profession in a thoroughly organized body, and that body is the American Medical Association.

It was hoped that the Medical Society of the State of New York and the State Medical Association could come together in union and earnest work had been done for that purpose.

The Committee of the Association met and removed each and every objection offered by the Committee of Society, and it was confidently hoped that the two bodies would be brought together, but finally the Committee of the Society decided to reject *all the propositions which they had previously accepted and to decline to promote union of the two bodies under an amended charter.*

As there is now no prospect of union of these two bodies, the only way the medical profession of the State of New York can become united is through membership in the New York State Medical Association and in the American Medical Association.

I inclose application blank, and if you are not a member I hope you will become one. If you are a member I hope you will explain the advantages of membership to some colleague, for we are anxious to have all the worthy members of the profession in our fold.

The New York State Medical Association is the only representative in this State of the American Medical Association, and it is only by becoming a member of the local and State organization that one can be eligible for membership in the national body.

The New York State Medical Association furnishes its members, free of charge, with the Medical Directory of New York, New Jersey and Connecticut, with that most excellent and useful periodical, the **NEW YORK STATE JOURNAL OF MEDICINE**, and with its moral support and the services of its counsel to defend a member in case he is sued for alleged malpractice or for anything affecting his professional standing.

The insurance given to a physician by our plan of defense in case of alleged malpractice is worth many times the amount of our annual dues. Unlike other insurance for the same purpose, it tends to prevent such suits and it has proved its efficacy in every case which we have defended.

The Directory is the best medical directory that has ever been published, and our **JOURNAL** is of great value to the Association and to its members, and in the near future will be a source of material revenue. It is a journal owned by physicians, managed by physicians, and it is run on broad and clean lines in the interest of the medical profession. It is one of the most valuable parts of our medical organization.

The Association's growing prosperity, we feel, is due to the fact that it is founded on a sound basis, and that it stands for that which is right. Hoping for your active interest and cooperation, I am

Very truly yours,

PARKER SYMS,

President of Fifth District Branch.

* * *

COUNTY ASSOCIATION MEETINGS FOR APRIL.

Albany.—Tuesday, April 7th.

Columbia.—Tuesday, April 7th.

Rensselaer.—Tuesday, April 7th.

Broome.—Tuesday, April 14th.

Kings County.—Tuesday, April 14th.

Orange County.—Wednesday, April 15th.

Rockland County.—Wednesday, April 15th.

Cortland County.—Friday, April 17th.

New York County.—Monday, April 20th.

Dutchess County.—Wednesday, April 22d.

Sullivan County.—Wednesday, April 29th.

Erie County Association.—The annual meeting of the Erie County Association was held at the University Club, Buffalo, on March 9th, and the following officers were elected: President, Allen A. Jones; vice-president, Carlton C. Frederick; secretary, Jacob S. Otto; treasurer, William I. Thornton; member of Executive Committee, Joseph W. Grosvenor; member of Nominating Committee, Fourth District Branch, William H. Chase. Fellows, De Lancey Rochester, Charles G. Stockton, Carlton C. Frederick, Alvin A. Hubbell, Charles A. Wall, Joseph W. Grosvenor, Edward E. Blaauw, Bernard Cohen, Francis W. McGuire, George F. Cott and Marcel Hartwig. Alternates, Allen A. Jones, W. Scott Renner, Grover W. Wende, William H. Jackson, James E. King, J. H. Potter, Orville G. Strong, William Taylor, Jacob S. Otto, Howard L. Hunt and Lorenzo Burrows, Jr.

The annual reports of the Executive Committee, secretary, treasurer and standing committees were presented. The Committee on Public Charities and Public Health presented the following resolutions, which were adopted:

WHEREAS, There exists at West Seneca, a suburb of Buffalo, an epidemic of typhoid fever, due to an inefficient sewerage system and a polluted water supply; and

WHEREAS, This adjacent territory, rapidly increasing in population, drains directly into Lake Erie at a point above and in close proximity to the intake of the water supply of the city of Buffalo, contaminating and rendering said water supply dangerous and unfit for human consumption and a menace to the public health; be it

Resolved, That it is the sense of the Erie County Medical Association that the authorities of the town of West Seneca, the city of Buffalo, and the State of New York be urgently requested to take immediate action to combat this source of danger and prevent a possible epidemic of typhoid fever, by so modifying and changing the system of water supply of the city of Buffalo as to insure safety to its inhabitants; and be it further

Resolved, That a copy of these resolutions be forwarded to the respective health officers of the town of West Seneca, the city of Buffalo, State of New York and the press.

A memorial of Dr. Jacob M. Kraus was presented by a committee consisting of Drs. Grover Wende and Arthur G. Bennett.

In the scientific session, Dr. Sidney A. Dunham presented a case of splenic enlargement of doubtful etiology, and Dr. William I. Thornton presented a specimen of malformation of the heart. Dr. David E. Wheeler read a paper entitled "Treatment of Fresh Fracture of the Leg by Massage and Passive Movements," which was discussed by Drs. John Parmenter and William C. Phelps.

Drs. Benjamin F. Rogers, Albert T. Post, John H. Daniels, Vertner Kenerson and George

C. Lewis were elected to membership, and the resignation of Dr. Henry D. Ingraham was accepted.

A collation was served at the close of the meeting. The next meeting will be held on Monday, June 8th.

MEMORIAL TO DR. JACOB M. KRAUS.

The Erie County Medical Association, convened in Buffalo on the 9th day of March, 1903, hereby gives expression to its profound sorrow at the death of one of its honored members—the first that has occurred since its organization—Dr. Jacob M. Kraus, of Buffalo.

Dr. Kraus died at his home in Buffalo, N. Y., on December 19, 1902. He was born in Clarence, N. Y., in March, 1866, and received his academic education at Parker Union School in that village. After spending a year in the study of medicine he was appointed interne to the Erie County Almshouse, a position he held until 1889, the year of his graduation from the medical department of the University of Buffalo. He then accepted an appointment as physician-in-charge of the Erie County Almshouse, which position he held until he decided to devote his whole time and energy to private practice.

Dr. Kraus was known for his amiable character and sound judgment. He possessed inflexible honesty and combined those qualities which constitute what is best in both the man and the citizen. The friend he made was the friend he held. His professional skill was pronounced, and his courtesy and integrity were proverbs among his fellows. While shrinking from all display and exercising a constant distrust of his own gifts, he, nevertheless, upon the score of mind alone, and in a period comparatively short, won an honorable place in his chosen profession.

Dr. Kraus devoted much time to diseases of the skin, and for a year or two previous to his death occupied the position of dermatologist to the Buffalo German Hospital and the German Hospital Dispensary. He was a member of this Association, the New York State Medical Association and the Roswell Park Medical Club, also a fellow of the Buffalo Academy of Medicine.

This Association adopts with sincerest sorrow this memorial relating to one of its most valued members, and orders that it be spread upon its minutes, and that a copy be sent to the afflicted family, accompanied by the assurance of its most cordial sympathy.

GROVER W. WENDE,
ARTHUR G. BENNETT,
Committee for the Association.
* * *

Genesee County Association.—A meeting of the Genesee County Association was held on Friday afternoon, February 27th. The following officers were elected: President, Dr. Albert P. Jackson, Oakfield; vice-president, Dr. Henry E. Ganiard, Stafford; secretary and treasurer, Dr. C. Louise Westlake, Le Roy; fellow, William D.

Johnson, Batavia, and alternate, A. F. G. Zurhorst, Oakfield.
* * *

Kings County Association.—The regular monthly meeting of the Association was held at 315 Washington street, Brooklyn, on Tuesday evening, March 10th, at 8.30. Dr. F. A. Jewett for the committee read an obituary on the late Dr. Susan R. Pray; Dr. H. M. Smith, for the committee, presented an obituary on the late Dr. Alexander Demby. It was voted that both obituaries be spread upon the minutes of the meeting and that copies be sent to the families of the deceased.

Dr. John O. Polak read a paper on "The Kidney of Pregnancy," and Dr. James W. Ingalls read a paper on "Albuminuric Retinitis of Pregnancy." The papers were discussed by Drs. J. C. Bierwirth, P. C. Jameson and H. N. Hoople.

Dr. Charles H. Shepard was elected a member of the Association.

After adjournment refreshments were served.
* * *

Monroe County Association.—On Friday evening, February 27th, the members residing in Monroe County met at the office of Dr. Richard Mott Moore, Rochester, and formed the Monroe County Medical Association. The following officers were elected: President, Dr. Thomas A. O'Hare, Rochester; vice-president, Dr. Richard Mott Moore, Rochester; secretary and treasurer, Dr. James Clement Davis, Rochester.
* * *

New York County Association.—The stated meeting was held March 16th. In the absence of the president, Dr. Frederick P. Hammond, vice-president, in the chair. The following new members were elected: Drs. Alfred C. Benedict, John S. Billings, Jr., Joseph H. Blake, Leon Bowman, Clarence S. Elebash, Percy Fridenberg, Leopold F. W. Haas, Frederic J. Levisieur, Fritz Maass, John P. Munn, Flavius Packer, Louis C. Pettit, Adolph Rostenberg, Warren Schoonover, Harmon Smith, George T. Stevens, Thomas M. Taylor.

The president announced the appointment of this Committee on Proprietary Remedies (their use by the medical profession and their relation to the advertising and literary departments of medical publications): E. Eliot Harris, M.D., chairman, 33 West 93d street, New York; H. R. Purdy, M.D., secretary, 149 Lexington avenue, New York; D. Bryson Delavan, M.D.; Charles E. Denison, M.D.; Francis P. Kinnicutt, M.D.; John J. Nutt, M.D.; Eden V. Delphey, M.D.; Smith Ely Jelliffe, M.D.; William G. Le Boutillier, M.D.; John A. Wyeth, M.D.; ex-officio, Frederick Holme Wiggan, M.D., president State Medical Association; Alexander Lambert, M.D., president County Medical Association.

The following candidates were nominated: For president, Alexander Lambert; first vice-president, Francis J. Quinlan; second vice-

president, S. Busby Allen; secretary, Ogden C. Ludlow; corresponding secretary, John J. Nutt; treasurer, Charles E. Denison; member of Executive Committee, Frederick P. Hammond.

In the scientific session Dr. Alfred J. Livingston, of Jamestown, N. Y., read a paper, entitled "Some New and Unusual Therapeutic Applications of Ergot."

The speaker began by saying that as with most physicians the use of ergot was confined to producing uterine contractions and hemostasis, his enthusiasm about its usefulness would no doubt surprise many of those present.

About twenty years ago he began to use ergot successfully in cases of hyperemia of the brain, but at that time he used the fluid extract by mouth. Gradually he extended its use, now using it hypodermically to the treatment of congestions of various parts of the body, and came to believe that ergot was the best drug we possessed for the equalization of a disturbed circulation. Further, it became his conviction that in most cases, pain of a so-called "nervous" origin was due to the pressure of over-filled blood vessels on the nerves involved. Thus ergot, in that it relieved the hyperemia, relieved the pain better than sedatives or all the nerve tonics or "nerve foods" ever invented.

Ergot is more useful in cases where continued hyperemia has not already caused a definite tissue change; but even in these cases it is useful, as by equalizing the circulation it tends to bring about a quicker return to normal conditions.

Dr. Livingston gave in detail many cases in which he had used ergot with great success. Among them were congestion of the lungs, pneumonia, asthma, angina pectoris, headaches of various kinds, insomnia, nervous excitement, delirium tremens, chorea, hystero-epilepsy, opium poisoning, both acute and chronic; iritis, deafness, gastritis and gastralgia and one case of appendicitis. He also uses it as an adjunct to the anesthetic before and after the operation.

In employing ergot it should always be used hypodermically. Squibb's solid extract is the best; one dram of ergot to one ounce of distilled water, into which a weak solution of formaldehyde has been introduced. The solution should be kept cool and made fresh every few days. The syringe should be scrupulously sterilized. The deltoid or the buttocks are the best places for making the injection. The dose of ergot is from 15 to 30 minims for a single dose, but this may be repeated in a short time. The solution should be injected very slowly. Dr. Livingston has never had a case of ergotism from using ergot in this way, even if it had to be continued for a long time.

DISCUSSION OF PAPERS.

Dr. Wiggin reported several recent cases wherein the use of ergot was very successful. One was a case of laparotomy, in which numerous intestinal adhesions had been broken up. After the operation, intestinal paresis occurred and the pa-

tient's condition became alarming. She was given two doses of ergot hypodermically, when the symptoms of collapse disappeared and the bowels could be moved. The ergot was repeated whenever the symptoms returned, and the patient recovered. The other cases in which Dr. Wiggin had used ergot were before and after operations, in severe colic, acute articular rheumatism, and in nervous headache.

Dr. S. W. S. Toms, of Nyack, had used ergot successfully in a case of congestion of the lungs with marked dyspnea, cyanosis, and the raising of bloody frothy mucus. The alarming symptoms were relieved in five minutes, and in twenty minutes the cough had stopped. His second case reported—a very recent one—was a man suffering from a purpuric skin affection, complicated by sleeplessness, abdominal pain, hematemesis and the passage of bloody stools. The abdominal pain and the hemorrhages from the bowels had at first been controlled by frequent doses of morphine, but the patient could not retain any food, and the restlessness and sleeplessness continued. The rash faded very slowly. Ergot and iron were tried by the mouth, but it was difficult for the patient to retain them. The ergot by mouth and the morphine were now replaced by ergot hypodermically.

The gastric and abdominal uneasiness disappeared, the patient retained some food, and very soon dropped asleep. In a few hours the rash showed signs of fading. The ergot was continued. At the time of reporting the patient was taking no morphine, the slight abdominal pain being relieved by heat, food was retained, the hemorrhages from the stomach and bowels had stopped, and the rash was slowly fading.

Dr. Charles Phelps reported using ergot in two cases of arterio-sclerosis, one in which the patient had attacks of hemiplegia with mental symptoms, the other being complicated with valvular heart trouble with marked dyspnea. Both cases were much relieved.

Dr. W. E. Ford, of Utica, had used ergot mostly in gynecological work, especially in cases of subinvolution occurring in multipara. He found it hard to believe that ergot could replace strychnine, nitroglycerine or digitalis in cardiac troubles, but said that Dr. Livingston's experience must count for much in those cases.

Dr. Alexander Lambert said he began by being very skeptical about the advantages of using ergot in diseases due to congestion of the blood vessels, but he had been converted to its use. He had experimented on many cases at Bellevue Hospital with surprising results, and enumerated many. Among these were congestion of the lungs, pneumonia, asthma, angina pectoris, delirium tremens, and notably cases of wet brain in alcoholics. Usually the mortality here is very large, but with the use of ergot seven out of ten patients were saved.

Dr. E. W. Lee has used ergot for many years in acute and chronic hypertrophy of the prostate.

Dr. Livingston, in closing, said that he had not been able to enumerate all the conditions in which ergot had been used successfully by him, or those in which it would probably be useful, but considered it applicable in nearly every case where engorgement of the blood vessels was the aggravating cause of the disease to be treated.

A full and detailed account of a broader therapy for ergot is published in *The Journal of the American Medical Association* for March 21, 1903, on page 774.

* * *

Orange County Association.—The regular meeting of the Orange County Association was held at the Russell House on March 18th. In the absence of the president, Dr. Willis I. Purdy, Dr. W. E. Douglas, vice-president, presided. Dr. Ralph Waldo, of New York, gave an interesting and instructive address on "Uterine Fibroids," which was followed by a general discussion by all present. A vote of thanks was tendered Dr. Waldo for his excellent remarks. The next meeting will be held April 15th.

* * *

Rensselaer County Association.—The annual meeting of this association was held on January 6, 1903, at 8.30 P. M. in Troy, N. Y. Routine business was transacted and all the officers for 1902 were reelected. The next meeting of this association will be held on April 7, 1903.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Armstrong-Hopkins, Saleni, Tyre, N. Y.
 Benedict, Alfred C., 453 West 162d street, New York City.
 Billings, John S., Jr., 32 East 53d street, New York City.
 Blake, Joseph A., 601 Madison avenue, New York City.
 Bowman, Leon, 108 East 73d street, New York City.
 Brownell, Frank V., Canajoharie, N. Y.
 Burrell, Dwight R., Canandaigua, N. Y.
 Culver, David J., Harrisville, N. Y.
 Daniels, John H., 434 Ashland avenue, Buffalo, N. Y.
 De Ceu, Robert Edward, 2134 Seneca street, Buffalo, N. Y.
 Douglass, Charles E., Lowville, N. Y.
 Dwyer, Thomas B., 618 South State street, Syracuse, N. Y.
 Elbash, Clarence S., 118 East 19th street, New York City.
 Fridenberg, Percy, 114 West 126th street, New York City.
 Ganiard, Henry E., Stafford, N. Y.
 Haas, Leopold F. W., 773 Forest avenue, New York City.
 Hagey, J. Moyer, Mount Morris, N. Y.
 Johnson, William D., Batavia, N. Y.
 Julian, John M., Pleasant Valley, N. Y.
 King, Herbert Maxon, Liberty, N. Y.
 King, James K., Watkins, N. Y.
 Lengfeld, Ellis, Lake Placid, N. Y.
 Leviser, Frederic J., 741 Madison avenue, New York City.
 McKay, James, Potsdam, N. Y.
 Maass, Fritz, 691 Lexington avenue, New York City.
 Merritt, L. John, Pine Bush, N. Y.

Munn, John P., 18 West 58th street, New York City.
 Nevin, Ethan A., Ogdensburg, N. Y.
 Packer, Flavius, Bellevue Hospital, New York City.
 Pettit, Louis C., Ward's Island, New York City.
 Phelps, Herbert E., Carthage, N. Y.
 Ransom, Julian B., Dannemora, N. Y.
 Ross, William James, Clayton, N. Y.
 Rostenberg, Adolph, 571 East 157th street, New York City.
 Schoonover, Warren, 115 East 59th street, New York City.
 Smith, Harmon, 122 East 34th street, New York City.
 Stebbins, Francis L., Geneva, N. Y.
 Stevens, George T., 22 East 46th street, New York City.
 Stowe, William H., Cross River, N. Y.
 Taylor, Thomas Madison, 113 West 40th street, New York City.
 Trowbridge, Grosvenor R., 416 Ellicott square, Buffalo, N. Y.
 Vincent, William H., Hinsdale, N. Y.

OBITUARY.

The death of Dr. Theodore Gaillard Thomas, a graduate of the Medical College of Charleston, S. C., class of 1852, has been regretfully announced as having occurred at Thomasville, Ga., February 28th.

The event, probably due as a primary cause to arterio-sclerosis, came with startling suddenness, and without much of a warning on the part of his numerous friends. His honors were of the highest order, and from the most appreciative class; his manners were attractive, his reputation without a stain, and many regarded him as the ideal physician. He was a member of many medical associations, among which was the American Medical Association, the New York State Medical Association and Academy of Medicine. His rank among operators, clinicians and writers is suggested by the mere mention of his name, and the world's regret is that he could not have been spared yet a while longer to consummate some of the larger ambitions which he had vaguely hinted to some of his intimates.

The New York County Medical Association adopted the following resolutions at the stated meeting March 16, 1903:

WHEREAS, The death of Dr. T. Gaillard Thomas has deprived our Association of one of its oldest members and the medical profession of one of its most eminent practitioners and teachers; and

WHEREAS, In this loss our Association wishes to express not only our own sorrow, but also the grief of this great community, whose members, both rich and poor, have for fifty years reaped the benefits of his noble example and of his professional skill; and

WHEREAS, He had advanced the science and art of medicine, not only by his practice, lectures and writings, but also through his professional generosity in example and precept to us, his colleagues;

THEREFORE, *Be it Resolved*, That we record our appreciation of his medical attainments, his broad liberality and high-minded loyalty.

Resolved, That as students, learning from his eloquence, his forceful literary style, his profound clinical experience and his skilful operations, we bear with us the memory of a great physician and a great man.

Resolved, That these resolutions be entered upon the minutes of our Association, and that a copy of them be sent to the family of Dr. Thomas, with the assurance of

our deep sympathy, and as an expression of the respect and esteem in which he was held by us.

(Signed),

HENRY D. NICOLL,
ANDREW J. McCOSH,
CHURCHILL CARMALT,
Committee.

Dr. George Beers, of 375 Central Park, West, New York, whose death occurred on March 16th, was a graduate of the New York University, 1891. Dr. Beers was a member of the New York State Medical Association.

Dr. Earle Eugene Woolworth died at the Brooklyn Hospital, on February 5, 1903, from the result of a fracture of the skull, received from being thrown from his carriage. Dr. Woolworth was born in Lyonsdale, N. Y., thirty years ago and graduated from the New York University in 1897. He served a term as interne in the City (County) Hospital. After leaving that hospital he began practice in Brooklyn and within a few years acquired a large clientèle. He was a member of the New York State Medical Association and of the Kings County Society.

The following resolutions were passed by the Society of the Alumni of Charity Hospital, March 11, 1903:

WHEREAS, Death has removed from our midst Dr. Earle Woolworth, of the staff of 1897, a man of sterling character, of high professional attainments, and one respected and loved by all who knew him;

Resolved, That through his death the Society has lost one of its most promising members;

Resolved, That the sincere sympathy of the Society be extended to his family in their bereavement, and that a copy of these resolutions be sent to the medical journals for publication.

T. F. REILLY,
W. C. KLOTZ,
LEOPOLD MARCUS,
Committee.

PERSONAL.

Dr. Charles I. Imperatori, of New York, and Olga Gilbert, of Stroudsburg, Pa., were united in marriage February 27, 1903, at the Church of the Transfiguration, by the Rev. Dr. Houghton.

Dr. William H. Thornton, vice-president of the New York State Association, has just returned from a six weeks' trip to Cuba.

Dr. Chauncey Biggs, of Ithaca, spent several days in the city last week.

Dr. Alfred J. Livingston, of Jamestown, member of the Chautauqua County Association, spent last week in this city as the guest of Dr. Wiggin.

Dr. Burtenshaw, on March 8th, while responding to a call, slipped upon a banana peel, fell, and dislocated his shoulder.

THE CONFERENCE CLUB.

In the early part of the year 1902 a number of the members of the New York State Medical Association, feeling that there were occasions when it would become necessary to confer with each

other regarding the affairs of the Association, concluded that this could best be done on some evening when no business would detract their attention. As a result, it was agreed to form a dinner club, to be known as the Conference Club of the New York State Medical Association, the membership to consist of all the officers-elect of the State, District Branches and County Associations, together with the members of all standing committees of State and County Associations. The number of members thus privileged were about one hundred.

At the first dinner Dr. E. Eliot Harris was elected chairman, Dr. J. R. Goffe, secretary and treasurer, and the Executive Committee was composed of the chairmen of the District Branches.

The objects of the club were declared to be the free discussion of all matters of interest to the medical profession, and, underlying this, it gave the members of the Council of the New York State Medical Association an opportunity of securing the unbiased opinion of their fellow-members. Arrangements were then made for four dinners, to be held at intervals on call by the Executive Committee.

On Wednesday, March 18th, the fourth meeting was held, and in his post-prandial remarks the chairman spoke of the work accomplished during the past years by the Association.

The subjects of his remarks were: Some of the results of the dispensary law; of the benefits that have already accrued to members from their protection in malpractice suits; of the increasing value of the Directory and JOURNAL, and of the very probable passage of the bill indorsed by the Association abolishing the Coroner's office.

The president of the New York State Medical Association spoke of the needs of the Association, having particular reference to increase in membership, prompt payment of dues, and showing how individual members can do much to lighten the labors of the Publication Committee by securing news, and ethical advertisements for the Directory and JOURNAL. He cited the instance of one member of the Association who had within a short time secured fifteen new members; of another member of the Association who had secured valuable advertisements for their publications. He referred to the splendid work done by some of the chairmen of the District Branches, and expressed the wish that some of the slower ones would "get busy."

Some very interesting remarks were made by Dr. Alfred T. Livingston, of Chautauqua; Dr. Bierwirth, of Brooklyn; Dr. C. E. Denison, Dr. Emil Mayer, Dr. J. R. Goffe and Dr. A. Lambert. These remarks took in a variety of topics, questions of ethics, and matters of general interest.

The president announced that this was the last of the series. It was voted to continue the existence of the club, and that in addition to those now entitled to be members, all those who have heretofore been so entitled may do so by signifying their desire.

The election of officers resulted as follows: Dr. Emil Mayer, chairman; Dr. J. J. Nutt, secretary and treasurer; Dr. J. C. Bierwirth, member of the Executive Committee. These officers to form the Executive Committee.

Before adjournment the thanks of the club were extended to Dr. Alexander Lambert, who had arranged the dinners so satisfactorily during the year. The retiring officers also received the thanks of the club.

SOME LEGAL NOTES OF EVERY-DAY IMPORTANCE TO PHYSICIANS.

BY JAMES TAYLOR LEWIS,
Counsel to the Association.

It is my purpose to furnish to members of the Association, through its JOURNAL, certain legal information, and to fix in the minds of the doctor certain notes for his guidance, of daily interest, which are now in force under our laws.

I cannot at the outset refrain from calling attention again to the *defense* feature provided by the Association. It is what insurance companies are writing policies for, and asking from \$10 to \$100 every year. Members of the Association receive it *gratis*. What valid reason any legally registered physician has at the present time for not seeking membership in the State Association it is very hard to conceive, if the members are doing their duty in the direction of informing their different friends what benefits the Association affords. The statistics show that each year about one in one hundred and fifty physicians is sued for alleged malpractice. Did it ever occur to you how much such a defense would cost you for the services of an attorney?

The field of information is so broad that it is with difficulty that I am able to condense what the physician should really know about law in the small space at my disposal, and will thereupon confine myself to the most important matters of every-day need.

The surgeon or physician is called to attend the bankrupt's wife or children. The wife has ample means. How can I get her to pay?

I am called in an emergency; whom shall I look to for my services, the man who calls me in or the man I treat?

The wife is living apart from her husband; shall I send my bill to her or her husband?

A large bill for services, and my patient goes into bankruptcy; what am I to do to collect my bill?

The patient dies and no executor or administrator; with whom do I file claim? How can I receive what is due for my services?

If there is an executor or administrator, and my bill is filed and refused, in what position am I then?

All of these and many more are of moment, but these seem to cover fairly well what may be expected in the every-day life of the physician.

I shall now devote myself to the subject of

some contracts arising under the family relation, implied and special.

For the purpose of this discussion we will divide contracts into two kinds, implied and special, and for a like purpose we will define implied contracts to be such as would be in force provided nothing was said by either party as to the amount or source of payment. Husbands are in such a case liable to pay what would be a reasonable sum for an operation or visit for treatment of their wives, children under age, and occasionally servants. Contractors, under like circumstances, who call physicians to treat employees, are not often responsible. I am a man employing hundreds of laborers; one of them meets with an accident. I call in a doctor to set his leg. I may or may not be responsible, therefore make a special contract. These are facts quite generally known. Now, suppose Mr. and Mrs. G., living on the avenue, called me in; I know that he is a bankrupt—is judgment proof; I also know that Mrs. G. owns the house they live in and the horses they drive, and I want my bill paid when I have finished. How do I go about it?

There must be a special contract, and the charge made a lien upon her personal estate. This is best done, to avoid question in the future, by a letter to her stating that you are giving her the credit, as you know she is responsible, and ask that your letter be returned with the statement that the arrangement is satisfactory to her, and with her name signed thereto. Sometimes these contracts are made verbally with no witness present, and are afterward denied in court. This method can be adopted immediately after the first visit, and no possible question raised afterward.

If these special contracts are made with reference to servants, you have the servant on your side, of course, and usually, therefore, the arrangement should be made with the wife or husband in the presence of the servant.

These special contracts must be made very plain and explicit, and if in a letter contain just what is needed and nothing more, for generally such a contract cannot be altered by oral testimony; therefore, have it complete.

Usually wards and apprentices are protected by the guardian or master, but these cases are infrequent, and it is a simple matter to ask if the latter is to be responsible; if not, then a special contract must be made, as I have suggested.

These written contracts need not be in ink, but, of course, it is preferable that they should be. Do not rely upon good fortune to collect your bills, but in the beginning see that an arrangement is made by which your bill will be paid promptly.

Last week a very well-known surgeon of New York was compelled to sue the wife upon such a special contract; she answered by a counter suit, alleging malpractice and claiming \$5,000 damages. It was not an easy matter to convince the jury, in

the face of the conflicting testimony, that the wife had made such a contract. The jury, however, did so find, and threw out the malpractice phase of the case. But if a courteous note had been written and the employment thereby clinched in writing, much time, money and energy would have been saved.

Paulo Cirrillo, a young Italian, of 7 Spring street, was arrested for illegal practice of medicine on complaint of the State Association. In the Magistrate's Court he waived examination, and is to plead guilty in the Special Sessions. He treated a young child in Murray street, who subsequently died, and the parents reported the case to Thomas E. Conway, the inspector of the Association.

Thomas E. Conway, for five years head inspector for the pharmacists, is now holding a similar position in the State Medical Association. Mr. Conway comes very highly commended for intelligence and honesty.

Complaints of violations of the Medical Law may be sent direct to Mr. Conway, 229 East 58th street, Manhattan.

MARCH 18, 1903.

DR. FREDERICK HOLME WIGGIN,
President the New York State Medical Association,
55 West 36th Street, New York:

Dear Doctor—I like to be identified with the New York State Medical Association, but I seem to have difficulty in placing my dues.

Will you kindly inform me to whom and when to send my dues for 1903, and oblige

Yours truly,

MARCH 20, 1903.

Dear Doctor—It is quite refreshing to receive such a letter as yours of the 18th and to find that there is at least one member of the Association who is sufficiently anxious to settle his account as to write and ask for it when the treasurer has neglected to send him his bill.

I am afraid, however, it does not speak well for the interest in our organization of the treasurer of your county association.

The gentleman to whom you should send your dues is Dr. ———, secretary and treasurer of your local association. See pages 113 and 114, March number of the NEW YORK STATE JOURNAL OF MEDICINE, also Article X, Section 3, By-laws the New York State Medical Association, page 74, *ibide*, for February.

Sincerely yours,
FREDERICK HOLME WIGGIN,
President the New York State Medical Association.

ASSOCIATION DUES.

The attention of members who have not paid their dues is called to the by-laws of the State Association relating to the payment of dues. See Article 10, Section 2, in the February number of the JOURNAL OF MEDICINE, on page 74. Members will receive a rebate of \$1 when dues are paid before April 1st. This rebate can be deducted on sending the amount of dues to the local treasurer.

ARTICLE IX.

Privileges of Members.—Sec. 4. Resident members shall have all the rights and privileges conferred by their respective County Associations and District Branch Associations. They shall be eligible to any office in the gift of the Association; shall be entitled to attend all meetings of the Council and Fellows, and shall receive all the protection, benefits and support conferred by the Association; but if a member's dues be unpaid at the time of the annual elections of his County Association

or District Branch Association he shall not be counted as a basis of representation in this Association, shall not be eligible for election as a Fellow, shall not receive the publications of the Association or be included in its published list of members for that year, nor thereafter until he has discharged his indebtedness in full.

Sec. 9. No member shall be permitted to resign while owing dues or assessments or while he is under charges which may lead to his expulsion.

ARTICLE X.

Sec. 2. The annual dues of resident and non-resident members shall be six (6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (1) dollar may be deducted.

Sec. 3. All dues shall be payable on the first day of January of each year.

Sec. 4. On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year, and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be dropped from the official roll of members.

Dues.—Members of the State Medical Association who are inadvertently omitted in the statements of the local treasurer of dues paid to the State Treasurer may find their names are omitted from the list of members published in the Medical Directory, as required in the By-Laws, Art. X, Sec. 4: "On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year." It is proposed to publish in the June number a list of members whose dues have not been received by the State treasurer. Members who find their names in this list should immediately communicate with the local treasurer, and before the first of July have their dues sent to the State treasurer. Their names will be properly enrolled in the list of members published in the Medical Directory for this year.

REQUIREMENTS FOR MEMBERSHIP.

1. To retain membership in the American Medical Association it is obligatory that a physician be a member in good standing of the affiliated organization of the State in which he resides. A physician is supposed to reside in the county in which he votes.

2. For the present an individual moving from one State to another is allowed two years in which to associate himself with the society into whose jurisdiction he has moved. In this case, however, he must keep in good standing in his old society.

3. Medical officers of the Army, of the Navy and of the Public Health and Marine Hospital Service of the United States are not required to affiliate with a society to hold membership in the American Medical Association.

4. In the State of New York the New York State Medical Association and its branches are the only organizations recognized by the American Medical Association.

6. The requirements for membership in the American Medical Association are the same now as they have been in the past. The basic principle regarding membership, on which the Association was founded, as outlined above, is now, for the first time in many years, being enforced, and will continue to be enforced in the future.

FRANK BILLINGS, President.

GEORGE H. SIMMONS, Secretary.

News Items.

Transactions.—We have still on hand a number of sets without Volume No. 1, that is, from Volume 2 to 16, inclusive, which we will be glad to furnish to members of the American Medical Association, New York State Medical Association, or to libraries on request, provided they pay the express charges.

* * *

Dr. William B. Atkinson, of 1400 Pine street, Philadelphia, Pa., who has the Transactions of the New York State Medical Association from Volume I to XVI inclusive, would like to exchange them for a copy of the Standard Dictionary.

* * *

The New York State Medical Association, which was represented at the recent Egyptian Medical Congress by Dr. Clarence G. Campbell, of New York City, was the only American medical society so represented. The delegate from the Army was Major Gorgas and from the Hospital Marine Service, Dr. Huyser. Dr. Campbell informs us that the Congress was a great success in every way.

* * *

The president of the American Medical Association has appointed a committee to investigate and report to the House of Delegates at New Orleans upon the advisability of incorporating a national bureau of foods and medicines to be controlled by five directors representing the American Medical Association and five directors representing the American Pharmaceutical Association. The committee to investigate and report consists of Drs. E. Eliot Harris, chairman, New York; S. Solis-Cohen, Philadelphia; Nathan Davis, Jr., Chicago; H. Bert Ellis, California, and Philip Mills Jones, California.

* * *

We should call the attention of our members to the fact of the phenomenal increase in the number of our members who have joined the American Medical Association during the last few years. A short time ago there were only 150 members of our State Association who were also members of the National Association, while at the present time the membership is nearly 900. We hope that the remaining 600 members of the Association who have not already availed themselves of their privilege of membership in this great and powerful organization will without further delay send in their applications for membership, accompanied by \$5 dues, which includes the subscription to *The Journal of the American Medical Association*, to the president of the State Association, Dr. Frederick Holme Wiggin, 55 West 36th street, New York City.

* * *

The American Association of Life Insurance Examining Surgeons will hold its next annual meeting in New Orleans on May 4, 1903, one day

previous to the opening session of the American Medical Association.

* * *

The Little Falls Hospital Association has purchased a site, and early in the spring will commence the erection of a twenty-bed hospital.

* * *

New York State Medical Examinations.—

The secretary of the State Board of Medical Examiners reports as follows regarding the January, 1903, State medical licensing examinations: Total number of candidates, 103; successful, 75, or 72.8 per cent.; unsuccessful, 28, or 27.2 per cent. Of this number 80 had previously passed in the medical primary branches. There was but one "honor" licentiate. Fifty-one candidates appeared for certificates of proficiency in the medical primary branches (anatomy, physiology and hygiene, chemistry). Forty-seven, or 92.1 per cent. of these were successful.—*Med. Record*, March 21st.

* * *

A man was arrested in Jamestown on the 28th of February, calling himself "Whiting." He represented himself as acting for the *Journal of the American Medical Association*. He called on one of our members to collect the dues of the American Medical Association for 1903. The man acting suspiciously, he was arrested, and a telegram to Dr. Simmons brought this reply: "Whiting not authorized to collect for the *Journal*. Have him held and notify the police at Reading, Pa."

CORONERS' BILL.

Dr. E. Eliot Harris conducted the presentation of the side in favor of the bill.

Dr. W. Travis Gibb, in the absence of Dr. Stephen Smith, presented the argument prepared by the Joint Committee on Coroners of the New York and Kings County Associations.

Dr. Harry R. Purdy presented the abuses in the Coroner's office.

Dr. Alexander Lambert, Dr. A. Jacobi, Dr. A. G. Root, of Albany, and James T. Lewis spoke in favor of the bill. After the hearing the bill was reported favorably by the committee.

INTRODUCTORY REMARKS OF DR. E. ELIOT HARRIS.

Mr. Chairman and Members of the Committee on Cities of the Senate.

The Committee on Legislation of the New York State Medical Association has always maintained before the several committees of the Legislature, that the interests of the medical profession, and the interests of the general public, are identical. And I am here as chairman of that committee to continue to apply these principles in the argument favoring Senate bill No. 283, otherwise known as the Elsborg Coroner's bill.

When I ask myself the question why is the office of Coroner in the city of New York the

butt of the paragrapher, the subject of ridicule by the press and so little respected by the community at large, the answer seems to me to be in the fact that the Coroner in the city of New York is a veritable Pooh-Bah, exercising extraordinary authority and fills many offices.

There is no man to be found to-day with such power of mind and versatility of talent, who as Coroner, can sit upon the Bench as a judge deciding the kind of evidence that shall be submitted to his jury, *I mean his jury*, who possesses the judicial authority to issue warrants for the arrest of those who fail to obey his command to appear before him; who leaves the Bench to answer a summons to go to any place to take the antemortem statement of some poor, injured mortal; who may be called to some hole in the ground to examine a body, and decide the question of the cause of death, incorporating in his decision the latest researches in chemistry, biology, toxicology and pathology; who, under Section 773 of the Code of Criminal Procedure, in cases of sudden death, if he has reasonable ground to suspect a crime, or in all cases of suicide—the Coroners in cities of the first class, only, must summon not less than nine or more than fifteen persons to serve as jurors, and Section 775, of the same code, commands that the jury must be present while the inspection of the body is being made.

The Coroner is higher than the Sheriff and replevins merchandise from him in civil suits.

Now, I ask you, gentlemen of the Committee, in all seriousness, to relieve the great city of New York of that officer known as the Coroner, whose numerous duties, as provided by the statute laws of the State, must surely, at some time in his official career, make him appear ridiculous.

The Coroner is an expensive relic of bygone ages. He has outlived his usefulness and should be placed with all those extinct species which evolution has shown to be unfit to survive.

By analyzing Senator Elsberg's Coroner's bill No. 283 we can understand how the several existing departments of our city government can do, with a great saving of the city's money, the work of the Coroner much more satisfactorily than it has been done heretofore. A wise economy and a better official service demand that the office of Coroner in the city of New York should be abolished.

The bill transfers the judicial functions of the Coroner to the present city magistrates, whose duties are not mixed, but are essentially those of judges.

The medical duties associated with the office of Coroner are transferred by the bill to the Department of Health; the work of its laboratories has received honorable mention in the great medical congresses of the world, and its results have stimulated other cities to copy its admirable work.

We feel very safe in delegating the medical

duties to the Board of Health as provided in the bill. *The legal* duties that are necessary for conducting the inquests properly are transferred by the bill to the District Attorney, where they naturally belong.

The civil duties of the Coroner have been transferred to the City Chamberlain, an officer of the city government who is in every way qualified for the responsibility imposed upon him by this bill. And it now remains for the Legislature, through the help of this Committee, to give to the city of New York the much-needed relief from the unnecessary and costly Coroners, and their useless juries, which add another terror to the thought of sudden death.

THE BILL ABOLISHING THE OFFICE OF CORONER.

Its Origin and Scope Explained.

Sir—As there is a misapprehension as to the origin, objects and scope of the bill now before the Legislature, abolishing the office of Coroner in this city, the following statement is submitted:

1. This bill had its origin in the New York County Medical Association, which has agitated the subject for many years. On the 17th of last November the Association appointed a committee to examine and report as to the advisability of abolishing the office of Coroner. That committee examined the organization and operations of the Coroner's office in New York, and, also, inquired as to the methods of verifying the deaths from unknown causes in other States and countries. The conclusion reached by the committee was that the present Coroner's system does not, and under the conditions by which the Coroners are selected, cannot, meet the demands of modern scientific medicine. They recommended that a system should be devised which would entirely divorce the organization and operations of the branch of public service devoted to the duties now imposed upon the Coroner, from political influences of every kind. The committee called to its aid Mr. Lewis, counsel to the Association, and prepared the draft of a bill which, with some modifications, is the bill now before the Legislature. Such was its origin.

2. To effect the reform proposed the committee determined to effect a complete removal of the entire system from the realm of politics as the first and most important feature of reform. To accomplish that result most effectually it was proposed to abolish the office of Coroner altogether. The constructive work was twofold in its character, viz., first, to provide for the performance of the medical duties of those relating to the determination of the cause of death; and, second, to provide for the legal and judicial duties of those relating to the determination of the nature of the crime when crime is a factor, and also the arrest of the

criminal. Fortunately we have in our municipal service two departments devoted to the performance of these duties and which can readily undertake these new functions. First, the Health Department is required by law to investigate and register the cause of death, and it is equipped with chemical and biological laboratories for such work. Under the present system all deaths from uncertain causes are turned over to the Coroner's office, and yet it is most important that this department should investigate these cases in order to be prepared to prevent other deaths from the same cause. Under the bill now before the Legislature the Health Department will assume all the duties connected with investigating the cause of death in every case, bringing to its aid well-equipped chemical and biological laboratories conducted by expert scientists. Second, in providing for the legal duties, it was decided to confer them upon the office of the District Attorney and require the inquest to be conducted in the Magistrate's Court.

3. The results which will follow the enactment of this bill may be summarized thus: 1. The investigation of the cause of death will be prompt in accordance with the uniform rule of the Health Department in all emergency duties. 2. The investigation will be accurate and reliable because it will be made by an expert pathologist. 3. The inquest, conducted by the District Attorney in a Magistrate's Court, will have that character and dignity which befits proceedings, always of solemn import to parties immediately concerned and often of far-reaching influence upon the welfare of the community in which the crime was committed.

In conclusion, we may add that Massachusetts and many other States have long since reformed their systems of verifying deaths, either by reorganizing the system or by abolishing the office altogether and substituting modern scientific methods. We believe that it is in the interest of sound public policy that the city of New York, which is so abundantly supplied in its different departments with the means of superseding the work of the Coroners, should be relieved of this antiquated office, and the system of investigating the cause of death in all cases where the cause of death is uncertain should be transferred to the Health Department, and the legal and judicial duties should be imposed upon the District Attorney and the Magistrate.

STEPHEN SMITH, M.D.,
Chairman Committee.

ALEXANDER LAMBERT, M.D.,
President the New York County Medical Association.

FREDERICK HOLME WIGGIN,
President the New York State Medical Association.
New York, March 21, 1903.

AMENDMENTS TO CORONERS' BILL AS PASSED BY THE SENATE.

The third bureau shall comprise the chief medical examiner and the medical examiners and the other assistants or employees of such bureau appointed as hereinafter provided, and shall be known as the "bureau of medical examiners of the department of health." The chief medical examiner shall be the chief officer of the said bureau.

To the chief medical examiner, a salary not to exceed six thousand dollars; to each medical examiner, a salary not to exceed three thousand and five hundred dollars.

Such medical examiners shall be citizens of the United States and residents of the city of New York, and shall be physicians learned in pathology, duly licensed to practice medicine in the State of New York, and who have practiced their profession within the city of New York for a period of at least five years next preceding their appointment. Such medical examiners shall in the first instance be appointed from the coroner's physicians in office when the office of coroner is abolished as provided in this act, and thereafter shall be appointed from among those standing highest upon an eligible list prepared by the Civil Service Commission after a competitive examination held therefor. The Board of Health may designate one of the medical examiners, in each borough, other than the borough of Manhattan, to be assistant chief medical examiner for that borough. The Board of Health shall establish and maintain one or more offices in each borough, in connection with the offices of the department of health already established, if that be possible and convenient, for the use of the "bureau of medical examiners." Such offices in the boroughs of Manhattan and Brooklyn shall be kept open on every day in the year, including Sundays and legal holidays, with a clerk in constant attendance at all time of the day and night. In the boroughs of the Bronx, Queens and Richmond, such offices shall be kept open during such hours as the Board of Health may determine. The Board of Health may appoint such assistants for the "bureau of medical examiners" as may be necessary for the performance of the work of such bureau. The salaries of such assistants shall be fixed in like manner as the salaries of other employees of the city of New York. The Board of Health may adopt rules, not inconsistent with the provisions of this title, prescribing the duties of the chief medical examiner, of the medical examiners and of all the employees of said bureau.

WHY THE "CROWNER" OUGHT TO "GO."

"The ridiculous assertion that the bill abolishing the office of Coroner in this city was inspired by personal spite has elicited from the County and State medical associations a statement of how the measure originated.

"As our readers know, the *Herald* has for years

advocated the abolition of the 'crowner's quest' and the adoption of a scientific, accurate and trustworthy system such as Massachusetts and other States have long since put into successful operation.

"Last autumn the New York County Medical Association appointed a committee to study the question, and its recommendations are embodied in the bill now before the Legislature. The purposes of its framers were to remove the service now performed by Coroners from political influences and providing that the medical duty of investigating the cause of death shall belong to the Board of Health, which has laboratories conducted by expert scientists, while the legal inquisition, where necessary, shall be conducted by the District Attorney in a Magistrate's Court.

"The expedition, dignity and efficiency of this method, as contrasted with the farcical proceedings that attend too many 'crowner's quests,' are too obvious to need exposition."—*New York Herald*, March 24, 1903.

The *Evening Post* of March 7th contains an explanation of the bill to abolish Coroners, which it obtained through an interview with the chairman of the Committee on Legislation of the New York State Medical Association.

It is this sort of publicity of facts and scientific statements by the lay press which teaches the public to discern between the claims of the self-interested and he who has the public good at heart.

THE CONGE OF THE CROWNER.

Should a body meet a body
And should that body die,
Crowner won't sit on that body,
Asking when and why.
Dickens' beadle is a relic
Rarely found to-day;
Here's another old invention
That must pass away.
Fees are fat and work is easy;
Age is moving fast;
Crowner makes a grand old master
Picture of the past!
Contraries are often met with.
There's a pro and con,
Though they've sat on heaps of people,
They'll be sat upon!

—LA TOUCHE HANCOCK.

MEETING OF AMERICAN MEDICAL ASSOCIATION, NEW ORLEANS, LA., MAY 5 TO 8, 1903.

By request of Dr. H. L. E. Johnson, chairman of the Committee on Transportation, attention is called to special rates.

On account of the above occasion, the Southern Railway will sell tickets for the round trip, limited ten days, for one fare.

From the Trunk Line Territory the rates will be based on regular fares to Washington, or Trunk Line western termini, added to one first-class fare therefrom, limited to continuous passage, and will be sold May 1st, 2d and 3d with final limit ten days from date of sale. By deposit of ticket by original purchaser, and pay-

ment of 50 cents, to Joint Agent, New Orleans, not later than May 12th, extension of final limit may be obtained to enable the purchaser to reach original starting point not later than May 30, 1903.

Excursion rates to New Orleans from

New York	\$37.50	Trenton	\$34.75
Philadelphia	33.50	Rochester	33.00
Baltimore	29.50	Elmira	33.00
Washington	27.50	Newark	37.25
Harrisburg	33.00	Canandaigua	33.00
Reading	33.50		

Corresponding low rates from other points will be furnished upon application.

The Southern Railway operates three trains daily from New York, carrying Pullman, drawing and stateroom, sleeping, dining and observation cars.

By the request of members of the American Medical Association in the East, on Saturday, May 2d, special service has been arranged to leave New York at 4.25 P. M., via Washington, Atlanta and Montgomery. Trains composed exclusively of Pullman, dining, drawing and stateroom, sleeping, library and observation cars. Those desiring Pullman reservation should send in their names as soon as possible to Dr. Frederick Holme Wiggin, president New York State Medical Association, 55 West 36th street, New York; Dr. Wisner R. Townsend, 125 West 58th street, New York, or to agents of the Southern Railway. Time, New York to New Orleans, 39 hours.

For further information, call or write New York offices, 271 and 1185 Broadway, Alex. S. Thweatt, Eastern Passenger Agent.

"BIOCHEMISCHES CENTRALBLATT."

The great strides made in medical chemistry and in those fields of medicine verging on chemistry necessitated the publication of a central organ, published in Berlin by Carl Oppenheimer. The object of the publication will be to report such experiments and observations of physical and employed chemistry which are of importance to the physician.

As this is the only international organ devoted to these scientific fields, American observers and investigators will find it to their interests to prepare abstracts of their papers which have appeared since January 1st, and will appear hereafter, and send them to Heinrich Stern, 56 East 76th street, New York City.

HOSPITAL CHARITY ABUSED.

To the Editor of the *New York Times*:

Referring to the article in the *Times* of February 22d, entitled "Hospitals in Dire Need," allow me to suggest one way of increasing the revenues of the hospitals—namely, compel those who seek treatment there and who are able to pay for it to do so.

After graduating from the New York College of Physicians and Surgeons in 1896 I spent a year as interne in each of two large hospitals in New York City. Since I began practicing I have worked continuously in some one of the large dispensaries connected with these hospitals. During all this time there has been growing in me, as in many of my colleagues, a feeling of deep resentment against the authorities of these hospitals because they allow so many well-to-do people to be treated free. Go into the out-patient department of

any hospital in the city and you will find there numbers of men and women who are being treated gratis who are able to pay and should be compelled to pay. I do not mean pay the hospital, but pay a private physician. Dispensary work should be either free or denied altogether.

Most of the physicians whom I know are always ready to treat patients at their offices for what those patients are able to pay, whether it be much or little or nothing at all. The hospital authorities should devise some way to determine an applicant's status, as does the Charity Organization Society.

As to those who apply for beds in the hospital, the abuse is even more flagrant. It costs between \$2 and \$3 a week to board a person at home. There is no reason why that person should be boarded and waited upon in a hospital for nothing. Most of the hospitals charge \$1 a day for beds in the wards. Usually the unsupported word of the applicant is taken as to whether he is able to pay that. Ask the collectors of personal taxes in this city how much reliance can be placed on the word of most people when it comes to a case of saving a dollar.

Some years ago Dr. Herman Knapp determined to try and make the New York Ophthalmic and Oral Institute self-supporting. He succeeded. The lowest charge there is \$1 a day in the wards. Many of the patients are of the very poorest class, but they find the dollar somewhere. I do not mean to say that all hospitals can be made self-supporting, but I do mean to say that with buildings and equipment furnished and those who can pay compelled to do so, they can be made more nearly self-supporting than at present.

There is an immense amount of misplaced sympathy expended on the average hospital patient. I know of whole families in the neighborhood of St. Luke's Hospital who never consult a private physician unless they are too ill to get out of bed. They go to the St. Luke's Dispensary and get free treatment. These people pay from \$15 to \$30 per month for rent, dress well, own pianos, go to the theater occasionally, and would be mortally offended to be classed as paupers or the recipients of charity. They get free medical treatment just as they would get free groceries, free coal and free rent, if they could find some one fool enough to furnish it.

There are hundreds of people in the neighborhood of the New York Hospital who pay \$1 a month for treatment in that institution and think they are giving an equivalent for what they receive. They should be treated gratis if they are unable to pay, or should be sent to some private physician if they are. As it is, the hospital is misusing the funds meant for the very poor, robbing the physician of his just fees and rendering the patient contemptible.

It is too much to expect the physicians who give their time without remuneration to these dispensaries to decide who is able to pay and who is not. Many of these physicians are young men who are sons of wealthy parents. They have no adequate conception of what constitutes ability to pay. Then, too, many of them, out of feelings of delicacy, refrain from saying anything to many who they feel are unworthy subjects of charity. This matter should be relegated to trained employees.

It would be doing many of the average dispensary patients a favor to send them home and let them understand that they should go to a private physician, for they waste a half day two or three times a week waiting for treatment, which, in the nature of the case, must usually be very indifferently given.

DAVID T. MARSHALL, M.D.

New York, February 23, 1903.

DISPENSARY REFORM.

STATE BOARD OF CHARITIES,
ALBANY, N. Y., March 17, 1903.

E. ELIOT HARRIS, M.D.,

Chairman Committee on Legislation, the New York State Medical Association, 33 West 93d Street, New York City:

My Dear Dr. Harris—In my opinion the Dispensary

Law, Chapter 368 of the Laws of 1898 (the enactment of which you and other officers of the Association worked so hard to secure) and the rules and regulations adopted by the State Board of Charities, pursuant thereto, have been productive of much good.

The Board, as you doubtless know, employs an inspector, whose sole duty is to inspect the dispensaries and to report in writing to the Board with relation to their observance of the rules. His reports are in turn brought to the attention of the officers of the dispensaries with the request that any violation of the rules be corrected.

While a few of the dispensaries are not as cordial as they might be in cooperating with the Board in its attempt to bring about a better system of administering medical relief, most of them are really trying to improve conditions in this respect.

That there has been more discretion exercised in dispensing medical relief in this State is shown by the fact that the dispensaries within the jurisdiction of the Board have reported a continual decrease in patients since the law took effect. In these dispensaries there were almost one hundred thousand less patients treated during the year 1902, as compared with the year 1898, before the Dispensary law was enacted.

The State Board of Charities means to continue its inspection of the dispensaries with confidence that greater improvement and more discrimination in their work will continue to be shown as time goes on. The Board will also continue to depend upon the State Medical Association for assistance in securing this and other desired reforms.

Respectfully yours,

(Signed), ROBERT W. HEBBERD, Secretary.

Correspondence.

MARCH 9, 1903.

To the Chairman of the Publication Committee:

Dear Doctor—Among the papers of an old physician was found a fragment of an article on "Ancient and Modern Practice Contrasted," which contains golden grains of worldly wisdom concealed under a facetious cloak. It tells much more than it appears to tell and still leaves many spaces between the phrases and many blanks between the lines to be filled by the thoughtful. The enclosed copy of this queer document is at your service if you choose to print it in the JOURNAL.

Yours, etc.,

W. S.

MELAMPUS AND PROETUS' MAD DAUGHTERS; OR,
THE GOOD OLD WAY OF TREATING OBSTIPATION.

Melampus Melampodidæus was not only the head medicine-man of his time—three thousand four hundred years ago or thereabouts—but was, in effect, Selectman, President of his village and political Boss, besides being the founder of a great family of soothsayers. His professional success was so great and his political influence so powerful that he drove away from the Kingdom of Argos, all those precursors of the root and yarb men, Indian doctors, and other pretenders of our days. Hearing of the madness of the daughters of King Proetus, he cunningly informed himself of their habits, deportment and symptoms and, having had no little experience in the observation of such

cases, surmised that these fair ladies were suffering from the ill effects of some form of internal obstruction, causing leucomainal intoxication and its sometime attendant grave cerebral disturbance, and wisely waited to be officially summoned.

The three beautiful princesses, Lysippe, Iphinoe and Iphianassa, had the same delusion. Believing themselves to be cows they were rambling through the country, even to distant woods and pastures. The least robust, Iphinoe, unable to withstand the great exertion of following her roving sisters, soon succumbed. It was after this sad event that Proetus consulted Melampus about the continued serious illness of the two survivors, vowing he would be willing to part with all his worldly possessions for their restoration to health, just exactly as fathers talk in our days. The true cause of their madness was readily discovered by the astute physician, who, however, kept his own counsel about the diagnosis and treatment of the mental malady excited by physical disturbance. The good, dear doctor, being modest in his wants and mild in his charges, did not demand all that the king had offered, but stipulated, for the cure of his two fair clients, that the fee be only one-third of the kingdom and one of the patients for wife.

The crafty king demurred and, apparently forgetting his liberal offer, said that the honor of medicating two such lovely members of a royal household would assuredly be ample compensation, to which might be added a high title of nobility; but the wily Melampus, entertaining entirely different notions on the question of remuneration for his services, glanced quizzically at the recusant monarch, blew his nose in a bandanna kerchief, took a fresh pinch of snuff, repacked his saddle bags, putting away his India-rubber fountain irrigator, his storage-battery, hypodermic syringe, his ergotin solution, licorice powders, compound cathartic, triplex and Lady Webster pills, belladonna pellets, oil can, wine flask, soothing potion and various tablets, or rather the equivalents of all these things; then, mounting his gray mare, he made a graceful bow and departed silently.

On the following day the sick became more violent and were absolutely uncontrollable. As parental anxiety was on the increase, the great splanchno-psychiatrist was again summoned to perform the needed service, which, with becoming dignity and suavity, he firmly declined, although the crocodilic-lachrymose father averred that he was then willing to part with anything, even with the precious third of his possessions, for the salvation of his dearly beloved children. The worldly-wise medicine-man, seeing his opportunity, then gently and softly hinted that no better evidence of this great parental love could be given than by his majesty's bestowal of a second third of the kingdom, together with the other daughter in marriage, on Bias his brother and assistant balneist and exorcist. "Agreed," said the sharp Proetus, still hoping to defraud the mild-man-

nered black-footed son of the learned Amythaon, grandson of the beautiful Tyro and great-grandson of the illustrious Salmoneus. But this shrewd, far-seeing man of the world, this consummate, self-reliant therapist, pragmatically demanded and obtained certified cheques on the royal treasury and deeds for two-thirds of the kingdom, besides provisions for the wedding feasts, before the treatment was undertaken.

A complete cure was soon effected by means of profuse purgation with the equivalent of calomel and castor oil, *i. e.*, black hellebore (*Melampodium*), administered by the accurate diagnostician, skilled, enterprising, bold therapist and able prognostician. Assisted by his sapient brother Bias in carrying out the heroic treatment on enlightened lines, he employed, besides ergot and the lapactics and purgatives, colonic lavage, Turkish-like baths for the purification of the body surface, massage and a kind of electricity to accelerate the blood circulation and to promote peristalsis, together with incantations aided by a powder equal to beta-naphthol for wind-colic, and a sort of salol for exorcism of noisome bacteria and of the evil leucomainic spirits that were lurking in and perturbing the minds of the sufferers.

The honoraria of nineteenth century medicine-men are not commonly kingdoms or even provinces, but, with seeming sincerity, almost as extravagant offers are sometimes made to them if they will only cure the incurable or restore to health the moribund. They are, however, content to exact fees commensurate to the services rendered, and, very properly, many are now wont to follow the salutary Melampic example of insisting upon prompt payment and, in consequence, have their rights, together with the respect of the public in general and of their clients in particular.

Scores of other illustrations might be given of the physical and psychological effects of inward disturbances, of the consequent freaks of the obstipated, and of the vast importance of the *sella familiarica*, but they would add little to the notable experiences of the ancient, eminent, enterical and cephalic specialist who so generously bequeathed to medical posterity such an excellent example of the pecuniary relations of patient and physician. It remained, however, for a canny Scottish epigrammatist to paraphrase so concisely the Melampian doctrine—"Take the fee while the tear is in the eye"—which also serves as a well-merited rebuke to the cant that doctors should be above lucre, just as if the laborer were not worthy of his hire.

PHARMACOLOGY IN OUR MEDICAL COLLEGES.

The two articles in the last number of the JOURNAL which deal with the subject of proprietary remedies cannot but excite a renewed interest on the part of our 11,000 physicians in New York State, in both the ethical and the scien-

tific principles involved in the manufacture, sale and use of these therapeutic agents.

Anticipating a desire by our readers for further information regarding the amount of instruction in pharmacology which our medical students are receiving to-day, we sent the following circular letter to the dean of each medical college in this State and received the appended replies:

To Dr. _____,
FEB. 16, 1903.
Dean _____ Medical College.

Dear Doctor—As an article is to appear in the March number of this JOURNAL, in which reference is made to the inadequate time devoted by our medical colleges to the teaching of pharmacology, and as we wish to publish in the same issue the number of hours assigned to laboratory, recitations and lectures on this subject, by each medical college in New York State, will you kindly lend us your assistance, by furnishing us with such information in regard to your college?

As we go to press on the 20th, an early reply will be greatly appreciated.

Yours truly,
CHARLES E. DENISON,
Chairman Committee on Publication.

corrected by the instructor and criticized by the student. The remainder of the exercise is given up to manipulative work in practical pharmacy, generally in the prescriptions and drugs already written on the board. This consists in making the various official preparations which may have been called for, compounding of the prescription, testing of any incompatibles which might occur, or which were erroneously called for. During the latter part of the course the various foods and preparations necessary for the care of the sick are compounded. A short time is given up to demonstrating the action of important drugs on animals. This work is in the hands of the instructor, and is calculated to show the principles of the action of drugs. The object of the course is to produce practical therapeutists rather than pure scientists. No time is wasted in making the student adjust delicate instruments and produce records from their use, which are so often unreliable and misleading. The course has proved one of the most popular in this college, and has demonstrated its advantages to the instructors of these students when they are brought to the dispensary and bedside in the third and fourth years.

Trusting that this summary of the course can be used in your article, as pharmacology is made a great point of in this college, I remain,

Very truly yours,
JOHN ROGERS,
Secretary.

THE UNIVERSITY AND BELLEVUE HOSPITAL MEDICAL COLLEGE.

NEW YORK, Feb. 17, 1903.

C. E. DENISON, M.D., Chairman Committee on Publication New York State Medical Association, 64 Madison Avenue, City.

Dear Sir—Your letter to Dean Janeway in relation to the teaching of pharmacology in this institution has been referred to me. As you will notice in the outline of the course from the annual catalogue which I inclose, pharmacology receives special attention in our curriculum. For the past few years we have been enlarging this department, until at the present time the pharmacological action of the drug is considered immediately after the men have been trained in the physiological laboratory.

The action of the different groups of drugs is presented in a thorough manner to the students in lectures and recitations. In the laboratory course the students have an opportunity of noting the effects of the drug on the different physiological processes, and at the same time their attention called to their therapeutic application. During the second year the teaching is that of pure pharmacology.

In the third year it is taken in connection with its therapeutic application and the teachers in pharmacology and therapeutics work in unison, so that the attention of the student is directed to the application of the principles of physiology and pharmacology to the treatment of the pathological condition.

Very truly yours,
EGBERT LE FEVRE,
Corresponding Secretary.

CORNELL UNIVERSITY MEDICAL COLLEGE.

NEW YORK, Feb. 18, 1903.

DR. C. E. DENISON, 64 Madison Avenue, New York, N. Y.

Dear Sir—Your letter to Dr. Polk in reference to the teaching in pharmacology has been referred to me.

The subject is taught during the second year in this college as a laboratory course, six hours weekly for fifteen weeks for each student. Each has a separate desk and apparatus. The first half hour of the exercises is taken up by prescription writing on the board of drugs previously given out. Prescriptions are then

COLLEGE OF PHYSICIANS AND SURGEONS.

NEW YORK, Feb. 18, 1903.

Dear Doctor—Replying to your favor of 16th inst. I would say we do not teach pharmacology in the College of Physicians and Surgeons by recitations or in laboratory. The Professor of Materia Medica and Therapeutics alone deals with pharmacology—"the science relating to drugs and their preparation"—in his eighty lectures.

Yours truly,

JAMES W. McLANE.

C. E. DENISON, M.D.

BROOKLYN, N. Y., Feb. 19, 1903.

DR. C. E. DENISON.

Dear Doctor—In reply to your letter of inquiry of the 16th I would say that at the Long Island College Hospital we do not give a course under the distinctive title Pharmacology. We do give a course in pharmacy, consisting of recitations and laboratory work, occupying two hours per week throughout the second year. The course covers the preparations of typical tinctures, fluid extracts, infusions, pills, capsules, etc., etc., followed by compounding prescriptions, the study of incompatible prescriptions in the laboratory, exercises in prescription writing, etc. The course in materia medica deals with the subject of pharmacology only in a descriptive way, but we have no laboratory course.

This course occupies three hours per week through the third year.

Yours,
E. H. BARTLEY, M.D.,
Prof. Chem. L. I. C. H.

UNIVERSITY OF BUFFALO, MEDICAL DEPARTMENT.

BUFFALO, N. Y., Feb. 20, 1903.

CHARLES E. DENISON, M.D.

My Dear Sir—Yours of February 16th came to hand during my absence from the city, hence the delay in replying to same.

We teach pharmacology three hours a week during the entire year, two hours being laboratory and one hour lecture.

Very truly yours,
JOHN PARMENTER,
Secretary.

A NEW MEDICAL LAW.

Which Is a Plea for a Single Board of Medical Examiners.

The bill pending before the Pennsylvania Legislature to regulate the practice of medicine is receiving high commendations from both the lay and professional press. It is especially praiseworthy because, if enacted, it would be what we would term a thoroughly American law; a law which would promote the welfare of the State without undue limitations upon the freedom of the individual citizen. There can be no cry of persecution where the law applies equally to all who practice the healing art.

The bill would compel every one who treats an injury or a disease to be a licentiate, thereby showing that he has the intelligence necessary to one who assumes such a responsibility. Having a license, he may seek to cure by such means as his judgment prompts him to use.

The cumbersome and far from satisfactory method of having three separate boards of examiners is unsatisfactory to all practitioners. A single board, having upon it representatives from the three schools, which appoint the present three boards, would be much more wieldy and harmonious, and equally as capable of granting licenses.

Having obtained his permit to practice, his method of treatment would be according to his own choice, providing, of course, it was satisfactory to the patient and to the present laws, which amply protect the public against maltreatment.

The *New York Times*, on March 6th, said editorially of this bill: "It goes as far as any law should in regulating the practice of medicine and will end a tedious and unprofitable controversy to the satisfaction of all except those who have hitherto practiced without qualifications. Under it, if the Christian Scientists elect to educate their disciples, the way is open to them, as it should be."

OUR CONSCIENTIOUS PRESS

Not Subsidized by Quacks.

We quote the following words of Dr. S. A. Knopf, from the columns of *American Medicine*: "To break the nefarious trade of the man who deals in 'sure and infallible' pulmonary tuberculosis remedies, to stop the practice of the man and woman who claim to be able to diagnose and treat pulmonary tuberculosis by letter, the Christian scientists, the faith curists, who ridicule preventive measures and the laws of cleanliness and hygiene—which are the laws of God—but who, as a token of faith, demand their fees in advance, we have but one weapon, and that is education—education by a conscientious press, the clergyman, and the teacher."

That the lay press is not dependent upon the quack's advertisements for its support, as is so frequently claimed, or, at least, that it has, above its natural desire for financial success, a keener sympathy for the public welfare than is usually

credited to it, is becoming daily more evident.

Our press, for the greater part, is conscientious, and is most willingly undertaking its great work of educating the public in the dangers of the self-administration of therapeutic measures, and the probable results from submitting to the treatment of a quack.

As an instance of this freedom on the part of the press to ignore the wishes of advertisers, we print a few lines taken from a longer article which appeared in the *New York Evening Post*:

"There are also nostrums which promote and intensify the very condition which they pretend to cure. These are composed largely of alcohol. Most of the so-called 'bitters' come under this classification. The annual report of the Massachusetts Board of Health for 1896 is a classic on this subject. It contains analyses of sixty-one kinds of bitters, tonics and sarsaparillas then in vogue, some of the most notorious of which are still on the market, and many of which have been advertised as 'purely vegetable,' 'free from alcoholic stimulants,' 'not a rum drink,' etc. Parker's tonic, 'recommended for inebriates,' was found to contain 41.6 per cent. of alcohol. Ayer's Sarsaparilla contained 26.2 per cent.; Hood's Sarsaparilla, 18.8 per cent., and Paine's Celery Compound, 21 per cent. A lot of 'blood purifiers' were found to contain iodid of potassium, which is classed among poisons by nearly every writer upon toxicology. There is another class of nostrums that may be called unmitigated swindles, as where bread pills are sold for the price of costly drugs. An instance of this kind was given in the Massachusetts report, where 'Kaskine,' a much-vaunted remedy, which sold at \$1 an ounce, was found to consist of nothing but granulated sugar."

THE LOCAL BOARDS OF HEALTH BILL.

The bill to amend the public health law relative to local boards of health, introduced in the Senate of New York State by Mr. Stewart, is well calculated to institute many much-needed reforms of present systems. Heretofore the local health boards have been managed on very loose principles of coordinate action with the State board, and the growing necessities for uniform action and proper centralization of executive power are alarmingly apparent.

In the larger cities the regulations are stringent enough to guard against the inroads of contagious and infectious diseases, but the country towns and rural districts are at the mercy of primitive regulations which, inefficient as they are, are seldom enforced. A recent and striking object lesson in point is the history of the recent typhoid epidemic at Ithaca. It is seemingly more particularly to meet such conditions that the bill in question has been framed. The general object of the measure is to make the local boards more directly and legally responsible for their acts.

In the matters of proper legal control of sewer-

age and stream pollution no regulations can be too strict or too comprehensive. Therein rests one of the fundamental requisites for the arrest and prevention of typhoid fever. In this connection it may be well to suggest to our legislators that it should be made obligatory on physicians to report all their cases of such fever the moment a diagnosis is made. This is required of the practitioners in the large cities, and there is no reason why similar laws should not apply to those in the rural districts and smaller towns. Everything depends upon knowing of the initiatory cases and in taking prompt preventive measures.

Another matter bearing on stream pollution should also receive direct attention. As contaminated oysters are a frequent cause of a typhoid-fever epidemic, there should be some rider in the law forbidding the planting of these shell-fish at the mouth of sewers for fattening purposes. No dealer, for instance, should be allowed thus to endanger the lives of his customers, under heavy penalties. The State board could be given ample jurisdiction in the matter without in any way making unreasonable restrictions upon the industry in question.

The bill, however, even as it stands, is a most excellent one, and with the State Medical Association behind it, bids fair to become a law. It certainly deserves all the support it can obtain from the profession of the State.

The Library of the New York State Medical Association is being constantly increased from time to time by contributions from members of the Association, as well as by books sent for review being returned to the library by the reviewer. While the number of new books is not large at the present writing, yet a beginning has been made, and we hope soon to open a department for lending books to members. Before long we intend to issue a list of new books, showing the books that can be obtained. Members of the Association willing to offer their services to review medical books will kindly send their names to the chairman of the Committee on Publication.

Book Reviews.

OBSTETRICS. A TEXT-BOOK FOR THE USE OF STUDENTS AND PRACTITIONERS. By J. Whitridge Williams, Professor of Obstetrics, Johns Hopkins University, Obstetrician-in-Chief to the Johns Hopkins Hospital, Gynecologist to the Union Protestant Infirmary, Baltimore, Md. With eight colored plates and 630 illustrations in the text. New York and London: D. Appleton & Co., 1903.

At a certain examination the question was asked: "Describe the management of a face presentation in the M. D. P. position." The examined men were like "sheep before the shearers"—*i. e.*, dumb. An investigation showed that the popular text-book made scant reference to the so-called "undeliverable" position.

Perhaps a knowledge of this fact led the reviewer of Dr. Whitridge Williams' work to consider, first, the description of the presentations in general, and, second,

those of the face in particular. The admirable methods employed in explanation and the ample demonstrating drawings illustrating these fundamentals of obstetric knowledge show that the author is that rare combination, a teacher and a student of students and their requirements.

Everything is detailed to the required minuteness, and beyond that nothing. The cuts and engravings are many, novel and good. They fill a definite purpose, and that purpose is not "padding." As one reads page after page the old-fashioned words, "Pleasure and profit," recur to the mind.

The volume is not absolutely flawless. About the utmost that can be expected of any work is, to be mathematically and absolutely correct, 51 per cent., yet here is a book which covers the greater portion of obstetrics in such a manner that the students may go to it for knowledge, and the oldest practitioner may turn to it for counsel. One does wish, however, that works on obstetrics would devote some space to the subject of "Intracranial hemorrhage in the new-born." The obstetrician's view of this accident is such a first-hand and comprehensive one that silence seems inexplicable. Why are not clots removed from the infantile brain frequently? Probably about one-third of the deaths soon after delivery are due to cerebral extravasation, and, so far as my knowledge goes, not a single surgical (brain) procedure has ever been attempted. Is there not a sin of "omission"?

As a sample of an up-to-date manual, characterized by care and clear thought, the book in question is decidedly among the very best.

It has all the earmarks of success; it is crowded with hints of practical value, and it shows what the trained hand and brain adopt as the best methods in overcoming the obstacles of parturition. Surely, if conscientious work and real merit count, we may expect to find this volume upon the lists of the colleges and treasured in private libraries.

DOUGLAS H. STEWART, M.D.

SAUNDERS' MEDICAL HAND-ATLASES—ATLAS AND EPITOME OF DISEASES OF THE MOUTH, PHARYNX AND NOSE. By Dr. L. Grunwald, of Munich. From the second Revised and Enlarged German Edition. Edited, with additions, by James E. Newcomb, M.D., Instructor in Laryngology, Cornell University Medical School; Attending Laryngologist to the Roosevelt Hospital, Out-patient Department. With 102 illustrations on 42 colored lithographic plates, 41 text cuts and 219 pages of text. Philadelphia and London: W. B. Saunders & Co., 1903. Cloth, \$3 net.

This series is so well known that it seems hardly necessary to again call attention to its excellence as an Atlas, and now with the addition of the epitome its value, both to the student, practicing physician as well as to the specialist, is much enhanced.

The American edition has been edited by Dr. James E. Newcomb, with his customary clear insight. The publishers are to be congratulated on the success that follows the presentation of these handy volumes.

EMIL MAYER, M.D.

ATLAS AND EPITOME OF HUMAN HISTOLOGY AND MICROSCOPIC ANATOMY. By Dr. Johannes Sobotta, of the University of Würzburg, Bavaria. Edited, with extensive additions, by G. Carl Huber, M.D., Junior Professor of Anatomy and Director of the Histologic Laboratory at the University of Michigan. Authorized translation from the German, with 171 illustrations on 80 lithographic plates and 68 text illustrations. Philadelphia and London: W. B. Saunders & Co., 1903.

This volume is a very welcome addition to the list of text-books on histology in English. It is, like the other volumes in Saunders' Series of Medical Hand-Atlases, a combination of a text-book and an atlas. The plates, eighty in number, present pictures that are exact counterparts of the original tissues. They owe their accuracy to the method employed in their production. This consists, in brief, in tracing microphotographs of

the original sections and filling in the details under a lens of high power. In clearness, accuracy, beauty and usefulness the plates certainly surpass any that have as yet been published in our text-books.

Some words of criticism regarding the selection of material for portrayal are necessary. Whereas, many subjects are profusely illustrated, others are but slightly noticed. Thus the "development of bone" is illustrated by four full-size plates—"the teeth" by four figures and two plates, "the skin and appendages" by six plates, while no less important a structure than the lung is represented by a transverse section of an injected and a small figure. This criticism, already anticipated in a general way by the author, could easily be avoided by a very few additions in future editions.

Certain plates, however, through their originality and the fact that they are not to be found in many of the current text-books, will be of value to the student, even if not absolutely essential. Such are sections of the vermiform appendix, spermatic cord, seminal vesicle, nasal mucous membrane, external auditory meatus, etc.

The text has been carefully translated under the supervision of Dr. C. Huber. The translation is very well done, and, except for those sections where the editor has thought fit to make additions and radical changes in the treatment of the subject matter, it conscientiously adheres to the original. Important and valuable changes are the revision of the section on the blood and the addition of a short description of the hemolymph glands.

The book can be safely recommended both to the student and the worker in histology as one of the best and most useful of the smaller works on the subject.

EMANUEL LIBMAN, M.D.

BOOKS RECEIVED.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Dr. Carl von Noorden, Physician-in-chief to the City Hospital in Frankfurt a.-M. Authorized American edition, translated under the direction of Boardman Reed, M.D., Professor of Diseases of the Gastro-intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia, etc. Part II, Nephritis. New York: E. B. Treat & Co., 1903.

OBSTETRICS. A Text-book for the Use of Students and Practitioners. By J. Whitridge Williams, Professor of Obstetrics, Johns Hopkins University; Obstetrician-in-chief to the Johns Hopkins Hospital; Gynecologist to the Union Protestant Infirmary, Baltimore, Md. With 8 colored plates and 630 illustrations in the text. New York and London: D. Appleton & Co., 1903.

THERAPEUTICS OF INFANCY AND CHILDHOOD. By A. Jacobi, M.D., LL.D. Third edition. Philadelphia and London: J. B. Lippincott Company, 1903.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. Being a Yearly Digest of Scientific Progress and Authoritative Opinions in All Branches of Medicine and Surgery, Drawn from Journals, Monographs and Text-books of the Leading American and Foreign Authors and Investigators. Collected and arranged, with critical editorial comments, by J. M. Baldy, M.D.; J. Chalmers DaCosta, M.D.; W. A. Newman Dorland, M.D.; George Fetterolf, M.D.; John H. Gibbons, M.D.; Virgil P. Gibney, M.D.; C. A. Hamann, M.D.; Howard P. Hansell, M.D.; Barton Cooke Hirst, M.D.; D. Brandin Kyle, M.D.; Wendell Reber, M.D., and J. Hilton Waterman, M.D., under the general editorial charge of George M. Gould, M.D., Surgery. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

TRANSACTIONS OF THE MEDICAL SOCIETY OF NEW JERSEY. Pp. 292.

This little volume contains the proceedings of the annual meeting of the Society. It contains 17 original papers, together with much useful information. There are 1,061 members in the Society, representing 20 constituent County Societies.

APPLIED SURGICAL ANATOMY. Regionally presented for the use of students and practitioners of medicine. By George Woolsey, A.B., M.D., Professor of Anatomy and Clinical Surgery in the Cornell University Medical College; Surgeon to Bellevue Hospital, etc., etc. With 125 illustrations, mostly colored. Lea Bros. & Co., publishers, 1902. Pp. 521.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. Being a Yearly Digest of Scientific Progress and Authoritative Opinions in all Branches of Medicine and Surgery, drawn from Journals, Monographs and Text-books of the Leading American and Foreign Authors and Investigators. Collected and Arranged with Critical Editorial Comments. By Samuel W. Abbott, M.D.; Archibald Church, M.D.; Louis A. Duhring, M.D.; D. L. Edsall, M.D.; Alfred Hand, Jr., M.D.; Milton B. Hartzell, M.D.; Reid Hunt, M.D.; Walter Jones, Ph.D.; A. O. J. Kelly, M.D.; John Marshall, M.D.; J. H. W. Rhein, M.D.; David Reismam, M.D.; Louis Starr, M.D.; Alfred Stengel, M.D.; A. A. Stevens, M.D.; G. N. Stewart, M.D., and Reynold W. Wilcox, M.D. Under the general editorial charge of George M. Gould, M.D., Medicine. Philadelphia, New York and London: W. B. Saunders, publishers, 1903.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Prof. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfurt a.-M. Authorized American edition, translated under the direction of Boardman Reed, M.D., Professor of the Diseases of the Gastro-Intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia. Part III. Membranous Catarrh of the Intestines (Colica Mucosa). By Prof. Carl von Noorden, with the Collaboration of Carl Dapper. New York: E. B. Treat & Co., 1903.

A MANUAL OF PRACTICAL HYGIENE FOR STUDENTS, PHYSICIANS AND MEDICAL OFFICERS. By Charles Harrington, M.D., Assistant Professor of Hygiene in the Medical School of Harvard University. Second Edition. Revised and Enlarged. Illustrated with 12 plates in colors and monochrome and 113 engravings. Philadelphia and New York: Lea Bros. & Co.

A TEXT-BOOK OF PRACTICAL MEDICINE. By William Gilman Thompson, M.D., Professor of Medicine in the Cornell University Medical College, New York City; Physician to the Presbyterian and Bellevue Hospitals, New York. Second Edition. Revised and Enlarged. Illustrated with 62 engravings. New York and Philadelphia: Lea Bros. & Co., 1902.

SURGICAL DISEASES OF THE GENITO-URINARY ORGANS. By E. L. Keyes, A. M., M.D., LL.D. Consulting Surgeon to Bellevue and Skin and Cancer Hospitals; Surgeon to St. Elizabeth's Hospital; formerly Professor of Genito-urinary Surgery, Syphilology and Dermatology at the Bellevue Hospital Medical College, etc., and E. L. Keyes, Jr., A.B., M.D., Ph.D., Lecturer on Genito-urinary Surgery, New York Polyclinic Medical School and Hospital; Surgeon Out-patient Department St. Vincent's Hospital; Physician Venereal Clinic, Out-patient Department, of the House of Relief of the New York Hospital. A revision of Van Buren's and Keys' Text-book. With 174 illustrations in the text and 10 plates, 8 of which are colored. New York and London: D. Appleton & Co., 1903.

PROCEEDINGS OF THE CONNECTICUT MEDICAL SOCIETY, 1902. One Hundredth and Tenth Annual Convention, held at New Haven, May 28th and 29th. Published by the Society. John A. Grannis, M.D.; Gould A. Shelton, M.D.; N. E. Wordin, M.D., Publication Committee, 1902.

THE INTERNATIONAL MEDICAL ANNUAL. A Year-book of Treatment and Practitioners. Twenty-first year. 1903. E. B. Treat & Co., 241-243 West 23d street, New York City; 199 Clark street Chicago.

Original Articles.

OUR NEEDS—THE IDEAL PHYSICIAN.¹

BY J. W. GROSVENOR, M.D.,

Buffalo, N. Y.

WE need money with which to replenish our treasury. Although we are in a sound financial position our income is barely sufficient to meet our current expenses. Whenever any financial contingencies arise a few of our liberal members meet the emergency. A sufficient financial supply should be constantly in our treasury to meet not only present demands, but also any wants of the near future. If by invitation a brilliant medical light visits us to enlighten us upon a specially intricate medical subject it is no more than courteous and right that we should pay, at least, his necessary expenses.

We need a well-filled treasury to maintain scientific truth against the rapacious inroads of charlatanry. Oftentimes this can be done only by an appeal to the law. Obligation rests upon our society to contribute its financial share in repressing and suppressing in our midst the various forms of medical quackery which filch hard-earned dollars from the simple and guileless victims of mendacity.

Not infrequently there are presented to our Legislature for enactment into law pernicious bills which are inimical to the medical profession and the sanitary welfare of the people of our city and county. For the prevention of such legislation an effective method is the sending a commission to the Legislature for the forceful presentation of the views of the medical profession. The members of such a commission should be paid for their services and expenses. Our society should deem it both a privilege and duty to draw from its treasury funds sufficient to discharge its obligations on this account.

The Fourth District Branch of the State Medical Association, of which this County Association is a member, has held a meeting in our city and will hold meetings here in the future. It is simply liberal courtesy on the part of our Association to provide suitable entertainment for that body. Such courtesies promote good fellowship in the ranks of the profession and unite its members more firmly in a helpful bond of fraternity. The financial demands of such entertainments should be met from our treasury and not from individual resources.

In such a society as ours unforeseen emergencies and contingencies are apt to arise which call for an expenditure of money in order that we may be helpful to each other and to the community in which we are located. We should be ready to meet any contingent demands with liberal financial aid.

Every organization that intends to endure through the wear and tear and wrecks of time must have money as one of its fundamental supports. Unexpected disasters come to the vast majority of individuals and societies. When the day of threatened trouble has arrived a full treasury is one of the most helpful and substantial of friends. This is not a plea for intense commercialism, but for the application of sound business principles to the future conduct of our society. No organization can fail to meet its financial obligations promptly without detriment to its reputation and standing in the community where it exists. All of us are dependent upon our reputation for our prosperity. Reputation is a large part of our professional investment.

Our Association can use at least two legitimate methods for replenishing its treasury. Its annual dues can be raised and its membership can be increased. To your retiring president the latter method seems the more desirable. It will cause less friction. An increase of a suitable membership will add not only to our financial prosperity, but will strengthen our organization along other lines. Every added member who is devoted to the success of the Association will be a helpful factor in accomplishing the objects to which it has dedicated its energy and life. Such a member will promote our scientific advancement; his presence at our meetings will add interest and éclat to our exercises; he will be useful in securing additional members; he will take his stand on a platform that is inimical to charlatanry, whether manifested inside or outside of the ranks of the legitimate profession of medicine; he will show himself as the friend of high professional morality and conduct; he will establish himself in a position which favors the medical profession as united for the laudable protection of its interests, for the elevation of its individual membership in every good word and work, for the exaltation of the physical and mental health of the people.

Our present membership just passes the century line. The coming year should close with a triple hundred membership. With the \$300 as dues which such a numerical membership would place in our treasury we should be able to do more and better work than at present. Each of the present membership is intensely urged to do his part in aiding our Association to reach the three hundred membership mark in the very near future. In no other way can a member be more helpful to this organization than by pledging himself to labor earnestly for this end and then by fulfilling his pledge. The writer's experience teaches that personal solicitation is the most effective means for securing this object.

Our Association needs a prompt payment of membership dues. So many privileges are granted for our dues that surely they are exceedingly moderate. By them a member re-

¹Presidential Address, read before the Erie County Medical Association, March 9, 1903.

tains his membership in the State Association, receives monthly a high-class medical journal and yearly a directory of physicians, is permitted to attend and take part in four medical meetings annually, at which are discussed the most pressing and most vital medical questions of the day; becomes eligible for membership in the American Medical Association.

Our by-laws require that if the annual dues are not paid within three months after the beginning of the year they shall be increased by the addition of \$1, and also, nine months after the time specified for the payment of dues, if a member's dues remain unpaid, said member's name shall be dropped from the roll of membership. If a member's name is dropped from the roll through his neglect to comply with the demands of the by-laws he is apt to criticize the officials for doing their imperative duty and complain that he has been subjected to unfair treatment. Promptness in the payment of dues would obviate many misunderstandings and harsh criticisms, and would maintain our treasury in a sounder financial condition. An appeal is hereby made to all members of our Association to satisfy its demands by a prompt and conscientious payment of their annual dues.

Our Association needs enthusiasm. No great enterprise can be carried forward to a successful issue, either by an individual or an organized body, without an enthusiastic faith in its importance and the outcome of its work. Enthusiasm is born of intense belief in the necessity and excellence of the work undertaken. Our Association was organized as a necessary adjunct of the State Association and as a helpful factor in maintaining the principles of the American Medical Association. Not one of our members will deny that our aims are high and worthy of our supremest efforts for their attainment.

We have many of the factors which will promote our growth and prosperity. Our membership consists of men and women of sterling moral qualities, broad intellectual acquirements and the adornments begotten of a liberal education. Our bills are paid with commendable promptness. Only a few of our members fail to pay their dues with promptness and even alacrity. Our scientific programs are rendered with rare wisdom, philosophical exactness, wide learning and entertaining method. Our social functions, by way of collation and interchange of thought, are of a high order, promote good fellowship and cement more solidly the ties of professional friendship.

These elements of success would seem sufficient to insure a solidity which could not be undermined by either internal dissension or external foes. We lack the element of enthusiasm, an esprit de corps, which believes more thoroughly in the great objects of our Association and shows its belief by its works. We

need to believe that our Association is the best of its kind and translate that belief into practical energy for its rapid and substantial advancement. We need electric forces which will set our tongues in judicious motion whenever we come in contact with persons whose favor we wish to acquire. We are an exalted community and we need to proclaim reliable reasons for our exaltation. Enthusiasm, like some diseases, is contagious. We catch it, each from the other. Its effect upon human conduct is clearly illustrated by the gallant soldier who follows up San Juan Hill his victory-shouting leader and the old flag or storms the fortress on the rocky heights of Chapultepec. So the Erie County Medical Association, thoroughly imbued with an enthusiastic spirit, will become invincible against all opposition and will win a foremost position among the medical societies of the State and nation.

We need an *ideal* physician to whom we can look as our example and guide. Although the ideal physician is a theme which has frequently received the attention of eloquent tongues and pens, its consideration may be occasionally repeated with profit for the winning of our profession to a higher standard of excellence and the merit of a more honorable name.

The ideal in tangible form does not exist; it is a creation of the imagination. Hence the writer cannot draw his picture of the ideal physician from real life. Each physician may be climbing toward his own ideal, but he never reaches it. Like the ignis fatuus, his ideal, as he approaches it, constantly recedes from the position which it seemingly occupies.

Turning his camera toward his imagination the writer beholds a photograph of which he will attempt an outline. The picture is composite, constructed from characteristics which the imagining eye has seen developed here and there in the greater luminaries of the medical profession.

Intelligence.—The ideal physician has a superior intelligence.

The interdependence and interrelation of the various systems of the human mind and body demand for the solution of the problems which are involved in the cause and effect of their functions an unusually keen and incisive intellect. Intricacies and complications arising from the constitutional and functional derangements of the physical organs can be unraveled only by extraordinary intelligence. The mysteries which still environ the "human form divine" are not surpassed by any of the unsolvable riddles in the universe. Stupidity has no part in the idealistic conception of the physician's intellectual construction. His mind is alert, diligent, comprehensive, thorough.

Education.—However broad, deep and high may be the intellectual capacity, it needs to be *trained* for the attainment of its highest and best

work. In vain will the mighty arm draw the bow at random; its muscles must be exercised in precision and intensity, else the arrowy shaft will not reach its mark. The far-penetrating eye must learn intentness and patience ere it can discover the animalcule and the wandering star. Education, according to the derivative signification of the word, draws forth the latent mental energies; it also prepares them for logical thinking and the physical forces for skilful doing.

It is a matter for congratulation that during the last quarter of a century the opinion of the medical profession of this country has favored the higher education of the physician and that the plans and work inaugurated for its accomplishment have been productive of such excellent results. Our own State has been a leader in this great and good work and to-day stands in the front rank of States that have been directing their laws toward the attainment of broader and deeper qualifications for the medical profession.

The *ideal* medical education will not be reached until farther advancement has been made along the same lines as in the past.

The day has disappeared for educating the physician to be a mere artisan and a dispenser of a few coarse drugs. The knowledge of the ideal physician is based on scientific facts and his art accords with genuine science. He acquaints himself with the historical life of the human race, with the mysteries that envelop the physical, psychological and spiritual nature of man; he explores the whole realm of nature for material with which to supply his armamentarium; in short, the ideal physician cultivates the fields of both nature and art for the fruit which he needs for use in the work to which he has consecrated his life. His professional obligation demands that he be not only a practitioner, but a student.

The ideal physician possesses a heart sufficiently sympathetic to appreciate the sufferings of weak human nature and large enough to prompt him to labor unceasingly for their alleviation.

The ideal physician is a refined and cultivated gentleman. The coarse and intolerant manners of the boor form no part of his mental or physical composition. The graces of kindness and politeness are shown in all his movements.

The ideal physician has not an itching palm for filthy lucre. He is entitled to a just reward for his unremitting services. It is his right to accumulate a competence for the decline of life, when "the grasshopper shall be a burden"; but without an intense regard for the almighty dollar it is his first duty to cure his patient.

The ideal physician recognizes that he is a citizen, as well as a physician. He is interested in the civic welfare of the community in which he resides and is willing to bear his share of the burdens that are inevitably connected with citizenship.

Especially does he take a keen interest in civic sanitation and advocates those measures which will inure to the advancement of preventive medicine. He is a promoter of all plans that tend to lift the human being to a broad plane of civilization.

Both by precept and example he shows his love for a high standard of morality. He trains his physical and mental nature for the highest utility by a moderate use of all good things and the exclusion of all things that are injurious.

Time would fail to enumerate all the mental acquirements and moral virtues that inhere in the natural and acquired character of the ideal physician. His nobility cannot be described by biographer's pen, nor pictured by artist's brush, nor expressed in sculptor's marble. He belongs to a royal family higher than that of any of the sovereigns of earth. His soul is akin to that of the ideal Master who spent his life in going about and doing good.

Each of us needs this ideal physician within himself, that we may preserve our bodies free from spot or blemish, that we may store our minds with the most useful knowledge, that with promptness and skill we may relieve the sufferings of humanity, that we may cultivate to the highest degree attainable our moral and spiritual nature, that we may exhibit the virtues and amenities of the good, the beautiful and the true. Thus may we drink deep of the cup of happiness and be prepared for a self-sacrificing service to our fellow men which is the high privilege and joyous duty of the ideal physician.

THE SIGNIFICANCE OF OXALURIA.*

BY J. BERGEN OGDEN, M.D.,
New York City.

OXALIC ACID may be regarded as a normal constituent of the urine. It is, however, present in very small amount, the quantity usually not exceeding 0.02 gram in twenty-four hours. This acid exists in the urine in combination with calcium—calcium oxalate—which, under ordinary circumstances, is held in solution by another normal urinary constituent, *i. e.*, monosodic acid phosphate. Whenever the production of calcium oxalate is excessive the monosodic acid phosphate becomes insufficient to hold the oxalate in solution, the crystals separate, and are found in the urinary sediment.

The term oxaluria is used to signify the presence of crystals of calcium oxalate in the urine. As the term is commonly applied, it may mean that the crystals are present temporarily or that their presence is persistent. Properly speaking, the term should be employed only to those cases in which the crystals are present for a considerable period, for, as we shall see later, oxalate crystals may suddenly appear and as quickly disappear from the urine of any healthy individual who is living on the average mixed diet. The number

*A paper read before the New York State Medical Association, New York County, January 19, 1903.

of crystals found in the sediment may be large or small, depending upon circumstances. It should, however, be borne in mind that a few large primary crystals may be of far greater importance than a large number of the small, secondary forms. The continued presence of the crystals always shows an overproduction of calcium oxalate, which in turn usually indicates some pathological condition that is acting as a cause.

CAUSES OF OXALURIA.

One important cause of an oxaluria is excessive fermentation in the gastro-intestinal tract. Dr. Helen Baldwin¹ produced experimentally in dogs a pronounced oxaluria by feeding the animals on meat and large quantities of cane sugar or glucose. These substances were given until a marked degree of gastric and intestinal fermentation was produced; indeed, in some instances a distinct gastritis was induced. We know that meat contains only an infinitesimal amount of oxalic acid and that cane sugar and glucose contain none; therefore, the oxaluria that was produced by the ingestion of these articles of food must have been brought about by other conditions. Dr. Baldwin noticed that the crystals of calcium oxalate were most abundant in the urine when there were distinct indications of an acute or subacute gastritis.

These experiments have proved highly instructive and important. Up to the time that Dr. Baldwin published the results of her research we were without a satisfactory explanation of the cause of oxaluria in many cases, and the treatment of such cases was consequently attended with unsatisfactory results. Although Dr. Baldwin has clearly demonstrated that a marked oxaluria may result from the excessive fermentation produced by the ingestion of meat and large amounts of carbohydrates, we have yet to learn whether or not the proteid element is essential for the production of gastro-intestinal fermentation, and if so to what degree; also whether these fermentative changes and the consequent oxaluria can be brought about by the ingestion of carbohydrates alone. We still have no knowledge of the fungus or organism, if there be one, that appears to cause the undue formation of oxalic acid during fermentation. There is practically no doubt that a permanent diminution or an absence of hydrochloric acid in the contents of the stomach favors and is, perhaps, necessary for the development of this fermentative oxaluria.

There is still another cause of oxaluria which must be constantly borne in mind, *i. e.*, articles of food containing oxalic acid. Some of these substances are sorrel, rhubarb, tomatoes, asparagus, spinach, onions, cabbage and some of the varieties of grapes and apples. Baroux² claims that when fresh fruits containing citric acid are

taken with some of the above-mentioned vegetables, oxalic acid is set free. He has reported nine cases, in one of whom, a young man, pain and an acute gastro-enteritis followed a meal which consisted partly of spinach and cherries. In two children the same symptoms resulted from the ingestion of spinach and oranges. We find no accurate record of the urinary findings in his cases. While the claim of Dr. Baroux concerning the chemical processes taking place in the stomach under such circumstances is largely conjecture, we know that oxalic acid is in many instances set free, but how and in what manner we have yet to learn.

Rhubarb and asparagus probably constitute the chief causes of oxaluria from the food. Since oxalic acid is the principal acid of rhubarb, we can readily appreciate the amount of harm that may result from the custom of taking stewed rhubarb and rhubarb pie. Sorrel is, fortunately, little used, while the tomato, the apple, the grape and the onion contain only minute amounts of the acid. If food rich in oxalic acid is taken only rarely and in small amounts, the resulting temporary oxaluria will probably very quickly disappear and be productive of little or no harm. But the dietetic element is no less important, especially in those individuals who are already afflicted with an overproduction of oxalic acid.

It is highly probable that many of the instances of oxalates in the urine are due both to the oxalic acid preformed in the food and to their formation by intestinal putrefaction or fermentation. If, after removing all oxalic-acid-containing substances from the food, the oxaluria persists, we can be fairly certain that the cause lies in the digestive tract.

INDOXYL-POTASSIUM SULPHATE AND OXALURIA.

Indoxyl, also sometimes called "Indican," is a normal urinary constituent, and exists in the urine as an ethereal or conjugate sulphate—indoxyl-potassium sulphate. It appears to be formed by the oxidation and absorption of indol, which, in turn, is a normal constituent of the intestine and a product of the natural (or normal) intestinal putrefaction. If this putrefaction or fermentation is abnormally great, the indol is produced in unusually large quantity and the output of the indoxyl sulphate is correspondingly large. The tests for indoxyl in the urine are, therefore, an index of the amount of fermentation taking place in the intestine. An important fact is that a well-marked oxaluria is almost always accompanied by an increased amount of indoxyl, showing that there is a more or less intimate relation between them and that they probably have a common cause.

CHARACTER OF THE CRYSTALS OF CALCIUM OXALATE.

Calcium oxalate crystallizes from the urine in two typical forms—the octahedral and the dumb-bell crystals. There are, however, various modifications of these two forms, according to the

¹An Experimental Study of Oxaluria, with Special Reference to Its Fermentative Origin. The Journal of Experimental Medicine, October, 1900.

²Journal des Sciences de Lille.

positions of the crystals. You are all perfectly familiar with the octahedral or so-called "envelope" crystal which is made up of two four-sided pyramids placed base to base, and when viewed from the side their characteristic appearance is that of a square crossed obliquely by two bright lines, presenting the resemblance to a sealed square envelope. Frequently these octahedra coalesce in such a way as to have the appearance of an open umbrella, constituting the so-called "umbrella" crystal. Sometimes each half of the octahedron is connected by a short quadrilateral prism and such have been termed "prismatic" crystals of calcium oxalate.

The dumb-bell and oval crystals are more rarely found in the urinary sediment than the octahedral forms. The dumb-bell crystals are always associated with the oval or circular forms which have bright centers, showing their biconcavity. Frequently two dumb-bells are found crossed at their centers, forming a double dumb-bell crystal.

Since calcium oxalate crystals may be found in either an acid or an alkaline urine, the colorless dumb-bell crystals should in all instances be distinguished from the yellowish-red or brown dumb-bells of uric acid and of acid ammonium urate, and the octahedral forms should not be mistaken for the ammonio-magnesium or triple phosphate crystals found in the sediment of an alkaline urine. These various forms of crystals are usually readily distinguished by their microscopic appearance and the accompanying elements, or by chemical tests.

PRIMARY AND SECONDARY CRYSTALS.

From a clinical point of view it is important that a distinction be made between those crystals that are likely to produce mechanical disturbances in the urinary tract and those that are harmless. Two classes of crystals are, therefore, generally capable of recognition, *i. e.*, the primary and the secondary. Primary crystals are those that have separated from the urine inside the body; they usually consist of the large octahedral and most of the oval and dumb-bell forms. Secondary crystals are those that have separated after the urine has left the body; they are usually the very small octahedral forms and perhaps a few of the very small oval, circular and dumb-bell crystals. These secondary crystals are most commonly found in a urine that has been allowed to stand for some time. They generally separate from a urine that is highly charged with calcium oxalate.

MECHANICAL ACTION OF THE CRYSTALS.

The primary crystals of calcium oxalate often produce a more or less marked irritation of the urinary tract, especially if they separate from the urine in the kidney itself or in the renal pelvis; the mechanical action is usually much less severe if the crystals separate in the bladder. Blood globules are the chief accompaniment of the oxalate crystals in the sediment, and there

may even be abundant hemorrhage. If the kidney is the seat of an acute irritation, renal casts with adherent blood globules, and sometimes with calcium oxalate crystals imbedded, will be found; if the renal pelvis is involved, the small caudate cells which are more or less characteristic of the superficial layer of the pelvis of the kidney will be found accompanying the blood and the crystals; and if the bladder is the seat of the mechanical disturbance, the large squamous cells and the round dense cells from the neck of the bladder will usually serve to locate the source of the blood. Such severe mechanical irritation is usually accompanied by pain, often frequent and painful micturition and by a more or less concentrated urine. If the separation of these primary crystals continues for some time, the tendency to a calculus formation in the pelvis of the kidney or the bladder is, of course, very great and especially in those cases in which there is or has been considerable hemorrhage.

OXALURIA AND DIABETES MELLITUS.

There appears to be a rather close relation between diabetes mellitus and an oxaluria. This is usually seen in two classes of cases: (1) those in which the diabetic patient is allowed to take such articles of food as he likes, and who, on account of his craving for sugars and starches, subsists largely on carbohydrates; and (2) those in which the food is restricted almost entirely to a meat diet. It seems to the writer that the explanation of the oxaluria in such cases is the gastro-intestinal fermentation which results from either the excessive carbohydrate diet or the abundant ingestion of meat—a nitrogenous diet.

Not infrequently a marked oxaluria is an accompaniment of nervous disorders, especially those attended with mental depression, a subacute or chronic prostatitis, and diseases of the heart and lungs. I am unable to give you any plausible explanation of what appears to be an excessive formation of oxalic acid in these cases. In some instances the food or the intestinal digestion may be at fault, but there often appear to be other unknown causal factors. It has been claimed by some that under pathological conditions oxalic acid circulates as such in the blood, and, on account of its poisonous action, causes a certain train of symptoms, of which nervous phenomena are especially prominent. This theory appears, however, to be untenable. We have no satisfactory proof that oxalic acid ever circulates as such in the blood, or that the nervous symptoms are the result of the direct or indirect action of the acid or of calcium oxalate. In diseases of the heart and lungs the accompanying oxaluria has been ascribed to definite oxidation. This theory is based on the belief that oxalic acid may exist in the body as an intermediate product between uric acid and urea, and that it is formed as the result of incomplete oxidation. This explanation may be, to some extent, true, but further investigation is necessary to prove that an oxaluria actually has such a cause.

THE PROGNOSTIC SIGNIFICANCE OF ALBUMIN IN THE URINE.

BY EDWARD W. LAMBERT, M.D.,
New York.

IS it possible to make a differential prognosis when albumin is found in persons apparently healthy?

Injudicious living is the cause of most of the bodily ills from which we suffer, and is also that which induces unduly early degeneration in the majority of cases met with by medical men. Injudicious living I mean to be taken in the broadest sense. It includes the excessive wear and tear of an active business life, the nervous strain and worry necessary in the mad rush to become rich; the incessant drain upon one's vitality by the daily excesses in eating, the abuse of alcohol and tobacco, and the excesses common to those who have never learned the art of self-control. In such cases, sooner or later, largely dependent upon the inborn vitality of the individual, occur changes in the minute tissues of the bodily organs. The organ which ordinarily gives the first hint of this commencing degeneration is the kidney. It would be a waste of time to describe either its minute anatomy or functions. We all know it is the most important excretory organ, and that perfect peace reigns when its functions are normal. One of the first symptoms the kidney gives that something has gone wrong in the complex mechanism and functions of the body is the passing of albumin with the urine, more or less abundantly. In my judgment no healthy individual has this substance in the urine, and its presence is a sure indication that something is out of gear somewhere in the functions of the body. On finding this albumin must we infer that the individual is doomed to an unduly early death or that he necessarily has any organic disease? By no manner of means, as the kidney is so sensitive to temporary disorders, so sure to carry off every abnormal product found in the blood, that it often suffers from temporary disability, quickly rallying when the offending substance has been eliminated. Again, when sudden excessive heat or cold prevails, and the nerve centers are temporarily depressed, the kidney feels the lack of its proper nerve supply, allows albumin to pass through, coming back to its normal function without permanent damage as soon as the excessive temperature ceases. It is not necessary to consider the many causes of albuminuria, known and suspected, because their name is legion, and you know well enough that most causes are temporary in character, doing no apparent injury unless the cause is continued long enough or is frequent enough to start tissue changes in the structure of the kidney and producing in time a fatal termination.

With this introduction this paper has been written from the point of view of a life insurance examiner, to see if any information can be given by which one can judge in any given case whether the albuminuria is due to temporary con-

ditions or is the beginning of a degeneration of the kidney tissues, necessarily fatal. In other words, is it possible to differentiate in regard to prognosis in apparently healthy persons between temporary albuminuria and that which means such tissue changes as must necessarily seriously interfere with the expected longevity of the individual? Please remember that an applicant for life insurance is not knocking at our door for treatment. He presents himself as a presumably healthy person. He is surprised, annoyed, often angered, sometimes frightened, when informed that anything is wrong. The medical man is abused, called a crank, narrow-minded and a fool, with strong adjectives prefixed to the fool. If a rejected man happens to live ten years the case is quoted, brought up as illustrating the absurd rulings of the doctor, the accuser forgetting the many apparently similar cases which have proved fatal in the meantime. Our learned Professor Osler wrote a very interesting article in 1901, showing how some men have been rejected by prominent life insurance companies were still living and in good health after many years, and emphasizing the importance of basing a judgment less on the urine than on the general condition of the applicant. Then he goes on to show very clearly that men living a most injudicious life are rejected, but being disturbed by the rejection consult their family physician, receive most excellent advice and live many years in excellent health. This is a good criticism, but the Professor must remember that the men did not change their injudicious living until the life insurance doctor had refused them, and their wise decision followed the rejection. The medical examiner cannot assume that any man having lived a reckless life for thirty or forty years is going to suddenly change to a sober, temperate one. Unfortunately, my personal experience has been that men of 40, 50 or 60 years, who have never exercised self-control in regard to their animal desires, do not change suddenly and become models of virtue. They may be frightened for a short time, try reformation, but the tendency is to return to their former habits. The Professor ends his article with this true statement: "That a trace of albumin and a few tube casts are danger signals, the red lights of danger, which may mean an open drawbridge or a wrecked road-bed ahead, and may be simple warnings for the engineer to go slow."

I can best illustrate my opinion on this subject by giving a few leaves from my experience during the past forty years.

From 1868, when I began regularly to test for albumin, until 1888, during which time I was daily engaged in making personal examinations, persons declined for albuminuria died within twelve months after their rejection, saving in losses to the company each year sufficient to pay the entire expenses of the medical department in New York City.

Let us look at the different varieties of albuminuria. First the so-called physiological albuminuria. Two partners came in for examination, both hearty, fine-looking specimens of physical vigor. Albumin was the only blemish in either case. Number one had such a faint trace that after repeated tests Dr. Edward Curtis and I thought it must be a case of the much-talked-of physiological albuminuria. The man died in eighteen months of Bright's disease. Case number two had excessive albuminuria, was rejected, but lived many years until I lost track of him. Our faith in this kind of albuminuria was badly shaken.

Secondly, let us consider the so-called cyclic or intermittent albuminuria. That such a condition is quite common is beyond dispute. A gentleman whom I had accepted a few years before came into the office one afternoon to take the largest policy the company then issued. He was a personal friend and a fine specimen of a healthy man. To my disgust and his very great annoyance I found distinct traces of albumin. He went uptown to see his family physician and was told to bring a morning specimen for examination. Nothing was found and on his way to his office he came to see me about 11 o'clock, and I could find nothing abnormal. At my request he called again about 3 P. M., with the result of albumin being distinctly present. I watched him for weeks and could always find albumin after 12 noon, but never before that hour. The man was taken by other companies and I was severely criticized. I received a long scientific explanation from an uptown expert that there was no kidney disease. The man died five years later of serous apoplexy due to disease of the kidney, the death certificate being signed by my learned uptown expert, who stated in his death certificate that the disease had lasted to his knowledge five years. On the other hand, many have come before me presenting albumin in the urine so evidently due to temporary causes that a favorable judgment was given, the parties living many years in the best of health. Tests made at our office upon members of the medical staff show that few men pass six months without occasionally having albumin and tube casts in their urine. Cases can be given in abundance illustrating the dangers of albuminuria, but enough has been said to demonstrate the difficulties presented to the medical examiner when called upon to make a differential prognosis in albuminuria. The amount of albumin found gives no necessary evidence of possible future danger.

Thirdly, let us take up the albumin of adolescence occurring in young persons between the ages of 17 and 30. These cases cause less worry to the medical man, as most are temporary and the prognosis is good. The physical condition and the mode of daily life are more important factors in young subjects than the albuminuria.

In the past few years we have brought the microscope to aid us in forming a prognosis, with

the result that it is confusion worse confounded. Hyaline casts abound, granular casts are not infrequent in urine free from albumin. The older the individual the more frequently do we find the various kinds of tube casts. In young subjects of both sexes having albuminous urine, the microscope often shows hyaloid bodies, usually club shaped at one end and tapering at the other, striated, somewhat larger than a tube cast, which have attached to their larger extremity a cluster of highly refractive, mononuclear, epithelial cells, about twice the size of a leucocyte. These cells, as a rule, show no granulation of the protoplasm. They are usually joined together at their smaller extremities, thus radiating from a common center. The albumin in these cases is usually transient, often disappearing in twenty-four hours. Ninety per cent. of these cases are 30 years and under, and it is extremely rare to find them in persons over 40.

What is the practical result to be drawn from this condition of the kidneys, and what is the prognosis in each case? The amount of the albumin gives no indication of the future result.

The presence of tube casts of any variety does not necessarily mean permanently diseased kidneys, as the casts are found too often in persons otherwise healthy. The most important factor, and one too often neglected, is the daily manner of the life of any individual. The worry necessary to the carrying out of large financial schemes, the habit of having too many financial operations going on at the same time, the excessive use of food highly seasoned, of great variety and containing too much nitrogen; the abuse of alcohol and tobacco, the excessive yielding to the other animal appetites, give as a natural sequence the loss of nature's best restorer, sleep. From my experience and point of view it would seem that the prognosis depends more upon the daily mode of life than upon the findings in the urine.

DISCUSSION.

BY BRANDRETH SYMONDS.

There are a few points with regard to the prognosis of albuminuria from a life insurance standpoint that I think need emphasizing.

1st. The importance of making a differential diagnosis between the various forms of albumin that occur in the urine is very necessary. The presence of nucleo-proteid, or nucleo-albumin, has not yet been fully appreciated by the profession. This proteid reacts with all the albumin tests that contain an organic acid. It will even react with heat when the urine is decidedly acid. In fact, the only test in which no confusion arises is the old-fashioned contact test with nitric acid, the so-called Heller's test. Although this is not very delicate, it is absolutely reliable, and if allowed to stand for fifteen or twenty minutes, it becomes nearly as delicate as the other tests. I have no doubt that a great many cases of albuminuria are really cases in which this nucleo-

proteid, or nucleo-albumin, is present, and not serum albumin, or paraglobulin. For clinical and for life insurance purposes it is necessary to differentiate this nucleo-proteid from these true albumins, for until we do so we will confound the two sets of cases which undoubtedly have very different prognoses.

2d. As to the clinical significance of nucleo-proteid, we know but little. In my own experience I came to the conclusion that it was not usually of any serious import, being due usually to some local congestion or subacute inflammation of the urinary tract. Certainly, the presence of a small amount of nucleo-proteid in a man otherwise healthy I should regard as of no clinical significance. On the other hand, I must acknowledge that the largest amount of nucleo-proteid that I have ever seen in urine occurred in two cases of puerperal toxemia, who nearly went to the eclamptic stage. Both cases required premature delivery to prevent the development of this condition. I think that you gentlemen who are doing active clinical work have a large field here for investigation which deserves a most careful clinical study. Unfortunately, I am out of that field now, and even make but few examinations, but the condition is one that merits a very careful and thorough investigation. Certainly, if there is a large amount of nucleo-proteid in the urine, I should look upon the case with suspicion, even though the applicant was otherwise well.

3d. As regards the clinical significance of true albuminuria, I think that all albuminurics should be suspected persons as long as they have albumin. The condition is not a physiological one, although some of the profession have attached that name to it. Undoubtedly many of the cases of albuminuria are transient, due to various causes of a temporary nature, and disappear after a limited time, leaving the individual in as good health as before the attack. But I do not think it would be right to call such cases physiological any more than you can call acute bronchitis physiological. Furthermore, we have no means of differentiating between these transient cases and the cases of a more serious moment until the albumin itself disappears from the urine. I suppose the most difficult cases are those in which the individual otherwise healthy, capable of doing good, solid work, shows consistently and persistently for years a trace of albumin. These are the cases which embarrass the medical examiner and the medical director, and cause him a great deal of anxiety.

An experience of my own will serve to show you the difficulty one case of this kind will cause. The applicant was a man well known as the treasurer of the Bryan campaign, and was the only banker of note in the East who affiliated with that party.

In 1875 he was examined for insurance, and was accepted, passing a clean examination at that time. In 1878 he was again examined for additional insurance, and at that time a small

amount of albumin was found in the urine. He was examined several times between 1880 and 1890, and his urine was always found to contain albumin. About 1890 I became acquainted with him, and obtained a specimen of his urine, which contained a trace of albumin. I also had a letter from his attending physician, a man of repute, who said that during the ten or twelve years that this banker had been under his observation, he had found his urine to contain albumin whenever he examined it. At times it was hardly perceptible; at times there was a little more.

In 1893 I examined him again, and still found albumin. During all these years the man performed the arduous duties of a bank president, and was apparently in good health. His attending physician stated that he was a man who was quite free from ordinary ailments, excepting occasional indigestion, and outside of the albuminuria, he would regard him as a perfectly sound man.

In 1897 this gentleman died of cerebral apoplexy, after an illness of a few hours, but his death certificate stated that he had had Bright's disease for the preceding five years.

In this party the albumin was first noticed in 1878, when he was 29 years old. He lived nineteen years, and the urinary condition was finally the cause of his death. His expectation of life at age 29 was about 36 years, so that he only lived a little more than one-half of his expectation. A life insurance company, therefore, would have lost money on such a case, although the duration of it was nineteen years. Furthermore, his freedom from serious illness during these twenty years was undoubtedly a factor in his long life, for it is evident that any acute illness occurring during that time would have been of a more serious prognosis to him than to a perfectly sound man.

I must agree with Dr. Lambert's well-known views in regard to albuminuria, that they are all unsound risks as long as the albuminuria lasts; that in many of them, especially those cases which are under 40 years of age, the albumin is only a transient affair, but for purpose of life insurance we cannot differentiate between these and the more permanent conditions in which the prognosis is much graver.

MEDICAL ETHICS UPHELD.

Under this heading the *New York Evening Post* reports a decision of the Appellate Division of the Supreme Court, written by Justice McLaughlin, in which a new trial is ordered on the ground that evidence was admitted which consisted of "a disclosure of information which the physician had acquired in attending the deceased in his professional capacity."

Section 834 of the Code of Civil Procedure states that a person duly authorized to practice medicine or surgery "shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity."

THE SYMPTOMATOLOGY OF COLDS.*

BY GEO. F. COTT, M.D.,

Buffalo, N. Y.

THE title allotted to me is somewhat obscure, since the symptomatology of colds may cover any part of the body or any organ separately. I think the meaning was to apply to that part only of the anatomy to which we refer when we say we have taken cold. The symptomatology of this condition, as commonly understood, is laid down in every text-book and needs no repetition here. Symptomatology, however, as applied by patients, is far different. The patient's idea of a cold and that of his physician are two vastly different things. The symptomatology to the different patients is something like this: "I have a cold; nose has felt stuffy for several days. When I lie on my side one or the other side of my nose is closed. If I reverse the position the upper cavity opens and the lower one closes. It is very annoying. My nose runs all the time. I use six or seven handkerchiefs a day. Every time the weather becomes damp my nose discharges freely and I catch cold in my head"; or, "Ever since I had the grip several years ago I have a continued cold and my nose discharges thick mucus"; or, "I come from a rheumatic family and am the subject of cold in my head four or five times a year, always finishing up by causing inflammation of my throat." The atrophic subject has cold all the time and does not know where he gets it; nose running profusely whenever the weather changes, and later large crusts come away. Those having polypi will complain: "My head is clogged up most of the time; during fall weather I am all stuffed up." The patient with a large tonsil of the tongue says: "Every time I sing a while my voice gets husky, or tired, or weak, or I feel something in there, or I catch cold so easily that I remain indoors most of the time." The patient with sluggish turbinates says: "I have a cold all the time; several times the doctor removed large pieces of flesh from my nose, but in a few weeks it was as bad as ever; my nose only runs occasionally, but is always closed up." The neurotic has all the most horrible symptoms one can imagine, principally among them being cancer and consumption, although the throat is but irregularly congested which seldom lasts more than a few days, when some other ailment claims the patient's attention. The catarrhal deaf will invariably give you a history of catching cold easily, which makes them more deaf during the time the cold lasts—in fact, giving no other symptom than hearing somewhat worse during the supposed cold—which in reality is but a slight exacerbation of the constantly existing condition. Those are a few of the conditions coming within the patient's symptomology of colds.

In our present state of knowledge the term "cold" has been discarded entirely from the nomenclature as meaning nothing and expressing nothing. Still the condition exists and calls at times for very energetic treatment; but a cold may be the result of many pathological conditions. That condition which the patient calls a cold is but an occasional symptom accompanying different pathological changes in the mucous membrane, which causes it to become easily influenced by change in temperature and humidity; the constitutional causes—such as rheumatism, syphilis, gout, Bright's disease, lithemia, intestinal toxemia, tuberculosis, struma, anemia, etc.—predispose to cold, but the local condition is simply that of the general constitution, only manifested in its weakest and most exposed part. Vegetation in the nasopharynx influences nutrition throughout the body and gives forcible notice of its existence by producing a more or less constant cold, again affecting the weakest and most exposed part. Aside from all these enumerated causes, we are called upon to treat colds locally more often than constitutionally.

The symptoms here are subjective and objective. The subjective symptoms vary considerably, from a slight stuffiness of the nose, profuse watery discharge, rhinopharyngitis and laryngitis to bronchitis. The objective symptoms, on the other hand, may show a slight reddening of the nasal mucosa, soft or hard hypertrophy, complete occlusion of nasal chambers, follicles in the pharynx prominent, tonsillar tissue elevated, larynx congested, extending down to the trachea and even the bronchi, the extent of this congestion and inflammation depending upon two factors, either body habit or dyscrasia.

A perfectly healthy body, under ordinary circumstances, does not take cold, while others again in certain parts of the country and under certain conditions take nothing else.

Therefore, a cold, according to the laity, is some sudden and radical change in the functions of the mucous membrane of the nose, nasopharynx, larynx and bronchi, manifested in a variety of symptoms, while to the physician a cold always means a condition depending upon some other cause and never of primary origin. Remove or improve the other cause and your patient will be free from colds in whatever climate and under all reasonable conditions.

THE TREATMENT OF COLDS.

BY A. ALEXANDER SMITH, M.D.,
of New York.

I DO not know exactly what is meant by the familiar term "a cold." It will be necessary for me, in order to keep within my limit of time, to put also a limit upon what I feel will be the limited application of the term "cold." One can hardly accept the interpretation of the

*Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

laity, who are inclined to attribute everything to "a cold." I, therefore, restrict my remarks on the treatment of cold to that which is ordinarily recognized by the symptoms which accompany a stuffing up of the mucous membrane of the nose and the adjacent mucous membrane of the throat, and shall not go below the upper air passages.

First, a word about prophylaxis. I am thoroughly in accord with the feeling that cold bathing of the upper extremities, in many cases, even including the head, is a certain amount of protection against what we call "catching cold." I am a believer in the view that many so-called colds in the head are communicable. I need not advance any arguments to prove this; clinical observation would seem to emphasize the fact. Consequently, isolation may be a prevention. I do not believe that all cases of cold in the head are due to an infectious organism, the results of whose activity can be communicated. Among those who are prone to the so-called contraction of colds, I am sure both adults and children are protected against them by the pretty constant use of cod liver oil. I refer particularly, of course, to those who have a low power of resistance. I have found, also, that in those who are subject to disturbance of digestion, particularly if this depends upon some diathesis, such as lithemia, for example, the timely treatment of such diathesis will often prevent what seems to be a marked susceptibility to the development of colds. I am quite confident that in many instances fatigue and anxiety diminish the resistance or, at least, increase the susceptibility to colds.

The first thing I do, when asked to prescribe for a cold, is to ascertain if there is an elevation of the body temperature. If this is 100 degrees Fahrenheit or over, I insist upon the patient remaining at home, and, better still, in bed. This may be for only two or three days. In the end the patient will save time by so doing, and be much more comfortable. I am very sure that the traditional and orthodox and long-time recognized use of opium and quinine at night, with a cathartic in the morning, often yields good results; not the large doses of quinine, however, that were given years ago, but, say, five grains of quinine and ten grains of Dover's powder or Tulley's powder, taken at night, and possibly also a hot drink and a hot mustard foot-bath. In the morning a saline cathartic or an active cathartic pill should be taken. This should be followed by a pill of quinine, two grains, three times a day. Frequently no further treatment will be necessary. The almost universal habit of giving a cathartic at the beginning of a cold is to be commended. Just here let me say that it is often difficult not to make too much of a cold, and, on the other hand, not to fail to recognize its possible gravity.

Some years ago a tablet, known as "Rhinitis Tablet," was brought to the attention of the profession as a valuable agent in the treatment of

catarrhal colds. This tablet consists of quinine, camphor and belladonna. In connection with this I would say that if these tablets can be taken during the first six hours—a half-strength tablet every hour for six doses, and then once every three hours until six more have been taken—the cold will often be thoroughly broken up. My own experience with these tablets is that if taken sufficiently early a certain proportion of catarrhal colds can be very much lessened in their severity, but after such a cold has existed for twenty-four hours I prefer to use some other agent.

In many patients the susceptibility to belladonna are such as to quickly produce the physiological effects, which are unpleasant; yet to get the benefit from these tablets it is necessary to produce at least slight physiological effects of the belladonna.

Another method of treatment which I have found exceedingly satisfactory is the alkaline treatment. This consists in administering, just as early as possible, a drachm of bicarbonate of soda in half a glass of water, and repeating the dose in one hour. The dose can be made much less disagreeable by adding a very few drops of lemon juice. If, after twenty-four hours, the cold does not seem to be decidedly better, this alkaline dose should be repeated.

My own impression is that the alkaline treatment has its limitations. In those of the so-called acid or lithemic diathesis I believe it is exceedingly valuable, but this treatment does not always accomplish the good results desired in those who are not of this diathesis. The salicyl compounds are often useful. The dose of sodium salicylate should be ten grains, repeated in an hour, and afterward given in doses of five grains at intervals of four or six hours, if well borne by the stomach. The other salicyl compounds are useful; I have only named the salicylate of sodium as a type. They are indicated in the same class of cases as the alkalies.

For a long time camphor has had a reputation, when given internally, and also when the fumes are inhaled, as a remedy for colds. I have seen cases in which a few drops of spirits of camphor, taken on sugar every hour or two, has given a great deal of relief, and the inhalation of the fumes of spirits of camphor often gives great comfort.

Since the introduction of the coal-tar preparations they have achieved quite a reputation in the treatment of colds. A combination of one of the coal-tar preparations, preferably of phenacetin or acetanilid in small doses, with quinine, often proves very beneficial in my hands for treating colds. These drugs are particularly useful when the skin is dry and hot, and there is unusual stuffiness in the nose, associated with muscular pains and headache. My objection to them is that while they seem to reduce the severity of the cold, they prolong convalescence if continued.

It is hardly necessary, perhaps, for me to say that the majority of simple catarrhal colds need

no treatment except the application of the simplest principles of hygiene.

Among other drugs which have been used in the treatment of colds may be mentioned creosote, guaiacol and ichthyol. In cases of moderate severity, with a tendency to an excess of mucopurulent secretion, I have found great benefit from the creosote preparations. The plan I follow is to give the creosote or guaiacol or ichthyol in rather small doses. A single minim of the beechwood creosote, or its equivalent in guaiacol, or a grain of ichthyol is given every hour for the first day. Usually by the second day it can be taken every second hour.

Carbolic acid has many advocates, and for many years I tried to satisfy myself that it did good in acute catarrhal colds, but I must confess that I have been disappointed with it. In some cases of gastric and intestinal flatulence at the commencement of catarrhal colds, I have felt that carbolic acid relieved the symptoms in a very satisfactory way. Indeed, I consider it of great importance, in any case of catarrhal cold, to give special attention to the digestive system.

In children, the giving of small doses of tincture of aconite will often be found useful. It is easy to take, it produces mild perspiration and often acts admirably. I give it in doses sufficiently small to allow of its repetition every hour. In those under 12 years of age I certainly prefer it to any of the disagreeably tasting preparations.

Baths.—If one is where one can take a Turkish bath or its equivalent, it sometimes acts very beneficially if taken at the very beginning, but I do not think it is of much benefit after a catarrhal cold has run for two or three days. The baths alone will not do much good; they should be used in connection with some such medication as small doses of quinine or the alkalies.

Now, a word as to the resinous preparations—turpentine, terebene and terpin hydrate. In simple catarrhal colds, where the air passages below the vocal cords are not involved, I have found no benefit from these resins. I admit that in the air passages below the vocal cords they are of decided benefit. I call attention to the fact that I have left out of consideration the affections of the air passages below the vocal cords.

Local Applications.—I am no believer in the local treatment of colds. I have tried to satisfy myself that they can be made beneficial in the treatment of these affections. I have used the various powders recommended, and have devised some myself; I have used the various sprays and have applied cocain. While I admit that some sprays give a certain amount of relief, they are, as a rule, in my opinion, of no benefit whatever. I do not use cocain in the treatment of acute catarrhal colds except in those cases in which there is pain under the cheek bone or in the sinuses; then I would make an application of a 2 or 3 per cent. solution of cocain to the mucous membrane of the nose, always with due consideration of the possibility of contracting the cocain habit. In other

cases I have failed to secure any beneficial results from such treatment.

I admit that saline solutions in the way of irrigations often give temporary relief, but I have felt that the aurists are correct in their emphatic denunciation of that treatment as likely to cause inflammation of the Eustachian tube and consequent inflammation of the middle ear.

The tendency to recurrence is noticeable in some cases. Some patients partially recover from a catarrhal cold, then it recurs, and continues to do this. It is apt to be accompanied by a good deal of depression and to result in an advancing anemia. When there is a tendency to such recurrence or to a persistence of a subacute condition, with much annoyance to the patient, I have sometimes observed much benefit from the administration of the tincture of the chloride of iron, for two or three days only, in large doses. I use in such cases twenty minims every two hours, and I find that usually after the second day it produces severe headache and must be discontinued.

Another agent which I have found very beneficial is cod liver oil. In convalescence from a catarrhal cold it is often of the greatest service; it will produce an absolute cure, and will often prevent a recurrence. For those depressed by the influence of a catarrhal cold it is one of the best of tonics. For those who find great difficulty in taking cod liver oil I give quinine in small doses—one grain, three times a day, or else one of the vegetable bitters or sometimes an iron and bitter tonic.

DISCUSSION ON COLDS.

Dr. William H. Thornton, of Buffalo, said, with regard to local applications, that the mistake was often made in applying agents which were irritating. His experience has been that the milder the application the greater the benefit. The object of such treatment was to relieve congestion, and this was best obtained by the use of a weak alkaline spray. It should be applied gently, and two or three minutes should be occupied in its application. This spray should be followed by a very mild oily spray, as, for example, five grains of camphor to the ounce of glymol. Many oily sprays contain too much eucalyptol and thymol, and while they opened up the nostrils very satisfactorily, the reaction often left the patient worse than before. If the patient came with the nostril completely blocked up the application of a weak solution of adrenalin chloride would certainly make the patient grateful. By following this with an oily spray, this pleasant action could be prolonged for several hours.

Dr. W. Freudenthal, of New York, said that he had listened with great interest to the papers just presented, but had been disappointed because he had come to learn what a cold really is, and this question had not been answered. Was it due to the influence of cold upon the system or

was it an infection? Dr. Walsh had taken the stand that all colds were infections. This was not in accordance with his own experience. Formerly everything was called a cold; now the tendency was to call everything an infection. There was no doubt that infections of the air tract were quite frequently observed, but the common cold was nothing else than the effect of a lower temperature upon the human system. If this were not so he would ask how it was that, of a large number of persons attending a place of amusement, one would get rheumatism, another bronchitis and another a cold in the head. Were there different bacteria here to give rise to these different effects? It was nothing more than the effect of the cold air upon the point of least resistance. Nansen and his men when in the Arctic regions did not catch cold, but quickly contracted colds on reaching warmer regions. He was glad that Dr. Walsh had taken up his observations on the dry air of houses. Dr. Freudenthal said that he had made this investigation about ten years ago, and he was glad that it was again receiving attention. He had measured the dryness of the air and had found that often there was only 15 to 18 per cent. of humidity, and the Academy of Medicine was as bad as other houses in this city. A person subjected to this dry air would develop a catarrh which would last perhaps all of the winter. It was not a true cold, but a chronic post-nasal or similar catarrh, which, at times, underwent exacerbations. To overcome the susceptibility to catching cold one should adopt prophylactic measures. Cold baths were not the only thing; the mode of dressing had a great deal to do with it. If we overdress ourselves and our children, as we usually do, we become very susceptible to taking cold.

Dr. Max Einhorn, of New York, said that after considerable exercise one was not so apt to suffer from changes of temperature. A man could safely ride a bicycle though only very slightly clad, because the exercise protected him. Once during the winter he had, himself, been compelled to go through a snowstorm without an overcoat, and had immediately developed rheumatism. He thought Dr. Freudenthal was perfectly right in the position he took about changes of temperature as well as with regard to the prophylactic measures suggested.

Dr. Harry R. Purdy, of New York, believed that, at the beginning of a cold, a diuretic, an antipyretic and a diaphoretic were indicated, but the stomach should not be disturbed. The old remedy, liquor ammoniæ acetatis, would do this, and would cure a cold in about three days.

Dr. T. J. Acker, of Croton, said that prior to taking cold he found that the bowels often became rather sluggish. The best remedy to break up the cold was ten grains of Dover's powder and ten grains of potash with five grains of quinine.

Dr. G. W. Murdock, of Cold Spring, said that nothing had yet been said regarding a remedy

that he had found very valuable, *i. e.*, the fluid extract of gelsemium. It was the one remedy which he especially relied upon in colds. If ten to twenty drops were added to the liquor ammoniæ acetatis the value of the latter would be greatly enhanced. One or two such doses, taken at night, would go a long way toward breaking up a cold. He had had patients send long distances for this remedy.

Dr. J. O. Stranahan, of Oneida County, said that his success in the treatment of colds had depended largely upon the study of individual cases. Some were rheumatic in their tendencies and were benefited by the salicylates, while the anemic subjects would be benefited by iron. His success with gelsemium had been chiefly in children presenting a flushed face and cerebral symptoms.

Dr. A. H. Brownell, of Oneida, said that in the treatment of colds the best way was to treat them before they occurred. If a child had enlarged tonsils or enlarged turbinates, or a severe catarrh, these should be treated, thus diminishing the liability to colds.

Dr. Wey mentioned a special preparation of eucalyptol which he sometimes used and which should be given in doses of a few drops until the ears began to ring.

Dr. Walsh said that he had endeavored to bring out the fact that colds could not be treated *en masse*, but must be treated individually. It was absurd to think of finding a specific for colds any more than for catarrh. The time to treat colds was certainly before their development—in other words, pathological conditions must be removed. We should not consider a person liable to "catarrhal conditions"; this meant nothing to the medical profession. What caused this condition? In a general way, we did not know, but in the individual cases we would determine it. He deplored the use of the word "diathesis." There was no such thing as increasing or decreasing the acidity of the blood. At one time we used to hear of the "hemorrhoidal diathesis," and people were afraid to stop the flux from hemorrhoids. Now we had the rheumatic diathesis and prescribed salicylates. Acute rheumatism was an infectious disease in all probability. Chronic rheumatism was a conglomerate mixture of a lot of diseases about which we did not know much, but they had very little to do with an acid condition of the blood. If it was thought, in the individual case, that there was a so-called rheumatic diathesis, attention to the condition of the stomach would probably produce the desired result.

Dr. Cott said he wished to speak of the common treatment of colds in children. In ninety-nine out of a hundred cases colds in children were due to obstruction of the nasopharynx, and the removal of this obstruction would do away with the colds. When the cold affected the trachea and produced a most harassing cough, it could be almost always relieved by the intertracheal injection of oil containing 5 per cent. of menthol.

INEBRIETY.

The following resolutions were presented and carried by a unanimous vote at the meeting of the American Association for the Study of Inebriety, held in Boston, Mass., December 18th, 1902. They were drawn by Dr. Louis D. Mason, of Brooklyn, N. Y., the president of the association, and a member of the New York State Medical Association:

Resolved, That it is the sense of this association that the indiscriminate sale and use of patent medicines and so-called "cures" for the alcohol and opium habits are not infrequently the cause of the formation as well as the continuance of these habits.

Therefore be it resolved, That this association memorialize the proper authorities not to issue any patent or proprietary right to any one desiring said patent or right for any remedy or medicine or "cure" or any compound whatever containing alcohol, opium, or other narcotic drug in which there is danger of habituation from its use.

Resolved, That all proprietary or patent medicines for which patent is issued have a label

on which are distinctly exhibited the ingredients of said preparation, said label being placed or affixed to the bottle, box or wrapper in which said preparation is dispensed; and furthermore, that a heavy penalty of fine or imprisonment, or both, be imposed upon any one who may manufacture, prepare, buy or sell, or have for sale in stock, all such preparations not duly patented and labeled under conditions specified.

Resolved, That we reaffirm and indorse a resolution passed at a meeting of this society held March 23, 1893, in reference to the licensing and proper inspection of all institutions for the care and treatment of inebriates, morphia habités, or other form of narcomania.

Resolved, That a copy of these resolutions be published in the medical and secular press.

Dr. Mason's address upon the occasion of that meeting is printed in full in the January issue of the *Journal of Inebriety*, under the caption, "Patent and Proprietary Medicines as the Cause of the Alcohol and Opium Habit or Other Forms of Narcomania—With Some Suggestions as to How the Evil May Be Remedied."

Officers of the New York State Medical Association—Continued.

First or Northern District Branch.

President—Jeremiah R. Sturtevant, Theresa.
Treasurer—Edgar H. Douglas, Little Falls.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranaaen.
Treasurer—John Groman.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Gildden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Pierson C. Curtis, Round Lake.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—Thomas Wilson.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Otis H. Bradley.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.
Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.

Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Frank A. Palmer.
Vice-President—Henry J. Allen.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Third or Central District Branch.

President—Chauncey P. Biggs, Ithaca.
Secretary—Franklin J. Kaufmann, 311 W. Genesee street, Syracuse.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberer.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Joseph Burke, 388 Franklin street, Buffalo.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Ornn C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davis.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; J. H. Potter, Grover W. Wende.
Committee on Legislation—Herman E. Hayd, chairman; Edward E. Blaauw.

Fifth or Southern District Branch.

President—Parker Syms, 50 West 47th street, New York.
Vice-President—Charles E. Townsend, 231 Liberty street, Newburg.
Secretary—Charles S. Payne, Liberty.
Treasurer—Edmund L. Cocks, 156 West 119th street, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.
Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.
Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.
Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.
Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.
Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr.; William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.
Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.
Secretary—Ogden C. Ludlow, 234 West 135th street, New York.
Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.
Treasurer—Charles Ellery Denison, 68 West 71st street.
Executive Committee—Frederick Holme Wiggins (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).
Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.
Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.
Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

Committee on Public Health and Medical Charities—Julius Ullman, chairman; Charles S. Jewett, De Lancey Rochester.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Richard Mott Moore.
Secretary and Treasurer—James Clement Davis.

STEUBEN COUNTY MEDICAL ASSOCIATION.

President—John G. Kelly.
First Vice-President—Charles O. Green.
Second Vice-President—George C. McNett.
Third Vice-President—Herbert B. Smith.
Secretary and Treasurer—Charles R. Phillips.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—Charles S. Payne.
First Vice-President—Howard P. Deady.
Second Vice-President—George R. Bull.
Secretary—John L. C. Whitcomb.
Treasurer—Charles W. Piper.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Alexander A. Stern, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Norton J. Sands.
Vice-President—J. Lindsay Porteous.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Benjamin Jerome Sands (1903), H. Ernest Schmid (1902).
Committee on Legislation—H. Ernest Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; Walton J. Carpenter, John W. Small.
Committee on Ethics and Discipline—Richard B. Coutant, chairman; Thomas J. Acker, H. Eugene Smith.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:

CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 5.

MAY, 1903.

\$1.00 PER ANNUM.

LARGE INCREASE OF MEMBERSHIP.

The members of The New York State Medical Association have found it advantageous to their interests and to the interests of the profession to belong to the American Medical Association. Numbers speak for themselves. Since the 1st of January seventy-eight new members have been enrolled in the membership of the American Medical Association.

TO OUR MEMBERS.

Members of The New York State Medical Association should always bear in mind that the organization is theirs, the officers theirs, the direction is theirs, the JOURNAL is theirs, the services of the attorney is theirs—theirs to use as they see fit, theirs to criticize, theirs to alter, change and use as they desire. Your officers, those you have placed in charge of your publications, and your attorney wish, are most anxious, to have your inquiries, your advice, your criticisms.

NATIONAL INCORPORATION FOR THE AMERICAN MEDICAL ASSOCIATION.

In reply to the letter addressed by the President of The New York State Medical Association to the Board of Trustees of the American Medical Association, January 31st, and which appeared in the March number of the JOURNAL, p. 104, the following letter has been received:

PHILADELPHIA, March 23d, 1903.

FREDERICK HOLME WIGGIN, M.D., President
The New York State Medical Association.

MY DEAR DR. WIGGIN—Your letter of January 31, 1903, written to me as secretary of the Board of Trustees of the American Medical Association and subsequently printed in THE NEW YORK STATE JOURNAL OF MEDICINE for March, was laid before the trustees at their meeting on the 20th day of February, and your letter, with other correspondence from you and the at-

torney of The New York State Medical Association, was referred by the Board of Trustees to its attorney for his careful consideration. Upon my return from Chicago I wrote you, acknowledging your letter, and stating that the trustees had declined to accept the responsibility of taking any steps toward national incorporation. In this letter you take exception to the manner in which Article XI of the Constitution was changed at the meeting in Saratoga, and say "the fact that by an oversight the Constitution or Articles of Incorporation adopted at St. Paul were not filed with the Secretary of State with the seal of the Association attached, as required by the laws of Illinois to make them legal, should not have been, in my opinion, taken advantage of by the attorney employed by your Board, who should, I believe, have followed the Constitution as adopted at St. Paul as closely as possible in drawing up the new Constitution or articles of Incorporation, making only such changes as the laws of Illinois required." The trustees, for their attorney, wish to disclaim that any advantage has been taken of an oversight or failure to comply with the laws of the State of Illinois. On the contrary, the trustees at the meeting in St. Paul directed the resident member of the Board to consult a lawyer and place before him the minutes and actions of the Association, and see if they conflicted in any sense with the laws of the State of Illinois, under which we were doing business as an incorporated body.

At our annual meeting in February a conference of the Board was held with the attorney, who informed the Board in what way the changes in the Constitution affected the Association as incorporated, and he was then instructed to draw up a report which could be presented to the Association, making plain the changes necessary in order to comply with the laws of the State. This report was so presented, and a committee appointed by the House of Delegates to confer with the Board of Trustees, which committee recommended that the changes

in the Constitution and By-Laws made necessary to comply with the laws of the State of Illinois be accepted by the Committee on New Constitution and By-Laws, which had been continued at the meeting in St. Paul to make such verbal changes in the Constitution and By-Laws as seemed necessary in their judgment. These changes were then acted upon by the House of Delegates, reported to the Association at its last meeting, and confirmed by the adjourned meeting in the State of Illinois in accordance with the laws of that State.

As regards your suggestion that the trustees should apply for a national incorporation, a large number of the Board of Trustees entered upon the consideration of this subject with the inclination to comply, if possible, with your wishes, and secure articles of incorporation from Congress, giving the Association greater freedom of action and more definite control, but it was found that Congress could not incorporate the body except under the laws of the District of Columbia, or one of the Territories under its direct domination. Such an incorporation is the one referred to as having been secured by the American Social Science Association, which would place upon us restrictions equally burdensome as those which we now endure.*

With this introduction, I now quote a summary of the conclusions reached, as presented by the attorney for the Board:

"1.—The amendments to the Articles of Incorporation and the By-Laws adopted at the Saratoga meeting, and ratified at the meeting in Chicago in 1902, are legal. The requirement above referred to—that they should have been proposed 'in open meeting' one year previous to being acted upon, and published, etc., had no binding validity, because, The American Medical Association is a corporation of the State of Illinois. Its meetings for the transaction of business could only be legally held within the territorial limits of this State. Therefore, the so-called Constitution and By-Laws, supposed to have been adopted at St. Paul, and the limitations they provide as to amendments, were not valid because not adopted at a meeting held within the State within which the Association is incorporated; besides which, the Statutes of Illinois expressly permit such amendments to be made at any annual meeting, or at any adjourned session thereof.

"2.—As to the propriety of so small a number constituting a quorum at an adjourned session, that is a matter which the Association must decide for itself. There is nothing in the By-Laws to prevent any number, even to the full membership of the Association, attending the adjourned session, if they so desire; nor does it seem probable that so small a number as constitutes a quorum will be likely, at such adjourned session, to exercise bad faith toward the remainder of the Association.

"3.—The Board decides that it was not its duty to take steps toward securing the proposed national incorporation, because:

"(a) It seems very clear that Congress has no power to create a national incorporation for the purposes mentioned in the charter of our Association, and to give to such Association the power to do business in any of the States or Territories of the Union.

"(b) While Congress undoubtedly has the power to create, by special act, a corporation of this kind, and has, in fact, created somewhat similar organizations,

among which is 'The American Social Science Association,' yet when created, such corporations are (as is The American Social Science Association) only a corporation of the District of Columbia, and not national,* and such corporations would have the same territorial limitations on it as would have charters issued by the various State Governments, so that whether the Association be incorporated in the District of Columbia, or in some of the other States or Territories of the Union, it would be necessary to have its meetings, for the transaction of business of the corporation, held in the District of Columbia, or in the State or Territory in which it is incorporated. This, however, does not prevent other meetings being held for other purposes outside the State or Territory creating the corporation. Precisely that condition exists to-day, so that unless it would be more convenient for you to hold your meetings for the transaction of the business of the corporation in the District of Columbia than it is to hold them in the State of Illinois, there would be nothing gained by the proposed change. In addition to this, your attention was called to the fact that as trustees for the American Medical Association, a corporation of the State of Illinois, having large property interests here, you were, in fact, trustees for the entity—the Association—and for its various members bound to preserve its and their property in this corporation, and that you would be justly censurable if, without unanimous consent, you took measures involving the expense and uncertainty of securing the proposed corporation to take the place of the present one."

This statement will, I hope, make evident to you why the Board of Trustees was unwilling to assume the responsibility of any attempt to push the matter before Congress for a national incorporation. Assuring you that the Board of Trustees will be only too happy to cooperate in any way that seems for the best interests of the Association, and the steps that have been taken by it have been those which seemed to the Board absolutely necessary in order to protect the financial interests of the Association which have been delegated to its care.

Very sincerely yours,

(Signed) E. E. MONTGOMERY,

Secretary of Board of Trustees of the American Medical Association.

To the above the president has sent the following reply:

APRIL 10, 1903.

DR. E. E. MONTGOMERY,

Secretary Board of Trustees, American Medical Association, 1703 Walnut Street, Philadelphia, Pa.

DEAR DR. MONTGOMERY—I have received your letter of March 23d—which will be printed in the May number of THE NEW YORK STATE JOURNAL OF MEDICINE—written to me in your official capacity as secretary of the Board of Trustees of the American Medical Association, replying to my letter of January 31st, addressed to your honorable Board, in regard to the importance of a *Special Congressional Charter* for the American Medical Association.

It seems to me that the strongest argument that can be brought to bear in favor of the necessity for a national charter for the American Medical Association, permitting it to transact its business finally in any State where it sees fit to hold its meetings—unless it be the desire of the

*See Dr. Osborne's letter, page 157.

majority of members that the annual meeting should hereafter *always* be held in Chicago or some other place in the State of Illinois—is the statement made in your letter to me that “the amendments to the *Articles of Incorporation and the By-Laws*, adopted at the Saratoga meeting, and ratified at the meeting in Chicago, 1902, are legal. The requirements above referred to, that they should have been proposed in open meeting one year previous to being acted upon and published, etc., had no binding validity, because the American Medical Association is a corporation of the State of Illinois; its meetings for the *transaction of business could only be legally held within the territorial limits* of this State (Illinois); therefore, the so-called Constitution and By-Laws, supposed to have been adopted at St. Paul, and the limitations they provide as to amendments were *not valid*, because not adopted at a meeting held within the State within which the Association is incorporated; besides which the Statutes of Illinois expressly permit such amendments to be made at *any annual meeting or at any adjourned session thereof.*”

Referring to the statement contained in your letter, relating to the application to Congress for a special charter for the American Medical Association, you make the following statement:

“It seems very clear that Congress has no power to create a national incorporation for the purposes mentioned in the charter of our Association and to give to such Association the power to do business in any of the States or Territories of the Union.”

In reply to this I submit herewith an opinion furnished me, at my request, by the counsel of our Association, James Taylor Lewis, Esq.:

NEW YORK, April 7, 1903.

“DR. FREDERICK HOLME WIGGIN, President The New York State Medical Association, 55 West 36th Street, New York.

“MY DEAR DOCTOR—Your request, that I make careful examination of the charters granted The American Social Science Association and The National Conservatory of Music of America, for the purpose of expressing an opinion as to their fitness as precedents in an application to Congress for a charter on behalf of the American Medical Association, is received.

“From your statements, and from other sources of information, I shall assume that the requisites of a charter for the American Medical Association are:

“1st.—To give it the right to hold meetings and legally and finally transact business in any State of the Union.

“2d.—To give to it the right to hold, receive or convey real or personal property, and

“3d.—To give it a real national character by the granting of a special charter from the Congress of the United States.

“To discover an identical condition in the life of some other corporation would, of course, be hopeless; therefore, it becomes necessary to seek conditions similar and adapt them to the present needs.

“My attention is called to these two corporations as having charters out of which the proper one could be carved, and which seems to me as nearly as one could

require just the groundwork for such a special enactment by our national Legislature.

“You are aware that, among its many other duties, Congress has the privilege of making laws for the government of the District of Columbia, in a sense quite as the Legislatures of our individual States legislate for such States. It makes laws governing all the civil and criminal branches of justice, and has, as our own State has, a certain supervision over institutions created under the general laws within such territorial boundary. Our own State has the right to grant extra privileges to certain corporations, the exact nature of which is not within the contemplation of our State Constitution, but not opposed to it. Congress has such a right for the District of Columbia, but Congress, from its added jurisdictional powers and sovereignty over the entire United States, is bound only by such territorial limitations on the one hand, and the Federal Constitutional limitations on the other, while our State Legislature must be confined both by the boundaries of the State and the supervision of its own Constitution.

“It would seem, therefore, that if there is within the Constitution of the United States any general or special legislative provision which might be said to contemplate a corporation with purposes like those of the American Medical Association, then Congress would have such a power to grant such a special charter.

“The avowed purpose of the American Medical Association as exemplified in the Articles of Incorporation, filed under the general corporation laws of Illinois, places the corporation within the great educational provisions of the Constitution of the United States. The National Conservatory of Music and The American Social Science Association are likewise educational.* Congress recognizes these institutions by the passage of a special act; why not the American Medical Association?

“There seems to be a misapprehension of the facts with reference to these two corporations, for neither of them are corporations formed under general corporation laws of the District of Columbia—such a corporation would lack the real national aspect—but both are the result of special enactment by our national Congress, voted upon directly by representatives of every State in our Union; no corporation charter could have truer national characteristics than one thus granted. The opposition you speak of appears to be almost entirely based upon that mistaken theory. There must, of course, be a locus, or home, for the corporation; the National City is certainly a proper place.

“There can be no serious contention that Congress has not the power to grant the special privilege of holding corporate meetings, or meetings of its directors or trustees, and prosecuting its business anywhere within the limits of the United States. The laws of any State wherein a meeting is held, of course, must not be violated. Congress could even, by such charter, add the privilege of organizing and maintaining subordinate local branches to do the business in their State. No one can honestly assert that such a corporation as the two referred to has not the right to hold real property.

“The charter of the National Conservatory of Music of America is extremely broad. No mention is made of the District of Columbia, except that the corporation thereby formed is empowered to ‘found, establish and maintain’ an institution in the District of Columbia, a thing which may never happen, at least has never happened; but the corporation has been and is now hard at work, ‘educating citizens of the United States and such other persons as the trustees deem proper,’ in the city of New York. They own property, their charter gives them the right to sue or be sued in any court of law or equity, and hold and convey personal or real property. The American Social Science Association has its home fixed in the District of Columbia perhaps because it was considered that such a provision would make it more national.

“There would be no new question involved, should

*For Charters, see page 156.

the explicit privilege be sought from Congress of meeting in any State, but even if that privilege were omitted from the charter the doctrine and principles of comity would doubtless validate the act of any meeting held in the various States, even though the meeting might not be properly so held. The Social Science Association meets in any and all States.

"Finally, the absence of power in any State to grant the needs of the great American Medical Association, the present policy of conducting business by this quorum of ten, in no way responsible by bond or property qualification, the need of recognition by a national Government for its effect upon similar foreign national representative medical organizations, clearly call for an application for a Congressional charter, with prospects of success.

"Very truly yours,
"(Signed) JAMES T. LEWIS, Counsel."

180 Broadway.

Proposed Special Congressional Charter for the American Medical Association.

The living ex-presidents of the American Medical Association (by name), the presidents of each State Association (by name), and the then Board of Trustees (by name), and such others as may be associated with them, and their successors, are hereby constituted a body politic and corporate by the name, American Medical Association, with perpetual succession; with power to sue and be sued, complain, or defend in any court of law or equity; to make and use a seal, and alter the same at pleasure; to acquire, take by devise, bequests, or otherwise hold, purchase and convey, such real and personal estate as shall be required for the purpose of its incorporation; to select such officers and agents as the business of the corporation shall require, and make by-laws not inconsistent with the laws of the United States.

Said corporation is empowered to found, establish and maintain, in the District of Columbia, an institution for the dissemination of general medical information to, and education of the citizens of the United States. Said corporation or its House of Delegates or Trustees may hold meetings, and conduct any business of the corporation wherever expedient within the United States with a like purpose, and for the further purpose of fostering the growth and diffusion of medical knowledge, of promoting friendly intercourse among physicians of the United States of America and of other countries, of safeguarding the national interests of the medical profession, of elevating the standard of medical education, of securing the enactment of medical laws, in directing and enlightening public opinion in regard to the broad problems of State medicine, and of representing to the world the practical accomplishments of scientific medicine.

Under such a charter I am informed that there is no reason why the business office of the American Medical Association should not remain in the city of Chicago. It is a well-known fact that every individual or corporation, whether created by State or Federal authority, must have some locus or place where it may be reached by process of law; that could easily be fixed in the city of Washington. It would be a simple matter to have some physician's office designated such a place in that city.

There is no question but that Congress has been extremely reluctant to grant these charters, and the request for one, if made on behalf of the American Medical Association, must be followed up by the most energetic endeavors, and a unanimous demand for such a charter must come with all the enthusiasm which a great body of educated men are able to throw into such an application.

Every affiliated State body must voice its sentiments direct to its representatives in both houses of Congress.

Certainly, to bring about the desired result, it is worth while to make an attempt, and though it is extremely easy to raise imaginary barriers in the way of such a development of our national Association, our energies should be bent to the contrary, and if necessary a few dollars expended for legal and other necessary expenses by a special committee or by your honorable Board, under direct authorization from the House of Delegates, to secure a charter from Congress which will place the American Medical Association where it should be, the first among the various national medical organizations of the world.

All of which is respectfully submitted.

FREDERICK HOLME WIGGIN,

President The New York State Medical Association.

The charters of The National Conservatory of Music of America and of The American Social Science Association are hereto appended, as they are special charters granted by Congress, and are therefore of interest:

Charter of the National Conservatory of Music of America, granted by the Fifty-first Congress, Second Session 1890. (See Vol. 26, United States Statutes at Large, Chap. 558, p. 1093.)

Be it enacted by the Senate and House of Representatives of the United States of America, in Congress assembled, that Jeannette M. Thurber, William G. Choate, Chauncey M. Depew, Abram S. Hewitt, Frank R. Lawrence, of the State of New York; William Pinckney Whyte, Enoch Pratt, of Maryland; Fitz Hugh Lee, William H. Payne, of Virginia; Olive Risley Seward, John Hay, S. P. Langley, Anthony Pollock, C. R. P. Rodgers, John M. Schofield, of the District of Columbia, and such others as may be associated with them, are hereby constituted a body politic and corporate by the name "National Conservatory of Music of America," with perpetual succession, with power to sue and be sued, complain and defend in any court of law or equity; to make and use a common seal and alter the same at pleasure; to acquire, take by devise, bequest or otherwise, hold, purchase and convey such real and personal estate as shall be required for the purpose of its incorporation; to appoint such officers and agents as the business of the corporation shall require, and to make by-laws not inconsistent with any law of the United States for the admission and qualification of members, the management of its property and the regulation of its affairs. Such corporation is hereby empowered to found, establish and maintain a National Conservatory of Music within the District of Columbia, for the education of citizens of the United States and such other persons as the trustee may deem proper in all the branches of music. The said corporation shall have power to grant and confer diplomas and the degree of doctor of music or other honorary degrees.

Charter of The American Social Science Association, granted by the Fifty-fifth Congress, 1899. (See Vol. 30, United States Statutes at Large, Chap. 63, p. 804.)

SECTION 1. D. G. Gilpin, O. L. Wright, Oscar Strauss, Simeon E. Baldwin, William T. Harris, St. C. McKelway, F. J. Kingsbury and others associated with them, members of the voluntary Association organized in the year one thousand eight hundred and sixty-five, and known as The American Social

Science Association and their successors, are hereby constituted a corporation by that name, in the District of Columbia, for the purpose of promoting studies and researches in social science in the various departments in which said Association is, or the said corporation may be organized.

SEC. 2. This act shall take effect upon its acceptance by said voluntary Association at its next annual meeting.

SEC. 3. The right to alter, amend and repeal is hereby reserved.

The following letters have been received by the president of the State Association from the officers of various affiliated state medical bodies, in relation to the advisability of procuring a national charter for the American Medical Association, and were called out by the letter of the president to the Board of Trustees, printed in the March number of the JOURNAL, page 104:

NEW HAVEN, Conn., March 28, 1903.

Dear Wiggin—Your letter and enclosure received and read with care. I have been unable to see Judge Baldwin, but communicated with him by telephone, and he says that "The American Social Science Association has a special charter, which will allow it to hold meetings anywhere in the United States." He says that "any national association can petition for a special charter, and if there is a little influence can get one at Washington, which means that it need not comply with the laws of the District of Columbia or any other territory, and that such special charter can easily be legislated through by a man of influence, and a few influential doctors could make this go through Congress very easily, which would then allow us to have an official regular annual meeting in whatever State the annual session was held."

Yours sincerely,

(Signed) OLIVER T. OSBORNE.

FLORIDA MEDICAL ASSOCIATION.

JACKSONVILLE, March 25, 1903.

DR. F. H. WIGGIN,

President The New York State Medical Association, New York City.

Dear Doctor—Your favor of the 21st at hand to-day, in regard to "National Incorporation for the American Medical Association." We have invited Dr. McCormack, of Bowling Green, Ky., who has charge of the reorganization of the profession under the direction of the American Medical Association, to be present at the coming meeting of our State Association, April 8th, at St. Augustine, and the doctor has accepted the invitation, so all of these matters can be taken up and explained to the members. I look very favorably upon your suggestion and will have your letter read at the meeting. There are some kickers in my State, and they don't like being whipped into line, as they express it, and think it a hardship that they have to join the State Association to retain their membership in the American Medical Association. I have replied to some of their communications in the same spirit in which they have written to me, and told them plainly that we did not want any such members who joined, as it were, under pressure. How willing are the many to have the few work for them, and they are the first to take advantage of the benefits to be derived. Such has been my experience in our State, and no doubt in yours also.

Very truly yours,

J. D. FERNANDEZ,
Secretary and Treasurer.

MEDICAL SOCIETY OF NEW JERSEY.

Office of the Secretary.

SOUTH ORANGE, March 27, 1903.

Dear Doctor Wiggin—I have read with much interest your letter in the March number of THE NEW YORK STATE JOURNAL OF MEDICINE. It seems to me pre-eminently fitting that a national association such as the American Medical Association should have a national incorporation.

Sincerely yours,

WM. J. CHANDLER.

INDIANA STATE MEDICAL SOCIETY.

Office of the President.

SOUTH BEND, April 2, 1903.

DR. FREDERICK HOLME WIGGIN.

My Dear Doctor—In reply to yours of March 31st I may say that I heartily indorse the proposition of securing a national charter. Furthermore, I had intended some time ago to make organization the principal theme of my address. I shall now make a plea for a national charter in addition to a reiteration of the pressing necessity of a Secretary of Health in the Cabinet.

It is positively pitiful when I read the medical history of the Spanish-American war or hear it from medical eye witnesses, what humiliating subordinate positions the medical profession was compelled to occupy; to be damned for sickness of soldiers resulting from conditions avoidable only in the hands of medical experts. Yet the future successful army will be the one where mortality from disease shall be the least. With a physician in the Cabinet, appropriations could be commanded and procured which are but crumbs to appease the gnawing hunger of a beggar.

I want to assure you of my hearty support as far as obtainable from our Senators and Congressmen. I shall not only work actively myself, but will secure the influence of other persons. If we meet in New Orleans we may have an opportunity to further discuss this matter.

Yours sincerely,

J. B. BERTELING.

BELLOWS FALLS, Vt., April 6, 1903.

Dear Dr. Wiggin—In regard to your suggestion that the American Medical Association be incorporated under a special act of Congress, I would most heartily indorse it. Our national association would then be national in fact as well as in name.

I trust that it can be done next winter.

Most cordially yours,

(Signed) GEORGE H. GORHAM,

Secretary Vermont State Medical Society.

KENTUCKY STATE MEDICAL ASSOCIATION,

CLINTON, Ky., April 19, 1903.

DR. FREDERICK HOLME WIGGIN,

President The New York State Medical Association.

MY DEAR DOCTOR—After asking you to excuse my delay in answering your communication of March 20th, which was caused by a press of business, I would state that I have read your paper on "National Incorporation for the American Medical Association" and heartily indorse your position. The Kentucky State Medical Association meets in Louisville next week on the 22d, 23d and 24th, and I shall call the attention of the Association to the subject. With best wishes, I am,

Very truly yours,

(Signed) W. W. RICHMOND, President.

At a regular meeting of the Council of The New York State Medical Association, held April 22, 1903, the following resolutions were unanimously passed:

RESOLVED, That The New York State Medical Association request the House of Delegates of the American Medical Association to appeal to Congress for a special charter, granting a national incorpora-

tion for the American Medical Association, and also that all changes in the Constitution and By-laws be printed in the *Journal* of the American Medical Association within three months after the annual meeting.

RESOLVED, That The New York State Medical Association, through its Council, request that the House of Delegates of the American Medical Association continue its Committee on National Bureau of Medicines and Foods and suspend final action for one year, as the subject is much too broad for thorough consideration within the time available.

RABIES.

The death from hydrophobia of the son of a well-known physician in New York City a few weeks ago has again drawn public attention to this dreaded disease. Fortunately, this disease is comparatively rare among human beings, but it is of more frequent occurrence than is generally supposed. It is, however, at the present time, of common occurrence among dogs, not only in this State, but in many other States of the Union. From private but reliable sources of information we know of at least 100 cases of rabies occurring in dogs during the past year in New York City. It is far from our intention to start an epidemic of Lyssaphobia among timid or hysterical people, but these facts cannot be denied, and as such should be faced and acted upon. That there are not more human beings bitten each year by rabid dogs is not due to any diminution of the disease, but to the fact that most dogs have the paralytic or dumb form and rarely bite unless provoked, rather than the furious form in which they seek to bite. Most of the rabid dogs which come under observation among the veterinarians have not bitten other animals or human beings and are therefore destroyed, and nothing further is said or done. It is only when they have bitten other dogs or animals or people that they are kept and the disease proven by further inoculations. The ratio of dumb to furious rabies is given by authorities as about two to one. But when the disease is given to horses and cattle, they almost always develop the furious form, and thus become a dangerous source for its transmission. Fortunately, cats, as a rule, develop the dumb form. The present preventive inoculations—the so-called Pasteur treatment—if given in time, protect the vast majority of human beings, who, bitten by rabid dogs, would otherwise develop hydrophobia, and thus keep down the number of human deaths. If we could stamp out the disease among dogs we could eradicate it, as it is kept alive by these animals. Killing the dogs when rabid is a necessity and killing all dogs and other animals known to have been bitten by them is simply the part of wisdom. But claiming that all or many unbiten dogs should be killed, because they may become rabid, is a foolish and unnecessary procedure. Rabies have been stamped out in Prussia, Vienna, Sweden and Great Britain by causing all dogs, when at large in public, to be muzzled. It is also interesting to read the statistics and see that when the muzzling

laws have been rescinded, the disease has become epidemic, and when the laws were again enforced, it has disappeared. In Holland the dogs are muzzled, and the disease only occurs along the frontier, where foreign dogs bring it in. In France and Belgium there are no muzzling laws, and the disease is prevalent.

The New York City Board of Aldermen are considering the passage of a muzzling law, and it is to be hoped that such a law will be passed. Experience has shown both the effectiveness and wisdom of such laws, but there is sure to be great opposition to this on the part of many sentimentalists who oppose it on the ground that it is disagreeable and cruel to the dogs, and also, *mirabile dictu*, by some who claim that hydrophobia is only a hysterical superstition. Well may the dogs crave speech to cry out against such false friends. Surely the truest friends are those who will protect both the dogs and humanity against this terrible disease.

MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

The following letter has been received by the president of the State Association:

NEW YORK, April 8, 1903.

DEAR DOCTOR—Considering the persistency with which you follow non-members of the American Medical Association to join the ranks, I find I cannot withstand your efforts any longer, having withheld as long as I could. Therefore, inclose check for dues with application.

Yours very truly,

All members of The New York State Medical Association should join the American Medical Association immediately if they have not already done so. Our voice and influence at the meeting in New Orleans of the national organization depends upon our membership. The representation of each State and Territory in the House of Delegates is in proportion to their membership in the American Medical Association.

Whether you live in a city block containing a score of doctors, or in a village where your nearest associate is several miles distant, your influence in this organization is equally necessary to its well-being. It is the organization of one as much as of the other. Your place cannot be filled by another. You cannot be so well known, so firmly established, as to be sufficient unto yourself. You cannot be so insignificant, so young or so isolated as not to be of value to the organization. We of the profession need the support of every licentiate to keep us from narrowness and selfishness when our fortune is in the zenith and to offer encouragement and hope when clouds seemingly hide the rays of success.

AN URGENT DUTY.

We believe that nearly all, if not quite all, of the members of the medical profession in this State are anxious to do whatever lies within

their power to relieve the sufferings of humanity, to preserve the health of our citizens and to advance their welfare and happiness.

Comparatively few, however, realize that their duties are not done with the daily labors which they are called upon to perform; they owe a duty, most urgent in its demands, to the broader work of medical organization.

The foreigner who lives among us criticizes, advises and has much to say of our laws and lawmakers, and yet takes no steps to become a citizen, but demands the protection of our Government for his personal interests; who finds it to his interests to live with us, and yet scorns us, is entitled to little respect, no matter how virtuous and honorable he may be in his personal dealings with individuals.

The American who bewails the corrupt condition of our politics and yet fails to do his duty at the primaries, fails to shoulder his own share of the responsibility for the condition of our politics, is certainly of small value to his country. His patriotism is at a low ebb.

The doctor who desires to see the best possible laws passed and enforced for the preservation of health, who desires to have upon our health boards none but capable men, who desires to have better protection offered to the laity against fraudulent and irresponsible practitioners and quacks, who desires to see his coworkers in this profession protected from those who would take advantage of their kindness of heart and sympathy, and seek through the courts to rob them of their characters and their money, and who desires to do his share in elevating the profession, and making its members more noble and better fitted for the work God has given them to do—that doctor will identify himself with the County, the State and the National organizations in all their proceedings; he will be proud and happy to do his share by filling the place in the membership roll to which he is entitled, by taking an active part when called upon so to do and by being ever ready to offer encouragement to those who are working for the organization—working for him.

COUNTY SOCIETIES AND PUBLIC QUESTIONS.

The county societies in Michigan have exclusive jurisdiction, as the State society guards them from any rival may come before them. If the question be one of public interest they can take the time needful to formulate exact statements and advise the wisest action.

In every county the knowledge and judgment of the medical profession are sought in matters relating to This encourages exhaustive study of any question which civic life and public health. In the past it has occurred that one society or set of doctors hastily gave one view, while another set gave an opposite. In supporting these views the public has been treated to a spectacle as edifying as a scrap of Kilkenny cats and as helpful to the public as a dog fight. As it sells their papers the newspapers egg on the fight.

With a monopoly of their counties the branch societies have no temptation to disagree. Being supreme in their field, they are encouraged to use this to advance the interests of every physician and the public whom all serve, so promoting mutual respect and confidence.

Hence, if their judgment on any matter relating to the laity be sought, they will, first, make a thorough study of the same; second, their judgment will be expressed in terms impossible to be mistaken by the laity.

To accomplish this the question should be referred to an appropriate committee, familiar with the subject, willing to study it exhaustively and able best to express its conclusions. This committee will usually be the Executive Committee, but it may consist of the president and secretary, or one especially selected. The make-up of the committee is unimportant, if only it fully master the question, and forcefully express the same. This done, there can be no controversy—nothing to mar the confidence of the laity in the profession. The result will be a uniform, up-to-date teaching of the laity on matters affecting their interest. It will eliminate the possibility of an individual or clique "working" the society for schemes for his or its own interest at the expense of others.

Only thus will the medical profession gain its birth-right as a teacher of the people and command the respect due disciples of science and guardians of health interests. Our branch societies have this end within their grasp. If done in each county it is done in the State; if done in Michigan it will spread till every county in the United States has seen and risen to its opportunity.

Let us discard—in county societies—superficial examination of public or quasi-public questions, snap diagnosis, haphazard treatment; let us follow our custom in capital operations, for which we are held responsible—make the most exhaustive study of the case and complete preparation of every detail ere speaking to the public.—LEARTUS CONNOR in the *Journal of the Michigan State Medical Society*, April, 1903.

ORGANIZE COUNTY ASSOCIATIONS.

The president has been informed by the secretary of the Nebraska State Medical Society, Dr. A. D. Wilkinson, that in that State they have recently organized forty-five county medical societies, which is of interest, showing how much can be accomplished in a short time in the way of organizing county associations when a little time and effort are given to the work. There are still thirty counties in this State in which there are no associations, and if it is possible to do such good work in Nebraska, why cannot this be accomplished in our State?

CHANGE OF ADDRESS.

The following correspondence between the president of The New York State Medical Association and one of its members will be of interest:

APRIL 7, 1903.

DEAR DOCTOR WIGGIN—Kindly note change of address, as I do not know who the officers of The New York State Medical Association are at this date. Will you kindly oblige me by sending *my new address to the secretary, etc.?*

Sincerely,

DEAR DOCTOR—I have received your letter of the 7th informing me of your change of address, also stating the fact that you are not aware of who the officers of The New York State Medical Association are at this date. As you are a member in good standing of The New York State Medical Association and receiving the monthly copy of the JOURNAL, our official organ, I would like to call your attention to the fact that the names of all the officers of the State Association are printed on the lower half of the front page of that journal.

Yours very truly,
(Signed) FREDERICK HOLME WIGGIN,
President The New York State Medical Association.

Association News.

All matter intended for this column, unless received by the 20th of the current month, cannot be printed until the following month. All such matter should be addressed to Dr. Louis C. Ager, corner Third avenue and Silliman place, Brooklyn, N. Y.

MEMBERS IN TRANSIT TO NEW ORLEANS.

We wish to call the special attention of the members of The New York State Medical Association, who expect to pass through New York to the meeting of the American Medical Association, at New Orleans, to the business office of the Association, where letters can be addressed, baggage left temporarily, appointments made to meet friends, or a visit made to the office, to see the work which the Association is there carrying on.

SPECIAL TRAIN TO NEW ORLEANS.

The New York State Medical Association Special leaves on Saturday afternoon, May 2d, at 4.25 o'clock sharp, from the Pennsylvania station, West 23d street. As eight cars have already been filled, it would be well to send word to the president, Dr. Frederick Holme Wiggin, at once to secure sleeping-car accommodations. Hotels with rates of \$1.50 a day and up are: New St. Charles, Cosmopolitan, Commercial and Gunewald. By addressing Dr. E. D. Martin, chairman Committee on Arrangements, 810 Common street, New Orleans, accommodations can be secured.

Among those who are going to New Orleans on The New York State Medical Association special train are the following:

Dr. E. H. Carpenter, Oneida, N. Y.; Dr. Percy Freidenberg, New York, N. Y.; Dr. C. S. Payne, Liberty, N. Y.; Dr. B. C. Moriarta, Saratoga, N. Y.; Dr. Elias Lester, Seneca Falls, N. Y.; Dr. A. C. Way, Perry Center, N. Y.; Dr. Francis A. Scratchley, New York, N. Y.; Dr. Ludwig Weiss, New York, N. Y.; Dr. W. R. Townsend, New York, N. Y.; Dr. J. O. Pollock, New York, N. Y.; Dr. Eugene Smith, Mt. Vernon, N. Y.; Dr. G. Lenox Curtis, New York, N. Y.; Dr. E. F. Brush, Mt. Vernon, N. Y.; Dr. G. F. Comstock, Saratoga, N. Y.; Dr. J. A. For-
dyce, New York, N. Y.; Dr. G. C. Weiss, Mt. Vernon, N. Y.; Dr. N. F. Pilgrim, New York, N. Y.; Dr. Augustin Goellet, New York, N. Y.; Dr. A. Palmer Dudley, New York, N. Y.; Dr. U. L. Rhein, New York, N. Y.; Dr. Wm. J. Robinson, New York, N. Y.; Dr. Samuel Alexander, New York, N. Y.; Dr. J. B. Leo, New York, N. Y.; Dr. T. J. Acker, Croton-on-Hudson, N. Y.; Dr. Dodin, New York, N. Y.; Dr. Squibb, Brooklyn, N. Y.; Dr. Burgess, Brooklyn, N. Y.; Dr. Jos. W. Malone, Brooklyn, N. Y.; Dr. Sheets, Brooklyn, N. Y.; Dr. L. M. Halsey, Williams-
ton, N. J.; Dr. Kipp, Jersey City, N. J.; Dr. Clarence E. Skinner, New Haven, Conn.; Dr. Marsh, New Haven, Conn.; Dr. J. W. Holland, Philadelphia, Pa.; Dr. George W. Guthrie, Wilkesbarre, Pa.; Dr. J. Gardner Cooper, Philadelphia, Pa.; Dr. Gardner, Wilkesbarre, Pa.; Dr. Tyson, Philadelphia, Pa.; Dr. R. G. H. Hayes, Bellefonte, Pa.; Dr. M. K. Formad, Philadelphia, Pa.; Dr. H. H. Halber-
stadt, Pottsville, Pa.; Dr. Elmer B. Boland, Pitts-
burg, Pa.; Dr. Richard H. Gibbons, Scranton, Pa.; Dr. C. H. Miner, Wilkesbarre, Pa.; Dr. E. E. Mont-
gomery, Philadelphia, Pa.; Dr. Lund, Boston, Mass.; Dr. Bottomley, Boston, Mass.; Dr. Craig, Boston,

Mass.; Dr. Henry O. Marcy, Boston, Mass.; Dr. John C. Mumroe, Boston, Mass.; Dr. Nichols, Boston, Mass.; Dr. Speare, Boston, Mass.; Dr. Greenwood, Boston, Mass.; Dr. H. B. Cheers, Baltimore, Md.; Dr. McCrea, Baltimore, Md.; Dr. W. P. Watson, Bal-
timore, Md.; Dr. Futcher, Baltimore, Md.; Dr. Far-
rell, Providence, R. I.; Dr. John Shedd, Conway, N. H.; Dr. R. A. Prouty, Keene, N. H.; Dr. H. L. Water-
man, Brattleboro, Vt.; Dr. Danley C. Hawley, Burl-
ington, Vt.; Dr. Seth Gordon, Portland, Me.; Dr. Gracelon, Lewiston, Me.

THE AMERICAN MEDICAL ASSOCIATION PROGRAM.

Our Representation.

On the program of the annual meeting of the national organization, to be held next week, we notice the following names of members from this State: Robert Abbe, Carl Beck, L. F. Bishop, E. F. Brush, L. Duncan Bulkley, Chas. Stedman Bull, J. H. Claiborne, Geo. F. Cott, G. Lenox Curtis, A. Palmer Dudley, John A. For-
dyce, C. C. Frederick, Geo. F. Fuller, Wm. Gies, A. H. Goelet, Wm. S. Gottheil, N. J. Heburn, A. A. Hubbell, Smith Ely Jelliffe, Charles G. Kerley, Egbert Le Fevre, Justin de Lisle, F. Park Lewis, George B. McAuliffe, Robert C. Myles, Seymour Oppenheimer, Francis J. Quinlan, William J. Robinson, M. L. Rheim, Harmon Smith, Sargent F. Snow, Thomas S. Southworth, George T. Stevens, J. Edward Stubbert, Edgar Thomp-
son, Ferd C. Valentine, J. J. Walsh, John E. Weeks, F. H. Wiggin, Robert F. Weir, L. Weiss and John A. Wyeth.

DISTRICT BRANCH NEWS.

District Branch Association Meetings.

First District Branch.—Tuesday, May 26th.

Second District Branch.—Thursday, June 4th.

Third District Branch.—Tuesday, May 5th.

Fourth District Branch.—Tuesday, June 16th.

Fifth District Branch.—Tuesday, May 19th.

First District Branch.—The annual meeting will be held at Washington Hall in Watertown, at 10 A. M., Tuesday, May 26, 1903.

The following papers will be read:

"The Surgery of Hernia," Dr. Gilbert Gregor, Watertown.

"Environment in Tuberculosis," Dr. Lawrason Brown, Saranac Lake.

"The Use and Abuse of the Obstetric Forceps," Dr. Charles H. Glidden, Little Falls.

"The Importance of a Correct Diagnosis," Dr. Alexander H. Crosby, Lowville.

"Movable Kidney," Dr. Grant C. Madill, Ogdens-
burg.

"Stab Wounds of the Intestines and Report of Cases," Dr. Fred J. Douglas, Utica.

"The Responsibility of the General Practitioner in Insane Cases," Dr. Richard H. Hutchings, Ogdens-
burg.

"A Report of Three Interesting Surgical Cases," Dr. William B. Reid, Rome.

"A Résumé of Forms and Symptoms of Acute Intestinal Obstruction, with Report of a Case," Dr. Douglas Ayres, Fort Plain.

"Some Peculiarities of the Pulse in Typhoid Fever," Dr. John N. Bassett, Canton.

Addresses will be given by Dr. Parker Syms, presi-
dent of the Fifth District Branch, New York City.

Dr. Jeremiah R. Sturtevant, president of the First District Branch, Theresa, on "The New Era."

Dr. Frederick Holme Wiggin, president of The New York State Medical Association, New York City, on "The New York State Medical Association, the Rea-

sons for Its Present Plan of Organization, Its Progress and Its Ideals."

Special effort is being made at this time toward the unification of the medical profession of this country and State through the American Medical and New York State Medical Associations, and it is hoped that there will be a very general attendance at this meeting, which, as the program indicates, will be of unusual interest.

* * *

Fifth District Branch.—The annual meeting will take place on Tuesday, May 19th. Reports will be read from the chairmen of the different committees, and the new officers will be elected for the coming year. The following papers will be read: "Laboratory Diagnosis and Life Cycle of the Parasite," W. T. Klein; "Morphology of Anopholes Mosquito—Its Habits and Modes of Destruction," with exhibition of live specimens, W. N. Berkeley; "Clinical Diagnosis and Treatment."

COUNTY ASSOCIATION MEETINGS FOR MAY.

- Kings County.—Tuesday, May 12th.
- Otsego County.—Tuesday, May 12th.
- Cortland County.—Friday, May 15th.
- Onondaga County.—Monday, May 18th.
- Steuben County.—Monday, May 18th.
- New York County.—Monday, May 18th.
- Ulster County.—Monday, May 18th.
- Orange County.—Wednesday, May 20th.
- Chautauqua County.—Tuesday, May 26th.
- Westchester County.—Thursday, May 28th.

* * *

Albany County Association.—The annual meeting was held at Watervliet, on April 7th. The following officers were elected: President, Dr. William E. Lothridge, Verdo; vice-president, Dr. Clement F. Theisen, Albany; secretary and treasurer, Dr. Merlin J. Zeh, Watervliet.

* * *

Allegany County Association.—The members of the Third District Branch of The New York State Medical Association, residing in Albany County, recently met and formed the Allegany County Association. The following officers were elected: President, Dr. George H. Witter, Wells-ville; vice-president, Dr. William Orson Congdon, Cuba; secretary and treasurer, Dr. Horace Leland Hulett, Allentown.

* * *

Broome County Association.—The annual meeting was held at the office of Dr. Orton, Binghamton, on April 14th. By a unanimous vote the by-laws were amended to correspond with the by-laws of The New York State Medical Association, as adopted in October, 1892. Dr. W. A. White read an exceedingly interesting paper on "Periodical Insanity," and Dr. Farnham read a paper on "Intestinal Hemorrhage in Typhoid Fever," reporting an interesting case. The following officers were elected: President, Dr. Le Roy D. Farnham; vice-president, Dr. William A.

White; secretary, Dr. Clark W. Greene, and treasurer, Dr. William H. Knapp, all of Binghamton. Dr. William A. White was elected fellow and Dr. Le Roy D. Farnham, alternate. The following committees were appointed by the president: Legislation, Drs. J. M. Farrington, J. H. Martin and B. W. Stearns; Public Health, J. H. Martin, W. H. Knapp and L. H. Quackenbush; Medical Charities, Drs. J. G. Orton, C. W. Greene and F. P. Hough; Ethics and Discipline, Drs. J. G. Orton, W. A. White and J. M. Farrington. The next meeting will be on July 14th.

* * *

Columbia County Association.—A special meeting of the Columbia County Association was held at Hudson on March 31st. Six members were present, and the following officers were elected: President, T. Floyd Woodworth, Kinderhook; secretary and treasurer, Henry Warner Johnson, Hudson.

* * *

Lewis County Association.—The members of the First District Branch, residing in Lewis County, recently met and organized the Lewis County Association. The following officers were elected: President, Alexander H. Crosby; vice-president, George H. Littlefield; secretary, Le Roy W. King; treasurer, Charles E. Douglass.

* * *

New York County Association.—The annual meeting was held April 20th, Dr. Alexander Lambert, president, in the chair. The following candidates for office were elected:

- President, Alexander Lambert, M.D.
- First Vice-President, Francis J. Quinlan, M.D.
- Second Vice-President, S. Busby Allen, M.D.
- Secretary, Ogden C. Ludlow, M.D.
- Corresponding Secretary, John J. Nutt, M.D.
- Treasurer, Charles E. Denison, M.D.
- Member of Executive Committee for three years, Frederick P. Hammond, M.D.
- Member of Nominating Committee, Fifth District Branch, Parker Syms, M.D.

FELLOWS AND ALTERNATES OF THE STATE ASSOCIATION.

<i>Fellows.</i>	<i>Alternates.</i>
Allen, S. Busby,	Barnes, George E.,
Austin, David P.,	Bodine, John A.,
Benedict, Charles S.,	Brickner, Samuel M.,
Berg, Henry W.,	Chappell, Walter F.,
Bissell, Joseph B.,	Child, Charles G., Jr.,
Brill, Nathan E.,	Curran, Martin W.,
Bryant, Joseph D.,	Smith, Harmon,
Burtenshaw, James H.,	Houghton, H. Seymour,
Carlisle, Robert J.,	Fielder, Frank S.,
Carmalt, Churchill,	Zwisohn, L. W.,
Chetwood, Charles H.,	Foote, Sherman K.,
Cocks, Edmund L.,	Townsend, Frederick M.,
Dawbarn, Robert H. M.,	Denison, Ellery,
Delavan, D. Bryson,	Forbes, Henry Hall,
Disbrow, Robert N.,	Evans, Samuel M.,
Dodin, Henry A.,	French, John H.,
Dougherty, Daniel S.,	Green, Nathan W.,
Eichberg, Louis R.,	Guiteras, Ramon,
Erdmann, John F.,	Rakestraw, Chauncey,
Fordyce, John A.,	West, William Edward,
Gibb, W. Travis,	Woodward, Julius H.,
Goffe, J. Riddle,	Graber, Sidney S.,

FELLOWS AND ALTERNATES OF THE STATE ASSOCIATION.

Fellows.

Gouley, John W. S.,
Greene, Robert H.,
Hammond, Frederick P.,
Harrison, George Tucker,
Hepburn, Neil J.,
Haynes, Irving S.,
Hotchkiss, Lucius W.,
Janvrin, Joseph E.,
Kalish, Richard,
Jelliffe, Smith Ely,
Kinnicutt, Francis P.,
Lambert, Alexander,
Leo, J. B.,
Leszynsky, William M.,
Lewengood, Samuel,
Loughran, Frederic W.,
Appleton, M.,
Marple, Wilbur B.,
Mayer, Emil,
Luckett, William H.,
LeBoutillier, William G.,
Nutt, John Joseph,
Oppenheimer, H. Seymour,
Purdy, Harry R.,
Quimby, Charles E.,
Quinlan, Francis J.,
Reilly, Thomas F.,
Roth, Henry,
Richard, Montrose R.,
Abrahams, Robert,
Rupp, Adolph,
Seabrook, Harry H.,
Silver, Henry M.,
Smith, Stephen,
Stewart, Douglas H.,
Townsend, Wisner R.,
Walsh, James J.,
Wyeth, John Allan,

Alternates.

Grad, Hermann,
Heller, Isaac M.,
Henschel, Joseph,
Herrick, William P.,
Hubbard, Ernest V.,
Weinstein, Joseph,
Huddleston, John H.,
Jarvis, Nathan S.,
Kerley, Charles G.,
Keyes, Edward L., Jr.,
Koonz, Albert E.,
Lusk, William C.,
Mewborn, A. D.,
Nagle, Joseph D.,
Roginsky, A. J.,
Schminke, John C.,
Shufelt, William A.,
Starke, Gustave H. E.,
Southworth, Thomas S.,
Stone, William R.,
Tuttle, James P.,
Fuller, Eugene,
Robinson, Andrew R.,
Grausman, Philip M.,
Harrison, Gessner,
Healy, James R.,
Helbig, Frederic M.,
Josephs, Charles S.,
Hoffman, I. L.,
Hogan, Edward J.,
Holden, Timothy N.,
Hope, George B.,
Howley, William E.,
Palmer, Edmund J.,
Jarecky, Herman,
Jennings, Walter B.,
Pryor, William R.,
Wurm, Carl.

The secretary submitted his annual report:

Mr. President—I have the honor to present a brief review of the work done by our Association during the past year.

It has been the policy to draw somewhat more liberally upon local talent and to invite fewer scientists from beyond our borders, the object being to stimulate the members to greater activity and arouse a deeper interest, because personal, in the scientific work. Although, perhaps, we may wish it otherwise, experience has demonstrated conclusively in this, as in other medical bodies, the necessity of arranging for certain persons to open the discussions in order to insure a lively and instructive debate, yet your secretary is confident that all of the officers are most anxious to draw out individual opinions and experiences and to elicit a general discussion on the various topics presented at the meetings.

In obedience to the growing sentiment everywhere in favor of set discussions, by which the important facts bearing on any particular subject are crystallized and presented in such a form as to make a vivid and lasting impression upon the audience, there have been provided during the year which has passed several symposia—*e. g.*, on "The Therapeutic Uses of Suprarenal Extract," "The Modern Treatment of Urethral Stricture" and a series of papers on the "Urine."

At the November meeting a committee was appointed to investigate and report on the question of the abolition of the Board of Coroners of New York City. This committee reported on February 16th in favor of the abolition of the Coroner's office, and recommended the transfer of the duties of investigating the causes of death to medical examiners belonging to the Health Department and of the legal duties to the District Attorney's office. The battle that has been fought before the Legislature in this connection is still fresh in the minds of all.

On December 15th a committee of ten was appointed "to investigate and report upon the subject of proprietary remedies, their use by the medical profession and their relation to the advertising and literary department of medical publications." The subject is an important one, and the task imposed upon this committee is so enormous that it is likely to be a number of months before a report can be presented.

At the meeting of February 16th the Committee on Public Health presented a very creditable report on the subject of street car transportation in this city and endorsed the efforts of The Merchants' Association.

The meeting of March 16th was exceptional, in that the paper of the evening was by a gentleman from out of town. Those who were fortunate enough to be present will not soon forget the "New and Unusual Therapeutic Applications of Ergot" mentioned by the author of the paper, Dr. Alfred T. Livingston, of Jamestown, N. Y.

The scientific work of the Association for the past year may be summarized as follows:

Medical papers	14
Surgical papers	7
Obstetric and gynecological papers....	1
Instruments and apparatus exhibited..	1
Specimens exhibited	12
Cases presented or reported.....	7

Total number of contributions..... 42

In the last annual report of your secretary attention was called to the fact that our Association had taken the initiative in the important matter of the medical defense of its members pending the assumption of this duty by the State Association. While no doubt the details of this work will be presented in due time by our counsel, James Taylor Lewis, Esq., it is but right to acquaint you with the fact that, as a result of our progressiveness in this direction, more than one member of this Association has been successfully defended in suits for malpractice. Even the most apathetic member can hardly fail to appreciate the practical value of such substantial assistance. Those who have been thus aided are loud in their praise of the far-seeing and liberal policy which is responsible for this novel departure in the organization and administration of medical societies. Membership in such a society is no longer an empty name. The lesson to be learned is obvious: Be not lulled into a false sense of security, for among those who have already availed themselves of this great privilege of securing associated defense are persons whose position, skill and experience would have led most of us to believe that they were certainly secure and in no need of such a plan of defense. But there is a broader aspect that should not be lost sight of. It is the tremendous moral effect upon the community at large, produced by the spectacle of a united profession of the members of a guild standing shoulder to shoulder, upholding principles and battling for the right.

Respectfully submitted,

OGDEN C. LUDLOW, Secretary.

The treasurer reported a balance on hand over that of last year of \$384. During the past year there was collected from dues, \$6,009; initiation fees, \$130; fines, \$30, and legal account, \$350; total amount collected, \$6,519. Expenditures include the sum of \$3,743 to the State treasurer for dues, initiation fees and fines; to legal account, \$782.52; to committee expenses, \$35; to commission honorarium and advertising, \$255.80; to rent, \$240; to general expenses and permanent fixtures, \$71.50; to postage, \$169.12; to printing and stationery, \$186.12; to collation, \$651.99; total expenditures, \$6,135.03, leaving a balance on hand of \$1,616.62.

C. E. DENISON, Treasurer.

Dr. Wiggin proposed the following resolutions, which were unanimously adopted:

WHEREAS, Rabies among dogs has been prevalent in this city during the past year; and
WHEREAS, Statistics show conclusively that the muz-

zling of dogs will eradicate the disease, as has been proved in Prussia, Sweden, Great Britain, Holland and Vienna. Be it

Resolved, That the New York County Medical Association petition the Honorable Board of Aldermen of this city to pass a law requiring all dogs to be muzzled while abroad in public in this city.

* * *

Orange County Association.—The regular meeting of this association was held at the Russell House, Middletown, on April 15th. Drs. Frank W. Dennis, Joseph B. Hulett and Edward D. Woodhull were appointed to represent the Orange County Association at the meeting of the Orange County Society in May, and endeavor to unite the two bodies. Dr. J. B. Hulett read a paper on "Gun-shot Wounds of the Abdominal Viscera," and reported the following interesting case of intestinal perforation and extensive injury of the mesentery with recovery:

Frank P., age 9 years, residence Bloomingburgh, was accidentally shot at close range with a 32-caliber bullet, from a revolver, about 5 o'clock in the afternoon of July 14, 1902. He was first seen late that evening by his physician, Dr. Frank Hauser, who, realizing the gravity of the case, ordered him removed to Thrall Hospital, Middletown, a distance of about ten miles. The patient arrived there about 10 o'clock and immediate operation was decided upon. Accordingly, with the assistance of Drs. Hauser and Hardenbergh, Dr. Hulett commenced to explore the wound, which proved to be a perforating one. On account of the profuse hemorrhage, the original wound was rapidly enlarged, when it was found that there were a number of perforations of the intestines. After careful search the source of the bleeding was discovered in an extensive laceration of the mesentery. The bleeding vessels were tied and the torn mesentery repaired. The boy collapsed and was thought to be dying, but under careful stimulation and filling the abdomen with salt solution, he revived. The perforations were then stitched up with a modified Cerny-Lembert suture and the abdomen again flushed out with salt solution, when two more rents were found low down in the sigmoid flexure. These proved the most difficult of all to repair through the small opening of two inches and a half on the right side. The bullet was found in the left iliac fossa, about three-quarters of an inch from the ureter, under the posterior peritoneum. A long drain was introduced from this point, out through the wound, and the external incision partially closed. Altogether eight perforations had been sewed up. A contused portion of the omentum was tied off and excised. The boy was returned to bed in a fair condition. The next day at 5 o'clock in the afternoon he was delirious, complaining of intense pain in the abdomen, temperature 103.2-5, pulse 133, respirations 34. Under hypodermics of morphine he became more quiet. The dressings were then changed, considerably soiled with discharges from the wound. The next day he was rational

and rested very well. The dressing was changed and drain shortened. About 11 P. M. that evening his bowels moved spontaneously. The further history of the case was uneventful and the patient was discharged from the hospital in three weeks with the wound entirely healed. The diet for the first fourteen days was entirely liquid, afterward semi-solid. No effort was made to move the bowels, but nature spontaneously established peristalsis. Early removal of the drain, on the fourth day, seemed to be a factor in the rapid recovery.

Dr. W. I. Purdy reported a similar case of multiple perforation, operated upon, and resulting in recovery. Afterward all present engaged in the discussion. Dr. F. W. Dennis reported an interesting case of pleural effusion which had been aspirated four times and a large quantity of sanguineous fluid obtained. Dr. Redfield and Dr. Purdy each reported a case of prolapse of the umbilical cord. Dr. Dennis also reported a rare case of hypertrophic cirrhosis of the liver in a child 5 years old. Dr. Wise reported a case of gastro-duodenitis. Dr. Hulett was tendered a vote of thanks for his interesting and instructive paper. The next meeting will be held May 20th.

* * *

Rockland County Association.—The annual meeting of this Association was held at the Riggs House, Suffern, April 15th. The following papers were read: "Treatment of Pneumonia, Especially the Use of Strychnia, Digitalis and Cardiac Remedies," G. F. Blauvelt; "Complications of Pneumonia—Pleuritic, Edema, Cardiac, Arteriosclerosis, Emphysema, Empyema, Pulmonary Abscess," S. W. S. Toms; "Pneumonia, Complicating Surgical Operations—Some Statistics on the Frequency and Mortality of Pneumonia," George A. Leitner; "Infection in Pneumonia, the Etiology of Pneumonia," C. D. Kline; "On the Diagnosis of Pneumonia, General and Differential," J. H. Crosby; "Ergot in Pneumonia," A. T. Livingston.

A discussion followed by Dr. Alexander Lambert, president New York County Medical Association, and also some remarks on the subject by Dr. Frederick Holme Wiggin, president The New York State Medical Association. The following officers were elected: President, D. Burr Van Wagenen; vice-president, George A. Leitner; secretary and treasurer, Norman B. Bavley. The next meeting will be held at Spring Valley, July 15th, at 2 P. M.

For papers see page 175.

* * *

Saratoga County Association.—The annual meeting was held at the Utopian clubrooms, Ballston Spa, on March 31st. The annual reports of the secretary and treasurer were read. In the scientific session the following papers were read: "A Study of Adrenalin," Dr. A. S. Downs; "Gonorrhoeal Rheumatism," Dr. G. F. Fish; "Postpartum Hemorrhage," Dr. W. E. Swan; "Report of a Case of Postpartum Hemorrhage,"

Dr. H. R. Bently; "A Study of Veratrum Viride," Dr. M. E. Varney. The following officers were elected: President, Dr. M. E. Varney, Saratoga Springs; vice-president, Dr. A. W. Johnson, Mechanicsville; secretary, Dr. J. T. Sweetman, Ballston Spa; treasurer, Dr. W. E. Swan, Saratoga Springs; member of the Executive Committee (three years), Dr. F. J. Sherman; fellows, Drs. F. J. Sherman, D. C. Morimarta, P. C. Curtis, G. F. Compstock and W. E. Swan; alternates, Drs. J. S. Prout, J. R. Swanick, T. E. Bullard, George Hudson and William Van Doren. The next meeting will be held on September 15th. * * *

Steuben County Association.—The annual meeting was held in Hornellsville, April 6th. There were eighteen members present. An invitation was extended to the Hornellsville Medical and Surgical Society to unite with the Association. The following officers were elected: President, Charles O. Green; vice-president, Dr. Frank H. Koyle; secretary and treasurer, Dr. Charles R. Phillips, all of Hornellsville. Dr. Charles R. Phillips was elected fellow and Dr. John G. Kelly, alternate. The following committees were appointed: Legislation, Drs. R. R. Wakeman, C. M. Brasted, W. E. Palmer; Public Health, Drs. J. D. Mitchell, W. E. Hathaway, H. P. Jack; Committee on Ethics and Discipline, Drs. J. G. Kelly, C. S. Parkhill, C. O. Jackson. The next meeting will be held May 18th. * * *

Tompkins County Association.—The members of the Third District Branch of The New York State Medical Association, residing in Tompkins County, met on April 14th and organized the Tompkins County Association. The following officers were elected: President, Dr. John S. Kirkendall, Ithaca; vice-president, Dr. William C. Douglass, Ithaca; secretary and treasurer, Dr. Marcus A. Dumond, Ithaca. Dr. Chauncey P. Biggs was elected fellow and Dr. E. R. Osterhout, alternate.

The following Executive Committee was appointed by President Kirkendall: Dr. Arthur White, Dr. C. P. Biggs and Dr. H. B. Besemer.

It was decided to hold the meetings the second Tuesday of each alternate month in the rooms of the Business Men's Association.

The following physicians who are members of the State Association are charter members of the Tompkins County Medical Association: Drs. Arthur D. White, W. C. Douglass, M. A. Dumond, H. B. Besemer, J. S. Kirkendall, V. A. Moore, C. P. Biggs, of Ithaca; Miles D. Goodyear, of Groton; George M. Gilchrist, of Groton; Willis E. King, of Newfield; Judson Beach, of Etna; E. R. Osterhout, of Trumansburg. * * *

Wayne County Association.—This Association was organized on April 19th, and the following officers were elected: President, Dr. James W. Putnam, Lyons; vice-president, Dr. M. Alice

Brownell, Newark; secretary, Dr. George S. Allen, Clyde; treasurer, Dr. Darwin Colvin, Clyde. * * *

Wyoming County Association.—The stated meeting was held at Castile, N. Y., April 21st. There was a large attendance present, and a new set of by-laws was adopted to correspond with the by-laws of the State Association. Dr. Charles E. Congdon read a paper on "Some Thoughts on Puerperal Infection," with a report on illustrative cases; Dr. J. E. Walker had a talk on "Diabetes," Dr. M. J. Wilson read a paper on "Empyema" and Dr. Cordelia Green had a talk on "Experience with Oxygen." * * *

Westchester County Association.—The annual meeting was held on March 27th at White Plains, the president, Dr. J. L. Sands, in the chair. In the scientific session Dr. T. J. Acker read a paper on "Overdose of Chloral, and Its Treatment." He said that in the individual 280 grains of chloral were taken and did not prove fatal. Dr. W. D. Granger presented a plan to erect a special wing to the Westchester Hospital, where tuberculosis patients could be treated. Dr. Granger's resolution for such a department received the hearty indorsement of the Association. A vote of thanks was tendered the retiring president. The following officers were elected: President, Dr. Thomas J. Acker, Croton-on-Hudson; vice-president, Dr. William D. Granger, Bronxville; secretary and treasurer, Dr. Donald T. McPhail. The following committees were appointed: Legislation, Drs. H. Ernst Schmid, William L. Wells and Edward F. Brush; Public Health and Medical Charities, Dr. W. D. Granger, chairman; Drs. H. Ernst Schmid and William J. Meyer; Ethics and Discipline, Drs. N. L. Sands, Peter A. Callan and Howard Kelly; Executive Committee, Drs. B. J. Sands and W. J. Meyer.

The next regular meeting of this Association will be held on May 28, 1903, at 2 P. M., in White Plains, N. Y. The following is the program for the meeting: "School Hygiene," Dr. H. Ernst Schmid, of White Plains; "Pure and Impure Air and Ventilation," Dr. Donald Thomas McPhail, of Purdy Station; "Some Generalities on Syphilis," Dr. William J. Meyer, of White Plains; "Puerperal Eclampsia," Dr. Thomas J. Acker, of Croton-on-Hudson.

Drs. Frederick Holme Wiggin and Parker Svms, of New York City, have accepted an invitation to be present at the meeting.

LIST OF NEW MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION, JANUARY 1 TO MAY 1, 1903.

Armstrong-Hopkins, Saleni, Tyre.
Ayer, Warren L., Owego, N. Y.
Ayvazian, Antranig, New York.
Bassett, John N., Canton.
Beers, Nathan T., Jr., Brooklyn.
Billings, John S., Jr., New York.
Bodine, John A., New York

Brouner, Walter B., New York.
 Brunner, William J., New York.
 Carpenter, Eugene H., Oneida.
 Carroll, Jane W., Buffalo.
 Cassell, James W., New York.
 Chauveau, Jean F., New York.
 Clark, George W., Waterloo.
 Crosby, Alexander H., Lowville.
 Culver, D. J., Harrisville.
 De Cen, Robert E., Buffalo.
 De Lisle, Justin, New York.
 Dennis, Charles W., Goshen.
 Donohue, Florince O., Syracuse.
 Dumond, Marcus Abner, Ithaca.
 Elebashi, Clarence S., New York.
 Flint, Austin, Jr., New York.
 Foster, George V., New York.
 Fridenberg, Percy, New York.
 Fuhs, Jacob, Brooklyn.
 Gallagher, Edward J., New York.
 Green, S. S., Buffalo.
 Heuel, Frank, New York.
 Jackson, Charles W., New York.
 Kirchof, Charles G., New York.
 Knapp, William H., Binghamton.
 Lester, Elias, Seneca Falls.
 Lewinthal, David C., New York.
 Lurie, Joseph H., New York.
 McCoy, John J., New York.
 McKay, James J., Potsdam.
 McAuliffe, Dennis A., New York.
 Mahady, Charles R., Rome.
 Mayne, Earl H., Brooklyn.
 Meyer, Oscar N., Monticello.
 Myers, John F., Sodus.
 Morris, Joshua W., Jamestown.
 Nevin, Ethan, Ogdensburg.
 Nour, George Elias, Niagara Falls.
 Parmenter, John, Buffalo.
 Payne, Albert E., Riverhead.
 Perry, John G., New York.
 Piper, Charles W., Wurtsboro.
 Peck, Charles, New York.
 Pettit, Louis C., Ward's Island.
 Rambaud, George G., New York.
 Ransom, David H., Buffalo.
 Rand, W. H., Keene Center.
 Robertson, Victor A., Brooklyn.
 Ross, William J., Clayton.
 Ruhl, Henry, New York.
 Saril, H., Davison, New York.
 Schlegel, Gustavus, New York.
 Schondelmeier, C. T., Brooklyn.
 Schroeter, Ludwig, Buffalo.
 Simmons, Charles E., New York.
 Simmons, John Gorse, Westchester avenue, New York.
 Slade, Mary, Castile.
 Smith, Alexander A., New York.
 Smith, Harmon, New York.
 Starke, Gustave H. E., New York.
 Stebbins, F., Lansing, Geneva.
 Steele, Wellington G., Mongaup Valley.
 Thelberg, Elizabeth B., Poughkeepsie.
 Tremaine, Annie M., Sonyea.
 Townsend, F. M., New York.
 Tracy, Ira O., Brooklyn.
 Tuttle, George Albert, New York.
 Ward, George G., Jr., New York.
 White, Arthur D., Ithaca.
 Wheelock, A. A., Elizabethtown.
 Wieber, Adolph, Brooklyn.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

First District Branch, Lewis County.—George H. Littlefield, Glenfield; LeRoy W. King, Lowville; Frank M. Ringrose, Constableville; Henry H. McCrea, West Ley-

den; Morris S. Hadsall, Dr. Ira D. Spencer, Croghan, Barnes Corners; J. H. Tamblin, Copenhagen.

St. Lawrence County.—John N. Bassett, Canton.

Second District Branch, Essex County.—George H. Beers, Ticonderoga.

Warren County.—Dudley M. Hall, Glens Falls.

Fourth District Branch, Allegany County.—Emerson W. Ayars, Richburg; George E. Burdick, Andover; Jasper W. Collier, Wellsville; Francis E. Comstock, Wellsville; Halsey E. Cooley, Angelica; Herbert F. Gillette, Cuba; George W. Hackett, Ceres; Charles F. Hoffman, Bolivar; O. N. Latham, Bolivar; Edward J. Loughlen, Andover; Erly H. Madison, Belfast; Charles M. Post, Alfred; George W. Roos, Wellsville; C. Oakley Sayre, Belfast.

Erie County.—Earl Danser, 592 Welden avenue, Buffalo; Thomas Francis Dwyer, 89 West avenue, Buffalo; John Hudson Grant, 715 Mutual Life Building, Buffalo; Stephen S. Green, 326 Niagara street, Buffalo; Lewis George, Jr., 6 Parker avenue, Buffalo; Benjamin Franklin Rogers, 221 Franklin street, Buffalo; Richard Wellington Trotter, Gold and Lovejoy streets, Buffalo.

Genesee County.—Charles D. Graney, Le Roy; William A. Macpherson, Le Roy; Augustus F. Miller, Batavia; Benjamin F. Showerman, Batavia; C. Louise Westlake, Le Roy.

Monroe County.—Clifford V. C. Comfort, 654 Clinton avenue, Rochester; Frederick H. Goddard, 265 Meigs street, Rochester.

Niagara County.—Thomas Snyder, Niagara Falls.

Ontario County.—Frank W. Spaulding, Clifton Springs.

Steuben County.—John D. Mitchell, Hornellsville; Samuel Mitchell, Hornellsville.

Wayne County.—George S. Allen, Clyde; George D. Barrett, Clyde; M. Alice Brownell, Newark; Dwight S. Chamberlain, Lyons; Thomas H. Hallett, Clyde; Harry J. Seamon, Alton; Lucius H. Smith, Palmyra; Jennie M. Turner, Lyons; Anna Warnecke, Newark.

Fifth District Branch, Kings County.—George M. Muren, 73 Orange street, Brooklyn; Charles H. Shepard, 81-83 Columbia Heights, Brooklyn; Charles F. Yerdon, 1276 Herkimer street, Brooklyn.

New York County.—Albert S. Ashmead, Jr., 333 West 23d street, New York; Harry Bock, 208 East 58th street, New York; C. Cole Bradley, 51 West 50th street, New York; Arthur B. Duel, 254 Madison avenue, New York; A. Ernest Gallant, 60 West 56th street, New York; Albert Church Lippincott, 235 West 103d street, New York; Justin de Lisle, 318 West 51st street, New York; Mattoli, 300 East 107th street, New York; S. M. Payne, 542 Fifth avenue, New York.

Richmond County.—Henry T. Goodwin, Tompkinsville.

Sullivan County.—Mary Krom, Bloomingburg; Oscar N. Meyer, Monticello.

Westchester County.—Purdy L. Hitchcock, Croton Falls.

OBITUARY.

William C. Fritz, M.D., of 164 East North street, Buffalo, University of Buffalo, 1892, a member of the American Medical Association, The New York State Medical Association and the Buffalo Academy of Medicine, who had suffered for four or five years from heart disease, died suddenly in the home of a patient in Buffalo, N. Y., March 31st, aged 36.

Dr. William Whitwell, a member of the American and The New York State Medical Associations, died suddenly at Fishkill-on-Hudson, on April 8th. Dr. Whitwell was a graduate of Harvard University, class of 1872.

PERSONAL.

The wedding of Mary Léonita, daughter of Mr. and Mrs. Stephen Joseph Therry, of 2051 Fifth avenue, New York City, to Dr. Frank L. Christian, of Elmira, took place on January 29th at the home of the bride's parents.

Dr. J. M. Heller and Miss Zippora Frenna were united in marriage on the evening of April 21st, at the Hotel Savoy, by the Rev. Dr. Grossman.

Dr. Francis W. Murray, of 32 West 39th street, narrowly escaped death on the evening of March 30th, when an electric car crashed into his cab on Sixth avenue. Dr. Murray was not thrown out, and he settled himself on the lower side of the vehicle and waited until help reached him.

Prof. J. Mikulicz, of Breslau, was the guest of Dr. W. M. Polk, of New York City, last week. Dr. Mikulicz conducted an operative clinic at Bellevue Hospital, on Monday, April 20th.

Dr. Harry Mead, of 758 Elmwood avenue, Buffalo, has gone abroad for a few weeks.

Dr. Arnold H. Knapp has been appointed professor of Ophthalmology at the College of Physicians and Surgeons, which was made vacant by the resignation of Dr. Herman Knapp.

Dr. Herman E. Hayd, of Buffalo, has been elected attending surgeon to the German Hospital, vice Dr. Herman Mynter, deceased.

We wish to congratulate Dr. T. J. Acker on his election as president of the Westchester County Medical Association, an account of which may be found in another column. Dr. Acker has ever been a prominent member of this organization and well deserves the honor he has received at the hands of its members.—*Croton Journal*, April 3, 1903.

Dr. Frank L. Christian, physician to the Elmira Reformatory, suggests in the recent annual report of that institution that the State provide separate accommodations for the inmates suffering from tuberculosis. This is entirely in accord with the most recent progress in the treatment of this disease and should receive the immediate attention of the Committee on Legislation.

The State Commission of Lunacy is gradually associating staffs of consulting physicians and surgeons and distinguished specialists in the scientific conduct of the institutions under its care. The following members of The New York State Medical Association are among those already appointed: Drs. Joseph D. Bryant, Austin Flint, Edward G. Janeway, Robert C. Kemp, W. Evelyn Porter, James P. Tuttle and William C. Lusk.

The present plan of the Board of Directors of the Stony Wold Sanatorium is to open their buildings at Lake Kushaqua in August next. This sanatorium is designed for working women, young girls and children suffering from incipient tuberculosis, who cannot receive the proper care at their own homes. It promises to fill a want long felt by those patients who could not afford the proper care of themselves and yet who would not be proper objects for the public charity of the State.

The following members of this association are upon the Medical Board: Dr. E. G. Janeway and Dr. Charles H. Knight.

LEGAL NOTES.

Legal Hints with Reference to Claim Against Decedent Estates.

BY JAMES TAYLOR LEWIS,
Counsel.

Every executor and administrator must proceed with diligence to pay the debts of the deceased according to the following order:

1.—Debts entitled to a preference under the laws of the United States.

2.—Taxes assessed on the property of the deceased previous to his death.

3.—Judgments docketed and decrees entered against the deceased according to the priority thereof, respectively.

4.—All recognizances, bonds, sealed instruments, notes, bill and unliquidated demands and accounts. Code Section 2719.

It will be seen at a glance that physicians' bills are in the last class, and it therefore behooves the physician to prepare his account promptly for presentation.

It may be added in reference to the special contracts before referred to that where a married woman has made such an agreement to pay and dies, the bill can be charged against her estate, but the law holds that such a contract cannot be *inferred* from the mere fact that she called the doctor in. There must be such a special contract actually in force.

Upon the death of the patient, a physician should immediately prepare an itemized bill, giving dates and amounts charged for visits. He must then learn from the records in the office of the Surrogate of the county where the decedent resided at the time of his death who the executor or administrator may be.

An executor is a person appointed by a last will to administer a decedent's estate; an administrator is one appointed by the Surrogate's Court for a like purpose, either upon the failure to appoint by will or the entire failure of a will, or death or removal of an executor, upon the petition of some person entitled to make such an application.

The statement of the bill should be addressed to the executor or administrator as such of the estate of deceased. Then should follow the carefully itemized and dated bill, to be followed by an affidavit. The following is a satisfactory form for the affidavit: City and County of —, ss. —, being duly sworn, says, that he is a physician and surgeon, having an office at —. That the foregoing is a just and true statement of the indebtedness due the deponent for services rendered to the decedent during his lifetime, and against which amount there is no offset or counter-claim to the knowledge of the deponent, and that no part thereof has been paid. Sworn to before me, etc.

This, of course, must be sworn to before a notary and delivered to the executor or administrator.

I might add that there can often be found in

a nearby stationer's blank affidavits to attach to proofs of claims against estates, which are often more convenient to use than to draft one's own affidavit, as suggested here.

There is a certain time—to wit, six months—during which claims should be filed after a decedent's death, but a failure to file within that time is not fatal. If the claim is presented before or upon the final accounting of the executor or administrator, it will be sufficient unless the claim should be barred by the statute of limitations, which in effect says, that there must be an attempt made by suit, to collect a bill within six years from the last item of charge or credit.

Within a reasonable time after its receipt, the executor or administrator, if he intends to object to the claim, must notify you that he holds its propriety or validity, and must offer to refer it or simply decline absolutely to pay.

In either of these cases it is imperative that you consult an attorney without delay, and when consulted follow his advice as implicitly as you would wish your patient to follow yours.

There is in these physicians' claims food for reflection by your Committee on Legislation. There can be no good reason why the doctors, druggists or nurses, who furnish attendance, services and materials, should not have preferred claims to be paid in full from decedent's estate, especially for such medical attendance during the last illness of a decedent. This is worthy of serious consideration, for it is a matter of no little importance to our membership.

In this connection a most important point arises with reference to the question of proving the services of a physician rendered a deceased person. The rule of law says, in effect, that a doctor suing an administrator or executor cannot testify to personal transactions had with the deceased person—the person he treated.

The decisions hold, however, that the doctor's books may be offered in evidence, and so prove the bill, provided he supplements such proof with proof that he keeps an accurate and correct set of books. This is simply to show how important are a complete record of daily entries, and an accurate set of books.

One of our own members was compelled, some years ago, to accept about \$150 on a bill of \$1,700 on account of this bit of law.

THE PROSECUTION OF QUACKS.

A warrant was issued for the arrest of one Rafael Cardamone, of East New York. After two adjournments he waived examination for trial at Special Sessions. This case was reported by a citizen of Brooklyn, on his own behalf, and the arrest was made upon his affidavit alone. No detectives were required.

The eastern section of Brooklyn is filled with these unlicensed foreigners, and it is rather remarkable we do not receive more complaints from respectable physicians in that vicinity.

Henry Surson, of 130 East 123d street, who was arrested and accused of practicing medicine without a license, was sentenced yesterday in Special Sessions Court to thirty days' imprisonment and fined \$100.

QUACKERY'S NEW ENEMY.

Fraudulent Doctors and Medical Concerns Offend the Public.

By boasting that they could cure consumption these cure-alls have incurred the lasting enmity of the Charity Organization Society, and the wholesale exposé of their methods of imposition upon the ignorant sick will doubtless do much to relieve this State of a class of men more to be despised than gamblers or keepers of disreputable houses.

Thousands of circulars have been sent out by this society, which state in brief that there is no special medicine which will cure consumption, and that alleged cures and specifics that are widely advertised are valueless.

In mentioning this subject the *New York Herald* of March 29th said: "From a statement made yesterday by an official of the Charity Organization Society it would appear that several of the concerns are of doubtful standing. Names of prominent scientists are used to boom 'cures,' but it is done in such an adroit manner that the men mentioned have no redress.

"People, principally those in poor circumstances, read these glowing announcements and believe in the representations," said a prominent member of the society. "Having failed to find a cure for throat or lung trouble, they take hope and immediately proceed to fall victims to them.

"Some of these concerns are frauds. The proprietors are men of brains, but utterly unscrupulous. One man features a noted German scientist in connection with his particular 'cure.' Poor persons believe that the famous doctor is interested in the concern and they pluck up courage. They visit the richly furnished offices of the 'cure' and pay their money for the treatment. Of course, they receive no benefit.

"Pathetic instances are named by the society, where patients who are incurable have spent all their money with the concern. One man, who receives \$18 a week, spends \$10 of it for the treatment. A woman who had exhausted her resources and was unable to continue the 'treatment' was told she would either have to sign a testimonial that she had been cured or the 'treatment' would be stopped. She refused to give a testimonial and reported the matter to the society.

"When Dr. Herman M. Biggs, medical officer of the Health Department, made an address on 'Tuberculosis' last summer his utterances were published in part by one of the concerns in an advertisement in such a way as to lead the reader to believe that he approved of that concern."

DISEASED BEEF FROM ——— COUNTY.

In the vicinity of ——— there lives a man who, until recently, had very little respect for our State Agricultural Department. He is now much wiser and may yet be much sadder. The law's arm is reaching for him.

Having a number of sick and dying cows in his herd, and loving a certain calf of a golden hue much more ardently than he loved his own cattle, or even his fellow-creatures, this rustic sharper loaded these suffering animals upon a car and shipped them to New York City. In some unexplained way the cows escaped from quarantine at Albany and were started for Manhattan, but the State inspectors were soon in hot pursuit. It was not a difficult matter to trace them, and the cattle were soon located in a slaughter-house. The

inspectors declare that they were about the most diseased lot of animals that has ever been brought to their attention.

Had the shipper been successful in eluding the State officers he would have found the local system of inspection so rigid that the meat from these animals would never have reached the retail market.

ASSOCIATION DEFENSE.

OFFICES OF COUNSEL, JAMES TAYLOR LEWIS,
180 BROADWAY, NEW YORK, April 21, 1903.

DR. ALEXANDER LAMBERT,

President New York County Medical Association.

DEAR DOCTOR—From my close relations to the county association of New York County it might not be ill-timed to say something of the work in the legal department.

As you know, the State Association has taken from the County Association of New York the plan used by that organization in defending its members, so that now the whole State is covered by the section of the State by-laws governing that subject.

Defense has been furnished three State Association members, and an application is now pending before the Council for the fourth, which will prove a most interesting matter if it ever comes out.

A young physician of this city has been charged by a woman patient with assault under very distressing circumstances, and I am frank to say that I believe the physician's version of the affair, and have expressed my willingness to defend him, provided the Council is of the same mind, though, of course, such defense is not within the provisions of our by-laws. It has nothing to do with malpractice, but as it affects the young man's future in his professional life the State Association may well consider it.

Those who are so unfortunate as to be caught by their blackmailing suitors are usually men of the highest standing, and no physician can say at what moment he may be attacked.

The work of prosecuting illegal practitioners of medicine is progressing, and the great medical organization of the State is making itself felt in many counties. The members should be ever watchful for these medical mountebanks and send complaints to the secretary or counsel without delay. Keep this in mind and the Association will soon be able to stamp out this menace to the public health.

Please accept my congratulations and best wishes for the coming year.

Yours very truly,

JAMES T. LEWIS.

Counsel The New York State Medical Association.

To Limit Malpractice Suits.—The Council of Physicians and Surgeons of New Brunswick, acting for the New Brunswick Medical Society, has sent to the Provincial Legislature a bill with the object of securing a limit of one year to the time in which an action may be brought for injuries resulting from alleged malpractice.—*Journal American Medical Association*, April 11, 1903.

DOCTOR SUES FOR \$10,000 FEE.

Dr. C. C. Rinchart, of Pittsburg, has entered suit against W. C. Jutte to recover \$10,000 for medical services. It was necessary for the defendant to give up business and he determined to go to Europe. At Mr. Jutte's request, the physician says, he accompanied him abroad, rendering him necessary and continuous service from July 8 to September 26, 1902.

PAYMENT OF DUES.

The following letter exemplifies the fact that doctors are too careless about their business affairs. This member would never forget a call he had to make, or mislay a prescription, but by mislaying his bill for dues he has lost \$1. Only \$1, but how many may follow it through such unbusinesslike habits:

APRIL 15, 1903.

DR. C. E. DENISON, Treasurer.

DEAR DOCTOR—This bill slipped my mind until I just came across it among some other papers, and I see the time for rebate is a little overdue, but I will inclose my check for \$8, and if you cannot accept it for the yearly dues, please return it and I will send you one for the full amount.

Very respectfully,

H. I. T.

Extract from by-laws of the State Association:

"All dues shall be payable on the first day of January of each year."—Article X, Section 3.

"If such dues be paid within three months of the date of submitting the bill, a rebate of one (1) dollar may be deducted."—Article X, Section 2.

MEMBERS IN ARREARS.

Dues.—Members of the State Medical Association who are inadvertently omitted in the statements of the local treasurer of dues paid to the State treasurer may find their names are omitted from the list of members published in the Medical Directory, as required in the By-Laws, Art. X, Sec. 4: "On the 1st day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year." It is proposed to publish in the June number a list of members whose dues have not been received by the State treasurer. Members who find their names in this list should immediately communicate with the local treasurer, and before the 1st of July have their dues sent to the State treasurer. Their names will be properly enrolled in the list of members published in the Medical Directory for this year.

INCREASED DEMAND FOR THE DIRECTORY.

The advance sale of the next edition of the Medical Directory of New York, New Jersey and Connecticut has already exceeded that of any previous edition. Each member of The New York State Medical Association is entitled to one copy. After these have been supplied subscribers will be furnished in the order of their applications until the edition is exhausted.

MEDICAL DIRECTORY FOR CALIFORNIA.

There is every reason to believe that the publication of the directory by this society would cost a considerable sum, but the directory published by The New York State Medical Association has cost that association several thousand dollars; yet the members are perfectly satisfied. They probably reason that a medical association has but one excuse for existence, and that is to be of use, help and benefit to its members, and that no better way of spending its revenues can be devised than in the publication of its journal and the directory, both of which are considered useful, helpful and beneficial to the members as individuals and to the association.—*California State Journal of Medicine*, March, 1903.

News Items.

Transactions.—There are a few more complete sets on hand of the Transactions of The New York State Medical Association, consisting of sixteen bound volumes in each set, which may be had by paying freight charges by any member of The New York State Medical Association or of the American Medical Association or any library, by applying at this office.

INTERNATIONAL MEDICAL CONGRESS.

The following members of the Association are attending the International Medical Congress in Madrid: Drs. Reginald Hall Sayre, Louis Fischer, A. E. Macdonald and John H. Huddleston.

The Congress of American Physicians and Surgeons will be held in Washington, D. C., on May 12, 13 and 14, 1903.

* * *

The American Urological Association will hold its annual meeting in the amphitheater of the New Orleans Polyclinic on May 8th and 9th.

* * *

Samuel D. Gross Prize.—The Philadelphia Academy of Surgery announces that the Samuel D. Gross prize of \$1,200 will be awarded January 1, 1905. The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding 150 printed pages octavo in length, illustrative of some subject in surgical pathology or surgical practice, founded upon original investigations, the candidates for the prize to be American citizens." The essays, which must be written by a single author in English, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 219 South 13th street, Philadelphia," on or before January 1, 1905. Each essay must be distinguished by a motto and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

* * *

Hospital Incorporated.—The Frederick Ferris Thompson Hospital, Canandaigua, has been incorporated. This hospital has been given to the village by Mrs. Thompson, in memory of her husband, and is now rapidly approaching completion.

* * *

Vaccination in the Schools.—Attorney-General Cunniff gave out an explanation of his opinion in the Dunkirk parochial school vaccination case. He holds that the State health law does not compel the authorities of parochial schools to exclude unvaccinated children from attendance, but that the local Board of Health may, if it deems it necessary, issue an ordinance directing general vaccination and providing a penalty for non-compliance. The opinion is an important one, as it is the first time the question has been passed upon.

NATIONAL BUREAU OF MEDICINES AND FOODS.

Certificate of Incorporation.

We, the undersigned, all being persons of full age, and at least two-thirds being citizens of the United States, and at least one of us a resident of the State of New York, desiring to form a corporation, pursuant to the provisions of the Membership Corporations law of the State of New York, do hereby make, acknowledge and file this certificate for that purpose as follows:

The particular object for which this corporation is to be created is:

To determine upon and fix standards of identity, purity, quality and strength and to secure adherence to prescribed formulas of all drugs, chemicals, foodstuffs and of all articles intended for use in the arts and sciences or for human consumption; to diffuse accurate and reliable information as to such articles, preparations or products and as to those making or dealing in the same; to procure uniformity and certainty in the customs, usages and methods of manufacture of those engaged in the foregoing or allied trades; to supervise the manufacture, preparation or production and distribution by its members of all commodities, articles or preparations mentioned, and upon sufficient evidence that the standards of identity, purity, quality and strength, as well as adherence to prescribed formulas, have been maintained, and that all requirements for manufacture, preparation or production as set forth in the by-laws, rules or regulations made and provided, have been complied with by the members manufacturing, preparing, producing or distributing such commodities, articles or preparations, to issue to such member a certificate of identity, purity, quality or strength and compliance with prescribed formulas, which certificate shall be of the form and nature and shall be used in the manner set forth in the by-laws, rules or regulations for that purpose made and provided; but no nostrum nor any medicinal preparation or proprietary remedy, of which the full formula embracing all active ingredients with their quantities and couched in the ordinary terms of pharmacy and chemistry has not been or may not be freely published, may at any time be so certified; to settle differences between its members and to promote a more friendly intercourse between business men and between its members; to aid, stimulate and encourage research, investigation and study that will tend to enlarge, improve or increase and diffuse knowledge and information of materia medica, chemistry, pharmacy, pharmacology, pharmacognosis, pharmacodynamics, therapeutics and all arts and sciences allied thereto.

Et c.—(Name, place of business, names of directors, etc.).

NATIONAL BUREAU OF MEDICINES AND FOODS.

General status of the proposed Bureau; legal opinion taken subsequent to the meeting of the committee of the New York County Medical Association, March 13, 1903.

The Bureau has by statute the right to determine what persons shall be or become its members and the qualifications or requirements for such membership. It also has the right to determine upon what conditions such membership shall terminate. The charter or certificate of incorporation of the Bureau permits it to certify to the standards of identity, purity, quality or strength of the various articles within its scope for its members. Consequently, it could not be compelled to certify any article not made by a member, nor any article made by a member, but not complying with the requirements of the Bureau in the matter of identity, purity, quality or strength, etc. As it would be a membership corporation, intended to do certain things for its members, who become such by voluntary association and by application, no cause of action could be maintained against it for refusal to accept an application for associate membership or to certify any given article not complying with its requirements.

Provisions of the Membership Corporations Act, giving limitations and requirements of certificate of incor-

poration, by-laws, rules, etc., together with outline of by-laws.

Certificate of Incorporation.—Any five or more persons, two-thirds of whom are citizens of the United States, and at least one of whom is a resident of the State of New York, may incorporate; the certificate of incorporation shall set forth: First, the special object for which the corporation is to be created; second, the name of the corporation; third, the place of its principal office; fourth, number of its directors; fifth, names and places of residence of the persons appointed to be its directors until the first annual meeting; sixth, the time for holding its annual meeting. These provisions are duly covered in the draft of certificate herewith.

By-laws.—May be divided into different classes and designated constitution, by-laws, rules, regulations or otherwise, and may provide different methods for amending and repealing such classes, respectively. In the following outline the provisions of the act covering the matter of each article will be found at the commencement of the proposed article.

ARTICLE I—*Members.*—By-laws may make provisions regulating admission, voluntary withdrawal, censure, suspension and expulsion of its members; fees and dues of members and termination of membership on non-payment thereof or otherwise. (By-laws, rules or regulations may be read synonymous terms throughout.) Membership to be divided into three classes—scientific, associate and affiliated. Scientific members to be the members of the American Medical and the American Pharmaceutical Associations and such other scientific societies (as, for example, the American Chemical Society) as may desire to associate with these two associations in participating in the work of the Bureau. The election of directors, however, as elsewhere provided, to remain in the hands of the two associations named, each having five directors. Associate members to be such corporations, firms or individuals as are connected with the investigation, manufacture, preparation, distribution or sale of products or articles covered by the work of the Bureau. All persons, etc., who would become associate members of the Bureau would be connected in some way with the commercial side of the question; they might be chemists of manufacturing houses, manufacturers, druggists, etc. It is essential that every corporation or person for whom goods are certified by the Bureau shall be necessarily a member of the Bureau, subscribe to its rules and regulations, and be subject to its discipline. The application for associate membership would contain a contract covering these points and of a nature to protect the Bureau against legal complications in case it should be necessary to discipline any associate member. Associate members could have no voice in the election to the Board of Directors, nor in the affairs of the Bureau. Affiliated members would be such persons as cared to receive the information diffused by the Bureau, or who were willing to aid in its work by having themselves identified with the Bureau. The intent of this section would be to enable the Bureau to secure the open indorsement of a large number of prominent persons all over the country, who would add stability in many locations, and who would not be eligible as members otherwise. Provision would also be made for dropping associate members for non-payment of dues. Dues of associate members would be \$5 per year, a sum that would add somewhat to the revenues of the Bureau, yet it would not be too large or burdensome upon even the smallest retail pharmacist. Dues of affiliated members would be merely nominal—\$1 per year—possibly enough to cover postage.

ARTICLE II—*Directors.*—By-laws may provide the number of members, not less than one-third, or if one-third be nine or more, not less than nine, whose presence shall be necessary to constitute a quorum at its (Bureau's) meetings; the qualifications of its voters, the eligibility of members to become directors, the classification of its directors into not more than five classes, so that the term of office of all directors of one class only shall expire each year, and that the term of office of their successors shall be as many years as there are

classes, but not so as to change the term of office of any director then in office, official designations, powers, duties and compensation of its officers, what shall constitute a vacancy and the manner of filling it; they shall be elected from the members, by the members and by such other persons as are authorized by or in pursuance of law to vote therefor.

It is clear from the foregoing provisions of the act that the qualifications necessary for election to the directorate or to office may be formulated in the by-laws. These qualifications should include the following specifications: No commercial connection whatsoever with any person, firm or corporation, manufacturing, preparing, producing, distributing or selling any article included in the work of the Bureau, or which might be certified by the Bureau; membership in good standing, either scientific or affiliate, in the Bureau, and nomination to the office of directors by either the American Medical or the American Pharmaceutical Association at a regular annual meeting of such association; that for a period of not less than one year prior to such nomination for director he shall not have had any financial interest or connection in any business manufacturing articles coming within the province of this Bureau.

Classification.—The directors would be divided into five classes of two members each, one of whom would represent the American Medical and the other the American Pharmaceutical Association; two directors of the same class would retire each year and their successors be elected for five years.

Manner of Election.—Under existing statutes the directors must be elected at the annual meeting of the corporation; as already indicated, however, it may be a requirement that such persons elected must have been nominated by one of these two associations. Nine or more members of the Bureau would constitute a legal quorum, and they could only elect to the directorate such persons as had been nominated for that office; consequently, nomination by either association would be equivalent to election. It would always be possible to secure the attendance of nine members of the Bureau at an annual meeting. A charter from Congress could be obtained later which would obviate the necessity of this and permit of election by the associations direct and at their annual meetings.

Vacancies.—Vacancies may occur by death, resignation or otherwise; continued absence from the country, failure or neglect to perform the necessary or required duties of the office, may constitute a vacancy, and such may be declared by the Board of Directors. Any vacancy occurring in the representation of the American Medical Association on the Board of Directors would be filled by the board, but the remaining directors representing that association must unanimously agree upon the person so elected to fill such vacancy. Similarly with the American Pharmaceutical Association representation. Vacancies should be filled until the next annual meeting of the Bureau following the annual meeting of the association having deficient representation, at which time it should be filled for the unexpired balance of the term by election of some person nominated for that purpose by the association having deficient representation. In case of any vacancy in the board the remaining directors shall continue to act, but if at any time the number of directors falls below eight they shall at once proceed to fill any and all vacancies. The directors shall act only as a board, and individual directors shall have no power as such. It should be provided, however, that any three or more directors could meet and act upon any subject, their determinations becoming the regular act of the board when the necessary approval shall have been received in writing from the remaining directors, or such portion of them as that particular act may require—a majority or eight-tenths, as the case may be. This in order to enable the board to transact its business, as much as possible, by mail. It may be provided that directors shall meet in New York or anywhere else they may by resolution determine. At least one director must always be a resident of the State of New York. It should be provided

that no directors other than the secretary and treasurer, who will probably have enough to do to occupy all his time, should receive any salary or other compensation, except mileage and per diem, when required to attend a meeting of the Board of Directors or of the Executive Committee. (For Executive Committee, *vide infra*.)

ARTICLE III.—As already set forth, the by-laws may indicate the qualifications of electors and the requirements for eligibility to election to office. They should state that only scientific and affiliated members may be eligible to vote at the annual meetings, but as all that could be done would be to elect the persons nominated for directors by either of the associations named, this is not essential. In this article, however, it should be specifically stated that only the House of Delegates of the American Medical Association and the regularly authorized voting delegates of the American Pharmaceutical Association would be authorized to nominate persons for election to the Board of Directors, and only at the annual meetings of these respective associations.

ARTICLE IV—*Officers and Committees*.—The statute allows full freedom in the matter of officers and committees, duties, compensation, etc.

It is suggested that there be a president, a secretary and treasurer (one person) and an executive committee. There may also be a vice-president and any other officers or committees that the Board of Directors may from time to time determine. The duties of such officers would be those customary. They should be elected at the first meeting of the Board of Directors after organization each year. The Executive Committee should consist of the president, the secretary and treasurer and three other directors. Either the Executive Committee or the Board of Directors should at once appoint a general manager.

The Executive Committee would first consider all applications for associate membership, certification of products, formulation of rules, etc. They may, however, submit any or all questions to the whole board. They should notify all members of the board of all matters under consideration by them and of their determinations. A four-fifths vote of the Executive Committee should be required for decision on any proposed rule, regulation, acceptance or rejection of application for certification, etc. It should be provided that in case of any such acceptance or rejection or formulation of rules or regulations, etc., by the Executive Committee alone, either the general manager, the secretary and treasurer or any director may request that the whole matter be referred to the entire board for action, and that the passage of any measure of the sort indicated be only upon the written approval of eight-tenths of the board. While it is true that this would enable three men to prevent any action by the Bureau upon any question whatever, it is probable that three men of the stamp and character of those whom it is believed will be chosen for directors would not thus hold up all work by the Bureau unless for good and sufficient reason. And further, it is desirable and necessary that as full and representative approval of the Board of Directors as possible be required for its acts in order to safeguard the acceptance of articles for certification. It, therefore, would seem the lesser evil by far to require at least four-fifths of the Executive Committee and eight-tenths of the Board of Directors to approve the acceptance or rejection of any article or the formulation of any rule concerning the same. The directors should pass upon all questions of a scientific nature or regarding the scientific work of the Bureau, but they should under no circumstances come into business relations or contact with any of its associate members, or with the business of carrying on the work of the Bureau other than to direct original investigation, formulate rules for conducting investigations required for certification, standardization, methods of advertising permitted associate members, etc.

General Manager.—The general manager should be appointed by the Executive Committee and be approved by eight-tenths of the Board of Directors. He should have authority to employ and dismiss such persons as

may be required to conduct the business of the Bureau, and he should be personally responsible for the proper carrying on of the work and of those employed by him for that purpose. He should have absolute authority in the matter of details and method of conducting the work of the Bureau, as indicated in its rules or regulations. If he is the right person he will do this work properly, and if he is not some one else ought to do it. The principle remains, however, that the general manager should not be subject to interference in the conduct of the business of the Bureau within the lines of the rules and regulations. In order to insure stability he should be subject to removal only for cause as follows: Continued inability to perform the duties of his office, disregard or failure to comply with the rules of the Bureau, malfeasance, general improper conduct that would tend to bring the Bureau into disrepute through its administrative head and only by four-fifths of the Executive Committee, approved by eight-tenths of the Board of Directors. His responsibility will necessarily be great, as he will be in possession of much confidential information in regard to the relative business of the various associate members, in addition to being responsible for the proper and honest working of the Bureau. His salary should be fixed by the Executive Committee and approved by the Board of Directors, and it should be sufficient to render the probability of his being unduly "influenced," to divulge any confidential information, remote. He should be required to have kept in his office full and accurate accounts and in such manner that they may be at any time audited without disclosing the relative business of the associate members. He should not be a member of the Board of Directors. He should have charge only of such funds as may be required in the transaction of the business of the Bureau, but not of any sinking fund, funds for research or investigation, etc., which should be in the custody of the treasurer, and all checks should be countersigned by the president, the treasurer or a director. He should be authorized to enter into contracts in the name of the Bureau between the Bureau and its associate members for the faithful performance of the obligations of associate members and for apportioning the assessments of such members, for defraying the expenses of the Bureau and for other similar purposes; but such contracts should be countersigned by the president or a director.

ARTICLE V—*Seal*.—This article should simply define the seal of the Bureau.

ARTICLE VI—*Amendments*.—The certificate of incorporation and the by-laws should contain as little detail as possible, and it should be made difficult to amend them. Not less than eight-tenths of the directors should concur in any proposed amendment to the by-laws. Details and specific requirements under the by-laws should be formulated in the shape of rules, and these made more easy of amendment as occasion may require. It might even be well to make unanimous approval necessary to amend the by-laws and eight-tenths approval necessary to amend or formulate rules, etc. The organic law of the Bureau should be broad and general, covering the ground thoroughly, but not in detail; for, while it is frequently necessary to modify the modes of procedure or minor details, as conditions change or arise, it should not be necessary to alter the general principles on which the entire plan is founded or which are to be followed in the course of the work. The power to amend the by-laws should certainly be confined to the Board of Directors, for in large associations like the two that control the Bureau and have power of electing its directors much harm could be done to the Bureau by a few who might succeed in manipulating in such a manner as to secure the passage of amendments that would tend to entirely upset the work of the Bureau or to destroy its integrity.

RULES.

Immediately upon organization the directors should adopt certain rules setting forth what class of articles should or could be accepted for certification and the requirements in the several cases as to standard of

identity, purity, quality or strength, etc. For instance, a rule should be passed stating that chemicals intended for reagents or otherwise should bear upon the label a statement of the substance contained other than the chemical itself, or else setting forth that the chemical so labeled is free from certain impurities commonly found associated with it. It should also formulate a number of rules of the general nature of the following:

No. 1.—No associate manufacturer or associate member having one or more products or articles certified by the Bureau shall be permitted to advertise or make any public statement to the effect that his products are certified by this Bureau, or which might be construed to carry that meaning; provided, however, that in all advertisements or statements of any article certified by the Bureau for such associate member the fact that such article is certified by the Bureau shall be made, and that if all products or preparations manufactured by such associate member shall be certified by the Bureau he may then so advertise or state.

No. 2.—No application for associate membership in this Bureau shall be declared accepted until it shall have received the written approval of four-fifths of the members of the Executive Committee and until the members of such committee have been advised by the general manager that said applicant for associate membership has signed a contract of the regular form and nature provided in rule No. "X," and that such contract is on file in the office of the Bureau.

No. 3.—No article, product, preparation or commodity shall be certified by this Bureau unless the firm, corporation or individual manufacturing, preparing or producing the same shall be an associate member of the Bureau, nor unless all persons connected with the chemical or scientific laboratories of such firm, corporation or individual shall also be associate members of the Bureau.

OFFICES OF COUNSEL, JAMES TAYLOR LEWIS,
180 BROADWAY, NEW YORK, April 9, 1903.

DR. E. ELIOT HARRIS,

Chairman Committee on Proprietary Remedies,
33 West 93d Street, New York.

MY DEAR DOCTOR—Your request of April 6th for an opinion on the subject therein mentioned I received.

This afternoon I had a conference with Frederick W. Garvin, of 27 Pine street, this city, who has been at work preparing the articles of incorporation for the proposed Bureau. The discussion with him confirms my own ideas as already expressed to you.

In expressing my opinion herein I shall assume that the facts are that our committee wishes to form a corporation, to be styled the National Bureau of Medicines and Foods, presumably under the membership law of this State, and it is your wish to elect as directors of such corporation such persons as are selected by the A. M. A. and the A. Ph. A. and none others.

It is perfectly legal and quite proper for such a corporation to make a by-law covering just that situation—*i. e.*, providing that members of the corporation thus formed should elect as members of its Board of Directors only such persons as were theretofore selected by the A. M. A. and the A. Ph. A. at their regular annual meetings. In other words, that such a by-law would make it illegal to elect any other person a director, except such persons as were duly qualified by having been previously selected by the two corporations referred to.

In order to absolutely guarantee the carrying out of such a by-law it might be preferable to make such a provision a part of your articles of incorporation, as well as one of your by-laws, thus absolutely binding all members of the Bureau, who, by becoming its members, of necessity subscribe to its by-laws and articles of incorporation.

Of course, the articles of incorporation must be very carefully drawn, so that there can be no mistake as to what the intentions of the corporation are, and when

such intentions are properly stated, as I have already indicated, you may rest assured that they will be based upon good legal principles and good statute law.

Very truly yours,

JAMES TAYLOR LEWIS, Counsel.

To the Chairman of the Committee on Publication:

On Monday, April 20th, the night of the meeting of the New York County Medical Association, I was called to a patient who developed a sudden dangerous symptom of his disease and therefore was unable to present the report of the Committee on Proprietary Remedies on the subject of the Incorporation of a National Bureau of Medicines and Foods. As the committee voted to report unfavorably on the question I submitted as a member of the council a full report on the Incorporation of a National Bureau of Foods and Medicines to the council of The New York State Medical Association at its meeting on Wednesday, April 22d, which is herewith appended.

Yours very truly,

E. ELIOT HARRIS, Chairman.

APRIL 14, 1903.

E. ELIOT HARRIS, M.D.,

33 West 93d Street, New York,

Chairman of the Provisional Committee on the
Proposed National Medicine and Food Bureau.

DEAR DOCTOR—I have just been reading the announcement on page 1002 in the *Journal* of the A. M. A. for April 11th in reference to the proposed National Medicine and Food Bureau. I have discussed this matter many times for years past with the gentlemen who originated the idea, and was invited to become a member of the original organization, but was so busy with other matters at the time that I could not then take it up.

As you are aware, I have given more of my attention to business during the last fifteen years than I have to practice, and my experience in the business world has impressed me with the great need for some plan to prevent false statements by the manufacturers of medicinal and food products. Perhaps a few of my experiences in this regard may be of some value to your committee.

A few years since, when I was a large stockholder in a manufacturing concern putting out a diastasic malt product, our representatives were constantly hampered in their work by physicians who ridiculed our claims as to the diastasic power and food value of the product, and analyses by chemists of repute appeared to have little effect upon the doubters. I found that their principal reason for doubting our statements was due to the fact that so many prominent houses made claims with reference to products that were not true, that they were inclined to doubt everything said, not only by the owners of legitimate and honest products, but even the reports of chemists of eminence in reference to their values—could not separate the sheep from the goats, so simply went it blind. About this time I saw an advertisement in the medical journals, in which it was stated that a certain malt food manufactured in ——— was rich in diastase. I knew from the physical characteristics of the product that it could not contain diastase; but, to be sure, I had it analyzed by two competent chemists, each without the knowledge of the other, and they both reported that it was absolutely non-diastasic. I wrote to the ——— house, called their attention to their misstatement of facts and urged them to withdraw their misleading statements. They replied in a sarcastic manner, made no defense—simply told me that it was none of my business, and that they could get chemists just as good as mine who would certify that it was diastasic! I reported the matter to the chemist of the United States Agricultural Department, Dr. Wiley, and asked him to give me an appointment to lay the matter before him in detail. He replied in an evasive manner, and although I several times afterward solicited an interview, I could not get to see him. This, of course, made me feel that

nothing could be done. I have known Dr. Wiley many years and he has always treated me personally with courtesy, so I reached the conclusion that it was not in his power to take the matter up, and let it drop. I do not wish to leave you under the impression that I am criticizing Dr. Wiley. I am merely giving you my experience with him at that time. He was doubtless so handicapped that he could not commit himself.

Another case was that of a ——— house making a liquid malt, claiming diastasic power. The State chemists of Pennsylvania published an analysis of this product, showing that it had no diastasic power, but they went on making their claims in their labels, and do so still, as far as I know. This, in spite of the fact that the product is simply a beer and has no diastasic value and very little if any food value. Still the profession has prescribed many thousand bottles of it during the last few years, believing the statement of the firm making it.

Another case was of a ——— importing house, which had sold enormous quantities of a liquid malt, claiming great diastasic and food value. It belongs to the same class as the one mentioned above, still the owners of the product have made a fortune from professional indorsements and prescriptions.

You can readily see the temptation is great to make false claims when it is cheaper to put out these products than those of real value. This will go on until some method is found of preventing this kind of fraud.

In my extensive experience as advertising counsel to a number of pharmaceutical houses this question has constantly come up, and I have seen houses making useful and honest products, needed by the profession, go to the wall, whereas those making "fake" and dishonest ones pile up millions, and I am not now speaking of "quack nostrums," but of products advertised in medical journals and daily prescribed by leading men in the profession.

Going into another field, you will recall, of course, the many published statements in the medical press during the last two years as to the great damage done to the unwary by advertised "cures" for neurasthenia, alcoholism and drug addiction. Well-informed scientific men have published formulas of many of these nostrums, which show that most of them are little more than alcoholic beverages, and some of them contain opium.

It seems to me that it is an insult to our civilization and enlightenment that these nostrum venders should prey upon the guileless public and cause untold misery without let or hindrance. We can expect nothing of the lay press; they get too much money from the advertisements of these products to make any assault upon them, and to our shame, be it said, the medical press accept advertisements of many of them, and in more than one instance, when I have reproached the editors of these papers for carrying these advertisements, they have simply answered that it is a matter of business and I would have to see the publisher about it. The publishers merely laugh if anything is said to them!

It seems to me that there is a great deal of Don Quixote business going on in the profession. We are fighting imaginary windmills and allowing cutthroats and robbers to scurry around through the bushes and destroy the ignorant!

There is no doubt but what every medicinal product which is advertised for sale should be required to carry a label giving its true formula, with a heavy penalty to the proprietors of the product if the label does not properly describe the contents of the package.

I admit that I take a very pessimistic view of the situation. *If we would come right down to the facts and find the real evil and not waste our energies in trivialities and split hairs over non-essential ethical questions, we could accomplish something,* but to do this it would first be necessary to recognize the broad proposition that when a man puts years of work and perhaps all of his capital into perfecting a product he has a right to be protected, and this he can only do by trademarking the name of the product. It is absolutely useless to

attempt to destroy proprietary rights. "The laborer is worthy of his hire," and unless we start out right nothing can be done, and it is necessary to clearly define this point before we have any starting point at all!

Personally, I have no interest whatever, directly or indirectly, in any proprietary preparation, so I am not speaking from a selfish standpoint, but from a full knowledge of the situation as it stands to-day.

It is a self-evident proposition that it will be useless to undertake to do anything with this question through State Legislatures. Unless it can be done by national enactments it would simply be lobbied out of existence every time a Legislature met. Therefore, it is a national question and must be so handled.

I am writing this as an outsider, not being a member of The New York State Medical Association. I am one of the victims of the new ruling of the National Association and am no longer a member of the A. M. A. However, my sympathies are entirely with all the efforts of the Association to prevent fraud and eliminate error. With apologies for troubling you, I am,

Very sincerely yours,

A. T.

DIFFICULTIES OF ORGANIZING A COUNTY ASSOCIATION.

A physician in one of the counties of this State, who has been for some time engaged in getting a sufficient number of members to form a County Association, addressed a letter recently to the President of the State Association, which is as follows, in reply to one received from him inquiring as to why he was so slow in sending in the necessary number of names:

MARCH 29, 1903.

DEAR DOCTOR—My gun has been loaded nearly a week and I have expected to light the fuse daily, but some of the doctors are so *cussed* slow about sending their money that I am delayed.

Although I have seventeen signatures (all good men) I have made up my mind that when the tenth pays I will immediately forward everything to you, and think I will be able to do so within a day or two.

I received yours with by-laws, but with two or three exceptions I am satisfied with those you first sent. I shall interline those exceptions.

I have written some of these doctors that if they manifest as little interest in their interest in the "here-after" as they have in forwarding their dues St. Peter will not be annoyed by their application.

Although I have long known of the difficulties of young doctors and young lawyers, yet among my applicants are men of good-sized bank accounts. But what of this? 'Twas ever thus. When a reply comes to my next I wish to have some application blanks for membership.

Eventually something will have to be said about a seal, etc. I never worked so hard verbally in my life.

Yours,

The Annual Report of the New York Board of Health for the year 1901, which was recently issued, gives the following interesting figures:

Taking the population of the city as 3,536,517, the death rate for the year was 20 per 1,000 living, as against 20.57 in 1900. There were 70,720 deaths from all causes in 1901. Tuberculosis caused more deaths than any other disease—9,839, or nearly one-eighth of the total number—and pneumonia came next.

Book Reviews.

A MANUAL OF PRACTICAL HYGIENE FOR STUDENTS, PHYSICIANS AND MEDICAL OFFICERS. By Charles Harrington, M.D., Assistant Professor of Hygiene in the Medical School of Harvard University. Second edition. Illustrated with 12 plates in colors and monochrome, and 113 engravings. Published by Lea Bros. & Co.

The fact that it is but a little over a year since the first edition was offered to the public is, in itself, a strong testimonial of the need of just such a work as this and of its being presented in the manner Dr. Harrington has adopted. To write a *manual* which contains only *practical* information on such a broad subject as hygiene demands the profoundest knowledge of the science and a keen appreciation of the differences between theoretical and practical values, and these qualifications are assuredly possessed by the author.

The eighteen chapters deal with the following subjects: Foods, Air, Soil, Water, Habitation, Schools, etc.; Disposal of Sewage, Disposal of Garbage, Disinfectants and Disinfection, Military Hygiene, Naval and Marine Hygiene, Tropical Hygiene, the Relation of Insects to Human Diseases, Hygiene of Occupation, Vital Statistics, Personal Hygiene, Vaccination and Other Preventive Inoculations, Quarantine, Disposal of the Dead. The first three chapters take up 420 of the 760 pages, the chapter on Food occupying more than half this space.

Under the subject of Meats not only are the varieties described in detail, their compositions, digestibility and their importance in the transmission of disease, but the characteristics of good meat are clearly set forth, thus assisting one to discern, by an examination of the raw material, as to its probable quality.

In speaking of "Red Meat" and "White Meat" the author says: "The prohibition of red meats (beef and mutton and venison) to patients with gouty and rheumatic tendencies dates from the time of Sydenham, whose dietetic rules allowed only of white meat (veal, goat, young pig and chicken) and fish to such persons. To-day many practitioners extend this prohibition to those with diseases of the stomach, intestines and kidneys and various neuroses. The foundation of this prejudice against the red meats is the supposed presence in them of a greater percentage of the nitrogenous extractives (creatin, xanthin, guanin, etc.), which are believed to exert injurious action in two ways. * * * Unfortunately, however, for the stability of this belief, exact analysis has shown that the very small amounts of these substances present are practically the same in both red and white meats. * * * Furthermore, these extractives are not eliminated as such, but as the normal ultimate product of metamorphosis—urea." Under the heading of Ice the experiments and views of eminent bacteriologists as to its being a possible danger in the spread of typhoid fever are reviewed, and then the instance is cited of eight officers in a French regiment having been seized with the disease after using ice at a dinner, where those at the same dinner who did not use the ice retained their former health.

Each topic taken up is handled in a most scientific and thorough manner, and the book will be found to be of great use by all of those for whom it is intended, be they students, physicians or medical officers.

BOOKS RECEIVED.

BACTERIA IN DAILY LIFE. By Mrs. Perry Frankland, Fellow of the Royal Microscopical Society, Honorary Member of Bedford College, University London, Joint Author of Micro-organisms in Water. The Life of Pasteur. London, New York and Bombay: Longmans, Green & Co., 39 Paternoster Row, 1903.

DISEASES OF THE HEART AND ARTERIAL SYSTEM. Designed to be a practical presentation of the subject for the use of students and practitioners of medicine. By Robert H. Babcock, A.M., M.D., Professor of Clinical

Medicine and Diseases of the Chest, College of Physicians and Surgeons (Medical Department of the Illinois State University), Chicago; Attending Physician to Cook County Hospital and Cook County Hospital for Consumptives; Consulting Physician to May Thompson Hospital, Hospital of St. Anthony de Padua, and of Marion Sims Sanitarium; Fellow and former President of the American Climatological Association; Member of the American Medical Association, etc. With 3 colored plates and 139 illustrations. New York and London: D. Appleton & Co., 1903.

NOTHNAGEL'S PRACTICE, DISEASES OF THE LIVER PANCREAS AND SUPRARENAL CAPSULES. By Leopold Oser, M.D., Professor of Internal Medicine, University of Vienna; Heinrich Quincke, M.D., Professor of the Practice of Medicine, University of Kiel; Edmund Neusser, M.D., Professor of Internal Medicine, University of Vienna; G. Hoppe-Seyler, M.D., Professor of Internal Medicine, University of Kiel. Edited, with additions, by Reginald H. Fitz, M.D., Hersey Professor of the Theory and Practice of Physic, Harvard University, and Frederick A. Packard, M.D., late Physician to the Pennsylvania Hospital and to the Children's Hospital, Philadelphia. Authorized translation from the German under the editorial supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

NOTHNAGEL'S PRACTICE DISEASES OF THE STOMACH. By Franz Riegel, Professor of Clinical Medicine in the University of Glessen. Edited, with additions, by Charles G. Stockton, M.D., Professor of Medicine in the University of Buffalo. Authorized translation from the German under the editorial supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A SYSTEM OF PHYSIOLOGIC THERAPEUTICS. A practical exposition of the methods, other than drug-giving, useful in the prevention of disease and in the treatment of the sick. Edited by Solomon Solis Cohen, A.M., M.D., Senior Assistant Professor of Clinical Medicine in Jefferson Medical College; Physician to the Jefferson Medical College Hospital and to the Philadelphia, Jewish and Rush Hospitals; one time Professor of Medicine and Therapeutics in the Philadelphia Polyclinic, etc. Volume V—Prophylaxis, Personal Hygiene, Civic Hygiene, Care of the Sick. By Joseph McFarland, M.D., Professor of Pathology, Medico-Chirurgical College, Philadelphia; Henry Leffmann, Professor of Chemistry in the Woman's Medical College, Philadelphia; Albert Abrams, A.M., M.D. (University of Heidelberg), formerly Professor of Pathology, Cooper Medical College, San Francisco, and W. Wayne Babcock, M.D., Lecturer on Pathology and Bacteriology, Medico-Chirurgical College, Philadelphia. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

SURGICAL EMERGENCIES; THE SURGERY OF THE HEAD. By Bayard Holmes, B.S., M.D., Professor of Surgery in the University of Illinois, Professor of Clinical Surgery in the American Medical Missionary College, Chicago; Attending Surgeon the Chicago Baptist Hospital. New York: D. Appleton & Co., 1903.

TRANSACTIONS OF THE LUCERNE COUNTY MEDICAL SOCIETY for the year ending December 31, 1902. Volume X. Organized March, 1881. Wilkes-Barre, Pa.: The E. B. Yordy Company, 1903.

COMMITTEE ON LEGISLATION.

The Association has every reason to be proud of the work done by its Committee on Legislation. It would be most fitting for every member to express his gratitude to this committee by a line or a word to one or more of them. The personnel of the standing committees is printed on the cover of the JOURNAL.

Original Articles.

SYMPOSIUM ON PNEUMONIA.

Read at Rockland County Association April 15th.

Etiology, Its Infectiousness, and Methods of Elucidating the Pneumonia Diplococcus.

BY DR. C. D. KLINE,
Nyack, N. Y.

THE generally accepted specific cause of pneumonia is the micrococcus lanceolatus of Fränkel, demonstrated by him in 1884 and reported to the Third Congress for Internal Medicine, held in Berlin. He isolated the diplococcus in pure culture on solid media from three cases of lobar pneumonia. He gives its morphological peculiarities, noted its fluctuations in virulence and mentions its occasional presence in the mouths of healthy human beings, a fact demonstrated by Sternberg in 1881. Pasteur, in the same year, discovered a diplococcus in the saliva of a child with hydrophobia, which had the same property as the Sternberg micrococcus, that of producing acute septicemia in the rabbit, but neither Sternberg nor Pasteur suspected its relation to pneumonia.

Weichselbaum, working at the same time as Fränkel, though independently, confirmed to a great extent his discoveries.

Friedlander, in 1883, announced the discovery of the pneumonia micrococcus, which for several years was considered very important, but later investigations proved that his capsulated, oval micro-organisms differed from the now recognized micrococcus of pneumonia in its morphological, cultural and pathogenic features, and showed itself to be a distinct species.

Prior to this time, Koch, Klebs and Eberth had each announced the discovery of a coccus as the cause of pneumonia.

It was Jergensen who, in 1874, made the first forcible plea to include pneumonia with the infectious diseases, maintaining that to explain fully its phenomena it was necessary to assume the existence of a specific cause.

The micrococcus lanceolatus appears in the form of capsulated, lancet-shaped spheres, united in pairs or short chains, more rarely in long chains. It stains with the ordinary dyes, and by Weigert's and Gram's methods. A simple method is to treat the cover slip preparation with glacial acetic acid and then, after washing off the acid, dropping on anilin oil and gentian violet, which is poured off and renewed two or three times.

The organisms are grown best at the body temperature in agar-agar plate cultures, which are greatly improved by the addition of blood, glucose or glycerine. Cultures are also made on gelatin, potato and milk.

Artificial cultures quickly lose their virulence, and the organism dies in from twenty-four to forty-eight hours; in dried blood or sputum it has been known to live as long as four months.

It is killed in ten minutes in a temperature of 52° C.

The micrococcus lanceolatus is very often present in the mouths of healthy human beings. Next to the pyogenic staphylococci and streptococci it is the most common cause of inflammations in the human being. Besides being the specific cause of acute lobar pneumonia it is frequently the cause of broncho-pneumonia, meningitis, otitis—media, pericarditis and endocarditis, and inflammations of mucous and serous membranes and abscesses in various parts of the body. In inflammatory exudates, as well as in cultures, it may die quickly or persist for several weeks or months.

According to Welch, the most virulent organisms are those in the freshly hepatized portion of a croupous pneumonia, whereas those in the older parts are less active.

While the micrococcus lanceolatus is believed to be the specific factor in the cause of pneumonia, systematic bacteriological research has shown that certain types of pneumonia are due to other micro-organisms; for instance, in the atypical pneumonia of typhoid we may find the bacillus typhosus as the cause; in influenza, the influenza bacillus, and with suppurative processes the common pyogenic organisms may contribute their share to the cause, and in fatal infections the pneumonic manifestations are frequently characterized by the organism that is accountable for the fatal termination.

The exciting micro-organisms of atypical pneumonia are frequently carried from the diseased lung by the blood or lymph, complicating the primary disease with secondary involvements of remote organs.

The mode of infection is probably by inhalation or through the mouth, which is frequently inhabited by the cocci. We must then consider that in order to develop the disease it is necessary that either the micro-organism be possessed of its full vigor and virulence, or that the individual have his natural resisting powers lowered by some depressing influences such as unhygienic surroundings, alcoholism or any habit which tends to depress the system, "catching cold," a condition which renders the mucous membrane of the respiratory tract more susceptible to infection. Males are more liable to pneumonia than females, probably on account of the difference in occupations and habits. Pneumonia is common at all ages, between 20 and 40 years being the time of greatest liability. Children under 5 years usually have broncho-pneumonia. Senility can hardly be said to increase the liability, but the mortality is greatly increased. The negro is more liable than the white man, and a person having had one attack is predisposed to another; as many as ten attacks in the same individual have been reported. I, myself, have treated a man through four attacks.

The use of anesthetics by inhalation in surgical

operations is also a cause of pneumonia, a form which is usually fatal.

Injuries to the chest are frequently followed by pneumonia.

Delafield states that the disease is more frequent in the South than in the North, that in New York City the majority of cases occurred in March, April, May, December, January and February, the minority in June, July and August. The curves of mortality in general correspond with those of temperature, the greatest mortality with the lowest temperature and the greatest daily range of temperature.

The disease may occur in epidemics, as reported in Osler's practice, by Rodman. A prison in Kentucky, containing 735 people, within a year had 118 cases with 25 deaths; similar epidemics have been described by others, both in this country and abroad.

The prevailing opinion, therefore, is that pneumonia is an infective disease, caused by the diplococcus pneumonia of Fränkel, whose favorite seat for development is in the lungs, where it produces its specific effect, though it may invade other parts, producing either an inflammation secondary to that of the lung or a primary, independent inflammation.

DIAGNOSIS IN PNEUMONIA—GENERAL AND DIFFERENTIAL.

BY DR. J. H. CROSBY,
Haverstraw, N. Y.

THE diagnosis of pneumonia is usually not very difficult if we have our subjective symptoms giving us the history of a chill, followed by high fever with a dry, hacking cough and pain in the side. These, with the facial expression—the mahogany flush over the malar bones, the open eye, with dilated nostrils and general appearance of intense anxiety—gives us a picture which is almost typical of the disease. Add to these symptoms our findings in the physical examination, and we are not likely to confound this condition with any other.

In the examination of a patient suffering with the lobar variety we find high fever, dry, hot skin, rapid pulse and a painful, hacking cough, with the scanty expectoration of rusty-colored sputum. The affected side shows diminished movement of chest wall, and on percussion we find dulness over the diseased area, which is usually the lower lobe of the right lung, with increased resonance over the healthy portion of the lung. This dulness persists along the same lines, no matter what the position of the patient, and it usually follows the line of the interlobular fissure, being directed upward and backward.

The respiration is broncho-vesicular, changing to bronchial as solidification increases. The crepitant râle is often present, and if so it is almost pathognomonic of the disease. But it must be remembered that it is often absent and it must not be confounded with the subcrepitant râle, the former, the crepitant, being fine, dry and with

inspiration only, while the subcrepitant is fine, moist and with inspiration and expiration. Vocal fremitus and resonance are increased over the affected area and bronchophony is also present.

It may be well to add in this connection that, in practice, we seldom see a case of pneumonia until it has passed into the second stage, and I have laid most stress on the symptoms of this period of the disease.

In the third stage the dulness diminishes, the cough loosens, fever breaks, moist râles appear and patient usually goes on to recovery, although abscess of the lung may develop and discharge into the bronchi, when there will be a copious expectoration of purulent material.

In broncho-pneumonia we find similar symptoms, except that the areas of solidification are not limited to one lobe, but are scattered throughout the whole lung in small patches.

The bacteriological examination of the sputum of pneumonia cases has of late years reached considerable prominence. The diplococcus of Fränkel is the germ most frequently found in the sputum, but the pneumobacillus of Friedlander, the streptococcus and staphylococcus pyogenes, the typhoid and influenza bacilli are also frequently found and must be considered as etiological factors in some cases. This being the case, the absence of the pneumococcus should not lead us astray should the other symptoms point to pneumonia. Its presence clinches the diagnosis.

In the differential diagnosis we have to distinguish between pneumonia and bronchitis, pleurisy, empyema, edema of the lungs, acute pharyngitis and gangrene of the lung.

Careful physical examination will serve to differentiate these conditions. Those most frequently confounded with pneumonia are pleurisy and empyema. As the symptoms of these two conditions, pleurisy and empyema, are alike, except as relates to the product of the inflammation, we can consider them under one head.

In the first stage we have the crepitant râle in pneumonia and friction sounds in pleurisy. In the second stage of pneumonia we have dulness over the affected lobe with bronchial breathing. In pleurisy we find, first, dulness, which is not so marked as in pneumonia, followed by flatness as the pleuritic effusion increases. This flatness is marked in the dependent portions of the pleural cavity and its level changes with the position of the patient; in this respect differing from the dulness in pneumonia, which remains the same, no matter what the position of the patient. The respiratory sounds are lost entirely over the area of flatness and are exaggerated above it. The intercostal spaces are obliterated, particularly in empyema, and we can sometimes get fluctuation and succussion sounds. We also have absence of the pneumococcus, although this germ may be present.

The physical signs should enable us to dis-

tinguish between pneumonia and bronchitis without any difficulty. Its bilateral location, the absence of dulness and the presence of sibilant and sonorous and large and small, moist mucous râles make the diagnosis in this condition.

In edema of the lungs the râles are of the moist variety, and are usually fine. The dulness is not so marked and the cough is loose and the expectoration consists of a frothy serum. As the heart and kidneys are at fault in a large proportion of these cases, careful examination of these organs will be of great aid to us.

Acute tuberculosis in its first stages may very readily be confounded with pneumonia. But the high, irregular fever of phthisis as compared with the more regular temperature of pneumonia, together with the longer duration of the disease, the rapid emaciation, and the character of the expectoration, which is muco-purulent and fairly free, should enable us to distinguish between these conditions without much delay. The bacteriological examination of the sputum showing the presence of the tubercle bacillus is also a great aid to us here.

Gangrene of the lung is a very rare condition. The symptoms of systemic poisoning of a septicemic nature, with the general fetor of breath, are our chief distinguishing symptoms.

COMPLICATIONS OF PNEUMONIA.

BY DR. S. W. S. TOMS,
Nyack, N. Y.

IN the symposium on pneumonia, presented to the Saratoga meeting of the American Medical Association last June, I listened to the papers and discussions throughout with much interest and the keenest disappointment. In an analysis of 338 cases treated at the Cook County Hospital in fifteen months, ending April 1, 1902, analyzed by Ingals, there was a mortality of 36%.

The complications in this number (all being lobar) were alcoholism, nephritis, delirium, syphilis and emphysema.

It will be seen by this representative group that the complications allotted to me and which I am to discuss are, or must be, of necessity, somewhat remote or infrequent. Speaking from my own observations during a practice of twelve years I cannot recall a single case of pulmonary edema complicating croupous pneumonia—and this condition in broncho-pneumonia is part and parcel of the pneumonic process in its terminal stage.

Pleurisy accompanies all pneumonias to a more or less extent and is generally of the plastic variety, except in children, where it frequently becomes an empyema.

The diplococcus seems to be responsible for the extension of the pneumonic process to the pleura. Often these symptoms so mask the pneumonia by the intensity of the pleuritis that the term pleuro-pneumonia is applied; the effusion is loaded with fibrin—a distinguishing feature in differentiating it from true pleurisy; a pleurisy on

one side with a pneumonia on the opposite often results in an empyema.

Empyema, instead of a complication, should be termed a sequel of pneumonia, because of its appearance following the crisis as it usually does.

"Indeed, empyema has of late been shown to be a frequent complication of pneumonia, but as far as my own observation goes, it would appear to rank as a sequel, rather than a complication, coming, as it usually does, several days after the crisis."

Pulmonary edema does not rightly belong to the complications of pneumonia, as it is a transudation of serum into the alveolar walls, connective tissue and air cells, the result of congestion. In a pneumonia the corpuscular exudate fills the air sacs generally, the interstitial tissue is distended, as are the capillaries with blood.

There may at times be a collateral edema complicating a pneumonia, but this is usually local, as is seen in pulmonary infarction. When it is a terminal condition of pneumonia, a failure of cardiac power, Bright's disease, anemia and cerebral lesions may be suspected as contributing factors.

Pulmonary abscess is the result of secondary infection by the streptococcus, either in lobar or lobular pneumonia, usually the former, and is most prevalent in deglutition or inhalation pneumonia. It is also seen in an extension of malignant disease of the esophagus, liver or hydrated cyst into the lung.

A case I well remember in hospital occurred in an alcoholic subject during the last stage of lobar pneumonia and was believed due to inhalation during a prolonged comatose condition, following a hypodermic of hyoscine hydrobromate for delirium tremens. He partially recovered, but subsequently died of tuberculosis.

The diagnosis, morbid anatomy treatment, etc., I have not dwelt upon, as others will treat of these departments.

PNEUMONIA COMPLICATIONS WITH SURGICAL OPERATIONS.

BY DR. G. A. LEITNER,
Piermont, N. Y.

THE reading of the title "The Complications of Pneumonia, Cardiac, Renal, Intercurrent or Complicating Surgical Operations, with Reference to the Treatment of Pleuritis, Empyema and Other Surgical Conditions," at first glance seems of itself to be entirely sufficient to occupy the time allotted to my share of this charming and most interesting symposium, and as I shall not be able to do justice to all the morbid conditions which my paper calls for in the remaining time permitted me, I shall at once plunge into a description of the surgical treatment of the most frequent and serious complication which arises as a sequence of this disease, viz., "pleuritis." The term pleuritis or pleurisy is defined as an inflammation of the serous cover-

¹From *Ander's Practice of Medicine*, 5th edition, page 148.

ing of the lung and of that portion of the thorax in which the main organs of respiration are confined. The classification of the different forms of pleuritis are subdivided as regards etiology into a primary, as by continuity or contiguity, and into a secondary, as the pleuritis of infection, tubercular, rheumatic, exanthemic, uremic, syphilitic, septic or any other causes which may produce inflammation in any other serous membrane. This class we shall to-day pass over in silence. We also have the topographical division, *e. g.*, anterior, posterior, diaphragmatic or interlobar. Again we meet with the pathological classification, *viz.*, dry, sero-fibrinous, purulent and hemorrhagic. In our discussion we shall deal first with the sero-fibrinous, then with the purulent, as they constitute the two varieties which are found as the surgical complications of pneumonia.

The physical signs of effusion into the pleural cavity are not always infallibly present, nor do they lend themselves in groups to aid the diagnostician in mapping out this morbid condition, but, generally speaking, we find on percussion, marked flatness extending from the base of the lung upward to the horizontal or C-shaped line corresponding to the height of the fluid. The apex beat of the heart is displaced to the right or to the left of the nipple line opposite to affected side. The vocal fremitus is entirely abolished, the respiratory murmurs absent or modified, but where fibrinous adhesions of the lung and the pleura have formed of sufficient strength to retain and immerse a portion of the lung beneath the level of the fluid, a distant, muffled bronchophony is often discovered. *Inspection* reveals a bulging of the intercostal spaces, and in the suppurative variety edema of the skin is noticed. *Mensuration* develops the fact of an increased circumference of the affected side. The thermometer also is an efficient aid, particularly in empyema, and last of all the exploring needle is the indisputable test.

Having now established the positive diagnosis of effusion, its pathological character and quantity, and having resorted to the many varied medical agents which are recommended to assist the lymphatics in the absorption of the retained fluid or pus, the questions arise, How long shall we wait for absorption? and, What mechanical means shall we employ?

A great diversity of opinion has existed as to how long we shall wait. While some eminent writers advise interference, even in the acute stage. Such authorities as Bowditch, Loomis, Donaldson, Matas, Powell and Flint counsel postponing surgical interference until defervescence of all febrile symptoms has occurred, unless in the meanwhile the quantity of fluid is so excessive as to endanger the life of the patient by intrathoracic pressure, either by threatening the cardiac power or by producing painful dyspnea, accompanied by symptoms of asphyxia, etc., or by downward pressure interfering seriously with

the functions of the liver, stomach or other intraabdominal viscera. All authorities, however, unanimously agree that if the fluid reaches to the second intercostal space, even in the complete absence of all disagreeable symptoms and regardless of the stage of the disease, thoracentesis is absolutely and imperatively indicated. In children, as a rule, sero-fibrinous effusions rarely demand surgical procedure, while in the aged, the practice of aspirating the chest is rarely curative, simply palliative, because generally the hydro-thorax is secondary to some other more serious morbid process. Having determined when to resort to mechanical means it now behooves us to consider the surgical means and methods at our disposal.

Simple incision with the scalpel, the actual cautery, the old trocar and canula methods have, owing to the dangers of perforating the lung, cutting the intercostal artery, the almost positive entrance of air into the pleural sac, the frequency of fistulous openings, the conversion of simple sero-fibrinous condition into a suppurative process, have all become entirely obsolete, and for many years placed surgical interference in the category of malpractice. Now, however, owing to the ingenuity of Bowditch, of America, and the modification of his principle by Dieulafoy, of France, thoracentesis, with the aid of antiseptic surgery, has been made a safe, innocuous and highly efficient operation. We will not dilate upon the *modus operandi* of the familiar Dieulafoy vacuum pump as now modified by Potain, except to state that the smaller the needle the more satisfactory and less dangerous will be the result.

As much antiseptic technique should be employed in preparing the needle, the field of operation and the hands of the operator and other minute details as should be exercised in an abdominal operation, in order to secure for the patient immunity to any further infection of the pleural cavity. The next question arises, Where to puncture? After placing the patient either in the recumbent or semi-recumbent position, the needle, as a general rule—although there is no fixed classical point—should be introduced into the sixth intercostal space at the anatomical angle of the ribs, closely hugging with the needle the inferior border of the fifth rib, pointed downward on an angle so as to escape wounding either the lung or the intercostal artery. The vacuum having previously been established, all that is now required is to turn on the proper stopcock and the fluid permitted slowly to flow into the glass vacuum receptacle.

How much shall we remove? This question is one that cannot be positively answered, as each individual case must be governed by consequent symptoms which follow the aspiration of the fluid; as a rule, 6 to 18 ounces are oftentimes sufficient, and I am sure you will agree with me that, in your own experience, cases have come under your observation where the removal of one or two ounces with the exploring needle has been

of itself sufficient stimulus to the rapid and entire removal of the contained fluid. This, however, is a good rule to follow: When the patient complains of acute pains in the chest, dyspnea, the tendency to a sharp, humid, hacking cough, or if evidence of syncope appears, the needle should be withdrawn, and whisky and aromatic spirits of ammonia administered; if necessary, clean, normal sal-solution may be reintroduced if fatal result threatens, as no harm can follow the repetition of the operation every few days until nature assumes the entire relief of this pathological condition. That there are objections and dangers should be impressed upon our minds. The most frequent and the most serious accident which clinicians of the present time lay particular stress upon is the serious collapse of the patient; there arises a sudden cough, accompanied with large quantities of frothy serous or sero-sanguinolent expectoration, the so-called "albuminous expectoration." The cause of this has been thoroughly and scientifically explained by Herard, who says that the too rapid relief of the pressure on the constricted capillaries and the sudden ingestion of air into the air cells produce an acute hyperemia in vessels whose walls have been weakened and then serous effusion occurs into the air cells and hence we have an acute edema of the lungs. This may be entirely avoided if too large an amount of fluid is not withdrawn at any one operation; rather repeat the aspirations and permit the lung gradually and progressively to accommodate itself to its previous natural expansion.

We have now arrived at that more serious and destructive condition which invariably requires surgical intervention, namely, empyema. This term as now used implies a suppurative effusion into and within the pleural cavity. The classification of the different forms is divided as regards causation—first, those resulting from pneumococcus infection; second, those due to the streptococcus; third, those produced by saprogenic or putrid infection; fourth, those due to the tubercular bacillus of Koch.

We shall confine ourselves to the symptoms, signs and treatment of that variety of empyema which follows the pneumococcus infection, as the other forms are not pertinent to the subject of the day, and besides their progress have a more unfavorable prognosis and more destructive termination and demand more severe and radical operative measures.

The symptoms and signs of empyema are essentially the same as in the sero-fibrinous form, but, in addition, we have the septic temperature, the more marked bulging of the intercostal spaces, oftentimes a pulsating tumor, the edema of the skin over the affected side, egophony or bronchophony is less distinct or entirely absent, the tubular character of the respiratory sound, particularly in the compressed apex, is more pronounced, and the loss of the whispered voice

(Bacelli's sign) progressively diminishes until entirely absent in the suppurative variety; but, as I formerly remarked, in speaking of the sero-fibrinous variety, the exploring or aspirating needle gives the infallible evidence of a positive diagnosis.

Netler states that over 65% of all empyemæ follow pneumococcus infection, and that of all forms this is the most benign and offers the most favorable prognosis.

Having established the presence of pus either with or directly following a case of pneumonia, and presuming its existence to be solely due to a pneumococcus infection, surgical intervention must expeditiously be sought. Its object, briefly stated, should be, first, to evacuate the contents of the pleura; second, to prevent reproduction or extraneous infection; third, to restore the normal physiological relation and functions of the lung and of the pleura.

As regards the first indication, the speedy disposal of the accumulated pus, we may select one of two methods—simple aspiration with the vacuum pump, as in the sero-fibrinous variety, or the more rational and more scientific procedure, viz., free incision and perfect drainage. In children, many cures follow one or several repeated operations of simple thoracentesis, but in the great majority of cases, incision and drainage become eventually necessary. The selection of the point for incision may vary with the individual case, but, as a rule, the point of election should be the sixth, seventh or eighth intercostal space on a line with the posterior axillary border, or about the angle of the ribs; this region will secure free and through drainage.

To prevent reproduction of the pus and outside infection we should employ sufficient size tubes to maintain unlimited drainage, and we should insist upon using aseptic and antiseptic instruments and dressings at the time of operation, and thorough surgical cleanliness at each subsequent dressing.

To restore the normal action of the lung and of the pleura, this is best accomplished by the early operation, before firm, dense adhesions have occurred between the two surfaces, and by not introducing, after the primary operation, any fluids into the pleural cavity unless the discharges assume an offensive, putrid character or contain large quantities of broken-down tissue. When this occurs our previous benign case has passed from the stage of a pneumococcus infection into one of a more malignant type, which entails the excision of a section of one or two ribs, or into the more serious operation of multiple resection of a large number of ribs; if, however, the morbid process remains a simple pneumococcus infection and does not become a mixed infection, paracentesis or simple incision, with proper drainage, holds out to our patient a sure, safe and favorable termination of the disease.

TREATMENT OF PNEUMONIA.

BY DR. G. F. BLAUVELT,
Nyack, N. Y.

THIRTY years ago Bristowe, in his work on Practice, wrote: "There are few diseases for which so many opposite plans of treatment have been employed with reputed success as for pneumonia. It is a disease, too, which, more, perhaps, than any other, has on this very account been appealed to in proof of the change of the type of disease. From the time of Laennec to about the middle of the present century, almost implicit reliance was placed in blood-letting, antimony and mercury. Since then, especially dating from the time of Dr. Todd, these remedial agents have been to a very large extent discarded, and have been replaced by the free exhibition of alcoholic stimulants. Many, indeed, now regard all medical treatment as of little or no importance, and it is quite certain that a large number of even severe cases recover perfectly if left to nature and the nurse." In more recent years Osler has said: "Pneumonia is a self-limited disease, and runs its course uninfluenced in any way by medicine. It can neither be aborted nor cut short by any known means at our command. Even under the most unfavorable circumstances it will terminate abruptly and naturally, without a dose of medicine having been administered. So, also, under the favoring circumstances of good nursing and careful diet, the experience of many physicians in different lands has shown that pneumonia runs its course in a definite time, aborting sometimes spontaneously on the third or the fifth day, or continuing until the tenth or twelfth."

You have all doubtless had experience of these facts in your practice, treating cases in which a positive diagnosis of pneumonia could be made, which have terminated in rapid recovery at the end of four to six days, others going through the usual period of ten to twelve days, all with very slight medication.

We have all also had the experience that, during some one season, cases of pneumonia have been treated, all by the same method and all have recovered. Next season we have treated an equal number of cases, in exactly the same way, but the percentage of fatal cases has been large. I mention these facts in order that we may realize that the recoveries from this disease are not always due to our treatment, and that statistics to prove the value of treatment in pneumonia must not be limited to a few cases in any one season, but must embrace a vast number of cases and extend over many seasons. During the past few years, since the causation of the disease by direct pneumococcus infection has been conceded, efforts have been made to find some remedy which will act directly on the pneumococcus in the lung, and by restricting its action, prevent, as far as possible, the formation and accumulation of toxins in the system. Until such specific has been found and certainly demonstrated we must

rely on the general principles of treatment agreed upon by all authorities which are conducive to the well-being of the patient and which do in many cases assist in preserving life. We may briefly consider these under three general heads:

1. Attention to the elimination from skin, lungs, kidneys and intestines.
2. Attention to the nervous and circulatory systems.
3. Attention to the nutrition of the body.

In the early stage of pneumonia we can assist the elimination from the lungs by keeping the room in which the patient lies freely ventilated; the skin should be kept clean by bathing with tepid or cool water, the kidneys should be stimulated to free secretion by draughts of pure water frequently repeated, the intestines should be cleared by a good cathartic. I prefer a moderate dose of calomel, 3 to 5 gr., followed by a saline.

Pain is frequent in the early stage of pneumonia and has an irritating and depressing effect on the nervous system; this should be relieved by opium, preferably morphia, used hypodermically. Hot fomentations often act well in helping to relieve pain, but at times use of the ice-bag will be more comforting. A broad adhesive strap applied firmly to the thorax, so that the ends overlap the median line, often helps to relieve pain by restraining the action of the walls of the thorax; this is especially the case where the pain is at the lower part of thorax. Sponge baths with cool water are of great use to allay the restlessness and nervous tension that accompany high temperature. They also tone up the nervous system and materially help it to resist the depressing effect of the toxins. Ammonia in form of carbonate, 5 gr. at two-hour intervals, has a quieting effect on the respiration. Strychnia in 1-60 to 1-30 gr. doses is one of the best remedies used to support the nervous system. I do not use alcoholic stimulants as routine practice, but in some cases they seem to have a quieting and supporting influence when the system shows signs of exhaustion. The inhalation of oxygen is very soothing to the patient when dyspnea becomes distressing; especially is this the case when bronchitis accompanies the pneumonia. To get the best results from its use it should not be left as a last resort, but should be used as soon as dyspnea becomes marked, and should be given slowly for fifteen to twenty minutes, frequently repeated. Cough, when painful and distressing, can generally be relieved by heroin in 1-12 to 1-10 gr. doses at two to four hour intervals.

As the disease progresses the circulation is likely to be disturbed by the action of the toxins on the vaso-motor system, also by the increased amount of work thrown on the muscle of the right ventricle. In such case the heart must be supported by strychnia, caffeine, camphor, sparteine, strophanthus and digitalis, in fairly full dose. When the venous system becomes engorged, and the pulse is hard and contracted, the nitrites, best given in form of nitroglycerin, are to be used in

order to dilate the arterial system, thus causing it to retain a larger proportion of blood. Oxygen inhalation also relieves the circulation, as it is a fact that well-oxygenated blood flows more easily and freely through the capillaries, and the labor of the right ventricle is lightened.

The nutrition of the body should be carefully watched. Only such food should be given and in such quantity as the patient can thoroughly digest and assimilate. All food taken in excess of this will cause distress to the patient by producing flatulence and increasing dyspnea or by loading the blood with absorbed material which cannot be assimilated. Milk in different forms, raw eggs, beef juice, kumyss, matzoon and some of the predigested food preparations will render good service and can be easily controlled. When food cannot be taken at all for a long time, alcoholic stimulants in fairly large quantity may be used in asthenic cases with benefit for a few days until food can be taken. Blood-letting I have not mentioned, as I have no personal experience of it. Osler says: "Pneumonia is one of the diseases in which a timely venesection may save life. In a full-blooded, healthy man with high fever and bounding pulse, the abstraction of from twenty to thirty ounces of blood is in every way beneficial, relieving the pain and dyspnea, reducing the temperature, and allaying the cerebral symptoms so violent in some cases."

I have endeavored to give you in brief outline the method I now try to employ in treating my cases of pneumonia. I think the results are about the average number of recoveries. I wish briefly to call your attention to the most important of the remedies directed toward the local process in the lung with the expectation of exerting specific action on the disease.

Fifty years ago mercury was administered to the extent of producing slight ptialism for the purpose of preventing exudation or hastening the absorption of exudate when it had already formed. Some years later, "Leaming advised a sedative dose of calomel of 30 to 50 gr. in the beginning of the disease."

"Quinine in large dose, 30 gr. a day, it is claimed by Flint, will modify the course of the disease."

"Hare believes that quinine with aconite of verat. vir., given before consolidation has occurred, will tend to abort the local processes and prevent exudation."

"Clemens, since 1850, used chloroform inhalation in all cases of pneumonia in his private practice, with such success that he did not lose a patient. He attributes this to the soothing effect on the nervous system, the lessening of shock and freer respiration. He claims there is a shortening of the disease by this treatment.

Oertel employed this method in Pfeiffer's Clinic in Munich from 1860 to 1863, mostly in the advanced stages of the disease, about the fifth or sixth day in cases in which there were extensive hepatization and marked involvement of the

pleura, when the expectoration was more or less suppressed, and the viscid exudate obstructed the air tubes; when coarse râles were heard over large areas and when rapidly increasing cyanosis indicated insufficient aeration of the blood. Inhalations were repeated as often as five or six times in twenty-four hours and pushed to commencing narcosis. The results were most satisfactory.

Dr. A. H. Smith has used chloroform inhalation in connection with oxygen by adding one to two drachms of chloroform to the water in the wash bottle.

Dr. Smith claims that from investigations made at his suggestion it was found that the pneumococcus was very sensitive to chloroform, and surmises that the good effects of this treatment are due to the chloroform rendering the exudate in the lung an unfit medium for the culture of the pneumococcus.

Creosote and carbolic acid, internally and by inhalation, have been used and advised to inhibit the activity of the pneumococcus and good results claimed. Salicy. sod. in dose of 1 to 2 drachms a day has been used by Liegel and Ferguson; very satisfactory results are claimed for this treatment.

The antitoxin treatment with antipneumococic serum is, so far as I can judge, in an experimental stage. Dr. A. C. Abbott, in an article in THE NEW YORK STATE JOURNAL OF MEDICINE, December, 1902, on pneumonia from the bacteriological standpoint, sums up this matter as follows: "I think that there is little justification for the belief that a reliable curative serum for use in the treatment of pneumonia has been produced or by the customary methods of procedure is likely to be produced in the immediate future. Just what the outcome will be of the group of investigations upon larger animals, now in progress in several quarters, cannot, of course, be predicted, but before results claiming to be positive are accepted as final it is fair to insist that they be much more firmly grounded in experimental proof than anything hitherto contributed to the subject."

The authorities consulted and quoted from in these notes have been: Watson, Bristowe, Strümpel, Flint, Osler and the article by A. H. Smith in *Twentieth Century Practice*, also articles in THE NEW YORK STATE JOURNAL OF MEDICINE.

Smallpox in Old Clothes.—A woman in Indiana is reported to have died of smallpox, and as she had been an invalid for years and had had no opportunity to contract the disease, the local Health Board made an investigation. It was learned that two weeks before she was taken sick she went to the attic and opened an old trunk which contained clothing that her father had worn. She aired the clothing and then placed the articles back in the box. Her father died of smallpox thirty-nine years ago this spring and the health officers believe that she contracted the disease by handling the infected clothing of her father.

ERGOT IN PNEUMONIA.

With Special Reference to the Serious and Fatal Elements of the Disease and Their Prevention or Modification from Treatment by This Drug.

BY DR. ALFRED T. LIVINGSTON,
Jamestown, N. Y.

“UNDER all circumstances a grave affection,” says Thomas G. Ashton, of pneumonia, in Sajous' Cyclopedic; and he states that of 285 cases occurring in the Philadelphia Hospital, 147 died—51.9 per cent.

Osler (*Amer. Jour. Med. Sciences*, January, 1897) says the general death-rate for pneumonia is considered to be 20 to 30 per cent.

Pepper compiled the deaths from pneumonia in New York City from March 1, 1871, to March 1, 1875, as 7,873, averaging $5\frac{1}{2}$ per day. He also compiled from the eighth and ninth census reports the deaths from pneumonia in the United States as averaging 77.5 per 1,000 deaths, nearly 8 per cent. of all deaths. He quotes Townsend and Coolidge on the records of the Massachusetts General Hospital from 1882 to 1889, which show that of the 1,000 cases of acute lobar pneumonia treated there, 25 per cent. died. This is sufficient to show the gravity of the disease, and therefore the importance of any treatment that will prevent or modify its serious and fatal elements.

While pneumonia in general is probably the localized chief symptom of a constitutional infectious disorder, it more concerns our present consideration to analyze the local affection, discover the dangers, and point out a remedy. Whatever the primary cause in any given case, the first apparent effect is *congestion*, which may be limited to one or more lobes of one or both lungs, or involve all of one lung and a portion of the other, or may be so general and extreme that respiration is so limited and the heart's action so obstructed that death quickly ensues.

Proportionately to the extent of the congestion, and, therefore, proportionately to the extent of the second stage of inflammation, exudation, which limits yet more the function of the lungs and adds to the labor of the heart by further obstructing the circulation, the case increases in gravity. The highest degree of these two phases is reached when the third stage, consolidation or hepatization, obliterates the air vesicles in that part of the lung or lungs so affected and the greatest possible burden from vascular obstruction is laid upon the heart. Then appears, if not before, that dreaded symptom, heart failure. This symptom is by some attributed to the action of the poison, or a poison, upon the heart center, but while this may be so in part, I believe that the principal causes of heart failure in pneumonia are exhaustion from the incessant and increased activity of that organ in a more or less futile effort to accomplish what, under the circumstances, is impossible, viz., the sufficiently rapid pumping of the venous blood through the lungs for the purpose of its proper oxidation, and the

lack of the stimulus upon the heart of a properly oxidized return current of blood from the lungs. I do not know of any other localized inflammation in which the direct blockade of the heart contraction is as great as in even an averagely extensive pneumonia. Added to these dangers are certain complications, the more serious being catarrhal bronchitis, acute pericarditis and acute meningitis. Edema, too, may occur in the portions of the lungs not involved. Previously existing chronic endocarditis or chronic nephritis also seriously or fatally complicates the pneumonia as to whatever infectious states may be associated as causative or otherwise; *e. g.*, the very depressing influenza poison which for many years has been a common causative or associated factor.

Now, if you will analyze the disease itself and the various complications, including even the infectious poisons (for their effect is to more or less paralyze vaso-motor centers), you will see that the fundamental element which is serious, whether causative, associated or produced, is *vascular dilatation*. This vascular dilatation is either the direct cause of death or the direct cause of the conditions which produce the fatality.

As to treatment, Pepper says: “Lobar pneumonia is a disease for which there is no routine treatment applicable to every case.” In this statement my late dear friend and universally honored teacher was mistaken, as I shall demonstrate to you. Osler says: “Pneumonia is a self-limited disease, and runs its course uninfluenced in any way by medicine. It can neither be aborted nor cut short by any known means at our command.” I quote again, “We have, then, no specific treatment for pneumonia.” If you will act upon the suggestions which I shall make, I am sure that you will demonstrate for yourselves that Osler, too, is mistaken. It would be useless to attempt to cite higher authorities than these two names.

In looking over the authorities at my command I fail to discover (beside nutritive support and hygiene, which apply to all diseases and healthful states as well) any suggestion of what I would denominate a rational treatment of pneumonia, except the single suggestion made by Pepper as applying to “excessive congestion of the lungs” or “general catarrhal bronchitis,” viz., dry-cupping. The treatment upon which the greatest stress is laid is the *support* (?) of the heart by various heart tonics and stimulants, and the application of cold by spinal or chest pack or general bath. As to the use of heart tonics and stimulants, I verily believe that more deaths are directly produced than lives saved by them, not alone in their application to this particular disease, but to all those disorders in brain, lungs, liver, kidneys, digestive tract and pelvic organs that finally impede the heart's action by what I will call a dam against free circulation, or that in some way irritate the heart center, in either

or both ways resulting in its fatigue or exhaustion. Instead of prodding an overtaxed and exhausted organ, the rational relief appears to me to be rather in altering the conditions that have wearied it, so that the demands upon it will be wholly or approximately limited to its capacity for work. If, when these conditions are so altered, it is still incapable, a gentle and careful application of such remedies as are stimulating and toning to it would then be rational and appropriate. As to the application of cold, the one indication for which it is used is fever, and as fever is only a symptom (usually, probably, nervous), it is surely not getting at the bottom of the trouble to reduce surface or even general temperature. This method is irrational, for the blood necessarily sent from the surface by the application of cold must then occupy internal vessels, and it will occupy those vessels most which are already distended and therefore least resisting, and so will add to the obstruction against the heart's action. It is also dangerous, and conservative authors do not countenance it.

One other thing I would *not* do, viz., apply poultices or hot fomentations over the lungs or encase the chest in impervious material, all of which relax, when the object should be tone, tone everywhere.

Now, as to the course which I deem rational in this very grave disease. We have seen that underlying the local inflammation and all the serious complications is the uniform element, *dilated blood vessels*. It follows that anything that contracts the dilated blood vessels of the lungs, or of other parts where such dilatation unfavorably affects the lungs or heart, or the chances of recovery, is desirable, rational and a proper treatment to be applied. If any one fact has been demonstrated in therapy, it is that ergot contracts dilated blood vessels and tends to equalize the circulation. If any one fact is clear in physiology, it is that, other things being equal, the easiest possible functional action of the heart exists when the general circulation is in equilibrium, a proper proportion of blood in every part.

Applying these principles to the disease in question and considering the fact (which I claim) that ergot is not only the best but the only specific general equalizer of the circulation, it follows that ergot is the most important and valuable drug that may be used in pneumonia and that it is, as nearly as that term may be properly applied to any drug as related to any disease, a specific treatment applicable to every case.

If you are called sufficiently early, while it is yet a matter of congestion, all that you need is a hypodermic syringe and a solution of ergot properly prepared for such administration. A free application of ergot in the first stage of pneumonia will abort or cut short, or markedly limit the extent of the second stage. It will also prepare against complications of the disease. It will often happen that you are not called sufficiently early to greet the stage of congestion and

you should always on general principles, when dealing with a disease so likely to prove fatal, apply polytherapy rather than take risk by trusting to a single therapeutic means. I therefore commend, as next important to ergot, through and extensive dry-cupping, not only over the portion of the lungs affected, front, side and back, but over the entire thorax, and such application not once but repeatedly. Shock is one of the best tonics to the vaso-motor centers and I would apply it to the spine from the occiput to the sacrum, but only with the alternation of heat and cold, as that method so localizes the shock that no chill nor other harm can result. Finally (and here I expect you to smile, but I will permit you to smile and go on with my suggestion) I would, especially if the case appears extreme, apply galvanism with a sponge electrode on either side of the spine, passing them up and down over the lines of the sympathetic ganglia, giving a current of 12 to 15 milliamperes and a seance of 20 to 30 minutes. Galvanism is a direct and powerful stimulant to the vaso-motor centers, which control the circulation.

With the complication of influenza or other infectious poison, I would use this formula :

℞ Cinchonidiæ salicylate. 3 grains
 Acetanilid 2 grains
 (or phenacetin, 3 grains.)
 Caffeinæ cit. ½ grain
 Sparteine sulph. 1-10 grain
 Ft.—Powder or tablet.

I would give one, or two, or three such tablets thrice daily, the largest dose at bedtime; but would precede by a full mercurial dose, followed by brisk saline. Abundant nourishment, fluid and easily digestible, plenty of water and the bowels kept free, daily or oftener, should go with-out saying.

I have now given you an outline of a treatment for pneumonia and its complications which I regard as rational, and I believe that if you are called in the initiation of the disease, or within any reasonable time, and apply thoroughly the course suggested, you will find that instead of 20, 25 or 30 per cent. of fatalities, you will be more likely not to have 1 per cent. The ergot, which is the central theme in this scheme of treatment, should be given only hypodermically.

I would suggest as a solution :

℞ Squibbs' solid extract of ergot, ʒi
 dissolved in sterilized distilled
 water. ʒi
 Filter the solution and add chloro-
 form. ℥ii

Of this solution give as a first dose at least 1 dram; if the congestion is extensive, 1½ or 2 drams, and follow with ½ dram or more every three to six hours, or less frequently, as indicated. The pain and dyspnea will be relieved by the ergot and dry-cupping. If cough is troublesome, use a petroleum or linseed oil emulsion, but no morphia. Do not *support* (?) the heart with heart tonics and stimulants until you have, by

the means suggested, lifted from it the load that, continued, must exhaust it and, if great enough, must finally paralyze it to death.

Discussion opened by Dr. Alexander Lambert, of New York, President of New York County Medical Association.

I wish to express my appreciation of the invitation which you have extended to me to come here and discuss this subject, my enjoyment in listening to the papers, and the pleasure which I feel in discussing them with you. First, beginning with the paper on the "Etiology of Pneumonia," the variation in the virulence of the pneumococcus is mentioned. It is true that in most artificial media the pneumococcus very rapidly loses its virulence. Some years ago, while working with the pneumococcus in the New York Health Department, I used a medium there in which the pneumococcus would retain its virulence for nine months in the ice chest. We used a mixture of ordinary broth and human ascitic fluid in the ratio of two-thirds broth and one-third ascitic fluid. This ascitic fluid I obtained from various patients as they came in to Bellevue, and who required tapping. It was very simple to do the tapping aseptically, as far as the operation was concerned, and also to obtain the fluid in aseptic vessels, and thus have it remain sterile an indefinite length of time, it simply requiring to be mixed with the broth when needed. With this germ I worked and obtained my pneumococcus serum from horses. The virulence of this pneumococcus was such that one two-hundred-millionth of a cubic centimeter was fatal to rabbits. In plating out this dilution I found that it contained from one to three germs, so that practically a single pneumococcus germ was fatal for a rabbit. Now, in making such dilutions, we must remember that we are not dealing with chemicals, such as the diphtheria or tetanus toxins, which remain of the same strength as they were in the original dilutions. Here we are dealing with living particles in suspension, which have the power, when once in the body, to grow and increase indefinitely. In the doses with which I infected my rabbits, when I tested the pneumococcus serum, there was one-thousandth of a cubic centimeter of the culture which contained from 200,000 to 240,000 living germs in suspension, and my serum would protect in the dose of one-tenth of a cubic centimeter against this large number of germs. Some of my serum, at times, would protect in the dose of one-twentieth to one-fortieth cubic centimeter, the control animals invariably dying. This pneumococcus retained its virulence for five years, and then for some unknown reason lost it, and I never could make it regain it, nor train another pneumococcus in the way that I wished it to go. About the serum in its connection with human beings I will speak later. Now as to the physical signs in pneumonia, I have often found that the very

first symptom of all, before the crepitant r le appears, and even before there is dulness or a change in the voice, is diminution in the normal breathing, due probably to the beginning congestion. After the crepitant r le occurs, although it is stated that it occurs only in inspiration and at the end of inspiration, it has been my experience to hear it in other points in the respiratory cycle: in fact, in Tyson and in other authors we find mention of a crackling r le which, from their description, is exactly like the crepitant r le, which is said to occur at any time during inspiration or expiration. This is, to my mind, nothing but the crepitant r le, and from their description it seems to be the same in their minds, they being in the dilemma of not desiring to contradict what they have been taught, and so have given a new name to the same thing. When in central pneumonia there are no r les, no dulness and no change in voice, there is often a faint bronchial coo, at the beginning of expiration, which is very characteristic; it is often very faint, and I have also heard it better with my ears than with my stethoscope. In my experience it is also usually heard in the axilla, often as high as one can push the stethoscope, or else it is heard at the angle of ribs behind, just below the tip of the scapula—that is, about the eighth rib. This is, in my experience, often the first physical sign that we get in pneumonia, and the pneumonia rapidly comes to the surface at this point. In influenza pneumonia Dr. Delafield taught me some years ago that in this form of the disease congestion was present out of all proportion to the amount of consolidation. This is very true, both from our physical signs and from what we see on postmortem examinations. Now, as to the question as to whether pneumonia can be aborted, Dr. Osler has been quoted as saying that it cannot, and that it cannot be influenced by any drugs. I remember, when an interne in Bellevue, that I was then trying Dr. Leaming's treatment in beginning pneumonia—that of giving 60 grains of calomel at a single dose, without any bicarbonate of soda—and to one patient, in whom there was a small patch of beginning pneumonia, the crepitant r les, dulness on percussion and broncho vesicular breathing and voice, I gave the 60 grains of calomel and showed the patient to Dr. J. West Roosevelt, who was then visiting for me in the absence of my regular visiting physician. The next day I showed him the patient, and all that remained of the pneumonic process was a slight dulness. I asked him at the time if it did not seem to be a case of aborted pneumonia, and he agreed with me it might fairly be considered so, although he thought it to be but the second patient in whom he had seen it. Twice since then, following the treatment given to me by my own father, from the late Dr. Metcalf, in which I have tried tartar emetic, with dover's powders, $\frac{1}{4}$ grain of the former and 10 of the latter, I have seen patients in whom I really be-

lieved that pneumonia had been aborted. This winter, in using ergot, two patients came to me in one day; the first a woman found asleep in a cellar, starving, alcoholic, and suffering from extreme exposure to cold; there was the diminished breathing over the entire right lung, there was dulness on percussion, her temperature was 105, pulse 120, her respirations about 30, and her leucocytes were 24,000. The other was a man, also alcoholic, at the end of a month's drunk, with a similar temperature and respirations and with the same leucocytosis of 24,000; he had also a patch of broncho vesicular breathing in one lung, besides a diminution of breathing over the whole lung. I gave these patients ergot every two hours, and that was the only drug they had for twenty-four hours. At the end of that time I found the woman with a temperature, pulse and respiration normal, also her breathing and leucocytes. The man I found with a very slight patch of broncho vesicular breathing, which cleared up in forty-eight hours, and instead of a marked tremor and general dilapidation from the alcoholism, his hand was perfectly steady, and he expressed himself as feeling perfectly well. Now, these cases of pneumonia, in my own experience, make me doubt the dictum of even the greatest teachers of medicine, when they make such broad and general affirmations, and deny the possibility of the cessation of certain processes in the treatment of pneumonia. As to alcohol, if I may be pardoned the apparent paradox, the more I give it the less I use it. I have been very doubtful as to its use in pneumonia for a great many years, and of late years it has become more and more strongly forced upon me that, except for its narcotic effect in soothing the mental restlessness of a patient, or using it in collapse, where it undoubtedly does good, most patients do better without it than with it, and I find myself using it less and less each year. Creosote carbonate has been highly recommended in a great many quarters in such cases, especially in broncho pneumonias which have a marked bronchitis. It seems to me that the pneumonia patients to whom I have given it, under these conditions, have shown marked benefit from its use. Some men in New York I know are using it as almost routine, and in other places in the country it is being used in the same routine way. By those who do use it, it is highly recommended. Oxygen undoubtedly does make a patient more comfortable, especially when there is a marked dyspnea, although I have often been told that oxygen cannot be absorbed under these conditions. It has seemed to me that the laws laid down in these observations were those that take place in the normal lung, and that, given an increased venosity of the blood and diminished lung space, the blood will readily take up the increased amount of oxygen and an improved aeration occur.

It certainly is true that its use in cyanotic patients will make them regain their rosy color,

their restlessness cease, and they become more comfortable and sleep more easily. As far as using quinine in pneumonia is concerned, I have been much struck in reading the article by Aufrecht, in Nothnagel's Encyclopedia, in the article on pneumonia, in which he says that he has in the past two years given hypodermic injections of $7\frac{1}{2}$ grains of quinine, on the fourth, fifth, sixth or seventh day, depending on the severity of the case, giving it once a day, and has found a very marked benefit from using it in this way. He quotes statistics in which he had formerly a 26% death-rate, but since he has used quinine his death-rate has fallen to 7.4% in 121 patients. I have used it on two or three patients in the way recommended, and while I do not know that it cured the patients, they certainly seemed to receive benefit from it, and to have shown a marked improvement under its use. These few cases are altogether too small to pass any judgment upon its use, but I was distinctly favorably impressed while using it. Now, as to ergot in pneumonia as an equalizer of the circulation, and thus diminishing the congestion, it is my firm belief that it does all that Dr. Livingston claims for it. Recently I have tried it on a baby 2 years old who had a very severe infection from pneumonia, and was rapidly becoming suffocated from the intense and increasing distension of its abdomen, sometimes seen in little patients. I tried everything I could to relieve this distension, and found nothing that could do it. I then thought of ergot as contracting the unstriped muscular fibers of the intestines. I gave 5 minims hypodermically and repeated this in an hour, and again in an hour. The baby, after the first injection, began to pass gas, and in a few hours the distension had entirely disappeared, and did not return, although from the severity of the infection and the enormous amount of lung involvement, the baby gradually suffocated. In edema of the lungs I have tried it in five cases, and all five cases were of the severe type of alcoholic pneumonia, and these patients recovered, and any drug which will benefit a Bellevue alcoholic patient commands my respect. I realize that I am a young convert to ergot, and like all young converts I may be somewhat enthusiastic, but, however that may be, I certainly have a great respect for ergot.

Now, regarding the use of pneumococcus serum in man. As I said, I had a strong serum, 1-10 cc. of which surely protected a rabbit against a large dose of a very virulent culture. I used it in twelve patients, choosing the severest cases, so that I could put to a good test. I lost 3, or 25%. In some patients it did not seem to be of any more effect than so much water; in others there did seem to follow an amelioration of the symptoms from its use; the pulse and temperature ran on a lower plane than before its use. One young alcoholic who began with a right upper and middle lobe involved went on to have his right lower and then his left upper and lower

lobes involved, and yet recovered under its use, and he had furious delirium tremens throughout the entire two weeks of his illness. One patient had a general pneumococcus septicemia in his blood, which cleared up under the use of the serum, and he recovered. Some patients had empyema and one abscess of the lung when I was using the serum, but as I had several other patients who had empyema and two others who had abscess of the lung from pneumonia when I was not using the serum, I do not believe the serum caused these complications. In using the serum we must remember we are adding only the specific immune body, and to kill the bacteria we must have both the specific immune body and the complement of Ehrlich or the alexin of Buchner and Bordet. Without the two bodies no action will take place on the bacteria. We can add all the immune body we wish, but without the alexin it is useless. We do not as yet know how to increase the alexin, which, according to the French school, comes from the normal leucocyte. Our processes of immunization do not increase it, and until we do learn how to increase this body we are baffled. From the experiments of Abbot, of Philadelphia, and some of his pupils, we do know, however, that large doses of alcohol prevent its formation, and that is, therefore, one more reason why we should give very gingerly our doses of alcohol. Until we can find some substance which, injected into the blood vessels, will act on the exudate in the alveoli of lungs, which is out of doors as far as the blood in the vessels is concerned, though surrounded by the blood vessels and absorbing substances from this exudate, we cannot hope to directly influence the growth of the bacteria. Among the complications of pneumonia, it has been mentioned that empyema is more often the sequela than a complication of the disease, and it is so stated in the systems of medicine in general use. My own experience has been just the opposite, and looking up my cases, I have found that empyema occurred as a complication of the fifth or sixth day, rather than a sequela and this in the ratio of five to one. I therefore believe that it is more a complication than a sequela and the reason that it is thought to be the opposite is that in alcoholic pneumonia, where it usually develops, the patient dies so quickly after its development that there is no chance for a septic curve of temperature, and often there is no change in the physical signs, and it is not recognized unless there is a post-mortem examination. In several of my patients, the only way in which I have recognized it, was from the leucocytes; that when the leucocytes double in twenty-four hours, or rise from 90 to 100%, I believe it shows empyema. It is true that the leucocytes will increase from 60 to 70% when there is new involvement of lung tissue or where there is a large surface of resolution taking place, or where there is resolution at one point and new involvement at another point of the lung, but under these conditions the leucocytes rise

more gradually, and they do not seem to rise more than 60 or 75% in a day, although at the end of forty-eight hours they may be more than 100% higher than they were, but it is where the leucocytes rise this 90 or 100% in the twenty-four hours that they indicate empyema. I speak thus confidently from my observations, which extend over five years, in which I took a daily leucocyte count of some eighty-five cases of pneumonia, and read a paper regarding it at the last meeting of The New York State Medical Association. This, then, has been my experience in pneumonia, and I must thank you again for the opportunity that I have had of discussing it with you.

Dr. Frederick Holme Wiggin, president of The New York State Medical Association, said in the discussion that pneumonia following surgical operations could be largely prevented by exercising more care in cleansing the disinfecting apparatus used to administer the anesthetic, and also by more care being taken to protect the patient's body from cold and wet, other than the part to be operated upon. The use of ergot prior and subsequent to the operation, as suggested by Dr. Livingston, would help, in the speaker's opinion, to prevent thus much-dreaded complication.

THE KIDNEY OF PREGNANCY.¹

BY JOHN O. POLAK, M.D.,
Brooklyn, N. Y.

THE so-called Kidney of Pregnancy is one in which there are no inflammatory changes, but a fatty infiltration of the epithelial cells lining the uriniferous tubules, associated with anemia of the organ. These degenerative changes in the epithelium of the renal tubules have been attributed by Lyden to alterations in the arterial pressure and to an interference with the renal circulation incident to gestation. Recent observers claim that the changes in the kidney, as well as the hepatic changes, are due to the circulation in the blood of *certain imperfectly oxidized* metabolic products, which produce more or less autointoxication. The excretory organs of a woman during gestation are called upon to rid themselves of an excess of waste material, the result of fetal as well as maternal metabolism. When women suffer from a retention of imperfectly oxidized metabolic products they become toxic. The appearance of albumin in the urine indicates a renal insufficiency and may lead to serious consequences to the mother, and if in sufficient quantity it is always detrimental, if not fatal, to the fetus. The dangers to both are greatly increased if the albuminuria develops suddenly.

During pregnancy the urine is increased in quantity and of a lower specific gravity, though its normal constituents, with the exception of chlorides, phosphates and sulphates, remain un-

¹Read before the Kings County Medical Association, March 10, 1903.

changed. Williams places the elimination of urea at from 20-24 grammes in the average woman, and takes exception to the statements that urea is increased in quantity during gestation. A trace of albumin may be demonstrated, at some period of gestation, in the urine of 50 per cent. of all pregnant women. Albumin is only of importance: First, *when it appears in abundance and is caused by an excess of toxins passing out through the kidney tissues, and is associated with diminished secretion.* Second, *when it is associated with tube casts and is an evidence of nephritis.* The time of its appearance in the urine during pregnancy has a prognostic significance. When due to renal disease antedating pregnancy albumin may be demonstrated during the early months, but when it occurs in the later months, unless the amount is excessive, it may be considered as truly a symptom of the "kidney of pregnancy." In a large proportion of cases albumin does not appear until late in the second half of gestation, and may be directly attributed to the increased abdominal pressure interfering with the renal circulation. It is more common in the presence of twins, hydramnios or primiparæ with rigid abdominal walls. Allbutt believes that toxins absorbed from the intestinal tract are responsible for the kidney irritation, producing albuminuria and not increased abdominal pressure.

When albumin is found in women who are enjoying perfect health during pregnancy, its clinical value is more suggestive than actual. It is also present in one-third of all cases during labor.

The urine of nearly all women contains hyaline casts and leucocytes *in the last month* of gestation. This is generally attributed to the increased abdominal pressure or increased metabolism, for the abnormal constituents rapidly disappear when the uterus has emptied itself.

The "kidney of pregnancy" is practically a condition of the last four months, particularly among primiparæ. More or less edema of the lower extremities is the most common symptom, aside from the changes in the urine already noted. The edema disappears and the urine becomes normal promptly after delivery. But the transition from this condition which may be considered as normal, in the last month, to one of concern, often culminating in eclampsia, is almost insensible, so far as the kidneys are concerned. The writer is therefore of the opinion that the eclamptic explosions are the result of a combined toxemia, produced by deficient elimination by all of the emunctories, of which the intestinal tract is the most potent factor.

Women having a chronic nephritis antedating pregnancy aggravate their renal condition by gestation and expose themselves to the dangers of serious toxemia. Again an acute nephritis may suddenly develop on the kidney of pregnancy and subject the woman to a dangerous complication.

While albumin indicates a renal insufficiency, its appearance, unless in quantity, is of *little clinical significance* unless it is associated with *diminished excretion, deficient urea elimination, or fatty, granular or waxy casts.* The presence of these abnormal constituents *determines the necessity of interrupting pregnancy.*

Inflammations of the kidneys may be accompanied by hemorrhages. These may separate the normally placed placenta and cause fetal death as well as endanger the life of the mother, or the placenta may contain large infarcts, which are almost invariably associated with albuminuria. These are due to an endarteritis of the villi of the chorion. An albuminuric retinitis, as well as hemorrhages from the nose, mouth and intestine, has been noted as associated with this form of renal lesion.

The kidneys are involved in about two-thirds of the cases of eclampsia and albumin in considerable quantity has been demonstrated in the urine of 84 per cent. during the convulsion. Albuminuria is always an important prodrome, and the quantity increases with each explosion and decreases after its cessation; the white and red blood corpuscles and casts also rapidly disappear from the urine after the convulsions have ceased.

A diminution in the excretion of urea is, however, the most important preclamptic signal, and indicates kidney inadequacy; a fall to 1.5 per cent. is always dangerous.

When the pre-eclamptic state is recognized by the toxic symptoms and urinary examination, the following suggestions may arrest further intoxication: 1. Reduce the amount of nitrogenous food. 2. Limit the production and absorption of toxic materials in the intestines and the tissues of the body, and assist their elimination by the bowel, liver, kidneys, skin and lungs. 3. And finally, if necessary, remove the source of the fetal metabolism and irritation.

Navy in Need of Young Surgeons.—There is a great demand in the navy for young medical officers. The need of assistant surgeons in the Medical Corps is very great, there being at the present time twenty-seven vacancies in that grade. Surgeon-General Rixey is trying to attract young medical men into the service. He is now in the South inspecting a hospital at Pensacola. He intends addressing several medical colleges and calling to the attention of the students the desirability of a naval career. Not long ago he delivered an address at the Jefferson Medical College, in which he dwelt upon the opportunities for young medical graduates in the navy. The work to be performed by the Medical Corps in the navy is growing every year. The authorized strength of the navy now is about 38,000, and within the next six years will probably reach 50,000. The enlistments and reenlistments require the constant attendance of surgeons to make physical examinations, and besides this routine work there are fourteen naval hospitals with naval stations, navy yards and receiving-ships, where the services of members of the Naval Corps are needed. Applicants for admission in this branch of the service must be between 21 and 30 years of age, physically sound, of good high-school education and master of their profession to a degree that would insure a successful career in civil life.—*Philadelphia Record, April 11, 1903.*

ALBUMINURIC RETINITIS OF PREGNANCY.*

BY JAMES W. INGALLS, M.D.,
Brooklyn, N. Y.

ALTHOUGH albuminuric retinitis is not one of the usual complications of pregnancy, yet this affection of the eye occurs with a frequency sufficient to justify us in choosing it as a theme for discussion. It would hardly be possible to write a paper on the subject under consideration without making some reference to Loring,¹ who was one of the first to advocate premature delivery for the relief of certain ocular diseases which were liable to occur during the period of gestation.

Loring's paper was read before the American Ophthalmological Society more than twenty years ago, yet in spite of the advances made in obstetrics and ophthalmology, the principles enunciated in that dissertation are still regarded as safe rules for guidance in doubtful cases. Loring has sometimes been quoted as advocating operative measures in all cases of retinitis of pregnancy. This is certainly a mistake. His exact words were as follows: "I do not mean to say that in every case where atrophy is detected in a pregnant woman an abortion should be performed, but I do say that where it has occurred in one confinement every precaution should be taken to explain the dangers of future confinements to the patient, and that in extreme cases, such as the one reported, premature delivery should be performed rather than let the mother go blind, or run the risk of going blind." Few conditions call for riper judgment and a more intelligent conservatism than the proper management of ocular affections resulting from child-bearing. The doctor is between the devil and the deep sea. On the one hand, no conscientious physician would ever think of operative interference unless for the purpose of saving either the life or the sight of the patient, for such an act would be a crime. On the other hand, to neglect the measures which experience has shown to be efficacious, and to allow a woman to go on to a state of blindness, is a blunder which is as bad as, if not worse than, a crime.

It has been aptly said that the early recognition of disease is next in importance to the prevention of disease. This well-recognized principle of medicine applies with particular force to the affection which we are now attempting to consider. Pooley,² in a paper before the New York Academy of Medicine, advised that in all cases of pregnancy not only should examinations of the urine be systematically made, but the eye should be examined with the ophthalmoscope, since in a large proportion of cases where eye-trouble exists the patients make no complaint of disorders of vision. This would be an ideal plan, but not feasible, except possibly in maternity hospitals. However, in most cases it will be useful, as a routine practice, to test the vision with the

letters of an ordinary test-card, such as is found in every physician's office. It should be kept in mind that it occasionally happens that the vision in one eye may be seriously impaired, and that the patient may be unaware of any defect because she sees well with the sound eye; for this reason the eyes ought to be tested separately. This procedure takes but a few moments, and answers all practical purposes. For even if there were some slight changes found by the ophthalmoscope, no interference would be justified as long as the patient's vision remained normal.

Diagnosis usually presents but little difficulty. The ophthalmoscopic picture of retinitis or neuroretinitis of pregnancy does not materially differ from that found in acute nephritis due to other causes. We may have nerve changes, which vary in appearance from a slight blur to complete obscuration of the outline of the disk. Also in the macular region there may be a few indistinct spots or there may be a typical stellate grouping of spots; the former cases present some difficulty in giving a positive opinion; the latter are easily recognized. Between these two extremes we have various combinations and modifications.

Treatment.—Of course, it is understood that any local treatment of the eyes is useless. The oculist can do nothing more than to verify the diagnosis. First of all, the usual remedies for the relief of acute nephritis should be thoroughly tried. These measures failing, it is to be decided whether it is best to empty the uterus. It is impossible to make cast-iron rules to which there may not be some exceptions. Indications are so precisely stated by Howe³ that liberty is taken to quote his conclusions: "When vision does not begin to be impaired until the last two weeks of the ninth month, then recovery almost invariably follows. When the retinitis began during the eighth month, less than half the patients recovered their sight, but when the retinitis made its appearance as early as the middle of the seventh month, and the case went to full term, permanent blindness resulted. Induction of labor is warranted when the retinitis appears in a comparatively early stage of pregnancy, and persists in spite of proper treatment, but it is not warrantable in the last few weeks." In order that the family doctor may be relieved of a considerable part of the responsibility, the facts ought to be plainly stated to the patient and her husband and a request made for proper consultants. If their advice is not accepted, the responsibility rests entirely with the woman and her friends. It is hardly necessary to add that the attending physician should explain both to the husband and to the wife the dangers attending a future pregnancy, for it is found in almost every case that each successive pregnancy causes more extensive degenerative changes in the retina.

The following cases are of interest by virtue of the fact that no disturbance of vision occurred until after delivery:

Case 1.—Referred by Dr. Henry Schelling, to

*Read before the Kings County Medical Association March 9, 1903.

whom writer is indebted for previous history. Mrs. —, at the age of 26, gave birth to a healthy child at full term. One year later aborted at the fifth month. No albumin found during second pregnancy. Became pregnant again in about a year and a half. At the sixth month albumin was found, and one month later—*i. e.*, at the seventh month—miscarriage took place. Vision all this time was normal, and continued so till the day after delivery, when sight began to fail. In the course of forty-eight hours became absolutely blind. Was unable to locate position of a lighted lamp. This condition continued nearly a month, and then her sight began to improve, and in the course of another month saw well enough to go about the house.

Mrs. — came to my office in October, 1899, nine weeks after her confinement. Ophthalmoscope showed in right eye the characteristic appearance of albuminuric retinitis—O. D. V. = 15/100, no improvement. Left eye a few scattered yellowish-white spots in macular region—O. S. V. = 15/40, no improvement. The doctor informs me that though no definite tests were made, yet a few months later patient affirmed that she saw as well as she ever did.

Case 2.—Mrs. —, referred by Dr. Palmer Townsend, who sent the following history: Mrs. — enjoyed very good health prior to pregnancy, except that she suffered occasionally from attacks of indigestion. During pregnancy nothing of significance occurred till the end of the eighth month, when albuminuria was discovered. The albumin increased very rapidly, and was very large in amount at end of ninth month, when she was delivered of a large (ten pounds) child. On February 3, 1903, she came to my office and gave following history: Never had any trouble with sight until a few hours after birth of child, which occurred four weeks previously. Then noticed that she was unable to discern objects about the room; no definite tests were made. In a few days sight began to be somewhat better; improvement has continued until the present time. Ophthalmoscope shows right eye normal, left eye slight haziness of the disk. In the macular region there are two small dots. O. D. V. = 15/15 + with -0.50 C180° from 15/20. O. S. V. = 15/30, no improvement. On February 17th, date of last visit, spots in macula had entirely disappeared. O. S. V. = 15/20.

BIBLIOGRAPHY.

1. Transactions of the American Ophthalmological Society, 1882.
2. *New York Medical Journal*, January 28, 1888.
3. *American Journal of Ophthalmology*, May, 1885.

DISCUSSION.

Dr. J. C. Bierwirth objected to the term *albuminuric* retinitis, on the ground that it is misleading and produces much mischief. He said that it was a great mistake to rely upon an albumin test. The important point is to determine the amount of waste eliminated. The amount of urea and the total solids must be kept track of.

Albuminuria simply indicates a deranged condition and may be transitory. Routine urinalyses will prevent many cases of retinitis. There have been many theories of the cause of the retinitis, but nothing more satisfactory than the explanation made in 1878 by McDowall, of Edinburgh, that the trouble is due to the retention of waste products in the circulation.

The excessive irritability of the female nervous system during pregnancy predisposes to eclampsia. Although cases have been reported in which the urine was said to be normal, the speaker had never seen any. In addition to urinalyses, symptoms of cyanosis, pallor and headache should be given careful attention.

Dr. Patrick Jameson did not agree with Dr. Ingalls that the ordinary test of vision by card is a good guide in these cases. There might be marked retinal changes without serious derangement of vision. He also stated that in his experience it was not possible to diagnose *albuminuric* retinitis from that due to other causes.

Dr. John Polak said that all the symptoms mentioned were due to toxemia, and that the urine would give the earliest indication of danger. That albumin was not an indicator, but that the volume of urine, the specific gravity and the total solids were the important matters to be watched.

In reply to Dr. Bierwirth I would say that I quite agree with him in his criticism of the term *albuminuric* retinitis, because a diseased condition might exist in spite of the fact that no albumin is found in the urine. This was true in Loring's first case. Dr. Wood has made a valuable suggestion regarding the use of colored glasses during convalescence from retinitis.

In answering Dr. Jameson I would beg leave to repeat what was said in the paper, namely, that it would be an ideal plan to have the eyes of every pregnant woman examined from time to time by a competent oculist. This is desirable, but not feasible. However, it is a very easy thing for the physician to test the vision with an ordinary test-card at fifteen or twenty feet.

It is readily conceded that occasionally a case might occur in which at the outset central vision would not be affected. But admitting this possibility, no one would think of terminating the pregnancy unless there was some loss of central vision, a condition which could be detected by use of the test-card.

Doctors Should Be Cheerful and Optimistic.—The *Cosmopolitan* says the longevity of the medical man is materially less than that of workers of other professions. Only those with a sound physique, other things being equal, can win in a struggle for success. The sick look with confidence to the well. They demand the hearty dogmatism that comes from the overflowing of animal spirits. They enjoy the cheerful optimism that comes from a good digestion. They lean upon the doctor in their weakness, and yield willing obedience to his kindly influence. Much of the power possessed for good may be outside of pills or potions, correct theories or sound deductions.—*American Medicine*.

THE PATHOGENESIS AND ETIOLOGY OF PUERPERAL ECLAMPSIA—A PLEA FOR THE MORE SYSTEMATIC OBSERVATION OF PATIENTS DURING PREGNANCY.¹

BY FREDERICK P. HAMMOND, M.D.,

New York.

THE trend of modern teaching is tending more and more to prove that the primary cause of puerperal eclampsia is one of a general systemic nature, in its earliest stages not depending so much upon the fact that a certain amount of toxins are manufactured in the system as upon the manner in which the various organs perform their function for the general good of the economy. In the earliest stages of eclampsia, as in Bright's disease, there are general functional disturbances of a sympathetic nature, which interfere alike with circulation, food and tissue metabolism, and the process of excretion, and it is these simple derangements, continuing without interruption for a longer or shorter period of time, which permit either the formation of new toxic compounds, or so lower the power of resistance in the vital economy as to predispose it to infection from the ordinary toxins of animal life, which at the normal pass off as inert and harmless.

Ever since Lever, in 1843, announced to the world his important discovery that albumen was present in the urine of the eclamptic patient, investigation has been trite to discover and explain the exact relation in which this symptom stands to the general phenomena of the disease. The late distinguished Virchow believed the physical changes in the kidneys to be much too insignificant to account for so grave a malady as eclampsia. Prutz, as a result of his studies, attained to the conviction that when the kidneys were the seat of grave organic changes, eclampsia would not occur. Braun, Frerichs and many prominent writers have believed the convulsions were due to the presence of urea, Frerichs later modifying his views to a belief that carbonate of ammonia, a decomponent of urea, was the real toxic agent; this only to be set aside by the investigation of the chemists, who discovered carbonate of ammonia to be a normal constituent of the blood. Peter, from the fact that the urine becomes scant or suppressed prior to the convulsive onset, believed the malady was caused by the retention within the blood of all the elements of the urine. According to Pinaud and Massen, the convulsions arise from the presence within the blood of non-oxidized products of cell activity, or the so-called leucomaine poisoning, from the sluggish liver. At the normal, the functional activity of this organ renders these substances innocuous, but in the sluggish state there is such an accumulation of these elements as to result in an eclamptic explosion. That the convulsions result from the absorption of certain effete material, originating

from the placental metabolism, is a very old theory, and has received support from prominent writers of the present day. Still other writers have believed that uric acid, or the extractives, creatin, creatinin and their various decomponents, were the real cause of the disease.

Closely following the investigators who have sought the cause in some abnormal characteristic of the blood or urine have been those who have tried to explain its origin through some anomaly of brain disease, or irritation of the hypersensitive cerebro-spinal system. Dewees, Meigs and Hodges, a generation ago, attributed the convulsions to congestion of the cerebro-spinal system. Meigs asserted that the convulsions were due to a long-continued or violent determination of blood to the head. Traub and Rosenstein have advanced a theory which has attracted much attention in literature. They believed the cause to be a cerebral anemia, due to the watery condition of the blood from the increased arterial pressure. The increased arterial pressure first produces a congestion, with edema, to such an extent as to cause constriction of the small arterioles. Brown-Sequard has substantiated a portion of this theory by showing that cerebral anemia is a normal precedent of the attack of epilepsy. McDonald, also upon autopsy, in two cases of eclampsia, found extreme cerebral anemia, with congestion of the meninges, but none of the edema which Traub and Rosenstein believed to occur. He believed the convulsions were due to irritation of the vasomotor center, in consequence of the anemic condition of the pregnant patient's blood. Other writers have recorded cases in which the convulsions seemed plainly due to reflex irritation of a mechanical nature from the hypersensitive cerebro-spinal system. La Motte, in particular, recites a case in which the fetal head was so disposed within the pelvis as to cause pressure upon the neck of the bladder, with consequent retention of an enormous quantity of urine. This relieved, there was an immediate cessation of the convulsions, which showed no tendency to return.

Within the past decade the pathology of the blood and urine in eclampsia has been the subject of thorough scientific study, and much valuable knowledge has been placed at our command, which is likely to prove of great value in elucidating the treatment of the disease. Ludwig and Savor have found that the blood serum of the pregnant patient is normally more poisonous than the unimpregnated, that of the eclamptic more poisonous than the normally pregnant. Chambulent has demonstrated that one-third the quantity of blood serum from an eclamptic patient when injected into a rabbit will produce death, which is required, if the serum be obtained from a healthy man. According to these observers the degree of toxicity of the blood forms a fairly accurate criterion upon which to base the prognosis in any case of eclampsia.

In the urine discoveries have been made of

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

such a nature that the hitherto accepted theories upon this subject are liable to entire revision of belief. Labadie-Lagrave, Boix, Noe and others from abroad, and more recently Drs. Mary Putnam Jacobi and Mary Mitchell Kydd, in our own country, have made this the subject of careful scientific review. These investigators inform us that the urine of the pregnant patient is less poisonous than the unimpregnated; that during the height of an eclamptic seizure, instead of the quantity of toxins being diminished, there is actually an increase. In fact, the quantity of toxins eliminated seems to bear a direct ratio to the saturation of the blood, though at no time is the urine so poisonous as in the unimpregnated condition. Such testimony as this, taken in conjunction with the fact that the principal change in the urine is an increase in the aqueous elements, the daily quantity of solids being nearly the same during pregnancy as at other times, we can hardly do otherwise than conclude that upon other organs aside from the kidneys must depend the extra work of caring for and excreting the excess of toxins which are the normal accompaniment of pregnancy.

In approaching the subject of the treatment of eclampsia, the fundamental principle underlying all others should be a judicious prophylaxis, based upon the elementary principles of hygiene and frequent personal observation of the patient. In every case of pregnancy we should obtain the antecedent history, so that hysteria, chorea, epilepsy or other concomitant nervous affections may be eliminated, and a proper comparison of the symptoms dependent upon pregnancy made in contradistinction to the normal. Headache, disturbance of vision, vertigo, the emotional irritability and epigastric pain have a direct bearing upon the premonitory symptoms of eclampsia. Of the headache, we should inquire carefully how much, if any, the patient has ever been subject to, its character, and particularly the region of the encephalon where it has been located. The headache of eclampsia is characteristic—we may almost say pathognomonic. It is a piercing, lancinating pain, most frequently located in the frontal or temporal region, though rarely occipital or general, and it is intermittent both in its severity and constancy. When it is constant the attack is not far distant. Every case of headache in pregnancy should receive attention, and patients should be taught the importance of repairing to the physician's office whenever there is the slightest change in the characteristics of this ordinary symptom. Whenever there is a suspicion of doubt as to its cause, it should be an established rule to examine the urine. If the urine show a specific gravity of 1012, or less, even though there be no other abnormal symptom, some agent designed to increase the quantity of toxins and solids should be exhibited, and for this nothing is superior to the familiar *tic. perchloride of iron* in 10-minim doses per t. i. d., preferably given in lemonade. For the relief of a transient headache, with no

alimentary or urinary disturbance, a remedy should be selected with regard to lowering of the arterial tension, the bromides being preferable to all other remedies. The coal-tar products should be given with great caution in pregnancy, as the deficiency in the red corpuscles, excess of serum and fibrin, as well as the overtaxed nervous system, are a direct contraindication against their too frequent employment.

Disturbance of vision and vertigo are very often direct concomitants of disorders of the liver or alimentary canal. Whenever these symptoms appear inquiry should first be made as to the condition of the alimentary canal. If there is flatus, epigastric pain, or excessive secretion of the gastric fluids, these should receive their proper remedial agents, and even though no constipation be present, a cholagogue cathartic should be given as a matter of routine, elaterium or podophyllin always proving efficacious.

The characteristics of the urine are the only guide furnished which enables us to judge of the amount of solids and toxins eliminated from the system. That it is far from accurate, we are made aware from recent studies. In pregnancy there is normally an increase in the daily quantity passed, due to the increase in aqueous elements, and urination becomes more frequent. The specific gravity is slightly lowered. The daily quantity of solids, according to Winckel, Chalvet and Barlemont, is but little changed from the unimpregnated condition. The more thorough and complete does the physician make any examination of the urine the better does he understand the condition of his patient. When all is said, however, it must be admitted that our knowledge of the pathology of eclampsia is thus far so incomplete that our reliance is as safely placed upon the older and more elementary principles of urinalysis as upon the progressive theories of the present day. A urine of moderately deep amber color, with specific gravity not exceeding 1012, and the daily quantity diminished below 35 ounces, is always a dangerous symptom in pregnancy. If, in connection with this, albumen becomes present, it is significant of grave omen, and seldom do these characteristics appear in the urine unless the subjective symptoms of headache, vertigo, disturbance of vision, or other premonitory symptoms of eclampsia have already become manifest. The presence of albumen is most deceptive. Parvin estimates that not more than one in five women who have albumen ever develop eclampsia. Imbert Goubreye found 95 out of 164 with albumen, and no eclampsia developed. Blot found 34 out of 41, with no other untoward symptoms. It would seem from such statistics that we might almost disregard the presence of albumen in the pregnant patient's urine. No physician, however, does disregard the presence of albumen, and the fact that so large a number have it present without developing eclampsia might be a means of proving how responsive are patients to treatment when it is discovered before the other symptoms have assumed

a grave aspect. Upon the other hand, albumen may often be absent from the urine previous to the eclamptic seizure, but authorities are agreed that it seldom fails to make its appearance nearly coincident with or shortly after the convulsions have developed. Braxton Hicks believes the same toxic agent which is active to produce the convulsions acts also to produce the albumen. Appropos to this subject is the following, in brief: In July of the present year I was hastily summoned to attend a patient 40 years of age, in her fourteenth labor. Finding a prolapse of the cord I immediately summoned assistance, and forcibly delivered her. A profuse postpartum hemorrhage followed, but gravity of another nature was not suspected. Twelve hours following delivery she developed the characteristic convulsion. The urine, per catheter, immediately following this showed a specific gravity of 1010, with no albumen, while the same operation repeated eight hours later showed no variation in specific gravity, but albumen at the rate of 30 per cent. The quantity of albumen rapidly diminished, until on the sixth day there was only a trace. Convalescence, however, was anything but satisfactory, and on the evening of the thirteenth day she developed an attack of vomiting, which was shortly followed by convulsions. The catheter at this time revealed eight ounces of urine, with specific gravity of 1010, and only the usual trace of albumen, while the same operation repeated the following morning, four hours before death, revealed twelve ounces of urine, with the quantity of albumen raised to 20 per cent. It is not amiss in this case to notice the influence of the postpartum hemorrhage acting as a stay to the initial convulsion, until the circulation had become largely restored.

The prophylactic treatment of eclampsia is best accomplished by selecting a diet which at once permits the least amount of toxins to form in the system, and at the same time irritates in the least degree an already hypersensitive cerebro-spinal system. The abnormal nervous phenomena of pregnancy are not unlike the conditions of nerve exhaustion described as neurasthenic. There are practical, well-established principles of diet commensurate to fit these conditions, and why they should not be as generally adopted here as elsewhere it is difficult to understand. With the exception of a few primary rules regarding the morning sickness, little or nothing is ever said regarding the diet of pregnancy. Eclampsia occurs more often in the late than in the early months of pregnancy, and the principles established to prevent the morning sickness should be continued with increasing care and observation to the termination of labor and throughout child-bed. The diet should be simple and consist of fluids in abundance, and bulk in sufficient quantity to exercise all the functions of the alimentary canal. Wheat bread, from its richness in nucleo-albumen, should enter into the diet of every meal taken. The morning meal should be light, and consist of an abundance of fresh

fruit, always peeled; the fluids may be water, weak tea or coffee; a cereal, toast or plain bread, milk or a rarely cooked egg, but no meat. The midday meal should be the chief, and here all the elements entering into the diet should be taken in abundance, and at this time, and this only, should the red meats be taken. If there is great psychical or nervous disturbance, the red meats should be withdrawn and chicken and fish substituted. Red meat is the particular emotional nerve excitant, to say nothing of the manner in which its juices act as a nidus for the growth of pathogenic bacteria; and last, but not least, is the tendency of nitrogenous food to produce the uric acid dyscrasia. The evening meal should be again light, but consist of greater bulk than the morning, with a moderate amount of plain pastry. If the food repeat, or there is excessive gastric secretion or heartburn, the coffee should be withdrawn, and hot water with milk or a similar beverage substituted. Whenever there appear symptoms of headache, disturbance of vision, vertigo or epigastric pain, it is not judicious to wait for a determination of what is their gravity, but place the patient upon a fluid diet at once, and determine their significance later. The fluid diet should consist of milk mainly, but there is no objection to the addition of the shellfish broths or artificial milk foods, but in no case should the meat extracts be given.

Equally important with the hygiene of diet is the hygiene of the alimentary canal. A majority of pregnant patients are habitually constipated. They will often take cathartics systematically, but will invariably wait for the call of nature before retiring to the closet. They should be taught the importance of a regular hour for this, and nature should be assisted by a warm saline enema at every stool if necessary. In the exhibition of cathartics, too, care should be exercised to consult the condition of the alimentary canal in its entirety. A patient who suffers much from heartburn or flatus requires a saline more often than one who does not. When the colon or lower bowel is at fault the cascara compounds are particularly indicated. When there is excessive gastric secretion three to five grains of calomel in combination with bicarbonate of soda at night, followed by the usual morning saline, is effectual. Persistent flatus as a symptom of itself requires treatment. The common mixture of rhubarb and soda is often its most efficient remedy. Spirits of chloroform and peppermint water, or the oil of turpentine with sweet spirits of niter, may be successively tried. If the patient is not averse to the enema, as a last resort glycerine and peppermint water are always agreeable, and may be tried with every assurance of success. A sluggish liver is the organ chiefly at fault in allowing an accumulation of toxins within the system. Elategium and podophyllin are the remedies par excellence. They are always best exhibited in combination with a stomachic of some sort.

Exercise in the open and the care of the skin are to be recommended and encouraged at all

ter informed it will be possible for them to live times. A biweekly tepid bath should be the regular rule, but oftener if desired. Cold bathing should be interdicted throughout the entire period of utero-gestation.

Having thus tided our patient over the necessary period to a point where there is safety in the viability of the child, say at any time beyond the beginning of the seventh month, with symptoms which are at all alarming, I am no sympathizer with the principle of delay, but believe that now, while there is still time for the deliberate induction of labor without resorting to drastic measures, it should in every case be resorted to. Usually nothing more is required than a moderate stretching of the cervix and the exhibition of an active cathartic, preferably croton oil, for it is to be remembered that the toxemia of eclampsia in itself is an agent which is always active to bring the labor to termination. If, after a period of twenty-four hours, there appear no signs of progress, a catheter should be introduced and manipulated as near the fundus uteri as possible without violence. The eclamptic patient has been likened to the strychnized frog, and for this reason too much care cannot be exercised to irritate the patient as little as possible throughout all manipulations.

To avert the attack when all the symptoms are indicative of an immediate explosion, I can only place my reliance upon the use of chloral hydrate. Of its dangers I am aware, but of its efficacy I cannot doubt, and it serves the great object of exercising control over the central nervous system. With veratrum viride I am practically unfamiliar, but observation in a recent case leads me to believe that its paralyzing effect upon the muscles is so great that labor will not progress of its own volition, and in this particular case the convulsions were not averted. No one, it seems to me, can feel at all safe who leaves his patient to the care of a drug whose virtues are mainly a low blood pressure and a slow pulse.

BIBLIOGRAPHY.

- American System of Obstetrics, vols. 1-2.
 Clinical Pathology of the Blood, Ewing.
 Transactions New York State Medical Association, vols. 8 and 13.
 Playfair's System of Midwifery.
 Byford's Theory and Practice of Obstetrics.
 New York Medical Record, November 8, 1897.
 Medical Review of Reviews, June and July, 1899.
 Wood's Materia Medica and Therapeutics.

NEW HOSPITAL FOR INSANE.

To prepare the way for the abolition of the pavilion for the insane in Bellevue Hospital, Senator Foley introduced a bill favored by the State Commission in Lunacy providing for the ultimate transfer of the examination of patients suspected of being insane from the city to the State and creating a psychopathic reception hospital where the insane may be sent for observation.

TREATMENT IN GYNECOLOGY FROM A MEDICAL STANDPOINT.¹

BY MARY GAGE-DAY, M.D.,
 Kingston, N. Y.

I WISH to state that the following opinions have not been the result of observations and experience at a large charity clinic, nor upon the poorer classes of foreign women in our population, but upon a well-to-do class, principally Americans, in private practice. In discussing the treatment of diseases peculiar to them we will present: First, some hygienic considerations; second, the medical treatment, general and local.

Hygienic Considerations.—There seems to be a common idea among women that the diseases from which so many of them suffer are peculiar to the present age. That the women of older generations were free from them, and the savage women to-day are exempt. This idea has a very depressing effect upon the natural cheerfulness of many women, and it seems there is no historic basis for it. According to Reed,¹ there is proof in the ancient papyri that the Egyptians had physicians devoting themselves especially to women's diseases, and later Hippocrates wrote a systematic treatise on this subject. The ancient physicians knew the use of the speculum, uterine dilators and pessaries, but then medical science passed through a long period of dark ages, while in our own time the ancient knowledge has been regained and greatly increased. Andrew F. Currier,² of this city, has broadened our knowledge of the real condition of the American Indian woman. While she ordinarily passes through the perils of childbirth safely, if complications arise they are usually fatal. The rate of infant mortality is high, and she is by no means free from pelvic diseases.

The most advanced knowledge would seem to indicate that the women of the present time are simply prone to the same diseases that all the generations before them have been, but the greater diagnostic skill of the present age differentiates her ills. The same is true in other departments of medicine.

Before beginning any treatment of pelvic diseases it is important to understand clearly as possible the condition of each patient's life, and if she is violating known physiological laws, explain the necessity of rational living. In making these preliminary examinations I have been astonished at the *real ignorance* of personal hygiene among women who, in general literary matters, are well informed. This makes me feel that, in addition to subjects ordinarily studied, a greater amount of general and personal hygiene should be taught to every young person. Until such time comes, for all who are under their care physicians should be teachers as well as practitioners. As women become bet-

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

more hygienically, and so prevent the development of many common pelvic ills.

Medical Treatment, General and Local.—How we can best treat the actual cases of disease, as they present themselves, is a problem of great importance to some of us. It is well to have clear ideas of the kind of cases which we have any reasonable hope of curing by medical treatment, and the kind of which the curative treatment is surgical. When patients present themselves to me for examination, and I find any of the following conditions present—cancer, tumors of any kind, pus collections and the results of injuries due to childbirth—I explain carefully to all such that the curative treatment for them is surgical, and whatever medical treatment is given is only palliative. When we have eliminated these pelvic diseases we have left only those which may be termed minor ones, such as “inflammations and displacements,” which we have any hopes of curing by medical treatment.

We realize the importance of endeavoring to cure these, when we think what a vast amount of suffering women endure on account of them, many wearing out wretched lives of half invalidism, never properly doing their duty to their family and friends, suffering mental depression to the very border of insanity. Then, according to Pozzi,³ Byford⁴ and others, malignant transformation takes place in some long-neglected cases of metritis. In treating pelvic cases my own experience has been that my patients get well faster if I make a thorough physical examination in the beginning, including urinalysis, and give the remedies indicated by the general condition at the same time that I am trying to relieve the local trouble. In making local examinations I wish to emphasize the importance of cleanliness, of having proper instruments of different sizes, and dexterity and gentleness in all manipulations.

My remarks will refer more especially to the chronic forms of pelvic disease, and for their relief, medically, we have the following aids: “Systemic medicines, local applications of drugs, and in some cases of electricity, douching, and in case of displacement, support by mechanical means.” In the local treatment, in women prior to the menopause, if I were restricted to the use of four drugs, they would be “iodine, ichthyol, glycerine and boric acid.” Others are sometimes of use, but these have been of greater service to me. In cases of metritis (I use the word in a clinical sense), where there is *not* marked tenderness in the adnexa, the following mixture, containing iodine ℥j, boric acid ℥ij, glycerine ℥iv, has been of great service to me, as illustrated in this Case 1:

Miss C., a healthy woman about 25, while walking on the street, stumbled and went through a coal opening. She fell seven or eight feet, was considerably stunned and bruised, and received a scalp wound. She was taken home and a physician called, who sewed up her scalp and attended her until he told her that she was well.

She complained of many queer sensations, and he told her that it was her nerves. Another physician was called, and he confirmed the diagnosis of nerves and applied electricity to her back. A third physician was called, and he agreed with the other two. Her family were getting very anxious by this time, and a nerve specialist from New York came, made a careful general examination, but could find no organic nervous disease. A friendly woman suggested that the girl must have “internal troubles,” and I was called to make a pelvic examination, when she gave me the history of her illness as stated. It had been six months since she received the fall, and she was then keeping her bed most of the time. I could discover nothing organically wrong in her general condition, but upon examining the pelvis I found the cervix just within the vaginal opening, and the body of the uterus turned against the rectum, all the parts extremely sore and tender. The girl nearly fainted from a very careful examination. She impressed me as belonging to the class of women who get decided nervous symptoms from slight uterine derangements, and hers was such a decided one that it seemed sufficient to account for all her symptoms. I explained her condition and told her that if she was willing to do her part I believed that I could relieve her. She was anxious for me to try. With the patient in the Sims position I introduced the smallest sized Sims speculum, and with dressing forceps and pledgets of cotton dipped in the iodine mixture, carefully cleansed the vagina and cervix. Then with the patient in the knee-chest position I carefully raised the body of the uterus with my fingers a little, then introduced the speculum and placed a small cotton tampon, saturated with the same mixture, under the body of the uterus to keep it up. It was difficult to treat her on account of the soreness and the faintness which any manipulation caused. I directed her to remove the cotton after twelve hours and take a douche. I prescribed comp. licorice powder, teaspoonful doses every night as a laxative, and ℥10 dilute phosphoric acid, ℥5 tinc. nux vomica in teaspoonful elix. calisaya bark, diluted in water, after meals as a general tonic, and forbid all the drugs which she had been taking to quiet her nerves and make her sleep. I treated her three times a week in her home, each time raising the uterus a little higher in the pelvis. She began to improve at once, and after two months' steady treatment she was up and dressed, eating and sleeping well, going out some, and had a normal menstrual period for the first time since her fall. I then treated her less frequently, but have her still under observation, and she is still improving.

When there is a marked tenderness around the uterus, or pelvic exudates, instead of the iodine mixture for local treatment I use ichthyol. To a 5 per cent. solution of ichthyol in glycerine I add ℥ij boric acid, and use it on the tampons the same as the other mixture. It is sometimes well to paint over the tender area a 10 per cent. solution

of the ichthyol, but for the tampons I prefer the weaker mixture. Several years ago when ichthyol was a less well-understood drug than at present, I had some patients to whom I had given a prolonged course of iodine treatment with very little benefit, and I had advised operative measures. This was refused, and seeing the reports in the journals of the use of ichthyol in the Vienna hospitals, I determined to try it, and was surprised to find it benefited the patients markedly. The milder forms of pelvic inflammation will promptly get well under appropriate medical treatment; the severer forms are very rebellious. In many cases of metritis I recommend curettage first, followed by medical treatment. Occasionally a case presents itself which it seems difficult to cure by any treatment. Case 2:

Miss D., unmarried, aged 30, had been under a physician's care for dysmenorrhea and menorrhagia, but receiving little benefit. She consulted a New York City physician, and entered his private sanitarium and had her uterus curetted. The pain was relieved for a few months, but the menstruation was as profuse as ever, the period lasting ten to twelve days. The pain became severe again and she consulted me. The general examination was negative, and locally there was nothing to account for the trouble but a metritis; the uterus was in normal position.

This patient was a thin, nervous person, and as she had been well treated surgically and was not cured, it did not seem wise to promise much medically. I explained this to her, and she wished me to do what I could; so I began gradual dilation with hard-rubber dilators, making applications of pure iodine to the cervical canal and using the iodine mixture on the tampons. Between periods general tonic. She improved markedly, and after a few months stopped treatment and was very well for over a year, when she had an attack of grip, and all her old symptoms reappeared. Another physician was attending the family when she was suffering, and he advised electricity, so she underwent a course of electrical treatment; but this was of short duration, as she was taken with a severe hemorrhage, which he had some difficulty in controlling. He was called away, and I was again called, as he had then advised hysterectomy. I examined her carefully, but could discover nothing new, and expressed the opinion that hysterectomy was very heroic treatment, with no certainty for a patient of her temperament that she would be well after it was done. They wished me to attend her, so I began a course of local treatment the same as before, but she did not show much improvement. The menorrhagia was severe, and about six months ago I determined to try adrenalin chloride 1-1000. As the dose of this is not very well settled, I concluded to try five-drop doses in water four times a day. This agreed with her stomach, and I increased the dose to ten drops four times a day, beginning on the fourth day of menstruation. She received so much benefit from it that I had her repeat in the same way at the next

period, and she has since used it with the same good effect. She says that it is the first medicine which she has ever taken internally which seemed to control the flow, and all the others disturbed her stomach. I had tried all the usual remedies. The adrenalin chloride had such a controlling effect on the flow in this patient that I determined to try it on another which was causing me much anxiety. Case 3:

Mrs. G., a widow, age 44, mother of three children. She had been in my care about eight months. At the time I was first called to examine her she had been flowing, all the time, more or less for about seven months, and during this time had been in the care of two different physicians. Upon examining her, there was nothing to account for the flow but her age and a metritis. As she had lost so much blood already, I advised her to enter the hospital and have a curettage, which she did, entering in the service of Dr. Henry Van Hoebenbergh. I sent the scrapings to Dr. V. A. Moore, Cornell University, Ithaca, for microscopical examination. He reported that the appearance was rather suspicious, but he could not be certain of malignancy, and advised me to keep her under observation. She left the hospital at the end of ten days. I gave her local treatment twice a week for two months, using the ichthyol mixture, and between periods nux vomica and dilute phosphoric acid in elix. calisaya as general tonic. She remained well for six months and then had an attack of tonsillitis. After recovering from this, at the next period she did not stop flowing. She objected to another curettage and wished me to try other means to relieve her. I made an intra-uterine application of iodine, tamponed the vagina with cotton balls, dusted with tannic and boric acid, gave stypticin internally, and directed the patient to lie in bed. The next day I removed the cotton, but was obliged to re-tampon. I did this for ten days before the flow ceased. At the next period there was the same trouble to control the flow, and at the third I tried the adrenalin chloride, ten drops four times a day in water, in addition to the other means. The effect was marked, and she took it for two periods, and after that was better, so she did not take anything. I know but little of the therapeutics of adrenalin chloride in these cases of hemorrhagic metritis, but if I am so unfortunate as to have any more I shall try it first before using virbrum comp., liquor sedaus, hydrastis, stypticin or ergot, for in these two instances it was more efficient than either of them. In the rebellious cases of metritis which do not get well under ordinary medical means, my own preference has been to use surgical treatment by curettage, and trachelorrhaphy if indicated, rather than the intra-uterine use of steam, electricity or strong caustics, although Reed⁹ reports favorably upon the intra-uterine use of carbolic acid. The technique is fully given in his text-book. In regard to douches, if the patient has an attendant and facilities for it, I believe that large amounts of hot water, taken in the recumbent position, are more

efficacious than the small ones; but if the patient must wait on herself, has facilities limited to a fountain syringe, I direct her to take a douche night and morning with water as hot as she can bear, filling the syringe bag and adding ʒi of borax to each quart of water used.

My experience has been that women past the menopause do not bear treatment with iodine, ichthylol and glycerine as well as women prior to that period. The atrophied tissues of old age, when inflamed or excoriated, will often grow worse under their use, and as these patients come frequently to me for help, I tried a good many different combinations with varying success, until now I have been using, for some time, the following mixture prepared for me by my druggist: Irish moss, ʒss; glycerine, ʒij; alcohol, ʒiv; boric acid, ʒij, and water sufficient to make a quart. This is considerable trouble to prepare, as the Irish moss has to be treated with water first, before adding the other ingredients. But when properly prepared, it is a bland, mucilaginous mixture, about the consistency of glycerine and very healing. When indicated, I often add a little tannic acid or iodoform with good effect.

The unrepaired lacerations cause trouble enough to patients during the vigorous period of life; but they frequently cause vastly more distress to women who should finish their lives in peace. In my own experience the cases of complete prolapse of the uterus have been rare before the climacteric, but common after. These cases present great difficulty in their management, and operative treatment for their relief has been less successful than upon younger women, although the operation for complete prolapse of the uterus, described by Dr. Frederick Holme Wiggin⁶ to this society last year, seemed to promise more than any other; yet many of these patients are poor subjects for operation, and we have to depend upon mechanical support to keep the uterus in position. The kind of pessary used for younger women is immaterial, so long as it fits properly and holds the uterus in normal position. A pessary with abdominal belt and hard rubber cup or ring with perforated stem, through which rubber cords pass, being attached to the front and back of belt, has given me the best results in old women. These patients have pendulous abdomens, and the belt is comfortable. There is usually extensive perineal lacerations, so that it is difficult to keep any internal pessary in place, and this one is kept from dropping out by the cords. Another advantage, the patient can remove it at night, take a douche, and replace it in the morning, so that the tissues are not subjected to the pressure all the time. In these cases there is always more or less of the adjacent viscera dragged down with the uterus, and when the latter is eroded it is not always easy to eliminate malignancy at the first examination, as in this Case 4:

I was called to the home of Mrs. C., a feeble

old widow, aged 65, to make a pelvic examination. I found the uterus completely prolapsed; the cervix was an eroded, bleeding mass. They informed me that a physician had been treating her twice a week for two months, applying pure iodine each time to the cervix to heal it. But for this information I should have hesitated about giving encouragement for help. I cleaned the parts carefully with the moss mixture, formula given above, to which I added a little iodoform, and with the patient in the knee-chest position I succeeded in replacing the uterus and prolapsed viscera. I saturated cotton tampons with the mixture and packed the vagina to hold the uterus up. As she was very poor, I attended to her myself every other day, removing the cotton, cleansing the parts and replacing it each time. As general tonic, quinine, iron and strychnia was given. The erosions soon began to heal, the hemorrhage stopped, and in two months the parts were well, so that I fitted an abdominal belt pessary.

In order to gain the best results in gynecology it is necessary for the physician to faithfully do his duty in regard to a few essential points.

1.—Be clean in his own person, instruments and work.

2.—Make a thorough examination of the patient.

3.—Give careful instruction as to the hygiene of daily life, prescribe appropriate systemic remedies, and exercise skill and gentleness in all local medical treatment.

BIBLIOGRAPHY.

1. Text-book of Gynecology, 1 Reed, p. 1.
2. A Study Relative to the Functions of the Reproductive Apparatus in American Indian Women. From the *Medical News*, October 3, 1891.
3. Medical and Surgical Gynecology, Pozzi, vol. 1, p. 180.
4. Manual of Gynecology, Byford, p. 315.
5. Text-book of Gynecology, Reed, p. 360.
6. Operation for Complete Prolapse of the Uterus, Dr. Frederick Holme Wiggin, *NEW YORK STATE JOURNAL OF MEDICINE*, November, 1901.

DISCUSSION.

Dr. Edward Wallace Lee, of New York, congratulated the author of the paper, and also the Association on this common-sense and practical communication. He also wished to comment upon the administration internally of adrenalin chloride as a styptic. He had not been aware before that it had such a marked action in controlling hemorrhage. Such treatment as had been recommended in the paper, he was sorry to say, was not employed as much as it should be. Prominent gynecologists to-day were disposed to discourage systematic local treatment. Cases were presented to them which had not received proper treatment previously, and the first thing suggested to the patient was an operation. If this were not agreed to, the luckless patient went on from bad to worse, until finally the patient was compelled to submit to operation. If the alleged authority consulted had given a judicious systematic treatment, such as had been detailed in this

paper, much of this surgical treatment would be avoided. Too often these poor women, instead of receiving common-sense treatment, were subjected to what had been aptly called "gynecological tinkering."

Dr. James Hawley Burtenshaw, of New York, said that this was one of the most practical papers to which he had ever listened, yet he wished to criticize in a friendly way one statement. He thought gynecologists did not do their duty with regard to the directions given for taking hot-water vaginal douches. A small quantity of hot water given as a douche for inflammatory conditions usually did more harm than good. For example, if one put the hands in very hot water, and kept them there for five minutes, on removing them they would be puffed up, because the primary effect of very hot water is to dilate the blood vessels. If the hands were, on the other hand, kept in very hot water for twelve or fifteen minutes they would be found shriveled, because the secondary effect of very hot water is to contract the blood vessels. This was what we desired to accomplish from the use of hot vaginal douches. If the hot douches were taken with the woman recumbent, and if from two to three gallons of hot water were used, the same result would take place as followed the prolonged immersion of the hands in hot water. If such douches were taken morning and evening, or possibly only once a day, and the woman rested for half an hour or more afterward, the very best results would often be obtained.

Dr. J. Riddle Goffe, of New York, said he wished to echo the expressions of appreciation that had been offered with reference to this paper. We were under great obligations for this presentation of the subject. If there was anything in which the general profession was lacking it was in the matter of general diagnosis in gynecology; hence, the importance of emphasizing this, as had been done in this paper. It was astonishing how many cases were treated for weeks and months under the false impressions obtained by the physician from his examination. He had just seen a woman who had been referred to him by the physician out of town for the confirmation of his diagnosis. The patient was an unmarried woman of 27, who complained of excessive menstruation. The physician said there was a retroverted uterus, complicated by tumor. On examination, Dr. Goffe said, he had found the uterus in a perfectly normal position, and there was not the least indication of a foreign growth. He thought Dr. Lee had been a little too sweeping in his remarks. All gynecologists were not exclusively operators. There were two schools, one exclusively operative, and the other which still made use, in appropriate cases, of the medicinal or local treatment, as described in the paper. He found that many cases of disease and adherent appendages could be absolutely relieved by the persistent and proper use of tampons, supplemented by the hot-water treatment. It was the duty of every physician to give every case in which such treatment

held out any hope of relief this opportunity. He had not given adrenalin internally, but had used it a number of times as a local styptic in plastic operations. When there was a large, raw surface in the vagina during the operation of anterior colpotomy or in the course of denudations for operations upon a lacerated cervix and perineum, a few drops of adrenalin solution swept over the tissues would give a clean field for operation.

Dr. George H. Peddle, of Perry, Wyoming County, said that he could only voice what had been already said with regard to the great value of this paper. He thought it would be well to replace the fallen uterus at one operation instead of doing this gradually, as had been stated by the author in the report of one of her cases. He also thought such reposition might be accomplished at once by force.

Dr. Richard H. Gibbons, of Scranton, Pa., said he would indorse the treatment described in the paper, but he thought too much had been said about the hot-water treatment. The originator of that treatment had not only advised the use of a very large quantity of water, but had insisted upon the impact of the fluid being secured by the use of the Davidson syringe. In the old days, at the Woman's Hospital, it used to be well known that Dr. Emmet could always tell which patients had been subjected to the hot-water treatment with the Davidson syringe and which had received this treatment by means of a fountain syringe.

Dr. Bemus, of Jamestown, said he agreed with the author that it was better to replace the uterus gradually. Where there were adhesions one might often do a great deal of harm by the sudden replacement of the uterus, particularly if the uterine probe were used, because this instrument was of considerable length and afforded powerful leverage. He would prefer, therefore, to make use of iodine and ichthyol locally at first, and then, with the vulsellum forceps, bring down the cervix and move the uterus a little at a time. This would break up the adhesions gradually and with less danger than where the uterine sound was employed for this purpose.

Dr. Peddle said that he had made no reference to the uterine sound; his idea was to make use of the vulsellum forceps.

Dr. William Finder, of Troy, congratulated the author on her paper. He had used adrenalin considerably, more especially in conjunction with cocaine, in nasal operations. He had often been enabled to do an almost bloodless operation. He had also used it for hemorrhages in other parts of the body. It was surprising that adrenalin was not more generally used, as it greatly facilitated operative work.

Dr. Eden V. Delphey, of New York, said that the forcible lifting up of the uterus was contra-indicated in acute cases because of the danger of lighting up a fresh inflammation; but if, after prolonged douching, the inflammation had become subacute, it was a different matter. The desired impact of the fluid could be secured with

the fountain syringe by the alternate pinching of the tubing. Quite a number of good gynecologists had pushed the uterine sound through the uterus; hence this instrument should not be used. The one special action of the glycerine had not been referred to—*i. e.*, its hygroscopic action. It depletes the tissues quite as thoroughly as hot water. He was accustomed to make use of carbolic acid and glycerine in the strength of 1 to 40. The carbolic acid exerted a decided anesthetic action. In some cases this mixture could not be used, and then boroglyceride should be substituted.

THE ROENTGEN RAY IN OBSTETRICS.¹

BY JOSEPH BROWN COOKE, M.D.,
New York.

IN considering the question of the use of the X-ray in obstetrics, the writer views the subject solely from the standpoint of the obstetrician, and not, in any sense, from that of the Roentgen-ray expert. This is a perfectly justifiable position, for the reason that, no matter how valuable this method of examination might be in certain obscure cases, the general practitioner, and even the obstetric specialist himself, would have so little need to employ the ray for diagnostic purposes that the expense and technical skill necessary for the production of satisfactory negatives would be entirely disproportionate to the results obtained, and, from the very nature of the case, such patients would be sent to a properly equipped X-ray laboratory for examination and report.

Before any method of precision can venture to compete with other methods directed toward the accomplishment of the same results it must present distinct advantages in one respect or in another. If it is not more exact it must be more simple or more easily performed; if it is not simpler or easier it must be more exact.

In these qualities X-ray examinations, as applied to obstetrics, fail utterly, and a careful consideration of the subject gives no encouragement that their use will ever supplant, or even equal, the ordinary methods followed by the obstetrician skilled in pelvic examination by means of pelvimetry and palpation.

It is true that the pelvis of the non-pregnant woman can be studied by means of the rays, and contractions, deformities and exostoses recognized, but even this work requires skill which can only belong to one of great experience in reading the negative or print. The difficulties which lie in the way of securing a satisfactory image of the pelvis itself, unencumbered by the presence of the gravid uterus, arise from the almost unavoidable distortion of the shadow cast upon the plate, and when to these are added the impediments due to the interposition of a fetus, with its envelopes, an enlarged and thickened uterine wall and the disturbances caused by the

movements of the child and the respiratory and voluntary movements of the mother, the resulting picture becomes so unsatisfactory as to be practically worthless to any one who has any knowledge whatever of the ordinary methods of antepartum examination.

To prevent the occurrence of this distortion of the image, Williams adopts the plan of taking two separate radiographs of the pelvis on the same plate, covering half of the negative with lead while the opposite half is being exposed to the rays, and to correct the distortion after it has occurred, when but one exposure of the entire pelvis is made, Monell reduces, by means of his "Divergence Chart," the various diameters of the image to their true proportions; but neither of these methods simplifies the matter to a sufficient degree to admit of comparison with expert manual examination.

With the Monell chart a certain amount of figuring and calculation is required, while the Williams plan necessitates a prolonged double exposure and produces a broken picture.

Moreover, as has been said, the technical skill required to draw trustworthy conclusions from the negative or finished print can only be acquired after long experience with X-ray work, and represents a training which the obstetrician has not the time to secure when its benefits to him as a diagnostician are bound to be so small.

Bearing in mind the difficulties of radiographing the pelvis on account of its dense bony walls, the inequality in the thickness of its tissues and in the distance of its various portions from the plate, and its position in the skeleton, these ideas would be sure to suggest themselves as probable objections to the use of the X-ray in this connection, and when the literature of the subject is studied this probability is found to be a certainty.

Varnier and Pinaud, of Paris, have made extensive experiments in photographing the gravid uterus in both living and dead subjects, and their results, quoting from Williams' admirable work on "The Roentgen Ray in Medicine and Surgery," are as follows:

"In one patient, who died of pulmonary congestion, the photograph showed the outline of the uterus, and within it the vertebral column of the fetus. In another, who died of eclampsia when the fetus was seven months old, the right border of the uterus was pressed to the left and the head of the fetus was presented at the superior strait. They also made X-ray photographs of the gravid uterus in sixteen living women, of whom seven had been pregnant from two to four and a half months and nine from five to seven and a half months. The conclusions drawn from these cases were as follows: The maternal pelvis can be completely seen up to four and one-half months, and more clearly the earlier the photograph is taken; but of the uterus and its contents no trace is perceived. These latter are traversed with such ease by the rays that they do not interfere with the study of the pel-

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

vis. After five months the uterus and its contents form on the negative a veil, as it were, which is badly defined and without definite contour, but which conceals the posterior wall of the pelvis and the vertebral column. In two cases a pale silhouette of the fetal head can be dimly defined in the pelvic area.

"In a second series of seven cases the same results (that is to say, negative) were obtained, whether the fetus was alive or dead. Two of these patients had been pregnant from two to three months and five from five to eight months.

"In the living patient the head of the fetus can be photographed at the opening of the pelvis as well at six and a half months as at the approach of full term, and the size of the fetus, its orientation and the amount of flexion and engagement can be estimated.

"In such photographs, taken in the reclining position, neither the spinal column nor limbs of the fetus are seen."

These results are certainly no better than those regularly obtained by ordinary methods of examination, and from the last sentence quoted, in which it was stated that in the reclining position neither the spinal column nor the limbs of the fetus are seen, it is difficult to understand how these investigators substantiate their claim that the presentation, position, degree of flexion and amount of engagement of the presenting part can be estimated by means of the rays, unless they advocate taking two or more radiographs at different angles. As the thickness of the tissues to be traversed by the ray in photographing the pelvis necessitates an exposure of from thirty-five to forty-five minutes for the production of a legible negative, such a procedure would be extremely trying to the patient, to say the least.

The researches of Bouchacourt, published in Paris in 1900, corroborate the findings already given as to the ability to study the pelvis itself and determine the existence and nature of contractions and deformities, but he finds the use of the ray thoroughly unsatisfactory when applied to the examination of the fetus in utero.

Mullerheim also agrees as to the ability of the rays to detect pelvic contraction and deformity, and adds, "not only can the presentation of the fetus be determined, but also the size of the fetal head and the dimensions of the pelvis." As the recognition of the presenting part is one of the very rudiments of abdominal palpation, and as the relation between the size of the presenting part and that of the pelvic brim can easily be determined by means of the well-known Hofmeier method of examination, Mullerheim's investigations cannot be said to have added materially to the obstetric value of the X-ray.

Davis, of Philadelphia, has done pioneer work in making photographs of the gravid uterus, but so far as I have been able to learn, he has not been in any way impressed with their importance as practical aids to diagnosis.

It is true that the osseous portions of the skel-

eton can be seen, even early in fetal life, but this can only happen when the uterus has been removed from the body or when the fetus itself is directly examined. As Varnier and Pinaud have shown, there is no trace seen of either uterus or fetus in living women up to the middle of the fifth month of pregnancy, and even as late as the end of this month the womb and its contents form no more than a filmy veil on the plate. At this period of gestation the fetal heart can usually be heard, active fetal movements are present, and ballottement can be practiced, so that as a means of early diagnosis of pregnancy the X-ray is of no assistance whatever. Even in the case of a dead child, with no heart-sounds and no fetal activity, the result of the X-ray examination would be negative, for unless the fetus had reached an age at which the positive signs of pregnancy would have been present before its death it would be too small to admit of detection by the rays.

A very rough idea of presentation, but hardly any evidence of fetal position, can be made out late in pregnancy when the fetus lies high up in the abdomen by photographing through the belly from one side to the other; but careful palpation would surely yield equally good results.

In cases of polyhydramnios, where accurate palpation of the abdominal contents is impossible, a distinct knowledge of presentation at least could probably be gained, but when it is remembered that in these cases both fetal position and presentation are constantly subject to change, the information obtained would have no permanent value and would be worthless in the end. With very fat women, whose abdomens are always palpated with difficulty, some slight benefits might be derived from the use of the rays, but even in these cases careful and patient manual examination will usually prove successful.

In extra uterine pregnancy the results of X-ray diagnosis are equally unsatisfactory, although Turbert reports a case in the *Lancet* (June 5, 1898) in which the X-ray is said to have confirmed the suspicion of ectopic gestation, showing a fetus five or six months old. In view of the relative thinness of the uterine wall at this period of normal pregnancy and the inability to see the non-pregnant uterus at all by means of the rays, it is difficult to understand how it was possible to determine whether the fetus was inside or outside of the cavity of the womb, and, in any event, at such an advanced period of gestation, the diagnosis by ordinary bi-manual examination should have been a very simple matter.

No reference has been found to the use of the rays in the examination of cases of suspected multiple pregnancy, and in this respect alone it would seem to the writer that they might be of possible value. If two distinct vertebral columns or two fetal heads could be discovered the diagnosis of twins would at once be confirmed, or in those cases where one fetus could be ac-

curately made out by palpation, the presence of another might be indicated in another part of the abdomen.

In pseudocyesis, or feigned pregnancy, the use of the rays would, of course, disclose the fact that there was no fetus in the abdomen unless the examination was made at a date when a fetus, if one did exist, could not be seen by this means. The existence of pregnancy in cases of pseudocyesis is usually suggested by the size and appearance of the abdominal tumor more than by anything else, and a careful examination, under general anesthesia if necessary, will always settle the question without difficulty. These cases seldom mislead the physician when he is called upon to make a diagnosis in the latter half of the supposed pregnancy, and it is only at this time that the X-ray could by any possibility be of assistance.

The rays have been used for medico-legal purposes to determine whether or not a child has breathed after birth, and Walsham has found that in the case of a still-birth the lungs are opaque to the ray; but this result could be obtained with probable equal accuracy by floating the lungs or the entire body in water.

No reference has been made to the use of the fluoroscope, for repeated experiments made by Delphey have demonstrated beyond question its absolute worthlessness as a means of examining the pelvis of the pregnant woman.

Conclusions.—The value of the X-ray for studying the dimensions of the pelvis is, for practical purposes, lost, because of the difficulties attendant upon its use, and at best it is probably not so reliable as mensuration and palpation performed by a skilled observer.

In the study of the gravid uterus the results are wholly unsatisfactory when compared with those obtained by the ordinary recognized methods of examination.

As a means of diagnosing certain forms of ectopic gestation fairly reliable presumptive evidence may possibly be secured, but it would need the corroboration of more positive methods before it could be definitely accepted.

Advanced pseudocyesis could doubtless be detected by the use of the rays, but the administration of a little chloroform would accomplish the same result in a far simpler manner.

In suspected twin pregnancies, where diagnosis cannot be made with certainty, the X-ray may have a distinct diagnostic value, and would doubtless be of assistance in these rare conditions.

PERSONALITIES VS. ORGANIZATION.

Every physician either is or is not honest and honorable and ethical, so far as the practice of his profession is concerned. If he is honest and honorable in his professional work, he should be a member of his local and State society; if he is not, he should not be permitted to join such societies nor to retain his membership in them if he has already joined. But no ques-

tion other than professional integrity should be allowed to enter into the matter of medical society membership. Personal differences of opinion, envy, hatred or malice, likes or dislikes, nor race, school nor religion should so much as be thought of when the one great question of professional organization and of membership in the local and State medical societies is considered. If there must be squabbles, let them be outside; let medical organization be on the broadest possible lines, for professional honor and advancement, and for the benefit and protection of all honest and honorable professional men, no matter what their personal differences may be. Let us have a State society so big that personalities will be lost in it.—*California State Journal of Medicine*, March, 1903.

THE USE OF CARGILE MEMBRANE IN THE NOSE IN ORDER TO PREVENT ADHESIONS.

Next to the abdominal cavity, the nasal cavity is the most liable to be the seat of adhesions. In the abdomen adhesions often give pain and occasionally cause obstruction; in the nose they rarely cause pain, but often do cause obstruction. The anatomical peculiarities of the two cavities especially favor the formation of adhesions.

Within the last two years an animal membrane made from the peritoneum of the ox has been coming into use in abdominal work for the purpose of preventing adhesions. It is called after the name of the inventor, Cargile membrane. The originator's name for it, "animal velum," describes it well. It looks much like gold-beater's foil, and comes sterilized in a double envelope.

Some time ago I tried the membrane in the nose, hoping to duplicate some of the results which had been obtained with it in the abdomen. I happened at the time to be working on a large postoperative adhesion which had been sent to me. I had gained a little on it by repeatedly cutting it through. Then I began with the membrane, and made quick and satisfactory progress. At once it was evident, however, that it could not be used in the nose exactly after the manner in which it was used in the abdomen, because it was very hard to make a single layer lie on the cut surfaces. With the bowel flat before the operator this is easy to do, but in a narrow nose the breath of the patient crumples the thin tissue into a tangled mass. If a drop of blood touches it the same thing happens. I found, however, that by folding the membrane into a wedge-shaped strip several layers thick, it would introduce more easily, and that I could then pack it firmly between the two cut ends of the adhesion. Packed in securely in this way, much after the fashion in which one calks a seam, the membrane will stay in place for several days before it needs to be replaced. Since using the membrane on this case I have given it a rather extensive trial, and have found it to be of much help.

I have used it on turbinates after cauterizing, in order to keep the cauterized turbinate from cauterizing the septum opposite, and I have used it on the raw surface left by sawing off a spur. Other uses in the nose which readily suggest themselves are: As a dressing on the septum after the operation for the correction of deflection; as a sleeve for a packing which has to be left in the nose for any length of time; to hold down flaps of mucous membrane after the submucous dissection of cartilaginous spurs; as a guide and stimulant to the growth of epithelium in order to prevent the formation of a perforation, and in order to help toward the closure of perforations after the refreshing of their edges; and as a dressing for the cartilage of the septum whenever it is found to be exposed.—HARRIS PEYTON MOSHER, M. D., in *Boston Medical and Surgical Journal*.

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—Jeremiah R. Sturtevant, Theresa.
Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Doug as.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

LEWIS COUNTY ASSOCIATION.

President—Alexander II. Crosby, Lowville.
Vice-President—George II. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Pierson C. Curtus, Round Lake.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

RENSELAEER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.
Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Third or Central District Branch.

President—Chauncey P. Biggs, Ithaca.
Secretary—Franklin J. Kautmann, 311 W. Genesee street, Syracuse.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.
Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank J. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutter.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberr
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Joseph Burke, 388 Franklin street, Buffalo.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Howard L. Hulet.

Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davs.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

CHAUTAQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; J. H. Potter, Grover W. Wende.
Committee on Legislation—Herman E. Hayd, chairman; Edward E. Blaauw.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; Charles S. Jewett, De Lancey Rochester.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.

Committee on Ethics and Discipline—S. Case Jones, Peter Stocksclaeder, James C. Davis.

STEBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Kogle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.

Fifth or Southern District Branch.

President—Parker Syms, 50 West 47th street, New York.
Vice-President—Charles E. Townsend, 231 Liberty street, Newburg.
Secretary—Charles S. Payne, Liberty.
Treasurer—Edmund L. Cocks, 156 West 119th street, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.
Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.
Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.
Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.
Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.
Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.
Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.
Secretary—Ogden C. Ludlow, 234 West 135th street, New York.
Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.
Treasurer—Charles Ellery Denison, 68 West 71st street.
Executive Committee—Frederick Holme Wiggan (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).
Committee on Public Health and Medical Charities—Robert J. Erdman, chairman, 44 West 48th street, New York; John F. Carlisle, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.
Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.
Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—Charles S. Payne.
First Vice-President—Howard P. Deady.
Second Vice-President—George R. Bull.
Secretary—John L. C. Whitcomb.
Treasurer—Charles W. Piper.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoevenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernest Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Ernest Smidt, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Howard Kelly.

The New York State Journal of Medicine.

Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.



PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 6.

JUNE, 1903.

\$1.00 PER ANNUM.

MEDICAL ETHICS.

About one-third of the members of the New York State Medical Association have not availed themselves of the opportunity to become members of the American Medical Association. The advantages to the medical profession of a strong central body, well organized and thoroughly businesslike in its methods, are incomparable. Stop and consider this. The advantages personally to you are faithfully set forth in another part of the JOURNAL. For the benefit of the third who do not read the *Journal* of the American Medical Association, we print in full on page 214 the "Principles of Medical Ethics," and in the words of the Committee on Medical Ethics, "invite your candid and unprejudiced attention."

MEDICAL BRIBERY.

Judging from the large number of circular letters that the physician daily receives, every goldmine promoter, mountebank and gold-brick purveyor in the country must be aware of the poor business ability of the average doctor. The most recent circular to hand is one from a most notorious concern, whose business is to cure alcoholism, offering \$25 bonus for any case sent to them. Some years ago this treatment was foisted on the authorities of a large metropolitan hospital, let us presume with perfectly honest intentions, by a then commissioner of this city. After a thorough and impartial trial, it was shown to be entirely without merit. Recently fortified by the names of a large number of clergymen, in matters of this nature the most gullible of all mankind, the concern enlarges its capital and seeks new fields to conquer. It has begun with the tramps and vagabonds of the medical press by getting inserts of its notices in the reading pages, and we are very sorry to note that one or two of the oldest and most reliable medical journals in this country have been led astray from the path of righteousness and honor, and have accorded these people a reading notice.

IMPROPRIETY OF ACCEPTING GIFTS FROM COMMERCIAL HOUSES.

Our attention has been called to an advertisement which recently appeared, in which a particular bandage is unreservedly indorsed by an eminent surgeon.

It seems that this doctor was supplied free of all expense with this bandage by the agent of the manufacturers and undoubtedly he considered it nothing more than due appreciation to write a letter of thanks and to praise the quality of the gift.

We are exceedingly sorry that this surgeon has been placed in such an unenviable position, but, after all, is he not more to be censured than pitied? It seems to us that professional men should be too wise to accept drugs, whiskeys, wines, bandages or any free supplies from manufacturers, or their agents, as they should realize that some sort of a return will be expected from them.

We do not believe there is anything in this world obtainable for nothing; the debt must be squared some day, in some way, and how any one can be so credulous as to believe that a business house will not collect, in full, all outstanding obligations, whether incurred under a bill of sale or under the guise of a charity or of a gift, is beyond our comprehension.

COUNTY ORGANIZATION.

Good Work in the Fourth District.

A copy of the following letter was sent to us by its writer who asked that it be published. We gladly accede to his request because of the good it undoubtedly will do. Dr. Morris is to be congratulated on the results of the work he has done in the Fourth District during the past few months, and his salutary example is well worth following in those districts whose organization is not yet complete.

MAY 16, 1903.

Dear Dr. Morris—It will be very gratifying to all

members of our Association when they know that your efforts in the formation of County Associations, to the end of completing the organization of the Fourth District Branch of the New York State Medical Association, have been crowned with such eminent success, and they surely will realize that the results of your noble endeavors mean patience, persistence, unremitting attention, great devotion and well-directed, systematic work; for all of which they will not fail to join in gratulations to you on this forward step for the weal of the Association. If the good example you have given is followed in other districts, we may fairly expect the organization of all the counties of the State before this year is ended. Yours fraternally,

W. S.

NATIONAL INCORPORATION.

At the New Orleans meeting of the American Medical Association, a Committee on National Incorporation was appointed composed of the following gentlemen: "Drs. Joseph D. Bryant, chairman, New York; H. L. E. Johnson, District of Columbia; Leartus Connor, Michigan; D. S. Fairchild, Iowa; C. G. Kenyon, California, and Frank Billings, *ex-officio*, to get the advice of the best legal talent in the United States as to whether the association could be incorporated under an act of Congress or not, and to report at the next annual session to the House of Delegates. *In the discussion it was understood that no money should be expended for this purpose.*" See page 1371, *Journal of the American Medical Association*, for May 16, 1903.

The President of The New York State Medical Association recently received a communication from the secretary of one of the State societies in affiliation with the American Medical Association, enclosing an opinion from a prominent attorney of that State, in regard to the possibility of obtaining a special act of incorporation from Congress for the American Medical Association, allowing it to hold its meetings in any State or territory within the boundaries of the United States, which is as follows:

MAY 1, 1903.

My Dear Doctor—Your favor of the matter of a National Incorporation for the American Medical Association at hand.

I should think such action would be desirable as a matter of policy for the Association if a national charter can be obtained. It is still an open question, I think, whether Congress has the power to grant charters under a national law.

There has been considerable discussion of this question for the past two or three years and in which eminent lawyers have disagreed. This discussion has been in the line of remedies for trusts. It has been maintained by some that an amendment to the constitution would be necessary before action could be taken.

I think, however, that Attorney-General Knox is of the opinion that Congress already has sufficient power. I have never seen where he stated this in so many words, but I should regard it as a fair inference from what he has said, while discussing the control of trusts.

The mere fact that such charters have been granted makes a strong presumption in their favor, but it is not conclusive, as Congress, like our State Legislature, sometimes passes laws which are afterward declared to be unconstitutional.

It is my own opinion that Congress now has such

power. It has granted charters to railroads. One railroad was incorporated to build from Texas to the Pacific Coast with authority to have an office in Philadelphia. It got into the courts of this State through the attempt to tax its property here on the ground of being a foreign corporation. Our courts held that, being incorporated by the General Government, it was not a foreign corporation, as it would have been if it had been incorporated by a sister State.

I apprehend that you would have trouble at this time to get such a charter. At least, there would be opposition on the ground of general policy. I think we are going through a transition period at this time so far as concerns the powers to be lodged in the General Government. Our expansion policy and laws about trusts are now bringing this matter to the front and are giving the General Government a somewhat different trend than it has maintained for the past twenty-five years or so.

To grant a charter to an association of the standing of the American Medical Association would attract attention and would be deemed an important step in the general policy of the Government and would be opposed on that ground.

I believe, however, that now is a favorable time to make such an attempt, if it be thought advisable.

However, the little State of Delaware will now give you almost any kind of a charter that you want with the right to hold meetings and do business where you please.

(Signed) _____

KEY WEST, Fla., April 22, 1903.

Dear Doctor—Your pamphlet relating to a Congressional Charter for the Educational affair known as the American Medical Association is at hand. I have always fretted because such a charter was not in force, and I will give my vote at New Orleans in favor of one.

The American Historical Association has a Charter by Congress with special privileges.

Yours sincerely, (Signed) R. D. MURRAY,
Medical Officer in Command Marine Hospital Service.

PHILADELPHIA, Pa., April 22, 1903.

Dear Doctor—In reply to your article on "National Incorporation for the American Medical Association," would state that I heartily favor the incorporation of the American Medical Association. It would certainly elevate the position and increase the dignity of the profession.

Very sincerely yours,
(Signed) J. M. ANDERS.

NORTHAMPTON, Mass., April 23d, 1903.

Dear Doctor—I am in receipt of your pamphlet concerning National Incorporation for the American Medical Association, and its contents interest me a good deal. I feel in hearty sympathy with your aim. * * *

Yours very truly,
(Signed) ARTHUR G. MINSHALL.

NEW BRIGHTON, Pa., April 25, 1903.

Dear Doctor—I have read your reprint with great interest, and, in my opinion, you are correct, and your suggestions should be consummated. *Answer of trustees is evasive and not to the point.*

If our annual meetings and business transactions there are only suggestive, and the election of our officers is farcical, and if in order to validate these a few must convene annually at Chicago and pass upon them, we are certainly in sore straits, and some remedy is essential.

I am sorry I cannot be in New Orleans to give you my earnest support. * * *

With kindest regards, and wishing you all possible success, I am, Yours respectfully,
(Signed) H. S. McCONNELL.

DELINQUENTS.

MAY 11, 1903.

Dear Doctor—I have been obliged to drop out of the Association for the year of 1903, and have so notified the treasurer of the Third District Branch. I found I was getting over my head in the number of societies which I have joined, and that some retrenchment was necessary. I expect, however, to rearrange things in 1904 and be with you again.

Trusting that you are well, I am,
Very respectfully yours,

MAY 15th, 1903.

Dear Doctor—I have received your letter of the 11th, informing me that you had notified the treasurer of your District Branch that you would like to have your name dropped from the roll of members for the year 1903.

As our fiscal year begins January 1st, if you did not send in your resignation before that time it will be necessary, before it can be accepted, that you send your dues for the current year to the treasurer of the District Branch; therefore, you might as well, it seems to me, remain in the Association, because it will cost you no more than dropping out now and then rejoining next year, as you propose.

The Association was never stronger and more popular than it is at the present time, we having added a great many new members recently—twenty yesterday having been elected to membership in Cattaraugus County, where formerly we only had four. Eight new County Associations have been formed within the last few weeks in the western part of the State, and long before October we will have organization in more than forty-five of the counties, we having now over thirty. Therefore, it does not seem to me that you can afford to be without the support which the Association gives to its members.

We find that the matter of legal insurance of our members from suits for alleged malpractice is proving very popular, as it is proving a matter of practical value to our members, we having already this year successfully defended three or four gentlemen from suits of this kind, and we have just undertaken the defense of another member residing in Buffalo, who has recently been attacked by blackmailers.

In addition to this, the American Medical Association, at its recent meeting in New Orleans, abolished the old Code of Ethics of 1847, adopting instead "Principles of Medical Ethics," making our organization satisfactory to 95 per cent. of the members of the profession of this State.

Hoping to hear that you have decided to send in your check for your 1903 dues, I am, with kind regards,
Sincerely yours,

PRESCRIBING PROPRIETARY REMEDIES WITH COPYRIGHTED NAMES.

"No, indeed, I am very much better now," ringing for a maid. "I want to show you what I am taking. It is perfectly lovely." Enter maid. "Mary, bring me that bottle of medicine off the mantelpiece in my bathroom." Exit Mary. "It is so nice-tasting, and there is nothing in it at all harmful. I am so afraid of most of those patent medicines. It is a medicine Dr. Moon recommends to all his patients. No, oh no, I haven't been to him, but Mrs. Spendthrift went to see him and he prescribed this; Restorethemall is the name, and he said he gave it to all his patients. It was the best thing he knew for nervousness and a general run-down condition." Enter maid with bottle and a medicine glass. "Now, I want you to try it. It is very nice-

tasting, and it doesn't make any difference whether you take it before or after meals. It is simply delicious—and if you take it before meals it increases your appetite, and if you take it after meals it doesn't make you feel tired and distressed, as I know I always used to after eating. You may return the bottle to my room, Mary." Exit Mary. "Do you know I got my first bottle at Corner's drug store and they charged me \$1.25? The next bottle I got at Sell's drug store and I only paid \$1, so I go there now for it. This is my seventh bottle. I told Mrs. Fay about it and she got a bottle and feels better than she has in ages. Oh! must you go?" etc.

Dr. Moon is an eminent specialist, connected with a large medical college, and the other characters live on the West Side of Manhattan.

Time, 4 P. M., May 5, 1903.

DIFFICULTIES ENCOUNTERED IN ORGANIZING A COUNTY ASSOCIATION OVERCOME.

In the May number of the JOURNAL, on page 173, we published a letter from a member of the Association, residing in one of the Western counties, detailing the difficulties encountered in the organization of a County Association. In connection with this subject the following letter was received from the same gentleman by the President of the State Association, announcing the successful accomplishment of his purpose, and will be of interest:

APRIL 19, 1903.

Dear Dr. Wiggin—At last I feel as did the lost Peri in Lalla Rookh:

"Joy, joy, my task is done;

The gates are passed and heaven is won."

While I use the word heaven reverently, still I feel the same joy. Notwithstanding the fact that I had the names of seventeen men who had signified their desire to become members of the Association, I determined to wait no longer, and I have sent in a draft in payment of the dues and applications for membership of nine new men. This, together with the five members we already have, will enable us to organize our County Association, and the others can then be elected later.

This matter of working for an organized profession would be a labor of love if it were not for the carelessness and indifference encountered on the part of the individual members of the profession to their interests and to those of the profession as a whole as well.

With kind regards, and with the fervent hope that this will be the last county organization in which the laboring oar will be in my hands, I am,

Sincerely yours,

MEDICAL JOURNALISM.

The *Philadelphia Medical Journal* of January 24th published an article on this subject by Dr. James C. Johnston. The doctor's experience of six years with the *Journal of Cutaneous and Genito-Urinary Diseases* makes this retrospect of his worthy of more than passing attention. Any one who has assisted in the publication of a journal or has had more or less correspondence with editors and publishers in reference to papers will appreciate and probably

learn by reading this article. We can only make a few quotations:

"The worst of the many evils with which the medical profession has to contend is one of which all our national experience has taught us the folly, decentralization. It is evident throughout. Its business is worse handled than any other. Instead of trusts, in which overproduction is restrained, in which wages can be fixed and maintained, and in which the incompetent and superfluous are eliminated, it is every man for himself and the devil and his colleagues for the hindmost. This is true of its material for investigation and of the journals it supports, as well as actual practice.

"Our exchange list numbers more than one hundred and twenty, the total varying from time to time, owing to untimely deaths and summary removal when a contemporary was caught in too barefaced a theft from the *Journal's* abstracts. Of these, the large majority, seventy-odd, are American. No imagination, however fertile, can conceive a use for so many. That some of them serve no purpose is amply testified by their contents. The whole of one man's time would be necessary to review them in the most superficial manner. We are 125,000, but it would be enough for us if we had only a few weeklies and monthlies and a periodical devoted to each specialty for the work which is too technical for the general reader. Their capacity would be limited and it would be possible for them to accept only what is really valuable. The reader would be saved the sifting process he goes through at present, authors would be compelled to be sure that they have something to say and that it be said in the tersest manner, and the journals themselves would be adequately supported. Such a beautiful Utopia, as the late Senator Ingalls said of purity in politics, is an iridescent dream. Being a practical people, we will have none of it, and the gentleman from the backwoods or the metropolis with an experience of two cases will go on piling up statistics of the result of treatment to the end of time. Worst of all, his work goes to leaven the lump and all the world gains mental indigestion, nothing more. We struggled against the flood of literature for a year, but self-preservation drove us with consuming regret to file about fifty periodicals in the waste basket, their wrappers still intact."

Such a Utopia may not be reached for many years, but we would not call it an iridescent dream. Centralization is rapidly taking place in the medical profession of the United States. The growth of the American Medical Association during the past year has been most astonishing and the New York State Medical Association has become the organization of the State, as an arm of the national organization. This is ideal centralization. Its effects upon journalism are these:

The *Journal* of the American Medical Asso-

ciation has a circulation of about 27,000—the largest of any medical publication. Doubtless we shall, before long, publish journals devoted to the sectional work of our annual meetings and these would be the best organs of specialties which could be produced. The State journals will continue to be organs of the State associations. A little further on Dr. Johnston says:

"The pertinence of these remarks lies in the explanation they give of the character of much of our literature, as well as of the fact that few men read anything nowadays out of their special lines, and in them the work of those whose names they know."

This emphasizes the way in which medical organization, as now advancing, will solve the question. The State and national journals of the Association will furnish such papers as should be widely read by every professional man who keeps up to date, while the organs of the sections will furnish the articles which are of interest mostly to the specialist.

In reference to the publisher's department Dr. Johnson says:

"One word and I am done. I am not of those who hold that medical literature is on so high a plane that there must be absolute divorce between it and the advertising which makes its existence possible. The journals subsidized from one source or another are in a fortunate position, for they are not compelled to carry advertising. The rest are."

Here, again, the power of organization will soon be seen. With our publications owned by our associations we can absolutely control the advertisements. A few chosen advertisements will pay better and not be the eyesores that three-quarters are of those published to-day.

MAGAZINE DECLINES CURATIVE ADVERTISING.

The publication formerly owned by John Wanamaker, *Everybody's Magazine*, has been purchased by the Ridgway-Thayer Company. In the June issue, the readers are advised of the proposed changes in the magazine. We quote the following, and commend the position thus assumed to every high-class publication:

"It is our intention to insert only high-grade advertising in our magazine. Not one fraudulent advertisement will be permitted to appear. We shall exercise a scrupulous censorship over all the advertising pages. Various lines of patent medicine and other curative and objectionable advertising will be declined, even when offered by well-known and reliable firms. Whether it is desirable to publish patent medicine, curative, and certain kinds of financial advertising in a magazine is a question for each publisher to decide. Some accept it. The majority of the magazine publishers, however, have already decided to discontinue advertising of that nature.

We believe the readers of *Everybody's* prefer not to see it in their magazine and we are making the magazine for them. June is not a heavy month for advertising, but we have declined \$900 worth of that kind of business—and we could use the money."

Possibly the owners of magazines which attempt to uplift human character on some pages and beg them to stoop to undignified and often immoral business transactions on other pages, will find their only excuse, fear of financial ruin, squashed by the courage of these young men.

Nor are these young men "going it" blindly. They have had some ten years' experience in just this kind of work. We are delighted at the prospect of at least one wholly wholesome magazine.

We call the attention of the members of the Association to the excellent principle of a well-known magazine, and earnestly desire to remind the members that some additional advertisements should be procured for the *JOURNAL* and Directory. You can help by sending in one advertisement.

The Committee on Publication are ready to furnish the necessary information and ask you to call at the office, 64 Madison avenue.

THE REASON WHY A MEMBER OF THE NEW YORK STATE MEDICAL ASSOCIATION DOES NOT APPLY FOR MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

The President of the New York State Medical Association recently received the following letter in answer to one addressed to a member requesting him to fill up an application blank for membership in the American:

NEW YORK, May, 1903.

DR. F. H. WIGGIN, President The New York State Medical Association, 55 West 36th Street, New York.

Dear Doctor—Your letter of yesterday is at hand. The reason why I do not apply for membership in the American Medical Association is that I do not wish membership in any body *where I do not have the right to cast a vote.* Yours truly,

To this the following reply was sent by the President:

Dear Doctor—I have received your letter of the 8th stating that the reason you would not apply for membership in the American Medical Association is that you do not wish membership in a body where you do not have the right to cast a vote.

You are mistaken in believing that you have no right to cast a vote in American Medical Association matters, for as a member of our County and State Association you have a right to help select the governing body of our State Association, which is made up of delegates of the different County Associations, who, together with the Council, meet and elect one delegate for each five hundred, or fraction thereof, of our membership, to represent our Association in the House of Delegates of the American Medical Association.

The scientific and other privileges of membership of the American Medical Association are opened alike to delegates and non-delegates, the only difference being that the business of the National Association is transacted by the representatives of the different component organizations, instead of by the entire membership, just as the business of the United States is transacted

by representatives in Congress and in the Senate. It would not be possible, on account of the large membership, to carry on the business of the American Medical Association by vote of the individual members, any more than that of the United States could be transacted by vote of the citizens in mass meeting assembled instead of by our representatives meeting in the capital.

In the first place, there would be no meeting hall large enough to contain the crowd which might assemble, and which, being more or less unorganized, would be a mob, easily swayed by eloquent medical politicians without regard to reason or right; besides, it being somewhat expensive to travel, and the meeting of the National Association being held in turn in different places, the result would be that instead of rule by the majority, we would be ruled by the majority of members of the profession residing in the locality where the meeting was held.

Hoping that you will, on account of the reasons which I have stated, reconsider your determination not to apply for membership in the American Medical Association, I am,
Sincerely yours,
(Signed) F. H. WIGGIN.

SERIOUS RESULTS FROM OVERCROWDED CARS.

It became necessary, a few days ago, to call an ambulance and have a passenger from a Third Avenue elevated train in Manhattan removed to a hospital. It was not a case of the sudden exacerbation of a constitutional disease, nor was the person, a young woman, injured by any railway accident; she was totally exhausted by the crowding of her fellow passengers. Others have recently been reported in the papers as having fainted from this cause and the number who are more or less seriously bruised every day must be countless.

The indecency of such close contact of both sexes, the physical dangers that overcrowding make imminent and the discomforts which are forced upon every one will not be endured much longer, of that we feel certain. If some ingenious person will offer a practical solution of the vexing question he will hasten the day of emancipation from this factor in metropolitan life for the making of moral, nervous and physical wrecks.

NEWSPAPERS CENSURED.

The Grand Jury of the County Court, says the *Buffalo Medical Journal*, lately felt constrained to administer the following censure:

"The Grand Jury of the County of Erie for February, 1903, believing that the newspapers of Buffalo are and ought to be powerful factors in the improvement of existing conditions in matters affecting our moral and municipal life, therefore, this Grand Jury in performance of its public duty, does hereby express its emphatic disapproval of the course of some of our reputable newspapers, in allowing the use of their columns for advertising transparent fakes and frauds for deceiving the public. The Grand Jury believes that in so doing these newspapers are lending their aid to schemes for fleecing the credulous and unwary instead of protecting the interests of the public

by exposing such frauds or by refusing to publish such advertisements.

"CHARLES N. BRAYTON, Foreman.

"GEORGE R. HOWARD, Secretary."

The opinion is frequently expressed that our publications, both magazines and daily papers, are too dependent upon their advertisers for financial support, to be able to discriminate between the wholesome and the injurious patrons of their advertising columns. The following statistics may be of interest to those who have not given much attention to this subject:

On Wednesday, March 11th, the proportion of the advertising space devoted to medical advertisements was, in the *Tribune*, $\frac{1}{137}$; in the *Herald*, $\frac{1}{53}$; in the *Times*, $\frac{1}{39}$; in the *World*, $\frac{1}{13}$; in the *New York American*, $\frac{1}{12}$. Among the magazines for February, it was found that the amount of advertising space devoted to medical advertisements was, in *Scribner's*, $\frac{1}{11}$; in *Harper's*, $\frac{1}{33}$; in *McClure's*, $\frac{1}{17}$, and in the *Cosmopolitan*, $\frac{1}{7}$.

AN ACKNOWLEDGMENT OF SERVICES.

It is so seldom that the active workers of the Association receive any acknowledgment of their services from their fellow members that the following letter recently received by the President will be of interest:

MAY 11, 1903.

Dear Dr. Wiggin—Just a moment to thank you for your efficient work that brought so much comfort and pleasure to the large delegation from New York, to the meeting of the American Medical Association at New Orleans.

The courtesy and kindness to me personally were all keenly and gratefully appreciated.

Yours faithfully,

JOHN U. HAYNES, COHOES.

Acknowledgments of this kind received by the officers and other active workers, showing an appreciation of their efforts on behalf of the Association, are very helpful and a great source of encouragement. Whereas when these efforts are accepted as a matter of course, it is, to say the least, slightly discouraging.

MALPRACTICE SUITS.

The following letter or, rather, part of a letter, shows how any one can be led into an error if he does not read. With the hope that the members of the Association will read, profit and digest, we print the letter and reply:

P. S.—Will you allow me to say a word on malpractice suits? Any physician that settles such a suit by compromise commits, in my opinion, a sin against the profession. I have had numerous solicitations; as the head of a hospital and dispensary of over 13,000 poor patients I am constantly menaced; but I never compromised. Two suits came to trial and were dismissed by the judge. If I compromised one I would have many on my shoulders every year. The villainy of the patients and the lack of character of the profession shows too many examples. Recently I was informed by the ——— Legal Aid Society that they had an application to sue me for neglect of a patient, a confessedly good operation for ———, with a bad constitution. The legal aid society wanted to have particulars from

me, as they were in the habit of bringing about "an amicable adjustment." I told them that their apparent kindness worked damage to the medical profession, it being known that almost without exception these suits were blackmail, where the lawyers did not want a trial, but a settlement, and this tendency they, the legal aid society, fostered.

Dear Doctor—Your letter received this P. M., and I am impressed with a statement of yours which is not borne out in our dealings with blackmailers. We do not compromise defense suits. Our plan is to defend. I also know from your own statement you have not been reading THE NEW YORK STATE JOURNAL OF MEDICINE. The purpose is to make plain the wish of The New York State Medical Association to assist in defense in malpractice suits. In a recent suit of a prominent member of the Association, his suit for professional fee was not only won, but the malpractice suit was successfully defended. The counsel was furnished by the State Medical Association. I agree with you in not compromising. You do right to fight. But think how many suits you save by merely intimating to a blackmailer or by letting it be well known, that you are a member of The New York State Medical Association.

New York, May 26, 1903.

SUITS FOR ALLEGED MALPRACTICE DEFENDED BY THE STATE ASSOCIATION.

State By-Laws, Article II, Section 7.—"The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the secretary, shall sign a contract renouncing his own and vesting in the Council the sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused; but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise."

INFANT MORTALITY.

The *Journal* of the American Medical Association, of May 9th, in speaking editorially of an article which appeared in the *Brooklyn Medical Journal* upon Infant Mortality, has the following to say:

Dr. Louis C. Ager compares the infant mortality statistics of the various boroughs of Greater New York, but more especially those of Brooklyn and Manhattan, and finds that while the deaths from diarrheal diseases in children under 5 years has been more than cut in two, the improvement has been of late much more marked in Manhattan than in Brooklyn

and the adjoining counties of Queens and Richmond. Brooklyn has been in the past called the city of homes, and its earlier health statistics were decidedly more favorable than those of old New York, certain portions of which are probably among the most densely populated areas in the world. Now, however, the more rural the region the worse the conditions in Greater New York. Thus, while in New York county (Manhattan Borough) the diarrheal mortality in 1900 was 170 per 100,000 population, in Kings County it was 209, in Queens County 216, and in Richmond County 228. Dr. Ager finds three principal causes for Brooklyn's greater mortality, the first, unsanitary tenements, which is being remedied to a considerable extent; second, unsanitary streets and lots, and third, and on this he seems to lay most stress, the greater prevalence of feeding with condensed milk, as compared with Manhattan or New York City proper as generally understood. He finds a striking difference in the methods of artificial feeding of infants in the two boroughs. Sixty per cent. of the infant diarrheal mortality in Brooklyn is in children fed with condensed milk as against 27 per cent. in New York. His paper is, in fact, a striking showing of the advantages of natural milk feeding as revealed by the mortality figures of these two boroughs. Good natural milk can be obtained from reliable dealers—not necessarily certified milk, the cost of which is prohibitive to most tenement house dwellers—but fairly good milk which can be made safer by pasteurization at times when most subject to contamination. Popular education on this point has done much, he states, in Manhattan, and the same good results can be brought about elsewhere if pains are taken by the medical profession to this end.

It seems probable that similar conditions and contrasts exist elsewhere than in Brooklyn and Manhattan, and that studies similar to that of Dr. Ager might bring out facts leading to useful generalizations.

LOCAL CONDITIONS OF INTEREST.

"Journal" Not Provincial.

A number of letters were written to members who delivered addresses before several county and district branch organizations. The following letter is one of many received and indicates a necessary education of the members as to the use of the JOURNAL:

MAY, 1903.

DR. C. E. DENISON.

MY DEAR DOCTOR—Referring to yours of the 4th relative to my address being published in the JOURNAL would say that the subject matter in body of the address referred only to local conditions in our immediate neighborhood and is not for publication.

Very truly,

MAY 8th.

DR. _____.

MY DEAR DOCTOR—YOUR letter of April 7th received. THE NEW YORK STATE JOURNAL OF MEDICINE, as the official organ of The New York State Medical Association, expresses the views and opinions, gives the local news and personal items that are of interest to all members. Yet how can you be certain that similar conditions to "local conditions in our immediate neighborhood" may not prevail elsewhere and a larger number of members receive the benefit of your views? Surely the absent member should know what you have to say and be greatly benefited by reading your address. The JOURNAL was inaugurated to give members an opportunity of being in close touch with each other and to learn the needs of the different parts of the State. A local journal is not wanted; every member should feel the same interest and know that he can communicate with the Committee on Publication for information at any time and have his views expressed, thus bringing us closer and giving strength to The New York State Medical Association.

Very sincerely yours,

C. E. DENISON, Chairman.

FOURTEENTH INTERNATIONAL MEDICAL CONGRESS.

MADRID, May 3, 1903.

Dear Doctor—Thank you for the appointment. The credentials were evidently lost, but your letter serves the purpose just as well. I send you a letter for the JOURNAL, in regard to which I must say, excuse great haste and a bad pen. Nobody can do English typewriting in Madrid. The Congress was, on the whole, as satisfactory as one could expect. There are too many diverse interests in such a gathering. The Spaniards got the best of it. You might have them send me some copies of the number with the letter in it care Munroe & Co., 7 Rue Scribe Paris. I hope, as I have no doubt you will, take good care of the interest of the New York State Medical Association at the American Medical meeting. Believe me,

Faithfully yours,

C. G. CAMPBELL.

MADRID, May 1, 1903.

To the Editor of THE NEW YORK STATE JOURNAL OF MEDICINE:

Sir—The fourteenth International Medical Congress, which has just closed, has been, on the whole, as successful as previous ones. In such a large undertaking there is always some confusion and dissatisfaction. Both are usually the result of imperfectly understanding new and unfamiliar conditions. Naturally, a large number of the congressists did not speak Spanish, to which fact, in many instances, disappointments were due. The General Committee, however, labored faithfully, and many features of the arrangements were excellent. By establishing a bureau of lodgings, the General Committee were able to provide lodgings for every member who applied to them, a matter which would have otherwise been impossible. Each member was provided with an excellent guide-book to Madrid which informed him on all matters of interest, general and medical. Each day of the congress

was published a *diario*, which gave complete information in regard to all the proceedings.

The medical profession of every country in Europe was officially represented. Likewise the United States, Canada, all of Spanish America except Bolivia, Egypt, India, Japan, South Africa, Australia and New Zealand. The meeting naturally had its official and social, as well as its scientific side. The congress was officially inaugurated at 3 o'clock on April 23d, at the Royal Opera House, by the President, Prof. Julian Calleja, of Madrid, the King and Queen Regent being present. After an inaugural address and speech of welcome responses were made by the representatives of the different countries. Surgeon-General O'Reilly, of the army, responded for the United States. On the same evening there was a reception for the congressists and their ladies, given by the municipality at the Ayuntamiento or Municipal Palace. On the following afternoon the King received the delegates in audience at the Royal Palace. The same evening the Minister of State held a reception for the official delegates. On the afternoon of the 28th the municipality gave a matinee concert in the Buen Retiro Gardens in honor of the ladies and gentlemen of the congress. On the 29th the King and Queen Regent gave a garden party in the gardens of the Royal Palace in honor of the ladies and gentlemen of the congress. The King and Queen Regent and also the princess, Maria Theresa, and the Infanta Isabella were present and conversed without ceremony with the members and their wives. There was also a special performance of Carmen at the Opera in honor of the congress.

For purposes of work the congress was divided into sixteen sections, namely: Anatomy, physiology, general pathology, therapeutics, internal pathology or general medicine, neurology, pediatrics, dermatology and syphilology, general surgery and urology, ophthalmology, oto-rhinolaryngology, adontology, obstetrics and gynecology, military medicine, sanitary science and legal medicine. It would be impossible to give any detailed account of the vast amount of work done. Among the most interesting sections was that of anatomy, where the brilliant Spanish anatomist, Ramon y Cajal, expounded his theories in regard to nerve cells and nerve structure. No less interesting was a communication by Professor Waldeyer, of Berlin, on the structure of the spermatozoon, also communications by Professor Van Gehuchten, of Louvain, on retrograde degeneration; by Professor Cavalie, of Madrid, on nerve terminations in muscles; by Professor Albrecht, of Munich, on the physical organism of the cell, and by Professor Golgi, of Naples, on the structure of the nerve cell. In general pathology, Professor Unna made valuable communications on the nature of protoplasm; Dr. Schrötter, on the pathology of scleroma, and Professor Chiari, on calcareous degeneration. In general medicine, notable com-

munications were made by Professor Bronardel, of Paris, on "*falsifications alimentaires*" and their influence on the development of diseases; on the etiology and therapeutics of pelagia, by Dr. Devoto; on the treatment of infectious endocarditis, by Sir Dyce Duckworth, and on the treatment of arteriosclerosis, by inorganic serums, by Dr. Trunececk. Tuberculosis, as a matter of course, came in for a large amount of attention, although no striking developments were reported. Professor Marigliano, of Genoa, ably upheld his inoculation, but did not make many converts. Robin, of Paris, strongly advocated active government measures against the extension of tuberculosis. Dr. Robin also made a suggestive communication on the prophylactic and therapeutic indications in tuberculosis, founded on the examination of the particular locality. In general surgery, the most important, as well as the most numerous, communications were on the surgery of the stomach, no less than fifteen communications being made on this subject. Dr. Doyen, of Paris, delivered a masterly address on this theme. Dr. Doyen is nothing if not versatile, having read papers in five different sections. There were also a considerable number of communications on the surgery of the kidneys, to which Dr. Doyen also contributed a good paper. The work in obstetrics and gynecology was unimportant and it would appear that the obstetricians and gynecologists prefer their own particular congresses.

America was represented by a fairly numerous delegation. Dr. Andrew H. Smith and Dr. Huddleston represented the New York Academy of Medicine; Surgeon-General O'Reilly, the army; Dr. Carpenter, the navy; Dr. Sayre, the New York University; Dr. Nammack, Cornell University; Dr. Page, Harvard University; Dr. Howard Kelly, Johns Hopkins University; Dr. Senn, Chicago University; Dr. Jackson, Missouri University; Dr. Stedman, the *Medical Record*; Dr. Weil, the *Medical News*; Dr. Wunderman, the Archives of Ophthalmology, and Dr. Campbell, the New York State Medical Association. The list of representatives and delegates is unfortunately incomplete. In addition to the delegates there were also a considerable number of American members. Dr. Watkins, of New York, contributed a paper on the micrococcus of syphilis; Dr. Crilé, of Cleveland, on an experimental and clinical research into the treatment of shock and collapse; Dr. Harvey Reed, on urethral implantation into the rectum; Dr. Stewart, of Chicago, on the permeability of cells, with special reference to hemolysis; Dr. Campbell, of New York, second paper on the constant quantity in the climatic treatment of disease; Dr. Seaman, of New York, on military hygiene; Dr. Brophy, of Chicago, on demonstrations of uranoplasty; Dr. Senn, of Chicago, on the treatment of traumatic hemorrhages of the intestine; Dr. Coakley, of Chicago, on experimental injections of the liver, heart, lungs,

spleen and kidneys; Dr. Nammack, of New York, on the American Italy; Dr. Kelly, of Baltimore, on the passing of a specialty; Dr. Allen, of New York, on the value of radiotherapy in cancers. Dr. Stuart was made an honorary president of the physiological section; Dr. A. Macdonald, of New York, of the neuro-pathic section; Dr. Sayre, of the orthopedic section; Dr. Reed, of the surgical section; Dr. Guiteras, of New York, of the urological section; Dr. Allen, of New York, of the dermatological section; Dr. Howard Kelly, of the gynecological section; General O'Reilly, of the military hygiene section, and Dr. Clark Bell, of New York, of the legal medicine section.

At the session of closure, on April 30th, the President, Julian Calleja, pronounced an eloquent discourse of adieu and the representatives of the different nations responded, Dr. Howard Kelly speaking for the United States. It was announced that the prize of Moscow was awarded to Dr. Metchnikoff, and that of Paris to Dr. Grassi. It was decided to hold the next international medical congress at Lisbon in 1906. Dr. Manuel da Costa Alemão, of Portugal, was named as the president, and Dr. Miguel Bombardi as secretary-general. Among the propositions submitted by the members of the various sections and representing the final conclusions of the congress the following are given as those of most interest:

Pathology.—Formation of an international committee for the revision and classification of known bacteria and the study of newly discovered organism.

Neurology.—1st. It was unanimously recommended that the congress request the press not to publish the details of crimes, because the contagion of these criminal impulses caused by their publication was unquestioned. 2d. At the same time it was accorded with unanimity that the governments of all nations be requested to make restrictions on the consumption of alcohol where it had not already been done, as its injurious effects in such communities was clearly evident. 3d. That all governments adopt the legislation in force in Portugal for reporting on criminals, also for legal councils of medicine (Law of April 3, 1896 and of August 17, 1899), providing for the constant observation of all prisoners by psychiatric specialists to examine into and report periodically on their mental state.

Pediatrics.—Alimentation during infancy should be the maternal milk. Artificial foods cannot replace live milk efficaciously. The industry of nursing should be regulated. It was urged that there be created an international league for the study of infant mortality and the means of diminishing it. 2d. Serumtherapy was commended in diphtheria, scarlet fever and typhoid of infants and further investigations were recommended. 3d. In view of the obscurity in the nomenclature and classification of infantile paralyzes a revision of the subject was recom-

mended. 4th. The session manifested the unanimous desire for the increase of the number of marine sanitariums and other fresh-air institutions for the improvement of the surroundings of child life.

Medicine.—Article 1. Tuberculosis is an essentially contagious malady and exercises its ravages over the entire world, and the members of the congress subscribe to the following views: 1st. That this affection should be classed among maladies requiring obligatory notification to the health authorities. 2d. That all the countries of the world organize measures of international prophylaxis for protecting the different nations from mutual contamination by food, merchandise, railway trains and boats.

Art. 2. The section approves of physicians moving to promote the study of medical science in higher schools in order that the marriages may be successful and the fatal consequences of the chronic propagation of degeneration may be avoided. 1st. In the budgets of countries a sum should be provided for a department of hygiene for the exclusive purpose of improving the hygienic character of the individual. 2d. In order not to augment the total burden of taxes each division of the budget should be assessed pro rata for the sum to support the department of hygiene.

Art. 3. This department should be administered by provincial sanitary inspection with the governing bodies of charitable organizations and where these do not exist by the administrators of public charities.

Yours, etc.,

C. G. CAMPBELL.

According to newspaper reports, a local New Jersey medical society has established a blacklist and, in the future, persons whose names are on the list will be refused medical attention by the members, unless the fees are forthcoming in advance. Only the names of people who possess the ability to pay are blacklisted. The New Jersey physicians are showing commendable sense in taking such action, and the best advice to all local societies would be "Go thou and do likewise."

Unfortunately, every community is burdened by the presence of a goodly number of human leeches who, believing the world owes them a living, fix themselves upon the sides of society and suck its vitality without measure and without price.

These persons are possessed of sufficient means to meet all indebtedness, but, true to their natures, fail to come to time. After they have sucked one town dry they migrate, as it is said to be cheaper to move than pay rent.

Physicians, more than any other class, suffer from the depredations of these pests. The average medical man, accustomed to doing much charitable work, takes care of the leeches with the worthy poor. He is thereby out his time, his medicines, and is often sorely tried in mind.

Most pests can be gotten rid of by the use of formaldehyde, petroleum or rough-on-rats, but this dead-beat pest is one which the laws of society and the land do not permit to be eradicated by such summary methods. For this reason, the physicians must band together and boycott the beats and continue the boycott as long as necessity requires. If this is done the doctor will have more time, more money and a less ruffled temper.—*Gaillard's Medical Journal, February.*

Association News.

AMERICAN MEDICAL ASSOCIATION.

The next meeting of the American Medical Association will be held at Atlantic City, N. J., June, 1904.

THE NEW YORK STATE SPECIAL TO NEW ORLEANS.

American Medical Association Meeting.
BY DR. JOHANNA BAPTISTELLA LEO,
New York.

Long before the appointed hour for the New York State Medical Association special trains to leave for New Orleans on Saturday, May 2d, even a careless observer was made aware of the fact that a special party was about to leave on a holiday trip. Numerous were the expressions of delight that the thermometer, which only a few days before had risen to summer heat, again made it tolerable to wear the extra wraps which forethought had compelled us to take.

At 4.25 p. m. the first section steamed out of the Pennsylvania Railroad Station, the second and third following at ten-minute intervals. The three carried 257 doctors, some of whom were accompanied by their wives and daughters, making the party a little over 300 strong.



DRAWING-ROOM SLEEPING CAR.

How commodious the train was; how elegantly equipped! What a luxury to travel in! It was like a most exclusive club. It had its drawing-room and stateroom sleepers, dining, smoking and observation cars. As the trains stopped at Philadelphia, Baltimore and Washington, the club increased in numbers.

By the time it had passed Philadelphia most members had enjoyed a good dinner, old friends had exchanged greetings, new friends had been introduced, calls had been made and returned, and the inhabitants of cars, "China," "India," "Japan," etc., though as diverse in character as the dwellers of these countries, had settled down to be members of one harmonious family.

As in every trainload of travelers, each car had its assiduous readers, its scenic observers, its students of human nature, its chatter, its much-envied noddors and sleepers, its ubiquitous smokers, and, last but not least, one car was preeminently favored by having a bridal couple on their honeymoon, bound for the balmy South. Nothing of moment transpired as the train whirled along over miles and miles of most uninteresting country, whose saving grace was that it had been kissed by the fairy touch of the spring. Occasionally the

superb white dogwood blossoms illumed a patch of sparse woodland, while all the trees looked dainty in their tender green, a striking contrast to the vast stretches of intensely red earth. Here and there the picturesque huts of the negroes, with a tiny pickaninny in the doorway hove in sight, and as the train stopped a short while at stations, the members in the observation car would be entertained by melodies sung by the negro children, who congregated about. Not till late Sunday afternoon did we reach Toccoa; then the landscape become more interesting, and we also saw some evidences of man's activity in the settlements clustered about the new cotton mills, a feature of the new South. Then night set in, and the following morning at sunrise we awoke in a more beautiful country on a most perfect, calm, clear, bright day, and those of us who had never been in the land where the palms grow as ferns, and the magnolia and live oaks vie with each other in beauty, read a new chapter of the Creator's wonder-book. Presently, as we gazed, we became aware that our destination had been reached by the never-failing assiduity of the porter in his concern about our dust-laden garments. Those of us with poetic imaginations must have received a shock by the first superficial glimpse of New Orleans. The neglected, unattractive levee on which the travelers were unceremoniously landed, the dirty streets, with the primitive "open plumbing" emitting foul odors, along which the conveyances hurried the members to their various hotels, were only offset by the ideal weather. A sweet, balmy breeze from the river seemed hypnotic in its spell; it was the evidence of a Pandora box which was to be disclosed to our shut-up sense, in New Orleans, the unique city, the fascinating ruin of a once brilliant center of active life, capable of inspiring a George Cable into giving us his incomparable stories in "Creole Days."



OBSERVATION CAR.

Once settled as to abode, the eager sightseers began their tours of investigation. What delightful experiences were our first gastronomic feats at the famous New Orleans restaurants. Such delicious sea-food, so delicately prepared, for who can excel the enthusiastic French cook in his art? Alas! we forgot entirely that there were physiologic laws which regulated stomachs! As though we had never heard of Foster's "Physiology" or Gray's "Anatomy," we plunged headlong, drugged with the "laissez faire aller" spirit of the place, until only a few survived without having recourse to blackberry brandy, sinapisms, hot-water bottles, etc., and a total abstinence régime.

The scientific sessions were undoubtedly attractive, but from the crowds of sightseers met at all places of interest in and about New Orleans at all hours of

the day one might conclude that New Orleans was well explored. Even the blue badges of the august members of the House of Delegates, while the latter were in session, could be spied here and there. Of course they accounted for their presence by their anxiety to give their alternates an opportunity to act. The St. Charles and Tulane belt-line cars carried admiring crowds from early morning till late at night through the residential portions of the city, or out to the pleasure resort to the West End, where even Dr. Adolf Lorenz enjoyed his ride on the Ferris Wheel like a child.

On Monday night many greetings were exchanged in the lobbies of the new St. Charles Hotel. Two distinct groups were apparent—that gathered about the towering figure of Dr. Adolf Lorenz, and that made by the members of the Outing Club of the American Medical Association, who had spent such happy days on their Canadian trip after the Saratoga meeting last year, and whose only regret was that no trip had been planned to Mexico or Cuba this year.



DINING CAR.

The special social functions planned for the entertainment of the American Medical Association were brilliant successes. At the reception in the Palm Garden at the new St. Charles the beauty of New Orleans was abroad to do the honors. But it was at the residence of Mrs. Cartwright Eustis that Southern hospitality was at its height. The house, with its broad piazzas and beautiful lawns, was most admirably adapted to entertain such a large gathering. Here in a recess a negro glee club entertained us with songs, there the mandolin and guitar players strummed soft melodies. A heavy shower had descended early in the evening, making the air redolent with the odors of the freshly moistened earth, while the grass sparkled with the raindrops. The many bamboo rods, to which were attached myriads of Japanese lanterns, curved and swayed gently in the breeze. The sight, viewed from the upper piazzas, was like fairyland. Could one properly attuned fail to catch the inspiration of the hour, the ecstasy of this existence?

The following night, the last in New Orleans, was spent at a fête champêtre at the City Park, where Dr. Billings, the president of the American Medical Association, received. The reception was on a vast scale, and the park, in its festive night array, a sight never to be forgotten. It was

"As when, upon a tranced summer night,
Those green-rob'd senators of mighty woods,
Tall oaks, branch-charmed by the earnest stars,
Dream, and so dream all night without a stir."

As a fitting ending to our beauteous dreams of day and night came the delightful river excursion on Friday. From the decks of the steamer, the "New South," the admiring hosts of sightseers viewed the interesting shores of the Mississippi River, caught glimpses of sugar plantations and old mansions, listened again to



CLUB CAR.

the plantation songs of the negroes filling the air with melody. The boat ride over, back to the levee from whence we started, one last delicious dinner for the epicureans at Antoine's historic restaurant, one long farewell to New Orleans, and the club once more occupied its commodious special train, en route for the North, some bound for the Congress at Washington, and some for home; all to feel—

"I stood upon a shore, a pleasant shore,
Where a sweet chime was breathed from a land
Of fragrance, quietness and trees and flowers,
Full of calm joy it was."

May this unique city long be spared the invasion of the new civilization, which will crush out its sentiments and level it to the rank and file.

NOTE.—The above cuts were furnished through the courtesy of Alexander W. Thweat, Eastern Passenger Agent of Southern Railroad Company.

Below we print the more important transactions of the House of Delegates.

REPORT OF THE COMMITTEE ON MEDICAL ETHICS.

Dr. E. Eliot Harris, New York, read the following report:

To the President and Members of the House of Delegates of the American Medical Association:

Your enlarged Committee on Medical Ethics, consisting of the Special Committee and one delegate from each State, have unanimously adopted the following report, entitled the "Principles of Medical Ethics of the American Medical Association," which is herewith submitted.

The following report of the Special Committee shall be printed as an explanatory preface to the Principles of Medical Ethics of the American Medical Association:

Gentlemen—Your committee has given extended and careful thought to the proposed revision of the Code of Medical Ethics referred to it for consideration. As you will note on reference to the caption of the report

the word "code" has been eliminated and the expression "Principles of Medical Ethics of the American Medical Association" adopted as adequately descriptive. In reference to this change, it is proper to say that such action on its part is based on the idea that the American Medical Association may be conceived to occupy some such relation to the constituent State associations as the United States, through its Constitution, holds to the several States. The committee, for this reason, regards it as wiser to formulate the principles of medical ethics, without definite reference to "code" or penalties, thus leaving the respective States to form such code, and establish such rules as they may regard to be fitting and proper, for regulating the professional conduct of their members, provided, of course, that in doing so there shall be no infringement on the established ethical principles of this Association. The committee regard as wise and well intended to facilitate the business of the parent organization and promote its harmony this course, which leaves to the State association large discretionary powers concerning membership and other admittedly State affairs. Your committee has retained, to a large extent, the phraseology of the existing code, while aiming at condensation of expression and a better understanding of some of its statements. The report of the committee has been reached unanimously, without dissension or distrust on the part of its members, each aiming to formulate a result based on principle alone, and without regard to any past or present disagreements or misunderstandings whatsoever; such being the case, the committee invites your candid and unprejudiced attention to the results of its labor, feeling that at least some good has been accomplished.

Respectfully submitted,

E. ELIOT HARRIS, Chairman;
WILLIAM H. WELCH,
T. J. HAPPEL,
JOSEPH D. BRYANT.

PRINCIPLES OF MEDICAL ETHICS.

The American Medical Association promulgates as a suggestive and advisory document the following:

CHAPTER I.—THE DUTIES OF PHYSICIANS TO THEIR PATIENTS.

SECTION 1.—Physicians should not only be ever ready to obey the calls of the sick and the injured, but should be mindful of the high character of their mission and of the responsibilities they must incur in the discharge of momentous duties. In their ministrations they should never forget that the comfort, the health and the lives of those entrusted to their care depend on skill, attention and fidelity. In deportment they should unite tenderness, cheerfulness and firmness, and thus inspire all sufferers with gratitude, respect and confidence. These observances are the more sacred because, generally, the only tribunal to adjudge penalties for unkindness, carelessness or neglect is their own conscience.

SEC. 2.—Every patient committed to the charge of a physician should be treated with attention and humanity, and reasonable indulgence should be granted to the caprices of the sick. Secrecy and delicacy should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted, in their professional visits, should be guarded with the most scrupulous fidelity and honor.

SEC. 3.—The obligation of secrecy extends beyond the period of professional services; none of the privacies of individual or domestic life, no infirmity of disposition or flaw of character observed during medical attendance should ever be divulged by physicians, except when imperatively required by the laws of the State. The force of the obligation of secrecy is so great that physicians have been protected in its observance by courts of justice.

SEC. 4.—Frequent visits to the sick are often requisite, since they enable the physician to arrive at a more perfect knowledge of the disease, and to meet promptly every change which may occur. Unnecessary

visits are to be avoided, as they give undue anxiety to the patient; but to secure the patient against irritating suspense and disappointment the regular and periodical visits of the physician should be made as nearly as possible at the hour when they may be reasonably expected by the patient.

SEC. 5.—Ordinarily, the physician should not be forward to make gloomy prognostications, but should not fail, on proper occasions, to give timely notice of dangerous manifestations to the friends of the patient, and even to the patient, if absolutely necessary. This notice, however, is at times so peculiarly alarming when given by the physician that its deliverance may often be preferably assigned to another person of good judgment.

SEC. 6.—The physician should be a minister of hope and comfort to the sick, since life may be lengthened or shortened not only by the acts but by the words or manner of the physician, whose solemn duty is to avoid all utterances and actions having a tendency to discourage and depress the patient.

SEC. 7.—The medical attendant ought not to abandon a patient because deemed incurable, for continued attention may be highly useful to the sufferer and comforting to the relatives, even in the last period of the fatal malady, by alleviating pain and by soothing mental anguish.

SEC. 8.—The opportunity which a physician has of promoting and strengthening the good resolutions of patients suffering under the consequences of evil conduct ought never to be neglected. Good councils, or even remonstrances, will give satisfaction, not offense, if they be tactfully proffered and evince a genuine love of virtue, accompanied by a sincere interest in the welfare of the person to whom they are addressed.

CHAPTER II.—THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE.

ARTICLE I.—DUTIES FOR THE SUPPORT OF PROFESSIONAL CHARACTER.

SECTION 1.—Every one, on entering the profession, and thereby becoming entitled to full professional fellowship, incurs an obligation to uphold its dignity and honor, to exalt its standing and to extend the bounds of its usefulness. It is inconsistent with the principles of medical science and it is incompatible with honorable standing in the profession for physicians to designate their practice as based on an exclusive dogma or a sectarian system of medicine.

SEC. 2.—The physician should observe strictly such laws as are instituted for the government of the members of the profession; should honor the fraternity as a body; should endeavor to promote the science and art of medicine, and should entertain a due respect for those seniors who, by their labors, have contributed to its advancement.

SEC. 3.—Every physician should identify himself with the organized body of his profession as represented in the community in which he resides. The organization of local or county medical societies, where they do not exist, should be effected, so far as practicable. Such county societies, constituting as they do the chief element of strength in the organization of the profession, should have the active support of their members and should be made instruments for the cultivation of fellowship, for the exchange of professional experience, for the advancement of medical knowledge, for the maintenance of ethical standards, and for the promotion in general of the interests of the profession and the welfare of the public.

SEC. 4.—All county medical societies thus organized ought to place themselves in affiliation with their respective State associations, and these, in turn, with the American Medical Association.

SEC. 5.—There is no profession from the members of which greater purity of character and a higher standard of moral excellence are required than the medical; and to attain such eminence is a duty every physician owes alike to the profession and to patients. It is due to the patients, as without it their respect and confi-

dence cannot be commanded, and to the profession because no scientific attainments can compensate for the want of correct moral principles.

SEC. 6.—It is incumbent on physicians to be temperate in all things, for the practice of medicine requires the unremitting exercise of a clear and vigorous understanding; and in emergencies—for which no physician should be unprepared—a steady hand, an acute eye, and an unclouded mind are essential to the welfare and even to the life of a human being.

SEC. 7.—It is incompatible with honorable standing in the profession to resort to public advertisements or private cards inviting the attention of persons affected with particular diseases; to promise radical cures; to publish cases or operations in the daily prints, or to suffer such publications to be made; to invite laymen (other than relatives who may desire to be at hand) to be present at operations; to boast of cures and remedies; to adduce certificates of skill and success, or to employ any of the other methods of charlatans.

SEC. 8.—It is equally derogatory to professional character for physicians to hold patents for any surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances; to assist unqualified persons to evade the legal restrictions governing the practice of medicine; or to dispense, or promote the use of, secret medicines, for if such nostrums are of real efficacy, any concealment regarding them is inconsistent with beneficence and professional liberality, and if mystery alone give them public notoriety, such craft implies either disgraceful ignorance or fraudulent avarice. It is highly reprehensible for physicians to give certificates attesting the efficacy of secret medicines, or other substances used therapeutically.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER.

SECTION 1.—Physicians should not, as a general rule, undertake the treatment of themselves, nor of members of their family. In such circumstances they are peculiarly dependent on each other; therefore, kind offices and professional aid should always be cheerfully and gratuitously afforded. These visits ought not, however, to be obtrusively made, as they may give rise to embarrassment or interfere with that free choice on which such confidence depends.

SEC. 2.—All practicing physicians and their immediate family dependents are entitled to the gratuitous services of any one or more of the physicians residing near them.

SEC. 3.—When a physician is summoned from a distance to the bedside of a colleague in easy financial circumstances, a compensation, proportionate to traveling expenses and to the pecuniary loss entailed by absence from the accustomed field of professional labor, should be made by the patient or relatives.

SEC. 4.—When more than one physician is attending another, one of the number should take charge of the case, otherwise the concert of thought and action so essential to wise treatment cannot be assured.

SEC. 5.—The affairs of life, the pursuit of health and the various accidents and contingencies to which a physician is peculiarly exposed sometimes require the temporary withdrawal of this physician from daily professional labor and the appointment of a colleague to act for a specified time. The colleague's compliance is an act of courtesy which should always be performed with the utmost consideration for the interest and character of the family physician.

ARTICLE III.—THE DUTIES OF PHYSICIANS IN REGARD TO CONSULTATIONS.

SECTION 1.—The broadest dictates of humanity should be obeyed by physicians whenever and wherever their services are needed to meet the emergencies of disease or accident.

SEC. 2.—Consultations should be promoted in difficult cases, as they contribute to confidence and more enlarged views of practice.

SEC. 3.—The utmost punctuality should be observed in the visits of physicians when they are to hold con-

sultations, and this is generally practicable, for society has been so considerate as to allow the plea of a professional engagement to take precedence over all others.

SEC. 4.—As professional engagements may sometimes cause delay in attendance, the physician who first arrives should wait for a reasonable time, after which the consultation should be considered as postponed to a new appointment.

SEC. 5.—In consultations no insincerity, rivalry or envy should be indulged in; candor, probity and all due respect should be observed toward the physician in charge of the case.

SEC. 6.—No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending, or by their common consent; and no opinions or prognostications should be delivered which were not the result of previous deliberation and concurrence.

SEC. 7.—No decision should restrain the attending physician from making such subsequent variations in the mode of treatment as any unexpected change in the character of the case may demand. But at the next consultation reasons for the variations should be stated. The same privilege, with its obligation, belongs to the consultant when sent for in an emergency during the absence of the family physician.

SEC. 8.—The attending physician, at any time, may prescribe for the patient; not so the consultant, when alone, except in a case of emergency or when called from a considerable distance. In the first instance the consultant should do what is needed, and in the second should do no more than make an examination of the patient, and leave a written opinion, under seal, to be delivered to the attending physician.

SEC. 9.—All discussions in consultation should be held as confidential. Neither by words nor by manner should any of the participants in a consultation assert or intimate that any part of the treatment pursued did not receive his assent.

SEC. 10.—It may happen that two physicians cannot agree in their views of the nature of a case and of the treatment to be pursued. In the event of such disagreement a third physician should, if practicable, be called in. None but the rarest and most exceptional circumstances would justify the consultant in taking charge of the case. He should not do so merely on the solicitation of the patient or friends.

SEC. 11.—A physician who is called in consultation should observe the most honorable and scrupulous regard for the character and standing of the attending physician, whose conduct of the case should be justified, as far as can be, consistently with the conscientious regard for truth, and no hint or insinuation should be thrown out which could impair the confidence reposed in the attending physician.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE.

SECTION 1.—Medicine being a liberal profession, those admitted to its ranks should found their expectations of practice especially on the character and the extent of their medical education.

SEC. 2.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder, nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician.

SEC. 3.—The same circumspection should be observed when, from motives of business or friendship, a physician is prompted to visit a person who is under the direction of another physician. Indeed, such visits should be avoided, except under peculiar circumstances; and when they are made, no inquiries should be instituted relative to the nature of the disease, or the remedies employed, but the topics of conversation should be as foreign to the case as circumstances will admit.

SEC. 4.—A physician ought not to take charge of, or prescribe for, a patient who has recently been under the

care of another physician, in the same illness, except in case of a sudden emergency, or in consultation with the physician previously in attendance, or when that physician has relinquished the case or has been dismissed in due form.

SEC. 5.—The physician acting in conformity with the preceding section should not make damaging insinuations regarding the practice previously adopted, and, indeed, should justify it if consistent with truth and probity; for it often happens that patients become dissatisfied when they are not immediately relieved, and, as many diseases are naturally protracted, the seeming want of success, in the first stage of treatment, affords no evidence of a lack of professional knowledge and skill.

SEC. 6.—When a physician is called to an urgent case, because the family attendant is not at hand, unless assistance in consultation is desired, the former should resign the care of the patient immediately on the arrival of the family physician.

SEC. 7.—It often happens, in cases of sudden illness, and of accidents and injuries, owing to the alarm and anxiety of friends, that several physicians are simultaneously summoned. Under these circumstances, courtesy should assign the patient to the first who arrives and who, if necessary, may invoke the aid of some of those present. In such a case, however, the acting physician should request that the family physician be called, and should withdraw unless requested to continue in attendance.

SEC. 8.—Whenever a physician is called to the patient of another physician during the enforced absence of that physician, the case should be relinquished on the return of the latter.

SEC. 9.—A physician, while visiting a sick person in the country, may be asked to see another physician's patient because of a sudden aggravation of the disease. On such an occasion the immediate needs of the patient should be attended to and the case relinquished on the arrival of the attending physician.

SEC. 10.—When a physician who has been engaged to attend an obstetric case is absent, and another is sent for, delivery being accomplished during the vicarious attendance, the acting physician is entitled to the professional fee, but must resign the patient on the arrival of the physician first engaged.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS.

SECTION 1.—Diversity of opinion and opposition of interest may, in the medical as in other professions, sometimes occasion controversy and even contention. Whenever such unfortunate cases occur and cannot be immediately adjusted, they should be referred to the arbitration of a sufficient number of impartial physicians.

SEC. 2.—A peculiar reserve must be maintained by fessional questions, and as there exist many points in physicians toward the public in regard to some pro-medical ethics and etiquette through which the feelings of physicians may be painfully assailed in their intercourse, and which cannot be understood or appreciated by general society, neither the subject-matter of their differences nor the adjudication of the arbitrators should be made public.

ARTICLE VI.—COMPENSATION.

SECTION 1.—By the members of no profession are eleemosynary services more liberally dispensed than by the medical, but justice requires that some limits should be placed to their performance. Poverty, mutual professional obligations, and certain of the public duties named in Sections 1 and 2, of Chapter III, should always be recognized as presenting valid claims for gratuitous services; but neither institutions endowed by the public or by the rich, or by societies for mutual benefit, for life insurance, or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege.

SEC. 2.—It cannot be justly expected of physicians to furnish certificates of inability to serve on juries, or to perform militia duty; to testify to the state of health of

persons wishing to insure their lives, obtain pensions, or the like, without due compensation. But to persons in indigent circumstances such services should always be cheerfully and freely accorded.

SEC. 3.—Some general rules should be adopted by the physicians in every town or district relative to the minimum pecuniary acknowledgment from their patients; and it should be deemed a point of honor to adhere to these rules with as much uniformity as varying circumstances will admit.

SEC. 4.—It is derogatory to professional character for physicians to pay or offer to pay commissions to any person whatsoever who may recommend to them patients requiring general or special treatment or surgical operations. It is equally derogatory to professional character for physicians to solicit or to receive such commissions.

CHAPTER III.—THE DUTIES OF THE PROFESSION TO THE PUBLIC.

SECTION 1.—As good citizens it is the duty of physicians to be very vigilant for the welfare of the community, and to bear their part in sustaining its laws, institutions and burdens; especially should they be ready to cooperate with the proper authorities in the administration and the observance of sanitary laws and regulations, and they should also be ever ready to give counsel to the public in relation to subjects especially appertaining to their profession, as on questions of sanitary police, public hygiene and legal medicine.

SEC. 2.—It is the province of physicians to enlighten the public in regard to quarantine regulations; to the location, arrangement, and dietaries of hospitals, asylums, schools, prisons and similar institutions; in regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labors for the alleviation of the suffering people, even at the risk of their own lives.

SEC. 3.—Physicians, when called on by legally constituted authorities, should always be ready to enlighten inquests and courts of justice on subjects strictly medical, such as involve questions relating to sanity, legitimacy, murder by poison or other violent means, and various other subjects embraced in the science of medical jurisprudence. It is but just, however, for them to expect due compensation for their services.

SEC. 4.—It is the duty of physicians, who are frequent witnesses of the great wrongs committed by charlatans, and of the injury to health and even destruction of life caused by the use of their treatment, to enlighten the public on these subjects, and to make known the injuries sustained by the unwary from the devices and pretensions of artful impostors.

SEC. 5.—It is the duty of physicians to recognize and by legitimate patronage to promote the profession of pharmacy, on the skill and proficiency of which depends the reliability of remedies, but any pharmacist who, although educated in his own profession, is not a qualified physician, and who assumes to prescribe for the sick, ought not to receive such countenance and support. Any druggist or pharmacist who dispenses deteriorated or sophisticated drugs, or who substitutes one remedy for another designated in a prescription, ought thereby to forfeit the recognition and influence of physicians.

PRINCIPLES OF ETHICS ADOPTED.

Dr. E. Eliot Harris, New York.—In view of the fact that the report I have just read was unanimously adopted by the enlarged committee, consisting of the Special Committee and one delegate from each State, I move the adoption by this house of the report as read.

Dr. Charles A. L. Reed, Ohio, in rising to second the motion, said that he wished to testify to the absolute harmony which has prevailed in this conference, and to congratulate the Association on the fact that by the adoption of this report we put an end to a controversial question which has disturbed our councils for many years. (Applause.)

The President put the motion, and it was adopted

unanimously, amid tumultuous and prolonged applause.

Dr. E. Eliot Harris, New York, then offered the following resolution, and moved its adoption:

Resolved, That the Special Committee engross a copy of the Principles of Medical Ethics of the American Medical Association, and that it be signed by the President and Secretary of this Association.

Seconded and unanimously carried.—*Jour. Amer. Med. Asso.*

DISTRICT BRANCH NEWS.

District Branch Association Meetings.

Second District Branch, Thursday, June 4th.

Fourth District Branch, Tuesday, June 16th.

Third District Branch. Thursday, June 25th.

First District Branch.—The nineteenth annual meeting was held at Washington Hall, Watertown, on Tuesday, May 26th. The meeting was called to order at 10.15, the president, Dr. Jeremiah R. Sturtevant, in the chair. The minutes of the last meeting were read by Dr. Edgar Douglas, secretary and treasurer, after which the Mayor of the city, James F. Pappa, welcomed the physicians in the following words:

"Mr. President and Members of the First District Branch of the New York State Medical Association:

"It is with feelings of pleasure that I appear before you to-day to bid you a cordial welcome to our city. The people of Watertown feel honored by your presence, and hope your sojourn here will be pleasant and agreeable.

"The progress which has been made in medicine and surgery commands the admiration of the world. Study, research, practice and the interchange of ideas have all contributed to this progress. Of the importance of the science of health much might be said. Everybody wishes to be well and healthy, and to avoid those things which bring disease and suffering. How to preserve health is one of the great questions of the day. To assist in its solution we have Boards of Health, established not only in the various towns and cities of the State, but under and as a part of the State government as well. Excellent medical schools are continually disseminating knowledge upon the subject, and the medical fraternity seems to be strenuously endeavoring to lift the standard of its profession still higher and higher. With all these beneficial influences at work good results will most certainly follow.

"As I understand it, one of the chief objects of your Association is to effect an interchange of ideas concerning the science and practice of medicine and surgery, thus keeping all of your members abreast of the times and giving patients the benefit of the newest and best methods. Working together in such a spirit and with such a purpose there can be little doubt of the result and effect of your efforts upon the profession and upon the public health.

"Gentlemen, we hope your present gathering will be most successful, profitable and pleasant, and that you will have no regrets that you selected Watertown as the place of this meeting.

"Again I extend you a most hearty welcome."

Dr. J. Orley Stranahan tendered his report as chairman of the Committee on By-Laws, and the following papers were read in the scientific session: An address on "The Surgery of Hernia with Special Attention to its Mechanical Treatment," by Dr. Gilbert Gregor, of Watertown. The discussion, which was general, was opened by Dr. Parker Syms, of New York. The next paper was "Eclampsia," with report of a case, by Dr. J. O. Stranahan, of Rome. This paper was received with much interest and was carefully discussed. "The Importance of Correct Diagnosis," by Dr. Alexander H. Crosby, of Lowville; "The Treatment of Prostatic Obstruction," by Dr. Parker Syms, of New York. The discussion was general and participated in by many present.

Afternoon Session.—The President of the First District branch, Dr. J. R. Sturtevant, delivered the annual address upon the subject "The New Era" (see page 229).

Dr. Frederick Holme Wiggin, president of the State Association, delivered an address upon the New York State Medical Association and its plan of organization.

Dr. F. J. Douglas, of Utica, read a paper on "Stab Wounds of the Abdomen."

Dr. Richard H. Hutchings, of the St. Lawrence State Hospital, read an exceedingly interesting paper upon "The Responsibility of the General Practitioner in Insane Cases."

Dr. W. B. Reid, of Rome, reported three interesting surgical cases. Dr. John N. Bassett, of Canton, read a paper on "Some Peculiarities of the Pulse in Typhoid."

Dr. A. H. Crosby, of Lowville, arose to a question of personal privilege and asked that a committee of investigation be appointed to investigate a matter in connection with a malpractice suit against a physician involving himself and Dr. C. E. Douglass, of Lowville. The request was granted and the matter referred to the Executive Committee.

The following officers were elected for the ensuing year: President, Dr. J. Orley Stranahan, Rome; vice-president, Dr. John R. Bassett, Canton; secretary and treasurer, Dr. Edgar H. Douglas, Little Falls; members of the State Nominating Committee, Dr. C. H. Douglas, Utica, and Dr. Le Roy W. King, Lowville. The meeting adjourned shortly after 4 o'clock.

Third District Branch.—The annual meeting will be held at the Academy of Medicine, Syracuse, on June 25th. A symposium on Typhoid Fever, with a general discussion, will take place.

Fifth District Branch.—The nineteenth annual meeting was held at the Academy of Medicine, New York, on May 19th. The meeting was called to order by the president, Dr. Parker Syms. After the reading of the minutes the treasurer, Dr. E. L. Cocks, read his report. Dr. Knopf introduced resolutions relative to the amendment of the Goodsell-Bedell bill, as to the establishment of public sanatoria, which were discussed and passed by the Association. The same was ordered to be sent to the Governor of the State. Dr. Frederick Holme Wiggin, President of the New York State Medical Association, gave a very flattering report of the work done in the State in the several branches. He also presented some very interesting specimens of carcinoma of the cervix, sarcoma of the neck, carcinoma of the rectum, varicose veins of the leg, etc. At 2.30 p. m. the scientific session was opened, and the following symposium on Malaria followed: "Morphology of the Anopheles Mosquito, Its Habits, Modes of Destruction," by Dr. W. N. Berkeley, of the New York Health Department; "The Concurrence of Anopheles Mosquito and Malaria," by Henry Clay Weeks, engineer in economics; "Laboratory Diagnosis and Treatment of Malaria," by Dr. W. T. Klein, of the New York Health Department; "Clinical Diagnosis and Treatment of Malaria," by Dr. Alexander Lambert. The discussion which followed was opened by Drs. Francis P. Kinnicutt, John S. Billings, Jr., and Hermann Biggs. The following officers were elected: President, Dr. Julius Bierwirth, Brooklyn; vice-president, Dr. Milton C. Conner, Mid-

dletown; secretary, Dr. Ernest Valentine Hubbard, New York; treasurer, Dr. Henry A. Dodin, New York.

County Association Meetings for June.

Erie County, Monday, June 8th.
 Kings County, Tuesday, June 9th.
 Orange County, Wednesday, June 17th.
 Cortland County, Friday, June 19th.

Cattaraugus County Association.—The members of the Fourth District Branch of the New York State Medical Association, residing in Cattaraugus County, met on May 12th at Salamanca, and formed the Cattaraugus County Association. By-laws were adopted and the following officers were elected: President, Dr. William H. Vincent, Hinsdale; first vice-president, Dr. James H. Taggart, Salamanca; second vice-president, Dr. Charles P. Knowles, Olean; secretary and treasurer, Dr. Carl Tompkins, Randolph.

* * *

Kings County Association.—The regular monthly meeting was held at 315 Washington street, Brooklyn, on Tuesday evening, May 12th. The vice-president, Dr. Arthur C. Brush, presided. Dr. Stephen H. Lutz read a paper on "Progress in Otolaryngology," which was discussed by Drs. J. E. Shepard and W. C. Braislin. Refreshments were served at the close of the meeting.

* * *

New York County Association.—Stated meeting was held May 18, 1903. Alexander Lambert, M.D., president, in the chair.

Carcinoma of the Rectum and Uterus.—Dr. Frederick Holme Wiggin presented a number of pathological specimens. The first one was a malignant carcinoma of the uterus, removed from a woman of 50, who had had a bloody flow at times for three years, but had not been concerned about it, believing that menstruation had returned. Her physician felt a soft mass protruding from the cervix, and made a diagnosis of polypus because he thought its consistency was too soft for cancer. The second specimen was one of carcinoma invading the body of the uterus. Six months previously the woman had been operated on for a scirrhus of the breast. The third specimen was a carcinoma of the rectum and posterior vaginal wall, and involved also the labium majus on each side. The disease was successfully removed by operation.

A specimen of sarcoma of the mixed cell type was shown, that had been removed from the neck after a troublesome dissection in which it had been necessary to ligate the common carotid. The hospital internes felt so sure that the patient would not survive the operation that they thought it hardly worth while to take a photograph of the case; nevertheless the patient was doing well at the present time, one week after the operation.

Dr. Wiggin also showed a large mass of varicose veins that he had extirpated.

Etiology, Serum Diagnosis and Serum Therapy of Dysentery.—Dr. W. H. Park presented a paper on this topic. He pointed out that until the work of Shiga in Japan there had been very little added to our knowledge of this disease for many years. The so-called Shiga bacillus was practically one of the colon group, and was present throughout the course of acute dysentery, but was not found in the stools of healthy individuals. Last summer Flexner's students studied the summer diarrhea found in children in Baltimore, and found the Shiga bacillus uniformly present. Dr. Park said that last September he had endeavored to make a bacteriological study of cases of epidemic dysentery occurring in the vicinity of Mount Vernon and Tuckahoe, but the subject was found unexpectedly complicated because in different localities the bacilli were found to present different cultural characteristics. Moreover, the serum reaction was not found wholly reliable. In young children the reaction was never obtained with a dilution of over one to ten if these children were healthy and free from intestinal disease, and the reaction was not reliable in adults with a dilution of less than one to twenty. In the epidemic already alluded to, the reaction was obtained with a dilution of one to thirty or forty in the cases of moderate severity, but in the milder ones it was not observed with a dilution greater than one in ten. Dr. Park said that he was very skeptical concerning the efficiency of serum therapy outside of the use of diphtheria and tetanus antitoxin, but we had the authority of Shiga and of Dr. Kinyoun to the effect that the serum treatment had already yielded positively beneficial results in dysentery. The method would be thoroughly tested during the coming summer, and to that end the Health Department would supply the serum to all physicians who would agree to carefully observe and report on the cases in which they used it. This treatment had been tried on fifteen hospital cases without any positive results, but this lack of success might, perhaps, be due to interference resulting from mixed infection.

Clinical Observations on an Epidemic of Dysentery.—Dr. Frank W. Shipman, of Mount Vernon, N. Y., read this paper. He said that the epidemic of dysentery occurring there last summer had developed along the valley of the Bronx River, extending eight miles along this valley and covering an area one mile wide. The epidemic had lasted from June to September and had attacked all classes. That it was not dependent upon infected milk or water was shown by the fact that in this district there were at least five different sources of water supply, and about as many of milk. In those attacked there were usually but few prodromal symptoms. Within twenty-four hours the stools assumed the characteristic appearance of dysentery, and by the end of forty-eight hours there was usually marked tenesmus.

associated with a pulse of 120 and a temperature of about 102 degrees Fahrenheit. Some of the cases exhibited a subnormal temperature and a tendency to collapse, thus showing the presence of a distinct toxemia. The treatment usually began with a dose of calomel or castor oil, after which heat was applied externally or in the form of colonic irrigation, and opium was used when required to control the painful tenesmus.

Surgical Treatment of Dysentery.—Dr. Charles L. Gibson described in this brief paper an operation that he had devised in 1900 for the relief of cases of chronic colitis. A small intermuscular incision is made over the caput coli and a tube is introduced and infolded in the cecal wall in such a way as to produce an artificial valve. The tube was removed at the end of a week, and was reintroduced several times a day, the colon being flushed out at first with normal saline solution, and subsequently with gradually increasing strengths of nitrate of silver solution. The advantages of the treatment were that the patient was not required to remain in bed more than ten days, that the opening readily closed when the tube was permanently left out, and no subsequent operation was needed. The results of this surgical treatment had so far been very encouraging.

Dr. John W. Smoth, of Tuckahoe, N. Y., detailed some of his observations of the epidemic of dysentery. He said that the epidemic reached its height in the middle of July, declined rapidly in September, and was at an end by October. The first case occurred in a filthy Italian tenement situated near a stagnant pool, and spread rapidly within a radius of about one thousand feet. The drinking water used by these people came from a well located between the house and this pool. Unless the person attacked possessed a decidedly low vitality recovery took place. Calomel, opium and ipecac were used for the adults, but did not seem to be beneficial in the children.

Dr. O. L. Austin, of the same place, had kept records of 234 cases. These showed that in 85 per cent. diarrhea was the first symptom; in 3 per cent. it did not develop for thirty-six hours after the onset of pain, vomiting and fever; the stools varied in number from eight at the beginning to fifteen at the height of the disease, and the approach of convalescence was heralded by the appearance in them of particles of solid fecal matter. Tenesmus was a very striking symptom, though it was absent in fourteen of his cases, and was not marked in thirty others. The abdominal pain was often out of proportion to the other symptoms, and at first was apt to be colicky. Tenderness along the course of the colon was uniformly present throughout the disease. There was usually not much fever, the temperature ranging between 99 and 102 degrees Fahrenheit, with a pulse in adults of 125 or 130, and in children under 4 years of age of 140. Severe prostration and extremely rapid emaciation were very prominent features of the epidemic. The dura-

tion varied from five days in the mild cases to four weeks in the more severe ones, and the mortality in his series was about 2 per cent.

Dr. Morris Manges said that it was certainly justifiable to resort to radical measures in the treatment of such a dreadful condition as chronic colitis, but from what he had seen and learned of the surgical treatment he felt that these sufferers were ill prepared to stand any operation. Some of them took a long time to fully recover even after operation, though it must be admitted that even if not cured their condition was generally decidedly improved.

Dr. Frederick Holme Wiggin reported a case of chronic amoebic dysentery, contracted in the Philippines, which he had successfully treated by surgical operation, followed by colonic irrigations with saline solution and with weak solutions of potassium permanganate.

* * *

Orange County Association.—The regular monthly meeting of this Association was held at the Russell House, Middletown, on May 20th. Dr. Willis I. Purdy, president, presided and opened the scientific session. Dr. E. W. Preston reported a very interesting case of gall stones, operated upon, and presented the stones, which numbered over 100. The patient is making a very uneventful recovery. Dr. H. E. Wise then read a paper by Dr. E. A. Sharp on "Epilepsy and Its Treatment," Dr. Sharp being unable to be present on account of professional work. A discussion followed, by Drs. Douglas, Purdy, Conner, Redfield, Woodhull, Dennis and Rushmore. The matter of meetings during the summer months was discussed and it was decided to omit them during June, July and August.

Dr. Rushmore, of Tuxedo Park, invited the members of the association and their wives to visit the park some time during June, at which time both a scientific and social meeting could be held. The members of the association were favorably inclined to such a gathering and thanked Dr. Rushmore for his kindness in extending the invitation. It was decided to hold a special meeting at the park at a date to be determined later.

The next meeting of the Association will be held Wednesday, September 16th.

* * *

Orleans County Association.—The members of the Fourth District Branch, residing in Orleans County, met on May 12th and formed the Orleans County Association. The following officers were elected: President, Dr. Edward Munson, Medina; first vice-president, Dr. John H. Taylor, Holley; second vice-president, Charles E. Fairman, Lyndonville; secretary and treasurer, Dr. Howard A. Maynard, Medina.

* * *

Otsego County Association.—The annual meeting of this Association was held at Oneonta,

on May 12th. Fourteen members were present, and the following officers were elected: President, Dr. Julian C. Smith, Oneonta; vice-president, Sylvester G. Pomeroy, West Oneonta; secretary, Arthur H. Brownell; treasurer, Frank L. Winsor, Laurens. Dr. Julian C. Smith was elected fellow and Dr. Andrew J. Butler alternate. Dr. Andrew J. Butler read a paper on "Foundation of Quackery," and Dr. M. Latcher a paper on "Arteriosclerosis," from which the following is an extract: The condition is a common one, and is an involution process, an accompaniment of old age. The varieties are toxic, senile and diffuse. The toxic is due to some of the poison such as alcohol, gout, rheumatism, syphilis or lead. The first symptom to appear is the increased arterial tension, which is produced by cardiac hypertrophy and dilation and various cardiac, venal and cerebral changes due to the impairment of the blood supply to those organs. Special attention is called to the diffuse arteriosclerosis as a condition incident to the modern American social and business life, which is responsible for the large increase in the number of cases of pneumonia, diabetes mellitus, renal and hepatic degenerations. The treatment is a radical change in the mode of living and is the only remedy. A general discussion followed, in which Drs. Luce, Wright, Cutler and Smith took part. In closing, Dr. Latcher said: "It is a subject which cannot be closed up, but will occupy the minds of the profession for years to come."

* * *

Sullivan County Association.—The annual meeting of this Association was held on April 8th at Liberty. The meeting was one of the best attended and the most interesting that has been held this year. The following officers were elected: President, Dr. John L. C. Whitcomb, Liberty; first vice-president, Dr. Sherman D. Maynard, Roscoe; second vice-president, Oscar N. Meyer, Monticello; secretary, Howard P. Deady, Liberty; treasurer, Charles W. Piper, Wurtsboro. Dr. Herbert Maxon King was elected fellow and Dr. Charles S. Payne, alternate.

* * *

Ulster County Association.—The regular quarterly meeting was held at "Ulster Villa," Ellenville, on May 18th.

Dr. J. Riddle Goffe, of New York, was present and gave a lecture on "Causes and Treatment of Retro-displacements of the Uterus." Dr. Goffe illustrated by blackboard diagrams the old idea of the anatomy of the pelvis, obtained from frozen sections of the cadaver, and he emphasized the point that the parts were relaxed after death, and the correct knowledge could only be obtained by examinations of living women, in both the recumbent and standing positions, and he demon-

strated that in the erect position a line dropped from the anterior surface of the last lumbar vertebra fell just posterior to the internal surface of the pubis. According to his idea the body of the uterus was in normal position as long as it occupied a position anterior to the promontory of the sacrum, and it would vary its position physiologically according to the fulness of the bladder. But when the fundus of the uterus slipped posterior to the promontory of the sacrum he considered it in an abnormal position. He also demonstrated clearly the fallacy of the old idea that the perineum is a support to the uterus, and did bring out clearly the fact that the uterus (following the law of the other organs of the body) is held in position by its ligaments, the utero-sacral ligaments being the especially important ones in preventing retro-displacements. As etiological factors he considered subinvolution, constipation and diseased appendages the principal ones. In treatment, he advocated the use of tampons, and said that a large number of women could be symptomatically cured by their use with glycerine, large douches, and they should have the benefit of this conservative treatment before resorting to surgical means in most cases. In his experience only about 5 per cent. could be cured with pessaries, but a larger number might be relieved. He condemned all soft rubber pessaries, because they became sources of infection. He advocated the use of the Smith or Thomas modification and illustrated that when it was in proper position in the pelvis it was nearly vertical, when the patient was in the erect position, and did not lie transversely in the pelvis with anterior end pressing back of pubis.

In cases of complete procidentia uteri, if the patient's condition would warrant taking an anesthetic, he had found hysterectomy the most satisfactory treatment. He explained his method of operating.

All of the physicians present greatly appreciated Dr. Goffe's clear, masterly presentation of the subject.

Dr. Henry van Hoesenberg, of Kingston, reported a case of a young man injured in a railroad accident. He was struck upon the abdomen and had a few bruises on his body, but gave no marked symptoms for thirty-six hours, when he began to have symptoms indicating abdominal trouble, and an exploratory incision was made and evidence of beginning peritonitis discovered, but no injury to bowels or bladder. As the patient was sinking rapidly no further efforts were made. Death occurred about forty-eight hours after the injury. The autopsy disclosed a rent in the upper curvature of the stomach one and one-half inches in length.

Dr. Eber H. Heston, of Clintondale, reported a case of abdominal injury due to the kick of a horse in that region. This patient gave marked symptoms, pain and vomiting at once, and died in thirty-six hours. No autopsy was made.

Five new members were elected.

LIST OF MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION, MAY 1 TO JUNE 1, 1903.

Baker, Sara Josephine, New York City.
 Barnesby, Norman, New York City.
 Brownell, Mary Alice, Newark, N. Y.
 Clayton, Mary, Ogdensburg, N. Y.
 Ehlers, Edward C., New York City.
 Kammerer, Frederic, New York City.
 Knapp, Hiram L., Newark Valley, N. Y.
 Loughton, Florence M., New York City.
 Robinovitch, Louise G., New York City.
 Rogers, Willard H., New York City.
 Warnecke, Anna, Newark, N. Y.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

First District Branch, Lewis County.—Charles R. Barlett, Lyons Falls.

St. Lawrence County.—Mary Clayton, Ogdensburg.

Second District Branch, Columbia County.—Hortense V. Bruce, Hudson; Eloise Waker, Hudson.

Third District Branch, Seneca County.—J. Ernestine Hills, Willard; Erving Holley, Willard; Frederick W. Lester, Seneca Falls; Donald L. Ross, Willard; John W. Russell, Willard; William L. Russell, Willard; Louis T. Waldo, Willard.

Tompkins County.—Homer Genung, Freeville; William C. Gallagher, Slaterville Springs; Edmund H. Kyle, Ithaca; Edward Meany, Ithaca; William A. Smith, Newfield; Roscoe C. Wilson, Ithaca.

Fourth District Branch, Allegany County.—C. Oakley Sayres, Belfast.

Erie County.—A. McNeal Blair, 217 Prospect avenue, Buffalo; Albert R. Satterlee, 922 Niagara street, Buffalo.

Cattaraugus County.—John P. Boothe, Olean; Erwin M. Goss, Cattaraugus; Myron C. Hawley, East Randolph; Charles P. Knowles, Olean; Jacob E. K. Morris, Olean; Cassar Smith, Olean; Edward Torrey, Allegany; William Teft, South Dayton; Carl S. Tompkins, Randolph.

Orleans County.—Edward Munson, Medina; George F. Rogan, Medina; Frank B. Storer, Holley; John E. Sutton, Albion.

Ontario County.—Joseph A. Sanders, Clifton Springs.

Wyoming County.—Henry Preston Slade, Arcade.

Yates County.—James F. Underwood, Penn Yan.

Fifth District Branch, New York County.—Sara Josephine Baker, 8 West 91st street, New York City; Norman Barnesby, 1967 Seventh avenue, New York City; Willis S. Cooke, 121 West 129th street, New York; Joseph W. Droogan, Westchester, New York; Edward J. Gilleran, 165 Lenox avenue, New York; Nathan Goodfreund, 253 East 72d street, New York; Frederic C. Hargrave, River avenue and 167th street, New York; Frederic Kammerer, 51 East 66th street, New York; Morris N. Karash, 140 St. Ann's avenue, New York; Florence Marion Loughton, 8 West 91st street, New York; Walter Eyre Lambert, 8 West 35th street, New York; Edward S. McSweeney, 153 Lexington avenue, New York; Richard Mollenhauer, 250 East 53d street, New York; Louise G. Robinovitch, 28 West 126th street, New York; John Rogers, Jr., 102 East 30th street, New York; Willard Rogers, 225 West 22d street, New York; Henry Clay Ruhl, 673 East 138th street, New York.

Rockland County.—William R. Sitler, Suffern.

Sullivan County.—Joseph W. Johnson, Monticello.

Ulster County.—Wilson P. Fuller, Kerhonkson; John Gordon, West Park; Eber H. Heston, Clintondale; James Krom, Phoenicia; Albert H. Palmer, Malboro.

OBITUARY.

Dr. Dwight S. Chamberlain, Lyons, N. Y., a member of the New York State Medical Association, Wayne County, died at his home, aged 65 years, on May 11th. Dr. Chamberlain was president of the Lyons National Bank, and had served as surgeon in the Civil War, later being in charge of the soldiers at Syracuse. He was a member of the Loyal Legion.

Dr. Hobart Cheesman, who died at St. Luke's Hospital on the evening of April 11th, had been a resident of New York City for more than twenty-seven years. He was born in Theresa, Jefferson County, 58 years ago, and was a man of sterling character and worth. Largely by his own efforts he received a college education, graduating at Amherst in the early 70's. He afterward studied medicine, graduating with honors from the University of New York and serving two years, 1878-79, in St. Luke's Hospital as interne. Life insurance work was his inclination and he has been prominently connected with that work during his whole professional career. The immediate cause of his death was from an operation for the relief of obstruction of the bowels caused by a malignant neoplasm attached to the caput coli, and which, being unremovable, was left, and a Murphy button anastomosis made between the ilium and cecum. Dr. Cheesman was a member of the New York Academy of Medicine.

PERSONALS.

Dr. Christian A. Herter has been appointed to fill the chair of Pharmacology and Therapeutics at the Columbia University.

Dr. Robert A. Weir has been elected professor of Clinical Surgery at the Columbia University.

Dr. Joseph A. Blake has been appointed lecturer in Surgery at the Columbia University.

Dr. Alexander Lambert was elected chairman of the Section of the Practice of Medicine at New Orleans.

Dr. Charles A. Kerley was elected chairman of the Section of Diseases of Children at New Orleans.

Dr. W. J. Robinson was elected member of the House of Delegates by the Section on Materia Medica, Pharmacy and Therapeutics.

Dr. Thomas F. Reilly, of 204 West 141st street, Manhattan, is booked to sail this week for Vienna.

Dr. and Mrs. Robert J. Carlisle, of 44 West 48th street, Manhattan, sailed on the Friedrich der Grosse for Bremen, May 19th.

Dr. and Mrs. James P. Tuttle, of 42 West 50th street, sailed for Hamburg on the Aguste Victoria, May 19th.

Dr. Charles G. Stockton, 436 Franklin street,

Buffalo, was recently the guest of Dr. Max Einhorn, of 20 East 63d street, Manhattan.

Dr. Harvey Russell Gaylord, 568 Delaware avenue, Buffalo, who is ill with typhoid fever, is reported to be progressing favorably as we go to press.

Dr. Nicholas Senn, of Chicago, Ill., was in New York City a few days last week.

Dr. Martin Linderoth, of 69 Greene avenue, Brooklyn, will hereafter devote himself exclusively to the practice of ophthalmology.

The appointment of pathologist to the Craig Colony for Epileptics, Sonyea, N. Y., has been given to Dr. B. Onuf, of Brooklyn.

Dr. James Cole Hancock, of Brooklyn, who has been suffering for some time from a severe injury to the knee, is now able to resume his practice.

Dr. Hermann M. Biggs, of New York, was elected Orator of Medicine of the American Medical Association to the meeting to be held at Atlantic City in 1904.

Dr. Frederick Holme Wiggin, of New York, was reappointed Secretary of the Judicial Council of the American Medical Association.

A reception was given at the house of Dr. Max Einhorn, of New York, on Thursday evening, May 7th, to meet Professor Ewald, of Berlin.

Dr. William H. Biggam, Dr. Samuel A. Brown, Dr. Louis C. Ager and Dr. E. Eliot Harris have been appointed as delegates from the New York State Medical Association to the meeting of the Connecticut Medical Society, which will be held in Hartford, Conn., May 28-29, 1903.

Dr. Frederick Holme Wiggin, Dr. Alexander Lambert, Dr. Emil Mayer and Dr. Walter Barry Jennings have been appointed delegates from the New York State Medical Association to the meeting of the Massachusetts Medical Society, which will be held in Boston, Mass., June 9-10, 1903.

THE AMERICAN THERAPEUTIC SOCIETY.

The fourth annual meeting was held at Washington, D. C., May 11th, 12th and 13th.

Among those who read papers were the following members of the New York State Medical Association:

Drs. Carl Beck, Charles H. Knight, J. E. Weeks and H. L. Taylor.

THE LEGAL DEPARTMENT.

The latest application for assistance from the State Medical Association has come from the other end of the State.

A well-known physician of Buffalo has been sued and an answer has been put in by our

counsel. The uniform success of the other suits convinces us that this will follow in the same course as the others and come off wholly to the satisfaction of the doctor.

Stanilaus S. Nowske, a resident of Williamsbridge and a persistent and vicious offender against the health laws, has at last been arrested and was held by Magistrate Mayo in the Yorkville Court for trial and his attorney has secured an adjournment upon the agreement to plead guilty; this case is an aggravated one and much time and money has been expended to secure this conviction.

Rafael Milite, an Italian, who resides in Williamsbridge, has also been arrested and will be tried probably May 22d. There should be some law to stop druggists compounding prescriptions of these quacks, but at present they hide behind the claim that they do not know that the doctor is not registered.

An amusing incident happened in the case of Franz Grossman, an illegal practitioner who has a drug store and an office at 278 Delancey street. He was arrested in January last and paid a fine of \$100, and the detective secured another case against him last week. When the officer went to arrest him he claimed that he was too sick to go to court, and the counsel was compelled to send to Gouverneur Hospital for an ambulance; when the ambulance surgeon examined Grossman he said that he would either have to go to court or to the hospital, whereupon he immediately got up out of bed, put on his clothes and followed the officer to the court.

Raffaele Mucio, of 123 Navy street, was arrested and arraigned before Magistrate Dooley in the Adams Street Court in Brooklyn, and upon the hearing was defended by able counsel, who put up a strong fight for his client. He was held for Special Sessions. Mr. Lewis has evidence in his possession tending to show that this man Mucio was not only practicing under his own name, but was using the name of another physician residing in the Borough of Manhattan; but owing to the fact that the physician whose name he uses declines to come forward it is doubtful if the case of practicing under an assumed name will be pressed. This offense is a felony and would preclude the doctor, who is an Italian physician, from ever being admitted to practice in this State.

Professor Maruches, a well-known quack of East New York, was held by Magistrate Dooley in the Adams Street Court on the 14th inst. This character has no semblance of any medical education, yet goes about in the neighborhood visiting and prescribing and in his drug store filling prescriptions.

Mrs. Edith E. Allen, of East New York, was arraigned before Magistrate Higginbotham, in Brooklyn, and her case set down for hearing on the 20th; the case against her is of a particular sort and a most aggravated one.

News Items.

TRANSACTIONS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

There are still a few sets of the Transactions of the old State Association, Vol. II to XVI, in the hands of the Committee on Publication, and they will be furnished while they last to members of the Association who have not already a set, if they will send word to Dr. Charles E. Denison, Chairman, Committee on Publication, 64 Madison avenue, New York City, that they would like to have them and are willing to pay the express charges for the delivery of the books, which charges average less than \$1; they will be forwarded them at once.

The Albany Medical College held its graduating exercises on May 5th. It was the seventy-second annual commencement. The chancellor, Dr. Adam T. Van Vrouken, of 1603 Third avenue, Watervliet, presented diplomas to thirty-four young men.

The late Warren B. Smith, the millionaire carpet manufacturer, left \$50,000 to St. John's Hospital at Yonkers.

The commencement exercises of Cornell University Medical College, will be held at Carnegie Hall, Manhattan, Wednesday evening, June 3d. The number of graduates will be sixty.

Dr. Justin Herold, of 325 East Eighty-seventh street, recovered a verdict of \$12,000 against the Metropolitan Street Railway Company in the Supreme Court.

Four years ago the doctor was riding on an Eighty-sixth street cross-town car, when at the corner of Second avenue and Eighty-sixth street the horse car was run into by a trolley car of the Second avenue line. The doctor testified that his foot was so badly crushed that it interferes with his walking, with the result that he has lost \$2,000 a year in his practice. The company conceded negligence, and the only question for the jury was as to award of damages.

ANOTHER DEATH FROM UNPROFESSIONAL ADMINISTRATION OF THERAPEUTIC MEASURES.

The Kronprinz brought with her to New York on May 6th the sad story of the entirely unnecessary death of one of her passengers. A little girl was suffering severely from seasickness; instead of seeking the attendance of the

ship's surgeon, the mother permitted a friend to give the child some medicine she had brought with her for that much-dreaded illness.

The result was quickly fatal, the patient dying from acute poisoning.

NEW LAW FOR REGISTRATION OF NURSES.

Who May Practice As Registered Nurses.—Any resident of the State of New York, being over the age of 21 years and of good moral character holding a diploma from a training-school for nurses connected with a hospital or sanitarium giving a course of at least two years, and registered by the regents of the University of the State of New York as maintaining in this and other respects proper standards, all of which shall be determined by the said regents, and who shall have received from the said regents a certificate of his or her qualifications to practice as a registered nurse, shall be styled and known as a registered nurse, and no other person shall assume such title or use the abbreviation R. N. or any other words, letters or figures to indicate that the person using the name is such a registered nurse. Before beginning to practice nursing every such registered nurse shall cause such certificate to be recorded in the County Clerk's office of the county of his or her residence with an affidavit of his or her identity as the person to whom the same was so issued and of his or her place of residence within such county. In the month of January, 1906, and in every thirty-sixth month thereafter, every registered nurse shall again cause his or her certificate to be recorded in the said County Clerk's office, with an affidavit of his or her identity as the person to whom the same was issued, and of his or her place of residence at the time of such reregistration. Nothing contained in this act shall be considered as conferring any authority to practice medicine or to undertake the treatment or cure of disease in violation of article eight of this chapter.

Board of Examiners; Examination; Fees.—Upon the taking effect of this act, the New York State Nurses' Association shall nominate for examiners ten of their members who have had not less than five years' experience in their profession, and at each annual meeting of said association thereafter, two other candidates. The regents of the University of the State of New York shall appoint a board of five examiners from such list. One member of said board shall be appointed for one year, one for two years, one for three years, one for four years, and one for five years. Upon the expiration of the term of office of any examiner, the said regents shall likewise fill the vacancy for a term of five years and until his or her successor is chosen. An unexpired term of an examiner, caused by death, resignation or otherwise, shall be filled by the regents in the same manner as an original appointment is made. The said regents, with the advice of the board of examiners above provided for, shall make rules for the examination of nurses applying for certification under this act, and shall charge for examination and for certification a fee of five dollars to meet the actual expenses, and shall report annually their receipts and expenditures under the provisions of this act, to the State Comptroller, and pay the balance of receipts over expenditures to the State Treasurer. The said regents may revoke any such certificate for sufficient cause after written notice to the holder thereof and hearing thereon. No person shall thereafter practice as a registered nurse under any such revoked certificate.

Waiver of Examination.—The regents of the University of the State of New York may, upon the recommendation of said board of examiners, waive the examination of any persons possessing the qualifications mentioned in Section 206, who shall have been graduated before, or who are in training at the time of, the passage of this act and shall hereafter be gradu-

ated, and of such persons now engaged in the practice of nursing as have had three years' experience in a general hospital prior to the passage of this act, who shall apply in writing for such certificate within three years after the passage of this act, and shall also grant a certificate to any nurse of good moral character, who has been engaged in the actual practice of nursing for not less than three years next prior to the passage of this act who shall satisfactorily pass an examination in practical nursing within three years hereafter.

Violations of this Article.—Any violation of this article shall be a misdemeanor. When any prosecution under this article is made on the complaint of the New York State Nurses' Association, the certificate of incorporation of which was filed and recorded in the office of the Secretary of State on the 2d day of April, 1902, the fines collected shall be paid to said association, and any excess in the amount of fines so paid over the expenses incurred by said association in enforcing the provisions of this article shall be paid at the end of each year to the treasurer of the State of New York.

This act shall take effect immediately.

PATENT MEDICINE TESTIMONIALISTS.

We suggest that our subscribers should invest 10 cents in the current number of *Physical Culture*, a popular magazine which in its way is doing a deal of good as regards some "curers"—at least in this number. This advice is given in order that our colleagues may have some "ammunition" for their patients who are addicted to the "Celery Compound" and "Peruna" forms of alcoholism. The career of Supreme Court Judge and Member of Congress H. Henry Powers as a taker and indorser of the popular tipples called patent medicines is entertaining. Facsimiles of the advertisements and portraits of Powers and of other notabilities appearing in the great yellow dailies are given. Mr. Iller, in *Physical Culture*, says:

Although cured by Paine's Celery Compound, Powers was still a long way from being a healthy man. He had taken so much of Celery Compound that he was literally full of "Pains." He decided in favor of Greene's Nervura. On the prominence gained by this second testimonial he was elected to the United States Congress. On his arrival in Washington, D. C., he found that this body no longer existed, and that it had long been replaced by the Peruna Congress. The majority of the Congressmen and Senators put forth their best efforts in trying to establish Peruna as the national tonic. Powers soon discovered that the cause of Nervura was a lost cause, and he promptly set about digging up a new crop of pains in his multicured anatomy to fit the regulation Peruna testimonial. Pitted in Congress against the Peruna faction was the Malt Extract party, which was led by the invincible Chauncey Depew. The Peruna faction was led by Amos Cummings, who was completely cured by Peruna, but died shortly afterward. Having been cured more frequently and by more varied remedies than any other Congressman, Powers was the most eligible candidate for leader, and was accordingly unanimously elected. Under his leadership the Peruna party made wonderful strides forward, but, strange anomaly, the more the Congressmen professed being cured the more feeble they grew, and, stimulated by the example of Mr. Powers, there are now over fifty "active" members of the party taking the cure. Powers' term expired in 1901, and his constituents failed to return him to Congress. They claimed that a man may have some pains all the time, that he may get rid of all the pains some of the time, but they doubted Powers when he got cured of all of his pains all the time.—*American Medicine*.

COMPENSATION FOR MEDICAL SERVICES RENDERED THE STATE.

BY T. D. DAVIS, M.D., Ph.D.,
Pittsburg, Pa.

What amount is a fair professional compensation is not easily decided. *Quid pro quo* is difficult to determine justly in regard to medical services. In law the fee is frequently decided by the value of the property in litigation; by the length of time consumed; by the importance of the case; or by the *nerve* of the lawyer. This fee is usually paid without complaint simply because it would be a waste of time and temper to object. Engineers, architects, etc., charge a percentage, which is quite uniform, on the value of the work, and the cost can be estimated beforehand.

The laborious yet gratuitous services to hospitals and eleemosynary institutions by the medical profession has also made public officials undervalue their services. I know of no just reason why a physician or surgeon should render entirely gratuitous service to a hospital when a lawyer charges the same institution. Many doctors seek these positions because of the supposed advertisement or that it may increase their practice or place them on a higher plane than their fellow practitioners or some such unworthy reason. *After thirty years active work in a number of hospitals I wish thoughtfully to say that the practical advantage of such work to a diligent physician, who is not a teacher, is wonderfully overestimated by the profession.* The time consumed, absence from office and study outweigh the advantages of the large practice, while hospital methods cannot be successfully transferred to the home or private practice. I might add, it used to be the staff alone that had the privileges of hospitals, but now in order to secure his influence an outsider receives more courtesies and as many privileges as if he were serving the hospital for nothing, for there is a real rivalry between hospitals. These institutions have changed greatly. When I first served in them they were for the poor and unfortunate, with but few, if any, private rooms. Now they are but luxurious, fashionable invalid hotels with possibly charitable annexes. Yet in many cases their managers still expect gratuitous services from their staff. Why a patient who can afford to occupy a private room in a modern hospital should not render some compensation to his physician is beyond my ken. A friend of mine recently found one of his wealthiest patients in a private room in a hospital he was attending, and was required to treat him without pay! He promptly resigned from that staff. Would that all others had the same good sense and manhood. Can you wonder that the governments underpay their medical officers? So also these very hospitals by receiving State or charitable aid are able to underbid a private surgeon and force down medical fees, yet the medical profession fosters this gross injustice. The free dispensary abuse is a well-known example of the lack of business

foresight in the medical profession. Its shameful abuses have been thoroughly exposed and need not be dwelt upon here. The fault is ours. The remedy is with ourselves, but so long as we hold our own knowledge and training so cheaply so long will the public authorities undervalue our services.—*Bulletin American Academy of Medicine, April.*

THE THERAPEUTIC POSSIBILITIES OF ERGOT.

Of the introduction of new drugs there is no end. We must confess to a more kindly feeling for an extension of the sphere of action of old ones, the actual value of which, in some degree at least, is witnessed, too, by their retention in the general medical armamentarium for a long period of time. When such a one is taken up afresh, its sphere of action investigated, some at least of its claims sanctioned by the authority of time sustained, and the field for its useful employment widened, we confess that we experience far more satisfaction than animates us on the first introduction of new medicaments, which, with some few exceptions, usually "go up like a rocket and come down like the stick." Of course, we do not wish our words to be taken as in any way implying a deprecation of the search for new remedies; but we do wish that there was not quite so great a tendency to neglect the old, many of which would doubtless well repay some of the more scientific investigation which we are now enabled to give them, than was the case of old time, and which is bestowed in profusion on the more recent introductions.

In a paper read before the New York County Medical Association, on March 16th, by Dr. Alfred T. Livingston, of Jamestown, N. Y., he gave a comprehensive view of the wide, and to a great extent unsuspected, field of therapeutical possibilities which lurk in ergot of rye, a drug largely associated in the minds of many practitioners almost solely with its use (or abuse) in the conduct of obstetrical cases. It is now nearly thirty years since Dr. Livingston began his clinical investigations into the various possible therapeutic properties of ergot, and if his experience can be confirmed by others, he will undoubtedly have succeeded in promoting an almost obsolescent drug to a post of highest honor in the *materia medica*. Dr. Livingston's first experience with ergot, outside of the beaten track, was in the case of a man who had been retching violently and constantly for over four hours, and was exhausted from the effects. The frontal veins were greatly distended, the pulse was full and bounding, and there was much pain. The injection slowly of a syringeful of a solution of ergot was followed by results of a character as remarkable as they were gratifying. By the time that the syringe was emptied the suffusion had vanished, retching had ceased, pain had disappeared, and the full and bounding pulse had become soft, though slightly more frequent. He soon fell asleep, and slept continuously for six hours. Since

that time Dr. Livingston, has followed up his researches into the clinical results of the use of ergot, and is now able to state that, in his experience, this drug can be used with advantage in a large number of morbid conditions. Among these he names insomnia, in which it produces a sleep more natural than that produced by any other drug; many cases of headache, iritis, opium poisoning, drug habits, acute alcoholism, asthma, hysteria, hysteroepilepsy, and catalepsy. Many cases of general paresis in the early stage are also said to have been relieved by it. In acute inflammations he gives it a prominent place, especially in meningitis, pneumonia, peritonitis, appendicitis, amygdalitis, erysipelas, erythema and inflammation of the veins and arteries. In surgery, also, it has a place, particularly as a preventive or modifier of shock.

As to the mode of administration, he strongly advocates the hypodermic method, and uses a solution of Squibb's extract of ergot, of a strength of a dram of the ergot dissolved in an ounce of water and containing chloroform as a preservation in the proportion of two minims to each drachm of solution. Twenty-five or thirty minims of this solution represent about three grains of the drug. The water in which solution is effected should be sterilized by boiling before use, and for some reason which he cannot explain, he finds that solutions a few days old are less painful and more satisfactory than those freshly prepared. Large doses, according to the requirements of the case, have been given by him, the maximum having been the equivalent of thirty grains of the solid extract in the twenty-four hours. The injection should be made slowly. This fact, we may add, was pointed out by Dr. Perrotin, in 1882, according to the *London Medical Record* for July of that year. In spite of his large experience with the drug, Dr. Livingston has never had an abscess consequent on its use, or indeed any other evil sequela.

This reads almost like a fairy tale, but much of what Dr. Livingston claimed for the use of the drug was corroborated at the same meeting by Dr. Frederick Holme Wiggin. Moreover, some of these applications are not altogether new, though they have not attained any general publicity. In erysipelas the local application of ergotine was used so far back as 1881, and a communication thereon was published in the *British Medical Journal* for December 10th of that year. In 1892, the author of that communication treated successfully on the voyage home from the West Coast of Africa a case of blackwater fever of the most virulent type, the drug acting in a manner that was as startling as anything recorded by Dr. Livingston. Professor J. M. Da Costa recommended ergotine, about 1881, as the best remedy to control the night sweats of phthisis. It was also highly praised by Dr. J. Dewar, in 1882, in pertussis, and its value in that disease was confirmed by the abstractor of Dr. Dewar's article in the *London Medical Record*. These

remarks are not made with any view to depreciating the credit that Dr. Livingston may be entitled to for his extended researches; on the contrary, they are adduced to support his plea for a thorough trial at the hands of the profession, of a drug that seems to be unusually richly endowed with therapeutic possibilities, greater, if his researches find confirmation, even only in part, than most of us were previously aware of. And the reasonableness of the claims made is suggested by the fact that most of the conditions in which it is said to have proved so preeminently useful are characterized by one central underlying condition, viz., vascular dilatation due to loss of tone. The fact that the middle coat of the arteries is composed of unstriated muscular fibers, and that ergot causes the contraction of unstriated muscular tissue, at once suggest a plausible explanation of its asserted wide-reaching action.—*New York Medical Journal*, May 9, 1903.

THE OBJECTIONS TO PRESCRIBING MEDICINES OF UNKNOWN COMPOSITION.

BY AUGUSTUS A. ESINER, M.D.,
Philadelphia.

If the proposition contained in the foregoing terms were always presented so clearly and so directly there would be little room for discussion, as I think it will be generally conceded that the fact of the composition of a medicine being unknown would constitute in itself the most serious objection to its prescription by physicians. Nevertheless, I fear that many prescriptions are written daily for preparations concerning whose composition the prescriber is not in possession of such fulness of knowledge as is requisite for the most intelligent and most successful employment of the articles of the *materia medica*.

The modern manufacturing pharmacist has exhibited marked skill and ingenuity, worthy of a better cause, in concealing ignorance behind the mask of false knowledge. It has become the vogue for this enterprising individual, firm or corporation to put forth products to which he gives fanciful names, for which he claims elaborately described marvelous effects, and of which he states the composition in accordance with his own views and purposes. He has a predilection for describing his product as a synthetic preparation with a formula comprising C,H,N, and O in startling proportions, and he gives it an almost interminable and unpronounceable chemical name, but is good enough to coin a descriptive and copyrighted substitute. Sometimes it is, at other times it is not, a coal-tar product, according to personal caprice. If the preparation be a mixture, only its constituents may be named, and sometimes not all of these, the proportions being omitted. In these and devious other ways a pretense of publicity is made, by which the careless and indifferent may be readily if not willingly deceived. Samples are distributed generously to physicians, who read with avidity the accompanying so-called literature skilfully devised by the

manufacturer, and it is not long before testimonials indorsing the new preparation are forthcoming, and clinical reports of cases treated with the new preparation appear in certain medical journals. Sometimes the aid of the physician is further invoked by securing him as a stockholder or officer in the manufacturing concern, and his interests may be further looked after in the way of commissions or concessions in return for prescribing the remedy. The preparation is now launched on a career of success and prosperity, which may be of longer or shorter duration in accordance with a variety of conditions. Mayhap when the profession has done all in its power to contribute to this end, direct appeals to the laity, supported by the indorsement of "the medical faculty," are made to the public through the advertising columns of the newspapers and the dead walls and spaces of the city and the country.

The practice of medicine, though an art, is based on scientific principles, and it will be successful in proportion to the fulness and precision of the knowledge underlying it. If the identity of a medicine is not known through its composition the prescriber has no assurance that he will always receive the same article, but, on the contrary, there is good reason for believing that he will get something different, in quantity or in quality, at different times. In this way he is liable to do discredit to his art, and injury, positive or negative, to his patient. Additionally, injustice is done the patient, in that he is compelled to pay a higher price for medicines of concealed or suppressed composition than he would if these were prescribed in the regular way. The practitioner who permits himself to fall into the habit of prescribing ready-made preparations surrenders thereby originality and independence in his therapeutics, and fails to make progress in his art. The manufacture and the use of secret preparations have also a blighting effect on legitimate pharmacy. Finally, after all has been said on both sides of the question, if there are two sides, there remains the practical argument that the prescription of medicines of unknown composition is unnecessary, as all that can be accomplished with them, barring the potent influence of secrecy, can be brought about as well if not better by means of medicines of known composition.

From the foregoing considerations it must be clear that the prescription of medicines of unknown or concealed composition is unscientific, unprofessional, unfair if not prejudicial to the sick, unprogressive and unstimulating and, most of all, unnecessary.

The remedy for the existing state of affairs is in the hands of the medical profession. *The manufacturing pharmacists will not make preparations that they cannot sell*, and if physicians will not permit the creation of an artificial demand for illegitimate preparations, and will cease to prescribe them, the manufacturers will soon discontinue their production. To this end it is the duty of all medical men having the interests of

their profession and their patients at heart to confine themselves to the employment only of such drugs or combinations of drugs whose composition is of public knowledge, and, further, is vouched for by some recognized authority, official or otherwise, such as the Pharmacopeia, the Dispensatory and the Formulary; or, in lieu of such indorsement, in the intervals between successive revisions, is given authentic publicity by investigators of acknowledged standing and competency through legitimate and recognized channels, such as the professional journals and independent publications. Above all things, the so-called literature of the manufacturing pharmacist and the reprints of articles from publications of questionable character should be viewed with suspicion.—*Journal American Medical Association.*

Book Reviews.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of John B. Murphy, M.D., Chicago; Alexander D. Blackader, M.D., Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landolt, M.D., Paris; Thomas G. Morton, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh, and John Harold, M.D., London, with regular correspondents in Montreal, London, Paris, Leipsic and Vienna. J. B. Lippincott Company, Philadelphia and London. Cloth, \$2. Volume 4, series 12th.

Like its predecessors, the present volume of "International Clinics" occupies a niche in the medical book world distinctly unique. The subjects touched upon are scientifically treated, and the papers, as a whole, well edited. Unfavorable criticism, however, might well be directed against the chapter devoted to selected prescriptions. For the most part they appear to have been "selected" from an old-time pocket formulary, without reference to newer and simpler remedies and combinations.

The biographical sketches of Drs. W. W. Keen and Horatio C. Wood, by Guy Hinsdale, of Philadelphia, will be read and enjoyed by many old alumni of Jefferson and the University of Pennsylvania, who have had the privilege of listening to their teaching. *En passant*, the present reviewer exhibits mild wonder that the biographer did not include in the sketch of Wood the incident during his early struggles, so well known in medical Philadelphia, regarding his purchase of an improved microscope for \$300, when his entire available worldly capital was but slightly in excess of that amount, in order to continue his studies on "Fresh-water Alge." This fact, surely, is an index of the earnestness and depth of purpose of the man which has characterized his subsequent career. Nowadays it is reasonable, if not complimentary, to think that most young men just launched in medical practice exhibit a tendency to invest their savings in the purchase of an automobile, on monthly instalments, rather than in scientific instruments. *O tempora! O mores!*

The space at the reviewer's disposal forbids notice of all the excellent papers contained in the book.

The opening one, descriptive of Gardiner's "Sanatory Tent, and Its Usefulness in the Treatment of Pulmonary Tuberculosis," is practical and timely. It would appear, however, that the initial cost of the tent (figures are not given) perhaps might prevent its general adoption. The principles of thorough ventilation which the inventor has applied in a practical manner are grounded in good, common sense.

The paper by Lanceroux, of Paris, on "Treatment of Aneurisms by Gelatin in Hypodermic Injections," is of great interest, and supplements his first article on this subject, published in 1897. Remarkable results, obtained in several cases, are detailed. Bishop brings out a number of valuable points in his paper on "Abdominal Diagnosis." His deductions on pain as a diagnostic feature are extremely lucid and satisfactory. This paper alone is worth more to the medical practitioner than many text-books. Only words of praise are due to A. O. Kelly's article on "Some Clinical Aspects of Aneurisms of the Aorta." Fallon's, on "The Radical Cure of Inguinal Hernia," is beautifully illustrated from original dissections.

Moynihan writes of "The Surgical Treatment of Gastric Ulcer." His conclusions, the result of considerable experience, are eminently sensible, and his example as regards indiscriminate operating worthy of emulation. Of very pronounced value is Bodine's lecture on "Fright and Deaths in Chloroform Narcosis; Mental Preoccupation as a Preliminary to General Anesthesia." He lays stress on the fact that when death takes place in chloroform anesthesia the cause is always a vasomotor paralysis. "That is to say, the nervous system lost control over the motor nerve leading to the blood-vessels, and especially the veins of the body, and as a consequence the patient bled to death into his own tissue. Now, it is well known that deaths from fright occur in just the same way as deaths from chloroform poisoning. No pathological conditions are found in fatal cases of fright except a dilatation of the large veins of the body, and consequent marked passive venous congestion." He much prefers chloroform as an anesthetic, but insists that a patient's mental state should be tranquil before its administration. The technic of resection of a tuberculous testicle is demonstrated in the same lecture. The editor of the book, in many instances, has eliminated the unnecessary hyphen in his proofreading; it would be well, and abreast of the times, if he were to do away with the diphthong. It is almost unpleasantly prominent in this particular paper.

In these days, when blood examination has deservedly taken the highest rank as a means of diagnosis, the monograph of nearly one hundred pages, by T. R. Brown, of Johns Hopkins, on "The Blood in Health and in Disease," which concludes the volume, will be read with absorbing interest. It shows painstaking research and rare discrimination in separating well-established laboratory findings from those which may well be classed as unconvincing microscopic experiments. The section on "Serum Diagnosis, Serum Therapy, and Immunity" brings these important subjects thoroughly up to date.

All in all, this Volume IV of the XIIth series of "International Clinics" possesses distinctive features, which commend it emphatically to every progressive physician. The advice of the reviewer is "Buy it, read it, and assimilate it."

MANUAL OF THE INTERNATIONAL CLASSIFICATION OF CAUSES OF DEATH. Adopted by the United States Census Office for the Compilation of Mortality Statistics, for use beginning with the year 1900.

The following statement is made by William A. King, Chief Statistician for Vital Statistics, concerning this valuable work:

The cases classified are those reported at the eleventh and twelfth censuses (1890 and 1900), including those contained in the transcripts of registration records. The list, therefore, covers the identical terms to be classified by registration officials for their

local reports. It also includes all terms found in the "Dictionnaire des Maladies," published by Dr. Bertillon.

I want to say, most earnestly, that the publication of the Manual, which has required a great amount of labor and much expense, was not dictated by any desire to enforce any peculiar opinions concerning the assignment of particular causes. In compiling the statistics for the annual report for 1900 (the first of the annual reports under the act creating the permanent census office), it was necessary to make an immediate decision upon each case covered by the records, and to make an index of the decisions to govern the assignment of other cases reported in the same terms. Covering the same ground as local statistics, it was thought that the index, so prepared, could be made useful to others, as being sufficiently accurate for present purposes, while serving as a basis for a more perfect work. The outcome is the Manual in its present shape.

It will be suggested to the Conference of State and Provincial Boards of Health, the American Public Health Association, and other societies, that a committee be selected from their members, and others interested, to consider the matter in detail, and to settle, in a satisfactory manner, all questions respecting the assignment of causes under the International Classification as it now stands, and thus clear the way for a united front by American registrars in the revision of the classification itself, in 1910.

I will be pleased to have you examine the Manual critically and to submit memoranda concerning any changes in assignment that appear necessary, with suggestions as to the best plan for harmonizing the differences of opinion that develop.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. Edited by George M. Gould, M.D. Published by W. B. Saunders & Co.

The volume on "Surgery" is the one we shall examine at this time, reserving the one on "Medicine" until next month.

Even with the careful reviews of current literature, which appear weekly in our surgical journals, it is impossible to keep abreast of the many daily improvements offered by collaborators in this and other lands.

This year-book presents all the advances made during the twelve months since the previous issue. Furthermore, it mentions the laudable attempts at improvements in the art and science of surgery, whether of themselves of any success or not. The contributors, the editors of the various subjects, do not force their own opinion upon the reader, but fill the pages with the best literature to be found in journals, text-books and monographs of this and foreign countries. The work in preparing a digest in such a thorough way must be enormous.

The book contains 700 pages of good paper, excellently printed and well bound. There is not a criticism to be found in the presswork.

Among the members of the New York State Medical Association whose papers have been quoted in this work, we notice the following names: Samuel Alexander, Carl Beck, Charles H. Chetwood, W. B. Coley, Charles A. Elsberg, Samuel M. Evans, E. D. Ferguson, Eugene Fuller, Virgil P. Gibney, J. Riddle Goffe, Ramon Guiteras, L. W. Hotchkiss, E. L. Keyes, Jr., W. M. Leszynsky, Charles McBurney, Willy Meyer, Robert T. Morris, B. B. Mosher, Francis W. Murray, Charles Phelps, R. H. Sayre, P. P. Satterwhite, Parker Syms, H. L. Taylor, Robert F. Weir, John A. Wyeth, F. C. Valentinc.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Cary von Noorden. Translated by Boardman Reed, M.D., and published by E. B. Treat, New York.

This little brochure challenges attention at once, because the teachings it contains are at variance with

the views generally accepted by the profession on the subject of diseased kidneys. In cases of acute nephritis the author allows each day $1\frac{1}{2}$ liters of milk, with $\frac{3}{8}$ liters of cream, together with well-cooked cereals. In chronic contracted kidney he limits the amount of fluid. In this way, he says, the percentage of albumen is somewhat increased, the amount of urine is diminished, but the general health of the patient is markedly improved. The misplacement of page 68 in the text is unfortunate. One meets typical Germanic egotism on every page, but perhaps this is pardonable, coming from one who believes so thoroughly in himself as our author does. The flaming red cover of the book is suggestive of the methods of advertisement employed by the publishers of the latest novels.

BOOKS RECEIVED.

A DIAGNOSIS OF THE DISEASES OF WOMEN. A treatise for students and practitioners. By Palmer Findley, B. S., M.D. Illustrated with 210 engravings in the text and 45 plates in monochrome. Lea Bros., Philadelphia. 1903.

A MANUAL OF DISEASES OF THE EYE. For students and general practitioners. By Clarence A. Veasey, A.M., M.D., Demonstrator of Ophthalmology in the Jefferson Medical College; Assistant Ophthalmic Surgeon to the Jefferson Medical College Hospital; Ophthalmic Surgeon to the Methodist Episcopal Hospital; Consulting Ophthalmologist to the Philadelphia Lying-In Charity. Illustrated with 194 engravings and 10 colored plates. Lea Bros. & Co., Philadelphia and New York.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otolaryngology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U. S. A., with the collaboration of William Osler, M.D., Baltimore; John H. Musser, M.D., Philadelphia; Jas. Stewart, M.D., Montreal; John B. Murphy, M.D., Chicago; Thomas M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Ljépsic, Brussels and Carlsbad. Volume 1, thirteenth series, 1903. Philadelphia: J. B. Lippincott Company. 1903.

COOKE'S SIGN OF PREGNANCY.

In a recent textbook written by a member of our Association, the following statement is made:

"Menstrual suppression and morning sickness are placed first in the list of presumptive signs, because the former is the symptom first noticed by the patient and the latter the one that usually brings her to the physician's office. Vesical irritability is, however, in the opinion of the writer, the earliest sign of pregnancy in the great majority of cases, and when, in a married woman, this symptom is followed by menstrual suppression the diagnosis of pregnancy becomes almost certain."—J. B. Cooke, in *Obstetrical Technique*.

Original Articles.

PRESIDENT'S ADDRESS.¹

BY JEREMIAH R. STURTEVANT, M.D.,
Rome, N. Y.

The New Era.

Members of The New York State Medical Association, fellow physicians, ladies and gentlemen:

The choice of your president one year ago, I fear, will ever be shrouded in mystery. I was not even present at the meeting when that honor was conferred upon me, and the first intimation which I received of the fact was its accidental discovery in a daily newspaper.

The association had not even given me an opportunity to say that I would not accept the office. You evidently committed the deed and coolly adjourned, with consciences more or less at rest in the fact that you had chosen an obscure country doctor for this responsible position. I began my task with fear and trembling, and I have feared and trembled still more as its many responsibilities have, one after another, stared me in the face. The one grand feature that induces me to forgive the perpetrators, lies in the fact that from my associate officers and from many others, I have received much kindly aid, given unstintingly, and without which I should have fallen by the wayside. And, while I thank the association for the greatest official honor ever bestowed upon me, I wish at this particular time to emphasize my gratitude to those who have thus so kindly assisted me, and to the gentlemen whose names appear upon the program to-day, particularly those who are our guests and not members of our body.

We, who have been engaged in the practice of medicine for the past thirty years or more, have been living witnesses of a great evolution in the science and art which we love, and as we look back thirty years upon the surgery of that late day even, we shudder as we remember the crude methods and appliances which were then used for the mitigation and removal of human suffering, especially in the light of the methods and means of to-day.

And if we call surgery of thirty years ago crude, what shall we say of the impossibilities and horrors of three-quarters of a century ago, before an anesthesia made possible a vast field of surgical work which, without it, would not be possible. In those days a candidate for amputation was strapped to the operating table, and, despite his shrieks and pleading for mercy, suffered the tortures of the knife and cautery, not that humanity was less humane, but because it was the only salvation of life and limb.

This condition of things necessarily limited the possibilities of surgery, for shock must be reckoned with, and shock is a prime factor in

many of the capital operations of the present day.

The large number of abdominal sections of to-day are rendered possible only by anesthesia. To-day, the victim of serious surgical disease lies down to pleasant dreams and awakens to realize that a new lease of life has been granted him and only made possible by modern surgical appliances. Previous to the last half of the nineteenth century, it is safe to say that millions went to premature graves for lack of that skill and knowledge of the healing art which now obtains. And it is even only during the last quarter of a century that the antiseptic promulgations by the immortal Lister have crystallized into the one word cleanliness, which is next to Godliness, not only in things moral, but in things surgical.

Who will say that boiled water and the normal salt solution have not contributed more to the success of modern surgery than any other means, aside from anesthesia.

A quarter of a century ago the operation for appendicitis would have been considered a capital operation. The country doctor who cannot do it to-day is of little account, and the doctor who does even minor surgery or attend a case of child-birth with finger-nails in mourning, and other conditions corresponding, is guilty of criminal malpractice; while we all remember with amazement how we have rushed into the house and, finding a terrific post partum hemorrhage, have not even waited to perform ordinary ablutions before the hand has been plunged to the rescue. Nothing but the profuse flushing with the life-blood of the patient could prevent dangerous and perhaps fatal contamination; and who knows how many mothers have lost their lives for the want of available precaution on the part of the medical attendant?

But the days of cleanliness have come, so far as the medical and surgical attendants are concerned, and woe be to him who is found guilty of negligence in this respect.

In the realm of medicine great achievements have been accomplished and bacteriology has laid the foundations for cures which heretofore have not been thought possible, and the names of the immortal Virchow, Pasteur and others have been written in letters of living light upon the wall of justly earned fame.

The wonderful X-ray has darted its mysterious, though potent, beams through solid, opaque bodies; and the grinning, living skeleton visually denuded of flesh and blood is exposed to the unobstructed gaze of the onlooker; and foreign bodies in the living tissues no longer are secretly hidden only to be possibly discovered by the dangerous probe or to fester their way out from an unknown hiding place.

The mortality of many of the dread diseases of the past has been greatly reduced. Who of us can doubt this as we so often see the malignant membrane of diphtheria evaporate in a few

¹Read at the annual meeting of the First District Branch in Watertown, N. Y., May 26, 1903.

hours after the timely administration of anti-toxin, and the loved ones saved to their anxious and grief-stricken friends, when, only a few years ago, we helplessly swabbed the throats of the sufferers with impotent remedies and saw them die from the loathsome disease while we stood helplessly by, only perhaps to see other loved ones stricken and we powerless to save them.

Only twenty-six years ago any one who chose could practice medicine without fear of legal prosecution, unless it was too evident that serious results followed; while two courses of lectures attended some time within a stipulated three years, with a certificate from a preceptor, perhaps of indifferent qualifications, brought a medical diploma and all the legal rights and prerogatives of a physician. Some of us know too well the flimsy foundation upon which many made preparation for the noble and glorious (or inglorious) work before them.

The regular medical colleges were slack enough in their requirement while sectarian schools sprang into existence and sought to impress the public with the superiority of their systems.

When, in the early eighties the Legislature enacted a law requiring the registration of physicians, and prohibiting from practice all who were not graduates from an authorized medical college or a licentiate of an incorporated medical society, a new era began, although the law was lenient in showing mercy unto thousands whose only qualification was the fact that they had practiced medicine a certain number of years; and thus was cleared the stream of progress of a large amount of "flood wood" with which it was encumbered.

I would not detract from the vast amount of good done by the honest empiric of those early days, for many of them were bright and shining lights in the medical and even surgical world and their names are still sacred household words in thousands of homes to-day. They were noble representatives of a noble profession and did their work with all their might, according to the facilities of their day and generation.

A vast number of these worthy men began practice after attending one course of lectures of three or four months, receiving years afterward a diploma from their alma mater as a recognition of their faithful service in the practice of the healing art.

But another forward step was taken when all medical colleges were deprived of the power to license their students to legally practice, and that power was vested in the regents of the university, who are supposed to be free from all temptation to flood the country with a horde of men indifferently qualified to cope with disease and injury. With the coming of the control by the regents, all medical colleges have made a vast change in their requirements for graduation, for they well know that students to whom

they have given merely "a lick and a promise" stand very little show of entering the active ranks of the profession.

There are yet, however, occasional survivals of past conditions. The existence in our great commonwealth of three separate State examining boards is a reflection upon the intelligence, not only of the people, but of the broader intelligence of the medical world regardless of the remnant of sectarianism which still, unfortunately, exists therein. Yet the skies are brightening. Few graduates even of sectarian schools are to-day willing to place upon their card or sign any indication of sectarianism, although some very good men still do so. The sectarian designation of years ago has been allowed to gradually fade from the sign-boards of many of our medical friends, as grim experience has broadened views upon the treatment of disease, never to be renewed by the painter's brush. Nearly all are content to be known as physicians and surgeons, and it is, indeed, a rarity to find in the laboratory of any physician or surgeon any evidence of dogmatism. Not so twenty-five or more years ago, and a physician who had been educated simply as a physician, with no special label on his title, could rarely be induced to share professional responsibility with one claiming to possess special qualifications by reason of the school from which he received his diploma.

Although a few of our medical schools still retain their special designation, the law requires so much of medical graduates that dogmatic distinction is a farce.

The New York State Medical Association to-day welcomes to its ranks all ladies and gentlemen who are legally qualified physicians and surgeons, and who will, over their signature, denounce any exclusive doctrine or system, and this regardless of the particular medical college from which they may have graduated.

The day dawns when there will be practically a united profession, and with union there will come strength and power never before known, and the possibilities of procuring the enactment of laws which will be of the greatest benefit to the profession and to all mankind in general become more hopeful. The day has indeed arrived when the physician who willingly lends his influence as a witness against another physician merely for the sake of personal gain is looked upon with well-merited scorn and contempt, as has been exemplified in this very city within the last decade.

A sympathetic and united profession, imbued with the principles of the fatherhood of God and the brotherhood of man, will form a mighty power for good, not only to its members, but to all mankind as well, and will be able to accomplish more than any other earthly organization.

I firmly believe that the two great State bodies will ere long be united in name and reality. But a medical millennium will not arrive

until more yet is accomplished, and, although a new era is upon us, there is yet much to be done. It will be many long years before superstition and charlatanism will be done away with and more legislation is much to be desired in the way of suppressing quackery and fraud upon the public and for the protection of the honorable physician and surgeon.

A law requiring unscrupulous persons who are not financially responsible to give bonds for the payment of costs in case they are defeated in attempts to extort damages from physicians for alleged malpractice is upon the statute books of at least one State, and should be upon those of every State in the Union.

These things will come in time, and in the meantime let us rejoice for the great changes already at hand, and especially that the land of the free and the home of the brave is no longer second to any nation on earth in the standing and advancement of the medical and surgical profession.

A NEW METHOD OF DENUDING AND INTRODUCING SUTURES IN PERINEAL OPERATIONS.¹

BY ALFRED B. TUCKER, M.D.,
New York.

Mr. President and Fellow Members:

THE aim of plastic surgery is to restore the normal relations of the injured parts, especially in all operations on the perineum. It occurred to me some years ago that all operations for laceration of the perineum where the stitches were passed through the skin inward were wrong, for the following reasons:

First.—During the last few weeks of pregnancy the bowels are almost always constipated. This condition causes distention of the levator muscles and a protrusion, or a pushing outward of the perineal body; this condition is increased by the pressure of the head during the third stage of labor, thus weakening the resisting power of the perineum, as all the force is from within, outward. The majority of lacerations of perineums are completed either by the delivery of the shoulders and arms, or use of forceps, the force of both being from within, outward.

Second.—The levator muscles being the support of the posterior of the vaginal wall, the perineal body acts principally as a buttress, deflecting the fecal matter toward the anus; in those cases where the sphincter muscle has not been torn, but the perineal body itself ruptured, so that the buttress effect of the perineum is weakened or de-

stroyed without the loss of power at the anus, the lower rectum is distended by an accumulation of fecal matter, so that the bowel pushes the unsupported posterior vaginal wall forward and outward, and we have a rectocele, which increases in proportion to the constipation and the length of time this condition has been going on. This pushing outward, or protrusion of the posterior vaginal wall (the rectocele), draws the cervix downward and outward into the axis of the vagina, the fundus falls backward and a retroverted or flexed uterus is the complication, and a prolapsus uteri follows to a great or less degree, according to the length of time this condition has been allowed to exist. While conversing, some twelve years ago, with the late Dr. Hunter McGuire, of Richmond, Va., he informed me that in some cases he had used a purse-string suture with some success; this gave me an idea as to the method of passing the suture from within outward. While experimenting with this operation upon the cadaver I found that the usual method of denuding did not lay bare the ends of the muscular fibers ruptured during confinement. I also found that passing the sutures from without inward brought the highest point of the rectocele outward, when it was already forced further in that direction by the forces I have described above than it should have been, this being caused by the greater resistance of the skin over the intravaginal tissues; also that the sutures were not passed outward for the sutures sufficiently to catch the muscular fibers; after eight or ten trials of this operation on the cadaver, I devised the following method:

Instruments.—The instruments needed are three or four artery forceps, a pair of blunt-pointed scissors, a needle-holder, two half-curved Hagerdorn needles an inch and a half long, a small cervix needle, two strands of silk-worm gut, threaded in the Hagedorn needles, and the cervix needle threaded with a mediumly long strand of No. 2 catgut.

Operation.—Starting at caruncle on the left side I split with the blunt scissors the mucous membrane from the skin at their junction, dissecting this flap with the point of the scissors closed until I can grasp it with a pair of artery forceps midway between the two caruncles. Introducing the closed fingers on the flap, I push them up to the highest point of the rectocele, which has been seized by a tenaculum, held by an assistant to steady it, being careful to keep the point of the scissors toward the vaginal mucous membrane. I then open my scissors to the full extent and pull them out. This nearly completes the dissection down as far as the caruncles. I then complete my dissection from without in with the finger, holding the flap between the forefinger and the thumb to steady it. I then cut out the flap from the caruncles, completely removing it. This leaves a denuded surface somewhat triangular in shape, the base formed by the skin from caruncle to caruncle and the

¹Read before the New York County Medical Association, April 29, 1903.

apex by the highest point of the rectocele, with a sulcus midway between the caruncles and the apex. Taking the Hagerdorn needle threaded with silk-worm gut, passing it through the vaginal mucous membrane, midway between the sulcus and apex on the left side, as soon as the needle is through the mucous membrane I pass it well beneath the mucous membrane outward and downward around the sulcus, then downward and outward through the denuded tissue down to (and in case of rupture through the sphincter muscle or bowel) through the sphincter muscle. I then turn the needle upward and inward, bringing it out in the medium line through the denuded tissue, pull the suture well through, catching the distal end of the suture with a pair of artery forceps to prevent its being drawn entirely through. Now pass the needle in, at the point of exit, carrying it well outward and downward, then upward, bringing it out through the mucous membrane at a point corresponding to its entrance on the other side. The second and last deep suture is carried through the mucous membrane midway between the other suture and the apex, carried down and inward until it comes out in the medium line one-eighth of an inch above the skin. Introduce the needle at point of exit, until it comes upward and outward at a point corresponding to its entrance. By drawing these sutures together you will find that the tissues are brought inward and toward each other in the medium line and the edges of the mucous membrane are almost in apposition. Beginning at the apex, with the cervix needle and catgut I make a superficial continuous suture down to the second suture introduced, which is nearest to the apex. This suture is now tied. Continue the superficial line of sutures down to the first suture introduced, which is now to be tied. Now complete the continuous suture until all edges of the mucous membrane are brought together and all bare surfaces covered. I generally dust with some antiseptic powder and apply sterilized gauze pad. The patient is allowed to pass urine herself, and the bowels moved within twenty-four hours. The stitches are removed a week from the day of operation, and the patient allowed to sit up. As nearly as possible I employ the same method in primary operations. In shortening the posterior vaginal wall the cervix is drawn backward toward the sacrum, and the fundus, unless adherent, is thrown forward. The last case I operated upon was a woman, upon whom I operated fourteen years ago, using Heger's method. She had to wear a pessary for ten years—since the birth of her second child, following the first operation. Four weeks ago I performed my operation. In this case I used catgut entirely, using a subcutaneous suture for bringing the mucous membrane together, the two deep sutures being subcutaneous No. 3 catgut. I got a good result, and the uterus is now in perfect position. These two deep sutures do the whole work.

THE ESSENTIALS FOR ASEPTIC LABOR.¹

BY A. ERNEST GALLANT, M.D.,
New York.

The painstaking practitioner will find that the means for carrying out asepsis in the lying-in room are very simple, provided they are worked out systematically, practiced faithfully, and repeated in each case, until from force of habit nothing else will suffice.

The conscientious care of a parturient and puerperal woman involves the same prophylactic measures against infection of the genital tract as the surgeon of to-day would employ before, during and after a major operation, viz., clean hands, clean vulva, sterile instruments, gauze, cotton, towels and boiled water.

Any one who accepts the charge of a pregnant woman should have, for obstetrical purposes only, at least one hand-bag of ample capacity—say, not less than 8x16 inches—of any special design to suit his fancy.

We have found it most convenient to arrange, under three headings, the things without which we feel that it is not safe to attend a maternity patient, without the probability of having to send to the office for something left behind:

DRUGS.

Whisky, 2 oz.; chloroform, 100 gm.; acetic acid, 2 oz.; silver nitrate sol., 10 gr. to 1 oz.; tinct. green soap, 2 oz.; hypodermic case and tablets; ext. ergot, 1 fl. oz.; washing soda, 4 oz.; stethoscope.

INSTRUMENTS.

Obstetric forceps, 2 artery forceps, vaginal dressing forceps, needles and holder, scissors, small and bandage; tenaculum, single, double; Chamberlain tube, nail stick or file, vaginal speculum.

SUPPLIES (*steam sterilized*).

Operating gown, cotton-ball sponges, gauze, 3 to 5 yards; one-half dozen towels (to be boiled in plain water), rubber gloves, nail brushes, rubber catheter, silk-worm gut, $\frac{1}{2}$ oz.; cord-tape or bobbin.

Sterile Supplies.—With the present simple means for sterilization there can be no excuse for the lack of properly sterilized materials, which can be ordered from the drug supply houses or prepared at home. A glance at the list shows that only four articles—gown, gauze, cotton-balls and towels—require to be steam sterilized; the other items can be boiled in plain water, and the instruments dropped in the same kettle, after adding the soda.

No practitioner can afford to be without one or other of the sterilizers now on the market: the sense of comfort and security which the use of sterilized dressings affords will more than repay the very moderate outlay of time and money. The gauze and cotton-balls we place in tin cans, open top and bottom, or small muslin bags; the towels, gown and instruments are wrapped up in

¹Abstract of a paper read before the New York County Medical Association, April 20, 1903.

towels or pieces of muslin about 16x22 inches, with the owner's name and a request that they be returned stamped thereon. These articles, after sterilization, are placed in the bag, and are not opened until the hands have been properly prepared at the bedside.

This plan necessitates keeping on hand several sterilized gowns, etc., in proportion to the number of obstetric engagements, and these should be placed on a convenient shelf or drawer ready to be dropped in the bag at a moment's notice, and the bag always refilled as soon as returned from a case. This bag, this set of instruments, dressings, etc., should be devoted to this purpose only, and the maid or nurse instructed to send it to the patient's home, by the messenger who calls him, thus saving time and the doctor's attendance without this all-important bag.

If the instruments, dressings, towels and gowns are spread out in an orderly way upon a table or stand, much time and confusion will be conserved and the work simplified. The table should be placed at the doctor's right hand, the coverings loosened *before* the preparation of his hands; the instruments and boiled supplies must be spread out upon the towels in which they have been boiled; the drugs can be taken out of the bag and arranged upon the mantel or other handy place; in this way we avoid having to fumble through the bag with soiled or bloody hands, not only destroying the bag, but making it necessary to rewash the hands.

Clean Hands.—Perhaps no term in surgery or obstetrics conveys so varied a meaning to the profession at large as that of clean hands. To us, as to Lawson Tait, that real pioneer in *clean* surgery and to those who follow the teaching of Koch and many others, especially during the past few years, the term *clean hands* is one fraught with immense significance; hands which have been scrubbed, scrubbed and scrubbed, and can be depended upon to do clean surgery, general or obstetrical; hands free from contact with any dangerous, alluring, deceitful, poisonous, anti-septic drug, of which, during the past ten years' work in surgery and obstetrics, I have never made use on a single occasion.

Hand Cleaning.—For this purpose I first thoroughly anoint the hands and arms, up to the elbows, with the tincture of green soap, rubbing it into the skin until dry, and again rub in more soap, being particular to work it well under the nails and between the fingers, and then proceed to scrub, scrub, and scrub again, in running water, until *all the soap has been removed*. This is not as easy a matter as you might imagine, but when all the soap has been scrubbed off, and the nails well cleaned with a nail stick or file, one can rest assured that his hands are clean. Do not stop short of complete removal of all the soap; do not use alcohol to remove the surplus lather; scrub, scrub in the running water until no soap remains. Perhaps some will say that this takes

too much time, but five minutes' additional scrubbing may make a great difference to your reputation and either save or kill your patient. Certainly one cannot afford to take such risks for the sake of five minutes' extra care of his hands. It will but rarely happen that matters are at such a pass that one cannot take time for this purpose. I know of no instance which calls for the introduction of the fingers or hand into the parturient canal which will not permit of taking time to thoroughly prepare the hands.

Rubber gloves appeal to me as very convenient if one has recently been handling septic wounds, or after operations in which the hands have come in contact with pus; though, whenever I anticipate pus at an operation, it seems much better to put on gloves than to soil the hands, keeping those members free from pus by every means in our power.

Examinations.—To the trained hand and ear external examination by palpation, percussion and auscultation will in most instances reveal all the necessary information as to position, presentation and progress, especially during the first stage of labor. We must not forget that the findings of Semmelweis, in 1868, still hold good—viz., that women who have not been examined internally before, during or after labor, rarely, if ever, develop puerperal fever. We may well make it a rule that if the position and presentation are found to be normal, and the labor progressing satisfactorily, the less we examine internally the safer for our patient.

Internal Examinations for diagnostic purposes need not, in every case, be preceded by scrubbing of the vulva, or a vaginal douche; but when any operative measures are to be carried out one cannot be too thorough in the preparation of the external, genito-anal region, cutting close the hair, anointing well with green soap, and thorough scrubbing, until all traces of the soap have been removed.

If seen early in the first stage it may be well to give a soapsuds enema, but if late, personally I prefer to remove formed feces as they are expressed through the anus, than to be annoyed with the fluid contents of the bowel, from a too recently administered enema, being ejected over everything and everybody within range.

Dr. George Tucker Harrison spoke in terms of high commendation of this operation, which he characterized as the best of the many so far proposed for the repair of the perineum. The trouble with most of the previous operations was that they ignored the true anatomical relations. This new operation not only yielded very satisfactory results, but caused the patient little discomfort and was attended by little loss of blood.

With regard to aseptic labor, he would say that he was opposed to frequent vaginal examinations, no matter how much care was exercised in cleansing the hands, for it was well known that

the hands could not be rendered sterile. In his opinion, the best method of cleansing them was by the use successively of alcohol and a one-to-one-thousand solution of bichloride.

Dr. Ralph Waldo said that while he had had no personal experience with Dr. Tucker's new perineal operation, his interest in it had been aroused because it contained certain elements of success, viz.: (1) It went well up the posterior vaginal wall; (2) it denuded through the thickness of the vaginal mucosa, and (3) it exposed the fascia and underlying muscle.

Dr. Joseph B. Cooke was disposed to lay the blame for much of the indifferent obstetric work met with in general practice upon the poor fees generally paid. He was not afraid to make as many vaginal examinations as were indicated because he was confident that his hands were clean. An obstetric outfit for use in general practice should not be so arranged as to require disinfection to be done at the physician's office.

Dr. Robert Abrahams did not think Dr. Gallant's outfit was well adapted for obstetric work among the very poor. His own methods, like those of many of his colleagues, were much less elaborate, but that they were effective was attested by the fact that deaths from puerperal sepsis were unheard of and there was only a trifling percentage of morbidity. If the obstetrician were clean, if he were carefully to completely remove all of the placenta and if all lacerations were promptly closed by suture he would rarely meet with sepsis.

Dr. James Moran, speaking from the same point of view, said that the physician in general practice could be spared the trouble of carrying around so many things if he would only see to it that his patients were instructed as to what things were needed, and to have them on hand before the expected time of confinement. This plan was most effectively carried out by handing to each woman when an obstetric engagement is made, a card with printed directions.

Dr. Eden V. Delphay said that the development of sepsis was largely a question of individual susceptibility. This would explain the apparent immunity from this scourge among the very poor, who, in spite of filthy surroundings and inadequate precautions, were not nearly so prone to become septic as their more well-to-do sisters. The perineal operation which he had found most satisfactory was then known as the Hegar-Martin operation. In this operation each layer of tissue was brought together accurately.

Consulting Physician to Manhattan State Hospital.—Dr. Carlos F. Macdonald, former president of the State Lunacy Commission, has been appointed by the present State Commission Consulting Physician to the Manhattan State Hospital, a position which his large experience as an alienist eminently entitles him to fill.

CLINICAL HISTORY AND TREATMENT OF DIABETES.¹

BY CHARLES O. GREEN, M.D.,
Hornellsville, N. Y.

DIABETES signifies simply an increased flow of urine; the term is applied to two affections, which differ notably from each other. In one affection, a low specific gravity (which means a small proportion of solid constituents). The specific gravity of this type is sometimes only a little above that of spring water; the morbid abundance of urine is due to the excessive elimination of water by the kidneys, and is therefore called diabetes insipidus. A morbid excess of water in the urine, as hydruria and polyuria, occurs in various pathological connections, as granular kidney, waxy kidney, enlarged prostate, and sometimes in other surgical affections of the urinary organs; also a symptom in cerebral diseases, lesions caused by injuries to the skull; it is often a symptom in some nervous affections, as hysteria, asthma, etc. There's no essential change in the composition of the urine, with the exception of an increased amount of water; the excessive need of drink and the frequent act of micturition occasion annoyance and interfere with sleep. It may not otherwise interfere with health. Patients affected in this way are able to perform manual labor; women have borne healthy children and their lives have not been shortened by it. Apparently, it does not interfere with appetite, digestion or nutrition. There are cases on record where it has been tolerated for fifty years. Of the prognosis Dr. Senator says: "Recovery is rare, and death is still more rare."

In the other affection—viz., diabetes mellitus—the notable increase in urine is usually the first symptom which awakens the suspicion of the patient; he describes frequent acts of micturition, passings large quantities of urine, which is pale in color, and usually clear; of a sweetish odor, and attracts flies and bees. The density is in proportion to the amount of sugar it contains. The specific gravity ranges from 1025 to the extreme 1070. The amount of water in the urine is increased, and hence the increase in the quantity of urine, which sometimes is enormous, amounting to fifty pints in twenty-four hours. The frequent acts of micturition are a great source of discomfort, especially during the night, when they interfere with rest and sleep. The action of sugar upon the mucous membrane of the urethra produces a sense of heat, and sometimes a stinging pain; in some cases it produces an excoriation of the prepuce and glands, which at times leads to phimosis.

In women, eczema of the vulva, which gives rise to distressing pruritis. Cases are reported where more urine is voided in twenty-four hours than the amount of liquids ingested during the same time.

The amount of sugar varies in different cases, usually being less at the onset, and increases as

¹Read before the Steuben County Medical Association, April 6, 1903.

the disease progresses. In exceptional cases the amount of urine is not increased, but abounds in sugar. The proportion of sugar varies between $\frac{1}{2}$ to (in extreme cases) 15 per cent.; usually from 2 to 4 per cent. is found. Emaciation is usually marked, after the disease has existed for some time; the rapidity of the emaciation is in proportion to the amount of sugar in the urine, and is greatly affected by the condition of the digestive organs. An increase of appetite is a prominent symptom; when the appetite is not increased it is an exception; it usually fails entirely as soon as the disease assumes a chronic form. Dryness of the mouth is a source of considerable annoyance; the tongue, besides being dry, is very red; the gums are also red, and bleed readily on pressure; the teeth become loose and carious. Constipation is the rule, but diarrhea alternates. The circulation often offers important symptoms; the pulse, if at all affected, is oftener retarded than accelerated; capillary congestion of the surface is a notable symptom. Failure of the heart action will occasion sudden fatal termination. The body temperature is abnormal, often as low as 95; itching of the skin often present. Carbuncles, boils and various eruptions, as eczema and psoriasis. Spontaneous gangrene of the lower extremities is an occasional occurrence, which resembles senile gangrene. Muscular weakness is more or less marked. Amblyopia occurs early in the disease; retinitis is a common symptom, and soft cataract is often developed. The mental condition undergoes a change; the patient becomes irritable, melancholic, hypochondriacal and hysterical; sometimes severe neuralgic affections, such as sciatica and trigeminal. The most important is diabetic coma, the advent of which may be very sudden.

The course of diabetes is usually slow, and before being brought to the physician's notice has existed for a considerable period; therefore, the date of the origin is usually obscure. Griesinger found the mean duration of 225 cases was between two and three years.

The subject of diabetes mellitus is especially interesting to me at the present time. I have a very important case, whose welfare has given me a great deal of anxiety, and, with your permission, Mr. President, I would like to give a brief history of the case since being under my observation:

In March, 1902, Mrs. K. came to consult me in regard to her eyes. Upon examination I found that she was suffering from amblyopia. Upon inquiry I learned that she had been passing large quantities of urine, drank a great amount of water, and had suffered alternately from constipation and diarrhea for the past five years, and was then beginning to lose flesh. The urine contained about 6 per cent. sugar; specific gravity was 1032, and the quantity was three quarts in twelve hours. She was put upon a strict diet, with an eighth of a grain of codeine every four hours, and a sumbul compound as a general nerve tonic.

The percentage of sugar rapidly diminished to 1 per cent.; she continued to lose flesh, suffered from loss of sleep and severe pruritis. This condition continued for several months, when, in consultation with one of my colleagues, the codeine was changed to morphia (the administration of which has been kept up to the present time), also hemaboloids, with nuclein, were prescribed, both of which her stomach would not tolerate. She has become irritable, lost her appetite, hysterical, developed stomatitis, gingivitis; has a dry, red tongue; became anemic and very much debilitated. Throughout it all her heart action has remained A No. 1. She has been unable to take any solid food whatever for the past three months. The dose of morphia has been gradually increased, so that she now takes $2\frac{1}{2}$ grains in twenty-four hours. When she is under the spell of the morphia she suffers no inconvenience, with the exception of the dry tongue and mouth.

Since the reading and discussion of this paper before the Hornellsville Medical and Surgical Association, March 2d, a complication has developed which has minimized her chances for recovery very much, this being a fibro-sarcoma, which to me was an unknown complication in diabetes mellitus, but Dr. Robert Sundby says that diabetes disposes to the growth of tumors. This tumor has developed very rapidly, and seems to increase the more rapidly as her system becomes weakened; its attachment seems to be to the left horn of the uterus.

The administration of arsenauo was commenced soon after the discussion, but met with the same results as all other remedies, a rebellious stomach.

Things have gone from bad to worse, until at the present writing she is in a diabetic coma, and I fear before the time arrives for the reading of this paper she will have gone to the far beyond.

Treatment.—The treatment of diabetes mellitus is divided into three forms—dietary, supportive and symptomatic—and until its pathology has been made more clear, the same routine will be followed out as in the past. The ordinary practice seems to be to copy a dietary out of the text-book or one furnished by a proprietary medicine company, hand it to the patient with a prescription for some preparation of opium, or one of its alkaloids. The diet list is too lengthy for me to attempt to give in this paper. Codeia seems to be the most favorable of the opium alkaloids. The powdered extract of jambul, or the tincture of the seed, has a great reputation in the East Indies. Innumerable specifics are recommended. Every writer of note has one. (Martineau's specific), antipyrine, in 15-gr. doses, thrice daily; (Germain's) sulphide of calcium, in $\frac{1}{4}$ to $\frac{1}{2}$ gr. doses, three or four times daily; (Caldwell's) creosote, 4 to 10 drops daily; (Valentine's) phenacetin and exalgin; (Beaumont's) camphor; (Peyrand's) iodoform; (Moleschott's) nitro-glycerine; (Kennedy's) salicin; (Dorn-

blüth's) carbonate of soda, with citric acid; (Stadelmann's) sulpho-carbolate of soda; (Monckton's) nitro-hydrochloric acid, with tincture of nux-vomica; (Wilk's) cocaine, $\frac{1}{4}$ gr., three times daily; (T. Oliver's) pepsin, 10 gr., three times daily; (Gemmel's) $\frac{1}{50}$ of a grain of phosphorus, three to six pearls daily.

In my own opinion, I do not think that any of these drugs are specifics; possibly, if the disease were discovered at the onset, some might act in a palliative measures. The support of the patient is the most essential thing; digestion must be guarded; consequently, predigested foods are necessary.

Symptoms must be controlled as they present themselves, and, to sum it all up in a nutshell, opium or one of its alkaloids is the only reliable drug.

In the management and treatment to a successful termination of diabetes mellitus, I, for one, am a total failure.

INTESTINAL OBSTRUCTION.¹

BY J. B. HARVIE, M.D.,
Troy, N. Y.

IN presenting this subject I feel that it is one in which the physician and the surgeon have a common interest. By obstruction of the bowel I mean any condition which will interfere with the continuity of the intestinal canal. This condition may be either acute or chronic, and the obstruction may be either partial or complete.

Of the acute lesions the different herniæ may be classed among the most common, while twists in the bowel and intussusception will follow in the order named; early postoperative adhesions, concretions, impacted material and foreign bodies claim a goodly percentage.

Late postoperative adhesions, malignant diseases and benign growths may be mentioned among the instances in which premonitory evidences of impending obstruction may be noted for some time prior to complete stoppage.

In arriving at a diagnosis in the acute cases a careful search should be made for a possible hernia. It is surprising how frequently a hernia may be overlooked. I have seen a number of instances in which severe abdominal, colicky pain and incessant vomiting had been going on for several days before this lesion was discovered. A certain hesitation to expose females to a more searching investigation may just result in this calamity.

In the case of external hernia, however, the cause of the trouble is usually readily cleared up. In this we have a distinct tumor to guide us, but in hernia of the diaphragm and obturator hernia, when no tumor can be felt, one is forced to rely entirely on the symptoms present for a diagnosis.

Whatever the cause of acute obstruction may be, the symptoms are generally quite marked.

The acute pain which at the outset is apt to be intermittent, soon becomes continuous, the persistent vomiting beginning with the food taken, then material mixed with bile or pure bile, until the rejected material is stercoraceous or fecal. Distention of the abdomen is generally present at this time, and obstinate constipation always, but that all these symptoms are ever present to make our line of action clear is far from usual.

How many of us have operated strangulated herniæ, which have existed for days, time and again with little evidence of trouble beyond the local tumor with devitalized bowel in the sac and general peritonitis present. All this occurring without the vomiting or distention and no marked discomfort.

This state of affairs applied to an internal block will wrap the case in sufficient obscurity very often, so that when the doubt can be cleared up, only one result can be looked for.

One will frequently find himself in a quandary regarding what to do.

We have all seen cases where the condition seemed reasonably positive that obstruction existed, but subsequent developments proved the contrary.

I was asked by Dr. English, of Troy, to see a case which he had diagnosticated as acute obstruction with reference to opening the abdomen. The patient had been suffering three or four days with severe pain, which was referred to the region of the umbilicus, constant vomiting of dark-brown offensive material and distention of the abdomen, but the constitutional symptoms were not quite so active. The case, however, seemed one in which delay was unsafe, and her removal to the hospital was decided upon.

While she was making preparation to be transferred, she felt something move, and shortly a free evacuation, followed with such marked relief that all necessity for operative work was eliminated. Within a few hours another movement brought along the concretion which I show you.

This concretion seems to be made up of cholesterine and bile salts, and no doubt had its origin in the gall-bladder, finding its way into the intestinal tract by a process of ulceration.

Postoperative adhesions may lead up to a sudden obstruction, but as a rule the premonitory evidences of interference with the patency of the tract are sufficiently in evidence to permit of relief before a complete tie-up.

The most common cause of chronic obstruction of the bowel will be found to depend on some malignant growth, and I desire to speak more particularly of obstruction created in that particular way.

When a diagnosis of malignant disease of the intestine can be made, it has usually made considerable headway. In the absence of obstructive symptoms or pain there is nothing, as a rule, to direct the patient's attention to the insidious process, and it may be that the disease may

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

have progressed far beyond its starting-point, that regional infection may have taken place and constitutional evidences have become marked, such as emaciation, blood disturbances expressed in anemia, etc. The disease can only arrive at this stage, however, without manifesting itself to the patient, in instances where the patency of the bowel is maintained and involvement of nerve trunks has escaped. Usually there is sufficient narrowing early in the history of a malignant neoplasm attacking the intestinal tract to cause some resistance to the passage of the contents, causing at times a partial block or accumulations of gas, which the patient is perfectly conscious of, and can very often locate and demonstrate its presence by his own sense of touch. A good deal of colicky pain is always present in such instances, and complete relief obtained when the bowels have been thoroughly evacuated.

The moment a malignant process involving the bowel is suspected and before the patient has suffered particularly from the inroads of the disease and extensive regional involvement has taken place, it would seem the opportune time for a radical operation.

When a diagnosis of malignant disease has been made and an operation has been decided upon, the work, if possible, should be as complete as the circumstances of the case will permit. The condition of the patient and the location of the growth will invariably determine our line of action. A radical operation with the removal of the entire portion of the bowel involved, together with the complete dissection of the corresponding attachment, insuring, if possible, its complete extirpation, is positively necessary.

Usually malignant tumors select some portion of the large intestine, with an unusual preference for either the sigmoid flexure or the rectum. Ordinarily the obstruction may be removed, and an intestinal anastomosis made, if the trouble occur not lower than the upper third of the sigmoid flexure of the colon; below that point the disease will be attacked from the rectal outlet and its removal effected in that particular way. If possible, the destruction of the sphincter ani muscle should be avoided, but its preservation should never be considered when the lower part of the rectum has been attacked. The establishment of an artificial anus is something to be avoided, but will come up as an inevitable proceeding in the instances where it is inexpedient to attempt the removal of the entire mass and the operation is undertaken solely for the purpose of relieving the obstruction and prolonging life.

F. W., on entering Troy Hospital, October 5, 1901, gave the following history: 71, married; flagman; F. H., negative. Personal history: Has never been ill, except with fever at age of 12 years; no specific history and no history of injury. About March, 1901, began complaining with some discomfort in right side of abdomen near caput coli. More or less constipation became evident, and very soon he was aware of a

collection of gases at this point which he could dislodge by pressure. The pain was not acute, and did not even disturb his night's sleep until the early autumn. When he entered the hospital he was aware of the existence of tumor in his right abdomen, suffered a good deal of colicky pain, and bowels moved with the greatest difficulty. He had lost flesh, appetite poor, and his nights very restless. Had never vomited and no evidence of mucus or blood in his passages.

Examination.—Somewhat emaciated, muscles soft, abdominal walls flabby, skin and mucous surfaces pale; a prominence noted at outer border of right rectus muscle on a level with the umbilicus. Patient refers all his discomfort to this area.

On manipulation distinct gurgling can be elicited, which causes well-marked discomfort. The mass impresses one as being more or less nodular and seems to extend from the caput coli to the commencement of the transverse colon. Its free border is movable, but the base firmly attached. The fingers can be pushed between the lower border of the ribs and tumor.

Diagnosis.—Malignant disease involving the caput coli and portion of ascending colon.

Operation.—Incision made over tumor at right border of right rectus muscle, about four inches in length. The new growth was seated in the *large bowel*. The mesentery of three inches of ileum, caput coli and almost entire ascending colon was the seat of a new growth, with attachments so deep that its removal seemed impossible. The small bowel was divided as you see in the specimen, and a process of dissection begun. The mesenteric glands were intimately adherent to and mixed up with important vessels. But as you can readily understand, with such widespread infection, and in this neighborhood particularly, the complete eradication of the disease was impossible. However, the intestine, as you see here presented, was excised, and represents a portion of the ileum, the caput coli and most of the ascending colon.

A lateral anastomosis was made by means of mattress sutures of fine silk. No bowel disturbance was noted after the operation. The post-operative history was uneventful. The patient returned to his work flagging at a railroad crossing, continued in good health for some time, the bowel performing its work in a perfectly normal way until the time of his death, which occurred eight months afterward.

Microscopical examination made by Dr. George Blumer, of Albany—adeno-carcinoma.

CASE II.

Mrs. H. R., entered Troy Hospital November 14, 1901, and gave this history: 43, married, Norway; F. H., negative, so far as she knows, except that one sister died with consumption.

Past history: Has always enjoyed good health; menstruation began at 15, always regular, nor-

mal in amount and duration; married at 30, and never had children.

Present history: Was perfectly well until the early part of June, 1901. Illness began with vomiting and pains in the abdomen, referred particularly to the left iliac region, some distention. June 10th took a dose of Epsom salts, which was followed next day by a movement. The dejecta was small in amount, and this was the last material passed of a fecal character until she was operated, November 18, 1901.

She had a constant desire to evacuate the bowels, but never succeeded in passing even the smallest amount of flatus. The abdomen became distended. The patient could see this becoming larger daily. The history of the case from the outset of the illness until she entered the hospital resolved itself into vomiting after all food taken; enlargement of the abdomen, absolute constipation and progressive loss of flesh. The vomitus consisted of food taken and never was bad-smelling or fecal in appearance.

Examination on entering hospital November 14th. Patient much emaciated, says she has lost fifty pounds; facial expression much the same as one would find in a well-advanced ovarian cyst. The abdomen is universally distended; the coils of intestine, particularly the large bowel, stand out prominently; percussion note is high pitched, not tympanitic, and manipulation gives one the impression of a solid mass. The abdomen is not sensitive; no areas of tenderness.

Bimanual Examination.—Uterus large, pressed down in the pelvis and immovable. Impossible to outline it on account of the enormous abdominal distention and engorged condition of pelvis. Rectal examination negative.

Diagnosis.—Probably uterine fibroid, causing a block in the lower bowel.

Operation November 18th.—Exploratory celiotomy. Finger passed in abdomen demonstrates a good-sized fibroid apparently blocking the entire pelvis and preventing the further descent of intestinal contents. Intestines completely loaded with fecal matter; large bowels distended to utmost capacity. A considerable quantity of serous exudate in peritoneal cavity escaped freely when abdomen was opened. Intestinal peritoneum much injected, but no exudate of lymph or acute peritoneal trouble. The condition of the patient, as you may well imagine, was not such that a hysterectomy could be done, and I closed the abdomen and did a left inguinal colostomy. The descending colon was plainly to be seen through the abdominal wall, and I cut down in it, bringing it into the line of incision, and after suturing it to the peritoneum, made a longitudinal incision. The amount of material escaping far surpassed my expectations. I should say gallons of fecal matter ran away, and continued to discharge at an enormous rate for days. The patient soon rallied from the operation, and soon evidenced a notable gain in spirits and ability to take food.

Second Operation.—The further history of the case until December 18th would be uninteresting and tiresome. On that date I reopened the abdomen for the purpose of doing a hysterectomy, the uterus being considered the cause of the block. A pan-hysterectomy was done, the patient standing the proceeding very well, but on examining the sigmoid flexure of the colon just as it passes over the brim of the pelvis, I found a complete closure in the gut, due to a malignant neoplasm. This meant an intestinal resection, and those who were present and assisted me will remember the difficulty associated with making an intestinal anastomosis at this point, working low down in the pelvis on a patient whose ability to withstand such a long-drawn-out performance was more than could be reasonably expected. A lateral anastomosis was made in this case also. I made no attempt to close the fistulous opening in the colon; the patient's condition would not permit of it. The postoperative history was uneventful. The patient made a rapid recovery, and the artificial opening has since closed spontaneously. The occlusion of the bowel was absolute, and occurred just at the pelvic brim. While the specimen was recent it was found impossible to pass even the smallest probe through the stricture.

Microscopical examination by Dr. George Blumer, of Albany—adeno-carcinoma.

The histories of these cases point strongly to the gradual onset of the trouble with well-marked clinical symptoms which should have been unmistakable, but notwithstanding this, all idea that interference could be practiced successfully seemed to be lost sight of. The operative histories were sufficient to demonstrate the practicability and the almost positive favorable outcome if early operation had been done. If any permanent good can follow such a proceeding, it is reasonable that with the earliest manifestation the abdomen should be opened. Malignant growths, no matter where located, are among the most insidious, and when their presence is demonstrated by the existence of pain, we might better not operate ordinarily, inasmuch as pain is always a late symptom of cancer and is sufficient evidence, as a rule, that the disease has traveled far beyond its starting point. The higher up the growth the greater the likelihood of regional infection. Most of our stomach cases are early associated with secondary deposit in the liver, and it will be rare indeed to find a malignant growth in the small intestine without engorgement of the mesenteric glands. Regional infection, however, in the large bowel, as a rule, comes later, and the prognosis for non-recurrence correspondingly brighter.

In conclusion, I desire to say that the intestinal tract, beginning with the stomach and extending throughout its entire length, furnishes the greatest opportunities for brilliant surgery, both as to immediate recovery and lasting benefits.

STRANGULATED HERNIA IN CHILDREN UNDER ONE YEAR.¹

Report of a Case, 27 Days of Age—Herniotomy—
Recovery.

BY W. B. REID, M.D.,
Rome, N. Y.

STRANGULATED hernia in a child so young is extremely rare, and it is my privilege to here record the youngest to have been operated upon by an American surgeon since the aseptic era.

Though the writer has been able to find 105 cases of herniotomy for strangulation in which the patient was under one year, this number is seen to be small when compared with the number who suffer with congenital hernia.

The ground for this statement is based on the result of a research through the German, French, English and American medical literature, and includes the last compilation on the subject by Dowd, in April, 1898.

Since the date of Dowd's paper a period of over four years has elapsed, and only six cases of strangulated hernia in children under one year of age have been recorded, and this number includes the one here reported. Thus in spite of the fact that congenital inguinal hernia is quite common in children, the occurrence of strangulation in a child under one year of age is extremely rare.

The explanation of the rarity of strangulation in infancy is to be found in the softness at this age of the involved structures.

Important and exhaustive studies upon the subject have been added to medical literature by Dowd,¹ Tariel,² Stern,³ Knobloch,⁴ Fere,⁵ Marsli⁶ and others.

Therefore, the purport of this article is simply to record my own case, and add the scattered cases which have been operated since Dowd's report in 1898, that it may help make statistical material from which future deductions may be drawn.

The Author's Case.—On February 21, 1902, in response to a call from the parents, the following history was obtained from the mother of the patient:

J. F., male, 27 days, the second child, had been to all appearances a robust babe at birth, and had given no more trouble than the first baby. The previous evening the child began to cry and fret, as if in pain, and without apparent cause. At the 9 o'clock feeding the nurse was refused, and the little taken was immediately vomited. The child vomited again during the night, was cross, and cried almost constantly. In the morning, on changing the napkin because of urinary soiling, the mother noticed a "bunch on the right groin" and sent for me.

At the time of my visit she made the positive statement that the bowels had not moved for thirty-six hours.

Physical Examination.—A fat, robust-looking child of usual development. The facial expression was one of pain and distress. A tumor was found in the right inguinal region the size of a hen's egg. Palpation showed it to be very hard and tense, no fluctuation, and absence of any impulse when the child cried. It was, in fact, very tender, any attempt at examination being followed by severe crying and demonstrations of acute suffering.

The diagnosis of a strangulated hernia was given. The child was suspended by the feet with the head hanging down, and by gentle taxis an attempt was made to reduce the mass. Failing in the attempt, and realizing the possibility of a hydrocele of the cord, counsel was asked for and agreed to by the parents. I sent for Dr. H. C. Sutton, who not only agreed with the previous diagnosis, but also suggested that before giving an anesthetic for the purpose of reduction, the child be removed to the hospital, where it would be possible, should taxis fail, to operate at once. The child was immediately taken to the hospital and prepared for operation.

In the interval hot sterile applications were constantly applied. Under anesthesia a most thorough, yet careful, attempt was made at reduction. Failing, we promptly resorted to the operation.

Operation.—An incision $1\frac{1}{2}$ inches in length parallel with Poupart's ligament was made over the most prominent part of the tumor. The overlying tissues were divided down to the sac. This was now opened and found to contain about 2 drams of dark, serous fluid, the lower part of the cecum and appendix and about 2 inches of the ileum. The intestines were very dark, due to the severe congestion caused by the strangulation. The point of strangulation was located at the internal ring. The constriction was found to be so very tight that it was impossible to return the gut before cutting the obstructing band. It was found necessary to divide the latter in two places. An incision was made with a blunt, pointed, curved, herniotomy knife, on the inner and upper portions of the ring. The sac was then separated, ligated and divided at the internal ring. The incisions in the ring were closed with catgut. The canal was closed with a running catgut ligature, care being taken to keep the cord well out of the way. The skin was closed with catgut and strengthened by two silk ligatures. During the closure of the canal the child suddenly became cyanotic and ceased to breathe. The anesthetizer failing to start respiration, declared the child to be dead. Suspending the operative procedure, blowing in the child's mouth, swinging it and using continuous artificial respiration, we finally succeeded in resuscitating the little patient.

The operation was then finished without more chloroform. In spite of the interference with the aseptic technique of the operation, primary union followed. The day after the temperature rose to 102, but dropped the same evening, and

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

remained nearly normal during an uninterrupted convalescence.

The wound was dressed with sterile gauze, and a large pad of cotton firmly bandaged over the incision. It seems the pad of cotton reinforces and helps to strengthen the canal during the healing process. Should it be necessary for me to perform this operation again in a child so young, I should use the plaster of paris dressing over the cotton pad. We found it extremely difficult to hold the pad in place with the ordinary bandage.

A word in regard to the technique of the oper-

ation. If the operator will start with this point in mind, that he not only wishes to relieve the immediate strangulation, but also produce a permanent cure of the hernia, he will be more particular in his dissections.

The incision should be well away from the point of strangulation where the tissues are nearly normal. When the point of strangulation is located at the external ring, the strangulation should be approached from above; when at the internal ring, the opposite incision and approach will render the technique more easy. The more

CASES OF STRANGULATED HERNIA IN INFANTS LESS THAN ONE YEAR OF AGE WHICH HAVE BEEN OPERATED SINCE DOWD'S REPORT IN 1898.

NO.	OPERATOR.	AGE OF CHILD.	VARIETY OF HERNIA.	CONTENTS.	DURATION OF STRANGULATION.	METHOD OF OPERATION.	RESULT.	REMARKS.
I.	C. C. Allison, Western Medical Review, April 1, 1898, Omaha, Neb.	34 days.	Left ing. region.	Eight inches of small intestine.	30 hours.	Bassini.	R.	Dr. Allison makes a misstatement of facts in the report of this case: "But one case of strangulated hernia in an infant at a younger age than this one has been reported." Note Case I, Case II. in Dowd's Report (1), and other cases previously recorded.
II.	Dr. C. McLarin, Lancet, 1281, May 5, 1900, Prince Alfred Hospital, Sydney.	14 days.	Cong. right ing.	Small intestine, 4-5 in., ileum (?). Some mesentery.	36 hours.	Stitching int. ring. Running stitch in canal. Sac left in situ.	R.	Possible recurrence owing to faulty technique.
III.	Mr. D. Arcey Powers, The Lancet, April 15, 1901.	5 weeks.	Left inguinal cong.	Little piece of mesentery. Knuckle of small intestine.	3 days.	Division of construction at int. ring. Sac isolated and ligated in two places. Distal portion left for tunica and agnialis. Proximal stitched to surface of abdominal wall. Ext. ring closed with a continuous suture.	R.	
IV.	Alexis C. Moschowitz, Med. Rec., 1901, page 612.	4 months.	Cong. right ing.	Returned without opening sac.	7 hours.	Sac separated and ligated without cutting or dilating. Closed with a continuous suture. No trouble in reducing contents.	R.	This case might have been reduced by gentle taxis at the hands of some operators.
V.	Alexis C. Moschowitz, Med. Rec., 1901, page 613.	3 months.	Right ing.	Large and small intestines.	2 days.	Opened over tumor. Sac not extirpated. Suturing of overlying structures.	R.	

CASES WHICH HAVE BEEN BROUGHT TO THE AUTHOR'S NOTICE THROUGH DISCUSSIONS AND CORRESPONDENCE, BUT AS YET HAVE NOT BEEN REPORTED.

I.	Dr. I. S. Haynes, New York.	5 weeks.	R. ing. oblique congenital.	Intestine, small.	From 4-6 hours.	Bassini. Fine chromic catgut for all sutures. Time of operation, 25 minutes.	R.	Primary union, perfect result. Dr. Haynes says: "This was a typical case. I have dissected a great many infantile subjects of this age, but never operated on the living for inguinal hernia. The structures showed beautifully, and though delicate caused no trouble, but came together nicely. The entire Bassini technique was carried out, only I prefer chromic gut to silk. The result was perfect; everything held, even when the baby cried. Of course, we didn't let him cry any more than we had to for the first week. Three months after the operation the scar was solid."
II.	Dr. M. M. Lucid, Tully, N. Y.	5 months.	Oblique inguinal.	Dark serous fluid.	12 hours.	MacEwen.	R.	
III.	Dr. M. M. Lucid, Tully, N. Y.	3 months.	Direct inguinal.	Small intestine.	6 hours.	Bassini.	R.	

closely it is possible to follow the routine Bassini operation, the more we may expect ideal results, so far as the radical cure of the hernia is concerned.

In a case of strangulated hernia in an infant two questions at once present themselves:

1. Should taxis be tried, and to what extent?
2. What is the prospect of relief by operation?

In answer to the former, all surgeons agree that gentle taxis should be made after the hot bath, or after hot applications have been applied a sufficient length of time to secure as complete relaxation as possible. During taxis, it is my suggestion that the child be suspended by the opposite foot on which the strangulation occurs, with the leg on the same side flexed, the head hanging down, the body being in the meantime held gently, yet firmly, by an assistant. This can best be accomplished by placing a thumb over either shoulder and holding the child's back in the palms.

The answer to the second question depends on the length of time after strangulation the patient is seen by the physician, and his subsequent treatment.

Operation is always demanded. Even in apparently moribund cases it may prove the life-saving measure.

The prognosis in a given case depends on the amount of previous damage by taxis, and how early to which operative measures have been resorted. "The operation of itself causes little danger to the patient. The real danger comes from injury to the intestines, through long-continued strangulation. These infants stand the operation remarkably well. Their recuperative powers are very good, and their wounds are less apt to become septic than those of adults.

"Thus we see that in hardly any of the fatal cases was the operation done promptly. In nine of them (speaking of the 100 previous cases) there was gangrene of the intestine, a condition of collapse, fecal vomiting, etc., at the time of operation. We find repeatedly that operation was delayed on account of the tender age of the infant, and that attempts at taxis were made, one after another, until the conditions were most unfavorable. Delay and repeated attempts at taxis are far more dangerous than operation. One cannot judge closely of conditions by the meager histories given, but so far as we may judge, the mortality of strangulated hernia in children under one year of age would be considerably less than 10 per cent., if the operation were promptly done by surgeons who have only the average experience."

The soundness of Dowd's logic is borne out in this report of nine operative cases without a death.

It is my sincere conviction that were these cases of strangulated hernia in children operated upon under aseptic conditions and early before

they had been maltreated by taxis, the mortality need not be more than 3 per cent.

W. R. REID.

REFERENCES.

1. Dowd's Archives of Pediatrics, vol. xv, 1898.
2. Stern. Centralblatt of Chirurgie, 1894.
3. Tariel. De la hernie unguinale estranglee chez l'enfant. These de Paris, 1894.
4. Knobloch. Inaug Dessertation, Breslau, 1890.
5. Fere. R vue de Chirurgie, 1881, p. 266.
6. Marsh. St. Bartholomew Hospital Reports, vol. x, p. 205.
7. Dowd. Archives of Pediatrics, vol. xiv, p. 326.

DISCUSSION.

Dr. A. J. Ochsner, of Chicago, was invited to open the discussion. He said he was glad to hear this paper, because of its great practical importance. Strangulation of hernia in children was not nearly so uncommon as one would suppose from the fact that the literature is so meager. He thought his own experience included fully as many cases as the entire number reported in the paper, but he had never definitely written upon this subject, and this seemed to have been the general tendency of surgeons. Surgeons operating in the hospitals of large cities did not make special reports of these cases, because they were at once, and without question, treated surgically. Undoubtedly there were many cases of strangulated hernia in children occurring in the smaller cities and towns which were not treated surgically because the attention of the profession at large had not been specially called to this feature. As a matter of fact, children bore herniotomies remarkably well. In herni e which were not strangulated about 3 per cent. only were not cured spontaneously. If, however, strangulation occurred, the very points made in the paper were of the greatest importance. Rough manipulation would cause gangrene and fatal peritonitis. The operation itself was simple. All that was necessary was to make the incision, reduce the hernia and introduce the sutures. It was not necessary to do a typical Bassini or other operation, as the inguinal canal would close promptly and firmly. The question of suspension was one of the greatest importance. The child should be suspended, as stated in the paper, by the opposite leg, so that the anterior tissues are relaxed.

A Careful Inquiry into the average height of the different nations has shown the English professional classes to be the tallest. Adult males attaining the high average of 5 feet 9.14 inches. Next on the list come the males of the United States, a minute fraction behind the Englishmen. Thus, the English and American nations are approximately of the same height. Most European nations average 5 feet 6 inches for the adult male. —*Philadelphia Medical Journal.*

THE ADVANTAGES OF NITROUS OXIDE IN GENERAL SURGERY—EXHIBITION AND DESCRIPTION OF A STOP-COCK FOR ITS ADMINISTRATION WITH VARYING PERCENTAGES OF OXYGEN.¹

BY H. W. CARTER, M.D.,
New York.

IN the short time allotted to this paper it would be impossible to discuss in detail the physiological action of nitrous oxide, and I shall only endeavor to describe as briefly as possible the method of its administration and state its advantages in general surgery. For this purpose it is necessary to consider the administration of nitrous oxide in its pure state, in combination with atmospheric air and with varying percentages of oxygen.

The successful administration of nitrous oxide is dependent upon perfect apparatus and close attention to details. All tight clothing about the waist or neck should be removed, and the patient's head should be in a straight line with the body, so as to make respiration free and natural. All articles of diet should be withdrawn for a period of three or four hours previous to the administration.

The best form of inhaler is one in which the bag is close to the face-piece and the stop-cock is so arranged as to enable the anesthetist to suspend valve action.

Before turning on nitrous oxide the patient should be shown how to breathe air through the apparatus, and the anesthetist should see that the face-piece is accurately applied.

The bag should be about two-thirds full and the gas should be administered as nearly as possible at atmospheric pressure. The channels through the apparatus should be large, and inspiration and expiration should be free and easy through perfectly working valves.

Herein lies the explanation of the frequent sensations of oppression and suffocation on the part of many patients when breathing nitrous oxide through the long tube connecting the bag with the face-piece.

I have often been told by patients after an administration that they did not experience the sensation of smothering that they had suffered from on a former occasion, and I can only attribute it to a difference in the inhalers.

The tube is not so objectionable when nitrous oxide is administered from a gasometer and a positive pressure is maintained throughout the administration, but when the patient has to draw the gas from a bag through a long tube, the resistance to respiration is certainly appreciable.

Furthermore, stertor, both vascular and spasmodic, is apt to supervene very much earlier under such circumstances, and the resulting anesthesia is sure to be of much shorter duration. After the administration has been started, under no circumstances must the patient be disturbed

until narcosis is fully established, as any interference, such as loud talking or rough handling, is apt to disturb the anesthesia and lead to failure.

When nitrous oxide is properly administered, the sensations produced are of a pleasant rather than disagreeable nature, and anesthesia is in the vast majority of cases induced in from 45 to 60 seconds.

Narcosis is known to be present by stertor, an altered color, widely dilated pupils and diminished or absent conjunctival reflex. If it is desired to prolong the period of anesthesia or the supply of gas unexpectedly falls short, valve action may be suspended and the administration brought to a successful termination by employing to and fro respiration. Nitrous oxide is far preferable to chloroform or ether for many minor operations of short duration, as it is safe, rapid and pleasant in its action and free from unpleasant after-effects.

The available anesthesia is quite sufficient for the successful performance of such operations as dilatation of the sphincter ani, puncturing of the ear drum, the opening of superficial abscesses, tonsilotomy, the reduction of dislocations and any other procedures of a momentary character.

Practically the only danger attending the administration of nitrous oxide is asphyxia, and its occurrence is incidental rather than essential, for if air is judiciously admitted anesthesia may be kept up almost indefinitely.

In the administration of nitrous oxide and air the anesthetist may adopt one of two distinct systems:

He may administer the gas in the ordinary way until the patient is partly or fully anesthetized, open the air slot for one or more breaths of air and then continue to administer gas and air alternately, or he may admit air concurrently with the nitrous oxide, being guided by the symptoms of the patient as to whether to increase or decrease the amount.

In actual practice, both of these systems are usually employed, the patient at one moment breathing pure nitrous oxide, at another air only, and at still another nitrous oxide mixed with a small quantity of air.

Gas and air, while not a satisfactory anesthetic for operations requiring quiet and relaxation, is very valuable when gas and oxygen is not available, and it is desired to avoid the danger and disagreeable effects of chloroform or ether.

I have administered nitrous oxide and air for breaking up old adhesions in joints, the dissection of epithelioma from the neck, dilatation of the cervix uteri, the removal of small tumors from the breast, painful dressings and many other procedures requiring from a few minutes to one-half an hour.

Nitrous oxide finds its greatest field of usefulness in general surgery when administered in combination with varying percentages of oxygen, for not only is this mixture the safest anesthetic

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

known, but under its influence most all of the major operations can be successfully performed.

Before describing the administration I wish to present a stop-cock which I devised for administering nitrous oxide with varying percentages of oxygen.

It was designed to use with Bennett's face-piece and gas-bags, the whole making a complete nitrous oxide and oxygen inhaler. Bennett's gas and ether inhaler being a standard American apparatus and being used generally by most anesthetists in this country, I decided to devise a stop-cock only, so as to enable any one who has a Bennett inhaler to secure a complete nitrous oxide and oxygen apparatus at a moderate price.

It is constructed upon the same principles as the stop-cock in Hewitt's apparatus, and is composed chiefly of a cylinder of the exact dimensions of Bennett's ether chamber. This cylinder is divided by a partition into two compartments, the deeper one for nitrous oxide, which also serves as the mixing chamber, and the other for oxygen.

Nitrous oxide and oxygen flow from their respective bags to these compartments through a Y-tube, the two gases being separated in the single arm of the tube by a longitudinal partition.

The partition which divides the cylinder into nitrous oxide and oxygen compartments is perforated by two sets of holes, the smaller ones, ten in number, representing a unit each, and the larger, four in number, ten units each.

Into each of these compartments is an accurately fitted closed cylinder, having slots so arranged as to enable the anesthetist to shut off both nitrous oxide and oxygen, or turn on nitrous oxide alone, or open any number of holes in the partition, thus admitting to the mixing chamber any proportion of oxygen desired.

In addition to the opening for nitrous oxide, the mixing chamber is perforated by two large holes, one above for air and the other at the inspiratory valve. During inhalation air or nitrous oxide enters this latter opening and passes through the inspiratory valve, the exhalations escaping through the expiratory valve into the surrounding atmosphere. On the outer surface of either compartment are a scale and index to enable the anesthetist to tell just what proportions of the gases are flowing into the mixing chamber.

When the index points to "air," nitrous oxide is shut off, and air passes through the inspiratory valve to the face-piece.

When the index reaches "N 20," air is closed off and only nitrous oxide is breathed.

As the index advances from "1" to "10" on the scale, all the small holes in the partition are successively opened, and nitrous oxide mixed with from 1 to 10 per cent. of oxygen is inhaled.

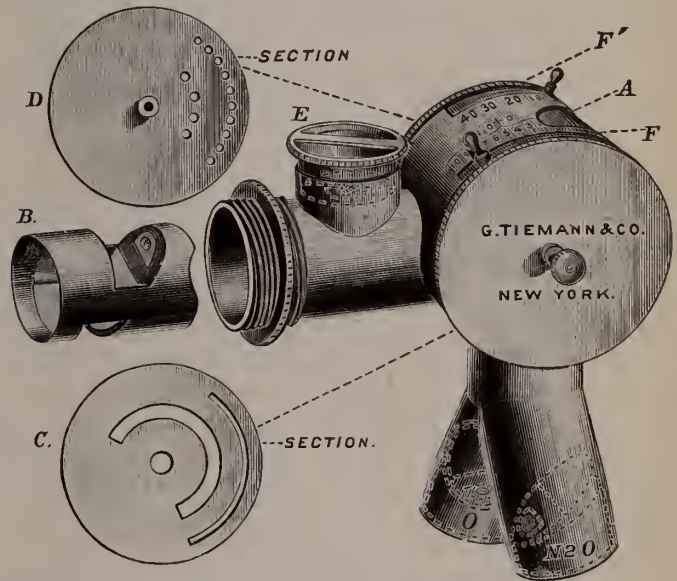
If it is desired to still further increase the percentage of oxygen, the index of the supplemental

oxygen stop-cock is advanced to the number "10," uncovering one of the large holes in the partition, and the main index brought back to "1," thus admitting 11 per cent. of oxygen.

When the main index again reaches "10," the supplemental index is moved to the number "20," the main index brought back to "1," as before, and so on until any desired proportion of oxygen up to 50 per cent. is admitted.

By simply binding together one of S. S. White's oxygen and two nitrous oxide cylinders with a pair of patent-leather skate straps, enough stability is gained for a convenient stand, which may be set upon a table within easy reach.

By means of a small, Y-shaped glass or metal tube and a few feet of rubber tubing, the two



nitrous oxide cylinders are connected with one of Bennett's gas-bags and with another piece of rubber tubing the oxygen cylinder is connected with a second bag.

When the nitrous oxide and oxygen bags are attached to their respective sides of the stop-cock just described, and Bennett's face-piece is screwed on, a complete nitrous oxide and oxygen apparatus is produced, which is equally as satisfactory as Hewitt's inhaler with Barth's cylinders, and enough gases are provided for an hour's administration. With no other anesthetic is such close attention to every detail so essential to the success of the administration as with nitrous oxide and oxygen.

The patient should be placed upon the table in the proper position for the intended operation and all preliminary preparation should be attended to before beginning the administration, as it is very difficult to change the posture afterward without disturbing the narcosis.

Having tested the apparatus to see that its valves are in perfect working order, the bags should be filled about two-thirds full of their respective gases and the rubber hood closely ap-

plied over the mouth and nose, so as to prevent any leakage of air under the face-piece.

The patient should now be informed that he is breathing only pure air and instructed to take full, deep respirations through the mouth.

When respiration is seen to be free and regular, the index should be immediately turned to number "2" or "3," at the same time admitting a steady stream of nitrous oxide to the gas-bag.

Oxygen should be admitted to its bag at intervals as necessary.

After a few seconds the index may be advanced to "3" or "4," and so on, one number at a time, until it reaches "7" or "8," permitting two or three respirations with each advance.

Should consciousness persist, or should signs of excitement, incoherent talking, laughter or struggling assert themselves, or should the face assume a bright-red color and the respiration become slow and noiseless, the oxygen should not be further increased for the present, or the index may even be turned back to "6" or "7" for a few seconds, and then advanced again more cautiously.

Should cyanosis, stertor, rapid and jerky respiration or muscular twitching supervene, the percentage of oxygen must be still further increased.

As a general rule a progressive increase in the percentage of oxygen will be necessary, and the longer the administration the larger the proportion of oxygen required.

As anesthesia approaches the patient assumes an appearance closely resembling natural sleep. The eyes are generally closed, the color normal, a little pale or slightly florid, and the respiration regular, tranquil and distantly snoring in character.

The conjunctiva is insensitive, the eyeballs fixed or slightly oscillating, the pupils usually of moderate size and the muscular system relaxed.

The pulse is strong, full and regular.

If the percentage of oxygen is too small, we may get the dilated pupil of typical nitrous oxide narcosis; if too large, the reflex dilatation of incomplete anesthesia.

Sometimes the conjunctival reflex will persist, in which case we must depend upon the respiration or other signs of anesthesia.

In administering this mixture for general surgical operations, the type of the patient and the nature of the operation should be carefully considered.

The best subjects are middle-aged women and elderly men. Robust, muscular men require little oxygen, while children, feeble and anemic adults or persons who suffer from pulmonary or cardiac complications require a large percentage of oxygen.

All lengthy operations requiring complete and continual muscular relaxation, or in which it is necessary to work in difficult or unusual positions, are more or less unsatisfactory under nitrous oxide and oxygen anesthesia.

On the other hand, nitrous oxide and oxygen is

an almost ideal anesthetic for all short operations in which complete muscular relaxation is not essential, and for all cases in which it is desired to avoid the danger of administering chloroform or ether to patients with diseased heart, kidneys or lungs.

Its chief disadvantages are that the administration is expensive, that it requires somewhat complicated and cumbersome apparatus, and much skill on the part of the anesthetist, as it is the most difficult of all anesthetics to administer successfully.

But the rapid and pleasant induction of narcosis, the quick recovery and almost entire freedom from nausea, vomiting or other unpleasant after-effects more than counterbalance all these disadvantages.

A MONTHLY JOURNAL VERSUS A YEARLY VOLUME OF TRANSACTIONS.

To the Editor of the Journal—From time to time the question as to the real value of a monthly journal, owned by a State Society, is seriously considered, and varied objections are made toward its continuance. The objections are as follows:

First, the expense; second, its naturally limited field of publication; third, competing with established journals, and fourth, its doubtful utility as a means of intercommunication between members.

Expense.—A yearly bound volume of the transactions is almost as expensive as twelve numbers sent monthly. The bound volume is all solid matter, and there is no income. The monthly journals contain ethical advertisements, which materially reduce the cost of publication, and will ultimately prove a source of revenue.

Limited Field of Publication.—Writers of repute are naturally averse to having their work "buried" in a journal of limited circulation, and many journals are desirous of publishing their articles. In such cases I arranged, during my editorship of the *New York State Journal of Medicine*, to have important articles published in the journal selected by the authors, and in the *State Journal*, simultaneously.

Properly conducted State journals do not compete with other journals, in that the former are reserved solely for such papers as are read in State and county associations.

As a means of intercommunication between members, conveying records of official action, suggestions as to new work, and constantly keeping the advantage of membership before the profession, a monthly journal is of incalculable value. This we have demonstrated over and over again. For instance, in former years through the liberality of committees on publication many more volumes of the yearly transactions were ordered than were necessary, and there were on hand recently over 2,000 such books, on which the storage expense was quite large. At the request of the treasurer I inserted a notice that full sets of eighteen volumes each would be given to members who would pay freight charges. The responses were prompt and gratifying, and a large number of these volumes were placed where they would be appreciated, and our end attained. News items from time to time, relative to fellow-members, are eagerly read. Association news is always interesting, and editorials on the art as well as the science of medicine find sympathetic readers. Altogether, then, the value of a monthly journal is incontestible, and those who have given this manner of presenting official news of the State organization a fair trial will never go back to old methods.

EMIL MAYER.

New York, March 11, 1903.

—*California State Journal of Medicine.*

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Pierson C. Curtis, Round Lake.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Third or Central District Branch.

President—Chauncey P. Biggs, Ithaca.
Secretary—Franklin J. Kaufmann, 311 W. Genesee street, Syracuse.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornborger.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Joseph Burke, 388 Franklin street, Buffalo.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Howard L. Hulett.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—James H. Taggart.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.

Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutter.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davs.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; J. H. Potter, Grover W. Wende.
Committee on Legislation—Herman E. Hayd, chairman; Edward E. Blaauw.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; Charles S. Jewett, De Lancey Rochester.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stocksclaeder, James C. Davis.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Connor, Middletown.
Secretary—Ernest Valentine Hubbard, 114 West 70th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.

Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.

Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.

Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.

Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.

Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.

Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.

Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.

First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.

Second Vice-President—Fredrick P. Hammond, 129 East 116th street, New York.

Secretary—Ogden C. Ludlow, 234 West 135th street, New York.

Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.

Treasurer—Charles Ellery Denison, 68 West 71st street.

Executive Committee—Frederick Holme Wiggin (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).

Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.

Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.

Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Henry A. Maynard.

STEBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Kogle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Treasurer—Charles W. Piper.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoebenbergh.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—II. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.



PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 7.

JULY, 1903.

\$1.00 PER ANNUM.

MEDICAL UNION IN THE STATE OF NEW YORK.

The President of the New York State Medical Association recently received the following resolution from the Medical Society of the County of Onondaga:

Resolved, That the Onondaga County Medical Society, which has always remained loyal to the State Society, because of the recent action of the American Medical Association, paving the way to unification of the regular medical profession of this State, believes that the time has come when the two State bodies shall become united in a single body, and that the Medical Society of the State of New York; that both the Society and the Association shall at once approach this scheme in a spirit of conciliation, willing to make such concessions as each body can consistently make, and that a copy of this resolution be forwarded to the President of the Medical Society of the State of New York, the President of the New York State Medical Association and to the Committee on Conference.

(Signed) A. S. HOTALING,
Secretary.

Dated, Syracuse, N. Y., June 2, 1903.

To which the following reply has been sent:

JUNE 18, 1903.

Dear Doctor Hotaling—I have received the resolution passed by your Society, dated June 2d, in which your organization expresses its desire for a union between the Medical Society of the State of New York and the New York State Medical Association, with which wish, I am sure, the members of the New York State Medical Association sympathize, and I sincerely hope that a satisfactory solution, to both State organizations, of the present condition of affairs may speedily be found.

It will give me much pleasure to lay your resolution, already referred to, before the Council of the New York State Medical Association at its next meeting.

Sincerely yours,
F. H. WIGGIN, President.

Dr. Albert Steuben Hotaling, Secretary, Onondaga County Medical Society, 801 E. Genesee street, Syracuse, N. Y.

A MEDICAL COLLEGE'S FORWARD STEP.

In the April number of the JOURNAL were two papers by prominent physicians upon the burning topic of proprietary remedies. In each of these articles much of the responsibility for the present intemperate use of such remedies was laid at the doors of our colleges.

In the May issue, we published reports from the medical colleges of this State, giving the time and method devoted to the teaching of pharmacology by each institution.

Many of our readers were agreeably surprised at the importance given to this subject in the curriculum of most colleges. What an advance had been made since they were themselves undergraduate students!

Therefore, it is a pleasure to quote the following announcement, made by President Butler, on Commencement Day:

"An entirely new Department of Pharmacology and Therapeutics has been organized and placed in charge of a group of thoroughly trained and successful scientific men, who will spare no effort to develop this important branch in the fullest possible way."

COMMISSIONS.

The following letter came to us recently:

Dear Doctor—If cases requiring treatment under my specialty are called to your attention and you recommend them here, I will pay you your usual consultation fee. Please send card with patient. I am

Very respectfully yours,

Upon making a few inquiries we find that the profession in New York City has been thoroughly canvassed by this—this—call him *thing* and let it go at that.

Furthermore, he is not alone in his method of practicing medicine. A number of specialists, otherwise, evidently, leading upright lives, and whose families are undeserving of any disgrace, are sending letters to physicians soliciting "trade" and promising commissions. They may call this money consideration a consultation fee, or a gift, or anything else, but a more comprehensive term is "graft." The boodlers in politics are not as despicable as the doctors who let selfish reasons influence their treatment of the health of a fellow-being. In such cases the publicity of the conspiracy between the two doctors would cause a much more sensational furor

throughout the country than have the recent exposures of the corrupt characters in Minneapolis, St. Louis and the United States Postal Service.

We cannot guard too jealously the freedom of our calling from any taint of commercialism.

The danger that the spirit of commercialism, which is trying to invade all walks in life, may infect some of the members of our profession is most imminent and appalling. Prophylaxis, however, is a part of our training, and the medical organization furnishes a fine antiseptic.

The Principles of Medical Ethics adopted by the House of Delegates, at the last meeting of the American Medical Association, contains the following pertinent paragraph:

"It is derogatory to professional character for physicians to pay or offer to pay commissions to any person whatsoever who may recommend to them patients requiring general or special treatment or surgical operations. It is equally derogatory to professional character for physicians to solicit or to receive such commissions."—Chapter II, Article VI, Section 4.

The fact of a doctor's indorsing this sentiment is evidence that he is a gentleman. Therefore, before these unscrupulous *things* approach a doctor with their nefarious propositions, we would advise them to look up his standing, and if there is reason to believe him to be a gentleman, then let him alone. Above all things don't try to tempt him in person. The possibility of a suit for assault and battery is of no moment when you can make a scoundrel *feel* your opinion of him.

It is most important that the members of our profession should set for themselves a high standard of conduct and endeavor to live up to it. The section here discussed is being constantly unheeded in the spirit if not in the letter. It is most wholesome for a man's character that he declares himself to be with the upright and honest, even when he is unable to give much time to actively assist them.

None knows where his influence begins or where it ends. Therefore, exert it for the good in every direction possible.

COUNTY WORK.

The energy shown in Erie County is worthy of imitation in other counties of the State. We commend the following letter to the readers of the JOURNAL:

THE NEW YORK STATE MEDICAL ASSOCIATION, ERIE COUNTY, JACOB OTTO, M.D., SECRETARY,
90 North Pearl street,

BUFFALO, N. Y., June 12, 1903.

Dear Doctor Denison—I beg to enclose a report of the meeting of the Erie County Medical Association, held in Buffalo on the 8th inst.

The attendance of this meeting was the largest in the history of our Association, and if the enthusiasm evinced at this meeting is any evidence of the general interest in Association affairs, and I believe it is, the membership will be increased largely in the near future,

and the Erie County Association will develop soon into a powerful and influential body in this part of the State.

Very truly yours,

JACOB S. OTTO.

COUNTY ORGANIZATION IN NEBRASKA.

Of the sixty-six counties in the State of Nebraska, fifty-nine counties are now organized under the reorganization plan. At the meeting of the State Society, held in Lincoln on April 28th, 29th and 30th, the membership was shown to be double that of any of the previous years of its existence.

NEWSPAPER ADVERTISEMENTS.

Last month we drew the attention of the profession to the highly commendable position taken by the editors of *Everybody's Magazine*. "Patent medicine and other curative and objectionable advertising will be declined," they have announced.

It is with great satisfaction that we are able to place another publication in this advanced class. A Buffalo weekly newspaper will not accept these disgusting advertisements. Mark S. Hubbell, the editor of *Truth*, makes this statement to his readers.

ANTITOXIN FRAUDS.

The announcement has been made in the public prints that sixty New York physicians have made it a practice to sell to the poor the antitoxin which they procured free from the city.

Justice Truax, in the Supreme Court, held that physicians who obtain antitoxin from the city free of charge, on the ground that it is intended for the use of poor patients, to whom it would be a hardship to pay for, are agents of the city until they have administered the medicine, and are guilty of petit larceny should they charge for the administration of the antitoxin. Justice Truax's decision is of importance, as a number of physicians are at present on bail, awaiting trial in the Court of Special Sessions on the charge of having obtained supplies of antitoxin for diphtheritic patients under false pretenses.

The defendant was the agent of the city to administer the antitoxin to Martha Horner, free of charge, if she was unable to pay for it, and he was the agent of the city to administer that antitoxin only in that event; but he administered it to her knowing that she was able to pay for it, and, therefore, in so administering the antitoxin contrary to the conditions upon which it was delivered to him, and contrary to the conditions under which he was authorized to administer it, he deviated from the terms of his agency, and did so to his own personal advantage.

In other words, the defendant, by administering this antitoxin, delivered to him for the purpose of being used on a patient unable to pay for the same, when he knew that the patient was able to pay for the same, and by accepting payment for the same, appropriated the antitoxin to his own

use and rendered himself amenable to subdivision 2 of section 528 of the penal code of the State of New York.

THE BUSINESS PHASE OF OUR DAILY WORK.

Thoughtful consideration leads to the belief that in proportion to the actual value of the services rendered the general practitioner of medicine receives less compensation than any man in the world. For instance, baseball players have been known to receive \$5,000 for a few months' work; a well-known merchant has given \$100,000 for a single picture; while it is an every-day occurrence for a lawyer's fee to run up into the thousands. If a man commits a capital crime he will gladly pay the lawyer's fee even if it requires the sacrifice of all his earthly possessions; if instead of committing a crime he is the victim of a suppurative appendicitis a remarkable difference is noted in his method of reasoning. The doctor removes the offending appendage, recovery ensues, and the grand final occurs when his benefactor asks him for a slight compensation, say \$100 or \$200. The pain is no longer located in the right lower abdominal quadrant, but has become a metastatic pang of financial stringency, and in a paroxysm of anguish he exclaims, "Great Cæsar, what extortion!" Some years ago I advised a client to send his wife to a hospital for the purpose of having an ovariectomy performed. The probable cost was placed at \$250 to \$350. I thought this a conservative estimate, but my client seemed greatly astonished and asked if that was not too much. I answered that it depended upon the money value he placed upon his wife. This "wizard of finance" contributed \$800 to the printers'-ink-practitioner before taking my advice, as the surgeon's fee seemed to him exorbitant. General practitioners are largely to blame for this ignorance on the part of the laity as to the value of their services. Where is the justice in the surgeon receiving the ordinary fee for removing an inflamed appendix, when a physician curing the inflammation (and he does do it sometimes) charges so much per mile for his services, amounting possibly to one-tenth the fee received by the surgeon? Why should we not charge as much for administering an antidote as for ligating an artery, or for giving a subcutaneous injection of diphtheria antitoxin as for performing a tracheotomy? Why should the physician receive less for curing an iritis than does the oculist? The general practitioner seems a dual personage; as surgeon he treats fractures and receives from \$10 to \$75; as a physician he may jugulate a case of pneumonia, which is more dangerous than the fracture, and receive possibly \$5. I allude to the foregoing, each example of which is familiar to all, in order to call attention to the difference in the customary compensation for the service which has for its object the saving

of life. In the parlance of the speculator, I do not wish to "bear" the fee of the surgeon, but simply to "bull" that of the general practitioner. I would suggest that charges should be made in proportion to the actual value of the services rendered; that we stiffen up all along the line and not look to a second or third party for remuneration.—*American Medicine*, December 20th.

TRUTH.

"There is nothing so powerful as truth—and often, nothing so strange."—*Daniel Webster*.

One of the rarest virtues possessed by man is the ability to state a fact. It seems a very simple and a very easy thing to tell the truth, yet to some how inexpressibly easier—is lying! To understand a fact—in all its entirety—and then to state it in language—with exact fidelity, requires a mind unusually gifted, evenly balanced—possessing a nice distinction between right and wrong. The greatest failures of our lives have generally been the outgrowth of our attempts to make falsehoods—truths—such attempts have sometimes entailed tragedies. Every day that passes we all lie—not, perhaps, consciously or criminally, but in the way that our language fails to state fact correctly—our truths are only half truths or distorted truths. This condition can be attributed to carelessness, to habit, to mental incapacity, and an inability to give a perfectly truthful inflection to our words. There are people in every community whom we all believe to be honest, yet they cannot tell the truth. "The brutal truth"—there is so to speak—a flaw in the crystal, causing everything to be distorted; some can understand a fact, and even state it correctly, provided it has no personal relation, yet the moment their personal interest is involved, the fact assumes false proportions and false colors. It must be borne in mind that all truth, unless the mind is most evenly balanced, is tinted by the medium through which it passes, and is directly affected by any personal imperfection or weakness. It is a rare mind that possesses the power to express in language a truth in the same degree of perfection in which it was received. Very little truth is received, so that it can be a matter of little surprise that very little is told.

Analytically speaking, truth is a trust, either in words or deeds. We are compelled to trust, and be taken on trust in this world, and our nice sense of honor eventually indicates our worthiness or unworthiness. Truth and trust lie at the basis of every scheme of human life. Trust is necessary, implying a confidence. A man who breaks a trust is, in a sense, a liar, for our confidence has been betrayed and we have been deceived, and deception is lying. Liars can be classed under two heads—conscious and unconscious. Of the latter we have spoken; to the former belong those who make a business of

lying and those who indulge in it from the wanton love of lying. Truth is indeed a rare article. Many, many times it goes begging. Few are capable of stating a fact, or telling the truth, for the reason that they lack the power to comprehend or express either.

Do not the great majority of people receive truth through the medium of prejudice, selfishness or indifference? It never enters their minds or souls in any degree of purity; hence their incapability of uttering correctly, even though the power of perception may be equal to the power of expression.

Could self-interest be obliterated, then the identity and power of truth would never be lost. The closer we come to a perfectly natural nature, and the farther we depart from the conventional and artificial, the nearer do we approach truth. "Truth lies at the bottom of the well, and not in the buckets that go up and down, as caprice or selfishness turns the windlass."—*Journal of the Medico-Chirurgical College, Philadelphia, Pa.*

CORONERS' OFFICE.

"No doctor's reputation or standing is so high as to be safe from the systematic blackmail that would prevail in this city but for the Coroners' office."—*Address of an ex-Coroner at a special meeting of the New York Medical Society, December, 1902.*

The attending physician to a married woman suffering from an acute pyelo-nephritis and a retro-mammary abscess called in consultation an eminent gynecologist of this city, with a view to operation for relief of the mammary condition. The gravity of the case having been explained to the husband, and his consent having been obtained, an expert anesthetist was employed for the operation, which took place the following day, February 22d.

When a total of fifteen drops of chloroform had been gradually dropped on the inhaler, and before the operation had begun, the patient died suddenly. The attending physician notified the Coroners' office within the hour, and a coroner—who was also a physician—went to the residence of the deceased to view the remains. On being ushered into the death chamber his very first words to the husband—spoken in the presence of the attending physician and the family of the deceased—were, "Whom do you want arrested?" To which the husband replied: "I do not wish any one arrested, as I am perfectly satisfied that everything was done that should have been done for my wife."

This self-same coroner, according to press reports, endeavored to conceal from the police that a violent death had taken place in a local fashion-

able hotel; failed to report the case at the Coroners' office, and, as a local newspaper stated, "showed an extraordinary concern in surrounding the case with secrecy." His excuses at that time for such behavior, viz., "I forgot." "My eyes troubled me a great deal." "I have too many confinement cases." "Anyway, it isn't anybody's business, as no one killed her but herself," seem instructive, especially as another coroner according to the papers, hinted that \$10,000 had been paid to suppress the report. We do not know or assert that the newspaper stories were true. We trust they were not; but that such charges should have had currency, without prompt and effective refutation, tended of itself to discredit the Coroners' office; it must be abolished.

"Let those, whom folly prompts to sneer,
Be told we sport with fable here;
Be told that brutes can morals teach,
And trees like soundest casuists preach."

—*The Medical Critic, June, 1903.*

MEDICAL ETIQUETTE.

At times there will be some misunderstanding as to one's conduct toward another, and an act that is in reality intended as an act of kindness may be construed as a slight, or unjust interference, but if in working our deductions we would judge as we would be judged, we would, in nearly every instance, arrive at the proper decision—that of no intentional hurt. All men are naturally honest, but it is the circumstance that makes them dishonest, and it is the dishonest man who finally brings his own condemnation.

When we hear things derogatory to the character of any fellow member we should be slow to believe, remembering the little rhyme:

"Believe not each slandering tongue,
As most weak people do,
But believe that story wrong
Which should not be true."

—*Transactions of Luzerne County (Pa.) Medical Society, 1902.*

A DIRECTORY OF BABIES.

Health Commissioner Lederle has directed the eighty physicians who are specially engaged to care for the health of the infants and children of the tenement-house districts to make an index directory of all babies under 1 year old. The list will contain, as far as possible, the names and addresses of all the babies in the five boroughs. It shows already 20,000 born since January 1, 1903. The city will be laid out in districts, to each of which one or more physicians will be assigned. They will be required to visit their district frequently and to report any cases of sickness to the department.

Association News.

AMERICAN MEDICAL ASSOCIATION MEETING.

The next meeting of the American Medical Association will be held at Atlantic City, N. J., June, 1904.

Report of the meeting of the American Medical Association at New Orleans, May 5 to 8, 1903, by Elias Lester, M.D., of Seneca Falls, N. Y., read at the nineteenth annual meeting of the Third District Branch of the New York State Medical Association, at Syracuse, N. Y., June 25, 1903:

Members of the Third District Branch of the New York State Medical Association, and Friends—It seems to devolve upon me, one of the delegates chosen to represent the State Association at the American Medical Association, which this year convened at New Orleans, to give a report to this branch, of which I am a member, of some of the doings there, as but few of us have had an opportunity of attending one of these large meetings where representatives of our noble profession gather once a year from every State in the Union. The number in attendance this year was smaller than in many former years, yet, notwithstanding that, there was a large gathering of intelligent and progressive physicians. The whole number registered was 2,050, although there were present several hundred from States near by who were not registered and who came to enjoy the advantages of the meeting.

On Saturday, May 2, 1903, at 4.25 P. M., the beautiful special trains steamed out of the Pennsylvania station in three sections, following each other at ten-minute intervals. It was a beautiful sight, and when we were off and looked about the finely appointed cars and saw so many happy physicians and their wives—some of them old friends, too—it made the heart glad and made one feel proud to be a member of such a noble profession and of such an organization as the Medical Association of the State of New York. The trip was in every way pleasant. The weather was cool and delightful, the company congenial and friendly, so no one could help having a good time.

There were many well-known physicians on the train. Dr. Marcy, of Boston, one of the oldest members of the Association, a physician distinguished as being a student of the great Virchow, of Berlin, and a man who has been a great credit to the profession. Dr. John H. Musser joined us at Philadelphia, and at that time was quite unconscious of the honor that was to be conferred upon him at New Orleans—that of being elected president of the American Medical Association. Also the venerable and distinguished Dr. Garcelon, of Maine, who for many years has been an inspiration to the younger members of the Association through his presence at and active participation in its meetings. Dr. Garcelon celebrated his 90th birthday during the session of the Association, and was presented with a loving cup by some of his friends. Dr. Garcelon is noted as being the only Democrat who has filled the office of Governor in the State of Maine.

On our arrival in New Orleans Monday noon, the local committees met us and were active in assigning apartments to the visiting members. The next morning the meeting was formally opened at the Tulane Opera House. The members of the Association were welcomed to the city by an address by the Mayor, and to the State of Louisiana by one given by a representation sent by the Governor. Mr. Dart, one of the leading attorneys of New Orleans, gave a welcome to the members of the medical profession from the legal profession in a humorous and sympathetic address. A response to these addresses of welcome was given by Dr. Witherspoon, of Nashville, Tenn., in a thoroughly appreciative spirit. The last address was given by Dr. Billings, of Chicago,

president of the Association. His theme was a plea for higher standards of education for physicians and for the better equipment of medical schools, especially the smaller ones. At the close of this general meeting the regular work of the different sections and of the House of Delegates began.

The House of Delegates is composed of 120 members chosen from States to represent the associations and societies in those States that are in affiliation with the American Medical Association. The average attendance of this body at the New Orleans meeting was 76 and they transacted all the business of the Association for the year. They passed on the reports of the officers, committees and special agents of the Association; looked over the accounts of the *Journal* offices and passed on the expenditures; and attended to all the business submitted to them by the Board of Trustees. There is a great deal of business to be gone through and we were occupied every day from 9 to 12 A. M., and from 2 to 5 P. M., during the whole session. So it is not so soft a snap to be a delegate as one might think. I did not attend a section or hear a paper read on any subject while I was there. On the second day of our meeting, Dr. Harris, of New York, offered the report of the Committee on Medical Ethics for consideration. It was well received and was about to pass, when Dr. Charles A. L. Reed, a delegate from Ohio, arose and moved a substitute, which he proceeded to read. It was very long, and as I closely attended to its reading, I could not see any difference between the substitute and the report of the committee, a copy of which I held in my hand. Dr. Harris arose, and with the presence of mind of a New York Senator, accepted Dr. Reed's substitute and moved that the committee be enlarged to one member from each State, excepting those States that were already represented; that they convene at the St. Charles Hotel immediately at the close of this session, to hear any suggestions or grievances from any member having views on the code, and that they report at as early a date as possible. This motion was carried and the committee were selected and convened afternoon and evening until all were heard. When this enlarged committee reported, Dr. Harris read the report they offered, adding that in view of the fact that the report just read was unanimously adopted by the enlarged committee he moved its adoption as read, by the house. Dr. Reed, of Ohio, seconded the motion, and said that perfect harmony had prevailed in the conference, and that he wished to congratulate the Association on the fact that by the adoption of this report we put an end to a controversial question which had disturbed our councils for many years. The president put the motion and it was adopted unanimously by the House of Delegates, amid tremendous and prolonged applause. Thus was adopted "The Principles of Medical Ethics."

On the last day of the meeting the election of officers for the Association for the ensuing year took place, and with that the business of the House of Delegates ended. Before closing this part of my report I might mention that the Association seems to be in a most healthy and prosperous condition financially. The last payment, \$43,000, was made on the *Journal* property and the acquisition of this plant seems to be a wise measure, judging from the excellent reports coming from those in charge.

Although I have dwelt at some length on the business side of this meeting of the Association, I cannot close my report without describing the social side as well. Under the able supervision of Dr. Dyer, ample provision was made that we should see the beauties and characteristic life of the Crescent City, and also enjoy the gracious Southern hospitality which one always finds beyond the Mason and Dixon line.

As many of the physicians were accompanied by their wives, the committee made it their first care to keep the ladies pleasantly entertained while their husbands were attending the meetings of the Association. One day they were given a trolley ride through the length and breadth of the city and a luncheon was served them in Audebon Park by Mrs. Delgado, one of the distinguished women of New Orleans. On another day they

were invited to walk through the French quarter and were shown many of the historic buildings of that part of the town.

Many functions were given to which both the doctors and their wives were invited. Receptions were given two evenings, one in the Palm Garden of the St. Charles Hotel and others at the homes of some of the citizens who were interested in the meeting of the Association. One evening a fête was given in the city park. This was a characteristic Creole festival, evidently, with music, fireworks and a unique dramatic performance.

On Friday, the last day of the meeting, a boat ride on the great steamer *New South* was given us. We went down the Mississippi nine miles and up six miles, and gained a good idea of the plantations of that section, as the river was very high, and thus we were enabled to see the country on either side. Refreshments were served and music was also provided, so that nothing was lacking to make this a most enjoyable occasion. We returned to the city at 8 o'clock, just in time to enable us to reach the train for our homeward journey.

DISTRICT BRANCH NEWS.

Second District Branch.—The nineteenth annual meeting was held at Hudson, June 4th, at the D. A. R. Hall. The meeting was called to order by Dr. E. D. Ferguson, president. After the business session the president addressed the meeting with some remarks on the present status of the Association, which he followed with a paper on "Some Reflections Relative to the Time and Method of Operating in Appendicitis." This was followed by several interesting papers. Dr. Wm. W. Seymour, of Troy, reported a few interesting clinical cases and presented Born's Dilator.

Dr. David W. Houston, of Troy, gave a few remarks on the "Diagnosis and Treatment of Some of the Commonest Forms of Disease of the Breast."

Dr. Herman C. Gardiner, of Troy, reported three cases of cretinism and two cases of leukemia: (a) of the lymphatic type without glandular enlargement; (b) of the pure myelogenous type of the acute variety.

Dr. William Finder, of Troy, gave a very instructive report of a case of salol poisoning.

Dr. James P. Marsh, of Troy, explained and illustrated the results of X-ray therapy.

Dr. James C. Hutchinson, of Troy, read a very excellent paper on "Hemophilia" with report of cases.

Dinner was served at the Worth House. One of the largest meetings in the history of the branch association, and in the variety and interest of subjects, one of the best.

* * *

Third District Branch.—The nineteenth annual meeting was held Thursday, June 25th, at the Academy of Medicine, Syracuse.

The new county association of this branch, that of Tompkins, was given a hearty welcome.

The meeting was called to order by the president, Dr. Chauncey P. Biggs, of Ithaca. The minutes of the last meeting were read by the secretary, Dr. Franklin J. Kaufmann, of Syra-

cuse, and the business of the meeting was then taken up.

At the morning session a paper was read by Dr. H. B. Besemer, of Ithaca, upon "Septicemia and Death Following X-ray Burn."

Dr. Elias Lester, of Seneca Falls, gave a most interesting report of the meeting of the American Medical Association at New Orleans. Such reports as Dr. Lester made cannot but arouse increased enthusiasm for the annual meetings of the National Association. See page 251.

This session was closed by the president's address. Dr. Biggs chose a most timely subject, a subject which could profitably be discussed at every district branch meeting. The address was upon "The Family Physician," and held the attention of those in the hall from beginning to end. It will be found on page 267.

At the afternoon session the program consisted of an address by Dr. Wiggin, the President of the State Association; a paper entitled "The Personality of the Physician," by Dr. M. B. Van Buskirk, of Aurora, and two short addresses on typhoid fever, by Dr. Philip N. Neary, of Cortland, and Dr. John S. Kirkendall, of Ithaca.

A paper headed "One Hundred Days of Typhoid Fever" was read by Dr. Frank Kenyon, of Scipio. The discussion was opened by Dr. Julian C. Smith, of Oneonta, and Dr. C. W. Greene, of Binghamton.

The symposium proved much more interesting and profitable than any one could have anticipated. Many expressed, after the meeting, how delighted they were that they had been able to hear the papers and the discussion upon this always interesting subject.

Dr. S. Armstrong Hopkins read a paper giving some of his medical and surgical experiences in India, many of which were very amusing.

The following officers were elected for the ensuing year: Dr. F. W. Higgins, of Cortlandt, president; Dr. F. J. Kaufmann, of Syracuse, vice-president; Dr. C. W. Greene, of Binghamton, secretary; Dr. Frank Kenyon, of Scipio, treasurer.

* * *

Fourth District Branch.—The nineteenth annual meeting of this Association was held at the Buffalo Club, 388 Delaware avenue, Buffalo, N. Y., on Tuesday, June 16, 1903. The meeting was called to order at 10.30 A. M. by the president, Dr. J. W. Morris, of Jamestown.

The report of the treasurer was read and referred to the Executive Committee for auditing.

An assessment of 50 cents was levied on the members present to defray current expenses of the branch.

Amendments to the by-laws, to conform to the State Association, were adopted.

The president, in his address, spoke of the extremely gratifying progress that the branch had made during the past year. Within this time seven counties had been organized, giving us ten in all. Of the remaining four unorganized, one,

Niagara, has a sufficient number to organize, and will do so shortly; another county has nine members, and the two remaining a less number. The membership increased from 186 to 336 during the year. The president spoke particularly of the help the following members had been to him in organizing the new counties: Drs. Strong, Jamison, Colvin, Jackson, Huggins, Taylor and Palmer.

The Nominating Committee reported as follows: For president, Dr. J. W. Morris, Jamestown; vice-president, Dr. Bernard Cohen, Buffalo; secretary, Dr. Wm. Irving Thornton, Buffalo; treasurer, Dr. Henry A. Eastman, Jamestown; members of Committee on Nominations to State meeting from Fourth District Branch, Dr. A. A. Hubbell, of Buffalo, and Geo. L. Preston, Canisteo.

It was moved by Dr. Wall and seconded by Dr. Jones that the secretary cast a ballot for the ticket presented. Carried, and the nominees declared elected.

The first paper on the program was by Dr. Samuel M. Brickner, of New York, entitled "The Obstetric Significance of Retroversion and Retroflexion of the Uterus." The frequency of displacements of the uterus being responsible for sterility was emphasized, a proper replacement often being followed by pregnancy. Retroversion, particularly with adhesions, is a common cause of abortion. (Dr. Brickner's paper will later appear in full.)

Dr. C. C. Frederick, of Buffalo, discussed the paper. He reported a case of pregnancy, with the uterus retroverted and bound down by firm adhesions, going to full term. He believed it was permitted to do so by marked hypertrophy of the anterior uterine wall. He stated that a frequent cause of retroversion was from compelling patients to remain too long in a recumbent position after labor.

Dr. Wm. C. Phelps, of Buffalo, read a paper entitled, "Intestinal Obstruction," reporting a series of cases with the symptoms, and treatment of the same. In one case there was such a great amount regurgitated from the bowel into the stomach, with vomiting, that the patient was literally drowned while partially under the anesthetic preparatory for the operation. He advises lavage of the stomach before each operation. Dr. Zera J. Tusk, of Warsaw, opened the discussion. He believes normal salt solution the most valuable agent to combat shock after these operations. Dr. Parker Syms spoke of the grave responsibility placed on the physician who sees these cases early, for there is a time in practically every case at which an operation performed would be followed by recovery. He urged the use of local anesthesia in cases of strangulated hernia. The paper was also discussed by Drs. LeBreton and Tinker. In closing the discussion Dr. Phelps said that he could not advocate the use of local cocaine anesthesia. He had very nearly lost a patient from cocaine absorption in one of

his case. (Dr. Phelps' paper will appear in full.)

Dr. Allen A. Jones, of Buffalo, read a paper entitled, "Spurious Gastric Symptoms." He related the various conditions which gave rise to symptoms referable to the stomach, but proved later to have no direct relation to the latter organ. The paper was discussed by Dr. J. G. Kelly, of Hornellsville, who reported two cases which were diagnosed acute gastritis. On autopsy, one proved to be acute pancreatic disease, the other ruptured gall-bladder. (Dr. Jones' paper will appear in full.)

Dr. John H. Musser, of Philadelphia, President of the American Medical Association, who was invited to the meeting, was presented by Dr. Morris.

The morning session adjourned at 1 P. M. for a luncheon given by the Erie County Medical Association.

The afternoon session was called to order at 2.30 P. M. Dr. Arthur B. Duel read a paper entitled "The Radical Operation for Chronic Suppurative Otitis," and presented a number of specimens, showing the different methods of operation. The various important structures within the ear were plainly marked in different colors by the essayist, making them of greater interest to the general practitioner. The paper was discussed by Dr. W. Scott Renner, of Buffalo, who spoke of the danger of injuring the facial nerve in operating, and of the necessity of thorough packing of the cavity in order to insure proper granulation. Dr. Cott, of Buffalo, also discussed the paper.

Dr. Parker Syms, of New York, presented a paper entitled, "The Results of Prostatectomy." The advantages of the author's method of operating by means of his hydrostatic intravesicle retractor and single perineal incision were demonstrated. A number of large prostates, removed by this method, were shown. The paper was discussed by Dr. Wm. C. Phelps, of Buffalo. Dr. H. D. Ingraham, of Buffalo, presented a modified steel sound for holding the prostate within reach while performing perineal prostatectomy.

Dr. John H. Musser, of Philadelphia, reported three cases of primary carcinoma of the lungs. In the first case the only physical signs were those of moderate pleuritic effusion. Operation revealed the consolidated lung.

In the second case there were emaciation and prostration, extreme dyspnea and evidence of pleural effusion. Aspiration brought one and one-half pints of bloody serum. An enlarged supraclavicular lymph node was removed and found to be carcinomatous.

The third case was remarkable because of its similarity to pulmonary tuberculosis. The patient had been sick for only three weeks, with loss of appetite and general malaise. First examination revealed but slight friction in right chest. No fever on entrance to hospital, but in twenty-four hours rose to over 103. Respiration rose to 34. Patient shortly began to cough or

well up enormous amounts of serous fluid which soon became sero-purulent, and with conical glass test showed the three layers characteristic of bronchiectasis. Physical signs of bronchopneumonia appeared in right chest at base, the areas involved rapidly increasing in size. Soon after left lung showed signs of trouble. Blood examination was negative. Sputum showed pus and staphylococci and ordinary mouth bacteria, no T. B., no pneumococci or bacilli of influenza and no groups of cells characteristic of malignancy. The dyspnea became more and more marked, and the patient died sixteen days after entrance to hospital. Autopsy showed 50 c.c. of cloudy serum in right pleural cavity; discrete grayish infiltration at surface of lung, diffuse and yellowish within. From the microscopic appearance a number of eminent pathologists called it tuberculosis. Microscopic examination, however, proved it to be cancer. The dyspnea was due to enormous number of enlarged bronchial lymph nodes. The paper was discussed by Dr. Chas. G. Stockton, of Buffalo, who reported a case of sarcoma of the left lung starting from the mediastinal nodes. The patient was a boy 18 years of age. The physical signs were: Motionless left chest, marked dullness on percussion, absence of fremitus, no râles or expectoration. There was no fluid in the chest.

Dr. Henry R. Hopkins spoke of the frequency of cancer of the lung following trauma, which, in his mind, pointed toward the parasitic theory of the causation of this condition.

Dr. Allen A. Jones urged greater reliance upon laboratory findings. In Dr. Musser's last case they were very valuable in a negative way. In closing the discussion Dr. Musser stated that the welling up of the great quantity of sero-mucous fluid was one of the chief elements in confusing the diagnosis, as it is supposed to be quite diagnostic of military tuberculosis of the lung following a local focus.

Dr. H. F. Gillette, of Cuba, read a paper entitled, "Hints on the Hygiene and Dietetics of Children," in which he strongly condemned the use of proprietary foods. In discussing the paper Dr. DeWitt H. Sherman, of Buffalo, stated that in some cases no fresh milk could possibly be tolerated and then one of the proprietary foods had to be used. He had seen a fatal case of intestinal infection following introduction of obstetrician's finger into new-born child's mouth to remove small amount of mucus which would be helpful rather than otherwise if swallowed, acting as a laxative. He believes many cases of supposed early intestinal colic are due to collection of uric acid crystals in renal tubules and is relieved by small amounts of soda bicarb., the condition being, in reality, a renal colic. The paper was also discussed by Dr. A. J. Colton.

Dr. Wm. A. Macpherson, of LeRoy, read a paper on "Smallpox," giving his experiences with the disease in an epidemic five years ago. In one case he used the red blinds as suggested by

Finsen, to prevent pitting, with favorable results. The paper was discussed by Drs. Himmelsbach, Grove, Gillette and Palmer.

Dr. Geo. A. Himmelsbach presented a radiograph of a nickel lodged in a child's esophagus. After being located it was readily removed by Dr. Roswell Park with a whalebone coin extractor, the child being under chloroform.

Dr. F. Park Lewis, of Buffalo, presented a paper entitled, "Ocular Incoordination and Cerebral Reflexes." (Appears in full, later.) It was discussed by Dr. A. A. Hubbell, of Buffalo.

Dr. Hubbell moved a vote of thanks to Drs. Musser and Wiggin and the other guests who had favored us by their presence.

A vote of thanks was tendered the Erie County Medical Association for its entertainment of the branch, to Dr. Morris for his efficient work in its interest and to Dr. Wm. H. Thornton for providing the Buffalo Club for the meeting. The attendance was 125.

A very enjoyable banquet was given in honor of Drs. Musser and Wiggin and the other guests, at the Hotel Iroquois. Fifty-four were seated. Informal toasts were given by Drs. Musser, Wiggin, Hopkins, Morris, Phelps, Lombard and several others. William Irving Thornton, secretary.

COUNTY ASSOCIATION NEWS.

Chautauqua County Association.—The regular meeting of this Association was held at the Dunkirk Club, Dunkirk, on May 26th. The by-laws were amended to conform to those of the State Association. Papers were read by Drs. Walter W. Hotchkiss, Jane Greeley, William M. Bemus and William C. Duke. Four new members were elected. The next meeting will be held at Brockton the last Tuesday in September.

* * *

Erie County Association.—The regular quarterly meeting of this Association was held at the University Club, Buffalo, on Monday evening, June 8th. It was the largest meeting in the history of the Association, and a number of new members were elected. The minutes of the previous meeting were read and approved, as was also the report of the Executive Committee.

It was voted to amend the by-laws so as to conform with those of the State Association. Papers were read on "The Relation of Common Forms of Pelvic Disease to the General Health," by Dr. C. C. Frederick, a discussion following by Drs. Maud Frye and Herman Hayd; on "Differential Diagnosis of Tumors of the Breast," Dr. E. J. Meyer, and the discussion by Drs. W. C. Phelps, Vertner Kenerson and Marshall Clinton; "Hemorrhage Following Tonsillotomy, with Report of a Serious Case," Adolph H. Urban; discussion by Drs. George F. Cott, E. J. Meyer and Frank W. Hinkel; "The Relation of the Physician to the Puerperal Woman and Her Child," W. G. Taylor. An adjourned meeting was held on June 16th, previous to the meeting of

the Fourth District Branch Association. The next regular meeting will be Monday, September 14th.

* * *

Kings County Association.—The regular meeting of this Association was held at 315 Washington street on Tuesday evening, June 9, 1903, the president, Dr. George H. Treadwell, in the chair. About thirty of the members were present.

The scientific work for the evening consisted in, first, a paper on "Laboratory Diagnosis in Malaria; an Exhibition of Stained Parasites in Blood Smears," by Victor A. Robertson, M.D.; second, "Cases," by Charles Dwight Napier, M.D.; third, "Foreign Body in a Bronchial Tube: Recovery," by T. A. McGoldrick, M.D.

Dr. Robertson gave a very clear and practical description of the methods for staining and examining the malarial parasites and pointed out the difference between the tertian and æstivo-autumnal varieties. His paper was illustrated by some excellent water-color reproductions and by drawings on the board during the delivery of the paper. At the close he exhibited some beautifully colored specimens of the various organisms.

Dr. Napier reported several cases of gonorrhœal rheumatism treated by fixation with plaster of paris splints. The results were highly satisfactory in all the cases reported.

Dr. McGoldrick's paper will appear in a later issue of the JOURNAL.

At the close of the meeting the regular collation was served. This was the last meeting of the Association until October.

* * *

Orange County Association.—The first annual outing of this Association was held at the Tuxedo Club, Tuxedo Park, on Wednesday, June 24th, and although the weather was so threatening the members were well represented from all parts of the county. Through the kind invitation of Dr. and Mrs. E. C. Rushmore, of Tuxedo Park, the members of the Association and their wives were extended the hospitalities of Tuxedo and entertained at the Tuxedo Club.

The party went from here on Erie train No. 30, and were met at Tuxedo by Dr. Rushmore and conveyed in carriages from the station to the clubhouse, arriving there about noon. Before luncheon a stroll was taken along the shores of the beautiful Tuxedo Lake, over the outdoor tennis courts and golf links, an inspection of the indoor tennis, squash and racquet courts, to the Turkish and Russian bathrooms, finally a visit to the fish hatchery, where the entire process of raising fish was to be seen, from those only a few weeks old to those fully matured and ready to be put into the lake, the sole object of the whole process being to stock the waters of the lake with the finest breeds of fish for angling purposes.

On returning to the club the guests were seated in the large dining hall and did ample justice to a very excellent luncheon.

At the conclusion of the repast the doctors

repaired to the smoking-room, where a short scientific meeting was held. In the absence of Dr. W. I. Purdy, who was unavoidably detained, Dr. W. E. Douglas, vice-president, presided and introduced Dr. M. Allen Starr, of New York, who gave an address on "Acute Multiple Neuritis." The doctor spoke very clearly and concisely on the subject, giving the causes, symptoms, diagnosis and treatment in such a manner as to impress many valuable thoughts in the minds of those present.

Dr. Starr's paper was discussed by Drs. Nugent, Dennis, Sharp, Conner, Rushmore, Douglas, Redfield and Distler. At the conclusion of the discussion Dr. C. W. Dennis, of Goshen, proposed a vote of thanks to Dr. Starr for his instructive address, which received the hearty support of all present.

Dr. W. S. Russell proposed a vote of thanks to Dr. and Mrs. Rushmore for extending to the Association and their wives such hospitality as had been the privilege of all present to enjoy, which met with the unanimous and hearty response of every one by a standing vote.

During the scientific program the ladies of the party were treated to a pleasant diversion under the kind leadership of Mrs. Rushmore in the shape of a "Country Fair," which was in progress at the club in the interest of a church at the park. Later the gentlemen of the party joined them at the fair and much amusement was afforded by the "grab bag," "gypsy camp," "fortune tellers" and vaudeville show to be found there, as well as the many beautiful and useful articles offered for sale.

After a hasty visit to the "fair," Dr. Rushmore invited the party to drive around the lake, and led the way to carriages in waiting. A most delightful ride was enjoyed. Starting from the clubhouse the circuit road was followed, along which are many magnificent residences, then along the western shore road and Turtle Point road, skirting the northern boundary, and then down the East Lake road with mountain, lake and forest forming a fitting background, for the many imposing and artistic residences formed a never-to-be-forgotten picture, and a revelation of beauty and grandeur which few Orange County people realize is within its bounds.

Two stops were made, the first at Dr. Rushmore's residence for a view from his library window, which only seemed to form the frame of a magnificent painting of lake and forest; the second on the highest elevation on the east side of the lake, where, as in a panorama, the entire park, with its beautiful trees, placid lake and grand buildings, stretched in continuous line for many miles.

After nearly an hour and a half drive the horses' heads were turned toward the station, where the party arrived in good season to take the old reliable Orange County Express for their various homes. All thoroughly enjoyed the trip and again thanked Dr. and Mrs. Rushmore for

their very generous hospitality before boarding the train.

Those who composed the party were as follows: From Middletown—Dr. and Mrs. J. B. Hulet, Dr. and Mrs. M. C. Conner, Miss Belle Horton, Dr. W. E. Douglas, Dr. and Mrs. C. I. Redfield; from Unionville—Dr. and Mrs. F. W. Dennis, Miss Dennis, Dr. and Mrs. E. A. Nugent; from Westtown—Dr. and Mrs. L. C. Distler; Slate Hill—Dr. F. D. Myers; Pine Bush—Dr. and Mrs. L. J. Merritt; Goshen—Dr. C. W. Dennis; Monroe—Dr. and Mrs. E. D. Woodhull; Turner—Dr. and Mrs. H. E. Wise; Highland Mills—Dr. and Mrs. W. S. Russell; Central Valley—Dr. E. A. Sharp; Tuxedo—Dr. and Mrs. E. C. Rushmore, Dr. Johnson; Newburg—Dr. Mary E. Dunning and Mr. Dunning; Dr. M. Allen Starr, of New York.

* * *

Ulster County Association.—A special meeting of this Association was held at the office of the president, Dr. Henry Van Hoevenberg, Kingston-on-Hudson. Dr. Frederick Huhne was elected member of the Executive Committee in the place of Dr. J. L. Preston.

LIST OF MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION, JUNE 1 TO JULY 1, 1903.

Dick, Andrew J., Watertown.
Heston, Eber H., Clintondale.
Kimball, Charles Campbell, Watertown.
Palmer, Albert H., Marlborough.
Sauer, J. George, New York City.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Jefferson County.—Charles J. Bacon, Fulton; George F. Gardiner, Ellisburg; Harvey W. Humphrey, Adams; Charles C. Kimball, Watertown; Michael J. Lawler, Carthage; Elbridge G. Minar, Mannsville; Cyrus J. Severance, Mannsville; Will H. Schwartz, Colton; Florence A. Sherman, Watertown.

Oneida County.—George C. Reid, Westernville.

SECOND DISTRICT BRANCH.

Essex County.—Theodore H. Canning, Port Henry; John P. J. Cummins, Ticonderoga; Robert T. Saville, Mineville; William T. Sherman, Crown Point Centre; Frank E. Sweatt, Essex; Charles B. Warner, Port Henry.

Schenectady County.—Norman B. Saunders, Schenectady.

THIRD DISTRICT BRANCH.

Cayuga County.—Frank C. Smith, Fleming.
Onondaga County.—Frank Fitzgerald Clark, Syracuse.

Otsego County.—Charles H. Herrick, Gilbertsville; Daniel Luce, Hartwick.

Tompkins County.—Charles P. Beaman, Ithaca; John Wesley Judd, Ithaca; Harry Thomas Rhodes, Ithaca.

FOURTH DISTRICT BRANCH.

Cattaraugus County.—James Ross Allen, Olean; Frederick C. Beals, Salamanca; Seba S. Bedient, Little Valley; Weldon A. Dickson, Salamanca; John H. Sackrider, East Randolph; James A. Taggart, Salamanca; John Sutherland Wright, Little Valley.

Chautauqua County.—Charles S. Cleland, Sinclairville; Frank W. Green, Sherman; J. L. Hutchinson, Jamestown; John A. Weidman, Dunkirk.

Erie County.—Charles R. Borzilleri, Buffalo; Marshall Clinton, Buffalo; Charles T. Crance, Buffalo; James A. Gibson, Buffalo; Wellington G. Grove, Buffalo; Edwin W. Janes, Hamburg; Charles S. Jones, Buffalo; Frank W. Love, Buffalo; John G. Miller, Lancaster; James J. Mooney, Buffalo; Frederick J. Parmenter, Buffalo; Albert E. Persons, Buffalo; Edward N. Pfohl, Buffalo; Fridolin Thoma, Buffalo; Hugh S. Townsend, Buffalo; Ira P. Trevett, West Seneca; George W. York, Buffalo.

Livingston County.—Frederick R. Driesbach, Dansville.

Niagara County.—Chester E. Campbell, Niagara Falls; Frank Guillemont, Niagara Falls; Charles N. Palmer, Lockport; Roy Henry Wixson, Niagara Falls.

Ontario County.—Claude C. Lytle, Geneva; William W. Skinner, Geneva; Martin B. Tinker, Clifton Springs; Gardiner B. Young, Geneva.

Orleans County.—Charles E. Fairman, Lyndonville; David Fraser, Lyndonville.

Steuben County.—Charles M. Brasted, Hornellsville; William E. Hathaway, Hornellsville; Charles H. Herrick, Gilbertsville; Charles O. Jackson, Cameron; William Everett Palmer, Hornellsville; Geo. L. Preston, Canisteo; Lyman B. Smith, Hornellsville; Irving P. Truman, Hornellsville; Bertis R. Wakeman, Hornellsville.

FIFTH DISTRICT BRANCH.

Nassau County.—William I. Cocke, Port Washington.

Orange County.—Mary E. Dunning, Newburgh; Edward C. Rushmore, Tuxedo Park.

Queens County.—Edwin A. Goodridge, Flushing.

Richmond County.—William Bryan, West New Brighton; Joseph E. Vidal, Stapleton.

Ulster County.—Albert H. Palmer, Marlborough.

Westchester County.—Georgiana Sands, Port Chester; George C. Weiss, Mount Vernon.

A young Viennese physician, Dr. Sachs, died Saturday from the bubonic plague in an isolation hut at Berlin. He was engaged in bacteriological work at the Institute of Infectious Diseases, when plague symptoms developed. Because of this, the Government has decided to issue a decree forbidding further experiments with plague germs, the risk of spreading infection being considered more dangerous to the public health than the knowledge gained in studying the microbe justifies.—*New York Evening Post*, June 8, 1903.

PERSONALS.

Dr. V. A. Moore, head of the Department of Bacteriology in Cornell University, has gone to California for the summer vacation, to organize the work for investigating infectious diseases of animals which the experiment station of the University of California is about to undertake. Professor Moore is an authority in this line of work, and has recently published an excellent treatise, "The Pathology and Differential Diagnosis of Infectious Diseases of Animals." Dr. Moore was one of the charter members at the recent organization of the Tompkins County Medical Association.

Dr. John F. Erdmann, 60 West 62d street, Manhattan, has been elected president of the Bellevue Alumni Association for 1903-1904.

Dr. William S. Terriberry, 148 West 74th street, Manhattan, has been reelected secretary of the Bellevue Alumni Association.

Dr. Guy Davenport Lombard, 6 East 32d street, Manhattan, the secretary of the New York State Medical Association, will spend until October 1st at St. Hubert's Inn, in the Adirondacks, with Mrs. Lombard.

Dr. Fred Walker Gwyer, 130 East 38th street, Manhattan, is spending his vacation on his farm in Vermont. Dr. Gwyer enjoyed a successful fishing trip in Canada a few weeks ago.

Dr. William A. Downs, 47 West 44th street, has returned from a month's vacation. The doctor and his wife have been visiting friends in the South.

Dr. Patrick Henry Fitzhugh, 36 West 35th street, Manhattan, returned the first of last month from a trip to Europe.

Dr. Christopher J. Hillis, of Griffin Corners, recently returned from Johns Hopkins University, Baltimore, where he took a post-graduate course in surgery.

Dr. Mary Gage-Day, of Kingston, took a vacation in June. She attended the commencement exercises of Cornell University in Ithaca, where her nephew, Lynn G. Wright, received an A.B. degree, June 18th. After a very enjoyable visit at her brother's, Prof. Simon H. Gage, she went to Worcester, N. Y., and attended the marriage of her niece, Miss Albertha Gage, to Rev. Ira Hotaling, of Bath, N. Y. The wedding took place at the old homestead of the Gage family in Worcester. Dr. Gage-Day was accompanied by her niece, Miss Nellie Mary Gage.

Dr. Edward Bradford Dench, 17 West 46th street, Manhattan, was recently elected to membership in the New York Yacht Club.

Dr. Charles McBurney, 28 West 37th street, Manhattan, who is spending the summer at Stockbridge, Mass., went on a fishing trip to Maine during June.

Dr. William B. Coley, 5 Park avenue, Man-

hattan, has been appointed instructor in surgery in the medical department of Columbia University.

Dr. Harry Meade, 758 Elmwood avenue, Buffalo, has returned from his trip abroad.

Dr. and Mrs. John T. Nagle, of 163 West 126th street, will go to Europe July 11th, where they expect to remain until the latter part of September, and return to the city about October 1st.

Dr. and Mrs. Francis J. Quinlan, of 33 West 38th street, will leave for Europe on July 20th, and will return early in the fall.

Dr. Ernest Danziger was married to Miss Martha Bachmann, at Delmonico's, June 2, 1903.

Dr. and Mrs. Louis Faugeres Bishop, of 54 West 55th street, left town Wednesday for York Harbor, where they will spend the summer.

The following members of the New York State Medical Association have been elected as officers of the Alumni Association of the medical department of the University of Buffalo: Drs. Jane Wall Carroll, George A. Himmelsbach, Devillo W. Harrington, Grover William Wende and John Parmenter.

Dr. Smith E. Jelliffe has been appointed instructor in materia medica and therapeutics in Columbia University.

Dr. George H. Treadwell, 64 South Portland avenue, Brooklyn, president of the Kings County Association, will leave, July 12th, for his summer home in Maine. Dr. Treadwell will not return until September.

Dr. Charles C. Barrows, 6 West 36th street, Manhattan, has practically recovered from the fractured patella he suffered a few weeks ago.

Dr. Hubert Arrowsmith, 180 Clinton street, Brooklyn, ex-president of the Kings County Association, is occupying his summer home at Huntington, L. I. Dr. Arrowsmith returns to town three days a week to attend to his patients.

Dr. Samuel A. Brown, 23 East 44th street, Manhattan, expects to spend part of the summer cruising on the New England coast. Dr. Brown is the chairman of the Committee on Arrangements of the State Association.

Dr. John J. Nutt, of the "Seminole," is spending the summer at Lake Placid, Adirondacks. The doctor will remain there until the fall.

Dr. George F. Maddock, 80 McDonough street, Brooklyn, corresponding secretary of the Kings County Association, left town, June 21st. He and his family will spend the summer at his camp on Lake Muskoka, Canada, returning in September. Dr. Maddock will have a new diversion this season from the usual canoeing, fishing, etc., of that region. He will have the pleasure of "breaking-in" a new gasoline launch.

Dr. and Mrs. Francis P. Kinnicutt and family have closed their residence, 39 East 25th street, and are now at Morristown, N. J.

COLLECTION OF DUES.

On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the Medical Directory for that year, and if those members still further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse, their names shall be dropped from the official roll of membership.

WHAT IS GOING ON IN THE LEGAL DEPARTMENT.

An interesting case was brought to the attention of the counsel of the State Medical Association early in 1901. Last week a second complaint was formulated against the same defendant, Francesco Tuscano, who is running a medical institute at 325 East Twelfth street. It was stated that this institute was under the supervision and protection of a physician in Brooklyn. For the purpose of preventing this physician from testifying that he was present in New York when the detective of the Association called on the defendant in the case, Mr. Conway went to his office in Brooklyn, and asked him where he was at the hour the defendant was examining the detective. The physician said that he was in Brooklyn. When the case was tried before Magistrate Breen, the doctor came forward promptly and testified that he was present in New York and examined the detective, and denied having ever seen Mr. Conway, and that Mr. Conway had never been in his office. He being, as far as the magistrate knew, a reputable physician, his word was taken as against the detective's and the defendant was discharged and the complaint dismissed.

The counsel of the Association, however, has drawn the affidavits of Mr. Conway and of Mr. Villone, the detective, and has forwarded these affidavits to the Regents, and they have been presented by the Regents to the State Board of Medical Examiners for their action. The defendant was immediately rearrested on the 1901 complaint and waived examination, and will be tried on a near date. The Brooklyn doctor, according to the directory, is not a member of any medical organization.

Dr. Sampsell, who was arrested in the institution conducted by Dr. E. D. Porter, at 65 West 36th street, was fined only \$50. It is claimed that there had been no licensed pharmacist in this place, but that an ex-ball player has been dispensing the drugs; the fact that Dr. Sampsell pleaded guilty, and was a graduate of another State Medical Board, had much to do, evidently, with the Court's decision in fining him but \$50.

Stanilaus Nowske, of Williamsbridge, who has

given much trouble to the doctors of that neighborhood, also pleaded guilty, but his poverty appealed to the Court and the fine imposed was but \$25.

Dr. Muoio, of Navy street, Brooklyn, pleaded guilty in the Special Sessions in Brooklyn, and was fined \$50, it being his first offense. Judge Courtney expressed himself very forcibly against these foreigners, and was in favor of a much larger sentence, but the other members of the Bench prevailed upon him to reduce it to \$50.

The interesting case of Carmela Rubino, of Villa avenue, Bedford Park, was sent to the office of the counsel from the District Attorney's office, upon evidence entirely outside of the State Medical Association. This woman is a fortune-teller and has been swindling the Italians of that district, who are extremely superstitious. In this particular instance she advised the withdrawal of all medicines given by doctors, and substitute a powder in their place; the patient had tuberculosis and soon died; the husband is the complainant.

Pauline Price, of 262 Second street, is another of the fortune-telling variety, and she was held for trial by Judge Breen, in the Fourth District Court. She was fined \$15.

During the past month another application has been made by one of the members of the Association for malpractice defense, and the counsel is convinced of a successful issue upon the trial. A codefendant with the member is another doctor, who unfortunately is not a member of the Association, and, of course, the Association cannot take up his defense.

This little incident emphasizes the advisability of all members of the profession joining the Association without further delay.

Mrs. Edith Allen, of 61 Carlton avenue, Brooklyn, was fined \$100 on June 15th.

MEDICAL PRACTICE ACT FOR NEW JERSEY.

The State Board of Medical Examiners of New Jersey has secured amendments to the Medical Practice Act of that State by which the academic standards for admission to the State examinations have been raised from a competent common-school education to a diploma issued after four years of study in a normal, manual training, or high school of the first grade in that State, or its equivalent. The medical requirements have been increased from three to four courses of medical lectures of at least seven months each, in different calendar years, prior to receiving the degree of Doctor of Medicine. The amendments go into effect on July 4th next. After that date candidates for examination, or for the indorsement of a license issued by a recognized examining board of another State, will be obliged to comply with the new standard of requirements for a New Jersey license.

News Items.

TRANSACTIONS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Vols. I and II.

The plates for Vols. I and II of the Transactions of the New York State Medical Association having recently been found, it will be possible to furnish members having sets of transactions which are incomplete on account of the absence of these numbers, with either of them at an expense not to exceed \$5 per volume, provided a sufficient number of members signify, within a reasonable time, to the President, Frederick Holme Wiggin, 55 West 36th street, New York City, their wish to obtain Vol. I or II, or both of them.

There are still a few sets of the Transactions of the old State Association, Vol. III to XVI, in the hands of the Committee on Publication, and they will be furnished while they last to members of the Association who have not already a set, if they will send word to Dr. Charles E. Denison, Chairman, Committee on Publication, 64 Madison avenue, New York City, that they would like to have them and are willing to pay the express charges for the delivery of the books, which charges average less than \$1; they will be forwarded them at once.

A fraud order has been issued by the Assistant Attorney-General of the Post-office Department against the proprietors of the Hulonius Magnetic Institute, of Buffalo.

* * *

The trustees of Bellevue Hospital have a plan for enlarging that institution by acquiring the block bounded by 28th and 29th streets, First avenue and the East River.

* * *

The Children's Hospital on Randall's Island is to have a new laboratory building. It will be built of brick and marble and cost about \$5,000.

* * *

"The time is not far distant when, to equip the university properly, the medical school must build and control a hospital of its own. In foreign universities the greatest medical schools command their own hospitals, and the striking success of the medical school of the Johns Hopkins University has been due in large part to the fact that a modern hospital was under its own immediate control."—*President Butler, of Columbia University.*

The *New York Medical Journal* and the *Philadelphia Medical Journal*, beginning with the issue of June 20th, are to constitute a consolidated journal.

AGED PHYSICIAN IN WANT.

Dr. Frederick W. Brodman, 76 years old, who says he is a graduate of a German university and of the Eclectic College of New York, was found in a feeble and irresponsible condition at First avenue and 33d street yesterday. He was taken to Bellevue Hospital and from there sent to the East 35th street police station, where the record of "temporary insanity" was placed on the blotter.

Dr. Brodman lives at 306 East 73d street with his wife and large family of children. He was taken home by a son. The home showed evidences of destitution. The aged man said that he was anxious to go to some institution where he could regain his health. He said he formerly had a large practice in New York, but that his family was now in want.—*New York Herald, June 20, 1903.*

THE BOYCOTT IN WATERBURY.

We have received letters from several of the physicians whose names were blacklisted recently by the strikers in Waterbury, Conn., and who in consequence were supposed to be suffering the effects of a boycott. Our correspondents, as a rule, make light of the affair in so far as it affected their material interests, but they all demonstrate very clearly that the intentions of the strikers were the worst possible, and that if these strikers did not accomplish their purpose of intimidating the physicians, this failure was due to the determined stand of the physicians themselves.

Waterbury, it seems, had been "unionized"; that is, an attempt had been made to put the city under the control of a combination of labor unions, which were affiliated with a central body. The fiat went forth that no one was to use the trolley cars, and it was for disregarding this fiat, and for using the cars in order to visit patients, that the physicians were boycotted. One of our correspondents sends us a graphic account (which we should like to print) of how a body of influential citizens, including physicians, finally met in council, and by adopting an energetic policy broke the boycott up, or at least disarmed it of its terrors.

The action of the physicians in Waterbury seems to have been resolute and successful. They persisted in attending to the sick and injured without regard to the behests of a self-constituted and irresponsible authority. Their action is an example to others, an example which others may have only too many opportunities to follow in these times of social unrest. The physician is always a privileged person when he goes to the aid of a patient; even savages have recognized that privilege in him. Even in war the red cross is recognized. It were a poor showing for labor agitators if they were to make war upon the sick and dying.—*Medical Examiner, March.*

NATIONAL BUREAU OF MEDICINES AND FOODS.

General Statement of Plan.

The joint committee of the American Medical and the American Pharmaceutical Associations presents in the following statement the plan for establishing a National Bureau of Medicines and Foods which it has been appointed to consider. In order to aid the committee in coming to a determination as to the proper recommendations to be made to the associations, physicians, pharmacists and manufacturers are requested to express to the committee their opinions regarding the advisability of establishing this proposed bureau and their reasons for approving or disapproving its establishment. The plan herewith published should be carefully read and considered before opinion or criticism is expressed. The subject is of the greatest importance and the scope and details as set forth in the plan under consideration should be fully appreciated.

The members of the American Medical Association Committee: E. Eliot Harris, New York; N. S. Davis, Jr., Chicago; Solomon Solis Cohen, Philadelphia; H. Bert Ellis, Los Angeles; Philip Mills Jones, San Francisco.

The members of the American Pharmaceutical Committee: H. H. Rusby, New York; Jas. M. Good, St. Louis; C. S. N. Hallberg, Chicago; A. B. Lyons, Detroit; S. A. D. Sheppard, Boston.

Kindly forward any criticisms, whether favorable or unfavorable, to either the chairman, H. H. Rusby, M.D., 115 West 68th street, New York City, or the secretary, Philip Mills Jones, M.D., 13 West 18th street, New York City (after July 25th, 31 Post street, San Francisco, Cal.).

It has seemed desirable to enumerate a few of the more important evils connected with the lack of standard in pharmaceutical preparations, adulteration of drugs, chemicals and food stuffs, and the exceedingly complex condition of the many remedial preparations constantly offered to the medical profession.

The Pharmacopœia in this country is not a compulsory document. As a result manufacturers are not obliged to follow it in the preparation of pharmaceuticals, and, as a matter of fact, there is much variation in the strength of their products. Fluid and solid extracts, etc., and many pharmacopœial preparations are made differently by different manufacturers and often are not, as they should be, identical within reasonable limitations. The strength of tinctures made by different manufacturers has been found to vary as much as 70 or 80 per cent. This variation is such that prescriptions filled with one set of products will have a certain appearance and therapeutic effect, but the same prescriptions when compounded from products of a different manufacturer will have a different appearance and therapeutic effect.

Chemicals are often adulterated or impure; even reagents marked "C. P." can, in most cases, not be relied upon. Lists of chemicals bought in open market and analyzed with the adulterants and impurities commonly found have been published from time to time and are accessible. The facts are so generally known that it is hardly necessary to enumerate them here. A few illustrations will suffice: Tincture of aconite, practically inert; aristol, containing 65 per cent. of free alkali; phenacetin, containing 90 per cent. of acetanilid; boric acid, adulterated with three times its weight of borax; "C. P." zinc, containing iron and arsenic in appreciable quantities; hyoscyamine, as pure atropine, etc.

Adulterations of food stuffs, the use of harmful coloring matters and preservatives, etc., are matters of common repute and have been noticed so many times in connection with proposed and urged national legislation that only summary comment is needed. Cotton-seed oil is commonly marked olive oil; coffee may be largely chicory; mustard is often not more than 10 or 15 per cent. mustard, the adulterant being corn meal; black pepper is usually adulterated with from 50 to 80 per cent. of foreign material; jellies and jams are seldom what they purport to be; salts of zinc, salicylic acid and the salicylates, borax and boric acid and other preservatives are very generally employed and not infrequently they are used in harmful quantities. So common is adulteration of food stuffs that there exists almost complete distrust in the public mind as to the purity or freedom from harmful preservatives of most common food stuffs. In the domain of prepared foods there is at the present time no means of determining their composition or suitability for the diets for which the makers recommend and advertise them. It has been found that many foods recommended for diabetics contained starch or sugar in considerable quantities, when the makers claimed absence of these ingredients for their products.

Many of the large number of special preparations that are put upon the market and strongly urged upon the medical profession probably are good and have certain well-defined uses. But the methods employed by the manufacturers are such as to induce a certain lack of confidence. The physician, as a rule, is not informed of the actual composition of the mixtures he is requested to employ, or if the composition is given it is vague or at best there is only the statement of the interested party—the manufacturer—to rely upon. If a physician uses many of these preparations in good faith and in good faith comments favorably upon them in the medical press—supposing that his comment has not been "blue-penciled" by the editor of the journal—he is in great danger of seeing his statement taken and even garbled by the manufacturer and extensively used for advertising purposes. This if his comment is favorable; if it be unfavorable the manufacturer ignores it entirely.

The prevention of adulteration in drugs, chemicals and food stuffs and the maintenance of standard in pharmaceutical preparations should be a Government function. For fourteen years effort has been made to secure proper national legislation for

this purpose, but without result. The existence of the evils pointed out is recognized by all, and in view of the failure to secure the requisite national legislation, correction, or attempted correction, of these evils has been suggested through the medium of a proper commission or bureau established by individual effort. Such a bureau could be formed by the association of professional men, on the one hand, and of those manufacturers who desire to put out only pure, standard and honest goods on the other hand. It is believed that such an association would be to the very great advantage of the public and probably to those manufacturers who associated with such a bureau in its proposed work.

At first glance and until the proposed plan is carefully studied it would seem that such an undertaking would be impracticable. When carefully studied in detail, however, the plan, though of tremendous magnitude, appears to be so far practicable as to demand further study.

The following (*infra*) statement of the plan which has been formulated for the purpose of meeting present conditions, of adulteration, lack of standard in pharmaceuticals, confusion in identity of preparations and brands of medicinal mixtures, etc., is herewith presented for your very careful consideration. This statement has been made as short as possible, though the effort to condense has not been permitted to go to the point of eliminating anything necessary for the proper understanding of the subject.

The friendly association of the best in the professions of medicine and pharmacy with large commercial interests necessarily demands the most careful and cautious treatment that it may be beneficial to the public and to the manufacturer without detracting from the reputations of the professional men who engage upon the work by casting suspicion upon their motives or their integrity. At the same time a large amount of work would necessarily fall upon the professional side of such an association and the cost of performing the work would have to be defrayed in some manner. It has seemed no less than right that this cost should be met by those who are commercially interested in and profit from the manufacture of the products which would be considered by such an association. Furthermore, it is vitally necessary that such an association should possess the right to determine who may and may not be received in association, and what products of its associates may receive its attention and the standards of identity, purity, quality or strength to which these products should comply. It must also be in a position to instruct the public and the professions upon matters connected with its work and upon subjects that are of sufficient interest to the professions or to the public.

To accomplish these ends and to secure the protection to the professional men who shall be chosen to undertake the work outlined the following detailed plan has been suggested:

Plan.

In order to have proper legal and business standing the work should be done by a corporation. As it is not intended that profit shall be made from the undertaking the corporation should be a membership and not a joint stock corporation. It is proposed to incorporate under the laws of the State of New York a membership corporation to be known as the National Bureau of Medicines and Foods.

The membership of this bureau should be of two or more classes. All members of the American Medical Association and the American Pharmaceutical Association should be scientific members of the bureau. The organization should be so effected as to fully protect the American Medical Association and the American Pharmaceutical Association, their agents and all their members who become members of the proposed bureau, from all possibility of being involved in legal or other complications that might assail the proposed bureau. Those manufacturers whose goods it might be requested to vouch for should be admitted to associate membership, but should have no voice in the control of the bureau.

The control of the bureau should be placed in the hands of a board of ten directors, five elected by each association, one from each association retiring annually and his successor elected for five years. This board of directors, with the exception of its secretary, who should devote all his time to the work, should not receive salaries, but should receive mileage and *per diem* when called upon to attend meetings of the board or of its committees. The board should, in consultation with the manufacturer, fix standards of identity, purity, quality and strength, not in conflict with the United States Pharmacopœia, and the manufacturer having agreed to these standards should contract with the bureau to comply with them until altered by common consent and a vote of the board; and to comply with all rules governing him in the manufacture of his product, such rules having been formulated in consultation between the board and the manufacturer and accepted by both. An eight-tenths vote of the board should be required to accept or reject any application for associate membership or to adopt any rule of the bureau or to accept or reject any product presented by an associate manufacturer for proper control by the bureau. No manufacturer or person employed by any manufacturer of products that might come within the scope of the work of the proposed bureau and no person engaged in their distribution or sale should be eligible on the board of directors unless approved by a three-fourths vote of the Council of the American Pharmaceutical Association or a three-fourths vote of the House of Delegates of the American Medical Association, respectively.

By-laws should be carefully drawn and adopted by the board and thereafter it should require a unanimous vote of the board to alter or amend them in any way. They should be very broad and general, covering only vital principles, and all details should be formulated in the shape of rules which could be altered or abolished as occasion required, only by an eight-tenths vote of the board.

The business side of the bureau should be considered with no less care than that devoted to the scientific side. While it

would not be the purpose of the bureau to make money, it should be the aim of its administration to confine the cost to the lowest amount consistent with properly carrying on the work, for in any event this sum would be a large one. Modern business methods should be adopted and one general responsible head appointed by the board of directors. Under him should be such persons as may be required to carry on the work under the rules and regulations established by the board and it should be their duty to see that proper and competent persons only were employed. The board of directors as such should not come into direct contact with the business side of the bureau nor with the commercial interests involved. It should act in a supervisory capacity; it should say absolutely what rules, standards, etc., were to be followed and it should see that a proper business department then carried out these rules.

It should be the purpose of the bureau to work in perfect harmony with the United States Government authorities and especially with the Department of Agriculture. In case of future legislation by the United States Government some of the functions of this proposed bureau might be modified or transferred to the proper Government department. The ever-present hope that such legislation will eventually be enacted should not, however, interfere with the careful consideration of the bureau plan nor with its acceptance if it be found satisfactory. Unless spurred on by some such individual effort many more years may elapse before the enactment of proper national legislation. Some features of the work of the bureau could hardly be assumed by the government; notably the dissemination of accurate and reliable information relative to manufacturers and their products and especially to newly discovered remedial agents, etc., together with a proper ethical supervision of advertising matter connected with the introduction of such products.

Existing laboratories should be utilized so far as practicable in prosecuting the work of the bureau, in making its original investigations and in carrying on the work of check control, for two reasons: First, in order to incur no greater expense than absolutely necessary; second, in order to encourage scientific enterprise where now already organized.

The bureau should not issue blanket certificates. Each package of any product that is manufactured under the supervision of the bureau and which complies with its rules and standards and for which compliance some individual expert is responsible, should, however, bear a label setting forth that fact for the benefit and guidance of the purchaser.

No nostrum nor any medicinal product of which the full formula giving all the active ingredients and couched in the ordinary terms of chemistry and pharmacy has not been or is not freely published, should at any time be permitted to come within the supervision of the bureau.

Detail Method of Operation.

Any manufacturer desirous of having one or more of his products placed under the supervision of and certified by the bureau would first apply to the secretary for associate membership, which application would carry with it a contract to abide by the rules of the bureau (Appendix A). The application would then be submitted to the board of directors, and on the written approval of a majority of them, such manufacturer would be accepted in associate membership.

An associate member desiring to have a given product certified by the bureau would transmit to the secretary a proper application for that purpose, together with two samples of the product in question. One of these samples should be sealed and deposited in the custody of the secretary; the other should be transmitted to the scientific department of the bureau, together with instructions to fully investigate the article, and to compare it with at least two samples bought in open market without the knowledge of the manufacturer. When the scientific department has obtained all the information desired by the board of directors, it would transmit the same to the board, who would then consider it in connection with the application. If found satisfactory, the board, in conjunction with the manufacturer, would determine standard of identity, purity, quality and strength, to which this product should thereafter comply and would formulate rules acceptable alike to the board and to the manufacturer for the guidance of the chemists of the manufacturer on the one hand and of the scientific department on the other (Appendix D).

These formalities having been complied with to the satisfaction of the board of directors the manufacturer would then be authorized to print upon the label of each package of each batch of the product that had been approved by the expert or experts in charge or to attach to each such package a separate paper, setting forth the fact that the contents of that unbroken original package had been certified by the bureau under certain rules, and the manufacturer might also print thereon the text of these rules. Each and every such label or paper should bear a number which would indicate, through records to be kept by the bureau, the date of the particular batch and the expert or experts responsible for having approved the standard thereof. At least two samples of each batch should be kept by the bureau for a period to be determined by the board.

At least three times each year two samples of each and every product bearing the certificate of the bureau would be purchased in open market in different localities and submitted to careful examination by the scientific department of the bureau in order to determine whether the standard established was being maintained by the manufacturer. If the standard established was not being maintained the certificate of the bureau should be withdrawn.

Unless all of the products of any manufacturer were certified by the bureau, such manufacturer should not be permitted to advertise that his products were certified by the bureau, but in all advertisements of any certified products he should state that such products were certified. If all his products were

placed under the supervision of the bureau he might so advertise.

An associate member who might desire to contract with the bureau to submit any and all advertising matter relative to one or more certified products to the censorship of the bureau could do so. (Appendix C). The bureau would then undertake to place the censored and approved information concerning such products before the physicians and pharmacists of the country in a dignified and strictly ethical and professional manner. These statements would and could with safety be relied upon by all the professional interests, for they would practically be the statements, not of the interested manufacturer, but of the disinterested board of professional men composing the board of directors of the bureau. Careful inquiry among a large number of physicians has revealed a unanimous desire to receive such accurate and reliable information from a wholly disinterested source. Statements issued by the bureau would receive attention where statements issued by the interested manufacturer would not be read at all or, even if read, would be regarded with a certain amount of natural distrust. It is not proposed that the bureau shall deliver official opinions as to the therapeutic value of any products; it would simply certify to their compliance with certain standards or to certain formulas. The statements which it could disseminate regarding such products would be confined to statements of fact regarding origin, composition, chemical and physiologic action, etc., and the opinions of qualified students and investigators which it might collect and diffuse for the benefit of all who might desire to investigate or make use of such products.

The Operation as Applied to Retail Pharmacists.

It is proposed that the retail pharmacist shall associate with the bureau on a sound professional basis. In every way possible the bureau should endeavor to aid and improve the profession of pharmacy and to make more cordial the relations between physicians and pharmacists. To this end the following general plan is submitted for discussion and careful consideration:

Any pharmacist who so desired could become an associate member of the bureau on application, contracting to obey and abide by the rules of the bureau. Rules governing him in the preparation of pharmaceuticals would be, as far as possible, similar to the rules governing the manufacturer, and a system consisting of careful and frequent inspection and analytic check control would be established, as in the case of the manufacturer, in order to protect the bureau certificate. Such associate pharmacists would agree to supply products certified by the bureau, when not otherwise called for, and the physicians would be advised of all associate pharmacists in their immediate vicinity. The bureau would also endeavor to have physicians call for products certified by the bureau and, whenever not absolutely necessary, refrain from specifying particular brands or makes, requiring only that the materials used by the pharmacist should be of the standards established by the bureau and certified by it.

It is hardly necessary to call attention to the very wide differences in the commercial relations of manufacturers and pharmacists to the medical profession. Obviously the problems attendant upon these differences would have to be met by the bureau by the formation of different classes of rules and by different forms of inspection. The detail work in connection with the undertaking, as applied to the pharmacist, would necessarily be very great, and for the sake of proper treatment of the pharmacist himself it should not be undertaken until the bureau had been established on a conservative basis. It should, however, be undertaken at the earliest practicable time.

Appendix A.

Application for Associate Membership.

.....[place and date].

A. B., the undersigned, engaged in the business or occupation of [manufacturing pharmaceuticals, pharmacy, etc.], herewith makes application for associate membership in the National Bureau of Medicines and Foods, and if duly elected under the by-laws of said National Bureau of Medicines and Foods to associate membership therein, will, and does by these presents formally enter into and agree to the following contract and agreement with the said National Bureau of Medicines and Foods, to wit, as follows:

(1) To abide and be governed by all the rules and regulations of the said National Bureau of Medicines and Foods now existing or which may be enacted with the following proviso and exception:

If at any time the said National Bureau of Medicines and Foods shall enact any rule or regulation to which the undersigned cannot subscribe or comply, the undersigned may voluntarily withdraw from such associate membership and the said National Bureau of Medicines and Foods shall make public acknowledgment of the voluntary withdrawal of the undersigned.

(2) To submit, without litigation, to the decision of eight-tenths of the board of directors of the said National Bureau of Medicines and Foods to the construction to be placed upon any and all rules or regulations herewith accepted and subscribed to, and to the decision of eight-tenths of the said board of directors, if the violation of any of the said rules and regulations by the undersigned becomes at any time a matter at issue.

(3) To pay to the said National Bureau of Medicines and Foods the sum of five dollars per annum, payable in advance on the second day of January of each year, to the treasurer of the said National Bureau of Medicines and Foods; and failure to make such payment, as provided in the by-laws of the

said National Bureau of Medicines and Foods, shall terminate the associate membership of the undersigned.

[Signed].....
[To be acknowledged before a notary.]
On vote of the board of directors[date]
was duly elected to associate membership on[date]
[Signed].....
[Seal of the Bureau.] Secretary.

Appendix B.

Application for Certification.

A. B., hereafter referred to as the party of the first part, herewith makes application to the National Bureau of Medicines and Foods, hereafter referred to as the party of the second part, to have the standard of identity, purity, quality and strength of (product or products to be specified), manufactured by the party of the first part, certified by the party of the second part, and for that purpose enters into, makes and acknowledges the following contract:

(1) The party of the first part agrees to comply strictly with all the rules or regulations now or hereafter enacted by the party of the second part governing the standards of identity, purity, quality and strength of the, manufactured by the party of the first part, and all other rules or regulations at any time enacted by the party of the second part.

(2) The party of the first part agrees to accept, without litigation, the ruling by eight-tenths of the board of directors of the party of the second part upon any question of failure, refusal or neglect to comply with the standards of identity, purity, quality or strength, or failure, refusal or neglect to comply with any of the said rules or regulations.

(3) This contract shall not take effect until any and all experts in the employ of the party of the first part, and who are in charge of and responsible for the manufacture of, manufactured by the party of the first part, shall be associate members of the party of the second part and shall have entered into a contract with the party of the second part to strictly comply with all rules or regulations of the party of the second part and to certify only to such batches of the, manufactured by the party of the first part, as do actually and truthfully comply with the standards of identity, purity, quality and strength established by the party of the second part, hereby agreed to by the party of the first part.

(4) (To apply to such products as cannot be assayed or analyzed.) The party of the second part shall have the right to have its duly qualified and authorized inspector inspect the material employed and the process of manufacture of by the party of the first part at any or all reasonable time or times, and either with or without due notice to the party of the first part.

(5) Not oftener than four times a year the board of directors of the party of the second part shall determine the percentage of ratio which the cost of conducting the work of the party of the second part bears to the value of all the products certified by it for a given time, and the party of the first part agrees to pay to the party of the second part a sum equal to this percentage of the total value of which has been certified for the party of the first part by the party of the second part during the time specified. The party of the second part agrees that this percentage assessment shall not exceed [percentage to be determined] of the value of certified during that time. The value of the products on which this assessment shall be based shall be considered as and estimated from the list price demanded by the party of the first part for

[Signed].....
[Signatures of two witnesses. Acknowledged before a notary.]
Accepted, National Bureau of Medicines and Foods.
....., president.
....., secretary.

NOTE.—There will doubtless have to be a number of special contracts covering special cases; this is suggested as a tentative form for the majority of products.

Appendix C.

Contract Covering Advertising Censorship.

A. B., the undersigned, an associate member of the National Bureau of Medicines and Foods and manufacturer of, a product manufactured under the supervision and certificate of the said National Bureau of Medicines and Foods, hereby agrees and contracts to submit any and all advertising matter or general or public statements relative to the said product to the censorship of the board of directors of the said National Bureau of Medicines and Foods, and further agrees and contracts not to make, nor permit, nor cause to be made, any advertisement or general or public statement in regard to the said product that has not been submitted to the said board of directors and approved by a majority thereof. In consideration for the agreement and contract hereby made by the undersigned,, the National Bureau of Medicines and Foods agrees to make or to authorize to be made and issued under its name or with its full approval and sanction, any and all such advertising or general or public statements relative to the said product as shall have been submitted to its censorship and have met its approval.

Appendix D.
Suggested Rules.

Rule A. The standards of identity, purity, quality and strength of the official raw materials used in the manufacture and of the official finished manufactured product for all substances or products recognized by and manufactured under

this rule shall be those of the United States Pharmacopœia, as indicated in the last published edition of that work.

Rule B. No manufacturer shall advertise or make any general or public statement to the effect that his products are certified by the National Bureau of Medicines and Foods or are placed under the supervision of the National Bureau of Medicines and Foods unless all of the said manufacturer's products have been accepted by the said National Bureau of Medicines and Foods for such supervision and control.

Rule C. In all advertisements or general or public statements made by a manufacturer concerning any product manufactured by him under the supervision of the National Bureau of Medicines and Foods and certified by it, the statement shall be made that such product is certified by the National Bureau of Medicines and Foods.

Rule D. The president and general manager, acting conjointly, may at any time notify any associate member to immediately discontinue the use of the certificate of the National Bureau of Medicines and Foods, upon sufficient evidence of departure from the standards of identity, purity, quality or strength of any product manufactured by such associate member, or for failure, refusal or neglect of such associate member to comply with or obey any rule or regulation of the National Bureau of Medicines and Foods. Such associate member may, however, appeal to the board of directors of the National Bureau of Medicines and Foods for decision in the matter or matters at issue, and the decision of eight-tenths of the said board shall be final.

Rule E. Each and every package of every product certified by the National Bureau of Medicines and Foods shall bear the following certificate, which may be printed upon the label customarily used, or be placed thereon in the form of a separate paster, at the pleasure of the manufacturer, together with the device of the bureau:

"The contents of this original unbroken package are certified to comply with the rules and standards of the National Bureau of Medicines and Foods."

The manufacturer may also, if he so elects, print upon such label or paster the text of the special rules governing the standard of his product so certified.

Each such label or paster shall also bear the device of the bureau.

Rule F. Each and every label or paster fixed to every package of a certified product (except in such cases as may be covered by a special rule), shall have printed thereon a number which will be so determined as to indicate, through the records of the manufacturer and of the bureau, the particular batch, the date of its manufacture and the name or names of the expert or experts who is or are responsible for certifying to the standards of identity, purity, quality or strength of that particular batch.

Drug Substitution and the New York College of Pharmacy.—Whereas, the substitution of one article when another is called for, or of an article of one brand when that of another is ordered, involves an act of deception and an abuse of the confidence of physician or patient, and an act of injustice toward the manufacturer of the article so specified; and, Whereas, the general commission of such acts is destructive of those mutual relations of confidence between manufacturer, pharmacist, physician and patient upon which the highest success of medical practice depends; and, Whereas, such practices appear to be increasing at the present time, and threatening serious professional and commercial difficulties; therefore, it is Resolved, that the College of Pharmacy of the City of New York publicly condemns all acts of substitution whether in prescription work or in ordinary trade; that it declares such practices to be violations of just dealings, opposed to the principles of professional ethics and subversive of good morals, and it is further Resolved, that we exert our utmost influence, both as individuals and as an institution, to discourage such practices and to promote professional and commercial confidence.

FRAUDS IN THE DRUG TRADE.

The exposure by the Health Department of New York of the adulteration of phenacetin, worth about a dollar an ounce, with acetanilid, worth eighteen or twenty cents a pound, has put a great many retail druggists in a very embarrassing position. It is known that more or less phenacetin is smuggled into the country, and those who bought job lots were, as a rule, or pretended to be, under the impression that they were smuggled. In point of fact, they were merely "faked." Samples of the drug known to have been smuggled into the country have been analyzed and found pure. The truth is, the druggists who were found to have been handling this worthless stuff were tempted by avarice to become accessories to a supposed crime against the revenue, and they have nothing to say which is not more to their discredit than that they did not know that the cheap outside job lots they offered were not as represented.

This kind of thing is going on all the time in the drug business. In stores which should be above such petty frauds upon the unsuspecting customer pancreatin and pepsin are found diluted one-half or more with inert additions to swell their bulk, fluid extracts and tinctures are often very different from what they purport to be, preparations which should be made with grain alcohol are made up with wood alcohol, involving risks to the user which might very well entail criminal responsibility upon the dispensing druggist, and so on.

Results show that the frauds are not confined to preparations bought from the supply houses or direct from the manufacturing chemists. They are equally numerous in preparations made for their own trade by the retail druggists and sold under their own labels. Few of them can truthfully plead ignorance of what they are doing. They are in a great many instances deliberately tampering with life by rendering abortive the efforts of the physician to aid nature in overcoming disease.

BOOK REVIEWS.

A COMPEND OF DISEASES OF CHILDREN. By Marcus P. Hatfield, A.M., M.D. Published by P. Blakiston's Son & Co., Philadelphia. Being No. 14 in their series of Quiz-compend.

This is the third edition, enlarged and revised, of this little volume. Condensed, as the subjects must be, they are, nevertheless, clearly set forth without the loss of the most important data.

The following is given under the treatment of Catarrhus Gastro-intestinalis Acutus: Keep child at

temperature below 80 degrees, better below 70 degrees (F.); in open air, if possible. Watch carefully diet and guard against initial diarrhea. During stages of evacuation give aromatic spirits of am. with calcined magnesia, teaspoonful every thirty minutes:

℞ Sp. am. aromatici..... 4 c.c.
Magnesii exsiccatae 2 gm.
Aquæ anisi 50 c.c.
Tr. opii camph. 4 c.c.

Might substitute bismuth for the magnesia, if much vomiting. Rectal injections of chloral hydrate, giving one grain for each year of child's age, and colodion over abdomen, or hot pack, mustard or red pepper in the bath. If this does not produce reaction, then give quinine hypodermically, with $\frac{1}{15}$ grain morphine.

BOOKS RECEIVED.

A SYSTEM OF PHYSIOLOGIC THERAPEUTICS. A Practical Exposition of the Methods, Other than Drug-giving, Useful for the Prevention of Disease and in the Treatment of the Sick. Edited by Solomon Solis Cohen, A.M., M.D., Senior Assistant Professor of Clinical Medicine in Jefferson Medical College; Physician to Jefferson Medical College Hospital, to the Philadelphia Hospital, and to the Rush Hospital for Consumption, etc. Vol. X. Pneumotherapy, including Aërotherapy and Inhalation Methods and Therapy. By Dr. Paul Louis Tissier, one-time interne of the Paris hospitals, Assistant Consulting Physician to Laennec and Laribière Hospitals, Chief-of-Clinic in the Faculty of Medicine of the University of Paris. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

Lea's Series of Pocket Text-books.

BACTERIOLOGY. A Manual for Students and Practitioners. By Fred. C. Zapffe, M.D., Professor of Pathology and Bacteriology in the Illinois Medical College; Professor of Histology in the Department of Medicine and in the School of Dentistry of the University of Illinois, Chicago. Series edited by Bern. B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, Columbia University, New York; Visiting Surgeon, Bellevue Hospital, New York. Illustrated with 146 engravings and seven colored plates. Philadelphia and New York: Lea Bros. & Co.

THE REFRACTION AND MOTILITY OF THE EYE. For Students and Practitioners. By William Norwood Suter, M.D., Assistant Surgeon, Episcopal Eye, Ear and Throat Hospital, Washington, D. C. Illustrated with 101 engravings in the text and four plates in colors and monochrome. Philadelphia and New York: Lea Bros. & Co., 1903.

MODERN MATERIA MEDICA AND THERAPEUTICS. By A. A. Stevens, A.M., M.D., Lecturer on Physical Diagnosis in the University of Pennsylvania; Physician to the Episcopal Hospital and to St. Agnes' Hospital; Fellow of the College of Physicians of Philadelphia, etc. Third edition. Entirely rewritten. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

THE PRACTICAL APPLICATION OF THE ROENTGEN RAYS IN THERAPEUTICS AND DIAGNOSIS. By William Allen Pusey, A.M., M.D., Professor of Dermatology in the University of Illinois; Member of the American Dermatological Association, and Eugene Wilson Caldwell, B.S., Director of the Edward N. Gibbs X-Ray Laboratory, University and Bellevue Hospital Medical College, New York; Member of the Roentgen Society of London; Associate Member of the American Institute of Electrical Engineers. Handsomely illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

DISEASE OF THE PANCREAS—ITS CAUSE AND NATURE. By Eugene L. Opie, M.D., Associate in Pathology in the Johns Hopkins University; Fellow of the Rockefeller Institute of Medical Research. Philadelphia and London: J. B. Lippincott Company, 1903.

Original Articles.

SOME REFLECTIONS RELATIVE TO THE TIME AND METHOD OF OPERATING FOR APPENDICITIS.¹

BY E. D. FERGUSON, M.D.,
Troy, N. Y.

FROM the amount of literature relating to the care of cases of appendicitis that has been printed during the last few years, it would be reasonable to suppose that the subject was worn "threadbare," but that the last word has not been spoken is evident from the divergence of opinions expressed, and the verbal force with which those opinions are often stated.

While this diversity of opinion exists, it is proper to go over the lines occasionally in an effort to revise the evidence in the hope that some dry land may be found in the sea of controversy. Such a result is desirable alike for the physician and surgeon, for the observation of the disease, and, in a great measure, the responsibility incurred, falls to the lot of each.

The somewhat lurid pictures drawn by some writers relative to the responsibility resting on the physician or surgeon, particularly for delay in operating, are not calculated to induce a peace of mind in those who feel that *ex-cathedra* words cannot be uttered, and yet some course is to be adopted in individual cases, and we must in every case decide whether to act or to delay.

While each case must have the special conditions carefully weighed, we cannot ignore the evidence that has been gathered during the active work of the last twenty years of medical and surgical history. And if doubt on any special feature of treatment is justified, that doubt should be honestly accepted.

It seems to the writer that sufficient experience has been accumulated and placed before the profession to justify an effort to formulate certain general conclusions that may prove helpful in deciding on the probable proper course in practical work, but that course should not be based on the result obtained in treating one or several cases, whether the result was favorable or unfortunate, but rather should be the outcome of a judicial review of all obtainable evidence.

It is not necessary to dwell upon the distinction formerly made as to medical and surgical cases of appendicitis, for it is generally accepted that it is a surgical disease, but surgery is not entirely divorced from medicine and it is apparent that a therapeutic element exists in all cases, the only problem being as to the territory belonging to each department. If the physician seeks unwisely to enlarge his field of care, it is just as reprehensible, but no more so, as for the surgeon to be injudicious in his claims.

Experience has amply justified the conclusions

that appendicitis is a serious disease, giving at the hands of honest and competent caretakers, physicians and surgeons alike, a certain mortality, and in no way can we shift the anxiety properly belonging to its management by any set of rules, but we may bring as a means of relief to our sense of responsibility the comfort of having acted under what seemed to us the wisest general plan.

The points of contest that recently have been the most actively debated relate, first, to the time for operation, and, second, to the method of operating.

The first line of cleavage may be said to be between those who advise "operating as soon as the diagnosis is made" (though such an unqualified dictum is probably adhered to by none, or by an exceedingly small number, it is certainly advocated), and those who would weigh the evidence as to risk between an immediate or a later operation.

All will probably agree that an appendix once inflamed is usually permanently damaged to a greater or less extent, and if it remains it does so as a surgical Mont Pelée, liable at any time to an explosion with dire results; hence the propriety for operative work is generally accepted, the only point of disagreement being as to the time. This problem can be approached from two standpoints, that of the natural history of the disease, and the results obtained by operating at the different periods of the disease as contrasted with each other and with the results obtained by purely medical measures.

Unfortunately, the statistics available may not be regarded as complete as we could wish, but it seems that sufficient evidence is available to aid materially in forming our conclusions. It is not so remote in the past when appendicitis was treated as a medical disease, unless it went on to the formation of an abscess, for most of us present to have forgotten the estimate made as to its mortality then, and while the figures varied considerably, the actual deaths were rarely, if ever, computed in that *laissez-faire* period as high as 10 per cent., the usual statement being from 2 to 5 per cent. That fact is not sufficiently recognized at present, nor does it seem probable that during recent years the material available has been handled in a way to allow of conclusions based on the observations of operators, but it is probable that a mortality of 5 per cent. in the acute attack, without operation, is not far out of the way, at least it seems a fair estimate.

All observers agree that the mortality of the miscalled "interval operation" is small, less than 1 per cent., and in the hands of most operators the mortality of the abscess cases is small, probably less than 5 per cent., though the complete recovery in the abscess cases often only results after two or more operations and a considerable period of invalidism.

If the mortality of the disease, *per se*, is only about 5 per cent., as based upon evidence furnished before operation was so generally resorted

¹Read at the Nineteenth Annual Meeting of the Second District Branch of the New York State Medical Association, at Hudson, N. Y., June 4, 1903.

to, we are entitled to place it in contrast with that existing in large numbers operated upon in the acute stage, and here we find that the mortality has risen to 17 to 18 per cent. Figures of that kind can have but one justifiable inference, and that is that a certain number of cases have ended fatally as the direct result of the operation, a reflection that should cause us to consider carefully our measure of responsibility, and not allow us to use flippant language about operating at once if we find appendicitis and can get a scalpel, needle, and thread, and it may be a comfort to us if we have delayed operating in a case that perished that we probably have avoided a fatal issue in several who have survived.

Now let us consider somewhat as to the indications furnished by the usual clinical course of the disease, though here we must allow for exceptional cases which are to be individually considered. The disease is usually sudden in its onset, the symptoms of "pain, tenderness and rigidity" in the affected region being usually rapidly developed. In the large majority of cases these early symptoms exist with the appendix inflamed, its lumen obstructed, and its morbid products retained therein, a septic peritonitis not developing until later. It is apparent that an operation at that time, if done under favorable surroundings, would be an aseptic operation, and the results should be, and are, favorable, but as soon as the morbid process has invaded the peritoneum, even if adhesions have formed, we must operate in a septic field, and will probably be the cause of diffusing infection to yet uninvaded areas, and at once the operative mortality mounts, and for manifest reasons.

The period during which this early operation is feasible is manifestly brief, probably not more, as a rule, than twenty-four hours, but as the diagnosis has usually not been made, and arrangements for operation completed within that time, such early interference is rarely practicable, but should conditions allow, it now seems right to proceed to operation in such cases, with the expectation of a mortality of about 1 to 2 per cent.

Granted that this early and favorable period has passed and we have come to the stage when experience shows that we would have a rapidly mounting mortality if we operate, what shall be our course? Here we have to consider those courses that the disease may follow. First the appendix may be perforated before previous irritation has produced adhesion and hence protection of the peritoneum, and the septic material is diffused more or less extensively throughout the abdominal and pelvic cavities, with the great risks belonging to extensive peritonitis. This result may have been favored or promoted by active catharsis, but the duty is clear: open, remove the appendix, and drain freely. Some wash out, I do not, but prompt action will occasionally save one of these somewhat rare and otherwise nearly hopeless cases,

as I have known from personal experience in several instances.

If the usual course of the malady is pursued more or less adhesion forms in the peritoneal structures at the seat of the disease, the general peritoneal cavity is protected, and the disease progresses to a subsidence of symptoms, or the formation of an abscess. This walling off the diseased area is the safety measure for the patient, and right here it seems to me the medical care of the case has an importance equal to the office of the surgeon. That this adhesive process may go on under as favorable conditions as possible, it is important that septic material should not be diffused by peristalsis, but that the parts should be placed at rest. To aid in securing this rest no food should be given by the mouth, and if vomiting is present, lavage of the stomach is often serviceable, while the rectum can be used for food and drink.

Do not give cathartics after diagnosis has been made. Patients often recover in spite of cathartics, but the possible injury from them is apparent.

Right here, too, can be applied the use of morphine hypodermically to relieve pain and secure intestinal rest, a measure formerly largely used, but recently much decried as masking the diagnosis and the course of the disease. I regard the objection as unsound, for the diagnosis should be made before any plan of treatment is adopted, and if an immediate operation is not done, the opiate in some, not all, cases will be needed to relieve pain, and may aid in lessening the diffusion of septic material. The remarkable recoveries under the opiate treatment since the time of Dr. Alonzo Clark are not to be forgotten in estimating the resources at our command.

Should subsidence of symptoms fortunately occur, we owe it to the patient, and he to himself, to operate as soon as the depressing effects of the illness have passed off, and right here the most brilliant results are obtained, a mortality of a fraction of 1 per cent. There is one drawback, however, to this Fabian policy. The patient readily agrees to an operation to be done after the subsidence of the disease, but as he improves he hesitates, and as we cannot insist that he will have another attack, it is apt to be put off indefinitely on the method of Dr. Rabelais' sick devil, until a second, probably more severe, possibly fatal, attack occurs. Such a course, however, should not influence our plan of management. It is our duty to advise, and the patient's privilege to decide, but a declination to submit to operation after a second attack would be adequate reason to me to withdraw from further participation in the care of the case.

We now come to the second element in our title, *i. e.*, the method of operating. It is not my purpose to go over the details relating to the incision, the method of removing the appendix and closing the stump, for many expedients may be adopted with excellent results. The only point I would

make in that respect is for the operator to select a method that seems sound, and then use it in proper cases so that he may become facile in its execution.

The special operative problems that I wish to consider relate to what are known as abscess cases in which the general peritoneal cavity has been protected by adhesions, and pus is contained in a cavity having varied elements in the walls, according to the location of the appendix and the portion of it involved, and the vagaries in that localization are numerous and often very puzzling. In these pus cases—and I here refer to those having a large collection of pus, not those beginning abscesses only found at operation—it has been urgently stated by sundry operators that it is our duty to proceed with the operation until we have found the diseased appendix and remove it, for they say that in no other way can we effectually guard against danger of future attacks, against fecal fistulæ, and unhealed sinuses. The greater satisfaction that comes from a complete operation is manifest and conceded, but when this satisfaction is secured at the expense of a largely increased mortality, we should hesitate, and it is in just these cases of complete operation in the presence of large abscesses that our highest mortality occurs, probably mounting to above 20 per cent. I grant that simply opening the abscess often leaves pockets of pus without efficient drainage, and consequent septic trouble, and I do not advise that all interference stop as soon as a buttonhole has been made. With care the incision should be extended so that gentle exploration can be made, so as to determine the probable location of pockets, and in particular those known as post-colonic, when posterior drainage may be needed, and should, during this exploration, which has been conducted with care alike in the incision and the manipulations so as not to open into the uninvolved peritoneum, the appendix be found it should be tied off and removed by what seems the least disturbing method. The direct mortality from such a procedure is very small, and though a future operation is often required for the removal of parts of the appendix not destroyed, that can be done at a time when the technical difficulties are less and the mortality small.

Without stating the method of operating pursued by those who start out with the purpose of removing the appendix in all these pus cases, I will state that on sound surgical reasons it should proceed along lines radically different from those frequently adopted, that is, hunting for the appendix from within the abscess cavity, for should the separation of adhesions open up the uninvolved peritoneum there is no protection against dispersion of the septic material to an unknown extent among the moving coils of intestines that are often much disturbed in location by the movements of the patient and the manipulations of the operator.

If the appendix is to be removed in all these cases, the incision should be made to the *left* of the area of disease, the free peritoneum opened, the bowels and other organs protected by gauze packing, and then the abscess cavity entered toward the right side by separation of adhesions under direct observation. It is manifest that in spite of all this care the extension of infection must often occur, and there is the additional fact that in some cases the appendix cannot be found by any safe dissection, as I have seen demonstrated in postmortem examinations where, without fear of doing harm, the appendix could not be found until all the intestine in the right iliac region had been separated from its mesenteric attachment and the puzzle of adhesions. Such an operation requires all the accessories that are to be found only in the operating room of a hospital, and even then it furnishes a high mortality, undoubtedly above 20 per cent., the deaths, after judicious opening and drainage, being probably below 5 per cent., while hernia is as liable to follow the one as the other.

Understand me fully that I do not advocate the buttonhole method where the operation ceases when pus has been found, but that all subsequent procedure be conducted with a view to avoid opening the uninvolved peritoneum to infection in our proper but not blind efforts to open up pockets and remove the appendix. It is fully as important to secure efficient drainage as to remove the appendix, for with the appendix removed, and a pocket left that does not drain, the patient may succumb to septicemia.

The conclusions that I have formed to guide me in the management of these cases is to operate on all cases who will submit to it within a few hours of the attack, but after that somewhat vague period, if tumor is found and the disease seems to be localizing, then to wait the subsidence of symptoms or the formation of an abscess, treating the patient medically so as to avoid those things that would tend to spread the septic material further into the abdominal cavity, or to interfere with the protective adhesion of the contiguous peritoneal surfaces.

All cases of appendicitis should sooner or later be subjected to operation. Do not flatter yourselves with the undoubted fact that many cases recover from one or two attacks without recurrence, for many perish who delay, and the operation at a time of election has small danger, and you will usually be rewarded by finding an appendix that is not only a useless anatomical affair, but a manifestly dangerous tenant.

The views here expressed are not peculiar to the writer, for they are virtually the views of probably the majority of surgeons, but the fervor with which other views are proclaimed calls at least for a review of the evidence.

One word more. Let no one underestimate the difficulties often attending the operation for removal of the appendix. In no operation will the

coolness, judgment and technical skill of the operator be more taxed than occasionally in appendectomy, and this is particularly true in the presence of relapsing cases with purulent foci.

THE FAMILY PHYSICIAN.¹

BY CHAUNCEY PRATT BIGGS, M.D.,
Ithaca, N. Y.

I DESIRE to express my obligations to the Third District Branch of the New York State Medical Association for the honor that has been conferred upon me in asking me to act as your president. I desire also to thank those of you who have in any way contributed to the success of this meeting.

The substantial progress that is being made by the New York State Medical Association is quite phenomenal, and I feel that it is an honor of no small moment to be identified with the most live, active and progressive body of medical men of the greatest State of the Union.

There seems to be a time-honored custom of selecting for a president's address some topic which deals with, or relates to, the profession of medicine, rather than with the infirmities of the human race that demand the greater part of our time and attention.

This is, I think, as it should be. To consider our profession in relation to other professions, to the laity or to the public, or our professional life as it relates to one another, or to consider the advancements that have been made in our profession in recent years, all these tend to give us a more comprehensive view of our life work, and tend to help us erect higher standards for our professional work in the future.

With these thoughts in mind I have selected as my subject, "The Family Physician."

From an address delivered at one of the annual meetings of the New York State Medical Association, by a clergyman, I quote the following: "Man's first want is something to eat, shelter and clothing. His next desire is for some kind agent to heal his wounds, rectify abnormalities of his body and prevent, as far as possible, future physical sufferings. The two most popular persons with the general public are the caterer and the doctor. Only an exceptional few admit the preacher to rank with these, for the order generally is first the body and then the soul. And so, very early out of the womb of necessity, that fertile mother whose varied offsprings have so enriched the world, there came the art of medicine. No one knows how soon Mother Eve began to tie up the stumped toes of her boys or tax her wits for a remedy to stop the aches and cries of the urchins who set the small boy the first example of dining on green apples. We are not told about Adam's midnight walks with the babies, or Eve's hysterics over the loss of her

flower garden. Yet with the first pains, births and bruises there began to whirl in the human brain those nebulous ideas of remedies and prevention which have since become more and more compacted into science. Out of the crude and coarse efforts to cure the first illness, and rescue from death the first stricken one, there has been evolved, slowly and superbly, the modern art divine."

I give you this quotation from a clergyman to corroborate my belief that we rank high in the mind of the public, and that this fact should compensate us for many of the petty trials of our professional life.

The province of the real physician is to cure. All therapeutic agents which tend to the prevention or alleviation of disease belong to the special province of the true physician. The domain of the general practitioner or family physician is the intelligent direction and application of the exact knowledge of the specialist and the results obtained by the scientific investigations of the scientist.

Under the general term, "The Family Physician," I include all physicians engaged in the practice of their profession who are not specialists. This includes a large majority of all medical men outside of large cities; at least, it is the family practice they do that makes up the great bulk of their professional work. The few thoughts that I have to present to you will not ignore the specialist, for I believe that he plays a very important part in the life work of the modern physician, and that a consideration of the professional work of the family physician would not be complete without him.

Much is said and written in these days of the advances in the various specialties of our profession and of the scientific investigation along different lines of our work, but there seems to be a feeling that the general practitioner works along in the same old rut, and that the results he attains are very much the same as they were fifty years ago. The field of usefulness for the family physician is broader to-day than it has ever been. The specialist should be looked upon as one of our most valuable adjuncts in the relief of human suffering and disease.

We all appreciate his value in his specialty because of the greater exactness of his knowledge and experience, and his greater technique in specialties requiring skilful manipulation or operative procedure. But in addition to this he is of great value to the profession as a peace-maker.

Physicians are proverbial for their little scraps, jealousies and misunderstandings among themselves. It is about as difficult for a physician to have a misunderstanding with a specialist as it is difficult for him to avoid them with a colleague who is a general practitioner. It is the specialists that assist us in smoothing over the differences and in harmonizing and in unifying our profession. They can do far more toward or-

¹President's address delivered at the Nineteenth Annual Meeting of the Third District Branch, New York State Medical Association, held at Syracuse, June 25, 1903.

ganizing the profession and increasing the membership of a medical organization such as the New York State Medical Association than the same number of general practitioners. They are the ones to whom we should go when we want to reach the medical profession in the larger towns and small cities. It is to the specialist's professional and financial interests to be on friendly terms with as large a number of physicians as possible, hence his relations with physicians should tend to cement friendship. Specialists have opportunities to assist the family physician in numerous ways and to make lasting impressions and lifelong professional friendships. I am very desirous of interesting all the specialists residing in the Third District Branch, in our Association, for I believe that they can do a great work for us.

The best results in the treatment of disease are reached when the family physician appreciates his limitations, and, at the proper time, calls for the assistance of the specialist.

The responsibilities that must be assumed by the family physician are great. The health and happiness of his patrons depend, in no small measure, upon the way he assumes and fulfils the confidences and trusts imposed upon him. It is my belief that the thinking and intelligent classes in every community virtually say to the family physician, "We expect you to guard our health and lives, and we depend upon you to advise us, to the best of your ability, in health as well as in sickness." I say in health as well as in sickness for the reason that the prevention of disease is, and is to be, a large part of the work of the family physician. Such responsibilities should not be undertaken without appreciating their gravity. There are many elements of danger to health and life in the habits and everyday living that can be largely minimized by the intelligent oversight of the family physician. In order that the best professional work shall be done by the family physician, it is of greatest importance that the closest confidential relations exist between the physician and his patients.

When I was an interne in Bellevue Hospital, New York City, one of my visiting surgeons used to say that the nature of our work is such that we ought not to be obliged to ask for financial remuneration for our services. Theoretically, this is a pleasant idea to contemplate, but the millennium is still too far off to make a practical application of it. Physicians must live, and they should be in a position to meet their financial obligations promptly, in order that they may be worthy of the respect and confidence of the community in which they reside.

The question of just medical fees is one in which opinions differ widely. While we should render fair bills for our professional services, we should not, on the one hand, belittle the value of our services by rendering bills too small, or, on the other hand, look upon the public as a

common prey from which to extort large fees, whenever an opportunity is presented. It not infrequently happens that the service rendered by physicians cannot be accurately measured in dollars and cents. Then, too, the same service rendered different persons must be discharged financially by fees of different amounts, depending upon circumstances, yet the latitude allowed physicians should have limitations.

Physicians and surgeons who charge the largest fees do, as a rule, the largest amount of work without compensation.

I believe that well-to-do clergymen and their families should pay fair fees for medical services. This custom would increase the self-respect of the patient, beside improving the quality of the service rendered by the average physician.

I had a conversation not long ago with a clergyman who advocated this idea. He said that the custom of treating clergymen and their families free of charge was the result of conditions that existed years ago, but that did not exist at the present time. Then, clergymen were remunerated for their services, largely, by donating parties, and gifts of articles of food and wearing apparel that were raised, manufactured, or sold by the members of their congregation. Instead of marketing their products and paying their clergyman money, they paid him in whatever they had to sell. Under those conditions, naturally, the physician did his share by rendering medical service free of charge. The clergyman with whom I was speaking said that, as long as his income was larger than that of many physicians, why should he accept medical services without compensation? I believe his idea was the correct one.

The "sisters, and the cousins, and the aunts" of physicians, too, are often treated without compensation. The immediate family of a physician should be treated without charge, provided the favor may or can be returned, or in the event that it is a hardship to pay a fee.

To sum up this side of the question, there are but two considerations which should influence us in remitting or scaling down our bills from just and fair fees. First, our duty to humanity, when one of our fellow men needs our services and has not the price; second, our obligations to our colleagues of the medical profession who should be entitled to our services.

The public sometimes look upon members of our profession as robbers, and I regret to state that I have known of several instances in which I have felt that the fees charged were out of all proportion to the service rendered.

Exorbitant fees, heralded through the popular press, give our profession a most undesirable reputation. A physician is the last person in the world with whom it should be necessary to make a bargain in order to prevent extortion. The responsibilities that we bear, and the confidences and trusts imposed in us, should teach us

honesty, integrity and a high sense of honor in our dealings with our fellow men. Because a patient has much of this world's goods, and has trusted to our honesty, is no good reason why we should exact from him an exorbitant fee. Another one for whom I am disposed to enter a plea is the poor but honest person. Unless a physician feels that he can afford to treat these people for the financial considerations that they can pay without any great hardships, he should advise them to avail themselves of the services of some younger physician whose time is less valuable than his own.

From the standpoint of a physician, the greatest care should be exercised in the selection of the family physician, and when the selection has once been made, unimportant considerations and minor causes of dissatisfaction should not be sufficient for a change of physicians. In other words, a physician should not be taken into the privacy of the home and intrusted with the confidences and infirmities of the family without being sure that he is a gentleman, as well as a skilful physician. When this entrée has once been allowed a physician, it is a grave mistake not to stand by him, unless he has given offense that is very unmistakable in character.

It must be admitted that the permanency of the patronage of any physician depends more upon his personality than upon his skill. It should not be inferred that all that is needed is to be a gentleman, and to be tactful and clever, but these are essential to the equipment of a skilful and well-trained physician in order that he may attain the highest degree of success.

We should attempt to look at situations through the eyes of others. The nature of our work is such that much that we do and say goes, without proof, but we must be broad enough, and liberal enough in our ideas, to consider complicated situations from several standpoints, if we retain the respect and confidence of our patrons for a long time.

The situations that a family physician is called upon to meet during a series of years may be very complex; these often unsettle the better judgment of those most concerned. If the family physician can meet them, and can appreciate their complexities and reach satisfactory solutions, a lifelong friendship may be formed by simply exercising a little good judgment and by giving a little very common-sense advice.

Intelligent people should be taught that there is no compromise between modern rational medicine and the old idea that a successful physician is a sort of a wizard born to his work, with all the knowledge and qualifications required. Granting that some persons would never make successful physicians no matter what their educational advantages or training might be, yet, on the other hand, in order to attain the highest type of professional work, nothing can take the place of thorough training.

MORPHOLOGY OF ANOPHELES MOSQUITO— HABITS—MODES OF DESTRUCTION.*

BY WM. N. BERKELEY, A.B., M.D.,
New York.

THOUGH this paper is meant to deal strictly with the more practical parts of the subject in view, a very brief historical note may be justifiable. Further details are scattered in the literature, particularly in the works of Howard,⁴ Giles⁵ and Theobald.³

The genus *Anopheles* (Greek *ανωφελής*, Latin *inutilis*, useless, harmful) was first recognized as a member of the family of *Culicidæ* and order of *Diptera* by J. W. Meigen in 1818.¹ He appears also to have devised the name. He mentions in the monumental work just quoted, which in its publication extended over many years, and contains for the most part labored Latin descriptions of the insects mentioned, that he caught his first specimen in a swamp (*sümpfigen Gegend*) in the springtime and apparently in the open air—a fact of some interest, in view of the conflicting opinions on the habits of this mosquito expressed since that time.

Anopheles for the next three-quarters of a century occupied a rather obscure and ill-recognized place among the mosquitoes, and while correct allusions occur to it from time to time, we find that so good an entomologist as Packard⁷ had apparently never seen one, though he alludes to *Anopheles quadrimaculatus* Say as "a large mosquito biting fiercely in the springtime and supposed to hibernate in houses and cellars." He adds (quite an incorrect observation) that it has but two spots on each wing.

That there are many species and a number of genera of the *Culicidæ* appears to have been viewed as a fact of rather recondite and purely entomological interest. Manson's early experiments² with *Filaria* in the mosquito (1879) called no special attention to the differences between *Culex* and *Anopheles*, or to any other generic differences, and Ronald Ross made his first successful malarial inoculations in India in 1897 with a mosquito which he was at the time actually unable to designate more specifically than that it was "dapple-winged."⁸ This deficiency he soon repaired, and was quickly able, after gaining access to the older entomological authorities, to give his genus the previously recognized name *Anopheles*.

Ross now very soon obtained eggs, larvæ and nymphs of this genus, and his original observations and descriptions of the dietology and metamorphoses of the insect have been confirmed over the entire world. These observations necessarily cover only a few species in the genus, but so far as they extend they form an admirable illustration of painstaking and exact labor—almost as admirable in their way as his simultaneous memorable discovery of the relation of this insect to the human malarial parasite.

Morphology.—As to morphology, I shall con-

*Read before the Fifth District Branch, New York State Medical Association, May 19, 1903.

sider briefly (1) the *development of the egg*, and (2) the *external appearances of the adult insect*.

The egg of *Anopheles* is laid upon water. It is a minute oval mass not quite one-twenty-fifth of an inch (0.8 mm.) in length. It is white when laid, but after exposure to air blackens in a short time. Caged insects sometimes sicken and lay what appear to be premature eggs. These never blacken and never hatch.

While the eggs are usually lightly adherent end to end, it is a mistake, I think, to suppose that the geometric figures the eggs sometimes assume after dropping are due to anything more than the physical influence of the ordinary laws of capillarity and adhesion. The eggs do not develop in any natural medium but water. Certain of the species of *Anopheles* can unquestionably (Bancroft and others) develop in salt water, but fresh water is the usual medium of all the species known in the vicinity of New York City and the State of New Jersey. There is not a scintilla of evidence from any reliable source that damp grass, tall weeds or damp earth can do more than *set free* the larva, which in its feeding habits and manner of breathing is aquatic, and aquatic only.

Prefacing with the general statement that rapidity of development is in a fairly direct ratio to the temperature of the water, and is completely arrested when the water is cooled to 32° F. (0° C.), it will be enough to add that the shortest developmental cycle I know of for the American species of *Anopheles* was observed by myself two years ago, in August, when precisely fourteen days elapsed from the dropping of the egg to the emergence of the imago or adult insect. Artificially the period could doubtless be further shortened.

To the fact that *Anopheles* prefers for its eggs pools of standing rain water on the ground Dr. Ross first called attention some years ago. It is very important to remember, however, that when such pools are lacking the insect will not hesitate to oviposit in any available water that can be found, and will reach its full development in rain barrels, roof tanks, flush tanks in water closets, and in general any clean shallow water where fish are absent. Caged insects will lay in any water provided them, and if confined in a dry tube, a gravid female will deposit her eggs in full tale upon the bottom of the glass. Here they remain viable for a surprising length of time, the maximum limit of which has not been determined.

Ordinary breeding places are ponds in sunken lots, sluggishly flowing streams, shallow and slimy margins of so-called ornamental pools in city parks, bad street drains, springs, rain pools in post holes and hollow trees, marshes, temporary water pools in the vicinity of building and excavating operations, and similar places.

In all of these places *Culex* will also breed,

but *Anopheles* has not been found, so far as I have been able to discover or learn, in such excessively filthy places as cesspools, manure tanks and brewery drains, in which *Culex* breeds freely. Nor have I found *Anopheles* in subterranean catch-basins where *Culex* was abundant and where *Anopheles* was breeding freely nearby in surface water.

The *larva* of *Anopheles* has a very peculiar and characteristic shape, swimming with a short breathing tube *flat on the surface of the water*, and not perpendicular, as is the case with the familiar *Culex* larva. It is a surface feeder, and lives mostly on the microscopic flora and fauna of shallow standing water, especially the softer, more attenuated Algæ like *Mougeotia* and *Protooccus*. Detailed anatomical descriptions are accessible in the text-books, and would be rather out of place in such a brief notice as this.

The *pupa* is so like the pupa of *Culex* and several other dipterous flies that for general observers it is safer to watch for the imago before committing one's self, unless the larva was previously identified. For precise differences the technical works on the subject should be consulted.

The *adult insect* may for the purposes of the practical physician be identified by its blood-sucking beak or proboscis, its two long palpi, which in both male and female are just the length of the proboscis, and, what is true for all the United States species, the spotted wings. The male can be told from the female by its excessively hairy antennæ and palpi. Only the female bites.

The posture of *Anopheles* on the wall is now a familiar phenomenon needing no further special description. This interesting fact is also an original observation of Dr. Ross's.

There are three species of *Anopheles* to be found in the Middle States—*A. maculipennis* Meigen, *A. punctipennis* Say, and *A. crucians* Wied. The last is rare north of Washington. The specimen I show here to-day is, I believe, the only one so far reported. It was caught alive by me two years ago in a bedroom on 26th street, in this city—origin unknown, but probably brought in by a passing grocery wagon or covered milk wagon from the suburbs. Roughly, it may be recognized by the peculiar multiple spotting of the wings.

Of the other two species each is common. *A. maculipennis* has four small spots on the surface of the wing inside the margins. *A. punctipennis* has only one large spot, which is distinctly on the front margin or costa of the wing, three-fourths of the way out.

Natural enemies of mosquitoes are numerous, specially in the larval stage, when they are eaten by the larvæ of dragon-flies, by toad-tadpoles (Wm. P. Seal), by several predaceous water beetles, and (a fact of great value and significance) by minnows.

The top-minnow (*Gambusia affinis*) has been

recommended specially by Mr. Wm. P. Seal, of Delair, N. J., as the enemy of *Anopheles* larvæ, because it feeds near the surface of the water and penetrates the shallows. Goldfish, small sticklebacks and almost all other fish, when small, will also eat mosquito larvæ. But when weeds, slime and grass around the margins of the pools are thick, the fish do not pierce the tangle of vegetation, and the mosquitoes breed by thousands unmolested.

Enemies of the adult insect are bats, small birds, adult dragon-flies and certain other insects—all entirely insufficient to stem the plague.

Parasites of larval mosquitoes have been described (Howard, *l. c.*), and it is not impossible that some innocuous parasite may yet be introduced which will effectually destroy them either in the larval or adult stage; but so far such hopes have been unrealized. The story of a "red scale" in the Canada woods which eradicates mosquitoes after July 1st has never been verified, though the original account came from quite a reliable source.

Internal anatomy I shall have to leave to succeeding speakers.

Habits.—Much has been incidentally mentioned already. *Anopheles* is a rarer insect than *Culex*, breeds in fewer places and with greater nicety in the choice of breeding water. As a rule, it appears later in the season than *Culex* (at least around New York) by perhaps six weeks or two months. The male dies in autumn, the female hibernates in cellars, attics, caverns and stables, and prefers colder to warmer parts of such places. The larva also hibernates in and under the ice of the pool it chances to occupy when winter comes. A vast number of both sexes probably fail to survive, but not the severest weather kills all. Adult males at any season of the year are short-lived. The average length of life of the adult female in summer time—unconfined—is probably seven months. They have been kept in cages over sixty days.

The female *Anopheles*—an important fact—is usually crepuscular in its feeding habits, biting after sunset or in the night. This, however, is not an invariable rule.* Hungry caged insects will bite at any time of day. They bite horses, birds and other animals as well as man. They have been observed to sit upon horses when the horses are in motion, thus being conveyed several miles from one place to another. This fact, which I believe to be an important one, was communicated to me by the gentleman already several times mentioned, Mr. Wm. P. Seal, of Delair, N. J., a naturalist whose practical experience with mosquitoes for years past is second to that of no one in this country.

The habit of night-biting in the bedroom explains most of the cases of malaria in persons who protest that they never saw a mosquito in their neighborhood—the insect simply entering

the bedroom window after nightfall, and leaving with the dawn.

Modes of Destruction.—This is a long story, though it ought to be a short one. Powders and gases are virtually impracticable except in selected instances. Pyrethrum powder, chlorine gas, formalin-sulphur candles, and *zanzolina* powder have been recommended. The last is an Italian invention—chrysanthemum powder, valerian root and "larvicide" (an aniline dye). When burned the smoke is an effectual insecticide. These may be occasionally useful to render a bedroom fit to sleep in. A regular hunt for the offending insects with a broom is about as effective and much less circumstantial.

The screening of windows and doors, to be effective, must be thorough and persistent.

To kill larvæ in pools, the application of light fuel oil or kerosene is temporarily efficacious, but, like the beggar to whom a gratuity has once been given, the nuisance recurs in a few days—and with more urgent importunity.

Necessary water for domestic purposes should be rigidly closed or screened. Ornamental pools, fountains and lily ponds, where such *must be had*, should have graveled or cemented margins two feet below and above the water line, deep edges, and a plentiful stock of minnows or goldfish. Green slime must be removed in hot weather as fast as it accumulates.

There is no permanent remedy against *Anopheles* or other mosquitoes except *drainage*. All standing water other than that described should be permanently abolished—by means adapted to each individual instance. This can be always accomplished when, as Mr. Frederick Sturges, of this city, recently remarked, the "money is forthcoming in sufficient quantity."

Running streams should have clean, graveled banks, an even grade, and no pools.

These measures are practicable, usually not excessively expensive, and are permanently effectual.

When the general public becomes fully alive to the necessities of the case and the ease of the remedy, mosquitoes will be relegated to the limbo where fleas and chinchies are now confined.

I expect in my own lifetime to see the mosquito evil, with all its attendant vexation, annoyance, depreciation of property values and malarial disease, become only a disagreeable memory.

AUTHORITIES.

1. MEIGEN, J. W. Systematische Beschreibung der bekannten Europ. Zwiflügeligen Insecten, Aachen-Hamm, 1818-1838.
2. MANSON, P. Trans. Linn. Soc., Vol. II, Part IV, London, 1884.
3. ROSS, R. *Brit. Med. Jour.*, December 18, 1897.
4. HOWARD, L. O. Mosquitoes, McClure, Phillips & Co., New York, 1901.
5. THEOBALD, F. V. Monograph of Culicidæ of World, British Museum, 1901.
6. GILES, G. M. Handbook of Gnats or Mosquitoes, London, 1901.
7. PACKARD, A. S. Guide to Study of Insects, Salem, Mass., 1873.

*Observers in various parts of this country are strangely at variance on this point. My own experience is that stated in the text.

THE CONCURRENCE OF THE ANOPHELES MOSQUITO AND MALARIA.¹

BY HENRY CLAY WEEKS,
of New York.

Gentlemen of the New York State Medical Association:

WHEN the courteous invitation of your president reached me a few days ago I concluded that if there was anything I could do or say that would further the cause in which I am so much interested I would run my chances as a veritable layman and appear before a body of men who have gone much more closely into the subject of mosquitoes and malaria than I have gone, and so I accepted. But I really supposed the discussion would be somewhat informal in character, and that I should not be expected to prepare any formal paper. But a further note from your president gave me only a short time yesterday in which to note down what I purposed to say, and I must therefore crave your considerate criticism.

THE CONCURRENCE OF ANOPHELES AND MALARIA.

Of course, we are working to the same end. Your researches show that such concurrence ought to exist; mine show that it does exist. You dig and delve in your work in this great and growing crusade, but it is in the intricacies of the system of the mosquito and of the man she has inoculated; I, in the mud and water in which she is propagated. You burn the midnight oil in your laboratory researches; I use the thick and highly smelling kind, a film of which will stop the breath of our enemy. You seek to clear the stream of knowledge on this new and vital subject; I work in the real waters, and sometimes when it is so foul that even the better class of mosquito seems to object. So we both work to clean up situations and get rid of ignorance and mosquitoes and make life more the worth living. And as thus I deal in the coarser elements of the contest, so my observations have been, so to speak, only those of the naked eye—what is patent on the face of the investigation. And such only I can give you.

It is about as disastrous to a man to be ten years ahead of his time as to be ten years behind. In the latter case he is simply stranded on the shores of progress, but in the former he is set down as a dreamy crank. Still it is consoling to know that it is cranks, so termed, that have effected a revolution of ideas—viz., that it is possible to exterminate mosquitoes from a given section. And now that your researches have shown that the Anopheles spreads one of the most disastrous diseases of the country, the urgency of extermination has been greatly increased and the humorous side of the proposition is fast disappearing.

In my lucid moments I indulged day dreams of a country without mosquitoes, and then later of a nation without malaria, and the ideas so

possessed me that if I had been called a Utopian I should not have objected. But latterly conditions have changed, and now so many persons and sections are offering me monuments as a benefactor that I am thinking of setting up in the monument business. I mention this to show how ideas develop.

A CASE IN POINT.

Before mosquitoes and malaria were a disgrace in a community, as we all now are trying to make them be felt, I had an experience in a section of the country which I am not free to name. When such disgrace is keenly enough felt there is no consideration which restrains an effort to abolish it—not even the susceptibility of real estate to a bad name. The high considerations of humanity should and do govern.

It occurred to me in the work to which I refer to show the concurrence of Anopheles and malaria, but while the presence of Anopheles was shown through the examinations of the entomologists and their results were published, the prevalence of malaria in the identical places, through the requested reports of the physicians, was also shown, but was not published.

The results of our examinations along both of these lines were prepared for the printer, but the physicians' work—much to my regret—never saw the light. I hold in my hands the galley proofs, and I affirm that this excision was not because, in any sense, that their reports showed unusually bad conditions—rather the reverse—only such as are exceeded in most sections, but that it was feared that any mention of the hated word malaria would work bad effects. It is to be hoped that the time is at hand when malaria will be published, that the disgrace may be the quicker removed. And I understand this is the purpose of the present Department of Health. I commend such a spirit of progress as is shown by the Board of Trade of Worcester, Mass., which exposed the fact to the country that malaria had come in and that the Board was going to combat it. In three volumes of their report they go into the charges most thoroughly. And thus it has been in other advanced sections.

So I can give you the questions we asked the physicians of the unnamed territory and the answers they gave—all new to everybody except two or three persons. I am violating no confidences, however, to say that the most startling proof of the concurrence of Anopheles and malaria was found—as startling as that reported in the *Medical News* of last August to have been found in Barbados and neighboring islands, where on certain islands unvisited by Anopheles malaria did not exist; and others not very distant where they were found, malaria strongly prevailed.

Some persons predicted that the physicians would not reply to these questions—that they would do nothing that would take from them so strong a feature of their practice—but I rejoice to record the fact that such an insinuation was

¹Read before Fifth District Branch, New York State Medical Association, May 19, 1903.

deservedly repelled by the magnanimous action of the profession, as I had said it would be. All the physicians, numbering about a score, responded, except two or three whose reasons I believe to be disconnected with such a charge.

In brief, the answers showed that in elevated sections there were none but imported cases of malaria, and none at all where there was protection by screens or otherwise, nor was there any in a certain other part where only salt pools existed, which produced myriads of *Culex*, but no *Anopheles*. I am aware that I am controverting a distinguished experimenter, who states that he has found *Anopheles* in salt water. I would say just here that I believe we have much yet to learn of mosquitoes, despite the fact that so much has already been learned.

A part of my report which was not published, relating to the work of the physicians, was thus introduced:

THE COOPERATION OF PHYSICIANS.

When it was learned incidentally by those making investigations of the territory that many persons were suffering from malaria immediately in the neighborhood of the breeding places of *Anopheles*, it was suggested that the physicians be consulted in regard to their experience in the matter, and certain questions were sent out to them, which are subjoined, as well as the almost unanimous answers to them. The replies show that malarial cases form a very large percentage of their practice. The interest taken by these physicians in this work furnishes another proof of the unselfish devotion of the medical profession to the cause of humanity.

From their full reports, as well as from interviews held with them later, many points of interest were gained which could not be tabulated. The sympathy of one of the physicians was clearly shown by the feeling with which he described the sufferings of a certain family in the midst of a very malarious section. In another case the indignation of the physician was strongly shown when he referred to the dwellings of the poor in such sections as places unfit for human habitation. Others called attention to the fact that, by reason of malarials attempting the treatment of their own cases with quinine, no adequate figures could be furnished of the proportion of malarials to the whole population, but in nearly every case it was rated as very large, increased largely by the excessive number of cases in low, wet sections, though instances were given by one physician of malaria in elevated sections, probably importations. Another physician mentioned, as the result of malarials treating themselves with quinine, that he finds many in his section affected seriously with deafness.

The reports of high land show a marked freedom from malaria, one physician stating that in nearly every instance his cases were imported ones. Thus another proof of the connection between malaria and *Anopheles* is shown indirectly.

One whose rate was low, though others practicing in the section reported high, personally explained that he confined his statement to pure malaria, and was not certain enough to report on all malarial diseases. Another stated that he found great difficulty in the treatment of other diseases where there were malarial complications, as the efficiency of his remedies was thus seriously affected.

The question was asked of one of the physicians whether in his experience he had found that cases of malaria ever occurred in situations where it was not possible that a patient should have been bitten by *Anopheles*. He mentioned an instance where a severe case occurred on shipboard. Going further into the subject, it was learned that the person lived in the neighborhood of Fifth avenue and 50th street, New York City, but had visited the country before sailing; indeed, had every week visited this section. Questioning, still, whether any breeding grounds were near the place visited, the answer was affirmative, and the location was given. The report of the entomologists for that particular spot, as well as the judgment of the engineer, showed *Anopheles* abundant. The attack occurred, though the party was far distant on the ocean, in just about the length of a period of incubation if the patient had been infected on a former visit.

I am free to quote some expressions in reference to infested places, but not by name. In every case the conditions for *Anopheles* were typical.

FROM REPORTS OF ENGINEER AND ENTOMOLOGISTS.

. . . and one of the physicians' reports states of the immediate section that every house this year and last year has malaria.

Malaria was found in the houses along the stream in ———. The attending physician said that the mosquitoes giving it were not bred there. (Expert found them abundant.)

Of a place where *Anopheles* were found more abundant than anywhere in the territory it says: Across the road is a house, all of whose occupants have malaria, and two or three of whom have recently died.

Malaria is rife here.

There is much malaria here.

The malarial reputation of this locality is well known.

. . . and almost without exception malaria was reported from these neighborhoods, the number and severity being in clear proportion to the abundance of *Anopheles*, as shown by the larvæ. And quite as evident was the lack of new important cases at any distance from such localities.

It would hardly be needed to refer to the reports of the physicians and entomologists in regard to this section; a walk through the town would result in one easily drawing his own inference.

The reports of the physicians and the house-to-house canvass show the section badly infected

with malaria. (Around deserted ice-pond, southeast of ———.)

QUESTIONS AND ANSWERS.

I give the questions and answers, the physicians being indicated only by numbers:

Question 1.—How prevalent has malaria been during the present year, as compared with previous years?

Answers.

1. 75 per cent. more.
2. More prevalent than in many years.
4. Much more—say, 50 per cent. more.
5. Much more prevalent.
6. More prevalent.
7. More than in the past eight years.
8. More than usual.

Question 2.—State roughly what proportion of the patients whom you have treated during the present summer have been treated for malaria.

Answers.

1. 60 per cent.
2. Fully 50 per cent.
4. One-half.
6. 35 per cent. directly and 15 or 20 per cent. more complicated.
10. 5 per cent. (high ground).
17. 40 per cent.

Question 3.—In your experience, during which months of the year has malaria been most prevalent?

(You will bear in mind that *Anopheles* larvæ are found much later in the opening of the season than *Culex*.)

Answers.

1. April, May, June, August, September, October.
 2. July, August, September.
 4. July, August, September.
 5. July, August.
 6. April to October.
 7. August, September; some in June.
- One careful researcher gave us numbers:
11. April, 2; May, 1; June, 14; July, 31; August, 52; September, 9.
 13. July, August, September.
 14. August, September.
 17. May, August and part September.

Question 4.—Please describe as closely as you can any special localities in the village or territory to which your practice especially applies, in which malarial cases are most frequently found, and in describing such localities please make special reference to any watercourses or bodies of water which are immediately adjacent.

Answers.

1. Along all shallow ponds of water and near new ground.
2. Near the ponds in most cases, but many remote.
4. Both banks of ponds in almost every house. Outside a few imported cases.

(There follow answers involving places by name, all being *Anopheles* sections, as experience showed me beforehand.)

Question 5.—Has it been your experience that it frequently happens that malaria, having appeared in one member of a family, is likely to affect other members of the same family?

Answers.

1. Yes.
2. Yes, frequently.
4. Always, except others after first case.
5. Cannot say that it has.
6. Yes, in most localities mentioned, but not among workmen.
7. Very often two or three in one house.
8. Occasionally.
11. Yes, and never when case is isolated.
17. Yes.

Question 6.—Has it been your experience that there are certain houses in which malarial cases are found from year to year, so that during the malarial season malaria in such houses becomes the rule rather than the exception?

Answers.

1. Decidedly yes.
2. Houses not noted, but localities.
5. Yes.
6. Yes.
7. Yes, where bad surroundings.
8. Yes.
10. No. (High and dry ground.)

Question 7.—Please give as close an estimate as you can of the number of persons in your village who have suffered from malaria during the present summer. It is, of course, realized that the answer to this question can only be approximate.

Answers.

1. Large percentage by complication.
2. Cannot answer.
4. Cannot estimate; two or three fresh cases daily for four months.
5. Cannot answer.
6. 175 to 200 typical cases, and many of malarial symptoms.
7. Prescribed for at least 125.
8. Over 30 per cent. of the whole population.
11. 97 cases, none in screens.
13. 100 cases.
15. No true cases during the year, and very few in fifteen years. (Explained by fact that only pure malaria was considered.)

THE INTRODUCTION OF MALARIA.

An investigator of varied and eminent scientific attainments, in his report in this connection, among other things, said:

As for the malarial conditions of the region, the evidence goes to show that up to about fifty years ago intermittent fever did not occur there. Its introduction into this district most likely came with a general slow advance of the disease from the southward, consequent on the quickened means of transportation, which permitted the poison-bearing *Anopheles* to be more readily carried to the northward from its original site. This advance led to the development of the malady in the Hudson Valley; thence it spread to the eastward, first to the Housatonic

Valley, thence to that of the Connecticut, and in time across Massachusetts to the region about Boston, where it arrived about ten years ago. The process of occupation of a district by the poison-bearing insects in this part of the country appears to be rather gradual, the species slowly finding its fit breeding places. This is probably due to the fact that it is near the northern limit of the region which is fitted to its needs. Except where the extension has been checked by efficient drainage, it appears to be gradually becoming more and more common, with a resulting increase in the prevalence of malarial diseases.

In the present state of malarial poisoning of the section the malady does not appear to have attained to anywhere near its widest extension. It is reasonable to be expected that if no drainage work is undertaken the *Anopheles* will year by year come to breed in more places and to extend their influence more completely over the field. Although not yet clearly proven, there is much evidence to show that these insects not often range for more than a thousand feet or so from their breeding place. It, therefore, requires time for its extension to all the stations fit for the uses of the species. Moreover, in most, if not all, cases the insect probably has to acquire the poison from the blood of some animal, man or other, which is already infected, before it is able to transmit the disease. These conditions may serve to explain the long term of years required to complete the infection of any considerable area.

When we consider that the existence of ague and fever in a country means not only a very considerable increase in the amount of disease, but a distinct reduction in the vital energy of a people, a lowering of their quality of mind and body, it appears justifiable to incur any expense in order to guard against it. Fortunately for the district we are considering, the cost of doing this good work will be relatively trifling.

IN CONCLUSION.

Gentlemen of the medical profession, the speaker knows somewhat of the wondrously interesting and important results of your patient work in this matter of demonstrating the concurrence of *Anopheles* and malaria—more, possibly, than you know of the practicability and the reasonableness of the means which may be adopted by engineers in this great crusade. These lines of work are both of vital importance in their way of getting rid of a great evil, and I am glad to do my humble part with you.

I should be pleased to have you look into the methods of work now under way in the southern part of the Borough of Brooklyn, in which I am now engaged—the details of its organization, which involves the cooperation of many branches of the general and local governments.

I thank you, gentlemen, for the opportunity of presenting the practical side of this subject and for your courteous attention to my remarks.

LABORATORY DIAGNOSIS AND LIFE CYCLE OF THE PARASITE OF MALARIA.*

BY WILLIAM T. KLEIN, M.D.,
New York City.

ALTHOUGH King and a number of other observers had previously suggested the mosquito as the probable intermediary agent in the transmission of malarial disease from man to man, it seemed to be the hypothesis formulated by Patrick Manson in 1894¹ and reiterated in 1896² that gave the impetus to serious work in this field of research. In brief, Manson's theory was as follows: That as the flagellating forms of the hematozoon malarie do not come into existence until the blood has been shed for some time, usually fifteen to forty-five minutes, the function of the flagellum lay outside of the human host, and the flagellated body was the first expression of an extra-corporeal phase of the parasite. As the plasmodium could not leave the body by its own effort, and as it could not be found in any of the excreta, the aid of some outside agency was necessary, and this was furnished by some blood-sucking insect, probably a certain species of mosquito whose geographical distribution corresponded with that of malarial disease. He believed that some of the parasites ingested with the blood by the mosquito developed flagella, which, breaking away from the parent body, pierce the stomach wall of the new host and begin their existence as independent organisms in the structures of the insect. He still believed that malaria could be air or water borne, the specific parasite infecting the air or the water upon the death of the mosquito harboring it in its extra-corporeal phase.

This hypothesis, as subsequent developments have proved, was true only in part, but it is of great historic interest, inasmuch as it suggested the lines along which the important researches were carried on, at first by Ross,³ and later by McCallum,⁴ Bignami, Grassi, Bastianelli, Koch and others, and which finally proved conclusively that the malarial plasmodium possessed two complete life cycles—an endogenous cycle in the body of the human host and an exogenous cycle in the body of the specific mosquito, the *Anopheles maculipennis*. This fascinating study of the double life cycle of the parasite has interested so many competent observers within recent years that at the present time there is scarcely a single link in the entire chain that has not been definitely proved by direct ocular demonstration.

The Endogenous Cycle.—Although the quartan parasite is the most favorable form in which to study the endoglobular phase of the malarial organism, owing to the fact that its segmenting forms are more numerous in the peripheral circulation than is the case with either the tertian or the æstivo-autumnal parasites, yet its comparative rarity in this country makes it rather

*Read before Fifth District Branch, New York State Medical Association, May 19, 1903.

difficult for an observer to avail himself of this advantage. Therefore, the tertian organism, being most common in this latitude, will be taken as the type for the study of the endogenous cycle of the hematozoon.

The parasite is seldom, if ever, found free in the plasma. During the chill or within an hour or two thereafter it is found within the red cell as a small hyaline, non-pigmented, disc-shaped or spheroidal body measuring about two microns in diameter. In the unstained fresh specimen it is actively ameboid, frequently changing its shape and position within the cell. In the specimen stained by the Nocht-Romanowsky method, which will be briefly described below, it is identical in appearance with the spore of the segmenting body from which it originated, and presents a bluish outer rim of protoplasm enclosing a nucleus, the essential element of which is the chromatin granule, which appears as a bright red spot, surrounded wholly or in part by a whitish unstained substance.

The next stage in the development is the formation of the characteristic ring which appears, as a rule, within two hours after the chill, and is retained more or less definitely for the first twelve hours of the cycle. It gradually increases in size and shows active ameboid movements in the unstained fresh specimen. While at first unpigmented, after a few hours melanin granules appear, which are endowed with an active vibratory motion. In the stained specimen, the bluish ring, with its chromatin dot, presents a very characteristic and unmistakable appearance. There is some doubt as to the significance of the ring form. Some observers claim that it is a true ring, while others are of the opinion that the clear central area, through which the hemoglobin of the enclosing erythrocyte can usually be distinctly seen, represents a vesicular nucleus. There are good arguments in favor of both views and the question does not seem to be definitely settled.

As the ring increases in size, a thickening of the protoplasm develops at one section, and this is the stage during which the organism exhibits its most active ameboid excursions. Then the body continues to grow, assumes a more spherical form, and its ameboid motion gradually diminishes and disappears altogether. The pigment granules increase in numbers, are scattered throughout the organism, or may tend to arrange themselves along the periphery. The chromatin breaks up into a group of granules, usually surrounded by the whitish nuclear area. At the end of the first twenty-four hours of the cycle the organism occupies about three-quarters of the invaded red cell.

The full-grown organism represents the pre-segmenting stage. The nucleus breaks up into a reticulum, which invades the protoplasm. The chromatin granules continue to divide and are distributed in groups throughout the nuclear reticulum. The pigment granules become fewer in

number and larger in size, and work in toward the center. Then, as the next rigor approaches the nuclear fragments close about the chromatin groups, which have each coalesced to form separate globules. The pigment forms a more or less compact central block, although sometimes it is somewhat distributed. The protoplasm arranges itself about the nuclear bodies, fifteen to twenty in number, each representing a prospective spore, and thus the evolution of the segmenting body, or *sporocyte*, is completed. These segmenting bodies are intracellular, almost completely filling the enclosing erythrocyte, only a thin granular rim of the latter being perceptible. They first appear about three or four hours before the chill, become more numerous as the rigor approaches, and some may persist for an hour or so thereafter. The breaking up of the segmenting body and the liberation of the spores is synchronous with the rigor. The spores set free in the plasma rapidly invade fresh red cells as parasites of the new generation and the cycle is repeated. This occurs approximately every forty-eight hours.

The associated changes in the invaded red cells are important and interesting. Almost from the very beginning the erythrocyte becomes swollen and deficient in hemoglobin, and soon exhibits a granular degeneration of its protoplasm, which is best demonstrated in the specimen stained after the method of Goldhorn to be described below.

The difference between the cycle of the tertian parasite and those of the quartan and æstivo-autumnal forms will be briefly mentioned:

The quartan ring resembles that of the tertian, but is slightly smaller. Its pigment granules are coarser and more numerous. The segmenting form is more frequently seen in the peripheral circulation than is the case with either tertian or æstivo-autumnal infections. The number of spores is usually between six and twelve, never more. The invaded red cell is not so swollen as in tertian infection. The cycle is completed in seventy-two hours.

The æstivo-autumnal young forms and rings are distinctly smaller than those of the tertian, and pigmentation is less frequently seen. The ring is a more delicate and symmetrical bow, showing a thickening of one segment, thus forming the characteristic "signet ring." The enclosing red cell is shrunken, and often crenated rather than swollen. In the unstained specimen it often presents a characteristic "brassy" appearance. Multiple infections of the same red cell occur more frequently in this type. The full-grown and segmenting forms are rarely seen in the peripheral circulation. The rosettes and their spores, which latter number twelve to fifteen, are smaller than the respective forms in the tertian. Two distinct types of æstivo-autumnal parasites are recognized as existing (Ewing,⁶ Manson,⁶ Craig,⁷ Grassi⁸ and others), one being the æstivo-autumnal quotidian, with a cycle of twenty-four hours, and the other the malignant tertian, with a cycle of forty-eight hours.

The Crescent Body.—This merits special attention, as it is the early form of the sexual cycle of the parasite. It is an intracellular body, crescentic in shape, with the ends usually somewhat rounded. The full-grown body, measuring about ten by two or three microns, contains one or two centrally located chromatin groups within a small, clear, achromatic area, surrounded by a zone of rod-shaped, motionless, pigment granules, arranged in a circular or figure-of-eight fashion. In the specimen stained by the Nocht-Romanowsky method, a thin rim giving the staining reactions of hemoglobin can usually be seen covering the convex surface and ends of the crescent, and springing as a faint bow from the concavity somewhat within the extremities.

Analogous to the crescentic form of the æstivo-autumnal type, there are in the tertian and quartan parasites certain full-grown forms which do not proceed to segmentation and spore production. These, the so-called *gametocytes*, are spheroidal bodies in which the pigment is distributed and motile. They are of two kinds, a hyaline body, which becomes flagellated in the shed blood and constitutes the male element in the sexual cycle, and a granular, non-flagellating body, which constitutes the female element.

The Exogenous Cycle.—In the shed blood under proper conditions of warmth, moisture and exposure to air, such as occurs naturally in the mosquito's stomach or can be produced artificially by various expedients, the crescents gradually undergo changes in shape, some of them developing into hyaline and others into granular spheroidal bodies. Then these crescent-derived spheres or the full-grown, non-sporulating tertian and quartan forms, as the case may be, exhibit very interesting and important evolutionary changes. The hyaline bodies seem to be agitated by violent spasmodic internal motions, their pigment granules vibrate actively and soon a number of long protoplasmic filaments are shot out, which lash about vigorously until one or more of them succeed in breaking away from the parent sphere. This is the phenomenon of exflagellation, and the flagella represent the male or fertilizing elements. They are the *microgametes*. In the stained specimen they are each found to be composed of a chromatin filament, covered with protoplasm. The granular spheres do not exflagellate. They represent the female element of the sexual cycle, and are termed *macrogametes*. The liberated flagellum, or microgamete, seeks to enter the macrogamete, and finally succeeds in doing so, merging with the contents of the sphere. After being thus fertilized, the granular body gradually changes its shape and assumes an elongated, oval and, finally, vermicular form, with an anterior pointed hyaline extremity and a posterior rounded pigmented extremity. This is the *vermicule*, or *ookinet*. These changes normally take place within the lumen of the mosquito's stomach. Moore,⁹ in an account of a personal observation, showing that the

flagella of the malarial parasite are fertilizing elements, states that he saw the act of impregnation take place. He had both the granular and the hyaline body within the same field of the microscope. Grassi⁸ gives the time for the development of the ookinet within the mosquito's stomach as thirty-two hours after the ingestion of the blood.

The ookinet, endowed with the power of spontaneous movement, pierces the epithelial layer of the mosquito's stomach and ensconces itself between the meshes of the muscular coat as a spherical or ovoidal body, the *zygote*. The number of zygotes in the wall of the mosquito's stomach corresponds with the number of fertilized granular bodies. They appear as minute, wart-like excrescences, projecting into the body cavity.

The zygote grows rapidly and soon exhibits a well-defined capsule. The nucleus and protoplasm subdivide and form a number of spheres, each containing a whorl of minute filamentous germinal rods, the prospective *zygotoblasts*, or *sporozoites*. After about a week, more or less, according to whether the temperature and other conditions are favorable to growth or otherwise, the zygote matures and the capsule bursts and discharges the sporozoites into the body cavity of the host, whence they find their way into the veneno-salivary glands, situated in the head of the insect. In the stained section of the gland the sporozoites are each found to contain a number of chromatin granules.

In some of the ruptured zygote capsules there are found remaining certain comparatively large, blackish or brownish sausage-shaped bodies, the nature of which is not understood. Ross called them "black spores," and Manson¹⁰ ventured the suggestion that perhaps they represented a resistant form, in which the parasite could survive adverse circumstances, and being liberated upon the death of the insect host, remain dormant in the water or in the soil. Manson further suggests that the parasite may be capable of passing from mosquito to mosquito without the intervention of man, either by the penetration of the sporozoite into the mosquito's ova or by means of a special type of sporozoite. This would imply the existence of another extra-corporeal phase, which Grassi holds to be impossible.

The parasite is transferred to man by the bite of an insect whose veneno-salivary glands contain the sporozoites. The disease usually develops about eight or ten days after the inoculation. Not all experimental inoculations are successful, and it is probable that there are certain necessary conditions, not as yet fully understood, which must be fulfilled before the parasite will enter upon the endogenous cycle. F. Schaudinn¹¹ claims to be the first to directly observe the entrance of the sporozoite into the red corpuscle and its evolution into the ring form.

The Latent Stage.—Beside the two cycles above described there must be a latent intravisceral stage, during which the parasite rests in

the intervals of apparent cure, to reappear again in the peripheral circulation in a fresh outbreak of the disease without the intervention of the mosquito, as occurs in the spring relapses so frequently seen. Grassi¹² suggests that the crescents and the macrogametes may undergo parthenogenetic subdivision in the viscera of the human host and thus produce the fresh outbreaks.

The Laboratory Diagnosis.—Blood suspected of containing the malarial parasite may be examined either in the fresh state or in the stained specimen. The blood should be taken before quinine is given, as that tends to expel the parasite from the peripheral circulation. The most favorable time for making the specimen is usually stated to be just before, during, or just after the chill, but Cabot¹³ states that either eight hours before or eight hours after the chill is preferable, and this statement is borne out by the experience of the writer. It is to be remembered that there is a tendency for the parasites to retire to the internal organs upon the approach of the chill. This is especially so in æstivo-autumnal infections. Directly after the chill there predominate the young, unpigmented forms, which may be very difficult to detect, and which, moreover, are the only forms of the parasite that can be mistaken. On the other hand, Ewing¹⁴ claims that in acute malarial fever, even when quinine has been administered, parasites can always be found if the blood be examined with care and persistence within eighteen hours after the chill.

Whether the blood be examined in the fresh state or stained, it is essential that the slides and cover glasses be absolutely clean, for the presence of particles of dirt constitutes a source of error and annoyance. A one-twelfth oil immersion lens is necessary, and a mechanical stage is desirable, but not indispensable. The examination will reveal: The presence or absence of parasites; the type of infection; the period of the cycle, and, in a way, the severity of the infection.

Examination of the blood in the fresh state is valuable for the study of the development of the parasite, ameboid movement, etc., but the present improved staining methods of the dried smear give much more reliable results for purposes of responsible diagnosis; therefore, a further discussion of the former method will not be entered into here.

Methods of Staining.—The Nocht-Romanowsky method is undoubtedly the best for the critical study of the malarial parasite. The polychrome methylene blue discovered by Nocht contains a principle that gives a beautiful differentiation of the chromatin, staining it a bright red, in sharp contrast to the light blue color assumed by the intracellular organism. The formula and method of using the stain are given in the recent text-books. (See Ewing's *Clinical Pathology of the Blood*, p. 380.) The objections that may be made to the method are that it requires accurate neutralization of the polychrome solution, long fixation, certain brands of methyl-

ene blue, prolonged staining, and the final mixture must be made just before using.

In the experience of the writer, who has made all the blood examinations for the New York Department of Health for the past five months, the best method for the rapid and reliable laboratory diagnosis is that devised by L. B. Goldhorn.¹⁵ He makes a polychrome solution by the digestion of methylene blue by means of a solution of lithium carbonate and heat. This stains the chromatin rapidly and is, moreover, the best method for demonstrating the granular degeneration of the infected red cells. The formula of the stain is given in the originator's article, published in the *Transactions of the Pathological Society*, February, 1901. The solution can be bought ready for use from New York dealers.

The directions for use are as follows:

1. Fix the smear in methyl alcohol (commercial) 15-30 seconds.
2. Wash in running water for a few seconds.
3. Immerse in one-tenth per cent. aqueous eosin (Grubler's reddish) 7-15 seconds.
4. Wash in water.
5. Immerse in Goldhorn's polychrome methylene blue solution 20-30 seconds.
6. Wash in water and dry by rapid shaking in the air; do not blot.

It stains nuclei blue; body of lymphocytes same; neutrophilic granules pale pink or lilac; eosinophilic granules deep pink; basophilic granules of mast cells blue-purple; red cells pink with a bluish tinge; blood platelets reddish purple; malarial organism light blue with red chromatin body. Granular degeneration of the red cells is well shown as a stippling. The entire fixing and staining process can usually be completed in one minute, and the results obtained are eminently satisfactory.

Another good stain is that devised by Jenner. It consists of a solution of eosin and methylene blue in methyl alcohol, and dispenses with a separate fixing agent, the alcohol in which the stain is dissolved acting as such. But the method does not give such a good differentiation of the chromatin, and, moreover, it stains the blood platelets blue. Therefore, with the Jenner stain a blood platelet superimposed upon a red cell, or an extrusion of some of the basophilic stroma of a red cell, forming a little disc thereon, is apt to be mistaken for the young spheroidal, non-pigmented malarial organism, and thus lead to an error in diagnosis. With the Goldhorn stain the sharp differentiation of the chromatin granule and the fact that the platelets and the cellular extrusions are stained reddish purple instead of blue, such mistakes are less apt to occur. It is best to learn to use one satisfactory stain, to study its peculiarities, its scope and its limitations, and then to adhere to it until something better is introduced.

Associated Changes in the Blood.—A study of the changes in the normal structures of the blood

is often of considerable importance in corroborating the diagnosis of malaria. A marked and rapid diminution in the number of red corpuscles is a constant occurrence, especially in initial paroxysms. The cells, moreover, are extremely deficient in hemoglobin, and the color index is always under 1. The granular degeneration of the erythrocyte has already been mentioned. The absence of leucocytosis is also characteristic. A rapidly rising temperature, without marked increase in the number of leucocytes, should make one suspect the presence of a malarial infection, and, on the other hand, a marked leucocytosis should make one doubt the existence of an uncomplicated malarial infection. Pigmented leucocytes should always be looked for. Craig (report of the Surgeon-General of the Army, 1901, p. 103) makes the following statement: "In æstivo-autumnal fever the parasites are always most numerous during the apyrexial stage, but there are often seen mild cases of the disease in which only after tedious and repeated examinations of the blood will the parasite be found. In such cases pigmented leucocytes are almost always present, and it is justifiable to make the diagnosis of malaria from them alone."

In conclusion, the writer would state that the examination of the blood for the malarial parasite should be more frequently resorted to than is ordinarily the case. All of the conditions, other than malaria, that produce chills and fever are serious ones, and such patients are often needlessly burdened with large doses of quinine, always to their detriment and sometimes at great risk, by the delay in instituting appropriate treatment while awaiting the results of the therapeutic test.

REFERENCES.

1. MANSON. *Brit. Med. Journal*, December 8, 1894.
2. MANSON. "Gouldstonian Lectures," *Brit. Med. Journal*, March 14, 21, 28, 1896.
3. ROSS. *Brit. Med. Journal*, December 18, 1897.
4. MCCALLUM. November 13, 1897. *Lancet*.
5. EWING. *Clinical Pathology of the Blood*.
6. MANSON. *Tropical Diseases*.
7. CRAIG. Report of the Surgeon-General of the Army, 1901.
8. GRASSI. *Die Malaria*.
9. MOORE. *Bulletin Johns Hopkins Hosp.*, October, 1902.
10. MANSON. *Tropical Diseases*, p. 29.
11. FRITZ SCHAUDINN. *Studien über krankheitserregende protozoen. Arbeiten aus d. Kaiserlichen Gesundheits-amte Bd XIX Heft 2*, 1902.
12. GRASSI. *Die Malaria*. Legend to Plate V.
13. CABOT. *Clin. Examination of the Blood*, p. 315.
14. EWING. *Clin. Pathology of the Blood*, p. 402.
15. GOLDHORN. A new and rapid method of staining the chromatin, etc. *Trans. Path. Soc.*, February, 1901.

Discussion by Francis P. Kinnicutt, of New York. "Treatment of Malarial Fevers."

I propose to confine my remarks to a few practical points in the *treatment* of malarial fever.

Inasmuch as our aim not only is to control the acute clinical symptoms, but also to prevent relapses—that is, to eradicate the parasites from

the economy—it is important to bear in mind certain facts in regard to the latent phase of the disease.

With the subsidence of the acute symptoms, either spontaneously or more commonly as the result of the administration of quinine, the plasmodium may disappear from the general circulation and assume a latent condition. The latent period, it is now admitted, may extend over many months, and Ross, Manson, Koch and others believe over many years. In other words, typical paroxysms may recur after very long periods, without reinfection.

As to the organ or tissue the plasmodium selects, or as to its appearance and structure during this stage of latency, or as to the exact conditions which cause it once more to resume active, propagating, circulating life, nothing is positively known. This much, however, we do know: that physiological strain or vital depression in the host tends to dissipate, and vital vigor and quinine to favor the latency.

A knowledge of the latent phase of the plasmodium is necessary for an intelligent treatment of the disease. Ross—than whom there is no higher authority—adopts the following method of treatment to control the acute symptoms and to prevent relapse:

Accompanying an effective dose of a purgative, a saline being preferred, 10 grains of quinine are given, and this dosage is repeated at intervals of twelve hours for a fortnight; 15 grains daily are given for the second fortnight; 10 grains daily for the second month; 5 grains daily for the third month, with 10 grains instead of 5 grains first twice a week, and then once a week; during the fourth month 10 grains are given once a week, and one or two 5-grain doses on intermediate days. The dosage of quinine mentioned is for a body weight of 150 pounds, and larger or smaller doses should be given in proportion to body weight.

By this prolonged treatment clinical experience has shown that it is often possible to destroy finally the parasites. If in spite of such treatment relapses continue to occur, a change of climate is imperatively indicated, and is often effective.

The rule of treatment which I would most earnestly urge is that in every case of infection with the malarial plasmodium, quinine should be given regularly for at least four months, whether a relapse occurs or not. Through a neglect of such a rule a relapse occurred in my own person in the winter months, four months after infection, and, in so far as it was possible to judge, without reinfection.

In my experience the most efficient form in which to administer quinine is in an acid solution. The next best form is in powder, shaken up in water. Where the digestion is impaired, as is frequently the case in malarial infection where there is a diminished secretion of hydrochloric acid which obtains in all fevers, quinine

dispensed in pill and tabloid form is not easily or quickly dissolved and absorbed.

Although the sulphate of quinine is probably the most commonly used salt, the hydrochlorate and the bihydrochlorate salts possess certain advantages. The hydrochlorate contains 81.8 per cent. of the alkaloid and is soluble in 40 parts of water. The bihydrochlorate contains 72 per cent. and is soluble in its own weight of water. The percentage of the alkaloid in the sulphate of quinine is 73.5 per cent. and it is soluble only in 800 parts of water.

For hypodermic use the bihydrochlorate and the bichlorate of quinine with urea are the most serviceable salts. If neither of these salts is procurable, the sulphate may be used, a solution being effected by adding half its weight of tartaric acid.

Ten to 15 grains of any of the salts of quinine which contain as much as 73 per cent. of the alkaloid constitute a full hypodermic dose. In the malignant forms of malarial fever, as much as 60 grains of quinine, given in divided doses by this method, are often imperatively indicated.

It may be added that in all cases of the pernicious form of fever, where the earliest possible action of the drug is of the utmost importance, the hypodermic method of administration only should be employed. Is there any drug which may be advantageously substituted for quinine in the treatment of malarial fever?

Arsenic.—There is a general consensus of clinical opinion that during the continuation of the fever little, if any, benefit may be expected from this drug.

Methylene blue, in doses of 2 to 3 grains, and pushed until the urine becomes deeply tinged, has been used principally in Germany and America. It apparently is capable of destroying malarial parasites, but it acts less quickly and certainly than quinine. Some of its effects are distinctly unpleasant.

Phenocol hydrochloride, in 10-grain doses, administered five, three and two hours before the expected paroxysms, may be used with advantage in cases where quinine is not well borne.

I might largely add to the list of drugs which have been used as substitutes for quinine, but it may be doubted whether a substitute of equal efficacy has yet been found.

In conclusion, personally I have never seen an ordinary, uncomplicated case of malarial fever fail to yield to quinine. In rare cases it certainly does fail. It is more certain in its good effects in the tertian and quartan types of fever than in the malignant form. It does not prevent relapses in any form unless its use is long continued.

It had been my intention to speak of the hemoglobinuric fever, sometimes called "black water" fever, which is believed to be due to malarial infection, but I have already consumed the time allotted to me.

RESULTS IN FIFTY CASES OF CANCER TREATED WITH THE AID OF THE ROENTGEN RAYS.¹

BY CHARLES WARRENNE ALLEN, M.D.,
New York.

SUCCESSFUL treatment of cancer can scarcely be considered to hold the second place to the nature of this widely distributed and universally dreaded disease. No question, in years, has attracted more attention, in this connection, than that of radiotherapy. I cannot, to-day, enter upon what the rays are supposed to be, or in just what manner they are supposed to act, and, indeed, these questions have been or will be discussed in other papers of the afternoon.

There is one point of probable importance: When we treat a pathological condition, such as that presented by a rodent ulcer or open carcinomatous growth, the action which takes place within the tissues is a chemical action. This we believe to be so from the fact that in the laboratory experiments it has been clearly demonstrated that the action of the X-rays is one of reduction; in other words, that the X-ray is a reducing agent. As a rule, no evidence of an objective or subjective nature of the activity is apparent when the ray is applied either to pathological processes or to the healthy skin, unless, perchance, due to certain, as yet ill-defined, conditions, of the individual or of the vacuum tube, changes occur, which are suggestive of dermatitis, such as is produced by heat and light, or in the case of open wounds, either a charring or a condition akin to necrosis. The conditions of the tube, which more especially than any other factor make this effect likely to occur, we will not enter upon at this time. I would suggest, however, that aside from personal idiosyncrasy, which I recognize, and the greater possibility of burning by the less penetrating rays which are readily absorbed, in part, at least, by the superficial tissues, there is a condition of the tube and of the degree of heat and color in the antikathode which makes the particular tube, at the particular time, likely to affect a so-called burn. Furthermore, the ray has a predilection, undoubtedly, for tissues of embryonic-like type or those which are strongly differentiated, or those not highly vitalized; also, if I may use the expression, for "cells out of place." Thus, epithelial overgrowths, such as are often seen in carcinoma, can at times be seen to melt away, as it were, under the ray's administration, without going through the more manifest changes of which I have spoken. At times healthy tissue seems to be built upon the site of the pathological tissues, which have undergone this strange metamorphosis, and at times the healing process is of such a nature as to lead to the belief that the production of healthy or normal cells is being coincidentally stimulated.

I have to present to you to-day a tabulated

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

series of 50 cases of cancer treated during the year. The patients' ages varied from 15 years to 80 years, 30 of them being over 50 years of age; 22 were males and 28 females; 33 were epithelioma of the rodent ulcer type, or nodular growths, or carcinoma of the skin; 10 were cancers of the breast, 7 being recurrent, 1 disseminated in the form of cancer en cuirass, 3 being primary; 1 recurrent cancer of the tissues of the neck, following cancer of the tongue; 1 primary rectal; 1 recurrent uterine; 3 sarcoma, and one tumor of the jaw, supposed to be sarcoma.

Of the 33 cutaneous cases 7 occurred upon the forehead, 5 were upon the neck, 4 being just beneath the eye, 4 were upon the lip; 2 large-sized carcinomas were situated upon the lower part of the arm, 2 were upon the chin, 9 upon the nose, or nose involving also the cheek; 3 were of the multiple or disseminated variety, being in a subject of Xeroderma Pigmentosum, whose eyes were also involved in the cancerous process.

Of these fifty cases, ten are still under treatment and improving, twenty-six have been discharged as clinically cured. Of the fourteen remaining, four have ceased treatment, improved, three unimproved, two have been referred to surgeons for operation and five have died.

In obtaining these results, while the ray has been the form of treatment most largely, and in many cases exclusively, used, other adjuvant means, such as curetting the base or margin, the application of caustic paste to limited areas, electrolysis, and the application of methylene blue paint on the open surfaces, have been taken advantage of to hasten the cure.

Conclusions.—From an analysis of the series of cases observed, the following conclusions seem justifiable:

1. The X-ray possesses decided therapeutic power.
2. It may produce decided injurious effects, aside from so-called burn.
3. Symptoms referable to systemic effects may arise from the direct action of the ray or indirectly by absorption of products of disintegration, which seem, at times, to be thrown into the circulation more rapidly than they can be eliminated from the system.
4. Not only can a condition of the tissues be produced by the rays, which predisposes to cancerous growth, but carcinoma may develop in scar tissue following an X-ray burn, as instanced in one of this series of cases.
5. The method is not one to be relied upon solely or exclusively in all cases of cancer.
6. The indiscriminate and reckless use of the rays is to be strongly condemned; and even the habit of permitting the patient to examine the bones of the hand for purposes of entertainment should not be encouraged.
7. The tube may at times suddenly acquire burning properties, independent of the resistance factor.

8. By the proper use of shields, the causation of dermatitis may usually be entirely avoided.

9. Even in those cases not cured the improvement is often greater than can be obtained at the present day by any other known method.

THE VALUE OF RADIOTHERAPY IN CUTANEOUS CANCER AND DISEASES OF THE SKIN.¹

BY CHARLES WARRENNE ALLEN, M.D.,
New York.

THE author bases his report upon 200 cases treated in private practice, 37 being cutaneous cancer of various kinds, and 163 skin affections or dermatological conditions, treated with the Roentgen ray, either exclusively or conjointly with other methods. The work done in America toward the solution of the problem of the ray's place in therapy is considered, and the many trans-Atlantic contributions to the improvement of methods, apparatus, etc., are brought out. The share taken by the United States in the development of radiopraxis is one to be proud of. Much credit is due to the department of dermatology, the world over, for the rapid strides made in the method, as one of value not alone in the less severe skin affections, but in the more serious rebellious conditions, including carcinoma and lupus. Methods of precision, or plans for measuring the quantity and quality of the rays employed for a given purpose, are considered, and a new radiometer is presented. This consists in a series of ten sheets of tin and lead foil of the width of the fluorescent screen and of diminishing lengths, so superimposed that each one overlaps the last with the exception of its last two centimeters, making a scale of twenty centimeters in length. The foil is .001 inch in thickness. By use of this simple scale, which any one can readily construct for himself, the penetration of any ray may be considered in terms of definite relation to others. Thus when held before the fluoroscope, if the ray can be discerned through the fourth plate and not at all through the fifth, we say that there is a penetrating quality of the ray equal to 4, or 4-1000. If this is determined to be the proper strength for a given case in therapy, means may be taken to reproduce the same strength in similar cases.

Regarding shields, the author looks upon them as of paramount importance, never having produced an undesirable amount of surface reaction when proper shielding was carried out. The perforated metallic disc mounted upon a stand and adjustable to all surfaces and orifices of the body, which he has devised and used daily for over a year, he finds convenient and time-saving, and it is more pleasant for the patient than the leaden mask, especially in face work.

He believes it is an error to depend upon the ray to the exclusion of other practical methods

¹Abstract of a paper read at the Fourteenth International Congress in Madrid, April 28, 1903.

usually successful in skilled hands. The conclusions drawn include:

1. The ray is capable by itself alone, and within a comparatively short space of time, of effecting a cure in certain rebellious skin cancers.

2. In a variety of other obstinate, inveterate, and in some cases almost incurable affections of the skin, it has a decided value.

3. A cure may often be hastened by combining other methods with the ray, including light-treatment, electrolysis, caustic pastes, etc.

4. The great majority of skin affections do not require this treatment and no necessity has arisen for the skin patient to desert the specialist for the electrical therapist or X-ray worker in other departments.

THE ROENTGEN RAY: ITS MECHANICS, PHYSICS, PHYSIOLOGY AND PATHOLOGY.¹

BY EDEN V. DELPHEY, M.D.,
New York.

MECHANICS.

THAT form of energy known as the Roentgen, or X-ray, is produced by the bombardment of molecules against a metal plate in a vacuum of high degree. So far the only means we have at our service for producing this intense bombardment and its consequent X-ray is the electric current. The X-ray is not some form of electricity, but is a higher rate of vibration even than light, and is the transformed energy of the electric current. This latter is simply the mechanism for its production. Any other form of energy which would bombard the metal plate with sufficient intensity would also produce the X-ray, and it may be in the future some such other method may be discovered.

The apparatus for producing this electric current is of two varieties: Static machines and coil machines, and this latter may be divided into two sub-varieties: Ordinary Rhumkorff coils and high-frequency coils, in which there are one principal and many minor surges to each interruption.

A good static electrical machine, having ten or more revolving plates, when run by a motor, produces a very efficient current for exciting the X-ray tube, especially for fluoroscopic work.

In using the static machine there are four methods of connecting up the tubes:

1. By connecting the anode of the tube to the positive terminal of the prime conductor, which may be distinguished as the one having the longest white end to the spark when the terminals are brought close together, and the cathode end of the tube to the negative end of the prime conductor.

2. By connecting as before with a spark-gap, either single or multiple, in series.

3. By connecting up as in 2d with the Leyden jars in parallel.

4. By connecting the cords to the outside of

the Leyden jars, bringing the terminals of the prime conductors close together, sparking across (or an adjustable spark-gap may be arranged in place of the single spark), thus producing an induced current through the tube, but in the opposite direction from the direct current, and therefore the tube must be connected up accordingly.

Sometimes, although the current is passing through the tube properly, as in 1, the X-rays are not produced, and this can often be remedied by putting a spark-gap, either single or multiple, in series, as in 2, and even that may be improved by putting the Leyden jars in parallel, as in 3. There is no absolute rule to determine the length of the spark-gap, and although it is generally required at the anode it may be necessary at cathode end of the tube or both. It must be learned by actual trial. I have found that the multiple spark-gap gives the steadier interruptions, and therefore a steadier output of the X-ray, and by its use a tube, whose vacuum and resistance have fallen so low as to seem to require re-exhaustion, may be excited to perfect radiance, and the life of the tube not only renewed but apparently resurrected.

The Rhumkorff coil of sufficient size to produce a spark six inches or more in length is an excellent means of exciting the X-ray tube. Its special advantages are its portability and its readiness for use in all kinds of weather. Its disadvantage is the greater amplitude of the current which is manifested by the fatter spark and its consequently greater likelihood to burn the patient.

All the best Rhumkorff coils have the secondary wound in sections so as to avoid the danger of sparking across from one point to another of the highest potential which, by burning out the insulation, would destroy the usefulness of the coil. Some coils also have the sections on movable spools, any one of which can be removed at will for repairs if needed. Some coils also have means of varying the length of the primary as in the Scheidel coil, in which there are three separate sections of the primary which may be used singly, part or all together, in series or parallel. This, of course, varies the amount of the inductance in the secondary coil, and, therefore, the output of the apparatus.

In his apparatus Heinze has arranged four Leyden jars, so that two are in series and two in parallel in succession, and the current from these can be used or not at will.

The current in the secondary coil is induced almost entirely by the break, not the make, in the primary, and is also almost in proportion to the suddenness or sharpness of such break in the primary current. Therefore, it is usual to employ some means to accentuate the sharpness of the break. This is done by placing a condenser in shunt with the primary winding. This condenser is composed of a number of layers of

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

tin-foil, separated by a dielectric, and produces the effect of a number of Leyden jars connected in parallel.

The Kinraide high-frequency apparatus has the coils wound in a flat spiral, the secondary inside the primary, in such a manner that there is small likelihood of sparking between the ends of the secondary. The interruptions are produced by sparks across the space between two water-cooled copper plates and consist of oscillations made up of one principal and many (about twenty) minor surges of current in the primary and consequently of the same number in the secondary coil.

The interrupters for the primary current in the coil machines may be divided into four varieties: The mechanical, the mechanico-electrolytic, the thermo-electrolytic and electrolytic.

For low-tension currents some form of the spring interrupter is usually satisfactory, but with high-tension currents the amount of erosion on the surface of the contact points is so great as to interfere with the flow of the current, thus rendering them practically useless. Therefore, other means have been devised to interrupt the circuit. One of these is the slate wheel, having a segment of copper, whereby a contact is made, completing the circuit at each revolution, the length of the make and break being proportionate to the length of the copper and slate arcs. It can be speeded up to 1,500 revolutions per minute and is one of the simplest and best interrupters made. There are two mercury-dip interrupters, one in which a rod is dipped perpendicularly and the other where the rods are radii of a circle. They both make a contact and complete the circuit with each dip of the rods. In the Max Levy mercury interrupter the liquid mercury is pumped up by an Archimedean screw and is forced out laterally through tubes and strikes the downward extending fingers of a rotating piece of metal, which is connected with one pole of the current, but is insulated from the other. The current flows through the mercury, the arms and the fingers and is interrupted as it passes across from one finger to the other. The Cunningham interrupter is similar, except that the screw and arms revolve while the insulated segment with fingers is stationary. Whenever these arms, ejecting mercury, revolve very rapidly (he claims as high as 20,000 per minute) the mercury is apt to feather, and to prevent this he has arranged two horns which scoop up the air, and as it passes out of the opposite end it blows off the jet as it passes each finger of the insulated metallic segment. In this interrupter the current does not pass through the whole mass of mercury, but it goes in at one segment across the mercury and arms and out at the other segment.

The Heinze mechanico-electrolytic interrupter is a combination of the slate wheel with the copper segment and the perpendicular dip interrupter. At each dip the current is conveyed by

the electrolyte and is broken by the state wheel, by the withdrawal of the platinum point and also by the bubble of hydrogen gas. A brush is so arranged that the current may be passing during the whole time or during only part of the time the platinum point is dipped into the electrolyte. In this manner the contact may be quite long or exceedingly short.

In the thermo-electrolytic interrupter of Caldwell the interruptions are caused by the tension of the current passing through the small hole in the partition which divides the two chambers. This heats the electrolyte to the boiling point and the bubble of steam cuts off all electric connection between the two chambers.

The Wehnelt is a pure electrolytic interrupter and the current is broken by the passing of a bubble of hydrogen gas through the hole in the partition. The rapidity of the interruptions in these last two apparatus and their several modifications is due to the size of the hole and the tension and amplitude of the current, and may be somewhat modified at will. The former claims that the interruptions from his interrupter are so sharp that a condenser is not needed.

The Bario-vacuum regulator consists of a hard rubber tube, enclosing two terminals, forming a spark-gap, and is connected in shunt with the adjustable tube in such a manner that, when the resistance through the tube is greater than it is across the gap, the current jumps across and passes through the adjusting chemical and thereby lowers the vacuum. Its advantage is that the sparks being enclosed do not annoy the patient.

The X-ray tube consists, usually, of a very thin glass globe about six inches in diameter with extensions at opposite sides four to six inches long and about an inch in diameter. These extensions convey and support the terminals and also form handles, whereby the tube may be supported. The cathode is a cup-shaped disk, usually of aluminum, and is situated just within the circumference of the globe. The anode is usually made of platinum, although in some imported tubes it is made of a peculiarly hardened piece of iron or steel, and it should be in the center of the sphere and at an angle of 135° to the current of the cathode stream. This is the simplest form of tube. Some others have an extra attachment for holding the tube; others have two anodes, claiming the output is very much increased thereby. Inasmuch as the vacuum of all tubes varies very much at different times during use and always tends to become higher, both in vacuum and resistance by absorption of the gas still contained in the tube or its adhesion to the inner surfaces of the sphere, a small extension is blown into one side of the tube handle, and this is filled with a chemical which gives off gas or vapor when the electric current passes through it. Different makers use different chemicals or combinations

of chemicals. The most common are potassic hydrate, sodium formate, nitrate and nitrite of ammonium, copper sulphate and dioxide of manganese, but the use of potassic hydrate is most favored. The electric connections can be so adjusted that as the vacuum becomes too high and the internal resistance too great the current, taking the path of least resistance, jumps across to the terminal imbedded in the chemical, letting off a small amount of gas or vapor, thus lowering the vacuum. Another adjustable tube is made, wherein an extra cathode, placed in a subsidiary chamber, is composed of such a substance that it gives off gas when the current passes through it, thus lowering the vacuum. On the opposite end of the same chamber is placed a spiral of platinum wire which gives off a shower of fine platinum particles, thus raising the vacuum when the current from the positive pole is passed through it. In this tube the vacuum can be raised or lowered at will. Some manufacturers have a method of treating the anode, others of making the anode of selenium iron and others of washing the inside of the glass with some secret chemical which gives out gas when heated by use or by other means. Some tubes are likely to drop their vacuum so as to be nearly, if not altogether, useless, and yet such a tube may often be excited to its former radiance by putting a single or multiple spark-gap in series.

On account of the liability of the anode to burn out when forced, a tube has been made with a rotary target, and when one part is burned through, by giving a slight jar, another place can be brought into focus, thereby increasing and extending the life of the tube. Other tubes are made, whereby the anodes are kept cool by a current of water which traverses the stem and carries off the heat from the back of the target.

From the alternating current the tubes may be made the same as for the direct current, but, by so doing, one-half of the energy is lost; or by placing cathodes at both ends and a double anode whose surfaces converge at an angle of about 60° in the center of the sphere. The wires are connected to the ends of the terminals indifferently, as the current is alternately positive and negative, and the anode is connected with a good "ground." The difficulty with this tube is to get the two sides of the double-faced target focused exactly alike. Although the current is an alternating one the output of X-rays is continuous.

In the Caldwell double-focus tube the two anodes are about three inches apart and it is used in connection with his stereoscopic fluoroscope. Caldwell's treatment tube, which is similar to the endodiascope of Bouchacourt, consists of a pear-shaped globe with the cathode in the bulbous end, the anode in the side and a platinum target at an angle of about 135° to the cathode stream at the extreme tip of the tube. The

cathode stream passes in straight lines to the target, while the anode stream turns the angle of the tube to meet it. Because of its smallness, its shape and general construction the smaller end can be introduced into any artificial or natural orifices of the body and the X-rays brought into close contact with the diseased part, thereby being much more efficacious. These tubes, of course, can be made of a high or low vacuum as desired.

As the X-ray is invisible it is necessary to have some medium to translate or transform it so that its manifestations can be perceived by the human eye. This is done by means of the fluoroscope. This consists of a piece of cardboard covered with a thin layer of some fluorescent substance, preferably platino-cyanide of barium. For convenience this is made the base, fluorescent side inward, of a pyramidal box, of which the apex is cut off and adjusted to the face about the eyes so as to cut off all external light in order that the fluorescent picture may be more distinct. Caldwell has arranged an alternating shutter which cuts off the fluorescent picture from each eye successively at a very rapid rate, this, in connection with his double-focus tube, giving a stereoscopic effect—solidity—to the mental perception of the image.

The actinometer consists of a small fluoroscopic screen, arranged in a pyramidal box with two sets of ten each of circular disks of tinfoil with holes punctured through them, so that any number of layers of tinfoil can be brought between the screen and the tube, and as one set of disks is ten times as thick as the other the resistance to penetration may be rated from one to one hundred. This apparatus determines the penetration, but not the amplitude of the X-ray, and as the actinic effect of the ray is determined by and in proportion to both the amplitude and penetration, it should more properly be called diaperimeter or diaperometer. Still this is a very useful instrument to register the quality of the tube in therapeutic work.*

PHYSICS.

The human faculties are capable of being influenced by certain variations, intensities and rapidities of energy, but not by all. The lowest of these is recognized as motion by the senses of touch and sight. When these vibrations increase in rapidity to the number of sixteen per second they are perceived as the lowest audible sound, although we have reason to believe that certain insects are susceptible to the

*Since writing the above I have learned of two methods of measuring the output of X-ray tubes. The first is the "X-ometer" of Buguet and consists of an apparatus for measuring the fluorescent effect of the rays in units of and compared to standard decimal candles.

The second is the chromo-radiometer of Holzknicht, the court expert of Vienna. The principle of this is the same as that employed to determine the length of time required to print photographs and have them all of the same tone, and it consists of a mixture of chemically pure chloride and sulphate of sodium, which turns from yellow to lavender, according to the time of exposure to the X-rays. By comparison with a standard scale he determines the actinic power of the given tube for a specified time, and he affirms that the physiological and pathological effects are in direct and exact proportion to the actinic effects indicated by his apparatus.

sounds which are inaudible to the human ear, both because of the slow vibration and the consequent low pitch and the rapid vibration and consequent high pitch. The highest audible sound consists of vibrations at the rate of 40,000 per second.

Between the waves of sound, which are air waves and the waves of heat, which are ether waves, there is quite a gap in the rapidity of the vibrations which the human faculties are unable to perceive. In this gap are the Hertz waves which are employed in wireless telegraphy and which are approximately 230,000,000 per second.

The next rate of perceptible vibrations is recognized as heat. Heat and light overlap. The infra-red rays being 100,000,000,000 per second, while the visible colors of the spectrum range from 400,000,000,000 to 750,000,000,000 per second. The ultra-violet rays vibrate at about the rate of 2,000,000,000,000 per second. The Becquerel rays are higher and the X-rays still higher yet.

Light passes through substances in direct ratio to their translucency—a quality which we cannot comprehend and which is not in inverse proportion to the substances' density. Light may be reflected, refracted and polarized; so may, also, the Becquerel rays, but not to the same extent as light nor even as the ultra-violet rays, and these Becquerel rays are undoubtedly midway between light and the X-rays. The X-rays are the highest form of vibration which we know as such. The waves are undoubtedly too small to be reflected by any polish we are at present able to obtain—when we do our best the surface is still too rough—or to be refracted by any mechanism we are at present able to construct. The rays travel in straight lines and cannot be bent or diverged by a magnet or by any other known means. They induce chemical action, are photographic, cause fluorescence, discharge electrified bodies by making the air a good conductor of electricity as it may be demonstrated by the electroscope. I had a number of pocket batteries in my X-ray room, and I found in a short time that they had been entirely discharged. As I had not used them I was at a loss to understand the cause, and at first attributed it to the deterioration of the ingredients, but it was either due to the X-rays short-circuiting the batteries or to the reduction of the chemical ingredients of the batteries by the X-rays which passed through the containing cells. Later by putting them—other pocket batteries—in another room with a thick brick wall intervening I found they did not discharge on standing.

The cathode stream in the X-ray tube consists of molecules of gas still contained in the tube and the negative ions moving in a free path on account of the tenuity of the vacuum (about one two-millionth of an atmosphere). They move in straight lines from the surface

from which they are given off; therefore, the cathode is made concave, so that the rays may converge to a point on the target. After these rays meet to form a pencil they do not cross, but continue in a straight line until they meet some resistance. Therefore, the target should be a little beyond the true focus of the concave disk. The cathode stream may be deflected by a magnet in the same manner as the electric arc, but the X-rays cannot.

When the cathode rays bombard the target there occurs a transformation of energy and the resultant X-rays are emitted in all directions from the point of bombardment.

Why the platino-cyanide of barium becomes fluorescent we do not know. We recognize the fact that it does so and make use of it accordingly. Inasmuch as the X-rays pass through substances in inverse proportion to their density, it follows that the denser substances will cast the deeper shadows, and these lights and shadows make the picture on the fluorescent screen and photographic plate. Since the X-rays diverge from a small point on the target the nearer the object is to the tube the greater will be the magnification and vice versa.

When the current is continuous the higher the vacuum the greater the penetration, because as the molecules have a freer path they strike the target with greater force, and consequently the X-rays are more intense. With all the other conditions and vacuum the same the resistance to the electric current in the tube is not always the same. A non-adjustable tube will vary its resistance both up and down while in use, as indicated by sparking across between the terminals of the prime conductor when they are adjusted at a distance just a little greater than the resistance of the tube. The larger the amplitude of the electric current the greater the amplitude of the X-rays, and therefore the more the actinic and physiological effects. Yet these effects are not directly proportional to the variation in the cause.

Sometimes the tube is so low as to give off no, or almost no, X-rays, but by putting a spark-gap in series with or without the Leyden jars in parallel the surges of the cathode rays are started in the tube and the bombardment against the target is thoroughly effective, producing X-rays of high penetration. The advice is often given not to heat the target, but I have found that if we wish good penetration we must force the current till the target is at a white heat. Of course, the target is soon burned through, but that is one of the expenses of doing good work. The heat does not produce the X-rays, but the cathode stream produces the heat, the X-rays and an undertone of vibration which is manifested as yellow or apple-green light.

When the X-rays strike some resistance another set called the S-rays are produced, and when the X-rays pass through some trans-

radiant medium still another called the S' or the Goldstein rays. These all have slightly different characteristics.

PHYSIOLOGY AND PATHOLOGY.

Whether it is the X-ray itself or some other similar form of energy which accompanies the X-ray which produces the physiological and pathological results, we are not at present able to determine with positiveness. There are a number of theories projected to account for these results, viz.:

1. Mechanical bombardment, producing congestion, just as any other irritant does.
2. Ionization, by disarranging the ions of the molecules of the protoplasm.
3. Induction by producing currents and counter-currents in the tissues.
4. Deelectrification, which would be the opposite of electrification, either direct or by induction.
5. Actinic or chemical effect. There is no reason to doubt that the X-rays may produce chemical action in the tissues, just as well as they do on the photographic plate, and this may be beneficial or harmful, according to the conditions and circumstances of each case.
6. Neurotrophic effect. As yet we have not learned on what nerve action depends, and therefore cannot determine whether or not the X-rays cause interference with this action.
7. Interference of energy. Every cell and every part of protoplasm of every cell in the body is producing energy, and the sum of these energies constitute life. What life is, investigators have tried for centuries to determine, and they are no nearer the solution now than in the beginning. It may be that it is only some higher form of energy than heretofore discovered, and it may be altogether different. But just as one form of energy may be modified by another, even though the interfering energy may be of a lower order, just so it may be that the physiological effects may be due to such interference.

The pathological effect of too long or too frequent exposure to the X-ray or a reasonable amount of exposure, in a case where there is a susceptible idiosyncrasy, produces a dermatitis, which is commonly called the X-ray burn. Beck (*Med. Record*, January 18, 1902) divides these into three stages or degrees:

1. Hyperemia with infiltration of epidermis, reddish terra-cotta color, itching, etc. (I have found also considerable tension and a pebbly condition of the skin, each "pebble" coming to the surface, often exuding a very small drop of thin serum and exfoliating as the burn heals.)
2. Blistering, with other symptoms increased.
3. A necrosis of the true skin and underlying tissues.

Codman (*Philadelphia Med. Jour.*, March 8 and 15, 1902) says that there have been less than 200 accidental burns reported. Less than one-half were serious and about one-third occurred in X-ray workers. One-third of all these burns

occurred within four days from the time of exposure, one-half before the ninth day, and if the part is not burned within three weeks it is not apt to occur at all. No burn will be produced by an exposure less than the equivalent of five minutes at ten inches. Low or soft tubes are more apt to burn than high or hard tubes. There is no good evidence of injury to the deeper structures without primary injury to the skin.

Scholtz (*Arch. f. Dermat. und Syph. B. LIX N. 1, 2, 3*) reviews the literature of X-ray burns and says that:

"Neisser compares the action of the X-rays to the inflammatory process of the tuberculin reaction.

"Kaposi ascribes the action of the X-rays to changes in the circulation and also to fatty degeneration and molecular disintegration, resulting from inflammatory infiltration.

"Oudin, Bartholomy and Darrier examined the skin from rayed guinea pigs and found thickening of the epidermis and increase of prickle cells, rete cells and nuclear epithelia, the vessels of the cutis and subcutis showing no change.

"Jutassy found similar changes in rabbits.

"Una found on examining human skin, using a special stain for elastic fibers, a change in the collagen. It was baso-philic, but the elastic fibers were not stained.

"Gossman found in an ulcer a necrotic structureless mass in the superficial portion and masses of fibers, neuclei, leucocytes and remains of connective tissue bundles in the deeper portion. The vessels showed a degeneration of the muscular layer and intima with vacuoles in the epithelia. The cell elements were swollen and the intersubstance increased with irregular spaces containing vacuoles, indicating edema."

Scholtz also made numerous experiments on animals, and says that the X-rays themselves are the only, or at least the essentially, active factor in producing the effects attributed to them, effect both at point of entrance and exit appearing in some days, the acme in some weeks. The bacteriocidal effect is insignificant and scarcely plays any rôle therapeutically. The changes in the blood-vessels have probably much to do with the further development and slow healing of the ulceration.

He made sections of the skin at the end of twenty-four hours and found the protoplasm of the prickle cells diffuse. The outline was not so sharp as in the normal and stained more than normal. Another section was removed at the end of seven days and it showed the nuclear layer loosened and containing fewer nucleated cells than normal. This layer was diminished and in some cases it had disappeared. The prickle cells were swollen and contour altered and the nuclei generally stained poorly. The chromatin appeared in clumps, the protoplasm of the cells and the nuclei swollen and often vacuolized. The corium was edematous; the connective tissue was somewhat swollen and

homogenous and stained poorly; the cells of the sweat glands showed slight degenerative changes, and the same conditions were found in the cells of the intima and media of the larger but not of the smaller blood-vessels. Often the cells of the intima were loosened and projected into the lumen of the vessel. In more severe cases a high grade of inflammatory reaction changes were observed with rich infiltration of polynuclear and mast cells. The elastic fibers of the skin stained poorly. The hair bulbs showed some degenerative changes in the rete cells and were often surrounded by masses of leucocytes. He summarizes as follows:

1. The X-ray causes slow degeneration. The connective tissue, the elastic fibers, musculature and the bones are not at all or are only slightly affected and only suffer secondarily to inflammatory action. The first change is a degeneration of the epithelia. There were also localized masses of the cells of the glandular organs, of blood-vessels, of muscles and of connective tissue which show degeneration. This degeneration is both of the cell body and nucleus.

2. As soon as the inflammatory reaction has reached a sufficient degree there is increased vessel dilatation with serous effusion, infiltration of cells and emigration of leucocytes until the structure is lost in a mass of infiltration.

It is evident from these investigations that the X-rays produce their effect upon physiological and especially upon pathological tissues, which effect is as peculiar and characteristic as the arsenic pastes which have been and are still employed for the destruction of superficial neoplasms in two ways: By producing a simple inflammatory exudate which chokes off the blood supply, causing a fibroid change; and by producing a fatty degeneration of all the epithelial elements of the tissues which are then absorbed and excreted through the ordinary channels. Therefore, these cases should be treated with caution lest a septicemic condition intervene.

The dual effect of the rays explains why they are most efficacious in the treatment of superficial neoplasms, because we can obtain the choking-off effect of the exudate, whereas in deep neoplasms the drainage is too good for this to occur, and we have to depend entirely upon the degenerative effect of the rays.

Inasmuch as the cases of deep neoplasms are seldom presented for treatment until the disease has made considerable progress, it is an unequal race between the two, with the chances against the beneficial effects of the rays surpassing and overcoming the malevolence of the growth. Therefore, all deep-seated neoplasms should be removed by surgical means, if possible, and the patient treated by the X-rays afterward to avoid recurrence, and when they cannot be removed by surgical means the patient should be given the benefit of the chance of cure by treatment as death is otherwise inevitable, and the X-rays certainly relieve the pain which attends these cases.

THE ROENTGEN RAY IN GYNECOLOGY.¹

BY EDEN V. DELPHEY, M.D.,
New York.

IN considering the use of the Roentgen ray in gynecology we find that its efficiency in diagnosis will depend a great deal upon the point of view from which we look at it.

The true gynecologist is one who has first been a general practitioner and who, because of his liking, aptitude and success, has drifted into this specialty. He has thoroughly familiarized himself with the anatomy, physiology and pathology of the female pelvic organs by close study, observation and careful dissection, and then by years of practice has educated his sense of touch to that intense degree of acuteness that he is able to perceive at his finger tips conditions which to the general practitioner are entirely imperceptible and almost unbelievable. In addition to this, his comprehension of conditions both physiological and pathological is so complete that he is able to see them in his mind's eye and to determine at once to which of these two classes the case belongs. To such a man the X-ray adds very little to his capabilities for ordinary pelvic cases.

The female reproductive organs are encased in the bony framework of the pelvis, and in such a position that it is very difficult to adjust the tube so that the rays will pass through the pelvic canal so as to make a picture on the screen or photographic plate. Moreover, the lights and shadows of the picture are caused by the different densities of the substances through which the rays pass. When the rays have passed through the dense bone, very little more shadow will be produced by the intervention of the trans-radiant muscular, glandular and connective tissue organs, and as the ratio between the lights and shadows is very close, the picture will be very indistinct.

In the examination of conditions above the pelvic bones we meet with somewhat better success, but still the picture is often very indistinct and unsatisfactory, and unless the suspected condition is pointed out it will sometimes be difficult for the un instructed person to find it. If we include the kidneys, ureter, etc., as a part of the gynecological system, much will be added to the range of efficacy of the X-ray in gynecological diagnosis, because a great many cases of kidney and ureteral calculi have been diagnosed and located by this means. The X-ray negative gives information which cannot be obtained in any other way. Prolapsed kidney can sometimes be seen in very thin persons (and these are usually the ones who are the sufferers from this condition), both by the fluoroscope and by the photographic negative, but much better by the latter.

In the diagnosis of abdominal tumors the X-ray adds almost nothing to the educated touch of the gynecologist. Although we do not

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

have the bony framework of the pelvis to obstruct our vision, nevertheless the differences in the densities of the tumors are so slight as to make very little difference in the shadows in the picture. Muscular tissue is nearly all water, and the remainder is mainly composed of substances of about the same molecular weight as water. Therefore the difference in the radiopacity between solid tumors and cysts is so small as to be sometimes indistinguishable by the X-ray. Tumors containing bone, however, such as extra uterine gestation or dermoid cysts, which may also contain teeth and bone, can be distinctly diagnosed by the X-ray photographic negative.

In all these cases it is necessary to avoid errors from shadows produced by buttons, etc., in the clothing, and also to avoid the danger of producing an X-ray burn by too long exposure while taking the picture. There are also several other methods of avoiding burns, and one is to anoint the skin with some viscid substance, as petrolatum, and the result of this is that the impact of the rays is first against this foreign substance, and the difference in resistance between it and the skin is so slight that the rays pass easily from the one to the other. The effect is analogous to moistening the electrodes with salt water when we wish to use the galvanic or faradic current. The resistance is lessened, and there is no pain or burning at the points of contact, as there would be if the electrodes were dry.

The main use of the Roentgen ray in gynecology is in the treatment of malignant neoplasms. Whenever the diagnosis is made soon enough, the tumor and often all the pelvic reproductive organs should be removed by surgical means, so as to get entirely beyond the malignant growth and prevent recurrence. When this cannot be done, the protuberant portion, if of the cervix, should be removed and the rest subjected to the influence of the X-ray. Quite a number of cases of carcinomata have been very much improved and epitheliomata have apparently been entirely cured by this means, and as certain death is otherwise the only outlook, the patient should be given the benefit of the chance. The rationale of the treatment is not yet completely understood, but it is plain that the X-ray in some way interferes with the life of the adventitious tissue, probably in two ways: by causing an inflammatory exudate, which chokes off the blood supply, and which is followed by a fibroid change, and by causing a degeneration of the cells of all the tissues which are absorbed and excreted through the ordinary channels. Consequently these cases must be treated cautiously, watching the pulse and temperature lest too large an amount of waste products be thrown into the general circulation for the eliminative organs to dispose of, in which case there would be likely to be an acute septic infection, or at least a severe toxemia. Therefore, if under treatment the pulse becomes rapid and the temperature rises—

and they cannot be attributed to any other cause—the treatment should be lessened or entirely stopped.

The X-rays seem to have as much and as special an affinity for and effect upon the neoplasms as do the arsenical pastes which have been and still are used for these cases. The rays have these advantages, however: they do not cause pain and they do not destroy tissue *en masse*. Soon after treatment is begun the pain and discharges are lessened, and later the neoplasms shrink and disappear entirely, and are replaced by healthy tissue. Should no effect be produced after fifteen or twenty treatments the case should not be despaired of, because cases are on record where the improvement did not begin until some time after they were given up as hopeless, but the improvement once begun continued to perfect cure.

The application of the X-ray is made by placing the part to be treated directly in the range of the X-rays, shielding the rest of the tissues in the vicinity with sheet lead or tinfoil and exposing the diseased part to the action of the rays from seven to fifteen minutes with the tube at a distance of 12 to 15 inches. If the tube is closer we are apt to get too much of the heat rays which accompany the X-rays; and longer exposure than fifteen minutes is apt to cause an X-ray burn. In case the diseased part is in one of the orifices, such as the vagina or rectum, a speculum should be inserted, in order that the rays may have as little resistance as possible before meeting the part to be treated. It must be remembered that if we wish to get the effect laterally as well as at the end of the speculum it should be made of a transradiant substance. I have found that if a thin sheet of celluloid of the proper dimensions be coiled on itself to a small diameter, introduced into the orifice and allowed to expand, there will be sufficient elasticity to open it up to the desired size. In the absence of celluloid I have found well-oiled cardboard to answer the purpose very well. I am inclined to prefer this method to the use of Caldwell's treatment tube, and others of a similar form, because I consider that I have the treatment under better control and that it is therefore safer. At first the sittings should not be more than seven or eight minutes in duration, and not oftener than every second day, and then increased in time and frequency according to the reaction or absence of reaction.

Inasmuch as we have no adequate means of measuring the output of the X-ray tube and its physiological effect in the treatment of disease, it is desirable to include in the report of the cases certain data, as follows:

Patient:

The age of the patient.

The length of time since it was first observed.

The situation, size and shape of the neoplasm and the result of the microscopical examination of a removed and stained section.

Exposure:

- Length of exposure.
- Frequency of exposure.
- Reaction of patient's skin.
- Reaction of patient's pulse and temperature.
- Effect or size of neoplasm.
- Effect or discharge.

Static Machine:

- The number of plates.
- The size of the plates.
- The number of revolutions per minute.
- Whether or not, in using the direct current, there is a spark-gap, either single or multiple in series; the length of same, and whether the Leyden jars are connected in parallel, and their size if so.
- If the tube is excited by the induced current, the distance apart of the terminals of the prime conductors and the size of the Leyden jars.

Coil Machines:

- The current traversing the primary coil, whether from street main or battery, and it is also desirable to know both the voltage and amperage of the primary current.
- The length and size of the wire of the primary coil.
- The length and size of the wire of the secondary coil.
- The size and number of plates in the condenser.
- The kind of interrupter.
- The number of interruptions per minute.
- The character of the interruptions, whether quick and sharp, or slow and dragging.
- If it is a high-frequency coil, how many secondary surges to each break.
- Whether or not there is a spark-gap, either single or multiple, in the secondary circuit, its character and length.

Tube:

- Variety, make, plain or adjustable.
- Length of spark-gap necessary to excite the tube.
- High or low penetration, as indicated by the actinometer (diapheiometer), or by the appearance of the bones of the hand through the fluoroscope.
- The observer should report the result of the treatment of the cases at a future date, because it may be that the condition may recur after treatment by the X-rays as well as after operative interference.

DISCUSSION.

Dr. William James Morton, of New York, said that the subject had been presented in an exceedingly interesting light. It was yet in an embryonic stage, and no one could speak authoritatively upon it. He was surprised that what had been said had been accepted with so much credence and enthusiasm; he doubted if this would have been the case only a year ago. The speaker then presented the Kjeldsen lamp, in order to show how the expensive and complicated

apparatus of Finsen could be simplified. This new lamp was portable and comparatively inexpensive. It had been found that simple iron electrodes used as an arc instead of carbon produced a light which was extremely rich in ultra-violet rays. The chief apparatus used in X-ray work were a good interrupter and a static machine or coil. He had recently prepared a tube for the diffusion of the X-ray at the end, so that it could be inserted into the cavities of the body. He congratulated the Association that it had been presented with the paper by Dr. Beck, as it showed the inevitable tendency of the X-ray in surgery toward accuracy in diagnosis. The well-equipped surgeon of to-day could hardly get along without an X-ray apparatus. He would not agree with all the remarks made by Dr. Allen with regard to X-ray burns, particularly in the matter of idiosyncrasy. People could be reduced by chronic diseases and cohexias so that not only the X-ray but any other irritant might produce a bad effect, but except in this way he did not think idiosyncrasy played any part. Dr. Allen's results were excellent, yet he thought there should have been 100 per cent. of successes in the X-ray treatment of rodent ulcer. He could not understand why Dr. Allen made use not only of the X-ray in these cases, but also of methylene blue, electrolysis, and other things, when it was known that the X-ray alone would effect the desired result. Dr. Morton then exhibited photographs of a case that he had cured. Continuing, he said he was particularly interested in the X-ray treatment of primary carcinoma of the breast. He had treated a large number of these cases. One of the most encouraging of these had been sent to him by a well-known German surgeon of this city. The growth at the time was about the size of a Mandarin orange. Some affected lymphatic glands were present. This morning the surgeon had sent him word that after a careful examination he could find no trace of the disease left in this patient. With regard to the use of screens and specula, he would say that he had no desire to screen off the action of the X-ray in the treatment of cancer, for every physician knew that it was only at the very beginning that the disease could be said to be strictly localized. On the contrary, he preferred to make a very wide application of the X-ray.

Dr. F. P. Kinnicutt asked if Dr. Allen and Dr. Morton, in their treatment of rodent ulcer by the X-ray, had found the indurated and rolled-up edges particularly rebellious to treatment. It had been claimed by the English observers that in this class of cases this portion of the ulcer proved extremely obstinate to the X-ray treatment. Dr. Morris, of London, had found that a combination of the X-ray treatment with the light treatment gave better results than either method alone. Dr. Kinnicutt also exhibited a recently devised and ingenious English tube for the light treatment of mucous cavities and of diseased areas of skin without affecting the adjacent skin. This tube

was now being used with satisfaction in the Presbyterian Hospital.

Dr. Allen said that he had found these rolled-up edges very rebellious, and this was one reason why he thought the man who pinned his faith exclusively to the X-ray made a great mistake. He believed that there were certain forms of cancer that might be subjected at the present time to the X-ray almost indefinitely without result. This was his reason for combining methods of treatment.

Dr. Morton said that he had had one case of rodent ulcer in which these edges had proved utterly rebellious, as well as some of the islands in the center, and he was glad to learn that the additional use of the Finsen light would facilitate the treatment of such cases.

Dr. William B. Coley, of New York, said that during the last eight months an effort had been made by him to determine the exact value of the X-ray treatment, especially in inoperable cancer. The diagnosis was not positive until the growth was removed and examined microscopically. He thought the X-ray should be used as an adjuvant rather than as a substitute for operation in this class of cases, but this criticism was not intended to apply to superficial forms of cutaneous disease, such as rodent ulcer. Since February 68 cases of cancer had been treated at the General Memorial Hospital, 25 being sarcoma and 17 recurrent carcinoma of the breast. In several instances the growths had disappeared, yet they could not be reported as cured at this time, simply because they had disappeared under the X-ray treatment. One case that had been reported by another physician as a probable cure had recurred in the lung, and had caused death about three months after the case had been reported as cured. His experience had been that many of these cases recur in a short time. The greatest value of the treatment seemed to be as a prophylactic agent used immediately after every operation for primary carcinoma. Dr. Coley then exhibited two cases of sarcoma. One of these was a particularly malignant form, a periosteal sarcoma of the femur. The case had come to him last February with a round-cell infiltration involving two-thirds of the left femur. Microscopical examination proved its true nature. Hip-joint amputation was advised but refused. His general condition had improved, and the tumor had been markedly reduced. He did not report it as a cure, but merely as an interesting case in view of the fact that these growths often prove fatal within six months or a year. Note.—The patient is in good condition June, 1903.

Dr. Homer Wakefield said that the X-rays acted by the conversion of ordinary oxygen into nascent (active) oxygen.

Dr. Milton Franklin said that the reducing action of the X-ray had been established beyond doubt. It had been explained on an electrochemical basis. It presupposes the theory that irons negatively charged are discharged into space

with tremendous velocity in the X-ray, that coming in contact with different chemical substances they saturate the electrovalency of the positive atom by their own negative charge and thus set free the negative element, which, in organized structures, is usually oxygen. Dr. Delphey had spoken of the X-rays being made up of waves of minute lengths. This was a very tempting theory, but there were two others which at the present time were just as well accepted. One was that molecules smaller than anything heretofore supposed travel into space in straight lines with great force, and penetrate the intermolecular spaces of substance in inverse proportion to their specific densities. In a dense medium, such as steel or glass, they are absorbed, while in lighter media they pass through the intermolecular spaces. A tube under ordinary atmospheric pressure would offer a certain resistance, and this resistance would decrease as the vacuum became higher, until a certain point was reached. Beyond this point the resistance of the tube greatly increased until finally no current could be passed through the tube. In a low tube, in which the volume of the discharge was large, the molecules would interfere with each other, and would therefore strike the target with less force than in an exhausted tube.

Dr. Delphey said he was a strong believer in the idiosyncrasy theory of X-ray burns, just as he was a believer in idiosyncrasy to sunlight and to certain drugs. The lower forms of vibration, he thought, perhaps acted better in superficial diseases. Ordinary sunlight was a general tonic. He had not had time to mention all of the theories, and hence would give the one which he thought the most plausible. The X-ray caused a degeneration of all the epithelial elements, both superficial and deep. It did not seem to him to be a reduction. Secondly, it produced a congestion of the tissues and an exudation of serum. When the drainage in the surrounding tissues was good, as in adenomata, the results of the treatment would not be so good. He had intimated in his second paper that carcinoma of the uterus should be treated by surgical operation, aided, if need be, by the use of the X-ray. He had said nothing about using a speculum, though he had referred to the use of a celluloid cylinder fifteen-one thousandths of an inch in thickness. It was most important that late reports of these cases should be published, just as in operative cases. There were many excellent forms of treatment tubes, among them one which he exhibited. This tube has a metal shield, and allows of the escape of the rays only at the end.

Drs. Frederick Holme Wiggin, Julius C. Bierwirth and Parker Syms were elected delegates from the New York State Medical Association to the annual meeting of the Medical Society of New Jersey, held at Asbury Park, June 23d to 25th.

A STUDY OF THE INDICATIONS FOR NEPHROPEXY.¹

BY AUGUSTIN H. GOELET, M.D.,
New York.

BEAR with me until you have heard me through if I say at the outset that the indication for fixation of the kidney is prolapse to the third degree or beyond; that is, when the whole organ is found prolapsed below the last rib in front. I make this statement without qualification except absolute contra-indication to operation. Even where there is apparent absence of symptoms or external evidence that the prolapse is causing disturbance, the contention holds good, because the kidney is necessarily crippled in consequence of the prolapse.

In order to ascertain the views of others upon the indications for nephropexy, I wrote to a number of gentlemen, and received the following replies:

Dr. Howard A. Kelly, Baltimore, writes: "Nephropexy has come to be one of the commonest operations I have performed. I base the indications for the operation upon the symptomatology and upon the displacement of the kidney and upon an infection of the kidney bringing on an artificial attack of colic, definitely proving that the symptoms complained of come from the displaced kidney. I operate in cases of displacement in which the upper pole can be palpated and in which there are attacks of intermittent pain referred to the right or left side. I am very hesitant about operating upon lesser grades of displacement, or where the symptoms are rather vague and the patient complains rather of ill-health, associated with digestive disturbances."

Dr. Robert L. Morris, of New York, writes: "Nephropexy is not indicated in cases of true floating kidney, with long mesonephron or in cases of acquired loose kidney, provided that there is no nephritis present, and provided that the pressure symptoms and reflex nervous symptoms are controllable by the application of a straight-front corset laced from below."

"In cases with nephritis that is apparently dependent upon vascular interference, due to the position of the kidney, nephropexy and decapsulations of the kidney are indicated even in cases in which artificial support gives relief from pressure symptoms and reflex nervous symptoms."

"Nephropexy is a futile resource in cases with general enteroptosis unless the suspensory ligaments of the liver are shortened at the same time, to prevent that viscus from pressing a kidney away from its anchorage. There is usually in such cases a diastasis of the rectus abdominis muscle, which requires repair before nephropexy is indicated."

"In general nephropexy is indicated in a large proportion of the cases of floating kidney and in practically all of that group of cases of acquired loose kidney in which the excursions of the kid-

ney cannot be controlled by the corset sufficiently to give relief from the pressure symptoms and the symptoms of reflex nervous disturbances."

Dr. Charles P. Noble, of Philadelphia, writes: "In reference to the indications for operation I would make the following:

"Careful discrimination in the diagnosis in order to separate cases in which movable kidney is a coincidence in a case of neurosis from those in which it is the cause of local and reflex symptoms.

"Resort to the rest cure for cases of slightly movable kidney, especially in young women.

"The employment of symptomatic treatment in cases in which the relation between the movable kidney and the nervous symptoms present is uncertain. Nephrorrhaphy should be employed in these cases only after non-operative measures have failed to afford relief.

"The immediate resort to operation in those cases in which local symptoms, such as pain, sense of weight, or symptoms of strangulation are present, and when the examination of the urine shows indication of congestion of the kidney, such as the presence of hyaline casts or albumin."

Henry Morris, of London, referred me to his article in the *Lancet*, November 30, 1901, as follows:

"Indications for Operation (Nephropexy).

"1. When movable kidney is associated with enteroptosis no operation should be done unless it is evident that the more serious symptoms are due to the movable kidney alone.

"2. When movable kidney is complicated by movable liver the same rule should be followed as in general enteroptosis.

"3. When the movable kidney occurs in a hysterical or neurasthenic subject, palliative means should be tried before resorting to operation.

"4. For uncomplicated movable or floating kidney in which the principal symptoms are pain and gastrointestinal troubles, the operation may be confidently advised and carried out without any previous trials of belts or of rest.

"5. When renal crises are a feature of the case nephropexy ought to be strongly urged, because of the constant risk of hydronephrosis and recurring pain.

"6. When a movable kidney gives rise to no inconvenience an operation ought not to be thought of, and a belt need not be worn."

Continuing, he says: "It is chiefly in the rare cases in which movable kidney is associated with enteroptosis that belts are of any real value. My experience leads me to attach next to no value to rest in the recumbent position. In several instances in which I have operated with most gratifying results the patients have kept the recumbent position for six to nine months before operation without the least improvement from it, all of their symptoms returning immediately after getting about again."

¹Read before the New York State Medical Association at the Nineteenth Annual Meeting, October 20-23, 1902.

I would like it understood here that I employ the term "prolapse of the kidney" to designate those degrees of descent of the organ where the upper pole can be palpated below the border of the last rib in front. So-called prolapse of the first and second degree, where only the lower pole and half of the organ respectively may be palpated at the same point upon deep inspiration, might be more properly designated loose kidney or movable kidney, and is no doubt the condition referred to by most authors as "movable kidney." These latter are the cases that are benefited by belts or corsets.

There are three principal indications to be found for fixing the kidney:

1. The symptoms or inconvenience it produces.
2. The influence it may exert in producing or maintaining disease of the female pelvic organs.
3. Its influence in causing disease of the kidney itself.

(1.) The symptoms produced by prolapse of the kidney appear to be viewed in a different light by different observers and indifferently by others. Though they have been attributed by some to other causes which may coexist, they are frequently relieved temporarily by artificial support of the kidney, and permanently by fixing this organ if the operation is resorted to early enough.

The disturbance that may be produced by prolapse of the kidney depends much upon the condition and environment of the patient. If the health is already impaired its influence is more pronounced and its evil effect is more noticeable. Then, again, if the patient is obliged to earn her living, or if her social or domestic requirements compel her to be actively employed and much upon her feet, she will suffer much inconvenience from it. If she wears corsets in the usual manner the symptoms will be more pronounced, whereas, if she be one of the fortunate few who do not wear corsets nor even wear clothing tight about the waist, she may suffer little inconvenience for a time. But while such omission of the requirement of fashion may remove one source of irritation of a kidney that is prolapsed, it does not obviate it entirely, and in time if the condition is neglected the influence of the prolapse will be manifested in an unmistakable manner.

Not only does prolapse of the kidney give rise to symptoms that are readily recognized by those who have given the subject careful attention, but it sometimes causes marked impairment of the health of the patient and at times considerable loss of flesh. The most frequent and most distressing symptoms are those which point to derangement of the digestive apparatus and of the genito-urinary organs, with fatigue and general depression following exertion of any kind in the erect position. Though the symptoms may not be always severe or unbearable, they frequently cause chronic invalidism, in which may be found sufficient indication for operation.

There can be no good reason offered for delay-

ing an operation that involves no risk because the symptoms which the condition gives rise to are not unbearable or until the health of the patient becomes so much impaired that recovery is doubtful or impossible.

More serious operations are done every day for conditions in the pelvis which cause far less inconvenience than does prolapse of the kidney.

(2.) In a paper presented at the last session of the American Medical Association in the Section on Diseases of Women,² I pointed out that the prolapsed kidney, by interfering with the return circulation from the pelvis, may cause or maintain disease of the female pelvic organs. This is brought about chiefly by pressure of the prolapsed kidney upon the ovarian vein in its course along the spine. When the kidney descends, its lower pole swings inward toward the spine and overlaps the ovarian vein and ureter. Therefore, when the abdomen is compressed by corsets or clothing at the waist, the kidney is forced backward and compresses the ovarian vein between it and the solid structure of the back. Thus, during the greater part of the twenty-four hours when the patient is on her feet, the return circulation from the pelvis is interfered with and pelvic congestion is the result. It will be unnecessary to detail here the conditions in the pelvis that may be produced or maintained in this manner by prolapse of the kidney. They have been set forth with sufficient fulness in the paper referred to.

The association of pelvic disease with prolapse of the kidney cannot be a coincidence, as has been contended by some who have opposed my views on this point, because, *first*, it is too frequent; *second*, the explanation of cause and effect is rational, and, *third*, these conditions in the pelvis are cured by fixing the kidneys in some instances where measures directed only to the pelvic condition have previously failed.

If the above premise is correct, the coexistence of pelvic disease may be considered a strong indication for fixing the kidney when it is prolapsed.

(3.) We come now to the third and most important indication for nephropexy—namely, the condition of the kidney itself produced by the prolapse. It will be admitted that we have in prolapse a condition which interferes with the function of the organ, produces congestion, and frequently retards or obstructs the outflow of excreted urine—a condition which, if left uncorrected, must eventually lead to inflammation of the organ or degeneration of its structure. Henry Morris, in his work on "Surgical Diseases of the Kidney," referring to the prognosis of movable kidney, says: "Besides the tendency of the mobility to increase, there is also a tendency for the kidney itself to undergo degenerative or inflammatory lesions. * * * Intermittent hydro-nephrosis due to repetitions of kinking or curva-

²Journal of the American Medical Association of August 23, 1902, p. 4177.

ture of the ureter, intestinal obstruction due to compression of the bowel by the displaced kidney, and, later, a pyelonephritis and pyonephrosis from septic infection of the dilated renal pelvis are complications which are occasionally provoked by movable kidney."

My own observations upon the operating table convince me that these kidneys are never in a healthy or normal condition after the prolapse has progressed to the third degree. I have already drawn attention⁸ to the marked difference of the two kidneys in the same subject when one is prolapsed to the third degree or beyond and the other is only in the second degree of prolapse when the operation has been done on both kidneys at the same time. These observations, more than anything else, have convinced me of the advisability of early operation if the whole of the organ is below the level of the last rib in front when the patient is on her feet. As a rule, I fix the other kidney at the same time if it is found in the second degree of prolapse; that is, when half of the organ descends to the lower border of the last rib in front on deep inspiration when the patient is in the erect position. This is done to avoid the necessity of a second operation later, which would inevitably be required.

It is my custom to submit the urine of every patient with prolapse of the kidney to careful microscopical examination to ascertain definitely just how much injury the kidney has sustained as a result of the displacement. These examinations are repeated at intervals until operation is decided upon to ascertain the progress of the disease. After operation the urine is also submitted to careful microscopical examination to note the improvement that follows operation. I have selected ten cases, taken at random from among those who have consulted me during the past month and where I have advised operation, and I append herewith the result. Some of these cases have already been operated upon:

In every case except two there has been found evidence of either marked irritation or inflammation of the ureter, pelvis or kidneys, and in many of them an associated cystitis. In one case only (No. 7) was there evidence of only moderate inflammation of the pelvis or the kidney. This patient, who had the right kidney prolapsed to the third degree, is a single woman, 30 years old, had not worn corsets since she was 17 years old, and has never worn her clothing tight, yet for the past few years she has had pain in the region of the kidney, with marked disturbance of the digestive apparatus occurring every few weeks, precipitated by some unusual exertion. I operated upon her recently and found the kidney enlarged, congested and adherent to the fatty capsule, showing evidence of perinephritic inflammation of long standing.

It will thus be seen that the kidney is always in a crippled condition as a result of the prolapse,

and we are not justified in disregarding it or in delaying operation until the health of the patient becomes seriously impaired or the kidney is irreparably diseased and recovery doubtful, more especially as the operation involves no risk and it is the only positive means of cure.

It must be admitted that a kidney constantly irritated or in a more or less constant state of congestion when the patient is about on her feet is a crippled kidney, and that such irritation or congestion, if unrelieved, must lead to inflammation of the organ. It must also be admitted that the constant pressure from belts or corsets, however well fitted and adjusted, must be a constant source of irritation to a kidney thus crippled.

Upon this subject Henry Morris, in a recent article in the *Lancet*, November 30, 1901, says:

"Belts and bandages have no efficiency in nephroptosis uncomplicated with enteroptosis, and when employed in cases of movable kidney they increase the pain and may otherwise do harm if not carefully and properly adjusted. Though some patients are rendered more or less comfortable by them, they are not cured by these appliances. Moreover, pads and bandages are not free from the risk of doing more harm than good."

According to my own observations, belts are often discarded by patients because of the discomfort they produce and the irritation of the kidney that they are able to observe themselves. Evidence of such irritation is quite apparent upon careful microscopical examination of the urine of these patients if the examination is conducted by an expert and the specimen selected for examination is taken at the proper time.

My friend, Dr. Gallant, will tell you that he cures these cases of prolapsed kidney with corsets adjusted and worn so as to support the kidney by external pressure upon the abdominal wall. I believe he is sincere in his statement, but believe he is deceiving himself. I have not seen one of his cases that he has cured, it is true, but my experience with prolapse of the kidney convinces me that it is impossible to maintain the prolapsed organ in anything like normal position by any form of artificial support. Hence such support is incapable of curing after the kidney has prolapsed to the third degree or beyond. I am confident that if the urine of these patients be submitted to microscopical examination, there will be found abundant evidence of inflammatory lesion either in the kidney or pelvis.

The sphere of usefulness of the corset, properly adjusted, is to prevent or retard an exaggeration of the earlier stages of prolapse (loose or movable kidney), which are inevitably progressive if disregarded. When, however, the kidney has descended below the border of the last rib in front—that is, when its upper pole can be palpated below this point—it is in a position where it is extremely liable to injury and where it is constantly subjected to irritation, both in consequence of interference with its circulation and the outflow of excreted urine. The most carefully adjusted sup-

⁸Technique of Fixation of Prolapsed Kidney, by the author, *American Medicine*, December 28, 1901.

NO.	NAME.	AGE.	MARRIED OR SINGLE.	CHILDREN AND MIS.	DIAGNOSIS.	MICROSCOPIC DIAGNOSIS.	MICROSCOPIC FINDINGS.
1	Mrs. M. K.	28	M. 2 years.	1 mis.	Pro. R. kidney 3d deg. Endometritis. Metritis.	Oxaluria.	Sp. gr. 1028, oxalate of lime, large amount; pus corpuscles; blood corpuscles; epithelia from pelvis of kidney.
2	Mrs. M. S.	33	M. 7 years.	2 children, 3 mis.	Pro. R. kidney 3d deg.	Chronic interstitial pyelonephritis, with catarrhal cystitis.	Blood corpuscles (few); pus corpuscles; epithelia from convoluted tubules of kidney, with fat globules; epithelia from straight collecting tubules of kidney, epithelia from pelvis of kidney, with fat globules; epithelia from ureter; epithelia from upper layer of bladder; epithelia from middle layer of bladder, with fat globules; free fat globules.
3	Mrs. L. M.	24	M. 4 years.	1 child, 3 yrs.	Pro. R. kidney 4th deg. R. Hydrosalpinx.	Subacute interstitial pyelonephritis, with catarrhal cystitis.	Oxalate of lime; blood corpuscles; pus corpuscles; epithelia from convoluted tubules of kidney, with fat globules; epithelia from straight collecting tubules of kidney; epithelia from pelvis of kidney, with little fat; epithelia from ureter; epithelia from upper layer of bladder; epithelia from middle layer of bladder, with few fat globules; few free fat globules.
4	Mrs. A. D.	27	M. 2 years.	3 mis.	Pro. R. kidney 3d deg. Pregnant 3 mos.	Subacute interstitial pyelonephritis, with catarrhal cystitis.	Blood corpuscles; pus corpuscles; epithelia from convoluted tubules of the kidney, with few fat globules; epithelia from the pelvis of the kidney, with fat globules; epithelia from middle layer of bladder, with few fat globules; epithelia from ureter; epithelia from upper layer of bladder, with few free fat globules.
5	Mrs. M. G.	24	M. 7 years.	1 child, 6 yrs.	Pro. R. kidney 3d deg. Pro. L. kidney 1st deg. Salpingo-oophoritis, chronic.	Acute interstitial pyelo-nephritis.	Uric acid gravel; blood corpuscles (many); pus corpuscles; epithelia from convoluted tubules of the kidney; epithelia from pelvis of the kidney; epithelia from ureter, also epithelia from upper layer of bladder.
6	Mrs. R.	40	M. 18 years.	4 children.	Pro. R. kidney 3d deg. Pro. L. kidney 3d deg. Endometritis.	Chronic catarrhal pyelitis and cystitis.	Uric acid gravel (few); pus corpuscles; free fat globules; epithelia from pelvis of the kidney, with few fat globules; epithelia from ureter; epithelia from upper layer of bladder; epithelia from middle layer of bladder, with fat globules.
7	Miss B.	30	Single.	—	Pro. R. kidney 3d deg. Right ovaritis, chronic.	Catarrhal pyelitis.	Incomplete triple phosphates; oxalate of lime; uric acid of three varieties; blood corpuscles; few pus corpuscles; epithelia from ureter; epithelia from upper layer of bladder; epithelia from pelvis of the kidney.
8	Mrs. S.	27	M. 4 months.	—	Pro. R. kidney 3d deg. Pro. L. kidney 1st deg. Small ovarian cyst of right ovary.	Chronic interstitial pyelonephritis, with catarrhal cystitis.	Blood corpuscles; pus corpuscles; epithelia from convoluted tubules of the kidney, with fat globules; epithelia from straight collecting tubules of kidney; epithelia from pelvis of the kidney, with fat globules; epithelia from ureter; epithelia from upper layer of bladder; epithelia from middle layer of bladder, with fat globules, free fat globules, mucus, triple phosphates.
9	Miss C.	37	Single.	—	Pro. R. kidney 3d deg. Anteflexion, with dysmenorrhea.	Catarrhal cystitis.	Oxalate of lime; bacteria (many); mucus; blood corpuscles; pus corpuscles; epithelia from upper layer of bladder; epithelia from middle layer of bladder.
10	Mrs. I. B.	29	M. 14 years.	1 child.	Pro. R. kidney 3d deg. Pro. L. kidney 3d deg. Retroversion of uterus.	Chronic interstitial pyelonephritis.	Blood corpuscles (few); pus corpuscles; urate of ammonia; oxalate of lime; epithelia from convoluted tubules of the kidney, with fat globules; epithelia from pelvis of the kidney, with fat globules; epithelia from ureter; epithelia from upper layer of bladder; free fat globules.

port will provoke increased and undesirable, and many times serious, irritation, owing to the pressure it must exert to furnish adequate support.

My contention, then, is that when the kidney is prolapsed so that its upper pole may be palpated below the border of the last rib in front, it should be fixed without delay, mainly because the organ, one of the most essential to the human economy, is already in a crippled condition owing to the prolapse, and that we are not justified in delaying operation until demanded either by marked impairment of the health of the patient or serious disease of the kidney itself. Operation is demanded when the condition is discovered, and if

it is done then we will save our patients much suffering and secure better results from the operation.

An analogy is to be found in appendicitis, which at one time was considered operable only as a last resort, when there was nothing else to be done, but which now, thanks to the light of modern surgery, has been placed in the list of curable diseases by operation early resorted to. In consequence the mortality has been greatly reduced, and thousands of lives are now saved every year, which but a few years ago were lost through ignorance and distrust of surgery.

Let us not commit the same error with this

condition of the kidney. It is too important an organ to be permitted to remain in a crippled condition when it can be restored to a state of health and usefulness by a simple operation that involves no risk.

Let me enter a strong plea here for more careful and more frequent microscopical investigation of the urine of female patients who we know are extremely liable to the condition under consideration. To be satisfied with testing the urine for sugar and albumen is both unscientific and careless. To regard the detection of albumen necessary for the existence of a nephritis is a serious error, because the amount may be so minute as to make its detection uncertain or practically impossible, or it may be absent, yet grave kidney lesions may exist (Heitzman). It is also a serious error to think the presence of casts in the urine the only microscopical evidence of nephritis (Heitzman).

It is true that some of these women with prolapse of the kidney apparently suffer little inconvenience therefrom, but, without careful microscopical examination of the urine, who can tell what is the condition of the kidney? The great risk is that it may progress to the danger point before it is detected, particularly if the medical adviser happens to be indifferent upon the subject. There can be no excuse for permitting the patient to live thus over a mine which may explode at any time.

DISCUSSION.

Dr. A. Ernest Gallant said that the treatment of movable kidney was divided into operative and non-operative. The men who operate on nearly all cases were but few. On the other hand, of those who favored operating only in extreme cases there were hundreds of prominent surgeons. It made very little difference whether we adopted the classification given in the paper or not, there would be in many cases more symptoms from a kidney lying but 2 cm. below the ribs than from one which lay in the pelvis. He had seen a woman operated upon four times by laparotomy with the kidney in the true pelvis. There are those who look upon the kidney as the chief source of trouble, whereas others look upon the prolapse of the kidney as only one part of a general enteroptosis. Even after the fixation of the kidney the symptoms still persisted in 95 per cent. of the reported cases. The case would not be cured after such operation unless great attention were given subsequently to the support of the abdomen. The speaker said that during the past nine years he had given considerable attention to the use of the corset in cases of movable kidney. Any kidney that can be held up in position cannot be forced down by the patient when the corset was properly applied. His plan was to put the patient on the couch and take the measurements in that position, and the corset made according to these measurements. When the corset is to be applied the woman lies on the couch with the hips raised, and laces the corset from the bottom in such a way as to make all the pressure possible

over the suprapubic region and as little as possible on the upper part.

Dr. Parker Syms, of New York, thought there might be many cases of floating kidney which did not require operation unless one was extreme in his views on this subject. These were the cases which were apt to escape the attention of the examiner who was not alert for floating kidneys. The cases which he had seen had exhibited marked symptoms reasonably attributed to the displacement of the kidney. In some of these, presenting also neurasthenia, there was room for difference of opinion as to the best course to pursue. In some of them operation would do harm rather than good; in other cases the neurotic condition was the result of the floating kidney. In the latter, if the operation were done sufficiently early, the result would be good. His own results, in a rather limited experience, had been favorable. If the woman were feeble and nervous he preferred to improve her condition before attempting operation. Many of the cases presenting symptoms of floating kidney upon which he had operated had been previously treated by retentive apparatus. He had no personal experience with these mechanical methods, but so far as he knew the results of such treatment had not been satisfactory.

Dr. Max Einhorn said he had seen a very large number of these cases, and had examined the urine systematically. Very seldom had he found disease of the kidney as such. Some of these patients had been kept under observation for a number of years, and had presented no evidence of renal disease. About four years ago he had read a paper on "Movable Kidney and Its Treatment," and in this he had pointed out the best treatment from the standpoint of the clinician. In most cases of movable kidney there was associated therewith a general condition of enteroptosis. In almost 95 per cent. of these cases there was gastroptosis, and in many the colon was also prolapsed, and in about 10 per cent. the liver was also prolapsed. It was obvious, therefore, that the restoration of the kidney to its proper place would not favorably affect the other displacements—indeed, he thought it favored further descent of the other organs, for the abdomen in such persons is usually too big. The indication was to make the abdomen smaller by improving the general nutrition and by bandaging. If the symptoms were not marked, the bandaging was not necessary. Even if the kidney were movable to the fourth degree, and remained in this position, it did not ordinarily give rise to any special disturbance, provided the patient was otherwise healthy. He had not yet met with any cases of movable kidneys which he thought required operation, and his results had been very satisfactory. He believed the literature showed that there was a mortality of 2 per cent. attendant upon the operation of nephropexy, and this was too large to be lightly disregarded.

Dr. R. H. Gibbons said that the special indi-

cation for nephropexy was the condition itself. Every patient with a loose kidney should be advised to have the kidney fixed, and it was the physician's duty to discover this loose kidney. It was a very simple matter. The kidney should be fixed, because otherwise serious diseased conditions would result—Bright's disease, stone in the kidney and malignant disease. The proper capsule of the kidney should be split, detached and cut away. About fifty years ago Dr. John Carnochan, of New York City, devised what is now known as the French corset for the purpose of relieving the symptoms now known to be those of gastroptosis. The symptoms were relieved by this corset, which is practically the one recommended by Dr. Gallant. It was an excellent one for those who took upon themselves the responsibility for the results of abstaining from operation. Ninety-five per cent. of these cases were cured by operation, and if the kidney were fixed the symptoms would disappear. At the same operation the kidney could be fixed if it were so desired.

Dr. Goelet closed the discussion. In reply to Dr. Einhorn's criticism that the operation carried with it a considerable mortality he said that this operation was yet in its infancy, and many of the early operations were necessarily failures. He had himself done 139 nephropexies on 112 patients, and had not lost a single case. On this experience he based the statement that there was no mortality to the operation. The mode of fixing the kidney would determine whether or not the result would be permanent. It was also important that the operation should be done early, before enteroptosis and other complicating conditions were present. He did not think general enteroptosis was associated with prolapse of the kidney in more than 25 per cent. of the cases. He would ask what was the aversion to this operation; there was just as much danger in sewing up the uterine cervix. He had not selected his cases, and the kidneys had remained permanently fixed. He recalled but two cases in which the symptoms had not been relieved very shortly after the operation, and in one of these they all disappeared after a period of six months. The other case had been operated upon only about six months ago. In that case iodoform poisoning unfortunately developed from packing 10 per cent. iodoform gauze under the kidney. This patient still complained of backache, which was the chief symptom before the operation. Frequently in other operations, notably those upon the cervix, it was well known that the full benefit of the operation was not attained for a year after the operation. The only way he could explain why Dr. Einhorn's patients were so different from his own was that they lived on different sides of the city. In not a single instance in which he had made a careful microscopical examination of the urine in cases of prolapse of the kidney to the third degree, or further, had there been absence of renal disease, or at least renal irritation. In every one of these kidneys, exposed on the

operating table, there had been evidence of perinephritic inflammation. He believed that nephroptosis was the most important element even in cases of general enteroptosis. The kidney should be fixed in those by operation and the other organs held in place by mechanical support.

SEPTICEMIA AND DEATH FOLLOWING X-RAY BURN.¹

BY HOWARD BURHANS BESEMER, M.D.,
Ithaca, N. Y.

The picture of acute septicemia is, unfortunately, only too definite; is a picture we have come to know only too well. The symptoms and course also are fairly constant. Following whatever operation or injury we get about the same train of symptoms. The first day the patient does well, better than we had always expected; the second day she looks a little anxious, her temperature is a little up and she may be nauseated; we attribute all this to the chloroform and nervousness and refuse to worry. The third day she has begun a habit of talking a little bit wild, temperature up still more, face more anxious, skin paler, may or may not be noticeable changes about wound; we take her temperature often and when it approaches 103 the declaration of war is on between us and sepsis. On our side we start in with the same old things, strychnine and other stimulants, saline infusion that is useless and antitoxin that is worse than useless—and the temperature and pulse go on up and out and the patient is dead before we have had time to explain to the family the philosophy of the trouble.

Whether it be septicemia from paralysis of intestine, extension of gangrene, septicemia following a clean hysterectomy, or following mastoiditis, trephining or an amputation, or whether it follow an insignificant pin-scratch or pimple, the symptoms are usually so definite that we can prognose death while yet the family are not alarmed.

In presenting a case to-day that had apparently no symptoms at all, I am in hopes of some comfort from this Association out of a most unfortunate case.

Case.—Girl 16 years old, delicate skin, light hair, history non-committal, fell and injured elbow. X-ray examination showed external condyle broken off and displaced inward, riding between internal condyle and ulna. Advised wiring. Operation next day, and for two days temperature; pulse and wound normal, no pain, nothing in case of any significance.

Third day there appeared on whole arm a crop of blisters, rather severe, covering, perhaps, three-fifths of surface from tips of fingers to top

¹Read at the Nineteenth Annual Meeting of the Third District Branch, New York State Medical Association, held at Syracuse, June 25, 1903.

of shoulder. Now, three days before I first saw her the arm had been X-rayed, chloroform given and attempts at reduction made, after which X-ray picture was made. The blisters appeared then, seven days after a rather long X-raying. Also chlorine sterilization had been used before the operation, which, with her exceedingly delicate skin, may have caused the blisters—which in that event appeared three days after chlorine.

Now I had never seen this blistering before from chlorine, but also at that time I did not give any significance to the X-ray; I therefore attributed it to the chlorine, and as pulse and temperature were normal did not think at all of sepsis. Blisters cleaned and dressed antiseptically.

Fourth day.—Temperature and pulse normal, arm not painful, somewhat more swelling and a new crop of blisters, patient beginning to be very peevish and fretful—had been by this time taken home and had kept everybody busy all night. Appetite good, but did not sleep at all.

Fifth and sixth days, same, nervous symptoms more and more pronounced, swelling slowly becoming worse, especially below operation from elbow to hand; no swelling or redness, especially about operation wound; I was dissatisfied with care she was getting and insisted on taking her back to hospital.

Seventh day.—Morning, temperature 98 flat, pulse 96, arm cleaned up and redressed thoroughly, cut stitches and opened wound, which was not firmly healed, and on opening which a few drops of clear serum came out. Attributed serum to general swelling. Patient very restless and dissatisfied with everything, complained of no pain, was fully convinced she was going to die, which was attributed to her fear of hospital. Solid food, and orders were largely to the effect that nurse was to get her contented if it took all day.

Eight P. M., temperature 99.2, pulse 86, nervous to almost insane degree, arm for first time in four days appeared appreciably better.

Nurse gave her trional in milk at 10 o'clock and was with her till about 11, quieting her nervousness, at which time patient went to sleep.

Nurse hearing no disturbance did not look in on her again till about 2 o'clock, at which time she appeared to be sleeping peacefully; half an hour later another nurse went in and found her dead.

I may perhaps be excused for what I first did, being awakened from sound sleep after having dismissed all worry in the case—I telephoned the Coroner. My first impression was that she had got hold of something and had committed suicide.

We discussed the theory of exhaustion, which would hardly fit a case that was eating and digesting solid food; shock was perhaps a good cause for death, brought on by auto suggestion, but it did not satisfy us, as there was apparently

going on an improvement at the time of death. I could think of no legitimate cause of death except heart defect, in which the Coroner helped me, informing me he had himself taken her through a severe diphtheria but a few months before.

I insisted on a postmortem, which I think is a debt the family owes humanity in cases of this kind; and two things only of significance were found, a blistered condition which I had not noticed on the hip, below the waist band, just where the X-ray would strike the body unprotected by the elbow, same in character as the blistering of the arm, but less in degree.

Second, a fairly normal heart containing small white clots which on examination proved to be practically pure cultures of the streptococcus, and which heart also contained in its muscle everywhere colonies of the same germ. Death due directly, then, to septicemia.

True septicemia as distinguished from sapremia, or infection followed by septic absorption.

I can find three hypotheses for the causing of this septicemia, none of which naturally can be proven, but the weight of evidence points in an interesting direction.

First, was the septicemia due to septic infection of wound at operation, followed by absorption, which increased so rapidly that septicemia resulted?

I naturally hope not. There were none of the signs of septic infection in wound at any time, the wound did badly only as you would expect one to do surrounded by blisters and swelling; there were no red streaks, no pus discharge, no rise in temperature, no pain in wound—in fact, all the visible signs of trouble were as bad or worse below the elbow as above. I have also never seen a septic infection without any rise in temperature.

Second, did the chlorine sterilization destroy enough epidermis, or, rather, put enough tissues into condition of good culture medium, for streps to multiply beyond all reason and overwhelm the system before there was a possible septic reaction? Or was it, third, the severe X-ray burning that furnished the culture medium for the germs?

Now, I have never seen chlorine do this before. The swelling and blistering went beyond the limits of the chlorine, but not beyond the limits of the X-raying. X-rays will diminish vitality in tissues and will do it deeply into tissues, while chlorine could only affect the surface. As to time limits, if it was X-ray burn it shows itself in seven days, which is good time; if chlorine it showed in three days, which would be late. Now as to when fatal septicemia began—that is, to define a day or an hour when it was not present, and to define the next day or hour when it *was* present—I am totally unable to even make a guess. Just as a diagnosis of septicemia had never entered my mind before the postmortem, just so I am still unable to guess when it really began.

Poisoning by Bichloride of Mercury Douche.—

In the December 27 (1902) issue of *American Medicine*, Dr. Horatio C. Wood, Jr., of Philadelphia, reports a case of corrosive sublimate poisoning from a vaginal douche, which recently came under his observation. In this case the patient suffered from leucorrhœa. She visited a dispensary and was ordered a daily douche of corrosive sublimate of the strength of 1 to 2,000. The injections caused so much pain that fearing a mistake she returned the next day to the dispensary and was told that the pain was due to an improper syringe. She bought a new one and again tried the injection, with a like result. On again consulting the dispensary she was told to use a douche of half the concentration. At this visit she called the attention of the doctor to her urine, which she said had become the color of blood after the first injection. She was informed that she had severe kidney disease, although the doctor apparently failed to recognize the cause. After a severe attack of acute nephritis, she recovered under appropriate treatment.

In 1891 Sebillotte collected and published the records of 148 cases of corrosive sublimate poisoning following the use of the vaginal douche in lying-in women. Thirty of these ended fatally. In the fatal cases the strength of the solution was 1 to 1,000 or over in ten instances; 1 to 1,500 in two, and 1 to 2,000 in the remainder. The absorption of the poison, the writer thought, probably took place in the uterus at the site of the placenta. The symptoms observed were profuse diarrhea with tympanites, vomiting, stomatitis, renal complications, pulmonary congestion, bronchitis and broncho-pneumonia; later on circulatory disturbances, torpor, prostration and collapse. The skin was either dry, or covered with cold perspiration; there was itching, which often preceded death. Various skin eruptions were also observed.

The writer concludes by stating that the corrosive sublimate douche must be used with "science and prudence in confinements, and that it is dangerous in inexperienced hands."

SUMMER COMPLAINTS OF INFANTS—KERLEY.

We have proved that the large mortality from summer diarrhea is preventable. Seventy-five per cent. of these children die needlessly. Hospitals and homes can help a little, but are very inadequate. Floating summer hospitals are of considerable service, but comparatively few can have these benefits. They are but temporary, at best, and with them the mortality remains high; less than it formerly was, but there is room for much improvement.

The lives of these children will be saved when

each child is treated in its own home, as becomes a human being of its size and age, and not until then. The individual infant requires really very little; *decent food, decent dwelling, decent care* solves the problem.

First, cow's milk. It is possible, during the months of July and August, for a mother with 8 cents in her hand to exchange it for a quart of safe milk. The Milk Committee of this Society will not certify to its safety. We do not give it to our own children. Safe milk is not to be had at that figure. Many can pay but 5 or 6 cents; some can pay nothing at all. *Safe milk must be supplied*, free or at a possible price to each.

Second. Indifferent milk purchased at 8 cents a bottle, to be kept from getting absolutely poisonous, requires ice. Ice many cannot afford. *Ice must be furnished.*

Third, and equally important. The average tenement mothers, and many in better circumstances, do not realize the care required in keeping the feeding apparatus clean. They do not know the dangers of exposed soiled napkins, they are ignorant as regards bathing, fresh air and most of the details of infant management. Mothers must be taught. Private individuals and semi-private institutions have demonstrated that the requirements mentioned under the three headings are practical. If Nathan Straus can furnish safe milk to several thousands of children, the municipality can supply hundreds of thousands.

The *New York Herald* has done most commendable work in supplying ice to the poor.

The workers in the College Settlements bear out our experience that the mothers are teachable and anxious to learn.

The credit of the low mortality at the Babies' Hospital is due more to the mother than to ourselves. We direct and teach; they execute, and they do it well and in the face of tremendous obstacles. The assertion that these people are thoughtless, indifferent, unteachable and generally hopeless is made by those only who know nothing of which they speak.—*N. Y. Med. Jour.*, June 6, 1903.

OBITUARY.

Dr. Isaac Newton Love, born in Barry, Pike County, Ill., in 1848, a graduate of the Washington University of St. Louis, 1872, died suddenly on June 18, 1903, on the *Aurania*, while coming into port. Dr. Love was formerly a resident of St. Louis, where he was well known as editor of the *Medical Mirror*, and devoted special attention to the diseases of infancy and childhood. In 1889 he was elected chairman of the Section of Diseases of Children of the American Medical Association. In 1901 he moved to New York and joined the New York State Medical Association. He was also a member of the American Medical Association.

A NOTE ON THE TREATMENT OF PUERPERAL INSANITY IN ASYLUMS.

When the premonitory symptoms are observed, that is, change of manner and feelings with excitability, extreme quietude of surroundings must be insured, and careful skilled supervision of patient enforced, to guard against infanticide or suicide by impulse. The bowels must be attended to, regular action being obtained by enemata and mild aperients. If there be early insomnia, a sedative draught of potassium bromide $\frac{1}{2}$ dr. and chloral hydrate 15 gr. must be given at night. The diet should be liberal and sustaining. For instrumental feeding a mixture of equal parts milk and strong beef tea, one pint in all at first, with two or three eggs beaten up in it and a little brandy, if indicated, administered thrice daily with esophageal tube and funnel. Later on we feed twice a day with one pint and a half each time and two eggs at each meal; lime juice or concentrated extract of green vegetables must be added. If the temperature be high the relative amount of milk must be increased at the expense of the beef tea, and diarrhea or sickness indicates excess of food administered, which must be diminished accordingly. Most patients will be sick after the first feeding, and perhaps after the second, until the stomach becomes accustomed to the means adopted.

A thorough examination of the uterus and its surroundings must be made, and any altered lochial discharge dealt with. In all cases the urine must be tested for albumen. In the medicinal treatment we must avoid as much as possible any free use, or rather abuse, of sedatives and hypnotics. If there be acute maniacal excitement with insomnia, we give potassium bromide $\frac{1}{2}$ dr. and chloral hydrate 15 gr. twice or thrice daily, carefully watching the effect, and never continuing it for any lengthened period. Subsequently sulphonal $\frac{1}{2}$ dr., or, better, trional 20 gr., may be given at night, or on alternate nights, with $1\frac{1}{2}$ to 2 dr. of paraldehyde, when a mild ferruginous tonic may be given by day to treat the concurrent anemia and albuminuria (if present). In all cases in the maniacal form opium and its preparations are to be avoided. The child, of course, is weaned at once, and any tendency to mammary congestion or abscess, which is rare, dealt with in the usual way.

If the mental symptoms when fully established are of the melancholic type, the preparations of opium and diffusible stimulants are indicated. We give liq. morph. acet. 20 min., sp. etheris 15 min. in aq. camph. 1 oz. thrice daily, and enemata to relieve constipation. Iron must be given also, and every effort made to re-establish—by hot baths, aloes, ergot, etc.—the menstrual function, which is suppressed. All patients with puerperal insanity lose flesh rapidly, therefore regular weighing records must be kept, and after the first few weeks ol. morrhue given. A gain in weight, except when dementia has supervened, is a favorable sign. Stimulants, carefully regulated, are indicated in all cases, as the disease is of an asthenic type; at first brandy with the artificial feedings; later on port wine during convalescence. In severe cases there is an early tendency to bedsores; therefore, if the patient be confined to bed for any length of time; we paint the back and hips with equal parts of liq. plumbi subacet. and tinc. catechu

once a day. For moral treatment, when the patient's physical health will permit, change of scenery is indicated. As soon as there is no marked febrile temperature, and if the strength be fairly maintained, she should, weather permitting, be got up, dressed, and taken out daily for from half an hour to two hours, but carefully guarded against all excitement. This course will often induce natural sleep. Faulty habits must be corrected. Fresh air and sunshine out of doors, gentle exercise, amusements, and all forms of diversion materially aid recovery, and indoor occupation of a light nature should be encouraged.

The relatives and friends should not see the patient until she has definitely improved, and even then the effect of the visits of the husband and child should be carefully watched. In the melancholic form these visits are less harmful than in the maniacal. Recovery in all cases is gradual and protracted, and in the early stages the mental state of the patient varies much, but the final result is eminently satisfactory, for about 80 per cent. recover.

SURGEONS IN EMERGENCY.

Without doubt there is a disposition on the part of some surgeons to use the knife on slight provocation. With modern aseptic surgical methods, cutting has come to seem to them as much a matter of course as the administration of a dose of calomel seemed to their predecessors of two generations ago. Under such circumstances there is a natural tendency to perform operations without in all cases giving due weight to the wishes of patients and their friends. This is particularly true in public hospitals, where treatment, not of persons, but of cases, becomes inevitable. Therefore, it is not a bad thing for the medical profession to be sharply reminded of its responsibilities, as it has been by a Chicago court, which gives \$3,000 damages to the husband of a woman who was operated upon without her consent or that of her husband. The court holds that the outcome of the operation is not to be considered. In acting without express consent of some person competent to give it, the surgeon commits a violation, or trespass, on the body of the patient.

Not having the full text of this decision we are unable to say how guarded its dicta may be. Undoubtedly it lays down a sound rule, applicable to most cases, and followed in general, we believe, by most surgeons. It might frequently happen, however, that in an emergency a surgeon would have to choose between leaving his patient to certain death and performing instantly a major operation on his own responsibility. It would seem as if in the interests of humanity, as much as of the surgeon, some protection should be given to him in exercising his discretion at such a time. It is not fair to ask him, when he sees a man choking to death for want of an incision in the windpipe, or stands over a stranger injured in a railway accident, to balance in his mind the duty of

saving life and the chances that some black-mailer may take advantage of his "trespass." We do not suppose that it would often make much difference. Few physicians in an emergency would let selfish fears stand in the way of what they knew ought to be done, let the risk to themselves be what it might. Yet they are entitled to a settled privilege in this regard, subject to full responsibility for its abuse.

It is proper to prohibit unauthorized operations in general, regardless of their outcome, but the law should hold a surgeon safe in operating when it is impossible to obtain permission and instant operation is necessary to save life. If he can show that necessity, and can likewise show that his work was skilfully and properly done, he should be held free from blame and damages. If it can be shown that he operated without the existence of a sufficient emergency, then he should be liable to penalties for malpractice. But it would be mighty unfortunate to deprive humanity of the instant service of surgeons when required. As well make it an assault forcibly to drag a drowning man from the water without receiving express permission to lay hands upon him.

HEREDITY, WITH A STUDY OF THE STATISTICS OF THE NEW YORK STATE HOSPITALS.

Heredity has been defined as that peculiar property of an organism which transmits to its offspring the characteristics of its progenitors. If those characteristics are ones of grace, beauty and strength, the offspring will inherit the corresponding qualities of the parent; if, on the other hand, defect and infirmity are the characteristics of the sire, then these qualities will reappear in the young, often with renewed impetus and reinforcement. Moreover, while it is an easy matter for the higher and nobler attributes to become through custom and environment deflected and deteriorated it is almost an impossibility for the baser and decrepit qualities and conditions to become regenerated and rehabilitated.

These laws hold good not only in the human family, but in the vegetable and animal worlds as well; they follow exactly the same course and terminate at the same place. Out of propagated weakness there cannot come strength; out of defects there cannot come perfection. To me heredity is nothing more than a mirror reflecting from one generation to another the grace, beauty and strength, or else the coarse, ugly, defective features of the one standing before it.

Heredity may also be compared to a composite photograph. If the facial lines of the individuals selected are regular, the facial angles of nearly equal degree, and the component parts symmetrical, the photograph will be clear, sharp and a good reproduction of the individual features.

If there exists asymmetry of the two facial halves, if the component parts are deformed, irregular and the facial angles of the individuals are of varying degrees, a composite photograph will be obtained that is blurred, distorted and defective. So also with a child of faulty parentage or grandparentage—it represents the ensemble of the vices and defects of successive generations, unless arrested or attenuated by environment. As

Kiernan has well said, heredity is a prophecy of what may be, not necessarily a destiny which must be.

The diagnostic value of a hereditary tendency to insanity depends largely on its degree. Thus the insanity of one parent would indicate a less degree of predisposition than that of one parent and an uncle, or still less than that of a parent and a grandparent, or of both parents. Again, the insanity of a parent and a grandparent with an uncle or an aunt in the same line may be held to indicate a stronger predisposition than even the insanity of both parents.

The significance of the insanity of parents will depend to a large extent upon the period of its onset. The insanity of a parent occurring after the birth of a child, if it arose from a cause adequate to excite it without previous predisposition, would be held, of course, as of no value in the formation of a hereditary tendency.

The insanity of relatives further removed than parents, uncles and aunts, brothers and sisters and first cousins is not worth anything except in corroboration of nearer and weightier facts. But the influence of other related diseases to insanity occurring in those near akin, such as eccentricity, alcoholism, epilepsy,

The number of cases having a distinct history of heredity varies from year to year. Of the whole number of admissions since 1888 an undoubted history of hereditary taint was present in 39.7.

It is a noteworthy fact that the reports of the New York State Hospital show that *maternal* transmission is increasing rapidly over *paternal* transmission, as shown by comparison of the figures given for the years 1895-1896 and 1899-1900.

Turning now to nervous diseases proper, we find heredity just as strongly represented in the various neuroses as was found for the psychoses—there is transmitted in the organism certain diatheses which favor certain diseases, such as Huntington's cholera, Friedreich's disease, running through successive generations. These diseases are termed hereditary, familial, embryonic, and this succession is what is meant by the term direct heredity or organic heredity. The severity of the heritage depends very largely upon the number of members and branches affected. Here again, as in the study of psychotic heredity, we find that maternal transmissibility far exceeds the paternal.

Indirect heredity is heredity by transformation from other neuropsychic diseases and is more common but of less consequence than direct heredity. Given a neuron feebly endowed with enduring qualities, it is not improbable that any condition capable of reducing the general health may act with unusual virulence upon it. The result is a neuropathic disposition, or a nervous organization with a tendency to yield readily to undue strains and unusual influences, though of themselves of no material importance. There is propagated from parent to offspring certain diatheses which favor certain neuropathic equivalents. Thus epilepsy, melancholia or inebriety may favor the production of hysteria, chorea or neurasthenia, while in the succeeding generations the transformation of the neuroses and toxic diatheses in propagation result often in imbecility. Thus the children of hysteric, epileptic, hypochondriac and syphilitic or alcoholic parents are liable to be imbecile. Phthisical parents also frequently beget imbecile children.

In the progressive degeneracy which leads to the extinction of families, imbecility is the next to the final stage, which ends with idiotic incapacity of reproduction. (Kellogg.)

There is thus nurtured a family tree whose branches become heavily laden with neuropathic fruit, yielding and bending to the slightest zephyr until through sterility it becomes barren and lifeless and falls by the way-side in the struggle for existence.

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.
Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutter.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberget.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Howard L. Hulet.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davs.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Albert E. Woehnert.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleeker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stocksclaeder, James C. Davis.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Connor, Middletown.
Secretary—Ernest Valentine Hubbard, 114 West 70th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.
President—George H. Treadwell, 64 South Portland avenue, Brooklyn.
Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.
Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.
Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.
Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.
Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.
President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.
Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.
Secretary—Ogden C. Ludlow, 234 West 135th street, New York.
Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.
Treasurer—Charles Ellery Denison, 68 West 71st street.
Executive Committee—Frederick Holme Wiggan (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).
Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keys, Jr.
Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.
Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Henry A. Maynard.

STUEBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Kogle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Treasurer—Charles W. Piper.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoebenber.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.



PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 8.

AUGUST, 1903.

\$1.00 PER ANNUM.

THE NEW YORK STATE MEDICAL ASSOCIATION.

When referring to the manifold advantages of membership in The New York State Medical Association, attention should be called to the following facts:

That The New York State Medical Association does not exist as an entity, but is composed of the United County and District Branch Associations. That membership in a regularly chartered County or District Branch Association carries with it membership in the State Association.

That The New York State Medical Association is the legal representative and only affiliated branch in New York State of the American Medical Association.

That it is only through membership in The New York State Medical Association that physicians residing in New York State can become members of the American Medical Association.

DIFFICULTIES IN APPREHENDING MALPRACTICERS.

We fear the recent exposure of the methods of an advertising medical concern will redound more profit than loss to its promoters. Swindlers of this class are much too clever to so act as to make themselves amenable to the law. The letter of the Medical Practice act is literally observed. No prescribing is done except by duly licensed physicians. The United States postal laws cannot reach them until the intention to defraud is proven.

They have already raised the cry of persecution incited by jealous doctors. If the District Attorney is unable to obtain an indictment, the fact will be widely heralded as proof of the efficiency of their cure.

It is not our wish to discourage those who would join us in taking up the cudgel against these impostors, but rather, by discussion and suggestion, to assist in reaching a solution of the problem.

Were it not for the ability to advertise, these concerns could not exist. The itinerant med-

icine man of a generation ago, and the patent-medicine vendor, were insignificant in comparison to their successors. The side of the barn and the board fence were the beginning. With the cheapening of the expense of printing, however, newspapers, periodicals and circulars have become the accepted fields of labor. No law can drive them out of these pastures unless the owners thereof forbid their trespassing.

To prove to a jury of laymen that a therapeutic measure has not the value claimed for it is next to impossible. The sciences of physiology, pathology and therapeutics would have to be elucidated by the plaintiff's attorney—a stupendous proposition.

Persuasion of publishers that such advertisements should not be received on account of their injuriousness to the public welfare has seemed thus far like the dream of the idealist; like looking for altruism in man when many claim that the age spells honor and success more readily with selfishness.

Yet to even the casual observer it is already apparent that the public is becoming aroused, and will demand more careful editing of the advertising columns. Several newspapers and magazines in this country have already declared themselves on the side of the right, and others are preparing so to do.

One of the most representative grand juries ever impaneled at Buffalo made recommendations a few months ago (see page 200, June issue of this JOURNAL) which distinctly show the direction public opinion is taking.

When fully enlightened as to the gravity of the situation, our metropolitan dailies, which fight for the right as they see it, irrespective of consequences, will gladly range themselves in line for the protection of their readers. They will become the worst enemies of these unscrupulous advertisers, who have been using their columns for their tools.

We are proud of our newspapers. American journalism is the finest example we have of American energy. With possibly a few exceptions, they are educational and uplifting in char-

acter. So true is this that, as soon as convinced of the irreparable injuries, frequently mortal, which are being perpetrated upon the poor and ignorant by these medical concerns, and in which they have been active partners, we have no hesitancy in declaring that the partnership will be quickly dissolved.

There is another way in which these frauds can be reached: Give our regents the power to revoke, as well as to issue, licenses to practice medicine. Proof of innocence would then have to be established before the courts.

The regents are certainly better able to judge of the danger to the public from permitting an individual to practice medicine than is a grand jury. Frequently the evidence that a criminal abortion has been performed seems perfect enough to convict, but a loophole is discovered by the defendant's lawyer, some technicality perhaps, and judge and jury are forced to see the undoubted criminal depart in freedom, a licensed physician.

Range the newspapers and magazines upon the side of the public welfare, and give to the regents the power of revoking licenses, and thousands of lives will be saved.

PAYMENT OF DUES.

The following correspondence between the President of the Association and a member in New York County, who had not settled his indebtedness to the Association in full, prior to July 1st, will be of interest to readers:

JUNE 26, 1903.

Dear Doctor—Dr. C. E. Denison, 68 West 71st street, this city, treasurer of the New York County Medical Association, has informed me that through some oversight on your part he has not as yet received the \$1 which you owe the Association.

Kindly attend to this matter before July 1st, if you have not already done so, as under the By-laws of the State Association, Article X, section 4 (page 74, February number, THE NEW YORK STATE JOURNAL OF MEDICINE), I will be obliged to request the Committee on Publication to omit your name from the published list of members of the Association in the forthcoming volume of the Medical Directory.

This I should very much regret having to do, as I believe you cannot well afford to do without the insurance against the legal expense of resisting unjust attacks furnished by our Association to its members in good standing.

Hoping that you will give this matter your immediate attention, I am,

Yours sincerely,

(Signed) FREDERICK HOLME WIGGIN.

NEW YORK, June 29, 1903.

Dear Doctor Wiggin—In reply to your note of the 26th I am happy to inform you that I do not owe the State or county any dues.

According to Article X, section 2, the annual dues of the State Association are five (\$5) dollars, and Article IX, section 2, of the County Association By-laws states that the annual dues shall be three (\$3) dollars, making a total of eight (\$8) dollars for the State and County associations. This amount I have paid to the treasurer, so I am not in debt to the Association for dues.

I do owe a fine of one (\$1) dollar for my negligence in not paying the annual dues before May 1st.

I fail to find any article in the Constitution and By-

laws, either of the State or County association, which gives authority for your statement that you will be obliged to request that my name be dropped from the roll of membership unless I pay this fine of one (\$1) dollar before July 1st.

I am perfectly willing to pay my fine, but I do not believe that my failure to do so before a certain date would give a committee the privilege of expelling me from the Association.

With great respect,

JULY 1, 1903.

Dear Doctor—You evidently refer in your letter to Article X, section 2, of the By-laws of the State Association as printed in the Directory for 1902, having overlooked the fact that the By-laws of the Association, from which I quoted, were the ones as revised at the annual meeting of the State Association, held in this city October 20-23, 1902, and printed in the February number of THE NEW YORK STATE JOURNAL OF MEDICINE on pages 71-74.

If you will refer to Article X of these By-laws, page 74, February number THE NEW YORK STATE JOURNAL OF MEDICINE, you will find that section 2 reads as follows:

"The annual dues of resident and non-resident members shall be six (\$6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (\$1) dollar may be deducted." Consequently, if you did not pay your dues prior to April 1st, you owed the Association \$6, State dues, plus \$3 for the County Association, equaling \$9.

As you state you have paid \$8 on account, please send Dr. C. E. Denison, 68 West 71st street, this city, treasurer the New York County Medical Association, \$1 in order to balance your account.

The rule requiring the omission of the names of members who have not paid their dues from the published list in the Directory reads as follows:

"On the 1st day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be *dropped* from the forthcoming list of members to appear in the Medical Directory for that year, and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be *dropped* from the official roll of members."

See THE NEW YORK STATE JOURNAL OF MEDICINE, Vol. 3, No. 2, page 74, Article X, section 2.

Yours sincerely,

(Signed) FREDERICK HOLME WIGGIN.

In response to another letter sent out by the president during the latter part of June to those members of the Association whose names failed to appear on the State treasurer's list of those who had paid their dues for this year, the following reply was received:

DR. FREDERICK HOLME WIGGIN,

President The New York State Medical Association,
New York City.

Dear Doctor—Your communication concerning my Association dues reached me to-day.

Have received no bill for them; therefore, do not know to whom to send them, as we have no County Association.

Have taken the liberty of sending them to you, trusting you will, if necessary, forward to the proper person.

Fraternally yours,

For the information of the member writing this letter, as well as for others experiencing similar difficulties in paying their dues, attention is called to the fact that members residing in counties where there is no County Association,

should pay their dues to the treasurer of their District Branch Association, who should, of course, send out proper bills on or before January 1st of each year to such members.

Attention is also called to the fact that under Article X, section 2, of the By-laws of the State Association, as revised at the annual meeting held October 20-23, 1902, the dues are \$6 a year, but if they are paid within three months a rebate of \$1 may be deducted.

ADVERTISING.

When the State Association elected the Committee on Publication, it placed in its hands the duty of keeping its advertising columns free from objectionable and unethical advertisements. This duty the committee has endeavored to fulfil to the best of its ability, even at the cost to the Association of many hundreds of dollars, as evidenced by the following letter:

JULY 25, 1903.

Dear Doctor—Yours of July 3d requesting an answer from the Committee on Publication, in regard to the proposition contained in the second paragraph of your letter, which reads: "I have about made up my mind not to scatter my business so much, but I will limit the number of papers I make offers to, and as I will not present any advertisements that ought not to be accepted, I will make it conditional that they are all to be taken."

The Committee on Publication of The New York State Medical Association will continue to be governed by the principles already established, and by acting on each application for advertising space in all of its publications.

The Committee requires that the quantity of the active ingredients of all internal and external medicines be published.

It also reserves the right to submit an edited copy of all advertisements.

And to reject any advertisement on account of the firm's standing.

While the Committee would be glad to receive advertisements of the kind you are able to place in its publications, you must realize that it is impossible for the Committee to delegate its power of admitting or rejecting an advertisement to any one, however careful he may be.

The Committee would be pleased to hear from you, and feels confident your clients cannot do better than to advertise in THE NEW YORK STATE JOURNAL OF MEDICINE, and will well repay the advertiser.

Very sincerely yours,

C. E. DENISON.

QUACKERY.

The action of a contributor to the JOURNAL is condemned. Sending reprints with a base circular letter, calling attention to the excellent work done by the writer, "the results in every case have been absolutely successful," and the danger of any one else engaging in his particular specialties, "producing considerable mutilation and the patient is very prone to bring suit."

We disclaim the responsibility, and regret the publication in the JOURNAL.

THE CALF-PATH.

One day, through the primeval wood, a calf walked home, as good calves should; but made a trail all bent askew, a crooked trail, as all calves do.

Since then two hundred years have fled, and I infer the calf is dead. But still he left behind his trail, and thereby hangs my moral tale.

The trail was taken up next day by a lone dog that passed that way; and then a wise bell-wether sheep pursued the trail o'er vale and steep, and drew the flock behind him, too, as good bell-wethers always do.

And from that day o'er hill and glade, through those old woods a path was made; and many men wound in and out, and dodged and turned and bent about. And uttered words of righteous wrath because 'twas such a crooked path. But still they followed—do not laugh—the first migrations of that calf, and through the winding woodway stalked, because he wobbled when he walked.

This forest path became a lane, that bent, and turned, and turned again; this crooked lane became a road, where many a poor horse with his load, toiled on beneath the burning sun, and traveled some three miles in one. And thus a century and a half they trod the footsteps of that calf.

The years passed on in swiftness fleet, the road became a village street; and this, before men were aware, a city's crowded thoroughfare; and soon the central street was this of a renowned metropolis. And men, two centuries and a half, trod in the footsteps of that calf.

Each day a hundred thousand rout followed the zigzag calf about, and o'er his crooked journey went, the traffic of a continent. A hundred thousand men were led by one calf near three centuries dead. They followed still his crooked way, and lost one hundred years a day; for *such a reverence is lent to well-established precedent.*

A moral lesson this might teach, were I ordained and called to preach; for men are prone to go it blind, along the *calf-paths of the mind*, and work away from sun to sun, to do what other men have done.

They follow in the beaten track, and out, and in, and forth and back; and still their devious course pursue, to keep the path that others do. But how the wise old wood-gods laugh, who saw the first primeval calf! Ah! many things this tale might teach, but I am not ordained to preach.

SAM WALTER FOSS.

THE MEDICAL SOCIETY HABIT.

So largely is medicine the personal teaching of one doctor by another that frequent meetings are indispensable to reach the highest standard. It is noted that when one has discovered some new method of operation or treating cases with better results than his fellows, some of the brighter make pilgrimages to learn the new methods. In this way the excellence of one is scat-

tered to far-distant regions. It seems that the mere verbal description of the book, or journal article, fails to tell the entire story.

Others meet in bodies large or small, for comparison of ideas, that each may glean from the other that which he lacks and the other possesses. These may be said to have acquired the "society habit." The great mass of the medical profession of Michigan has never acquired this habit.

The organization in Michigan, unfolding with such astonishing results during the past eight months, is an intelligent effort to enable every reputable physician to acquire the medical society habit. It has already planted a medical society in seventy counties, and hopes to include the entire eighty-three in the State ere the annual meeting. Anterior to this at most only fifteen medical societies existed in the State.

As in all organizations, the strong will help the weak, so that those who are real or potential members will give the aid the one needs and the others possess. It is quite impossible for any earnest seeker for better equipment to spend an hour in discussing a medical topic with a brother doctor without reward, large or small.

Since no little skepticism exists as to the benefit of any medical society, it is for the friends of organization in Michigan to show that the present movement differs from all ever preceding it to so large a degree as to remove the basis of said skepticism. This calls for a clear knowledge, overflowing enthusiasm and a determination to enroll the skeptic in the movement—a clear-headed educator in this branch of medical sociology.

Indolence or indifference is everywhere. The first is met by the awakening of interest in the broader outlook of the organization, the stimulus of a new hope for better things, the stirring of an ambition to excel. The latter is overcome by showing that indifferent physicians will be outdistanced by neighbors working for and in a medical society, unless they, too, cast their lot therein.

It is confidently believed that the Michigan State Society and its branches offer so much to the individual doctor, of high or low degree, that he would join one of its numerous branches—if only some person make the advantages clear to him.

To teach the "society habit" to Michigan's five thousand doctors calls for persistent, tactful, broad-minded, unselfish devotion to the best interests of the profession. It is suggested that from this time onward every young doctor be brought into the county branch as soon as he locates. The older members of the profession are more difficult to reach, but few will prove invulnerable to the attractions now offered to all in Michigan. Let each member join in the work of "gathering them in" heartily, as if he were the sole worker—and the thing is done.—LEARTUS CONNOR, in *The Journal of the Michigan State Medical Society*, April, 1903.

HEATING AND FRESH AIR.

The prejudice against night-air ventilation turns out to be in part, at least, the result of the experience of the people of malarial countries. The word malaria itself suggests the reason for the prejudice. Unless the bad air were shut out the bad mosquito was not shut out. Those who shut both out escape one of the world's greatest scourges, and even in the present year the Baedeker guide-books of Italy contain the advice, "windows should be closed at night." Somebody should send the guide-book publishing company some mosquito netting. It is claimed that the descendants of the window-closers so well learned their lesson that those who did not obey the beatitude, "Blessed are they who do not ventilate their sleeping-rooms," have been cut off from perpetuating the race by the pitiless laws of Darwinism. In this way the race escaped malaria, but found a worse evil in tuberculosis and pneumonia. Now that it is known that it is not malaria, but malmosquito, that brings the evil, the crusade against malventilation and the prejudice against night air may be undertaken with greater certainty of success and the ravages of tuberculosis may be checked.

The theory that the necessity of excluding from houses the injurious night air is the cause the world over of the practice of poor ventilation will not hold. It is at least not the sole nor the chief reason of the prejudice against fresh air. Manifestly it does not obtain for countries in which there is no mosquito, and these form a relatively small part of the world inhabited by civilized peoples. In cold climates, and especially in the winter season, the theory has no applicability, and another explanation must be found. This is, we believe, the necessity that exists, especially among the vast majority of the poor, to economize warmth. A large portion of the peasants of France to-day secure this economy by keeping their domestic animals at night in the combined house and stable. In Arctic climates, and in winter even in temperate zones, and especially in previous centuries, the securing of sufficient clothing and saving the loss of warmth has doubtless been a chief cause of the universal fear of ventilation. In this way to-day in some countries medical college lecture-rooms get on without the expense of fuel by utilizing the foul but warm exhalations of the bodies of hundreds of students, who in anger cry out against a door ajar or a crack in a window. The greatest and best remedial agent in tuberculosis and many other devitalizing diseases is fresh air, by night or by day, ever fresh air! Now that the mosquito is "barred," and that civilization can provide the poorest with good houses and fuel, there should be a speedy lessening of the death-rate by perfect ventilation.—*American Medicine*.

Association News.

NEW YORK STATE MEDICAL ASSOCIATION MEETING.

The Committee of Arrangements, under the able management of Dr. Samuel A. Brown, chairman, are planning for the next meeting, October 19th to 22d, an extensive series of entertainments in addition to the scientific program. Members should communicate with Dr. Brown, 23 East 44th street, at once for information concerning the dinner, which will be held on Wednesday evening, October 21st.

Allegany County Association.—The regular meeting of this association was held at Belmont, on Tuesday, July 14th. In the scientific session, Dr. C. Oakley Sayres read a paper on "Puerperal Eclampsia," Dr. H. F. Gillette one on "Hints on Dietetics" and Dr. H. W. Loughran one on "Smallpox." The papers were most interesting, and a very lively and spirited discussion followed. It was one of the best meetings ever held in Allegany County.

* * *

Jefferson County Association.—The members of the First District Branch Association residing in Jefferson County met at Watertown on June 6th and organized the Jefferson County Medical Association. The following officers were elected: Dr. Byron C. Cheeseman, president; Dr. Florence J. Sherman, secretary and treasurer; Dr. Andrew J. Dick, Fellow, and Dr. Charles C. Kimball, Alternate.

* * *

Niagara County Association.—Nineteen of twenty-four members of the Fourth District Branch, residing in Niagara County, met on June 30th, at Lockport, and organized the Niagara County Medical Association, adopting by-laws and electing the following officers: Dr. Charles N. Palmer, of Lockport, president; Dr. William Q. Huggins, of Sanborn, vice-president; Dr. Alva LeRoy Chapin, of Niagara Falls, secretary, and Dr. Frank Guillemont, of Niagara Falls, treasurer. Executive Committee, Dr. F. J. Baker, of Lockport, for three years; Chester Emerson Campbell, of Niagara Falls, for two years; Dr. Frank Guillemont, of Niagara Falls, for one year. Fellows, Dr. Allan N. Moore, of Lockport; Chester E. Campbell, Niagara Falls. Alternates, Jacob E. Helwig, Frank Guillemont. Member of the Nominating Committee of the Fourth District Branch, Dr. William Q. Huggins. Alternate, F. J. Baker.

* * *

Rockland County Association.—A meeting of this association was held at Dr. J. A. Dingman's office, Spring Valley, July 15, 1903.

There were present, Dr. D. B. Van Wagenen, Suffern, president; Dr. Geo. A. Leitner, Piermont, vice-president; Dr. N. B. Bayley, Haver-

straw, secretary and treasurer; Dr. J. C. Bierwirth, of Brooklyn, president Fifth District; Drs. G. F. Blauvelt and C. D. Kline, Nyack; Dr. R. R. Felter, Pearl River; Dr. J. A. Dingman, Spring Valley; Dr. S. Bogert, Pearl River, and Dr. A. O. Bogert, Spring Valley.

The scientific session was opened with a discussion upon X-ray work, by Dr. Bierwirth, who explained in a most instructive way the installation of the apparatus and his experience with the various tubes. The therapeutic application of the X-ray in malignant growths, inflammatory formations, tumors and leucemia had, in his hands, received confirmatory evidence of its value. But the X-ray is an agent capable of doing much harm. A thorough knowledge of the present known properties of the X-ray, experience and personal equation are factors which will make for success in the use of this agent.

In the therapeutic exhibition of the X-ray current the relief of pain and sleeplessness in neuritis and other painful conditions has been most marked and gratifying. As the result of faulty technic, imperfect tubes, or of personal equation, painful conditions, other than dermatitis, are occasionally developed, that are very similar to rheumatism, and which are relieved by elimination treatment. Some urinary examinations resulted in finding an excess of urea, amounting in some cases from 500 to 700 grains in the twenty-four hours, in cases of rheumatic conditions following too powerful currents on malignant neoplasms. In the therapeutic application of the X-ray will be found many surprises, and from the work now being done the field for its use will be largely extended.

A vote of thanks was tendered to Dr. Bierwirth for his instructive conversation.

A discussion upon the hypodermatic use of ergot followed, in which the consensus of opinion that the enthusiastic reports of its use had not been borne out by subsequent experience, was made manifest by cases cited by Drs. Blauvelt, Leitner and Kline. In alcoholism its use had been a distinct failure, also in a case of shock in a patient operated upon at the Nyack Hospital for appendicitis. In post-operative abdominal distension, also in tympanitis occurring in the course of broncho-pneumonia in children, and in acute catarrhal laryngitis (with probable edema) good results had followed its use.

The next meeting of the association will be held at Haverstraw, October 21st. Digitalis will be a subject for discussion.

* * *

Seneca County Association.—The members of the Third District Branch Association residing in Seneca County met on June 6th and organized the Seneca County Medical Association, by the adoption of by-laws and the election of the following officers: President, Dr. William Austin Macy; vice-president, Dr. George O. Bellows; secretary, J. Spencer Purdy; treasurer, Carroll B. Bacon.

LIST OF MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION, JULY 1 TO AUGUST 1, 1903.

Daniel, John H., Buffalo.
 Driesbach, Frederick R., Dansville.
 Delmage, Frederick W., Hermon.
 Gladman, Everett G., Fulton.
 Goss, Alfred, Adams.
 Nelson, Stuart W., Old Forge.
 Satterlee, Albert Robinson, Buffalo.
 Weiss, George C., Mount Vernon.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Herkimer County.—Stuart W. Nelson, Old Forge.
 Jefferson County.—Alfred Goss, Adams.
 Oswego County.—Newton Cook, Sandy Creek; Everett A. Gladman, Fulton.
 St. Lawrence County.—Frederick William Delmage, Hermon.

SECOND DISTRICT BRANCH.

Albany County.—William N. Campaigne, Green Island; George H. Houghton, Albany; Howard E. Lowax, Albany.
 Columbia County.—Robert Woodworth Bell, Claverack.
 Green County.—Robert Selden, Catskill.
 Saratoga County.—George P. H. Taylor, Stillwater.

THIRD DISTRICT BRANCH.

Tioga County.—William A. Moulton, Nichols.
 Tompkins County.—Eugene Baker, Ithaca.
 Seneca County.—Harvey E. Brown, Fayette; John F. Crosby, Seneca Falls; Thomas J. Currie, Willard; J. Spencer Purdy, Seneca Falls; Thomas W. Salmon, Willard; Charles F. Sanborn, Willard.

FOURTH DISTRICT BRANCH.

Cattaraugus County.—William B. Johnston, Ellicottville.
 Erie County.—Edward L. Frost, Buffalo.
 Niagara County.—Flavius J. Baker, Lockport; William Robertson Campbell, Niagara Falls; Alva LeRoy Chapin, Niagara Falls; Thomas B. Cosford, Lockport; Frank A. Crosby, Lockport; Bernard F. Dennis, Niagara Falls; Jacob E. Helwig, Martinsville; William H. Hodson, Lockport; Alfred W. Jackson, Gasport; Henry H. Mayne, Lockport; Allan N. Moore, Lockport; Frederick R. Pickett, Olcott; Edwin Shoemaker, Newfane; William G. Sprague, Barker; Erastus W. Wollaber, Lockport.

FIFTH DISTRICT BRANCH.

Kings County.—Eugene Paul Harman, Brooklyn.

OBITUARY.

Dr. J. Ernestine Hills died at the Willard State Hospital, Willard, N. Y., on July 11, 1903. Dr. Hills was a graduate of the University of Pennsylvania, 1893, she was a member of The New York State Medical Association and was at the time of her death assistant physician at the Willard State Hospital.

Dr. John Gillespie, Jr., died at his home at Warrensburg, N. Y., on May 26, 1903. He was a graduate of the University of Pennsylvania, class of 1880, and was a member of The New York State Medical Association.

Dr. Thomas Moore Rochester, Brooklyn, N. Y., died at the home of his mother, in Rochester, on July 12, 1903. Dr. Rochester was a graduate of the University of Buffalo, class of 1878. Directly after his graduation he settled in Brooklyn, where he practiced until his health broke down. Dr. Rochester had been a member of The New York State Medical Association, from which he resigned early in the year on account of ill-health. He was also a member of the New York Academy of Medicine and the Kings County Society.

PERSONALS.

Dr. and Mrs. Glover C. Arnold and family are spending the summer in Europe.

Dr. F. Park Lewis, Buffalo, has been appointed chairman of the commission to investigate the condition of the adult blind of New York State.

Dr. and Mrs. Robert Abbe will spend the summer season at Brook End, Bar Harbor.

Dr. and Mrs. Ellery Denison are spending the summer in the Catskills.

Dr. Samuel A. Brown, chairman of the Committee on Arrangements, has been appointed assistant visiting physician to Bellevue Hospital.

The Medical Society of New Jersey, the oldest medical society in the United States, at its 113th annual meeting, held at Asbury Park, June 23d, 24th and 25th, reported a new constitution and by-laws to conform with those of the American Medical Association. The following officers were elected: Dr. Henry Mitchell, president, Asbury Park; Drs. Addison W. Taylor, Beverly, Walter B. Johnson, Paterson, and Henry W. Elmer, Bridgeton, vice-presidents; Dr. Ellis W. Hedges, corresponding secretary, Plainfield; Dr. William J. Chandler, recording secretary, South Orange, and Dr. Archibald Mercer, Newark, treasurer.

The following were elected members of the Council: Drs. Thomas W. Harvey, Orange; John L. Leal, Paterson; Cornelius Shepherd, Trenton; Daniel Strock, Camden, and Philip Marvel, Atlantic City.

News Items.

"The Physicians' Wives' Club," of Sullivan County, held their annual meeting and outing at Wurtsboro, June 18th. By invitation of Mrs. C. W. Piper, the members and friends met at her home, where a delightful day's outing was enjoyed. After luncheon they had a fine mountain drive to Sullivan County Park.

The following officers were elected: President, Mrs. R. A. DeKay, of Livingston Manor; vice-president, Mrs. Frank P. Houser, of Bloomingburg; secretary, Mrs. C. S. Payne, of Liberty; treasurer, Mrs. E. W. Maynard, of Roscoe.

* * *

A new institution called the Hospital for Convalescents has been opened by the Department of Public Charities. There has been no public institution in New York for convalescent patients. By a few weeks' rest, with healthful surroundings and nourishing food, these patients may be restored to a useful life. Chronic, contagious and incurable diseases will not be received. The hospital is in the building formerly occupied by the Manhattan State Hospital on Blackwell's Island.

APPEAL TO THE MEDICAL PROFESSION.

To the Editor of the New York Tribune:

Sir—It needs no argument to prove that the medical profession is deeply interested in the question of educational unification now extensively agitated in this State. If such unification is to be accomplished it can only be effected by vesting the powers of the present Department of Public Instruction in the University of the State of New York, to be exercised and performed by its regents, for the simple reason that, being embedded in the constitution, it cannot be eliminated by the Legislature.

The evils arising from the dual system of supervision of the educational interests of the State, which have been so injurious in the past and have entailed unnecessary expense, would thus be entirely eradicated, and the schools would forever be taken out of politics.

It is hardly necessary to call the attention of medical men to the fact that at the time of the initiation of the present admirable system of medical examinations the greatest solicitude was felt as to the proper and most fitting place in which to lodge the power for the administration of the boards proposed to be created, and only when the proposition was made to place them under the control of the Board of Regents, and the fact became self-evident that its constitution, mode of election and life tenure of office made it necessarily an independent and impartial body, was the profession induced to give the movement its cordial support.

In point of fact, the failure to adopt the New York system in other States has in several instances resulted from the reason that no precisely similar body existed in those States in which to lodge the requisite power for the administration of the boards of examiners intended to be established.

In all the other States where regents actually exist they are elected for only a brief number of years, and thus are liable to be subjected to political control and to all the contaminating sectarian and partisan influences which flow therefrom. Such boards, on account of the absence of permanence of tenure, do not and cannot have the independence of action which has always characterized the Board of Regents of this State.

An experience of more than eleven years of the workings of the present system of medical examinations in

this State has demonstrated not only that the regents have administered their trust with perfect independence and judicial impartiality, but that the results attained have commended it to the good sense of the people of the State and gained for it the hearty and cordial approval of the medical profession of all schools of practice in every portion of our country, and it is now conceded by scholars and publicists to be the most perfect in the world.

Any radical change in the constitution or life tenure of the board would tend to demoralize the present system and create imminent danger of lowering the standards of medical qualification which have given New York a proud position among her sister States.

Every member of the medical profession should, therefore, immediately interest himself in favor of the unification of the entire educational system of the State under the exclusive supervision of the regents of the University of the State of New York.

WILLIAM H. WATSON.

Utica.

POWERS OF BOARDS OF HEALTH.

A decision has just been handed down by the Appellate Court which is of interest to boards of health. A man by name of Van Fredenburg collected refuse and garbage from hotels and other resorts in and near Liberty, N. Y., with which he fed hogs. The Board of Health of Liberty issued an order forbidding him to use the sanatorium refuse. On his refusal to comply with the order, he was arrested, brought before a justice, tried in the County Court, convicted and sentenced. Van Fredenburg appealed, and the Appellate Court, in reversing the judgment, laid down the principle that boards of health must keep within legal limits or they cannot enforce their orders. The Court summed up as follows: "The gist of the crime which the defendant is said to have committed is the disobedience of a lawful order of the Board of Health. Unless, then, the order disobeyed was one lawfully made by the Board of Health, defendant has been guilty of no crime. There is no proof that this refuse from the sanatorium for consumptives is any more dangerous than the refuse from any hotel, and we cannot assume such to be the fact in sustaining this conviction."

MAY BUY DRUG SAMPLES.

Attorney-General Cunneen furnished an opinion to the State Board of Pharmacy as to the right of that board, through an inspector, to take samples from bottles of drugs exposed for sale in a pharmacy for the purpose of analysis to ascertain whether the substance is of the standard strength, quality and purity established by the latest edition of the United States Pharmacopeia.

Proprietors of some drug stores are unwilling to furnish such samples to the inspector of the State board, although the board is perfectly willing to pay for the samples which the inspector takes.

"I think it entirely clear that it is the duty of a proprietor of a drug store to furnish to a member of the State Board of Pharmacy, or an authorized inspector thereof, samples of his goods upon being tendered the purchase price therefor, and that in the event of his refusal to do so, he thereby becomes liable both to criminal prosecution and to an action for the recovery of a penalty."

THE EDUCATIONAL VALUE OF THE MEDICAL SOCIETY.

There are many problems and difficulties in the education of a medical student, but they are not more difficult than the question of the continuous education of the general practitioner. Over the one we have some control, over the other, none. The university and the State Board make it certain that the one has a minimum, at least, of professional knowledge, but who can be certain of the state of that knowledge of the other in five or ten years from the date of his graduation? The specialist may be trusted to take care of himself, the conditions of his existence demand that he shall be abreast of the times; but the family doctor—the private in our great army—the essential factor in the battle, should be carefully nurtured by the schools and carefully guarded by the public. Humanly speaking, with him are the issues of life and death, since upon him falls the grievous responsibility in those terrible emergencies which bring darkness and despair to so many households. No class of men needs to call to mind more often the wise comment of Plato that education is a life-long business. The difficulties are partly adherent to the subject, partly have to do with the individual and his weakness. The problems of disease are more complicated and difficult than any others with which the trained mind had to grapple; the conditions in any given case may be unlike those in any other; each case, indeed, may have its own problem. Law, constantly looking back, has its forms and procedures, its precedents and practices. Once grasped, the certainties of divinity make its study a delight and its practice a pastime; but who can tell of the uncertainties of medicine as an art? The science on which it is based is accurate and definite enough; the physics of a man's circulation are the physics of the water works of the town in which he lives, but once out of gear, you cannot apply the same rules for the repair of the one as of the other. Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease. This is the fundamental difficulty in the education of the physician, and one which he may never grasp, or he takes so tenderly that it hurts instead of bodily accepting the axiom of Bishop Butler, more true of medicine than of any other profession: "Probability is the guide of life." Surrounded by people who demand certainty, and not philosopher enough to agree with Locke that "*Probability supplies the defect of our knowledge and guides us when that fails, and is always conversant about things of which we have no certainty,*" the practitioner too often gets into a habit of mind which resents the thought that opinion, not full knowledge, must be his stay and prop. There is no discredit, though there is at times much discomfort, in this everlasting *per-*

haps with which we have to preface so much connected with the practice of our art. It is, as I said, inherent in the subject. Listen to the appropriate comment of the Father of Medicine, who twenty-five centuries ago had not only grasped the fundamental conception of our art as one based on observation, but had labored also through a long life to give to the profession which he loved the saving health of science—listen, I say, to the words of his famous aphorism: "*Experience is fallacious and judgment difficult!*"

But the more serious problem relates to the education of the practitioner after he has left the schools. The foundation may not have been laid upon which to erect an intellectual structure, and too often the man starts with a total misconception of the prolonged struggle necessary to keep the education he has, to say nothing of bettering the instruction of the schools. As the practice of medicine is not a business and can never be one, the education of the heart—the moral side of the man—must keep pace with the education of the head. In every age there have been Elijahs ready to give up in despair at the progress of commercialism in the profession. Garth says in 1699 (*Dispensary*):

"How sickening Physick hangs her pensive head
And what was once a Science, now's a Trade."

Of medicine, many are of the opinion expressed by one of Akenside's disputants at Tom's Coffee House, that the ancients endeavored to make it a science and failed, and the moderns to make it a trade and have succeeded. To-day the cry is louder than ever, and in truth there are grounds for alarm; but, on the other hand, we can say to these Elijahs that there are many more than 7,000 left who have not bowed the knee to this Baal, but who practice *caute caste et probe*.

For better or worse, there are few occupations of a more satisfying character than the practice of medicine, if a man can but once get interested and bring to it the philosophy of honest work, the philosophy which insists that we are here, not to get all we can out of the life about us, but to see how much we can add to it. The discontent and grumblings which one hears have their source in the man more often than in his environment. In the nature of the material in which we labor and of which, by the way, we are partakers, there is much that could be improved, but, as Mrs. Poyser remarks, we must accept men as the Lord made them, and not expect too much. But let me say this of the public: It is rarely responsible for the failures in the profession. Occasionally a man of superlative merit is neglected, but it is because he lacks that most essential gift, the knowledge how to use his gifts. The failure in 99 per cent. of the cases is in the man himself; he has not started right, the poor chap has not had the choice of his parents, or his education has been faulty, or he has fallen away to the worship of strange gods, Baal or Ashtoreth, or worse still,

Bacchus. But, after all, the killing vice of the young doctor is intellectual laziness. He may have worked hard at college, but the years of probation have been his ruin. Without specific subjects upon which to work, he gets the newspaper or the novel habit, and fritters his energies upon useless literature. There is no greater test of a man's strength than to make him mark time in the "stand-and-wait" years. Habits of systematic reading are rare, and are becoming more rare, and five or ten years from his license, as practice begins to grow, may find the young doctor knowing less than he did when he started and without any fixed educational purpose in life.

Now here is where the medical society may step in and prove his salvation. The doctor's post-graduate education comes from patients, from books and journals and from societies, which should be supplemented every five or six years by a return to a post-graduate school to get rid of an almost inevitable slovenliness in methods of work. Of his chief teachers, his patients, I cannot here speak. Each case has its lesson—a lesson that may be, but is not always, learned, for clinical wisdom is not the equivalent of experience. A man who has seen five hundred cases of pneumonia may not have the understanding of the disease which comes with an intelligent study of a score of cases, so different are knowledge and wisdom, which, as the poet truly says: "Far from being one have oftentimes no connection." Nor can I speak of his books and journals, but on such occasions as the present it seems appropriate to say a few words on the *educational value of the medical society*.

Unity and friendship! How we all long for them, but how difficult to attain! Strife seems rather to be the very life of the practitioner, whose warfare is incessant against disease and against ignorance and prejudice, and, sad to have to admit, he too often lets his angry passions rise against his professional brother. The quarrels of doctors make a pretty chapter in the history of medicine. Each generation seems to have had its own. The Coans and the Cnidians, the Arabians and the Galenists, the humorists and the solidists, the Brunonians and the Broussaisians, the homeopaths and the regulars, have, in different centuries, rent the robe of Aesculapius. But these larger quarrels are becoming less and less intense, and in the last century no new one of moment sprang up, while it is easy to predict that in the present century, when science has fully leavened the dough of homeopathy, the great breach of our day will be healed. But in too many towns and smaller communities miserable factions prevail and bickerings and jealousies mar the dignity and usefulness of the profession. So far as my observation goes, the fault lies with the older men. The young fellow, if handled aright and made to feel that he is welcomed and not regarded as an intruder to be shunned, is only too ready to hold out the hand of fellowship.

The society comes in here as professional cement. The meetings in a friendly, social way lead to a free and open discussion of differences in a spirit that refuses to recognize differences of opinion on the non-essentials of life as a cause of personal animosity or ill-feeling. An attitude of mind habitually friendly, more particularly to the young man, even though you feel him to be the David to whom your kingdom may fall; a little of the old-fashioned courtesy which makes a man shrink from wounding the feelings of a brother practitioner—in honor preferring one another; with such a spirit, abroad in the society and among its older men, here is no room for envy, hatred, malice or any uncharitableness. It is the confounded tales of patients that so often set us by the ears, but if a man makes it a rule never under any circumstances to believe a story told by a patient to the detriment of a fellow practitioner—even if he knows it to be true—and though the measure he metes may not be measured to him again, he will have the satisfaction of knowing that he has closed the ears of his soul to ninety-nine lies, and to have missed the hundredth truth will not hurt him. Most of the quarrels of doctors are about non-essential, miserable trifles and annoyances—the pin-pricks of practice—which would sometimes try the patience of Job, but the good-fellowship and friendly intercourse of the medical society should reduce these to a minimum.

The well-conducted medical society should represent a clearing house, in which every physician of the district would receive his intellectual rating, and in which he could find out his professional assets and liabilities. We doctors do not "take stock" often enough, and are very apt to carry on our shelves stale, out-of-date goods. The society helps to keep a man "up to the times," and enables him to refurnish his mental shop with the latest wares. Rightly used, it may be a touch-stone to which he can bring his experiences to the test and save him from falling into the rut of a few sequences. It keeps his mind open and receptive, and counteracts that tendency to premature senility, which is apt to overtake a man who lives in a routine. Upon one or two specially valuable features of the society I may dwell for a moment or two.

In a city association the demonstration of instructive specimens in morbid anatomy should form a special feature of the work. After all has been done, many cases of great obscurity in our daily rounds remain obscure, and as postmortems are few and far between, the private practitioner is at great disadvantage, since his mistakes in diagnosis are less often corrected than are those of hospital physicians. No more instructive work is possible than carefully demonstrated specimens illustrating disturbance of function and explanatory of the clinical symptoms. It is hard in this country to have the student see enough morbid anatomy, the aspects of which have such an important bearing upon the mental attitude of

the growing doctor. For the crass therapeutic credulity, so widespread to-day, and upon which our manufacturing chemists wax fat, there is no more potent antidote than the healthy skepticism bred of long study in the postmortem room. The new pathology, so fascinating and so time-absorbing, tends, I fear, to grow away from the old morbid anatomy, a training in which is of such incalculable advantage to the physician. It is a subject which one must learn in the medical school, but the time assigned is rarely sufficient to give the student a proper grasp of the subject. The younger men should be encouraged to make the exhibition of specimens part of the routine work of each meeting. Something may be learned from the most ordinary case if it is presented with the special object of illustrating the relation of disturbed function to altered structure. Of still greater educational value is the clinical side of the society. No meeting should be arranged without the presentation of patients, particularly those illustrating rare and unusual forms of disease. Many diseases of the skin and of the joints, a host of nervous affections, and many of the more remarkable of general maladies, as myxedema, cretinism, achondroplasia, etc., are seen so rarely and yet are so distinctive, requiring only to be seen to be recognized, that it is incumbent upon members to use the society to show such cases. A clinical evening devoted to these rarer affections is of very great help in diffusing valuable knowledge. The importance of a clinical demonstration was never better illustrated than at the International Congress in London in 1881, when Dr. Ord and others presented one morning at the Clinical Museum a group of cases of myxedema. There were men from all parts of the world, and the general recognition of the disease outside of England dates from that meeting. The physiognomy of disease is learned slowly, and yet there are a great many affections which can be recognized sometimes at a glance more often by careful inspection, without any history. The society should be a school in which the scholars teach each other, and there is no better way than by the demonstration of the more unusual cases that happen to fall in your way.

The presentation of the histories of cases may be made very instructive, but this is often a cause of much weariness and dissatisfaction. A brief oral statement of the special features of a case is much to be preferred to a long, written account. The protocol or daily record of a long case should never be given in full. The salient points should be brought out, particularly the relation the case bears to the known features of the disease and to diagnosis and treatment. There is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language.

In no way can a society better help in the education of its members than in maintaining for them a good library, and I am glad to know that

this is one of your functions. It is most gratifying to note the growing interest in this work in all parts of the country. In the last number of the *Bulletin* of the Association of Medical Librarians there is a list of twenty-five societies with medical libraries. An attractive reading-room, with the important weekly journals, and with shelves stocked with the new books in different departments, becomes an educational center in which the young man can keep up his training and to which the older practitioner can go for advice when he is in despair, and for reassurance when he is in doubt. The self-sacrifice necessary to establish and maintain such a library does good to the men who take part in it; harmony is promoted, and, in the words of your fathers, the dignity and usefulness of the profession are maintained.

Why is it that a large majority of all practitioners are not members of a medical society? Dr. Simmons estimates that there are 77,000 physicians in the United States who do not belong to any medical society whatever! In part this is due to apathy of the officers and failure to present an attractive program, but more often the fault is in the men. Perhaps given over wholly to commercialism, a doctor feels it a waste of time to join a society, and so it is if he is in the profession only for the money he can get out of patients without regard to the sacred obligation to put himself in the best possible position to do the best that is known for them. More frequently, I fear, the "dollar-doctor" is a regular frequenter of the society, knowing full well how suicidal in the long run is isolation from the general body of the profession. The man who knows it all and gets nothing from the society reminds one of that little dried-up miniature of humanity, the prematurely senile infant, whose tabetic marasmus has added old age to infancy. Why should he go to the society and hear Dr. Jones on the gastric relations of neurasthenia when he can get it all so much better in the works of Einhorn or Ewald? He is weary of seeing appendices, and there are no new pelvic viscera for demonstration. It is a waste of time, he says, and he feels better at home, and perhaps that is the best place for a man who has reached this stage of intellectual stagnation.

Greater sympathy must be felt for the man who has started all right and has worked hard at the societies, but as the rolling years have brought ever-increasing demands on his time, the evening hours find him worn out, yet not able to rest, much less to snatch a little diversion or instruction in the company of his fellows whom he loves so well. Of all men in the profession the forty-visit-a-day man is the most to be pitied. Not always an automaton, he may sometimes by economy of words and extraordinary energy do his work well, but too often he is the one above all others who needs the refreshment of mind and recreation that is to be had in a well-

conducted society. Too often he is lost beyond all recall, and, like Ephraim joined to his idols, we may leave him alone. Many good men are ruined by success in practice, and need to pray the prayer of the Litany against the evils of prosperity. It is only too true, as you know well, that a most successful—as the term goes—doctor may practice with a clinical slovenliness that makes it impossible for that kind old friend, Dame Nature, to cover his mistakes. A well-conducted society may be of the greatest help in stimulating the practitioner to keep up habits of scientific study. It seems a shocking thing to say, but you all know it to be a fact that many, very many men in large practice never use a stethoscope, and as for a microscope, they have long forgotten what a leucocyte or a tube cast looks like. This in some cases may be fortunate, as imperfect or half-knowledge might only lead to mistakes, but the secret of this neglect of means of incalculable help is the fact that he has not attained the full and enduring knowledge which should have been given to him in the medical school. It is astonishing with how little outside aid a large practice may be conducted, but it is not astonishing that in it cruel and unpardonable mistakes are made. At whose door so often lies the responsibility for death in cases of empyema but at that of the busy doctor, who has not time to make routine examinations, or who is "so driven" that the urine of his scarlet fever or puerperal patients is not examined until the storm has broken?

But I hear it sometimes said you cannot expect the general practitioner, particularly in country districts, to use the microscope and the stethoscope—these are refinements of diagnosis. They are not! They are the essential means which can be used and should be used by every intelligent practitioner. In our miserable, antiquated system of teaching we send our graduates out wholly unprepared to make a rational diagnosis, but a man who is in earnest—and, thank heaven! most of the young men to-day in the profession are in earnest—can supply the defects in his education by careful study of his cases, and can supplement the deficiency by a post-graduate course. A room fitted as a small laboratory, with the necessary chemicals and a microscope, will prove a better investment in the long run than a static machine or a new-fangled air-pressure spray apparatus.

It is not in the local society only that a man can get encouragement in his day's work and a betterment of mind and methods. Every practitioner should feel a pride in belonging to his State society, and should attend the meetings whenever possible, and gradually learn to know his colleagues, and here let me direct your attention to an important movement on the part of the American Medical Association, which has for its object the organization of the profession throughout the entire country. This can be accomplished only by a uniformity in the organization of the State societies, and by making the

county society the unity though which members are admitted to the State and national bodies. Those of you interested will find very instructive information on this subject in the *Journal* of the association in a series of papers by Dr. Simons, the editor, which have been reprinted in pamphlet form. As now managed, with active sections conducted by good men from all parts of the country, the meeting of the National Association is in itself a sort of brief post-graduate course. Those of you at the receptive age who attended the Saratoga meeting last June must have been impressed with the educational value of such a gathering. The Annual Museum was itself an important education in certain lines, and the papers and discussions in the various sections were of the greatest possible value.—WILLIAM OSLER, M.D., Baltimore, Md., in the *Yale Medical Journal*, April, 1903.

PRACTICE IS POOR.

The Medical Congress recently held at Vienna revealed a sorry, and at the same time anomalous, condition of affairs in the Austrian Empire. Twenty thousand communities, or 86 per cent. of all, are so poor that they cannot afford regular physicians, and 30 per cent. of the dead (in Galicia 75 per cent.) are buried without medical certificate. Yet, while there is much need of doctors, the number of medical students is decreasing at a surprising rate. Of every 1,000 students in the Austrian universities this year, only 132 are in the medical departments. The total number of medical students is only 2,120, as against 5,277 in 1888-89—a decrease of about 60 per cent. in a little over a decade. And the decrease is likely to continue. At the congress referred to, Dr. Wichmann earnestly warned all young men against choosing the profession of medicine; which, he declared, the Government had practically killed by its faulty laws in favor of the laboring man. Other speakers dwelt on the same point. They were not opposed to compulsory insurance against illness as such, but to the manner in which it is managed and to the abuses to which it has given rise, and which call for prompt remedies. From the country communities good physicians have long been excluded, because they cannot be supported there, and now that already one-third of the Viennese are taken from private practice by the *Krankenversicherung* and its underpaid employees, the outlook in the cities becomes hopeless, too. Quackery naturally increases under such circumstances, and the medical man's resources are further cut off by the fact that, thanks to his own hygienic reforms, the number of cases of illness is now little more than one-half of what it was twenty years ago.—*Evening Post*, July 11, 1903.

Compound tincture of lavender is an excellent addition to a solution of ammonium carbonate. Much of the disagreeable taste of the ammonium salt is in this way overcome.

SUITS OF ALLEGED MALPRACTICE AGAINST MEMBERS DEFENDED BY THE STATE ASSOCIATION.

By-laws of The New York State Medical Association.

ARTICLE II, SECTION 7.

The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the Secretary, shall sign a contract renouncing his own and vesting in the Council sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused, but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise.

Book Reviews.

A TEXT-BOOK OF PRACTICAL MEDICINE. By William Gilman Thompson, M.D., Professor of Medicine in the Cornell University Medical College, New York City; Physician to the Presbyterian and Bellevue Hospitals, New York. Second edition. Lea Bros. & Co.

It is about three years since the appearance of the first edition of this work, and considerable revision was necessary in order to bring it up to date. Dr. Thompson has given us, however, a book which is thoroughly up to date in every respect. One review has criticized the author for the following statement found under the subject of pneumonia: "Medicinal treatment has no positive influence upon the course of the disease, * * * and attempts at so-called abortive treatment are delusive." Yet we do not believe that the physiological action of creosote and of the salicylates in this disease has as yet been demonstrated in a thoroughly scientific manner.

The great advances made in the study of dysentery, yellow fever and malaria are set forth clearly and concisely. Much new material has been added to the article upon Diseases of the Digestive System. Throughout the book the author has been most thorough and comprehensive. Of especial value are the pages upon treatment. Few, if any, text-books contain as much information in regard to the care of the patient.

The physician who desires to review those diseases with which he is infrequently brought in contact, or wishes to learn of the latest scientific knowledge in reference to any medical disease, will appreciate this new edition.

The paper and the typographical work are excellent. A thousand pages, however, are too many to be bound into one volume. It makes the book unwieldy and the more easily damaged. The book of such a tome is certain to be broken unless bound in calf.

MODERN MATERIA MEDICA AND THERAPEUTICS. By A. A. Stevens, A.M., M.D., Lecturer on Physical Diagnosis in the University of Pennsylvania; Physician to the

Episcopal Hospital and to St. Agnes' Hospital; Fellow in the College of Physicians of Philadelphia, etc. Third edition. Entirely rewritten. W. B. Saunders & Co.

The two sciences of which this book treats are advancing so rapidly that only the latest editions of such books can be of practical value. Many of the older drugs and their preparations will probably never be replaced, but new indications for their exhibition and new methods of administration are constantly being discovered by the physiologist and the clinician. The newer remedies are being urged so persistently upon the attention of the physician that at times he feels inclined to disregard them all, rather than try and select the worthy ones. Therefore, this work of Dr. Stevens will be welcomed as a guide by the busy practitioner of medicine.

In the former editions the author considered the drugs in their alphabetical order, but in this he has classified them according to their pharmacologic action. This is a step in the right direction. It is the only way to teach the subject.

Materia medica is taken up in the first 500 pages; the balance of the book, about 250 pages, is devoted to applied therapeutics.

The pages are free from the names of proprietary remedies—a fact to which we would call the attention of the profession.

The freedom from unnecessarily long descriptions of the drugs and from merely conjectured physiological actions is a commendable feature. Facts are stated in a terse but attractive way, which does much to impress the memory.

The paper, printing and binding are in every way of a high class. Those who recognize their need of knowledge of materia medica and all those who have drifted into the habit of ordering prescriptions as prepared by wholesale druggists will do well to make the acquaintance of Dr. Stevens' book.

DISEASE OF THE PANCREAS—ITS CAUSE AND NATURE. By Eugene L. Opie, M.D., Associate in Pathology in the Johns Hopkins University; Fellow of the Rockefeller Institute of Medical Research. Philadelphia and London: J. B. Lippincott Company, 1903.

The thirteen chapters of this volume, of some 360 pages, are devoted to the following subjects: The Anatomy of the Pancreas and Its Variations, Anomalies of the Pancreas; Histology of the Pancreas—the Islands of Langerhaus; Varieties of Acute Pancreatitis; The Etiological Relation of Gallstones to Acute Hemorrhagic Pancreatitis, Hemorrhagic and Gangrenous Pancreatitis; Fat Necrosis; The Varieties of Chronic Interstitial Pancreatitis; The Etiology of Chronic Interstitial Pancreatitis; Hyaline Degeneration of the Pancreas; The Pathology of Diabetes Mellitus; The Relation of Diabetes Mellitus to Lesions of the Pancreas; Hæmochromatosis and Bronzed Diabetes; The Symptoms and Treatment of Pancreatic Disease. The text is supplemented with twenty-one illustrations, two of which are colored plates.

The author's description of the topography of the gland is the clearest we have seen. By reviewing the embryological study of the pancreas and then giving the results of his own observations, besides those of Shirmer and others, he offers a lucid explanation of the relations of the ducts of Wirsung, of Santorini and the common bile duct.

Both the surgeon and the physician must have a perfect understanding of the frequent anatomical peculiarities of the pancreas and their physiological significance. Would he diagnose correctly certain pathological conditions?

In the chapter on Etiology of Acute Pancreatitis attention is called to the rôle played by gallstones in this disease.

By referring to the previous chapters—to autopsies and to experiments upon animals—the conversion of the common bile duct and the pancreatic duct into one patulous channel by the impaction of a stone in the

diverticulum of Vater is explained and the resulting pancreatitis from the invasion of bile made plain.

Speaking of the examinations of diseased organs, Dr. Opie says: "No sharp distinction, therefore, can be drawn between hemorrhagic and so-called gangrenous pancreatitis. The lesion begins with necrosis of tissue and hemorrhage takes place into the necrotic area; inflammatory changes soon occur, and should sufficient time elapse those alterations which give to the organ the macroscopic appearance of gangrene ensue."

At the end of Chapter XI the author gives his conclusions. After a summary of the occurrence of glycosuria and diabetes in association with lesions of the nervous system and with diseases of certain ductless glands, he mentions the following facts as being established: In considerably more than half of all cases diabetes is the result of a distinctive lesion of the pancreas; where diabetes is the result of pancreatic disease injury to the islands of Langerhaus is responsible for the disturbance of carbohydrate metabolism. The most common lesions which injure the islands of Langerhaus are chronic interstitial inflammation of the interacinar type and hyaline degeneration. Other lesions of the pancreas do not exhibit a tendency to select these islands, but produce diabetes, because they destroy the interacinar islands along with the secreting parenchyma.

The bibliography is extensive and complete. The entire work is scientific in every detail. No physician can afford to go without the information it contains.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. Being a Yearly Digest of Scientific Progress and Authoritative Opinion in All Branches of Medicine and Surgery, Drawn from Journals, Monographs and Text-books of the Leading American and Foreign Authors and Investigators. Under the general editorial charge of George M. Gould, M.D. W. B. Saunders & Co., publishers.

MEDICINE.—These volumes have become too well known to the profession to need an introduction. No matter how profound a reader he may be, no doctor can possibly keep abreast of the times without the assistance of some such summary of the year's work. The volume on Surgery we recently reviewed in these columns, calling attention to the number of members of The New York State Medical Association who are quoted by the editors. We have equal reason for being proud of the position held by our physicians in the advances made in medicine. This book contains 700 pages. The first 255 pages are taken up by General Medicine. Pediatrics occupies 58 pages; Pathology and Bacteriology, 80 pages; Nervous and Mental Diseases, 60 pages; Cutaneous Diseases and Syphilis, 50 pages; *Materia Medica*, Experimental Therapeutics and Pharmacology, 47 pages; Physiology, 25 pages; Legal Medicine, 30 pages; Public Hygiene and Preventive Medicine, 30 pages, and Physiologic Chemistry, 20 pages.

DISEASES OF THE HEART AND ARTERIAL SYSTEM. By Robert H. Babcock, A.M., M.D., Professor of Clinical Medicine and Diseases of the Chest, College of Physicians and Surgeons (Medical Department of the Illinois State University), Chicago; Attending Physician to Cook County Hospital and Cook County Hospital for Consumptives; Consulting Physician to Mary Thompson Hospital, Hospital of St. Anthony de Padua and of Marion-Sims Sanitarium; Fellow and former President of the American Climatological Association; Member of the American Medical Association, etc. With three colored plates and 139 illustrations. D. Appleton & Co.

This is a volume of 850 pages, prepared for the use of the student and practitioner of medicine. The first few pages are devoted to the anatomy and physiology of the circulating organs. The author states in the preface that he does not go more fully into the normal conditions of these organs, as he believes it would be out of place in a work devoted to diseased conditions.

However, in thirty-six pages Dr. Babcock gives an excellent description of the heart, with its location and

relations, the position of the great vessels and the valves and the normal heart sounds. Especial attention is given by the author to the treatment of the various diseases. We know of no other publication where the minute details are taken up with such care. Writers, and even the lecturers in our colleges, will frequently dismiss the subject of treatment with "Digitalis is indicated in these cases, possibly in combination with strychnine, and the patient should be instructed to take very little exercise." On the other hand, Dr. Babcock devotes three chapters, ninety-two pages, to the Treatment of Valvular Heart Disease. Under the subject of Exercise each form of lesion is taken up separately and the mechanical condition reviewed. Various forms of exercise are then studied, with their effects upon this condition. With such knowledge only is it possible for the physician to intelligently direct the patient with heart disease how he may avoid serious and perhaps fatal complications. In this chapter he takes up, besides Exercise, Occupation, Habits, Marriage, Clothing, Baths, Illnesses, Food, Use of Drugs, Climate, with special reference to High Altitude, and the treatment of the complications.

BOOKS RECEIVED.

A TEXT-BOOK OF SURGERY. For Students and Practitioners. By George Emerson Brewer, A.M., M.D., Lecturer on Clinical Surgery at the College of Physicians and Surgeons, Columbia University, New York; Attending Surgeon to the City Hospital; Junior Surgeon to the Roosevelt Hospital; Consulting Surgeon to the Perth Amboy Hospital; Fellow of the American Surgical Association, of the American Association of Genito-Urinary Surgeons, and of the Society of American Anatomists; Member of the New York Academy of Medicine and of the New York Surgical Society; Membre Correspondent de L'Association Française D'Urologie. Illustrated with 280 engravings in the text and seven plates in colors and monochrome. New York and Philadelphia: Lea Bros. & Co., 1903.

GYNÆCOLOGY. A Text-book for Students and a Guide for Practitioners. By William R. Pryor, M.D., Professor of Gynæcology in the New York Polyclinic Medical School; Attending Gynæcologist New York Polyclinic Hospital; Consulting Gynæcologist St. Vincent's Hospital, New York City Hospital, St. Elizabeth's Hospital. One hundred and sixty-three illustrations in the text. New York and London: D. Appleton & Co., 1903.

INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY. Authors and Subjects. Second Series. Vol. VIII. Insane-Kysthospitalet. Washington Government Printing-office, 1903.

THE MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND CONNECTICUT. Published by the Medical Society of the County of New York, 1903.

TRANSACTIONS OF THE RHODE ISLAND MEDICAL SOCIETY, Volume VI, Part IV, 1902.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and especially prepared original articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology; Rhinology, Laryngology, Hygiene and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U. S. A. With the collaboration of William Osler, M.D., Baltimore; John H. D. Musser, M.D., Philadelphia; James Stewart, M.D., Montreal; John B. Murphy, M.D., Chicago; Thomas M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Vol. II. Thirteenth series, 1903. Philadelphia: J. B. Lippincott Company, 1903.

Original Articles.

OBSERVATIONS ON AN EPIDEMIC OF DYSENTERY.¹

BY FRANK W. SHIPMAN, M.D.,
Mt. Vernon.

THREE or four hundred cases in a community of three thousand, spreading in the course of two months from house to house, until scarcely a home was left that had not seen a manifestation of the disease in a more or less severe type, in nearly all cases causing acute suffering, and frequently removing one or two of a family in as many weeks, with a mortality among cases seen by physicians of about 4 per cent. Such is the history of a disease that does not appear upon the list of contagious and infectious diseases which we report to the Board of Health, causing no very great disturbance in the minds of the community and eliciting no aid and very little interest on the part of the State Board. On the other hand, a single sporadic case of smallpox resulted in the expenditure of several hundred dollars, a few cases of scarlatina caused the schools to be closed, local boards of health have not only maintained bacteriological laboratories for the detection of the Klebs Löffler, but the State has furnished antitoxin free of charge and literature for distribution in abundance.

Such was the condition existing in Tuckahoe, the center of the area affected, in the lower part of Westchester County last summer. I can only find one reason for this difference in the handling of infectious diseases, and the general disturbance of the community.

"What we don't know doesn't worry us." In the case of smallpox, scarlatina or diphtheria we know what we are dealing with, its means of propagation and how to prevent it; on the other hand, with the disease under discussion—viz., dysentery—we know the organisms that cause it—in this instance the Shiga bacillus; we know, however, comparatively little about checking an epidemic, and we know less about the treatment of the disease (unless serum therapy gives better results than drugs).

Briefly, the epidemic was in the valley of the Bronx, extending about eight miles north and south and one mile east and west, with its greatest intensity at Bronxville and Tuckahoe. Its duration was from the middle of June to the middle of September. It is of interest to note how sharply the epidemic was confined to the valley

and the proximal slopes of the east and west ridges. Just beyond these ridges lie to the east the city of New Rochelle and to the west the city of Yonkers, and in neither of these cities was any dysentery noted.

As the detailed description of the epidemic and environs in Tuckahoe have been reported, I have confined my observations largely to the conditions in Mt. Vernon.

The city of Mt. Vernon lies adjacent to and north of the Borough of the Bronx, and about three miles south of the village of Tuckahoe. It has a population of about 25,000, among whom there were probably 250 or 300 cases of dysentery, while there were none in the Borough of the Bronx. Just why the invasion stopped at the New York border line I am at a loss to know. I can find no topographical reason, and the settlement of the upper part of the Borough of the Bronx is continuous with the lower part of the area affected.

The published report of the Tuckahoe epidemic states that the area is thickly populated, unsanitary and inhabited by the lower class. I did not find a similar condition in Mt. Vernon. In the Italian district, the most thickly populated and unsanitary portion, there were very few cases, although I saw one fatal case in an adult, a robust man of about 30 years.

In Mt. Vernon it was no respecter of persons, for, although it was confined in a great measure to a certain section, yet a sufficiently large number of cases occurred in various parts of the city to show that it was not through the intercommunication of any particular class, nor was the area most affected overcrowded, unsanitary or populated by a very poor class. The houses are nearly all detached, containing one or two families, all or nearly all are connected with the sewer and have the city water supply, and, on the whole, the locality is about as sanitary as any part of the surrounding country. However, where uncleanness did occur, there is no doubt it increased the tendency to spread among other members in a family affected.

There is abundant evidence that the outbreak was not due to infected water or milk, for there were five distinct water supplies, besides many wells, and the source of milk supply was as varied.

It is worthy of note that the section most affected in Mt. Vernon was that nearest the Bronx, a small stream, with adjacent marshes, and it is the area in which malaria has been much more prevalent than in other parts of the city. This, in connection with the peculiarly favorable conditions of the weather for the development of mosquitoes and other insects, lends some weight to the theory of propagation by insects. The time of the epidemic was identical with that of the prevalence of flies and mosquitoes, viz., beginning in June, with the greatest intensity dur-

¹Read at the stated meeting of the New York County Medical Association, May 18, 1903.

ing July and August, and declining in September, with only sporadic cases occurring thereafter. That the infection has not entirely disappeared is evident from the fact that occasional cases have occurred during the winter. I have heard of three mild ones within a month, two occurring in one family.

Clinical History.—Prodromal symptoms, when present, were of short duration; occasionally headache and malaise were noted, but more frequently there were no prodromal symptoms, the disease beginning in adults with a chill, rise in temperature to 102 or 103 degrees, and diarrhea. In the mild case the chill seldom occurred, the disease beginning as a summer diarrhea, with a moderate rise of temperature. Vomiting, when present, occurred during the first few days, but only occurred in a small percentage of cases, and more frequently in children. The stools consisted at first of fecal matter, the quantity rapidly diminishing with increased frequency. Usually within twenty-four hours the stools had changed to the characteristic dysentery stool, varying in amount from a dram to an ounce of fecal matter, blood and mucus. At first the blood was of a bright red color, alternating later on with the dark, coffee-ground color seen in typhoid with hemorrhage. With increased frequency of the stools, tenesmus and abdominal pain became marked. The tenesmus was so marked as to present a pitiful picture among children, whose suffering was so great as to make one wish that Christian Science was a reality. The disease was at its height in forty-eight hours, with complete anorexia temperature 101-102 degrees, pulse about 120, prostration pronounced, abdominal pain and tenesmus almost constant, stools consisting almost entirely of mucus, with more or less blood; the skin dry, abdomen retracted and the patient rapidly emaciating, this condition lasting from one to three weeks, varying with the intensity of the disease.

In some of the very severe cases toxic symptoms quickly developed, with a subnormal temperature, coma or low delirium, paralysis of the sphincters and a rapid pulse. The temperature seldom ran high, and frequently the most severe cases had subnormal temperature. One of the worst cases that recovered occurred in a clergyman whose temperature during the entire course of the disease was subnormal.

It appeared in some cases that an existing infection only awaited some exciting influence in the way of disturbing injesta to light up the disease. For instance, a boy had been eating green apples. The characteristic symptoms of dysentery appeared, and after a few days subsided. The boy repeated the indiscretion, and the dysenteric symptoms returned in greater force, and he was quite ill for a couple of weeks. The same condition was noted following the eating of ice cream while the person was overheated.

Pathology.—The pathological lesion consisted of an inflammatory condition of the mucous coat,

with small ulcers more numerous in the colon, giving rise to the more or less severe hemorrhage, in some instances amounting to half a pint, but usually there was only a small quantity. There was less tendency to perforation than in the ulcers of typhoid. I only know of one case, and this was not confirmed by autopsy.

Concerning the relationship between dysentery of this type and summer diarrheas, I have sought information on this point from a number of sources, and so far as I was able to ascertain, there was no evidence of any connection between them. For instance, where a case of unmistakable dysentery occurred, the subsequent cases in the same family were in almost every instance undoubtable dysentery, as evidenced by bloody stools. The register of vital statistics shows for the months of July and August only ten deaths from gastro-enteritis, enteritis and enterocolitis in the city of Mt. Vernon.

Treatment.—Careful attention to the diet. This gave little trouble at first, for there was no desire for food until convalescence began, when hunger frequently became troublesome. Kunnys and beef broth made the best diet, but with increasing appetite patients would sometimes digress, usually to their sorrow.

The most generally followed plan of treatment was a dose of calomel or castor oil, followed by salines, a small quantity of saline used every day to keep bowel flushed out. Constipation was never present, so there was little trouble about flushing. Opium gave very little result. Even when used in large doses it did not control the pain, and only large repeated doses would check the tenesmus.

Probably the greatest amount of relief was afforded by heat applied externally and internally. Hot applications to the abdomen in the form of a hop bag (for the hot-water bag was too heavy) gave some relief. That and the flushing of the bowel with warm water were about the only things that gave any relief. Great objection was usually made to the lavage, even when done with a rubber nozzle, on account of the inflamed and irritable rectum, and in some instances in my own practice, even when done by a trained nurse, it caused so much pain that it had to be discontinued, while, on the other hand, the majority of cases, after a day or two, looked forward to the time for washing the bowel, as it afforded so much relief.

Prostration and emaciation were very pronounced, and stimulation as well as nourishment was needed. Occasionally hypodermoclysis in cases of collapse would restore the circulation.

The usual intestinal antiseptics were used, but I do not believe they did any good; in short, outside of the relief afforded by heat, internally and externally, I think very little was accomplished either in modifying or relieving the disease, so if there is anything in the serum treatment, I believe all who worked through this outbreak will agree with me and be glad to try it, feeling

that at least there is little to be lost, and possibly something gained.

In conclusion, I would call your attention to the following considerations:

First. That though dysentery is a tropical disease, there is sufficient evidence that under favorable conditions it does become epidemic in this climate.

Second. That sporadic cases have occurred here for several years, *without* any very apparent tendency for the disease to become epidemic.

Third. That during the epidemic in question, the means by which the spread of typhoid from one individual to another in the same family could be accomplished almost to a certainty were oftentimes ineffectual.

Fourth. That the almost simultaneous outbreak of the disease over a large area reasonably precludes personal contact as a prime factor in causing the disease to become epidemic.

Fifth. That there were five distinct water supplies besides wells, and the milk supply was as varied.

It seems to me that the issue with us at present is not so much the diagnosis of dysentery, for although in each epidemic there may be certain characteristics differing from another, yet in the main there is no difficulty in the diagnosis, and there is plenty of literature on the subject. We can all make a diagnosis on a case of dysentery, although occasionally mistakes have occurred and intussusception and rectal epithelioma have been called dysentery. But the question is, What are we going to do about it? Some will devote their energies to the discovery of new treatments, but there will be comparatively few who will see cases enough to tell anything about their treatment individually. But it is *time* that we took concerted action tending toward a better knowledge and understanding of the modus operandi by which this infection is spread so rapidly through a community. *Time* that dysentery should be put on a par with other infectious diseases and reported to the public health authorities, and time that *they* gave the same attention to an outbreak of this disease that they would to typhoid. In the recent outbreak of typhoid at Ithaca no pains were spared to find the cause, and the spread of the disease was promptly controlled. But an epidemic of dysentery can and has existed right here on the outskirts of this great metropolis, and no one save a dozen or so physicians practicing in that locality knew anything about it until it was over. Yes, there was a representative of the State Board of Health sent there after two or three appeals from the local authorities, and to this day there has never been one word received by the health officer either of advice, instruction or conclusion. I say this in no sense of criticism of the State Board of Health, but simply to show the present status of dysentery in this State and the necessity of taking measures to ascertain more definitely than we know at present the mode of propagation and the means of checking epidemic dysentery.

THE SURGICAL TREATMENT OF COLITIS.¹

BY C. L. GIBSON, M.D.,
New York City.

ONLY the severer cases—that is, those failing to respond to medical treatment—come under the surgeon's care. Probably surgical aid will be oftener required in the future, if improved methods, devoid of the disagreeable features and dangers attending the present surgical treatment, are employed.

In these severer cases usually involving the entire large intestine, local treatment of the lower bowel is of little or no use.

Heretofore, surgical measures have consisted in the establishment of an artificial anus for side-tracking the contents of the bowel and removing a source of irritation and for washing out or treating the affected bowel. To get the best effects the artificial anus must be a complete one—complete division of the bowel so that no feces may pass into the intestine below. Such an artificial anus has later to be repaired by a dangerous operation, excision and anastomosis of the bowel.

The partial artificial anus, a simple lateral opening, does not give complete relief, and not sufficient to reconcile the patients to their added affliction.

Surgical measures will oftener be employed if a compromise operation which I have devised is resorted to. This consists in making a valvular opening in the cecum, which is intended not to give exit to the feces, but solely to permit of thorough and yet easy treatment of the colon by irrigation. Its technique and other details have already been described in the *Boston Medical and Surgical Journal*, September 25, 1902.

The great advantages of the operation are, that it only requires ten days' after-treatment in bed, the patient does not have to wear a tube or a dressing, and owing to the valve formation there can be no leakage. The closure of the fistula is spontaneous so soon as one discontinues the daily introduction of the tube.

The treatment is extremely simple and, if need be, can be carried out by the patient himself. Several times a day the catheter is passed into the valvular fistula and through and through irrigation with large quantities of solution employed. In addition various medicinal agents, such as weak nitrate of silver solution, may be used.

The results of this treatment have been good; in fact, perhaps fully as good as after colotomy.

Dr. Weir has attempted lately to modify my operation by introducing a tube through the stump of the appendix. Viewed superficially from the standpoint of technique, it certainly seems to simplify an already very simple operation. By omitting, however, the valve formation, it deprives the procedure of its essential advantage, does not allow the patient to go about free from leakage or the annoyance of a tube and dressing and requires further manipulation for its closure.

¹Read before the New York County Medical Association, May 18, 1903.

THE PHYSICIAN'S PERSONAL SIDE.¹

BY M. B. VAN BUSKIRK, M.D.,

Aurora, N. Y.

TO-DAY we come together as members of the medical profession, working together in the same field, meeting the same problems, and gaining the same fresh experience.

The practice of medicine has two sides—a greater or scientific side, and a lesser or personal side.

To-day it is my pleasure to take the physician from his purely personal side. After thirty-eight years of active work in the medical field, it is the personal side which stands out to me as the most vivid picture—a picture filled with all the hues and shades of life's colors. Here, bright colors, warmed with the loyalty and friendship of a valued patient. There, a duller shade, when after days of anxiety and nights spent at the bedside, every effort exerted to relieve, there is no appreciation, and probably unkind words. Again, a glow of brighter hue, when the name of some brother physician comes to our mind's eye—one whom we could always rely upon and turn to when our own strength weakened. Then, the black, threatening effect, when some one whom we trusted turns against us, and by a word or look dishonestly given changed a success into a failure.

All these pictures, to the older man, stand out as preeminent. Disease and its cures have become a part of him—his really second nature. To the young man, it may be his future that I touch upon to-day; to the older man, it will be his life, his memory, his very existence.

I wish to consider the physician as he stands by himself alone, and then in his relation to his brother physicians. The best introductory letters one can have is his own success, founded on individual effort.

First, we should say to the young man: Keep whatever is honest, true, pure and just foremost in your mind, and be governed by it. Professional reputation is a physician's chief capital; ambition to increase this by all legitimate means is not only fair, but commendable. Honest, courteous rivalry between physicians is advantageous to the community, because it compels each to try to be skilful and successful. But how important that this ambition for reputation should be free from professional tricks; but it is hard always to escape misrepresentation, for the evil eye, the wicked heart, the lying tongue, are ever present.

There are two kinds of legitimate reputation—a popular one with the people and a higher one with one's professional brethren. We all hope we have both kinds of reputation; and, while we cannot all attain eminence, we can at least have respectability. We are made in the colleges, but tried in the world. Whether in the mansion of plenty or in the hovel of hunger, every man,

woman and child aids in making us physicians, in fact as well as name, by enriching our experience and shaping public opinion.

Every one of us in the profession is supposed to be a gentleman. Professional morals are an important part of one's medical education; to observe and practice professional etiquette is our first principle. Every physician has his or her successes and failures. With professional honesty as our pilot, we can strive ahead with determination.

To me a medical society seems a great moral good. Here we can cultivate agreeable relations with our professional neighbors and keep old friendships in repair. Organization into brotherhood gives protection, both to the profession and to the individual. Society membership is a guarantee of one's good standing, or, at least, ought to be. The medical society is, in a way, a sort of postgraduate school. Here, mind colliding with mind, and thought with thought, new reflections and deeper reasoning are awakened, and the mind is opened to new ideas. The mutual forces are stimulated and strengthened. The medical horizon of every speaker and listener is broadened, and his views liberalized, and this new impulse leavens the entire profession. The individual and his methods come out. The specialist, the general practitioner, and the scholarly bookworm, all meet—each contributing something, if only a grain here and there. Here we can compare ourselves with our abilities. Rivalries and jealousies can be softened, and friendships be formed and cemented. Medical societies will not necessarily be a specific for personal deficiencies, nor a panacea for every professional sore; spending a few hours now and then among honorable physicians will not purify the backbiting man, nor convert the tricky one, nor create a conscience for him of double ways. There is nothing infallible. We cannot expect too much.

It is a fine thing to be young; the charm of novelty, the delightful illusion which belong to this period make us often look back to it with a sigh of longing for the earlier days. But it is decreed that all illusions must perish. The young need all their illusions, the high hopes, the boundless assurance, the over-running egotism. Otherwise, where would be that elasticity with which they meet the buffets of fate?

There is a type of young man who overestimates himself and underestimates his seniors. Fresh from college, and ours being a progressive science, he may excel with microscope and other scientific aids and technical tests, but long experience has been to the older man a great teacher. He has a clinical acquaintance with disease which gives him almost an intuitive perception as to the disease and its remedies; there are peculiarities which belong to almost every disease about which little can be learned from books; knowledge and skill derived from observation are more like a part of oneself, because they are fixed indelibly

¹Read before the Third District Branch of the New York State Medical Association, at Syracuse, N. Y., June 25, 1903.

on both the senses and the reason, to be brought forth again when needed.

The young man must grow old, and is he willing to acknowledge that the older he grows the less he will know and the less capable he will be to battle with disease? Youth has its advantages. But we ask a greater respect for the older man on the part of the young physician; but let us not envy the young, for, after all, there are no illusions that can equal the joy of a wise, honest and courageous man who has fought a good fight.

The physician's life is like a pantomime, full of changes. Self-reliance and self-possession are all-important elements, but consultation is too often an efficient help, lessening personal responsibility and risk of blame. If it is possible for us to choose, let us strive to select a high-minded, honorable man, with good judgment, and a sense of what is right.

To the honor of our profession, be it said, the vast majority of its older members are not only just, but truly kind, remembering the cares, anxiety and responsibilities of their own early professional struggles.

The advance of scientific observation is constantly teaching us to distinguish more clearly between trifling cases and those of more fatal issue; consequently, there is now less vague and rash prescribing, and not so much heroic treatment in the simpler cases. As members of the regular school, nothing prevents us from giving whatever we believe to be the best for the patient. We do not pledge ourselves to any party, but follow truth wherever she leads the way.

There is, to-day, nothing of any value in any exclusive system or school that is not taught by the teachers of the regular profession; irregulars of every kind know that to exist they must be at war with the regular profession; hence, they style us the "old school," who are the heroes of medical science.

What leaders of thought and action are bearing forward the banner of medical progress, and who make the torch of truth and light shine everywhere? Who are to-day the great authorities, and who hold the most advanced views? None other than the regular physicians. We are like the bee, taking the honey of truth wherever we find it. Ours is the age of quackery—grim quackery—in law, religion and medicine. Medical quackery subsists on credulity and ignorance. What we need are more stringent laws and a uniformity of laws in all our States.

The physician's battle is a personal, ever-day fight to the end. In the course of our professional career we come in contact with humanity in all its aspects and in all its phases; disease and death are parts of the plan of creation; fear of disease and dread of death are parts of human nature experienced by all.

The prince in his palace, the peasant in his cottage, the man with the millions and the man with the hoe, wherever are sickness and suffering

mankind turns to our worldwide guide for relief.

We see all of life's panorama, from the entrance cry of infancy to the parting sighs of old age. We must keep the greatness of this trust and the responsibility of our ennobling profession.

Medicine, by experiment and science, is compelled to march forward; it has no goal; its watchword is progress. This never-ending struggle to enlarge our field of knowledge is our life-blood, our strength, and medicine will go onward as long as sickness and suffering exist.

Let us revere the past, have confidence in the present, and hope for the future of our glorious profession. We may each and all follow our noble path bravely, faithfully and successfully.

FINSEN'S PHOTOTHERAPY IN VARIOLA AND VARIOUS DERMATOSES.*

BY FRANCIS P. KINNICUTT, M.D.,
New York City.

I OWE an apology to the members of the Association in presenting a report which of necessity is almost wholly a résumé of the results obtained by other workers than myself in the field of phototherapy. To Prof. Niels R. Finsen, of Copenhagen, belongs the honor of having first successfully utilized the beneficent action of light in the treatment of various pathological conditions, of having created phototherapy.

In Denmark his researches have been followed with great interest, and in 1896 a public institution, supported by the State, was established "to make and support scientific research concerning the action of light upon living organisms, and especially to apply the results to the service of practical medicine."

The institute contains laboratories and a clinic for the carrying out of phototherapy and particularly for the treatment of lupus and other diseases of the skin by concentrated chemical light.

It would be of interest to consider at length the experimental researches of Professor Finsen upon both the physiological and pathological properties of light, but it will be necessary to confine my report to the deductions which he has reached from his researches and the practical utilization of them.

In 1893¹ Finsen proposed a new treatment of variola based upon observations of the injurious effects of the so-called chemical rays of light upon the skin. It consists in placing the patients in rooms from which the *chemical* rays of the solar spectrum, the blue, the violet and ultra violet, are excluded by the interposition of red glass or thick red cloth.

The results claimed for this method were: The avoidance of the stage of suppuration, the practical termination of the disease coincidentally with the conclusion of the stage of vesication.

*Read before the New York State Medical Association, at the Nineteenth Annual Meeting, October 20-22, 1902.

It will be of interest to quote in full Professor Finsen's directions for the successful carrying out of this method of treatment:

1. "The exclusion of the chemical rays must be absolute. The thickness of the red material employed to filter the light depends upon its nature. If paper or thin cotton material is used, four or five layers will, perhaps, be sufficient. If rather thick flannel is employed, two or three layers will suffice. It is more convenient to employ red glass, but in that case the glass must be very dark. To put it in another way, smallpox patients must be protected from the chemical rays with as much care as the photographer uses for his plates and paper. For artificial light, neither electric light nor any too brilliant illuminant must be used. The globes and lamp-glasses should be of a very dark red. A candle is permissible on account of its feeble illuminating power. It may be used to examine the patient and give light while he is having his meals.

2. "The treatment should be continued without the least interruption until the vesicles have completely dried up. Even a short exposure to daylight may produce suppuration, with its sequels. It is, therefore, absolutely necessary to nail up the curtains, to prevent the patients and nurses from allowing the light to penetrate, for it has been found that these people, tired of being in the semi-darkness, let in the light and so reduce to nought the good results hoped for from the treatment.

3. "The treatment must be begun as soon as possible after the appearance of the rash; the nearer one gets to the suppurative period, the less chance there is of a good result.

4. "It must be understood that death from smallpox will not be prevented by this treatment, especially before the suppurative period.

5. "If the patients are subjected in time to this treatment and if the rules stated above are followed out, suppuration will not occur, as a rule, and the patients will recover without scars or only with almost invisible cicatrices. It is to be noted that during six to eight weeks the skin remains covered with hyperemic or pigmented spots; at the end of this time, however, they finally disappear."

The first trial of Finsen's method of treatment of variola was made at Bergen, in Norway, by Dr. Lindholm,² Chief Physician of the military service, and by Dr. Svendsen.³ Eight patients were treated by red light. Four of them were unvaccinated children, presenting, for the most part, confluent vesicles upon the hands and face. The results are reported by Dr. Svendsen as follows: The period of suppuration did not appear; there was no elevation of temperature and no edema. The patients entered the stage of convalescence immediately after the stage of vesication, which seemed a little prolonged. Scars were avoided.

In January, 1894, Professor Feilberg,⁴ Physician-in-Chief of the Smallpox Hospital in Copenhagen, treated eleven patients in a similar manner

with the following results. "Of the eleven patients, three unvaccinated infants were cases of such severity that a more or less prolonged fever of suppuration was to be expected. In no instance did this develop. In all the patients the vesicles began to dry up from the ninth to the eleventh day of the disease and the patients entered the convalescent stage at once. In every instance the patient left the hospital with pigmented or hyperemic spots, but without loss of substance."

Twenty-three cases were treated by Dr. Abel⁵ in the Smallpox Hospital in Bergen. Eight of the twenty-three cases were of a very severe type. All the cases recovered. Suppuration occurred in only a single instance, in a case in which it had developed before the treatment was instituted on the tenth day of the disease. Dr. Abel remarks in regard to this case "that the favorable effect was immediately visible." . . . "In the course of twenty-four hours the fever diminished and the irritation of the pustules lessened." Dr. Abel concludes from his clinical observations that "in Finsen's method of treatment of variola we possess a therapeutic measure which, if instituted at the onset of the disease and carefully carried out, so modifies its course that suppuration and its consequences may be avoided."

Since 1894 the treatment has been carried out by many physicians in Norway, Sweden and Denmark, both in institutional and in private practice, with results comparing very favorably with those claimed by Finsen.

In a short paper published by Professor Finsen in 1898 he gives a résumé of various communications which had appeared in the interval since his first publication on this new therapeutic method, all of which confirm its very definite effects on the vesicles of smallpox.

Such clinical observations furnish an urgent claim for a careful trial of this method of treatment of the disease in our own country, which, so far as I know, has not, up to the present date, been attempted.

In 1897 Professor Finsen published his first⁶ paper on the treatment of lupus vulgaris by concentrated chemical rays.

Although the powerful bactericidal influence of light had been demonstrated through the researches of Downes, Duclaux, Roux, Geissler, Buchner and others, its employment as a therapeutic agent practically had been neglected. Inasmuch as the bactericidal effect of light is very slow, Finsen found that it was imperative for its therapeutic use to concentrate it by means of mirrors or lenses, and at the same time to exclude the *heat* rays of the spectrum—the ultra red, orange and yellow. These rays, when concentrated, cause combustion of the tissues, and, moreover, the bactericidal action of light is now generally believed to reside in the *chemical* rays; that is, in the blue, the violet and ultra violet rays of the solar spectrum. The ingenious apparatus originally devised by Finsen for a maximum concen-

tration of the chemical rays of light I shall not describe.

It has since been modified by him and by others, and an example of one of its latest modifications I am able to exhibit to the members of the Association.

Lupus vulgaris is a disease which presents conditions peculiarly favorable for the observation of the therapeutic effects of concentrated chemical rays. The disease is caused by the tubercle bacillus. It is a local affection. It is often quite superficial, and light is inimical to the life of the bacillus.

A paper by Dr. Forchhammer,⁷ the chief of the clinic of the Finsen Light Institute in Copenhagen, entitled "The Finsen Treatment and Its Present Position in Dermatology," was read at the Congress of the German Dermatological Society in Breslau in 1901. It contains statistical tables of all the cases of lupus vulgaris and other dermatoses treated at the Finsen Institute from the date of its inauguration. Two tables are given. In the first table the cases are grouped according to the area of the disease. Cases are called "extensive where the lupus patch is more than fifty square centimeters in area, and slight where the affected area is less." In the second table the cases are grouped according to their duration before treatment.

TABLE I.

CASES OF LUPUS VULGARIS TREATED AT THE LIGHT INSTITUTE, COPENHAGEN, TO THE END OF DECEMBER, 1900.

	Slight Cases.	Extensive Cases.	Total.
1 Chief treatment completed	331-83%	125-52%	456-71%
2 Under treatment.	45-11%	72-52%	117-18%
3 Treatment abandoned	25- 6%	42-18%	67-11%
	401	239	640

TABLE II.

THE SAME CASES, CLASSIFIED ACCORDING TO DURATION.

	Less than 10 years.	More than 10 years.	Total.
1 Chief treatment completed	265-78%	191-63%	456-71%
2 Under treatment.	49-15%	68-23%	117-18%
3 Treatment abandoned	25- 7%	42-14%	67-11%
	339	301	640

Of the 456 cases in which treatment had been completed at the end of 1900, 20 were free from recurrence of the disease at the end of one to five years.

Of the 117 cases under treatment, it is stated that there is a prospect of a successful treatment in 42; 53 are cases of great obstinacy and the treatment at the best must be very tedious. In 22 cases there have been recurrences.

Such results in the treatment of lupus vulgaris are very remarkable, especially so when it is recalled that patients suffering from the severest and most extensive forms of the disease in Scandinavia are attracted to the Finsen Institute.

Forty-four cases of lupus erythematosus were treated; 14 were cured, and in 15 improvement was noted. The results were more favorable in the early cases. In 49 cases of alopecia areata, a cure was obtained in 30. Twenty-four cases of rodent ulcer were treated, with a favorable result in 11. Of 25 cases of acne vulgaris which had resisted ordinary therapeutic measures, 13 were cured.

Similar excellent results from the use of concentrated chemical rays in the treatment of a variety of dermatoses have been obtained by other clinicians, notably by Sabouraud (Hôpital St. Louis, Paris), Lortet and Genoud, of Lyons; Peterson and Wiljaminoff, of St. Petersburg; Segueira and Malcolm Morris, of London. Segueira, up to August, 1901, had treated about 200 cases of lupus vulgaris at the London Hospital, with results which compared very favorably with those obtained at the Finsen Institute. I have had the opportunity of studying at the London Hospital, both in the summer of 1901 and again in September of the present year, many of Segueira's cases, and I have been greatly impressed with the success of this method of treatment.

The lamp which I am able to show you is similar to those used in the London Hospital.* It is a French lamp, devised by Lortet and Genoud, slightly modified by Segueira.

The object attained is to enable the electric arc to be used within a short distance of the patient's skin. The effect of bringing the arc close to the skin is to increase the area treated as well as to greatly shorten the time of application. The body of the lantern forms a water jacket, and the lenses through which the light passes to the skin form part of this jacket, being situated in front of the lantern. Cold water is circulated constantly through the jacket and between the lenses, thereby preventing the heat rays from reaching the skin. A jointed support enables the lantern to be set and fixed at any angle, so that the patient can be treated when lying on a couch, sitting in a chair, etc. Awkwardly situated parts of the skin can be treated without placing the patient in an uncomfortable position.

It is readily seen that the lamp can be tilted and fixed in any position. The shield is nickel-plated and can be easily sterilized. It is of open pattern, all parts being easily accessible and in view of the operator. The lamp is hand-controlled, and the current required is about 10 amperes with continuous current, and 16 amperes with alternating current—at about 45 volts in either case.

A criticism of this lamp is that the rays are not concentrated as in the original Finsen lamp, but

*The original Finsen lamp is also used.

the patient is brought close to the light before its rays diverge. It is claimed that the rays do not penetrate to the same degree as when they were brought to a focus, and consequently the action is more superficial.

Malcolm Morris believes that it is efficient in all cases of superficial lupus vulgaris, but where the disease process extends deeper, it cannot be regarded as a reliable substitute for the Finsen lamp.

The lamp which I have had the pleasure of showing you was recently procured by me in London and is now in daily use, under my supervision, in the light department of the Presbyterian Hospital.

The technique of the treatment is very simple.* The area selected for treatment is outlined with an aniline pencil to assist the operator in confining the light exactly to the diseased part; it is also desirable to protect the immediately contiguous healthy skin by a film of photographic paper. The lens is then placed directly in contact with this area, which is rendered exsanguine by pressure of the lens against the skin. The pressure should be firm and maintained throughout the exposure, as the blood prevents the penetration of the rays in a quite remarkable manner.

The length of the single application to a diseased area is fifteen minutes, with a current of 10 amperes. Dr. Segueira has recently increased the length of the application to a half hour and this plan is now adopted at the Presbyterian Hospital.

It is desirable to obtain a local reaction from each application. As a rule, where there is no reaction, comparatively little benefit results. The degree of the reaction with continued applications varies. In many cases the reaction remains the same; in some it becomes more severe, in others less so. The onset of the reaction varies from five to six hours to twenty-four after the light exposure. It is in the form of a more or less circumscribed and superficial inflammation, with or without the formation of blebs and serous crusts. With slight reactions a repetition of the treatment is possible at the end of forty-eight hours; with more pronounced reactions the interval between the exposures is longer. The reactionary effects are treated with a simple dressing of a boric acid solution or with some simple ointment. No constitutional disturbance is ever noted.

In conclusion: The general consensus of opinion among clinicians in Europe and Great Britain, where the light treatment especially has been employed, is that the Finsen treatment of lupus vulgaris gives results not previously attainable:

The question of recurrence after an apparent cure has been effected by this treatment is still sub judice. Recurrence would seem at least to be much rarer than after other methods of treatment, and it may be fairly questioned in such instances

whether the disease was entirely eradicated during the period of treatment.

Admirable results also have been obtained in many cases of lupus erythematosus.

The more superficial forms of rodent ulcer are apparently cured by the light treatment.

In many cases of alopecia areata and of acne vulgaris cures are effected.

The disadvantages of the treatment are the expense of the apparatus and its tediousness.

While occasional cases of lupus vulgaris, especially of the more superficial character, are apparently cured after six to twelve exposures to the light, the duration of the treatment in the severer forms is one of months.

BIBLIOGRAPHY.

1. Finsen, Hospitalstidende, July 5, 1893; also Phototherapy, Finsen, by James H. Segueira, London, 1901.
2. Lindholm, Hospitalstidende, September 6, 1893.
3. Svendsen, Medicinsk Rev., October, 1893.
4. Phototherapy, Segueira, London, 1901.
5. Abel, Medicinsk Rev., August, 1897.
6. Finsen, Traitement du lupus vulgaire par les rayons chimiques concentrés. La Semaine Médicale, December 21, 1897.
7. Résumé by Segueira, Phototherapy, London, 1901.

DISCUSSION.

Dr. William S. Gottheil, of New York, said he had been working a great deal with the Finsen light for two years, and the only criticism he would make of the apparatus exhibited was that it was not sufficiently powerful. Only about 10 amperes of current were employed, and the exposures were necessarily prolonged and the treatment was time-consuming. He personally made use of an apparatus made in this city in which 60 amperes of current were used. Out of the last four cases so treated, three were entirely cured in sessions varying in number from six to fifteen. Lupus vulgaris and tuberculosis cutis were positively curable by this means. It had been proved that a sufficiently intense light from this source would penetrate the entire body, and he had in his possession photographs taken by the light which had passed completely through the body of a stout man.

Dr. Milton Franklin, of New York, said that if the apparatus employed glass in any part through which the rays have to pass, it could be stated at once that the apparatus was inefficient. He had made some experiments, and had found that the only known crystalline transparent substance which would transmit the ultra-violet rays to any extent was rock crystal. Experiments were now in progress with the manufacture of glass which would transmit these rays, but at the present time no such glass was upon the market. Glass as at present made was absolutely impervious to the ultra-violet light.

Dr. L. Duncan Bulkley said that last summer he had gone to Copenhagen to study the effect of the Finsen rays. An enormous number of these cases was being treated there. One morning while there he learned from the nurse that 92 cases had been treated that morning. The re-

*It is necessary to protect the eyes of the patient from the intensity of the light by a bandage of a dark color, and the operator should be protected by smoke-colored spectacles.

sults of this treatment in lupus vulgaris were certainly remarkable. It could not be denied that the treatment was exceedingly slow, some of the patients having had from 300 to 500 sittings of one hour each. Some of these patients had been exhibited two years ago at the Congress in Paris, with the photographs of their condition before treatment. Some of them had been well for two or three years, showing that the treatment was thoroughly efficacious, and he was a thorough believer in this method in appropriate cases. Sometimes it was the practice to give the same patient two or three sittings in one day. It was rare for even the most favorable cases to be cured in twenty sittings. He would say, however, that the treatment at the Finsen Institute comprised many other things besides the Finsen light. After each treatment with the light the patients received applications of various ointments, or sometimes curetting was employed, and the speaker said he did not believe the same results could be obtained from the light treatment alone. Some burning resulted in almost every case, and when it occurred the affected part did not receive further light treatment for about one week. All cases were photographed on beginning the treatment, and from time to time afterward. The treatment had been carried out originally by the use of sunlight, but the electric light had been used for the past two years.

FURTHER OBSERVATIONS OF GENERAL INTEREST REGARDING THE COURSE AND MANAGEMENT OF INCIPIENT SENILE CATARACT.¹

BY J. H. WOODWARD, B.S., M.D.,
New York City.

WITHIN recent years several papers have been published in discussion of the management of immature, or incipient, uncomplicated cataract of the senile type occurring in patients of various ages. Among all the authors, so far as I know, only one has undertaken to ascertain what may be the *natural course* of these opacities in the crystalline lens. All of the others have devoted their attention especially to the treatment, with more or less relevant observations upon the etiology of the condition.

Now, every therapist knows that the first essential to a true conception of the effect of treatment upon any malady is a knowledge of the behavior of that malady when not subjected to any treatment whatever. In other words, the natural course of the disease must be studied.

Four years ago I presented to this Association a study of that character, in reference to senile cataract, and adduced the histories of twenty-four patients having forty-four incipient cataracts, uncomplicated by any local or systemic malady. The cases were culled from a large number of patients having cataracts, all of which had been carefully examined and recorded,

and of which several hundred had been operated upon in the regular way by myself. I was induced to inaugurate the inquiry resulting in that paper by two considerations:

1. I had been surprised to find that many cases of incipient senile cataract had not matured for operation as early as I had expected, or as early as the common opinion of ophthalmologists then maintained should be the fact. Hence, I determined to review my personal experience that might bear upon the subject, and to try to ascertain whether only exceptional cases developed slowly, or whether it was common for senile cataract to develop slowly.

2. Again, the great number of cataract "cures" of every sort and description had naturally attracted my attention. Each variety had placed to its credit a long list of cures, by men whose honesty should not be questioned, to say nothing of the others. A "cure" meaning, so far as I can determine, an improvement in function, not a complete clarification of the lens. Each advocate of his method was just as sure of his results as was every other. There must be some explanation of this heterogeneity of therapeutics, and uniformity of results in a class of cases presenting practically the same pathological conditions, and in the hands of a great variety of men, both honest and competent, and dishonest and incompetent. It occurred to me that the clinical picture of the disease as commonly known might be defective, and that the development of senile cataract to a maturity warranting operative interference might be slow, not in a few exceptional cases that had appeared in literature, but in a majority of instances in which the incipency of the disease had been under observation for a number of years.

The forty-four cataractous eyes described in detail in that communication demonstrated three propositions: 1. That in the natural course of senile cataract there is not always a progressive loss of vision. 2. That without any special cataract "cure," or massage, or electricity, or the instillation of any sort of drug into the eyes, improvement of vision in such cases is often observed; and, 3. That complete cataractous degeneration of the senile type is a process often requiring many years for its consummation.

In those propositions may be found the explanation of the changes that are no doubt seen by all who apply a "cure" for immature cataract. This is not a theory in any sense of the term. It is a statement of fact, which examination of my own case-books and those of other ophthalmologists will, I believe, surely substantiate.

Moreover, he must be a careless observer, or one to whom patients are not wont to return, who has not seen small opacities in the crystalline lens disappear without any further attention than the application of measures for the relief of eye-strain. A large number of cases have been recorded in which mature senile cataracts have disappeared without treatment, and it may be safely

¹Read before the New York State Medical Association, at the Nineteenth Annual Meeting, October 20-22, 1902.

assumed that not more than a small fraction of the total number of such spontaneous cures have been published. Such spontaneous cures of mature senile cataract are comparatively exceptional, of course. But the possibility of their occurrence has been denied in very inflammatory language until very recent times. My own efforts to point out a few ignored facts in the development of senile cataract have been assailed by misrepresentation and ridicule.

There is only one possible fallacy in the argument that is here presented. For, to the cases published by the absorptionists, and to my own published and unpublished cases, one fact is common—namely, the errors of refraction have received attention. It may be that therein lies the secret of the retardation of the development of senile cataract, and it may not. But the contention that the disease is due to any systemic malady, or to malnutrition, which in my former paper I was willing to admit, I am now convinced is not true. Uncomplicated senile cataract, mature and immature, does not develop in consequence of functional or organic disease in any part of the general system. The bulk of clinical evidence is distinctly in favor of this proposition.

Finally, it is unscientific and cruel to deprive an individual of the pleasure of reading and writing because signs of incipient cataract have appeared. It is not harmful to permit the use of eyes in which cataracts are manifestly present, unless such usage be carried to fatigue that is harmful to any eye, sick or well. This proposition, contrary as it may be to established opinion, is unhesitatingly enunciated, for it is based upon an experience sufficient to vouch for its truth. I have for many years permitted my cataract patients to use their eyes a reasonable amount even by artificial light, after each eye-strain has been corrected. Some of them have passed on to maturity of the cataract and an easy operation; others have now been under observation fourteen or fifteen years, enjoying their reading and sewing, and they are likely to go on as happily many years longer.

Viewed in the light of these facts, incipient, uncomplicated senile cataract is not the blight upon life that so many would like to have us believe, and a simple and rational management is capable of securing results equally as good as those that have thus far been attributed to any of the "cures," medicinal or mechanical.

A CASE OF ABSCESS, DIAGNOSED AS ONE OF BRAIN TUMOR.¹

BY HERMON C. GORDINIER, M.D.,
Troy, N. Y.

THE case to which your attention is directed is of interest because of the apparent sudden onset of the convulsions, their strictly localizable character, the entire absence of febrile reaction, save just before death, optic neuritis or other symptoms of cerebral compression, together

with the absence in the history of injury, nasal, middle ear or antrum disease, or suppurating foci, the result of local or general infection. Lastly, the unusual position of the abscess cavity.

The case was diagnosed as one of tumor of the right motor area, lying upon or just beneath the cortex.

J. E. H., age 52, married, farmer by occupation, entered the Samaritan Hospital, February 17, 1900, under the care of Dr. E. D. Ferguson, who asked me to see the case in reference to the possibility of an operation. His father died from rheumatism. His mother is living, but is rheumatic. One brother is living and well. No history of cancer, tuberculosis, insanity or nervous diseases in family. Patient had had the usual diseases of childhood. During the past two years he has had several severe attacks of indigestion. Denies having had any sort of venereal disease.

Present illness began suddenly January 5, 1900, with a severe unilateral convulsion, followed by unconsciousness. The attack began with convulsive movements of the head and eyes toward the left side, then the whole body became convulsed and the patient lost consciousness. The effects of this attack passed away in a short time and none other occurred until January 31, 1900. The patient appeared perfectly well during the interim. On the aforesaid date the second attack began in the same manner as the preceding one. Neither attack was preceded by numbness. The second attack began with convulsive movements of the head and neck to the left. Almost simultaneously the arm and lower facial muscles of the same side were convulsed. This attack was not followed by loss of consciousness. A half hour later a third attack began, identical in character with the second.

February 14, 1900, the fourth attack occurred, but milder than the second or third. Convulsive movements occurred in the muscles of the head, neck, arm and face of the left side; none of these paroxysms was preceded by numbness or other sensory disturbances. After this last attack the patient noticed that the movements of his left arm were awkward and weak. A gradual failure of memory has followed these attacks, particularly for names and dates. He has never had severe headaches, but complains of constant, dull, frontal headaches. Has noticed no loss of vision. Never vomits, bowels constipated. Urinates frequently, especially at night, but has perfect control of the bladder and rectum.

February 17, 1900, status præsens.

Patient moderately well built; height, 5 feet 10 inches; weight, 160 lbs. Musculature flabby, no cyanosis. Respiration, 16. Pulse, 80 and regular, full and of fair tension. Veins over right side of scalp prominent. Movements of eyelids and eyeballs normal. Pupils midwide and react to light and accommodation. No contraction of the visual fields. Vision normal. Optic disks normal. No defect of hearing. Slight facial paralysis of central type, as evidenced by the obliteration

¹Read before the New York State Medical Association, at the Nineteenth Annual Meeting, October 20-22, 1902.

ation of the left naso-labial fold, and dropping of the angle of the mouth on the same side. No rigidity of the neck. Tongue is protruded straight. No atrophy or fibrillary twitching of same. Left arm held in a position of semi-flexion and partially paralyzed. Slight contracture of flexor muscles, which is easily overcome. All movements of left leg normal.

Reflexes.—Triceps tendons reflexes present on left side. No wrist tendon reflex or clonus on that side. Umbilical and epigastric reflex slightly exaggerated on left side. Cremasteric reflex present, but not as active as on right side. Left patellar reflex exaggerated and marked ankle clonus exists. Babinski's phenomenon present. All reflexes normal on right side.

Sensations.—Tactile, painful and temperature sense everywhere normal. Slight impaired muscular sense in fingers of left hand. Patient is able to recognize at once all objects placed in his hand.

Cerebration decidedly slower than normal. When a question is asked, some time elapses before his answer comes. He often errs in names and dates. No aphasic symptoms were present. The patient was right-handed. No difficulty in writing. No unilateral convulsive seizures have occurred since patient has entered the hospital.

Physical examination of internal organs negative. Urine, sp. gr. 1020 and acid. No scars or enlarged lymph glands were detected. No albumen, sugar, pus, blood or casts.

February 22, 1900.—Patient was anesthetized and the right Rolandic area was exposed after the method of Reid. No pulsation of the brain was noticed beneath the opening. The dura was incised and the vessels of the pia were found injected. No tumor was detected. The opening was then enlarged by a rongeur cutting-forceps, more especially forward, but in spite of the large opening, nothing was found save a circumscribed area, which did not pulsate. This area was explored with an aspirating needle, but, meeting no particular resistance, it was concluded that the lesion was subcortical and inoperable. The wound was then closed. No hernia cerebri followed. The following day a careful examination was made, and his condition was the same as before the operation. The optic disks were normal. He complained of no headache after the operation. A few days later it was noticed that the left arm was almost totally paralyzed. No sensory disturbances were present. No special change occurred in his condition after the operation until March 12th. Then he became quite delirious, and lapsed into an unconscious state, from which he died on the following day.

Examination of the Brain.—Postmortem was confined to an examination of the brain. On the right side of the scalp a large horseshoe-shaped cicatrix exists, not perfectly healed, with the drainage opening at its most dependent part. The scalp is firmly adherent to the defect in the bony tables of the skull. Healing is well advanced and no pus was found. The defect in the

skull begins $2\frac{1}{2}$ cm. below the sagittal suture, and measures $4\frac{1}{2} \times 3\frac{1}{2}$ cm.

The crucial incision through the dura is united and no hernia cerebri exists. The brain is normal in size and shape and the membranes are free, save beneath the defect in the skull, where they are intimately blended, and the dura adherent to the edges of the overlying bone defect. There is a slight increase of the subarachnoidean fluid. The right cerebral hemisphere presents a prominence in the region of the central convolutions, especially in their upper half. Over this area exists a local collection of subarachnoidean fluid, confined by delicate adhesions in the meshes of the pia arachnoid. After removal of the pia arachnoid there was found a tumor-like projection which involved the middle third of the anterior central or ascending frontal convolution, and extending forward and upward involved the bases of the superior and middle frontal gyri. This mass produced an evident bulging of the cerebral cortex, arising, probably, from the centrum semiovale, being covered only by a thin shell of cortical tissue a centimeter in thickness. The mass had an elastic feel, as if it contained fluid. It measured 4 cm. in its antero-posterior diameter and $3\frac{1}{2}$ cm. in its vertical diameter.

The exact location of the mass is in the centrum semiovale, just beneath the cortex of the middle third of the ascending frontal gyrus, whence it extends forward and upward across the precentral sulcus, involving the bases of the first and second frontal convolutions, which gyri are pushed forward by it. The ascending frontal convolution is, from below upward, distinctly widened. The cortical portion of the posterior central gyrus is not involved. The fissure of Rolando, in its upper part, is narrowed. The superior portion of the ascending frontal, the paracentral lobule, the marginal portion of the superior frontal gyrus, as well as the outer and median surfaces of the superior parietal convolutions, are normal.

The right hemisphere was sectioned after the method of Pitres and an abscess was discovered surrounded by a distinct capsule 1 cm. in thickness. The abscess is entirely subcortical, and measures in its antero-posterior diameter 5 cm., in its vertical $2\frac{1}{2}$ cm., and at its broadest part $3\frac{1}{4}$ cm. The abscess cavity extends forward into the frontal lobe, involving the centrum ovale just beneath the cortex of the bases of the superior and middle frontal convolutions. It then broadens out beneath the anterior central convolution, where it has its greatest development. The superior wall of the capsule is covered by a thin shell of cortex half a centimeter in thickness. The abscess proceeds backward, diminishing in size and depth, and beneath the cortex of the middle third of the posterior central convolution, it terminates. An area of softening exists in the centrum semiovale at the junction of the ventral portions of the inferior and superior parietal lobules.

The pus in the abscess cavity was thick and

contained much broken-down brain tissue. Cover slips taken from it showed a rod-shaped organism, resembling one of the colon group, and completely decolorized with Gram's method. The identity of this organism could not be determined because the brain was sectioned only after several months of hardening in formol-solution. The surrounding brain tissue showed only inflammatory changes, evidenced by the presence of numerous dilated vessels and with much small round-celled infiltration, especially about the vessel walls. There was no proliferation of the neuroglia elements.

It is to be regretted that, in this case, a complete autopsy could not have been made, as it would doubtless have cleared up the unsolved problem, *i. e.*, the causation of the abscess.

The following conclusions may be drawn from a careful study of this interesting case:

1. First and foremost, the necessity of an exploratory puncture or incision in every apparently inoperable brain case, where the symptoms are strictly localizable, regardless of the supposed pathological lesion.

2. This case confirms the opinion expressed by the author in an article published in the "Albany Medical Annals," of October, 1898, on "The Diagnosis of Lesions of the Centrum Semiovale, with a Report of a Tumor in that Region"; namely, that typical Jacksonian epilepsy may be excited as well by a lesion in the white matter beneath the motor cortex as one upon it.

3. The ataxia of the arm in this case may be explained in two ways: either by the involvement of the sensory fibers in the white matter of the inferior parietal lobule, as both Professors Starr and Von Momakow have observed cases of loss of the muscular sense due to lesions in this area, or by the destruction of a part of the fibers of the fronto-cerebellar tract.

4. It is interesting to note in this case that no disturbance of general sensations, other than ataxia in the arm, was observed, and that the Jacksonian attacks were not preceded by the usual signal symptoms of numbness in the parts convulsed, even though the lesion was located in the white matter of the sensoro-motor area. Why this was so is difficult of explanation. It is possible that the lesion was at first of such a character that the sensory fibers were gradually displaced before being destroyed, allowing the establishment of compensatory channels for the conduction of sensory impulses, owing to the great tangle of sensory fibers in and just beneath the cortex.

5. The paresis of the left arm, which followed the local convulsive seizures, was due both to compression and destruction of the motor fibers of the arm area by the lesion.

6. It is noteworthy that with an abscess of such dimensions as the one observed in this case, at no time did symptoms of compression exist, manifested throughout by the absence of optic neuritis, coma, drowsiness or slow respiration

and pulse rate. While the presence of these symptoms are of great value in the diagnosis of brain tumors or abscesses, their absence does not preclude such a diagnosis. Another interesting fact connected with the clinical course of this case was the almost complete absence of fever until the day before death.

7. This case confirms the value of local convulsive movements in diagnosing focal brain disease. It also confirms the position of the centers for conjugate movements of the head and eyes, as well as those for the movement of the arm. It proves, furthermore, that these local convulsive seizures may be excited as well by a lesion in the white matter just beneath the cortex as one upon it. It proves also that the true motor area, as many experimental physiologists believe, is located ventral to the fissure of Rolando.

DISCUSSION.

Dr. William M. Leszynsky, of New York, thought the reader of the paper was to be congratulated in having obtained an autopsy in this case. The remarkable features had been very well stated, and those who were accustomed to study brain cases knew that one of the greatest difficulties was in making a correct diagnosis of brain abscess when there was no history of a purulent focus in any other part of the body, such as in the nose or ears. He had seen a case some time ago in which the diagnosis had been correctly made, but too late. The case was one of tempero-sphenoidal abscess without a history pointing to a purulent focus in another region. At the autopsy a larger accumulation of pus was found in the pleural cavity, showing that the abscess was either metastatic or secondary in some way. He could not see how the author could have made any other diagnosis in his case, and the only criticism was that it was unfortunate that a further exploration had not been made, as the symptoms pointed to a subcortical lesion or one in the cortex itself.

SUGGESTIONS FAVORING A STANDARD TECHNICS IN OPERATIVE SURGERY.¹

BY EDWARD WALLACE LEE, M.D.,
New York City.

FAIR be it from me to wish to be considered as one opposed to progress or advancement, especially when advancement is a benefit to mankind. I appreciate full well the great strides operative surgery has made in the last twenty years, and what a blessing it has been to suffering humanity. But the thought has occurred to me of the possibility of advancing too rapidly and of the substitution of *new* methods for methods *not yet old*. In the present day there is a strong tendency to accept that which is considered new; to experimentation; to develop new methods without due regard to those already

¹Read at the Nineteenth Annual Meeting of the New York State Medical Association, October 20-22, 1902.

known but as yet undeveloped to their fullest benefits.

Many medical and surgical theories seem quite appropriate at the time of their utterance, but after the searchlight of scientific investigation has been thrown upon them, they find a *still more appropriate place in oblivion*. The scientific surgical profession should be the first to willingly discard a theory of yesterday for a truth of to-day, and when a true principle is once established it should be indelibly impressed on the records and thereafter become a part of them, so that mankind would receive the benefit, and it would not be cast aside by some new theory which might at the time seem more plausible. This constant change from one theory to another, from one practice to another, has a demoralizing effect not only on the profession, but what is worse, on the laity.

If our procedures were based on a technics that was more universally standard, we would not have so many different opinions, or such an amount of adverse criticism when a prominent citizen was under our care, as in the case of the late President McKinley and King Edward. We would know that what was done was the best that could be done. We would not hear the question, Why did they not do this? or, Why did they do it that way?

To show the grand results and everlasting blessings that modern surgery has given mankind one has but to read the very able paper by Joseph D. Bryant, presented to this Association a year ago, in which he called attention to the methods practiced and results obtained to-day in Bellevue Hospital as compared with those of twenty years ago. Twenty-five years ago the art of surgery awoke from a long sleep; the dark curtain of ignorance was lifted, and the glorious light of modern science cast its intelligent rays on possible but as yet undeveloped thoughts to the extent that it has called them into action sufficiently to bring forth what may be termed to-day, The Scientific Art of Modern Surgery.

All this has been accomplished and to-day the world is receiving the benefit, and the names of the men who, by their sacrifice, courage and constant application, made this possible should be engraved on everlasting tablets. I repeat that the art and science of surgery has been accomplished. Not that I do not believe in progress, but I do believe that surgery has developed to such an extent that it is *now time* to review—to go through a process of sifting; to discard much that is taught and much that is written; and to establish a standard technics. I believe we are now at a stage of repair in that old wound caused by ignorant surgery; that we can now permit it to close, and be fairly well satisfied with the result. If we do not look well to that old wound, it will soon be covered with abundant superfluous, superficial and suppurating granulations requiring heroic measures to subdue. The prophylaxis recommended is a *standard technics* in our operative work.

To establish a standard technics in operative surgery will, I know, be a difficult task, for when we have many minds we have many different opinions. You may say that a man has a right to his own technics; that all methods of technics are based on the same principles; that they all aim at the same results; that they accomplish favorable results. This is not a question of who is right or who is wrong, but what is right and what is wrong. It is like saying that all religious doctrines lead to heaven. Religious doctrines are simply matters of faith—surgical doctrines should be matters of scientific demonstration.

If this constant, ceaseless, restless desire to launch something new in the surgical arena continues in the future as it has *continued* in the last few years, we will soon be drowned in our own secretions and surgical literature will become a Babel of confused theories and practices. I think we have, up to the present time, bitten off quite a sufficient bolus of surgical theory and practice to demand our full powers of mastication, digestion and assimilation, and erstwhile a thorough purgation is indicated. I will admit without argument that all that has been said and done in the last twenty years to establish a surgical technics has been of benefit, and without it we would not be in the position we are to-day, namely, to stop for a while promoting new theories and come to a conclusion as to which are the best methods in vogue at the present time.

We must establish a standard, for if we do not, it will not be long before *any* procedure will do for *any* condition. In the last three years I have taken advantage of opportunities to visit a number of the well-known hospitals of the world. I have seen many of the leading surgeons of the world operate, and what has surprised me most are the entirely different methods used to accomplish the same purpose; and I have often been pained by hearing a well-known operator advocating the advantages of his methods and at the same time adversely criticizing the methods of others.

In a conversation lately with Nicholas Senn he stated to me that his recent trip around the world, when he visited all the leading hospitals, demonstrated to him that the science of surgery was suffering for lack of a standard technics. What will be the result if this continues? There will be as many schools of surgery as there are masters, and the high standard of scientific surgical excellence will be destroyed instead of being maintained and promoted. In the last three years I have seen eleven total extirpations of the tongue for carcinoma. The anatomical relations and the pathological conditions in each case differed but slightly one from the other; in each case the patient was operated on by a different surgeon, and in no two could the surgical technics be compared. Such diversity of theory and practice is not scientific; it has a tendency to destroy rather than to maintain scientific principles; at least, it confuses the student and leaves only doubt in

his mind. One has but to hear the experiences of practitioners and students who visit our great medical centers. They confess that they are greatly in doubt as to what to do, for they have heard so many different theories and have seen so many different demonstrations to accomplish the same purpose that they are confused and bewildered. Even in the same hospital and in the same school they are told by one professor to do this, by another to do that, at the same time hearing the first professor's methods criticized adversely. All this leaves in their minds a confused, distorted and uncertain idea of the true principles and methods of scientific surgery. To be told that they must depend on their own judgment is poor consolation, and is often the cause of bad surgery, for their judgment is not always good. Judgment is good or bad according to the knowledge a man possesses. He had better go forth with one principle thoroughly established rather than with confused ideas of a dozen.

In order to arrive at a standard method in our operative work we must establish a more fixed and definite method of reaching a diagnosis. We need more knowledge of pathology and bacteriology; but, at the same time, we should not depend solely upon the pathologist and the bacteriologist; their opinions should be confirmatory. The surgeon is often told that he must not operate until his case has been examined by an expert diagnostician, who is too often a highly "laboratorily" educated gentleman whose sick-bed experience is generally limited to that of inoculated guinea-pigs and rabbits. Develop, as suggested by R. C. Coffey, a psychology of habit in our surgical technics, which would become universal, and standard methods would then be so impressed on our minds that they would become habits fixed and accurate. Too many methods confuse the mind and interfere with the habitual accurate muscular action which is so essential to perfect manual dexterity.

Diagnosis.—In order to establish anything like a standard technics in our operative work it is absolutely necessary that we should have a more definite idea of what we are going to operate for. The nearer we approach an accurate diagnosis the better work will we do. The object of operative surgery is to cure or benefit our patients, not to establish a diagnosis which should be done before the operation is advised.

Because antisepsis and asepsis have made it possible to make exploratory abdominal sections and permit the patients to escape with their lives is no excuse for resorting to this procedure in the reckless and indiscriminate manner in which it has been done in the past. Exploratory abdominal section is often more serious than an operation directed to some known and definite condition. In the latter the work is accomplished in a decided manner; in the former there is unnecessary manipulation of tissues and organs, which often causes serious disturbance. In some cases the procedure often ends by removing the appendix or an innocent ovary in the hope that

the trouble might be due to some reflex disturbance which will be cured by the sacrifice of the often annoying appendages. More attention given to methods directed toward establishing a correct diagnosis will obviate, to a great extent, this unnecessary and unscientific exploratory procedure.

Preparation.—We often read and hear the following: "The patient was prepared for operation, the usual antiseptic and aseptic precautions being observed." If we had a standard technics, this statement would signify much, but as we have none, it goes for naught. All sorts of poisons and chemicals are used as antiseptics, and all sorts of procedures are resorted to for the purpose of establishing an aseptic condition. There should, therefore, be a universal standard procedure in the preparation of surgeon, nurse and patient. This would be not only scientific, but immeasurably beneficial to all concerned. Our nurses have been taught so many different methods that they are in a state of confusion and embarrassment every time they are called upon by a surgeon whose methods are unfamiliar to them. It is unnecessary, in fact time would not permit, going into detail of half the methods in vogue at the present time which are used to accomplish asepsis and maintain antisepsis. One has but to visit the various surgical amphitheatres throughout the country to be impressed with the diversity of opinion regarding these simple matters of technics. The question of materials to be used, such as sutures, sponges, drainage, ligature, dressings, etc., is in a chaos of confusion. One surgeon damns that which another praises. It is far from being amusing; it is sad and discouraging to hear one professor extol the wonderful merits of a certain kind of suture in his hernia operation and the next hour hear his colleague condemn the same material as useless and possibly harmful. One surgeon states that certain dusting powders are essential to the protection and healing of wounds; another, as high in authority, condemns those same powders, saying that they act as foreign bodies, prevent union and are only a nursery for pathogenic bacteria.

There are too many methods used to accomplish asepsis; too many methods advocated to maintain antisepsis. If what is true in Smith's clinic, the same should be true in Brown's clinic. By visiting a dozen different clinics one will obtain a dozen different ideas widely differing as to how the same result should be accomplished. We are told by one surgeon that, in order to sterilize our hands and the region for operation, we must use green soap, corn meal and mustard; another tells us to use green soap, potassium and soda; another, permanganate of potassium and oxalic acid; another, only green soap and a 1 to 1,000 bichloride of mercury solution. By another we are told that the skin cannot be sterilized and that we must protect the patient's tissues by wearing sterilized gloves. I once asked an eminent German surgeon if he wore

gloves. "Yes," he answered, "when I go to church." Another surgeon will say that the only way to sterilize the external tissues is by the use of carbolic acid and alcohol. Then we hear that carbolic acid is an irritating poison and should never be used. We hear of many indications for the use of iodoform and next we hear that it is absolutely inert as an antiseptic.

Actual Operations.—I am fully aware that experimentation and the introduction of new methods are necessary in order to arrive at anything like perfection in any certain line, but at the same time I am convinced that perfection will not be attained if new methods are being constantly brought forth before older ones are more fully developed. Of course, every surgeon has a right to his own technics, and it is perfectly proper that he should introduce his method of doing this or that operation. But I do not believe that so many new methods would be introduced if we studied more carefully those already in vogue.

Surgeons are ambitious and aggressive, and it pleases them greatly to know that they have placed a procedure on record which is considered to be *par excellence*, named after them, and is looked upon as a standard procedure by their *confrères*. But if these new methods are maintained with the rapidity that they have obtained in the recent past, every surgeon will be his own authority—follow his own technics. This is, of course, all very grand, but it is not scientific, nor is it to the best interests of the profession or of their clientèle. Surgery is too important a science to have too many leaders. We should be content to follow masters. Often a man, through politics, favoritism or some scheme, obtains possession of some institution where he has unlimited surgical material at his disposal, and instead of following the established technics of some master, begins to introduce new methods and new operations, when in reality he is not acquainted with those already in vogue. The result of all this is that many new volumes containing surgical theories are brought before the medical profession, and have the effect of influencing others, often, I am sorry to say, in the wrong direction.

It is not necessary that we should have so many opinions, theories and practices regarding the materials and procedures to be used in the treatment of wounds, such as dry dressings, wet dressings, sterilizing, antiseptics, etc. If our technics was more uniform we would have specific indications which could be scientifically met; as it is now, personal preference is the only guide. The same applies to suture and ligature material. Linen, silk, plain catgut, silverized catgut, silkworm gut, silver wire, kangaroo tendon, horsehair and squirrel tails all have their advocates, and in advocating their own special stuff they denounce that which some one else believes to be the only thing.

The question of drainage is to-day a much-disputed one. How, when and where to drain is

not yet definitely settled. Joseph Price, in a recent article, stated that many otherwise good surgeons were ignorant on the subject of drainage. This should not be, and it would not be if we had a standard technics and more specific indications. A great deal of bad surgery is being done because the men doing it are under the belief that they are doing first-class, scientific work. They evolve theories, carry them into practice, and because they are fairly successful are lulled into the belief that their work is all that could be desired.

In the healing of wounds the result largely depends on the technics used. The simpler the technics, the shorter the time, and a minimum amount of manipulation of the tissues are all important factors which favor good results. Simplicity of technics, adequate to the demands of the condition, shortens the time in an operation, and time is a great factor, for the amount of shock diminishes in proportion to the time consumed. Generally speaking, the shorter the time, the less shock. There is a limitation to human endurance and, although anesthetics have made it possible to continue our operative work indefinitely, so far as suffering is concerned, the fact that the patient is not suffering immediate pain is no indication that his physical economy is not undergoing a severe strain. Too much advantage should not be taken of the benefits of anesthetics. Well-formulated, definite rules governing our procedures in each individual case will do much to promote better results. I believe we have too many different operations for the relief of the same conditions. It is all right to say that each case must be treated on its own merits, but I do not believe that pathological anomalies exist to such an extent as to demand so many different procedures.

Time will not permit going into the details of the various methods in vogue for certain familiar operations; a few will illustrate my idea. In amputations we have too many methods of technics; in appendectomy we should have a more standard operation. True, various methods may be similar, but I believe there can be a "best of all," and that is the one we *all* should use.

One can scarcely pick up a medical journal that he does not see described a new method of intestinal anastomosis, either by some new mechanical button, bobbin or clamp, or some new complicated suture. Intestinal surgery I believe to be the most important of any with which we have to deal, and the rules governing it should be simple and thoroughly established. Constant modification, never-ending introduction of new methods retard scientific work and embarrass the usefulness of surgery. If I did not believe that we had efficient methods at our command, I would then be in favor of the introduction and use of new ones; but in the last twenty years surgery has developed methods that I believe are equal to our demands, and for the present we

should be content to perfect that which we now have.

There is something lacking somewhere when we hear a surgeon, high in authority, condemn what is supposed to be a standard operation. As, for instance, when I hear a surgeon condemn Bigelow's litholapaxy as being unscientific, unsafe and not surgical. We hear men condemning the Bottini operation, and we have more different methods advocated for prostatectomy than we have pathological conditions which indicate the operation. Hemorrhoids, a pathological condition as old as man, have as many different methods devised for their cure as there are specialists in that department of surgery. The technics governing herniotomy is in a chaos of confusion, and it would take a volume to describe the various methods employed in the treatment of hernia. Watch a dozen surgeons anchor a floating kidney, and you will see a dozen different methods pursued. Perineorrhaphy has been modified to such an extent that no two men operate alike. And so we could go through the whole list of ordinary surgical operations and observe the same diversity of practice.

This, of course, shows the individuality of the operator, but I maintain that it is not scientific, that it is not in the best interest of the profession or of their clientèle. We must be content to have fewer masters and more followers. I would not presume to tell you what I consider to be the best methods in our operative work, but I would suggest a surgical congress made up of men who are considered authorities and have them take up in detail the various methods and operations; discuss them freely; sift the wheat from the chaff; establish certain rules about which there could be no question, and arrive at a unanimity of thought regarding details.

After all, it is attention to details that goes to maintain the truth and efficiency of a principle, and by following some such course we might be able to establish a scientific "*standard technics in our operative work.*"

DISCUSSION.

Dr. A. J. Ochsner, of Chicago, thought we were all tending in the direction spoken of in the paper. There was a little principle in surgery which was appreciated by almost all surgeons, and which was at the foundation of a tendency toward perfect operations. Almost every surgeon had found that all of the original things which amounted to anything had been simultaneously discovered by a great many men working in the same field. The little principle referred to was that all of the useless things done at surgical operations must be at the same time harmless. If a surgeon had a foolish idea with regard to some particular operation, and it was harmful, it would certainly be eliminated; whereas if it were harmless it would be allowed to go on. This would eventually result in far greater uniformity in surgical technique.

Dr. William J. Mayo, of Rochester, Minn., said that he did not feel as did the author of the paper, perhaps because he was not so well satisfied with his own technique. He was glad to see the young fellows do things in a different and perhaps better way. One could take his choice between several lines of railroad between the East and the West, and it would be unfortunate to have some commission declare that a certain line of railroad alone must be patronized. So with the question of having a standard surgical technique. He did not think this was required. We were all pretty well agreed upon the treatment of malaria. Why? Because it was reasonably satisfactory. On the other hand, our journals were filled with various methods of treating eczema, because the treatment of that affection was not satisfactory in a large class of cases. He was sorry he could not feel as Dr. Lee did that he had reached the point where he could not improve, and was in the position of Confucius, but he could not, and he looked forward with pleasure to constant improvement.

Dr. J. J. Walsh said that medical history was simply full of the effort of the older men to establish a standard against which the younger men should do nothing. Once upon a time when Harvey discovered the circulation of the blood, the greatest living professor of physiology at that time, and the one who had taught Harvey said that Harvey might hear the heart beat in London, but they could not hear it in Bologna. This was because the professor in that place had never tried it. About twenty-five years before Lister introduced his great innovation in surgery it was declared by an eminent surgical authority of that time that surgery had reached a state of perfection. It would be nice to have a standard, but art is long and time is fleeting, especially for this generation. Medicine is not a science, but an art, and we must, therefore, allow the pendulum to swing a little here and there. Only lately we had found, for instance, that laparotomies for tuberculous peritonitis do, perhaps, no good at all, yet it took twenty or more years to discover this. Thirty years ago a surgeon in Pennsylvania opened a pelvic abscess through the vagina, and this is what is being done at the present time, yet it had taken many years of operating through the abdomen to discover this fact.

Dr. Lee said he did not wish to be understood as being satisfied with any technique; he was perfectly willing to see true advancement made. The object of the paper was to show the folly of one teacher insisting that his method was perfect, while his colleague just as vigorously condemned the plan. He had heard this thing right here in the city of New York. One professor would extol the advantages of his method, and an hour later his *confrère* would condemn these methods, not knowing what had been said by the other surgeon a short time before. The students hearing these different views go away with their minds full of confusion. Men who only do

surgical work occasionally should have fixed ideas as to what should be done when they encounter a strangulated hernia or some other emergency demanding their best surgical care. If they turned to the medical journals for help they would only be still more confused by the numerous opinions expressed.

THE THERAPEUTICS OF CONVERSATION.¹

BY J. L. GREELEY, M.D.,
Jamestown, N. Y.

THE Century Dictionary, in defining therapeutics, states: "It includes not only the administration of medicines properly so-called, but also the application of other non-medicinal influences to the preservation or recovery of health." If this definition may be assumed to include influences which work indirectly as well as those which work directly, and upon the community as well as upon the individual, the title of this paper may not be altogether a misnomer. The problem is this: What is the value of the physician's talk with the patient and with the public? Should he talk at all, and, if so, to what end? Is it possible that there is any field lying in this direction which he does not always fully occupy?

At the outset I will grant freely that the dangers are more frequent and grave on the side of a multiplication of words. If I had been twenty years longer in practice I should probably not be writing any such paper as this; I should have learned to be wise and say nothing—it is safer so, and one is never misquoted. But before I have solved the problems of the earlier years of practice, before I have gone too far from days as a patient to forget that point of view and the attitude of the unprofessional mind in general, I venture to bring up the subject of the doctor's conversation. You who know well through long years of experience how truly the doctor must be first and foremost a man of deeds rather than of words will yet take it not amiss to be reminded of the way in which the community stores up your words, while those of us who are never to the work may with some profit consider responsibility in this line as well as in the use of drugs and instruments.

I do not propose to dwell upon the most obvious application of the remedial power of words. To say that the speech of the physician should always increase the courage of the patient, even if only by helping him to look to a better to-morrow out of a serious to-day, or, if it must be, to face quietly and bravely a condition which must inevitably grow worse—this is to state a principle old as the fathers of medicine, and one which is daily, hourly observed. If there are ever lapses from it I am inclined to think they are only from sheer weariness or worn-out patience with some tiresome case, rather than from a light estimate of the value of this adjuvant. However, freely as that value is admitted, our Christian Science friends and other quacks daily show the extent

beyond our common practical recognition to which this force can carry the body in recovery from disease—even real disease. 'Isms and 'pathies are folly, yet every one of them that has swayed the populace has done so by reason of some element of genuine power covered over with fantastic trappings, and to discern the legitimate under the sham is the part of the scientific student of human nature. Progressive medicine has been wise enough to take to itself from time to time the kernel of truth in many an extreme of folly or one-sided enthusiasm, and to test and weigh and adapt forces new to it at least in their emphasis. Is it any less strictly scientific to believe that pills work better plus courage—that there is a real and genuine degree of change in circulation, for instance, due to that courage—than to believe, as we must, that the sight or mention of a favorite dish causes an increase in the flow of saliva, and that a fit of anger has been known to cause jaundice? We admit the scientific fact, but are slow to consider seriously the practical application of it, a little too ready to abandon that whole territory to quacks, a little inclined to talk about the patient's mental attitude as if it were something impossible to reduce to a cold scientific basis.

However, it is rather the question of the patient's enlightenment which interests me at this time. In the interest of recovery of health or preservation of health, individual or general, how much ought to be said to him about his present condition, his tendencies, his treatment, the principles of medicine in general, the welfare of the community, the relation of the doctor to the public—of the public to the doctor? More, I contend, than is sometimes said; though I grant freely that no definite answer can be given, that each doctor must judge each case and each set of circumstances by itself. No two patients are alike. To some, the less said, beyond orders, the better—a whole life through. But people have the right to expect from the doctor, professionally, something besides wise medication and skilful handling, great as these services are. Preventive medicine has a right to expect more of him. A dumb doctor would not be a perfect workman.

As to the patient's knowledge of his present condition, although more information is often demanded of a doctor during acute sickness, undoubtedly less should often be given than at other times and places. I am not now speaking of the honest admitting of serious facts, but rather of the explaining of conditions. Certainly the patient should not be given the main burden of his case to carry. However intelligent he may become, however generously stocked with medical information after a few more decades like the past of general diffusion of it through press and platform, he will never cease to come when he is sick to the doctor, virtually saying: "Here, you know more than I do about these things—take care of me!" A sick man does not want to know all his doctor's thoughts nor all his problems, nor to be reminded too forcibly just then of his limitations

¹Read at the meeting of the Chautauqua County Medical Association, May 19, 1903.

and those of medical science in general. He wants to have a suggestion of the old feeling that somehow the doctor is in touch with occult powers. But he should, after one experience with sickness, be a little wiser to escape a second time; a little better prepared to keep the physical machinery in good running order for long service; a little more sensible with regard to the need of his cooperation in remedial measures instituted for him; a little more intelligent in regard to the doctor's life and work; and, above all, a little nearer to that famous state of knowledge which knows that it does *not* know. It is not necessary to gratify his curiosity as to what chemical formulas he may be taking—he would be only less wise, in most cases, if he knew—but he may with profit many times enter into the general plan of the doctor for him, and understand intelligently along what lines the fight must be carried on, so that he may at least refrain from aiding the enemy, and with some effective enthusiasm take his share in bringing the campaign to a victorious close. The doctor is no longer the magician of the Dark Ages, who kept his power by virtue of the mystery with which he worked. Traces of the old feeling survive in patient and in practitioner, but only traces, at least among the educated classes. The patient of to-day expects no incantations and no magic spell, though it must be confessed he often expects little short of miraculous results. He can enter into causes and processes to a degree, and should be made to do so in many cases.

Docco—doctus—doctor. I like the old derivation—the man who teaches, explains, shows how. Is there any one who needs to do more of it, or who has more compelling opportunity? Is it not possible that *physicus* sometimes puts him altogether in the background? To teach men how to be their best physical selves and to do their best work, how to avoid the nearby pitfalls, how to raise the standards of the race, how to diminish the sweep of scourges, how to combat the great causes of public ill-health—who shall do these things if *doctores*, the teachers, do not talk? Not necessarily publicly, but in daily, commonplace conversation.

Take, for example, the abominable habit of consumption of patent medicines. Who will explain, if the doctor does not, the folly of attempting to fit an unknown remedy to an unknown disease, the danger of trusting to compounds which at once relieve conditions which in the nature of things can only be righted slowly, the stupidity of imagining that one coat could fit all shoulders? Of course, people ought to know these things without being told, but equally of course, they do not; and grown people, as well as children, I find, are usually more amenable to explanation than to fault-finding without it. Of course, patients will believe that all our talk against nostrums and quacks is founded on self-interest. So be it, if only they see the sense of it. It is not enough to smile at the throngs that shovel over silver dollars by the peck to the Boy

Phenomenon—not enough even to see that the strong arm of the law comes down upon him and his like in their triumphal march. We have a certain share of responsibility in the education of the public which he gulls.

Especially do I believe that the doctor should aim to increase general knowledge of real advances made from time to time in medical science. By a willingly accepted code of ethics he carefully refrains from self-advertisement, direct or indirect, but occasionally it would seem that his modesty carried him rather too far, and forbade him to show any pride in his profession, or, I may add, in his professional brethren. Take it from the side of the patient simply: Is it not true that whatever raises the general estimate of the profession, or of any individual member of it, tends to make the work of every doctor with every patient more satisfactory and effectual? Does not the patient come into more effective cooperation with a member of a profession which he heartily admires and defers to for what it is accomplishing as a whole and in individual instances? How can we expect people to have an intelligent trust in the methods of scientific medicine if they know nothing about them—nothing of the patient adding of fact to fact in long, elaborate investigation, the working out of probabilities into certainties, the marvelous gleams of light that flash out now and then in fields yet almost unknown? As they read, it is all one to some of them—the newspaper item of the mosquito as a germ carrier, and the carefully worded announcement that Mugg's Microbe Killer will exterminate all germs. Who is to help straighten things out? Might we not be pardoned a little more conversation about the conquests of genuine medical science, a little more enthusiasm over what our brethren have accomplished and are daily accomplishing? I venture to add, even a little more cordial word of admiration for those near by, as well as for those far off and conspicuous? What is the gain to the patient, the profession, or, even in the long run, to the doctor concerned, of endeavoring to give the impression that no one is quite so discerning or quite so wise as the speaker? Too many people already have the idea that there is no solid body of accepted facts in medicine, that there is no common foundation of principles, that everything is a matter of opinion, and that it is a rare exception when one doctor honestly thinks that another knows anything, even though he has to agree with him if he is called in council. I submit that this mistaken impression is to be remedied largely by doctors themselves, and that, not by maintaining a discreet silence when the work of others comes up in conversation, or by very evidently refraining from criticism. Why not emphasize a little more the common ground in diagnosis and treatment? Why not give hearty credit for what has been accomplished? And even if different treatment appears to be demanded, would it not often be possible to dwell more on changed conditions or to indicate some of the difficulties in the way

of reaching a satisfactory diagnosis earlier? Patients cannot always be kept from commenting on previous medical care, but the conversation can be made to right many a mistaken notion perhaps long and bitterly cherished. It is not by way of apology—that is not called for—but simply clearing away misconceptions or giving credit where it is plainly due. For instance, take the matter of cervical lacerations in labor. Repeatedly I have heard patients speak of learning through a second physician of the existence of these, and inferring that they were due to neglect of the attendant at the time of labor, as if he could have prevented them or wisely remedied them at the time. Is it not better to be sure that our statements leave no impression of blame as regards former treatment? To comment with approval upon another's skilful management if opportunity offers? Selfishly it helps to make patients more considerate in their judgment of ourselves later, and certainly it adds weight to medical opinion as a whole to emphasize unity of knowledge. And what if it makes no special difference for us with any given case—is it only Cicero's farmer who plants trees for another generation to enjoy?

I am not advocating the general discussion of personalities in conversation with patients. The doctor is above all things never a gossip. But half the ill-will in the world grows out of a failure to understand another's point of view, and no one runs across more ill-founded judgments of physicians than we do, or can more easily correct some of them. Certainly we are too wise to let our personal views be based upon reported statements of another physician. Who that has ever met on its rounds, in all its curious and exasperating transformations, a remark of his own to a patient can ever form his opinion of a brother physician by any such criterion? More than once have I writhed inwardly and vowed that in future I would dispense pills and unbroken silence. But patients and their friends have a right to information and attempted explanation, even if they sometimes murder it.

As to talk not *to* patients, but *about* them—there is no difference of opinion here. And yet I remember well a few years ago an otherwise successful doctor who had a habit of telling one-half a story of some patient at one visit, and, forgetting that he had done so, telling the other half later, so that almost without choice the listener pieced together many a bit of gossip that the individuals concerned would have been loath to give to the public. I thought I learned my lesson then; I hope I shall not forget it. It always grinds me a little to be asked to regard a patient's coming to me or talk with me as confidential, but the general run of people do not seem quite to understand even yet that that is something that goes without saying. Would it do any harm if our reply educated them a little as to the regular observance of this detail? Certainly they need education in the matter of inquiring about others. It seems to me that now and then a word of explanation in regard to this matter is not amiss,

though many times there is no fit place for it, or for anything but white lies over which the Recording Angel does *not* weep, or abrupt refusals to talk. Now and then I am sure there is good soil for the statement that what a patient chooses to say he may say for himself; the doctor is not the source of information regarding him.

There is a real and pressing need of a better educated public in one special detail of which I wish to speak, and that is in the matter of demanding immediate diagnosis. With what gratitude to a predecessor does one begin to treat a patient whose family say, "Doubtless you cannot tell us for a day or two just what we are to expect"! *Rara avis*—rare almost as a white blackbird! But we can labor to increase their number. Take, for instance, the very present matter of smallpox. Imagine for a moment that ideal community in which people are willing to be watched for a day or two, with judgment suspended; or that still more heavenly frame of mind in which they would in any acute sickness keep away from others, on general principles, till they were better or knew what ailed them! Is it quite impossible to train mothers of families to separate a sick child from others in the early days of its illness, both for its own sake and theirs? Why not, when a slighting remark is made about slowness of diagnosis or mistaken diagnosis, take a moment to explain some very natural reason why? Who knows how soon one may himself profit by the greater intelligence?

Ought the physician to talk to the general public through the daily paper, the magazine, or on the platform? I hardly know. Certainly not much or often. Even if he felt inclined, he is usually too hard-pressed with daily work. And yet the physician is a citizen possessed of special knowledge, and therefore of special responsibility, in many matters that concern the public. His work tends to a certain kind of isolation; he is necessarily shut out from much of the daily current of life, and sometimes almost too easily he lets public affairs take their course. Recently, however, there are signs of a general arousing to a different stand with reference to public affairs, and of a stronger tendency to identify the medical profession with forces working toward great civic and national ends—a tendency shown plainly in the movement toward securing representation in the Cabinet at Washington. Can any one deny that such a share in public affairs is wholly right and fitting? The whole duty of the medical profession is not done unless it *talks*, collectively and individually, and talks to some purpose.

Briefly to sum up: The words of the physician are remedial agents not to be despised nor carelessly handled; they give force to nature herself; they render the patient a powerful collaborer; they add influence to the profession, individually and collectively; they dignify in the thought of the people the agent, the means, the art, of preserving health; they further the advance of truth in the home, the community and the nation.

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Byron C. Cheeseman.
Secretary and Treasurer—Florence J. Sherman.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Committee on Legislation—E. D. Ferguson, chairman; William F. Finner, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberco.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Committee on Legislation—Henry D. Didama, Charles Walsli, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank J. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutter.

SENECA COUNTY MEDICAL ASSOCIATION.

President—William Austin Macy.
Vice-President—George O. Bellows.
Secretary—J. Spencer Purdy.
Treasurer—Carroll B. Bacon.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Howard L. Hulett.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davs.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Albert E. Woehnert.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stockschlaeder, James C. Davis.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer
Vice-President—William O. Huggins.
Secretary—Alva Le Roy Chapin.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Connor, Middletown.
Secretary—Ernest Valentine Hubbard, 114 West 70th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.

Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.

Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.

Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.

Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.

Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.

Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.

Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.

Secretary—Ogden C. Ludlow, 234 West 135th street, New York.

Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.

Treasurer—Charles Ellery Denison, 68 West 71st street.

Executive Committee—Frederick Holme Wiggan (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).

Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.

Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.

Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

Treasurer—Frank Guillemont.

Executive Committee—F. J. Baker, E. E. Campbell.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.

First Vice-President—John H. Taylor.

Second Vice-President—Charles E. Fairman.

Secretary and Treasurer—Henry A. Maynard.

STEUBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.

Vice-President—Frank H. Kogle.

Secretary and Treasurer—Charles R. Phillips.

Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.

Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.

Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.

Vice-President—M. Alice Brownell, Newark.

Secretary—George S. Allen, Clyde.

Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.

Vice-President—Lyman C. Broughton.

Secretary and Treasurer—L. Hayden Humphrey.

Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.

Vice-President—William E. Douglas.

Secretary and Treasurer—Charles I. Redfield.

Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.

Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulet.

Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.

Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.

Vice-President—George A. Leitner.

Secretary and Treasurer—Norman B. Bayley.

Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.

Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.

First Vice-President—Sherman D. Maynard.

Second Vice-President—Oscar N. Meyer.

Secretary—Howard P. Deady.

Treasurer—Charles W. Piper.

Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.

Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.

Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoevenberg.

Vice-President—George S. LaMoree.

Secretary—Mary Gage-Day.

Treasurer—Alice Divine.

Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.

Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.

Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.

Vice-President—William D. Granger.

Secretary and Treasurer—Donald T. McPhail.

Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.

Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.

Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.

Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York.
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 9.

SEPTEMBER, 1903.

\$1.00 PER ANNUM.

THE NEW YORK STATE MEDICAL ASSOCIATION.

When referring to the manifold advantages of membership in The New York State Medical Association, attention should be called to the following facts:

That The New York State Medical Association does not exist as an entity, but is composed of the united County and District Branch Associations. That membership in a regularly chartered County or District Branch Association carries with it membership in the State Association.

That The New York State Medical Association is the legal representative and only affiliated branch in New York State of the American Medical Association.

That it is only through membership in The New York State Medical Association that physicians residing in New York State can become members of the American Medical Association.

POST-GRADUATE INSTRUCTION.

Every physician in active practice of eight or ten years feels the necessity of freshening up his ideas by a short course of study. Often this is preliminary to his taking up some special line of work. Up to twenty years ago it was customary to go to Paris for this instruction. In later years the bulk of those going abroad have made Vienna or Berlin their objective point, and to-day there are more than a hundred American physicians in each of those cities doing post-graduate work. Scattered over Europe will be found at least 300 others busy at work. The question naturally arises, Have we not post-graduate medical schools here in this country competent to teach these men as well, if not better, than is done abroad?

Why should men go to the expense of a voyage of 4,000 or 5,000 miles; why should they

strive to listen to a lecture, the language of which they but half understand, even after weeks and months of residence abroad; why should they sacrifice time and comfort if they can get the same thing here? It is high time that we should determine these reasons and adapt and improve on European methods in this matter. The city medical societies supply a vast amount of post-graduate instruction of a superior kind, but they are not properly appreciated. Perhaps in the future they may successfully solve the problem of post-graduate instruction.

The following letter was sent in answer to a communication recently received at the business office of The New York State Medical Association:

—, Aug. 4, 1903.

Dear Doctor—My attention has been called to the statement which you recently made to the business office of the Association that "Dr. — has paid his dues in the County, and says that he is going to drop his State membership and retain that of the County." This is under our plan of organization impossible, as the State Association is simply composed of the members of the County and District Branch Associations, and is made up of the delegates of the component County organizations who meet at the annual meeting and vote upon the dues, by-laws, etc., of the Association for the government of the whole.

The dues of a member are \$6 (State dues), plus the dues of the County Association to which he belongs, and the treasurer of a County or District Branch Association cannot take less than the full amount. Therefore, if Dr. — does not pay his dues for 1903 immediately we will be obliged to drop his name from the list of members, about to be printed from the *Medical Directory*, and, of course, his name cannot appear as an officer of your County organization. It seems to me that the doctor cannot understand this, as the \$6 which he will pay to the State Association in the way of dues insures him against the legal expense of defending suits for alleged malpractice, Article II, Section 7 of the By-Laws of the State Association. This in itself is worth far more than the annual charge of the Association.

Yours very truly,

(Signed) FREDERICK HOLME WIGGIN.

MEDICAL DIRECTORY.

The Committee on Publication of The New York State Medical Association beg leave to present the fifth volume of the *Medical Directory of New York, New Jersey and Connecticut* to the members of the Association.

In compiling the list of physicians the same general order has been followed as last year, giving membership in all societies having a recognized standing in the profession, hospital and dispensary appointments, with residence, office hours, telephone call and college and year of graduation.

No change has been made in the use of tinted paper, it having been found to be of great practical value and meeting with high commendation.

The list "received too late for classification" may appear unduly large, but in order to increase the usefulness of the book it became necessary to add changes of address received after the page proof had been returned to the printer, as well as the physician registering at a late date with the county clerk.

The committee have added a list of medical libraries in the three States, which makes a very useful reference to the physician.

Our endeavor to make the *Medical Directory* the best reference book for the profession can be furthered by the members assisting your Committee on Publication in notifying us of errors and omissions, and securing subscriptions from your friends by showing them a copy and pointing out the value it has been to you and the great usefulness it may be to others.

MEDICAL DAILY.

During the past month we have received a preliminary announcement of the advent of the daily medical journal.

At first sight the presence of a new medical journal seems superfluous, but on closer scrutiny one is convinced that there is an ever-widening field open for a daily publication of this kind. It is another expression of American progress. Few of us will take a medical book that has been published five or even three years ago, and so we want our medical news and society proceedings of the night before, just as we would the doings of Congress. For many years most of the other learned professions have not been compelled to wait weeks and months for news in their particular lines of work, but have maintained daily publications. The daily law reports are on the breakfast table of every city lawyer. That such a prompt service of news is infinitely more necessary to a physician than to a member of any other profession, no one who values a human life can deny. Every one will remember with mingled feelings of shame and disgust the circumstances attendant on the publication last winter of the proceedings of a meeting of a prominent medical society in this city, wherein a member advocated a new method of treatment for puerperal sepsis. It was many days before the

medical press could handle the matter; meanwhile the yellow press went screeching up and down the land with the news that this or that prominent surgeon who had tried the method bowed down before the daily yellow humbug and admitted that he had exactly followed the directions given in that organ for the successful treatment of the disease. So much so that the laity believed that they knew as much concerning the method and disease as their physician did. The prevention of such and similar instances of newspaper science would alone suffice for the presence of this publication. It will doubtless serve as an educator to the daily press and thus prevent the laughable blunders concerning things medical that are so commonly present.

The present publication has been almost the only lay journal in this country to stand shoulder to shoulder with THE NEW YORK STATE JOURNAL OF MEDICINE in refusing to print reading and puff notices, publishers' columns and other advertising baits. This policy will, we hope, be continued in the new publication, and as such we wish it a safe launching.

MEDICAL DISCOVERIES BY PRACTICING PHYSICIANS.

In his recent address before the graduating class of the Yale Medical School, Dr. Henry M. Hurd rightly emphasizes the fact that laboratories and the exclusive devotion to research work are not at all necessary, and not, indeed, the chief requisites for medical discovery and progress. Laboratories in which teaching is not required may and do fail to make such discoveries, and others seemingly overwhelmed with routine work do make them. In the same way, as the history of medicine amply shows, the busy practitioner is precisely the one to whom we are indebted for the great truths which have placed our science in the position of power and honor it holds to-day. The motive of vital love of one's fellowmen is needed to create the spur of endeavor and to quicken the inventive brain, and this is fully as likely to be found in the man busied every day with concrete cases of disease and suffering, as with the one who is more isolated. No one would surely wish to discourage the foundation and support of city laboratories. Both methods of research are useful and necessary. But in the acknowledgment of their great function that of the lonely and country practitioner is too easily underestimated. The possibilities of beneficence and of discovery open to him are as great and he should never lose sight of the fact. He sees disease at first hand and in the making; the expert pathologist too frequently sees but the end results, the completed dead products of disease. It must be remembered that by no means are infectious diseases all that exist or all that we have to study, and, moreover, that we are possibly now neglecting attention to those functional changes which are the first stages of organic disease.—*American Medicine.*

Association News.

MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The twentieth annual meeting of The New York State Medical Association will be held at the Academy of Medicine, 17 West 43d street, New York City, on the 19th, 20th, 21st and 22d of October. You cannot afford to be absent. Be sure to come early and bring your friends.

PROGRAM OF THE MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The program of the twentieth annual meeting of The New York State Medical Association, to be held October 19, 20, 21 and 22, 1903, is in course of preparation, and will be published in full in the October number of the JOURNAL. The Committee on Arrangements will send to each member a program of the meetings and are prepared for a large attendance. Come early and stay late.

ANNUAL DINNER OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Arrangements are being made for the annual dinner of The New York State Medical Association on Wednesday evening, October 21st.

The request for contributions is made by the chairman of the Committee on Arrangements, Dr. Samuel A. Brown, of 23 East 44th street. As money to be expended for such entertainments can be better met by voluntary contributions the chairman finds it necessary to make and complete arrangements at an early date, and as he is very anxious to have a large attendance he would appreciate it if you give this matter your early and favorable attention.

REDUCTION OF FARE FOR THE NEW YORK STATE MEDICAL ASSOCIATION.

The Committee on Arrangements have secured a reduction of fare on the certificate plan for those attending the meeting of the Association, to be held in New York City, October 19, 20, 21, 22, 1903.

When purchasing your ticket be sure you request a certificate.

On your arrival at the meeting, present your certificate at time of registration.

Register at the place of meeting, Academy of Medicine, 17 West 43d street, as soon as you arrive in New York.

The special agent of the Trunk Line Association will be in attendance to validate certificates on October 20th and 21st.

You will be entitled to a continuous-passage ticket to your destination by the route over which you make the journey, at one-third the limited fare.

You can secure certificates for members of your family on the same terms.

Even if you do not wish to return by the same route, ask for a certificate, as by so doing you can help your fellows, as a contingent of not less than 100 persons holding certificates showing payment of not less than 75 cents, is enforced by the Trunk Line Association.

When you register, state if you have a round-trip ticket, as this also counts as one certificate.

Ulster County Association.—The regular quarterly meeting of this association was held at the "Nordrach," in Phœnicia (by invitation of Dr. A. J. Benedict), Monday, August 17th. Carriages were waiting at the station to take the doctors to the sanitarium, where an elaborate dinner was served, after which Dr. C. J. Hillis, of Griffin Corners, read a paper on "Movable Kidney—Its Frequency, Etiology, Symptoms, Diagnosis, Prognosis, with Special Reference to the Operative Treatment." He said in the normal condition the kidney could not be palpated, but when a patient complained of dragging pain in the right side, more or less constant, and of long duration, with attacks of nausea and occasional vomiting, such a person should be carefully examined in the following manner: The patient should have the clothing removed, lie in the dorsal position, with head slightly elevated and knees drawn up. The physician should place one hand below the costal margin at the outer border of the rectus muscle and the other upon the lumbar space just below the ribs, and press forward, when a movable kidney could usually be readily detected, whatever the degree of movability. The disease rarely ends fatally, but produces much discomfort and patients frequently become markedly neurasthenic. The satisfactory treatment is surgical, although some relief can be afforded by the use of bandages. In the surgical treatment he gave preference to the form of suture known as the "Bradley stitch," and to the operation as done by Dr. Thomas Cullen, of Johns Hopkins. After a careful description of this operation, the advantages of it were noted as follows: 1. The sutures in the kidney do not tear out, and will control any hemorrhage which may have been occasioned by their introduction. 2. No tissues have been cut, except the skin and subcutaneous tissue and a hole in the lumbar fascia. 3. The ease with which the kidney can be reached. 4. The results of this operation are universally good.

Dr. A. H. Palmer, of Marlborough, next read a paper on "Infantile Diarrhea." This term was used in a clinical sense, and included all conditions attended by an abnormal number of loose evacuations from the bowels. He thought a peculiar susceptibility existed in children from 6 to 18 months of age. This, combined with season, artificial feeding and bad hygienic surroundings, summed up the etiology. This disease he believed to be quite different from true cholera infantum, which, in his opinion, had a death rate

of 70 to 80 per cent. He emphasized the prophylactic, hygienic and dietetic treatment, and said all mothers should be instructed, so that, as soon as a child had sour stomach or vomited, the regular diet should be suspended and barley or rice water substituted a few times, and frequently the trouble would be averted and the regular diet could be gradually resumed. In the medicinal treatment, unless they had already emptied the stomach by vomiting, he emptied it, and gave small doses of calomel or castor oil to thoroughly clear the alimentary canal. This was all the treatment needed in the milder cases. In the severer forms, bismuth, salol, opiates and stimulants would be required. In some severe cases of entero-colitis which had been very troublesome, small doses of castor oil, 10 to 12 drops in emulsion, with starch and laudanum injections, afforded much relief. Cocaine suppositories were sometimes useful.

After a general discussion of the papers by the members and guests present, the doctors were treated to a fine carriage drive, and before leaving all tendered very sincere thanks to Dr. Benedict for his kind and generous entertainment. Those in attendance were: Dr. C. J. Hillis, Griffin Corners; Dr. Mary E. Dunning, Newburgh; Dr. A. H. Palmer, Marlborough; Dr. Wilson P. Fuller, Kerhonkson; Dr. Alice Devine, Ellenville; Dr. A. J. Benedict, Phœnicia; Dr. Henry Van Hoevenberg and Dr. Mary Gage-Day, Kingston.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

THIRD DISTRICT BRANCH.

Broome County.—Chalmers J. Longstreet, Binghamton.

Seneca County.—Daniels F. Everts, Romulus.

FOURTH DISTRICT BRANCH.

Erie County.—Frank A. Helwig, Akron.

Monroe County.—William B. Cochrane, Brighton.

Niagara County.—Owen E. McCarty, Niagara Falls; Charles L. Preisch, Lockport; Warren C. Wood, Lockport.

Orleans County.—Phebe A. Sprague, Holley.

OBITUARY.

Dr. Charles W. Piper, of Wurtsboro, N. Y., died at the New York Hospital on August 11th. He was born at Coventry, N. Y., in 1856, and settled in Wurtsboro eighteen years ago, where he had practiced ever since. He was a graduate of the University of Michigan, class of 1884. The doctor was a member of the American Medical Association and The New York State Medical Association, holding the position of treasurer of the Sullivan County Medical Association.

Miss Minnie Edith Lusk, the only daughter of Dr. Zera J. Lusk, of Warsaw, N. Y., died at Newton Centre, Mass., on Saturday, August 1st, of typhoid fever. She was a Wellesley College

graduate of honor, of the class of 1903. She took a leading part in the college play, and was chosen by election to represent the senior class at the freshman "March." We deeply sympathize with Dr. Lusk in his loss.

PERSONALS.

Dr. Thomas D. Merrigan, of 167th street and St. Nicholas avenue, is now in Europe.

Dr. Thomas F. Reilly, of 204 West 141st street, has returned, after a trip to Germany.

Dr. W. P. Herrick, of 30 West 54th street, has returned from his European trip.

Dr. and Mrs. John T. Nagle, of New York, arrived at the Royal Hotel, Edinburgh, on July 30th. From Edinburgh Dr. and Mrs. Nagle go to the Trossachs, thence to Glasgow and later to Ireland.

Dr. and Mrs. Louis Faugeres Bishop are passing the summer at Mason's White Cot, York Harbor, Me.

PRIVILEGES OF MEMBERS.

By-Laws of The New York State Medical Association

ARTICLE IX.

Sec. 4. Resident members shall have all the rights and privileges conferred by their respective County Associations and District Branch Associations. They shall be eligible to any office in the gift of the Association; shall be entitled to attend all meetings of the Council and Fellows, and shall receive all the protection, benefits and support conferred by the Association; but if a member's dues be unpaid at the time of the annual elections of his County Association or District Branch Association he shall not be counted as a basis of representation in this Association, shall not be eligible for election as a Fellow, shall not receive the publications of the Association or be included in its published list of members for that year, nor thereafter until he has discharged his indebtedness in full.

Sec. 9. No member shall be permitted to resign while owing dues or assessments or while he is under charges which may lead to his expulsion.

ASSOCIATION DUES.

By-Laws of The New York State Medical Association.

ARTICLE X.

Sec. 2. The annual dues of resident and non-resident members shall be six (6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (1) dollar may be deducted.

Sec. 3. All dues shall be payable on the first day of January of each year.

Sec. 4. On the first day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the *Medical Directory* for that year,

and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be dropped from the official roll of members.

LEGAL NOTES.

To the Editor:

My Dear Doctor—Your editorial comment upon the "Difficulties in Apprehending Malpractices," which appeared on the first page of the August number of the JOURNAL, was most timely and is of the utmost importance not only to the public, but to the profession as well. If marked copies could be sent to each one of our great dailies it might make some slight impression upon their thoughtlessness of the public in their scramble for money through their disreputable, dangerous and degenerating medical advertising.

I cannot share with you the belief that the advertising which we see in the many daily papers of our city to-day is received without full knowledge of its character, and I fear that so long as our Legislature permits the publication of such advertisements, the newspapers will continue to receive them. When the law prohibits their publication they will cease.

Within the last few months I have succeeded in dragging from one of these advertising places an unlicensed physician who was there practicing medicine, and where drugs were sold and compounded by an ignorant ex-ball player; neither a physician nor a pharmacist was in the place. Upon the conviction of this charlatan I sent a typewritten report of the occurrence to the papers in which the place was advertised, but there was not a word said. Why? Simply because had it been published the newspaper would, perhaps, lose the advertiser, or would at least be convicted of publishing such advertising on one page, while upon another would appear the notice of its character.

It would seem wholly within the province of the work of the Committee on Ethics to bring such situations directly to the attention of the public, through such newspapers as are not engaged in the sale of space for that variety of advertising, and possibly thus bring home to their editorial brethren that notice, behind the lack of which they now often seek to shield themselves.

The Board of Regents of the State of New York has ample power to revoke as well as to issue licenses to practice medicine, and licenses have already been revoked; yet individuals are not often willing to take the trouble to bring the acts of these licensed and advertised wrongdoers to the attention of the Board, or to present proper evidence to convict them.

I do concur most heartily in the conclusion contained in the last paragraph of your editorial; but as yet the public has not been sufficiently alarmed, nor is public opinion sufficiently strong to insist that our newspapers apply ethical rules

to their advertising matter, which now is so debasing to the ideas of decency and morality.

JAMES TAYLOR LEWIS.

SUITS OF ALLEGED MALPRACTICE AGAINST MEMBERS DEFENDED BY THE STATE ASSOCIATION.

By-Laws of The New York State Medical Association.

ARTICLE II, SECTION 7.

The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the Secretary, shall sign a contract renouncing his own and vesting in the Council sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused, but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise.

The thirteenth annual convention of the American Electro-Therapeutic Association will be held in Atlantic City, N. J., September 22, 23 24, 1903. Among the papers to be read are:

"Electrotherapy as a Specialty," Alfred William Bayliss, Buffalo, N. Y.; "Some Principles Upon Which Is Based the Use of Electricity in Nervous Diseases," Alfonso David Rockwell, New York, N. Y.; "The Use of Electricity in the Treatment of Diseases of the Heart," Sigismund Cohn, New York, N. Y.; "Employment of Static Electricity in the Treatment of Nervous Diseases," William Benham Snow, New York, N. Y.; "Electrical Treatment of Trachoma and Corneal Opacity, with Illustrative Case," Margaret Abigail Cleaves, New York, N. Y.; "The Successful Treatment of Eighteen Cases of Granular Lids by the X-ray and High Frequency Vacuum Electrodes," Albert Charles Geyser, New York, N. Y.; "The Use of the X-ray in the Treatment of Malignant Growths, with Relation of Cases," Marcus Morton Johnson, Hartford, Conn.; "The Position of the Roentgen Ray and Ultra-Violet Light in the Therapeutics of Malignant Diseases of the Uterus and Adnexa," Margaret Abigail Cleaves, New York, N. Y.; "The Present Status of X-ray Therapy in the Management of Cancer," Clarence Edward Skinner, New Haven, Conn.; "Radio-Histo-Fluorescence," William James Morton, New York, N. Y.; "The Roentgen Ray as an Aid in Diagnosis," Herman Grad, New York, N. Y.; "Retrospect of the Second International Congress on Electro-Therapeutics at Bern," Robert Newman, New York, N. Y.; "Some Therapeutic Indications for the Use of the Radiant Light Bath," Thomas Davidson Crothers, Hartford, Conn.; "Some New Points in the Treatment of Tuberculosis," Wolff Freudenthal, New York, N. Y.; "A Case of Asthma with Fibroids and Pelvic Adhesions Cured by Galvanism," Charles Augustine Covell, New York, N. Y.

News Items.

Albany Hospital for Contagious Diseases.—Ground was broken for this institution on the 3d inst., near the Albany Hospital; the work is to be pushed as rapidly as possible.

* * *

Buffalo Marine Hospital.—Of the \$125,000 appropriated for the new marine hospital at Buffalo, \$22,000 is to be expended for the site, \$100,000 for the building, and some \$3,000 for unforeseen expenses and for beautifying the grounds.

* * *

St. Peter's Hospital, Albany.—The exterior work on this building is nearly completed and the interior construction has begun. It is hoped to have the institution finished by the end of September.

* * *

New Hospital on the Upper East Side.—The Sydenham Society has founded a hospital and dispensary at 347 East 116th street, at which the poor may receive free treatment. The dispensary is situated on the lower floors and on the upper floors there are twenty beds and an operating room.

* * *

New Building for the Manhattan Maternity Hospital.—Plans for a new building to be erected on East 60th street for the Manhattan Maternity Hospital have been filed with the Building Superintendent. The structure is to cost \$58,000, and will be of ornamental brick, 45.3 feet front and 66.3 feet deep, on a lot 100x100.3 feet. It will be four stories high and fireproof throughout. There will be four wards (one for babies), four isolating rooms, a diet kitchen, an operating room and an amphitheater.

THE NEW WOMAN'S HOSPITAL

The plans for the new building to be erected for the Woman's Hospital, to replace the old hospital at Lexington avenue and 50th street, have been filed. The building will be six stories high, with basement and attic, and have façades of granite, limestone and terra cotta. It will be 188 feet front and 40 feet deep, with two wings each 40 feet wide and 60 feet deep, and will occupy the 110th street front of a plot, 300 feet front and 171 feet deep, between 109th and 110th streets, 200 feet east of Amsterdam avenue. The first floor will contain the administration offices, a lecture hall and a chapel capable of seating 144 persons. The second floor will be fitted up as a dormitory for the nurses, and the third floor will contain the private wards.

MEDICAL CERTIFICATES.

It will be well for its pocket if the medical profession will take to heart Section 2 of Article VI, of the Revised Code of Ethics, which discourages the giving away of certificates

of inability to serve on juries, and the testifying to the state of health of patients in insurance and pension cases without compensation to the physician. Rich insurance companies, amply able to pay, receive thousands of dollars' worth of these certificates every year, and with few exceptions the doctors who write them are too indifferent or too easy-going to ask for the fee that is justly due. The whole subject of compensation is a neglected side of medical practice, and if the "Principles of Medical Ethics" should arouse the medical profession on this point alone, they would fully justify their existence.—*St. Paul Medical Journal*, July.

BOARD OF HEALTH'S DUTY TO FURNISH CARE TO SMALLPOX PATIENTS.

It is the undoubted duty of a town Board of Health to take immediate and efficient steps, when smallpox develops within its jurisdiction, not only to furnish care and attendance to persons afflicted with the disease, but to protect, as far as possible, the residents of the town from the danger to which they are exposed by reason of its contagious and malignant character. To this end the Board of Health is authorized, according to a decision of the Supreme Court, to incur any reasonable expense, and the expense thus incurred becomes a charge upon the town.

PURE FOOD.

Dr. H. W. Wiley, of the Department of Agriculture, proposes an examination of such products as spices, peppers, canned goods, cheese and other articles imported as food. A test will be made to discover whether they should be barred out under the provisions of the law against the admission of impure, adulterated and mislabeled foods.

NEW RULES FOR BARBER SHOPS.

The new regulations which the Board of Health has adopted for enforcing the provisions of the Sanitary Code are eleven in number, and are as follows:

1. Barbers must wash their hands thoroughly with soap and hot water before attending any person.
2. No alum or other astringent shall be used in stick form. If used at all to stop the flow of blood, it must be applied in powder form.
3. The use of powder puffs is prohibited.
4. No towel shall be used for more than one person without being washed.
5. The use of sponges is prohibited.
6. Mugs and shaving-brushes shall be thoroughly washed after use on each person.
7. Combs, razors, clippers and scissors shall be thoroughly cleansed by dipping in boiling water or other germicide after every separate use thereof.
8. No barber, unless he is a licensed physician, shall prescribe for any skin disease.
9. Floors must be swept or mopped every day, and all furniture and woodwork kept free from dust.
10. Hot and cold water must be provided.
11. A copy of these regulations is to be hung in a conspicuous place in each shop.

The regulations also advise customers to have their own brushes, combs, razors and cups in order to avoid as far as possible the contracting of skin diseases.

INFLUENZA IN NEW YORK STATE.

The bulletin of the State Board of Health for July contains a review of the mortality from influenza during the first half of the present year. On the basis of the reports for the months of January to June, inclusive, the review concludes: "The first decade of life, and, in fact, the first twenty years, seems to be almost immune to the effects of the disease, and the middle period of life, to the age of 45 or 50, is resistant to it so far as reported fatality is an indication. The susceptible age of infancy is an apparent exception, as more deaths are ascribed to it in the first year than in the next twenty. Prior to the age of 50 only one-fourth of these deaths occurred; after which there is a marked increase in each decade, the greatest number falling between 70 and 80. The months of December, January, February and March, during which influenza is prevalent, have much larger mortality at 70 years of age and over than the remainder of the year. There are considerably fewer deaths of males than females, and this is true of every decade except during the first year of life, and especially true in old age."—*Record*.

PRACTICERS' QUALIFICATIONS.

From an address by Sir Frederick Treeves:

"All knowledge is of value in the making of a successful practitioner, and the mass of all that is to be known in the science of medicine is colossal to contemplate. It must not be assumed that the education of the physician can be founded exclusively upon textbooks and treatises, even when it is supported by work in the laboratory and at the bedside. A man may possess all the learning that a well-equipped library may contain and all the erudition attentive observation in the wards may bestow and yet be short of complete success as a practitioner of his art. Absolute efficiency cannot be gauged by academic distinction, nor can it be discovered by the touchstone of the examination table. In the accomplishments of the most learned physician there may be one thing lacking, the need of which may stand between him and the fullest equipment for success, and that one thing is a tactful and sympathetic knowledge of his fellow-man. It is possible that a doctor may be acquainted with all that is to be known of the diseases of man and yet know too little of the man himself. Indeed, it is not too much to say that the highest qualifications of the practitioner of medicine are not to be represented by any university degree nor discovered by any system of inquisition.

"In the treatment of the sick a certain profession of dogmatism is essential. The sick man will allow of no hesitancy in the recognition of his disease. He blindly demands that the appearance of knowledge shall be absolute, however shadowy and unsubstantial may be the basis of it. Moreover, the sick man in his weakness looks to his doctor for the supporting hand and the strong arm; he is moving in the dark and he needs to be led; he is haunted by apprehension and his fears must be allayed.

"It is this succoring of the weak, this guiding of the feeble, which represents that which is best in the pro-

fession of medicine. This great privilege, this kindly power, is the heritage of all who embrace the healing art, and it is the possession of all others, upon which the influence of the physician is based.

"The second need in the equipment of the medical man is absolute fidelity. All those who profess to attend upon the sick undertake a solemn trust which needs to be observed with punctilious care. The sick man must place implicit faith in his doctor or no faith at all. The fulness and simplicity of this confidence are the measure of the scrupulous honesty with which it must be received. In accepting this trust every physician takes upon himself a grave responsibility, and he who is most exact in the right observance of this confidence has the greatest claim to be worthy of his calling. The burden of such a trust is little appreciated beyond the confines of the medical profession, and every physician of any experience has had to learn with much bitterness how much self-denial and self-effacement this trust implies, how little the responsibility of it is appreciated and how much injustice to the doctor its honest acceptance may involve.

"The public are apt to talk glibly of 'medical etiquette' and to assume that it is founded upon some special code of ethics and based upon a system of morals especially constructed for the advantage of the medical profession. Such criticism is unjust, as criticism usually is which is based upon imperfect knowledge. It is needless to say that there is no precept in 'medical etiquette' which is other than the outcome of the simplest justice, the simplest right doing, and, above all, the truest care for the interests of the patient."—*British Medical Journal*.

BOOKS RECEIVED.

A THESAURUS OF MEDICAL WORDS AND PHRASES. By Wilfred M. Barton, M.D., Assistant Professor of Therapeutics and Materia Medica, and Lecturer on Pharmacy, Medical Department, Georgetown University, and Walter A. Wells, M.D., Demonstrator of Laryngology, Georgetown University; Adjunct Professor of Laryngology, Washington Post-Graduate School; Fellow of the American Rhinological, Laryngological and Otological Society, etc. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A MANUAL OF OBSTETRICS. By A. F. King, A.M., M.D., Professor of Obstetrics and Diseases of Women and Children in the Medical Department of the Columbian University, Washington, D. C., and in the University of Vermont; President (1885-86-87) of the Washington Obstetrical and Gynecological Society; President (1883) of the Medical Society of the District of Columbia and of the Medical Association of the District of Columbia, 1903; Fellow of the British Gynecological and of the American Gynecological Societies; Consulting Physician to the Children's Hospital, Washington, D. C.; Obstetrician to the Columbian University Hospital; Member of the Washington Academy of Sciences; Fellow of the American Association for the Advancement of Science; Associate Member of the Philosophical Society of Great Britain, and Member of the Medical, Philosophical, Anthropological and Biological Societies of Washington, D. C., etc. Ninth edition, revised and enlarged. With 275 illustrations. Philadelphia and New York: Lea Bros. & Co., 1903.

A NURSE'S HANDBOOK OF OBSTETRICS. For Use in Training-Schools. By Joseph Brown Cooke, M.D., Fellow of the New York Obstetrical Society; Lecturer on Obstetrics to the New York City Training-School for Nurses; Surgeon to the New York Maternity Hospital, etc. Philadelphia and London: J. B. Lippincott Company, 1903.

TRANSACTIONS OF THE SEVENTIETH ANNUAL SESSION OF THE TENNESSEE STATE MEDICAL ASSOCIATION, NASHVILLE, 1903. The seventy-first annual session will be held in Chattanooga, commencing second Tuesday in April, 1904.

Book Reviews.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otolaryngology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners by Leading Members of the Medical Profession Throughout the World. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, etc. Vol. I, Thirteenth Series. Philadelphia: J. B. Lippincott Company, 1903.

This volume of *International Clinics* opens with an interesting clinical lecture by William Osler on Aneurism of the Descending Thoracic Aorta, in which he discusses at length the salient points of the fourteen cases of this disease encountered in the wards of Johns Hopkins Hospital since its opening and a number of cases recorded by other observers. It is noteworthy that, in the treatment of certain of these patients, Osler has given the gelatin-injection method of Lancereaux a thorough trial, and while in some instances it has relieved pain, in no case has the aneurism been cured. This fact is of interest in connection with the paper by Lancereaux which was published in Vol. IV, Twelfth Series, of *International Clinics*, page 36. In his fourteen cases Osler did not encounter one in which he thought it advisable to employ the method of wiring with electrolysis. A very complete report of the Johns Hopkins cases, with post-mortem findings, is appended to Osler's paper.

Nauheim Methods in Chronic Heart Disease with American Adaptations, by T. E. Satterthwaite, of New York, is a distinctly valuable contribution. Its many illustrations amply elucidate the text. The preface to the author's explanation of his methods is as follows: "Successful application of the Nauheim system requires the closest attention to details. Disregard of them means miserable failure. The largest success comes from the most careful attention to each apparently insignificant feature." He then proceeds to describe the exercises in minute detail, in each instance fully stating what is to be accomplished and how it is to be accomplished, so that the merest tyro cannot fail to understand and successfully follow his teaching. Diet, baths, massage, etc., all necessary features of the treatment, are also fully considered. The physician himself will take heart in the treatment of this discouraging class of cases after having well studied Satterthwaite's article.

The Treatment of Chronic Urethritis, by Ernest Finger, of Vienna, is interesting reading, but presents nothing new. Genito-urinary subjects are always of interest to the general practitioner, but the teaching varies so greatly that he is at a loss, in many instances, to determine the best treatment to adopt in a given case. A multiplicity of papers by different authors, all containing the same principles, clothed in different language, will not materially assist the student in his search for varied knowledge. The present reviewer, however, does not remember that a thoroughly scientific paper on Impotency: Its Causation and Treatment has yet appeared in *International Clinics*. In the face of the charlatanism and out-and-out quackery, so widespread in the so-called treatment of this very prevalent condition, it would appear that such an article would be timely and of great value.

Acquired Umbilical Hernia, by Ross, of Philadelphia, and the *Causation, Treatment and Prognosis of Convulsions in Young Children*, by Thomson, of Edinburgh, are comprehensive papers, but neither is strikingly original. *The Treatment of Weak Feet and Flat Feet*, by Shands, is a good article, clearly and concisely written, and replete with valuable points. This subject is one which has not been given the attention by the general practitioner which it merits. *Functional Reversion and Its Importance in Medical Practice*, by King,

of Washington, bears evidence of much scholarly thought and investigation. The reviewer regrets that the space at his disposal will not permit of an extended notice of this paper. The same may be said of Ballantyne's *General Principles of Embryology*. The student that peruses this masterly paper must indeed be obtuse if he is not able to obtain a clear idea of the intricacies of this perplexing subject. The English construction is the best of any article in the volume.

Progress of Medicine During the Year 1902, by Watson and Cattell, is concisely and well reported, as well as quite profusely illustrated.

All in all, this volume of *International Clinics* is eminently pleasing and instructive.

INTERNATIONAL CLINICS. Vol. II, Thirteenth Series.

A symposium on *The Summer Diarrheas of Children*, containing six well-written articles by eminent authors, introduces this volume. The *Causation, Nature and Prevention* of this distressing and widely prevalent ailment, by Alfred Hand, of Philadelphia, is the most comprehensive paper of the series. Westcott's *Dietetic Treatment* and Nicoll's *General Treatment* are extremely well handled. It would appear that a careful study of these papers and a rigid observance of the rules laid down should materially lessen the mortality from summer diseases of children.

"Few conditions present greater difficulties of diagnosis than do the various forms of pancreatic disease," remarks Opie, of Johns Hopkins, as an introduction to his paper on *The Symptoms and Treatment of Disease of the Pancreas*; and again, "Disease of the pancreas is rarely recognized during life, since the symptoms, though not infrequently of great severity, present little that is characteristic." The author then reviews certain pathological changes affecting the gland and points out their bearing on clinical medicines. Symptoms and treatment are dwelt upon at length. This paper alone is worth far more to the practitioner of medicine than the cost of the entire volume.

The succeeding paper on *Trunecek's Serum in Arteriosclerosis*, by Levi, of Paris, is a revelation. Trunecek himself has reported his success with the serum bearing his name in a large number of cases, and Levi substantiates his findings in many cases of his own. Before Trunecek built well on the foundation laid by Hoppe-Scyler arteriosclerosis was considered absolutely unamenable to any form of treatment which would result in the amelioration of symptoms or in structural benefit. Now, as in the Nauheim treatment of cardiac disease, in selected cases there is not only hope, but positive certainty of success in treatment. Verily, the world moves on, and slowly but apparently none the less surely the science of medicine approaches nearer and nearer to the goal that is far removed from empiricism.

The Rest Treatment: When Indicated and How Conducted, by Taylor, of Philadelphia, is interesting reading, and the same may be said of *The Etiology, Prevention and Treatment of a Common Cold*, by Haig, of London. Certain of the statements in the last-named paper, if one were to consider them of sufficient importance to merit controversy, which decidedly they are not, are as remarkable as well-remembered ones by this author in his book of some three years ago in the chapter on *Diet in Uric Acid Diathesis*.

Satterthwaite's *Etiology and Diagnosis of Valvular Affections of the Heart* is an admirable supplement to his paper in the preceding volume of *International Clinics* referred to above. *Abdomino-Pelvic Diagnosis: Abdominal Swellings*, by E. Stanmore Bishop, is practically a continuation of his paper published in Vol. IV, Twelfth Series, of this work. It is an equally valuable contribution.

The Surgical Relief of Traumatic Epilepsy, by Roncali, of Rome, presents nothing that is new. *Cirrhosis of the Liver in Children*, by Hamilton, of Montreal, shows careful study of the three cases presented. Under *Obstetrics and Gynecology* are published three papers—*Sterility in Women*, by J. Riddle Goffe, of New York; *Ectopic Gestation*, with Notes on a Case of Tubal Mole,

by Cuthbert Lockyer, of London, and *The Significance and Some Suggestions Regarding the Treatment of Cervical Lacerations*, by C. D. Palmer, of Cincinnati—all of interest. The volume concludes with a paper, by Landolt, of Paris, on *Surgical Intervention in Paralysis of the Ocular Muscles*.

A TEXT-BOOK OF SURGERY. For Students and Practitioners. By George Emerson Brewer, A.M., M.D., Lecturer on Clinical Surgery at the College of Physicians and Surgeons, Columbia University, New York; Attending Surgeon to the City Hospital; Junior Surgeon to the Roosevelt Hospital; Consulting Surgeon to the Perth Amboy Hospital; Fellow of the American Surgical Association, of the American Association of Genito-Urinary Surgeons, and of the Society of American Anatomists; Member of the New York Academy of Medicine and of the New York Surgical Society; Membre Correspondent de L'Association Française D'Urologie. New York and Philadelphia: Lea Bros. & Co., 1903.

The preface tells us that the author has felt the need of a comprehensive, yet abridged, text-book on surgery during his experience as a teacher. It is his endeavor in this work to give the essential facts in practical surgery as briefly as is compatible with clearness.

The book consists of about 700 pages, illustrated with 280 engravings and seven plates in colors and monochrome.

There are thirty-one chapters. The first eight chapters, consuming 140 pages, take up: Infection; inflammation; acute and chronic surgical diseases; tumors; shock and allied conditions; surgical technic and anesthesia.

The succeeding chapters consider the injuries and diseases of the skin and subcutaneous tissues; the heart, pericardium and blood vessels; the lymphatic system; muscles, tendons and bursæ; the nerves; the brain and spinal cord; the head, face and neck; the thorax, pleura and lung; the mammary gland; the abdomen; the kidney and ureter; the bladder and urethra; the penis and scrotum; the testicle, seminal vesicle and prostate; the rectum; bones and joints. Fractures and dislocations have each a chapter, as also have hernia, amputations and deformities.

It is to be noticed that surgical diseases of the female reproductive organs are ignored. There are so many text-books on gynecology that Dr. Brewer may have thought it unnecessary for him to take up the subject. Yet there are also splendid text-books upon genito-urinary surgery and upon orthopedic surgery and upon rectal surgery. As a text-book for students beginning the subject of surgery, this work will be welcomed by instructors. Heretofore it has been a difficult task to impress the essential parts of the larger books upon the student. The detailed descriptions of many operations are confusing to the beginner. Not more than one or two methods of treating a surgical affection are given.

Some of the sentences would be much clearer if not so lengthy, but most of the pages are written in a good literary style.

A TEXT-BOOK OF LEGAL MEDICINE AND TOXICOLOGY. Edited by Frederick Peterson, M.D., President of the New York State Commission in Lunacy; Chief of Clinic, Department of Nervous Diseases, Columbia University; General Consultant to the Craig Colony for Epileptics, Sonyea, N. Y., and by Walter S. Haines, M.D., Professor of Chemistry, Pharmacy and Toxicology in Rush Medical College, Chicago; Professional Lecturer on Toxicology in the University of Chicago. Published by W. B. Saunders & Co., 1903. In two volumes, containing about 1,500 pages, fully illustrated.

The list of contributors to Vol. I contains the following names: Samuel Treat Armstrong, Pearce Bailey, Lewis Balch, James Ewing, Graeme M. Hammond, Smith Ely Jelliffe and Frederick Peterson, of New York City; Charles Gilbert Chaddock, of St. Louis; John Chalmers DaCosta, of Philadelphia; J. T. Eskridge (deceased), Josiah N. Hall, and Edward Jackson, of Denver; Ludwig Hektoen and Walter S. Haines, of Chicago; F. W.

Langdon, of Cincinnati, and Allen J. Smith, of Galveston.

In the preface the editors state that the object of this work is to fill the field found between the manuals of limited size and scope, and those systems of legal medicine which are of encyclopedic dimensions.

In order to enhance the value of the book to the legal profession, the articles are inserted as written by the authors, without change or editing. Thus individual responsibility, with the accompanying weight of authority, is offered at the occasional sacrifice of harmony of views.

It is not alone to those who are directly interested in medico-legal questions that we would recommend this work. As keen observation is essential to the successful physician and surgeon, we believe every doctor will find this book of value in sharpening that power. It is in our law courts that statements receive the closest scrutiny, and it is in private, or semi-private, life that fraudulent claims and ridiculous assertions do the most injury. If lawyers and doctors will but make a study of this text-book we are of the opinion that the number of quacks and empirics will be greatly reduced. Every so-called cure offers a certain amount of evidence and testimony as to its power and trustworthiness. Even men trained in the examination of evidence, as well as all others, are at times unable to detect the error in a false statement. Consequently we find men of reputable character and profound intellect believing sufficiently in fraudulent devices to lend their names as references and advocates. What medicinal compound, or "healing power," has not the names of ministers, lawyers and business men upon its lists of patrons? And many of these men are honest. They are simply unable to detect the falsity in the evidence which has convinced them.

In the introduction the chief sources of error are summed up. They are:

1. Deliberate fraud, as in all species of quackery.
2. Wilful perversion of facts by pseudoscientists.
3. Objective errors through limitation and defect of the senses.
4. Limited horizon through defective experience and education.
5. Insufficiency of imaginative faculty.
6. Vitiating of evidence under influence of the emotions.
7. The innate tendency of the mind to completeness, to dramatic unity in unraveling a mystery.

SURGICAL EMERGENCIES—THE SURGERY OF THE HEAD. By Bayard Holmes, B.S., M.D., Professor of Surgery in the University of Illinois; Professor of Clinical Surgery in the American Medical Missionary College, Chicago; Attending Surgeon in the Chicago Baptist Hospital. D. Appleton & Co., publishers.

Judging from the volume before us, we feel assured that this series of books by Dr. Holmes will find a hearty welcome awaiting them from the busy physician. Students will find this volume, and probably those to follow, especially useful, in that the subjects taken up are only such as every doctor is continually meeting, irrespective of his location. Many authors of medical works, perhaps with an eye to increased sales, place "A Text-Book" on the title page, or else they recommend their book to "students and physicians." This work on surgery needs no such introduction. Advanced students will find it just what they need while attending clinics and obtaining experience in dispensaries and hospitals. Physicians will find it most useful in training them in the common surgical diseases, so that they will be less likely to make the serious errors in diagnosis which an inexperienced physician may make any day.

The author says in his preface: "Probably nine-tenths of all the surgical work which the general practitioner is called upon to perform is confined to one-ninth of the subjects found in an encyclopedia of surgery, and it is therefore unreasonable that the discussion of surgical rarities should overshadow that of the every-day emergencies of the average practitioner and confuse him by

their bulk." Very true and very sensible. Yet our encyclopedias must be complete, and we cannot dispense with any part of them. For that very reason this series will be found to be most useful by those who have little to do with surgical cases except in the more common forms.

With such books as these within his reach it is nothing short of criminal negligence for a physician to allow a surgical disease to progress beyond the possibility of a cure where time is an all-important factor, as in otitis media, brain abscess and malignant growths.

The volume contains 570 pages, with 90 illustrations and 14 plates. The typographical work is excellent. It is a handy and useful book.

GYNECOLOGY. A Text-Book for Students and a Guide for Practitioners. By William R. Pryor, M.D., Professor of Gynecology in the New York Polyclinic Medical School; Attending Gynecologist New York Polyclinic Hospital; Consulting Gynecologist St. Vincent's Hospital, New York City Hospital and St. Elizabeth's Hospital. D. Appleton & Co., publishers.

By confining himself to subjects which are strictly gynecological and by giving but little space to the rarer diseases and to operations now generally abandoned, Dr. Pryor has produced a most useful book.

There are 380 pages, well printed, well bound and profusely illustrated with 163 cuts, most of which are original. In the first part the author considers the diseases and in the latter the operations are described. Non-operative, as well as operative, methods are fully discussed. The absence of bacteriology and minute anatomy is unusual in works of this kind and is most commendable.

The literary style of the author is very pleasing. Without being verbose he is explicit. We would like to quote portions from several chapters, but have not the space in these columns.

In view of the recent journal articles upon curettage, we think the doctor has inserted a timely paragraph under this subject. He says: "To illustrate how carelessly this most valuable operation is often performed, I am sure I have performed as many vaginal hysterectomies for pelvic pus due to unclean curettages as for lesions due to disease. If due care is exercised in its performance curettage of the uterus is devoid of danger."

THE SURGICAL DISEASES OF THE GENITO-URINARY ORGANS. By E. L. Keyes, A.M., M.D., LL.D., Consulting Surgeon to the Bellevue and Skin and Cancer Hospitals; Surgeon to St. Elizabeth Hospital; formerly Professor of Genito-Urinary Surgery, Syphilology and Dermatology at the Bellevue Hospital Medical College, etc., and E. L. Keyes, Jr., A.B., M.D., Ph.D., Lecturer on Genito-Urinary Surgery, New York Polyclinic Medical School and Hospital; Surgeon to the Out-Patient Department, St. Vincent's Hospital; Physician to the Venereal Clinic, Out-Patient Department, of the House of Relief of the New York Hospital, etc. Published by D. Appleton & Co., 1903.

This book contains about 825 pages, with 174 illustrations and 10 plates, 8 of which are colored. It is the second revision of the text-book published thirty-five years ago by Van Buren and Keyes. The original title included syphilis. This subject is entirely eliminated, "since it is a genital disease only in its method of approach, not at all in its manner of expression."

The book is divided into two parts. The first part treats of diseases of the urinary organs, including gonorrhoea, and the second treats of diseases of the genital organs.

The literary style of the entire work is of a high standard. The descriptions are clear and lucid and yet sufficiently concise. That the authors have not confined themselves to their own experiences and opinions is shown by the number of writers quoted. The teachings, treatment and operations of some 400 Americans and foreigners are described.

Not only as a text-book will it continue to be valued, but this new edition will doubtless be studied and referred to by all having to do with this domain of surgery.

NOTHNAGEL'S PRACTICE. Authorized Translation from the German, under the Editorial Supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Published by W. B. Saunders & Co., 1903.

DISEASES OF THE LIVER, PANCREAS AND SUPRARENAL CAPSULES. By Leopold Oser, M.D., Professor of Internal Medicine, University of Vienna; Edmund Neusser, M.D., Professor of Internal Medicine, University of Vienna; Heinrich Quincke, M.D., Professor of the Practice of Medicine, University of Kiel, and G. Hoppe-Seyler, M.D., Professor of Internal Medicine, University of Kiel. Edited, with additions, by Reginald H. Fitz, M.D., Hersey Professor of the Theory and Practice of Physic, Harvard University, and Frederick A. Packard, M.D., late Physician to the Pennsylvania Hospital, and to the Children's Hospital, Philadelphia.

We believe it to be a most desirable part of a physician's education that he be able to read in the original the medical works published in modern languages other than his own. He should not be dependent upon another's translation. Nevertheless, there are many of our members who are not familiar with either German or French, and who are not likely to apply themselves to their acquisition. Therefore, such correct translations and careful editing as these volumes represent are most welcome.

The German editors of this volume have shown themselves to be familiar with the advances recently made in the study of these organs, not only in their own country, but on this side of the Atlantic as well. The American editors have made such additions as were necessary, in view of the progress in the medical and surgical treatment of diseases of these organs, since the publication of the original edition. To be up to date one must read and study up-to-date literature on the subjects in this volume. We heartily recommend it to the profession.

NOTHNAGEL'S ENCYCLOPEDIA OF PRACTICAL MEDICINE—AMERICAN EDITION. Authorized Translation from the German Under the Editorial Supervision of Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Published by W. B. Saunders & Co., 1903.

DISEASES OF THE STOMACH. By Franz Riegel, Professor of Clinical Medicine in the University of Giessen. Edited, with additions, by Charles G. Stockton, M.D., Professor of Clinical Medicine in the University of Buffalo.

Members of our Association who are not sufficiently familiar with German to have been able to read this series of monographs by Professor Nothnagel will now have the opportunity to study these excellent books. The German author has been consulted in all cases with regard to the publication of this edition, and the editors have been requested to make such additions as seem necessary to bring the articles fully up to date.

This volume on the diseases of the stomach has received comparatively few additions. All new matter presented is included in brackets, so that the reader has, as nearly as the translation will admit, the work of Riegel, with the additions of some views of the editor.

In the preface Dr. Stockton says: "The text has required but few modifications and additions to make it thoroughly represent the thought of the year." This is so, for the reason that although many contributions have been published since the appearance of the German edition, some of these have been the thrashing out of old straw, and others have been anticipated by the far sightedness of the author. This is a volume of 835 pages, fully illustrated, including six full-page plates. It is divided into two parts, the first of which treats of general diagnosis and treatment of diseases of the stomach, the second of special diagnosis and treatment.

The various methods of obtaining and examining the stomach contents are discussed with great accuracy and clearness. Full consideration is given to the hydrochloric acid question as a factor in the pathology of stomach diseases. The pages on treatment will be found of great value to all.

Original Articles.

TYPHOID FEVER.¹

BY PHILIP M. NEARY, M.D.,
Cortland, N. Y.

WHILE the exact date, or anything approaching it, of the origin of typhoid fever is not known, there is reason to believe it existed before the beginning of the Christian era, and it is thought to be recognized in the descriptions of Hippocrates, and here we are to-day, still confronted by it, still wrestling with it, still admitting it to be a dreadful disease. But, notwithstanding all of this, a great amount of valuable knowledge of the disease has been acquired within the last quarter of a century; yes, within the last decade.

The recent epidemic in our neighboring city of Ithaca has awakened keen interest in the disease, not only in professional ranks, but among the laity as well, in every part of our land. The fact of this widespread interest is, or was, due to several causes:

1. The fact that Ithaca is an educational center, and known as such throughout all the civilized world.
2. Because the students at Cornell hail from all points of the compass and the friends of each student became personally interested in the epidemic.
3. Because of the condition of things, especially the water supply, that was the cause of this epidemic.
4. Because of the extent and mortality of the epidemic.
5. Because it was preventable.

It is now a well-settled fact that the bacillus of Eberth is the exciting cause of typhoid and that its most frequent route into the system is through the medium of drinking water into the stomach; but milk, vegetables, flies, oysters and many other things are bearers of the germs. Some believe that air is a medium that will convey the germs to the mucous membrane of the respiratory tract, and the initial colonization of the bacilli takes place there rather than in the gastro-intestinal tract. If this be so it no doubt is very rare as compared with the old and well-tried idea of a liquid medium carrying the bacilli directly into the gastro-intestinal tract. Fifteen years ago we were taught to disinfect the typhoid stools, later the urine was found to contain the germs, and hence it is now considered essential to disinfect this also, and now we are advised to disinfect the typhoid sputum as well; because the bacillus of Eberth has been found in this also. These are some of the things that have come to us within a few years. Thoroughness in the use of germicides is therefore more than ever important.

Diagnosis.—It is principally through signs and symptoms that we arrive at a diagnosis in any disease, and unless we interpret aright these guides, and some we may call mile-posts, we are shooting at random and results may be disastrous accordingly. Important as is treatment, diagnosis is even more important. Within the last few years at least two very important and valuable means of diagnosis have come to our aid in making quite early and quite positive diagnosis of typhoid.

I refer to Ehrlich's test or the "diazo-reaction" and the "Widal" test.

The principle of Ehrlich's test depends upon the fact that diazo-sulphobenzol unites with certain aromatic substances met with in the urine in typhoid which form anilines. A full description of the test and the proper method of its manipulation are described in all complete works on urinary diagnosis, and I will not take your time by giving it here, as you no doubt are all familiar with it. It (the reaction) is met with as early as the fourth day, whereas the "Widal" is not usually present before the sixth, eighth or tenth, hence its value as an aid to an *early* diagnosis is all-important.

The diazo-test has also the advantage over the "Widal," in that it can be made in every practitioner's office without loss of time. The test must not be considered positive unless a distinct red coloration extends to and includes the foam on shaking.

The "Widal" reaction is altogether absent in rare instances only. It is present at some time in the course of the disease in 95 per cent. of all cases, which per cent. is greater than is the case with Ehrlich's test, but, as before said, it is seldom obtained before the end of first or middle of second week, and it is, therefore, not of so much value for an *early* as for an *exact* diagnosis, as it is now considered the most valuable single symptom that we have.

Both the Ehrlich and the "Widal" test should be made in every case of doubt. The "Widal" test should be made by an experienced pathologist, and the State munificently provides for this; and on more than one occasion I have sent blood and serum in the evening and received a telegram the next noon.

There has long been more than a suspicion that one or more distinct conditions or diseases were confused under the term "typhoid." We all meet cases not typhoid, but something else that we call "catarrhal" or "continued" or something else, and the term "para-typhoid" has recently come to our rescue, this differentiation being largely brought about by the "Widal."

Treatment.—Within the past ten years surgery has come to our rescue in cases of perforation, and while this operation, outside of large cities, is not as yet in general use, it stands to reason that lives otherwise doomed can be saved by surgery. It is practically the only hope there is for these

¹Read before the Third District Branch of The New York State Medical Association, at Syracuse, N. Y., June 25, 1903.

cases. About 33 per cent. of the cases operated on live.

Serumtherapy, which has done so much for some diseases, notably diphtheria, has as yet accomplished nothing very definite in this disease. The world is looking with interest just now at Dr. McFadden, of Pasteur Institute, of London.

Most of us treat typhoid under three heads, viz.:

1. Rest and diet.
2. Hydrotherapy.
3. Medicines.

Rest and diet are of the greatest importance. First select the best room possible, with air, light, quiet, etc., in view. Never use feather beds. Bathe prominent points where pressure comes with alcohol. A great many suffer from pressure on heels and a heel pad is of service. Change patient's position frequently. Keep mouth clean with boracic solution. Cleanse after each time milk is given, as milk makes a foul mouth. All are agreed that liquid diet is the proper one for these cases. If milk agrees with the patient it is probably the best, but as in infancy, where it is the food, it often has to be modified or discarded entirely for other liquid foods for a time. Milk and lime-water, albumin-water and chicken broth may each be tried.

No matter what diet be used, and especially if a milk diet, the stools should be examined frequently, and their character guide us in the administration of the diet. Undigested curds, if we are giving milk, will indicate that the milk should be peptonized, reduced in amount or frequency, or altogether discarded for a time; while if we are giving animal broths and diarrhea occurs our indication is to try milk and lime-water instead.

I think it will aid us in handling the diet problem of our typhoid cases to consider our patient's stomach very much as we do an infant's or a young child's stomach. Hence the need of short intervals between feedings, but, of course, we must also bear in mind the physiological fact that the stomach, like all organs, must have periods of rest alternating with periods of activity, and this leads me to believe that the period of two hours, recommended by some, is too short; even if the diet is predigested, the stomach must be kept rather busy when even a few ounces are turned into it every two hours. It seems to me that eight ounces every four hours (to an adult) is better than four ounces every two hours, but, as before stated, the character of the stools must aid in the solution.

Hydrotherapy.—In regard to cold water, we all know it to be a powerful agent, and its proper use does great good in many cases; its improper use also does harm.

Personally, I prefer cold sponging with alcohol and water rather than the "Brand Method." It excites the patient less. It is more agreeable. It gives satisfactory results, and if it is less powerful it is also less dangerous.

Medicinal Treatment.—Coal-tar derivatives

should never be given to lower the temperature.

Elimination and intestinal antiseptics look rational. Calomel and salol are valuable remedies here. Acetozone is a new remedy that claims our attention. I have used it in one case only. In this case there was a slight relapse or reinfection in the fourth week, that lasted one week.

Prophylaxis.—"An ounce of prevention is worth a pound of cure." This trite expression nowhere has more force than in the disease in question. In the Ithaca epidemic we can look back and see how it all might have been prevented and all the lives saved, but when the epidemic was once in its force and fury all the science of the twentieth century could not save all the lives, and I doubt if the time will ever come when all lives can be spared from typhoid except if it be through prophylaxis. All life, whether animal or vegetable, has a limit to its existence, has an extreme age limit—a limit to the time during which it can reproduce. Suppose under the most favorable conditions the bacillus of typhoid could live no longer than ten years, and during the next ten years the most scrupulous and rigid rules in regard to germicides be carried out in every case of typhoid, even in suspected cases, the world over, what would be the result? Concerted and organized effort along this line under a central head might in time toll the death bell for the last bacillus of Eberth.

ONE HUNDRED DAYS OF TYPHOID FEVER.¹

BY FRANK KENYON, M.D.,
Scipio.

I FEEL like offering an apology for taking up the time of this Association with the report of a case that possesses so little of instruction as the one which I now present. There is no peculiar or notable feature about the case, except its duration, as shown by the chart which I have prepared, to assist me in making myself understood, by appealing to the senses of sight, as well as to the hearing. To call attention to a few points, as shown in the chart, is all that I propose to do.

The man is a farmer, 41 years old, slim, spare-built, with normally but little adipose tissue. Though 5 feet 10 inches tall, his normal weight is below 140 pounds. For two months before he had complained of malaise, loss of appetite, and, as he said, "He had no sand." He claimed, and his wife corroborated the statement, that he had had fever for five days before I saw him, and for three days he had not been out of the house. He complained of headache, pain in the back and bones, chilliness, inability to sleep and thirst. He had taken some physic, which

¹Read at the Nineteenth Annual Meeting of the Third District Branch of The New York State Medical Association, at Syracuse, N. Y., June 25, 1903.

operated, but now his bowels had not moved for three days. I gave him a laxative, which produced hypercatharsis. On the tenth day I found the characteristic irruption of rose-colored papules over the abdomen. His boy, 12 years old, had typhoid fever two years before, and I had believed, from the time that I first saw this case, that it was typhoid fever, and now I considered the diagnosis positive, and kept a record of the pulse and temperature. This is the reason why the chart begins with the record of the tenth day. From this time until the fortieth day he had a moderate amount of diarrhea. From the fortieth day he required gradually increasing doses of cathartics to obtain a passage from the bowels. On the fifty-second day his bowels moved in the bed, without his knowledge. After this, partly from being weak and emaciated, and partly from indifference on his part, he did not use the bedpan. His wife used to spread a newspaper under him, and put some cotton batting on that, and when it got soiled she removed and burned it.

On the thirteenth and fourteenth days he had tympanites, but after that the abdomen was sunken. He had abdominal tenderness continually, until the ninetieth day.

There are some points in relation to the pulse and temperature to which I desire to call attention:

1st. The daily rise and fall of the temperature during 100 days.

2d. The frequent and sharp rise and fall of the temperature in a few hours' time.

3d. The frequent and sharp rise and fall of the pulse in a few hours' time.

The daily rise and fall of the temperature was not discovered to be peculiar or unusual until the twenty-fourth day, when I began to take the temperature twice daily, and first discovered how much the daily fluctuation was, and when on the thirty-third day we took the temperature every four hours I was amazed at finding a rise from 98 degrees to 103.5 degrees, a rise of five and one-half degrees in five hours, and followed by nearly as abrupt fall. On the thirty-fifth day I began the administration of quinine. During the next twenty-four hours the temperature varied only a degree, staying near to 103 degrees all of the time, and it seemed to continue steadier for a few days. Was this the effect of the quinine? On the forty-first day, both the pulse and temperature became very irregular, and I changed from quinine to digitalis. On the fifty-second day the pulse dropped from 92 beats per minute to 46 beats, a fall of just one-half. Here arises the question: Was this the effect of the digitalis? I changed from digitalis to strychnine. On the sixty-second and sixty-third days the pulse and temperature both went up high. The temperature from 97.2 degrees to 104.8, a rise of 7.6 degrees; and the pulse rose from 51 per minute to 116. I recommenced giving digitalis. On the sixty-sixth day the temperature had subsided to 94.6 degrees, and the

pulse had come down to 47 beats per minute. On the sixty-seventh day I commenced giving a teaspoonful of whisky every three hours, which was continued until the end of the case. On the sixty-ninth day he had a mild attack of phlebitis in the internal saphenous vein just below the knee; it gave rise to pain, swelling and soreness between the knee and ankle; this was accompanied by an exacerbation of the pulse from 44 beats to 66, but there was no material change in the temperature. These symptoms lasted about seven days and then disappeared. Apparently the circulation through the obstructed vein was resumed. From the sixty-seventh day the temperature was almost constantly below normal, but every day there was a rise and fall of from 1 to 2 degrees, until the ninety-third day. On that day I saw the last of the petechiæ, and after that the temperature gradually approximated the normal.

From the thirteenth day he took about one-half of a teacupful of milk, and one-half of a teaspoonful of essence of pepsin after it every four hours. We tried to give him beef-tea a part of the time, but he did not relish it, and sometimes it was difficult to get him to drink a half of a teacupful of milk at one time. After the thirty-fifth day the milk was sterilized, and all of the water that he drank was boiled. After the fiftieth day he had a half of a teacupful of peptonized milk and half of a teaspoonful of essence of pepsin after it, every three hours, until the end of the case. From the fortieth day we gave him considerable sugar. The pepsin was put into two tablespoonfuls of water, with a heaping teaspoonful of granulated sugar dissolved in it. His medicine was put into water with plenty of sugar. The whisky was put into water, with a heaping teaspoonful of sugar, so that altogether he took about twenty teaspoonfuls of granulated sugar in twenty-four hours, and this with the half of a teacupful of peptonized milk every three hours was taken steadily for seven weeks. On the seventy-fourth and seventy-fifth days he was hungry and asked for things to eat, but it lasted only two days and then it was difficult to get him to drink the usual amount of milk. On the eighty-fourth day his appetite returned, but the amount of nourishment was not increased until after the irruption disappeared on the ninety-fourth day.

When he had so far recovered as to be able to walk down a flight of stairs he weighed only eighty-three pounds. I have no doubt but that if he had been weighed at about the eighty-third day, his weight would not have exceeded seventy-five pounds, for during the next week, after he was first weighed, he gained nine pounds and the next week he gained eleven pounds. He has since weighed 160 pounds.

I shall make no comments on the case, except to say that I used to think that I could do something with typhoid fever. But with this case I could do nothing, except to wait very impatiently for it to get ready to stop.

**OTITIS MEDIA PURULENTA FOLLOWED BY
MASTOIDITIS AS A SEQUELAE OF TYPHOID
IN THE RECENT EPIDEMIC OF ITHACA.¹**

BY JOHN S. KIRKENDALL, M.D.,
Ithaca.

IN reporting the cases of otitic complications of the most severe epidemic of typhoid known to-day, among the same number of people, I do not feel that I am taking the caudal (?) portion of this symposium. While the number may seem small the results of work done to prevent a fatal termination was all that could be wished for. A careful compilation of cases reported by the Board of Health up to May 1, 1903, was 955 in a population approximating 18,000 people.

In order to obtain the number of otitic cases I personally phoned every physician, inquiring as to this symptom among their cases. Of the large number of severe typhoid cases there were only seven cases of otitic complications.

Case No. 1.—Mr. V., a student at Cornell, æt. about 21, was sick only about ten days before the ear symptoms developed; epistaxis was an early symptom with the high fever; was taken with severe pain in the left ear; acute otitis media, with rapid rupture of the tympanic membrane and extension to the mastoid cells. Pus examined soon after the rupture and streptococci was the predominating micro-organism at work, and an immediate classical mastoid operation was performed. Aside from the natural typhoid run he made an uninterrupted recovery and was able to return to his home.

Case No. 2.—Mr. S., a student at Cornell, sick with fever for seven weeks, when he was taken with double otitis, which soon became purulent; was treated wisely for three or four weeks by the family physician. I was called to see him and found that he had already well-developed mastoid complications; did not stop for an examination of the pus, but immediately prepared for opening of the cells, which was done thoroughly, with relief to the patient. He made a complete recovery. This patient had repeated attacks of epistaxis.

Case No. 3.—Student, had acute otitis media supurata, following epistaxis, which was controlled by the physician in charge.

Case No. 4.—Little girl, æt. 6, after a long and tedious illness, accompanied by epistaxis, developed double acute otitis media suppurata, which later developed mastoiditis of the left side. Mastoid cells were found filled with pus, which

were relieved by an operation, and the little patient made a quick recovery.

Only one mastoid was opened; the right ear recovered by proper treatment.

Case No. 5.—Mr. W., æt. 29, was very ill with typhoid for a long time, accompanied by repeated attacks of epistaxis and hemorrhage of the bowels. Had double otitis media suppurata and the left mastoid became involved, which was thoroughly opened, and he made an uninterrupted recovery. This was also of the left ear, the right getting well by proper treatment.

Case No. 6.—Mr. D., æt. 30, had epistaxis many times, followed by double otitis media suppurata. The left mastoid became involved, but recovered by the use of the ice-bag and other treatment.

Case No. 7.—Miss B., æt. 19, ill eighteen weeks; during that time she had many attacks of epistaxis, soon followed by acute otitis media, later with ruptured drum membranes. This patient, after having had complications of pneumonia, nephritis and neuritis, had extension of the suppurative process to the mastoid cells, developing mastoiditis, this being the fourth complication in the history of her case.

She contracted the disease while at Ithaca during her Christmas vacation, returned to her school in Washington, where the primary typhoid symptoms were developed, with the above complications. She returned to her home, by special-car conveniences, at the sixteenth week of the disease, after which she developed mastoiditis. The patient was very much prostrated. The pus found by the pathologist was known as the bacillus pyocyaneus or bacillus of green pus. It being one of the milder bacteria accounts for the long continued and slowness of the diseased process in the mastoid. It was found necessary to open the cells and give drainage to the mastoid antrum, which was done, and resulted in immediate relief of the septic symptoms in the case.

The patient recovered rapidly from the operation and is now convalescent, although not entirely recovered from the neuritis, but it is expected that she will make a complete recovery.

The object lesson which was most prominent in these cases, and should be remembered by us all, was the fact that all of the cases reported developed epistaxis early in the development of the fever.

Their nasal passages were more or less plugged. free nasal respiration was interfered with and the nose, also the naso-pharynx, was more or less filled with degenerating blood clot and suppurative process which extended to the middle ears, causing the otitis.

I am of the opinion that if these patients could have had their noses and naso-pharynxes thoroughly cleansed early in the onset, some of the severe effects could have been avoided.

¹Read before the Third District Branch of The New York State Medical Association, at Syracuse, N. Y., June 25, 1903.

HINTS UPON THE HYGIENE AND DIETETICS OF INFANCY.¹

BY H. F. GILLETTE, M.D.,
Cuba, N. Y.

IN the words of Holt, "There is no more promising field in medicine than the prevention of disease in childhood." The majority of ailments from which children suffer is within the power of man, in a great measure, to prevent. Prophylaxis should aim at the solution of two distinct problems:

First. The removal of the causes which interfere with the proper growth and development of children.

Second. The prevention of infection.

The former can come only through the education of the profession and the general public upon the fundamental principles of infant feeding and hygiene.

The latter must come through the profession, and through legislation, the purpose of which shall be more rigid quarantine, more thorough disinfection and improved sanitation in all its departments. In this paper only a few points may be discussed, and at the same time we must keep in mind the different environments of children in our cities and in the country. Infant mortality in our cities is appalling, and medical science and sanitary enactments can only stay the existing condition of things, at the best.

But little may be done to furnish light and air, and suitable food and care, for the tender infant in the crowded tenement. On the other hand, much may be done by intelligent effort in the country. An infant seems endowed by nature with great powers of resistance, and its hold upon life is very strong, if it is given half a chance. An infant will survive falls and accidents of many kinds common to home life, and be seriously ill, and still recover; on the other hand, adults would not survive similar lesions.

As soon as an infant is born, the eyes should be cleansed and the mouth wiped out. (Boric acid sol. or some form of silver sol. may be needed in the eyes.) If the infant is strong it should be given a bath of soap and water, preceded by an oil rub. In feeble or immature infants it is the practice of many to give an oil rub, and then to roll the child in cloths, and defer the bath until stronger. That procedure has caused severe dermatitis in several cases under my observation, and has, as a result, imperiled the life of the victim. The cases are extremely rare where any harm will be done a feeble infant in giving an oil bath, and then patting the body clean with soap and water.

After that is done the body can be suitably protected, without dressing it in the usual clothing, until it is stronger. An infant can be rolled in cotton batting, and no clothing be used for some time, with perfect comfort and success.

The prevalence of hernia is well worth a passing mention. A tight binder is applied to prevent umbilical hernia, and, as a result, the tight and unyielding bandage causes inguinal hernia, if the child cries, or strains at stool or urination.

I think that if all clothing and slips were suspended from the shoulder, and no bandage was applied about the abdomen, we would very rarely see any case of infantile hernia. The protrusion must follow lines of least resistance, and if the abdomen be bandaged the natural elasticity of the abdominal wall is destroyed. The force is all placed upon the inguinal region, and hernia results. For the relief of inguinal hernia the hank of yarn truss is successful. For umbilical hernia, a flat button, held in place by strips of surgeon's plaster, will effect a cure in time if constantly worn.

Do not use any bulging pad, because the elevated portion, if pressed down into the hernial opening, will tend to keep the opening from closing, so defeating the very end we are seeking.

Remember that phimosis, when severe enough to require force to empty the bladder, is a frequent cause of hernia, and that prolapsus ani may be looked for as one of the results of phimosis.

Adenoid vegetations of the vault of the pharynx is a very common condition in early childhood, and is very frequently overlooked by the practitioner. It is the source of more discomfort, and the origin of more minor ailments, than almost any other pathological condition of childhood. Our damp and changeable climate is the exciting cause of many cases, yet I believe that many cases are congenital, so early is their presence manifest. Delicate and rachitic children will be found to be very subject to adenoids. The results of adenoids will be in various bony deformities of the face and chest, owing to the obstructed breathing, and in pronounced cases, if unrelieved, the mental condition will be found blunted, and the child will be called stupid, or even worse. The child subject to adenoids should be dressed in wool and should be bathed in cool water, followed by active friction of the skin, and a general toughening process should be carried out.

Attacks of indigestion will be followed by an increase in symptoms. The syrup of iodide of iron is about the only remedy which may be expected to help proper hygiene. If no relief is obtained in a few months, the growths should be removed by the surgeon. Let me again ask you to give these cases careful attention, and do not allow them to go unrelieved until deformities—mental obtuseness and deafness—forever handicap the victim. It is very important that the infant obtain sleep and food at regular intervals. Too many mothers allow the children to remain up until the older members of the family retire. A child will be stronger in mind and body if it obtains sufficient sleep. The foundation is laid to many mental disorders, nervousness and irritability of temper, if the child is kept awake when it

¹Read at the Nineteenth Annual Meeting of the Fourth District Branch of The New York State Medical Association, held at Buffalo, N. Y., June 16, 1903.

should be gathering new strength and energy in slumber.

The feeding of an infant affords a theme of which much might be said. Fortunes have been spent in experiments in preparing a food to take the place of breast food, and what is the result? The manufacturer and liberal advertiser is the only one benefited. The foods are made to sell, and when sold, the maker washes his hands of the whole proceeding.

We are deluged with samples of foods, accompanied by statements which have little regard for the truth. Yet there is some little use for the foods which I have so strongly condemned. Their temporary use in some cases is a benefit; especially in our large cities among the poorer classes, their use is allowed because better food cannot be procured.

The foods are so deficient in life-sustaining properties that the nutrition of the body is affected, and as a result, in our large cities, rickets and scurvy are frequently found among infants whose diet is confined to some of these so loudly lauded preparations.

Even in the country, cases of rickets are found quite frequently, due to the same cause. People are so willing to believe what they read that they will rush to some drug store, and buy a food without the advice of their medical attendant, and in a few months the physician is called, and finds the child suffering from malnutrition, greatly to the surprise of the fond mother who bought the food because of some picture of a fat baby in the advertising pages of a magazine.

It is needless to say that the child should be fed with regularity, and no child should be fed simply because it cries. The growth of a child should be constant, and that alone should be enough to determine whether the food is in sufficient quantity, and that it furnishes proper nourishment.

When the infant is sick, all food should be taken away, if possible, for a day or so, and some laxative administered. Castor oil may be given if the child is not vomiting. If, on the other hand, vomiting is a feature of the case, the mild chloride of mercury, with some bismuth, should be given. Do not forget to insist that the infant should have water to drink. Many times food is given to a child to its harm, when water would have been taken eagerly, and to its advantage. For a substitute of the breast I would name some modification of cream. It has been demonstrated many times that cream and water in sufficient amounts will afford a healthy child an ideal nourishment. In order to make a mixture which will test the same as mother's milk, something more than diluted cream is needed.

For one pint take—cream, 3 ounces; milk, 2 ounces; water, 10 ounces; sugar of milk, 7 drams; lime-water, 1 ounce. This mixture gives us 88.42 water, 11.58 total solids, 4 parts fat, 1.11 albuminoids, 6.26 sugar. The product is slightly alkaline. Many infants do well on cows' milk

properly diluted. The casein in cows' milk will cause trouble, if the infant is feeble or has indigestion. Many infants are taken about with mothers to picnics, fairs, excursions and so on, and as a result the child gets completely tired out, and indigestion sets in and announces its presence by vomiting masses of milk curds. Children can stand almost any amount of abuse to their digestive organs, and the fact that they can live upon proprietary products, and poor cows' milk, only tends to prove the statement.

There is one point in caring for cows' milk which is not given its due importance. Milk to be in its best condition for food should be handled with great care. Milk which is carried a few rods by hand will give better results than milk which is jolted about in a milk-cart, or carried many miles by train.

For the many intestinal ailments of infants, milk or cream will rarely be found to agree. Albumin water, made by putting the white of a fresh egg in half a pint of sterile water, adding one tablespoonful of brandy, and some cinnamon or nutmeg, and shaking thoroughly, will help out many a case. Beef juice, plain gruels made from pearl barley and strained, will agree in nearly every case of indigestion.

When the mother's nurse is not in sufficient quantity, or when for various reasons the nurse is thin and lacking in nourishment, the child should be weaned. As a rule, the infant will not thrive when the effort is made to compensate the lack of nourishment in the breast food, by giving some other food along with the nurse.

"We should endeavor to obtain simplicity of food and method of preparation, rather than to confuse the mother by intricate formula and complexity of directions."

DISCUSSION.

Dr. DeWitt H. Sherman cautioned against cleaning the mouth of the new-born infant with a finger that might be infected from the escape of the rectal contents at the passage of the head over the perineum, referring to a case of gastrointestinal infection probably resulting therefrom.

He called attention to the fact that the colic of the new-born might be from the passage of uric acid crystals, small renal calculi, as indicated by the color and staining qualities of the urine. He advised the more frequent use of some alkali as an alkaline diuretic. He criticized the reciting of so-called good formulæ for feeding infants and urged the mathematical modification of milk, stating that it was easier to remember the ingredients of milk, fat, sugar and casein and modifying therefrom, than trying to remember stated formulæ. He uses the upper quarter of a bottle of good milk that has stood five to eight hours and calls it a 16 per cent. butter-fat milk, and the upper half, which has stood the same time, and calls it an 8 per cent. butter-fat milk. As the casein and milk-sugar are approximately the same in all forms, modification is simple. The milk-sugar and lime-water are to be added as de-

sired. He acknowledged that home modification of milk is inaccurate, but if the child is gaining four to eight ounces a week, eats and sleeps well, and is happy, inaccurate as the formula may be through the richness of the milk used, it is of little moment. As for proprietary foods, he urged that they be used only as adjuvants, and that if they were used, milk should form a part of the dietary whether the food called for it or not.

He urged that infants be wakened to be fed at the proper, regular intervals during the day, and felt that the rule for the night need not be so strictly adhered to, providing the child did well. If it did not gain, as it should, he urged wakening it for feedings at proper intervals at night, to prevent too long a fast.

A CASE OF MELANCHOLIA AGITANS.¹

BY W. E. DOUGLAS, M.D.,
Middletown, N. Y.

IN the older literature of melancholia we often find cases reported under descriptive names which denoted the chief manifestation or type of the disease. The prevailing varieties were melancholia passiva, melancholia activa—also known as *m. agitans* and *agitata*—melancholia attonita, melancholy with precordial oppression, melancholy with catalepsy, etc. This old classification is by no means extinct, but the tendency to-day is to look upon melancholy itself as one and the same condition, which varies in accordance with the physical and mental state of the patient. Thus Weir-Mitchell has recently classified a large number of cases of melancholia from this point of view—melancholia in hysterical subjects, in neurasthenic subjects, etc.

According to the older standpoint it was instructive to present melancholia as an affection having several clinical types; and we believe that this classification is still available for clinical purposes when a case is encountered which presents some clinical phase in peculiar form. The newer arrangement may be the more scientific, and the more in touch with modern ideas, but well-marked clinical pictures of disease will always be recognized as such, and will never be entirely displaced by advances in our knowledge.

It is not within the province of our paper to take up the subject of melancholy in general. I quote from Lewis *Melancholia Agitans* in full:

"We have referred to delusional forms of melancholia as a deeper reduction than the simple affective form; now, such cases of delusional insanity frequently exhibit acute symptoms—*i. e.*, restlessness, incessant movement, insufferable anguish and every indication of an agonized state of mind—these forms of acute melancholia are still deeper stages in reduction; they are in every sense an approach to the maniacal reductions. By melancholia agitans we do not indicate this acuteness or intensity of mental pain, for the

actual pain is often far more superficial in character than might at first sight be apparent; but we denote by this term the prevalence of a motor agitation, which, in like manner, approximates to the maniacal states. Such forms of melancholia may be of short, but usually are of prolonged duration, even lasting over several years; they may form but a stage in any mental disturbance, or may characterize the case throughout, to its termination in recovery, in dementia, or in death. Dr. Fleury recognizes the intensity of suicidal proclivities, as well as the unfavorable prognosis of agitated melancholia occurring at the climacteric in women; he also draws attention to the frequent association of such disturbance with drinking propensities.

"The patient is quiet only when asleep; rocks her body to and fro, or paces up and down the room incessantly; the hands are in constant movement, grasping the head, tearing the hair, rubbing the chest, picking the skin until it bleeds, biting the nails, tearing or disarranging the clothing—or huddled in a corner, her face buried in her hands, she sways to and fro, lamenting her fate in loud sobbing or ejaculations sufficiently expressive of mental distress. Almost invariably the delusive ideas from which she suffers are prominent from the first—her soul is eternally lost; she is cast out from God and the world; she is disgraced, or has brought ruin upon herself and family.

"Hallucinations do not appear to prevail in this form—they may have occurred as a prelude to this stage of reduction, and in their recall may constitute material for delusive ideas. The hypochondriacal forms may exhibit this state of motor agitation at different periods of its course."

We may therefore proceed at once to report the following case, which we prefer to style, after the old nomenclature, one of melancholia agitans or activa:

Miss E. S., aged 27, called at my office on December 29, 1891, giving the following history: Five years ago had a slight attack of what I presume, from the history, to have been melancholia agitans. There is no insanity in the family on either side that I can trace. She was well developed and had always been fairly healthy, excepting during menstruation, when she would have severe headaches, and, as she expressed it, couldn't keep still, must either walk or rock, and these attacks would pass off in a few days. But five years ago, for a period of about eight weeks, she suffered from insomnia and restlessness and worried a great deal about the welfare of her soul. On December 29th she presented symptoms of a severe cold with hysteria; would get up and walk around the office and wring her hands; said she was worried about the ways and means of the livelihood of people dwelling on her street. The insomnia and restlessness increased until January 15, 1892, when she developed a desire for self-destruction. There was some slight improvement

¹Read before The New York State Medical Association at its Nineteenth Annual Meeting, held in New York, October 20, 21, 22, 1902.

under treatment during the next fortnight, sleeping only at short intervals and was very restless during the entire time of her sickness. One day she turned herself in bed seventy times in one hour; another she protruded her tongue constantly for the greater part of one day. She attempted on several occasions to kill herself by strangulation.

She was given simple and nourishing food (which was sometimes refused), and the bowels were kept open by enemata. The only drug used was tinct. gelsemii.

Early in February her mind seemed more natural, and she was sleeping well. Although her diet consisted of such simple articles as cereal, cocoa, baked apple, milk, etc., she had periods of vomiting and her physical state appeared to fail in strength. Her average temperature was 100 or more, while the pulse ranged from 110 to 134. Her mental state continued to be one of excitement and hysteria. On account of the prominence of vomiting as a symptom, she was placed upon peptonized milk on February 4th.

By the middle of February the patient had become very weak and all violence had subsided. She was nervous and hysterical and picked her lips. Her mind was confused and articulation difficult. Her temperature and pulse, which had been improving, rose suddenly about February 18-19th, coincident with a bladder complication (vesical tenesmus, etc.). This subsided under appropriate local and internal treatment and the pulse and temperature improved greatly. At the end of February hysteria and nervousness were more marked and there was more insomnia. Patient longed to die.

During the first few days of March restlessness and insomnia were marked. The bladder was again troublesome and constipation had become a feature. From March 3-7th patient wept continually. A menstrual period was missed. Constipation had become obstinate and attempts to move the bowels failed.

March 8-10th the bowels were thoroughly evacuated. Urinary retention developed, water being drawn with catheter. The patient cried and talked incessantly. For a number of days she had lived on raw milk, but a return of nausea necessitated the resumption of peptonized milk.

Obstinate constipation was succeeded by a state of fecal incontinence about the middle of March. By March 16th both diarrhea and vomiting were profuse. The mental state was one of hysteria, with delusions and insomnia. Patient would laugh, scream and weep alternately. When exhausted she would sleep a little.

During the balance of March the symptoms fluctuated greatly in character. At one period vomiting would interfere with nutrition, the bowels would be confined and the mental state bad; then the patient would respond to medicine, the pulse and temperature would improve, sleep would return and the mind would be more clear. The great number and variety of complaints on

the part of the patient suggested the hysterical quality of the case.

On April 1st the record was as follows: Temperature, 100.5; pulse, 140. Patient able to retain considerable raw milk. Some vesical tenesmus, urine passed in bed.

On April 8-9th the bowels were loose and acted involuntarily at times. Milk, cornstarch, beef-tea, etc., were retained. The patient was inclined to restlessness and insomnia. Her pulse and temperature exhibited wide variations.

By April 16th her digestion had improved to such extent that she was eating solid food (egg on toast, peaches, steak, bread, prunes, etc.). This improvement may have been due to the stimulation of morphia, which had been used as a last resort for the numerous symptoms for which this remedy might be exhibited.

From this time on the patient was sustained by morphia, which appeared to control the leading symptoms. Thus on April 19th it is noted that she received, during twenty-four hours, about one and one-half grains morphia, together with brandy and diarrhea mixture. She took barley and rice gruels as nutriment. Her mental state was one of quiescence, she having some hallucinations.

Upon the day of her death (April 23d) patient was able to take gruels of rice and barley. She had much vesical tenesmus, which was relieved by hypodermics of morphia. No autopsy could be furnished.

As already stated, melancholia agitans is no longer widely recognized as a special clinical form of melancholia. Authors continue to use the term to some extent in describing the disease and in case-histories. A special literature of melancholia agitans, however, can hardly be said to exist. Generally speaking, there is but little monographic literature upon melancholia as a whole, so it is not surprising that we do not find monographs upon the particular form under consideration. The best account of melancholia agitans known to us is that of von Krafft-Ebing. While the work is not of recent issue, the clinical pictures of the disease, and the conclusions drawn therefrom by the author, will, of course, hold good for all time. We append what he has to say of melancholia agitans:

"This type of melancholy forms a marked contrast to the passive form. The patient is in a state of constant excitement and activity, the nature of which is unlike mania. This agitation is not a separate disease-state, but a sort of acme or crisis occurring in the course of otherwise ordinary melancholia. It should not be confounded with mania, although often classed with the latter. The motor excitement of the melancholic patient is a reaction due to the painful thoughts and emotions of the latter. In mania, on the other hand, we see an increased susceptibility to the transmutation of ideas into motor impulses.

"Melancholia agitans may pass rapidly into the passive type or into cataleptic rigidity. At the

height of a crisis consciousness is always disturbed, and may be lost entirely; as that recollection of the episode is incomplete or wanting.

"If the violent period is of long duration there is danger of death from exhaustion if the subject is old or feeble. Or we may see the subsequent development of incurable dementia.

"During these paroxysms the patient threatens to destroy everything and is in a state of constant agitation, so that the resemblance to mania is marked. Delirium may also develop, but is quite unlike that of mania, as originally shown by Richards in 1858.

"The association of an increase of precordial anxiety with the development of active melancholy is common.

"The delirium of active melancholy is monotonous, a persistent variation of one theme. We do not see one idea lead continually to another, as in mania, with inability to keep to one subject.

"The prognosis of active melancholy is in general more favorable than that of the passive type, for the latter has more tendency to pass into dementia."

The author gives no *special* directions for the treatment of melancholia agitans.

THE PRESENT POSITION OF GALL-STONE SURGERY.¹

BY WILLIAM WOTKYNs SEYMOUR, M.D.,
Troy, N. Y.

OVER a quarter of a century has passed since Marion Sims did the first-planned operation for gall-stones, and sufficient time has now elapsed to permit a fairly correct judgment as to the present position of gall-stone surgery. But before gall-stone surgery will show its best results the profession, as a whole, must recognize that there are no solvents which will dissolve gall-stones in the gall-bladder and bile ducts, and must, furthermore, recognize their own culpability if operative interference is delayed until the vital powers are exhausted. No field of surgery gives greater relief from agonizing pain, or gives greater capacity to do one's normal work than judicious early operations for gall-stone disease. Not for an instant would I be understood as advocating operation in every case of pronounced gall-stone colic. But when the attacks recur frequently, show a tendency to increase in severity, and become more and more incapacitating, then an operation is imperative and should be done before the recuperative powers are greatly impaired. In the advance which gall-stone surgery has made in the past twenty-six years, the surgeons have been obliged to lay several popular and professional errors. The first in magnitude and, unfortunately, still prevalent among the profession is that stones can be dissolved by internal medication. An heretical doctrine which claims yearly its hecatombs of mis-

guided victims. The more deplorable because any one with an extensive experience knows that long periods of time sometime elapse between attacks. I know of one case of over nineteen years' interval and another in which six weeks before his fatal attack a brother physician boasted to me that he had dissolved by daily doses of soda the gall-stones from which he had formerly suffered, and for nine years had been absolutely well. Within six weeks of that day he died from perforation of the gall-bladder, and 153 stones were found in his gall-bladder. Right here it is well to recall the present teaching that it is the associated inflammation which occasions the pain and cramp and not the mere presence of the stones. This seems a rational explanation of the quiescence of stones found at autopsy in so many persons who never have suffered from gall-stone colic or other condition commonly associated with gall-stone disease. It furthermore explains the fact of putty-colored stools often preceding for a day or two the appearance of gall-stone colic. This last fact I with apprehension noticed many times in my own case. The profession is and has been slow to learn that pronounced jaundice is not a common symptom of gall-stone disease. Upon this Lawson Tait laid great emphasis, and also that when jaundice was very deep and persistent it pointed rather to a malignant complication. This experience of Tait has been borne out by the experience of Mayo Robson and Kehr. Kehr declares that jaundice is absent in 80 per cent. of gall-stone cases. Even when large stones are in the common duct, the jaundice is never so deep and persistent as in malignant disease. Another important diagnostic factor is that in case of stone in the common duct the gall-bladder is usually contracted and often a mere rudiment, whereas a very largely distended gall-bladder accompanied by jaundice is almost invariably due to malignant obstruction. Courvoisier, who first statistically demonstrated this fact, claims that the repeated attacks of inflammation necessary to extrude a stone of any size from the gall-bladder into the common duct lead to thickening and contraction of the walls of the gall-bladder. Now, if gall-stone disease is a surgical affection, what are the operative procedures which offer the best chances of cure? Lawson Tait commonly did a simple cholecystotomy, incising the gall-bladder, evacuating the stones and then stitching the gall-bladder to peritoneum and aponeurosis, with temporary drainage by rubber tube. This operation in the hands of Tait, Mayo Robson and Kehr has proved curative in the vast majority of cases, with a mortality of less than 2 per cent. Tait was accustomed to crush stones in the cystic and common ducts by fingers or padded forceps, and Thornton commended breaking up common duct stones by passing needles through the ducts into the stones. When Courvoisier and Marcy deliberately excised stones from the common duct, a new era dawned on gall-stone surgery, for it not only showed that

¹Read before The New York State Medical Association at its Nineteenth Annual Meeting, held in New York, October 20, 21, 22, 1902.

stones could be safely excised from any portion of the common duct, but that in cases of severe infection the common and hepatic ducts could be drained for weeks to the relief of patients previously at death's door. With the improvement in technique in common duct cases the removal of the gall-bladder has steadily gained in favor. The removal of the gall-bladder commonly removes the laboratory in which the stones are formed and does away with the fixation of the gall-bladder in an abnormal position, to the increased chances of adhesions and to kinking of the common duct. While commonly no great inconveniences may result from the suture of the gall-bladder to the parietes, occasionally the traction upon the adherent gall-bladder may be very painful. For years after Tait operated upon me I was able to row, box and fence without a particle of inconvenience, but an attack of pneumonia last February, with the coughing attending it, made me feel like cursing the fact that my gall-bladder was so firmly attached to the parietes. With our increased knowledge of common duct stones and the methods of dealing with them, we need no longer be deterred from excising the gall-bladder if the stones are found only in it and the common duct seems free. Kehrer, from his enormous experience, believes excision of the gall-bladder or cholecystectomy to be the method of choice, and his cholecystectomies have given only a mortality of 3.3 per cent. Kehrer has added another valuable procedure to our means of relief—the drainage of the common and hepatic ducts—which he frequently executes after removal of stones or even when no stones are present if there is evidence of infection of the bile ducts. In this way he has succeeded in saving many cases which otherwise would have been hopeless. The same thing may be done at times with less danger, even though with diminished certainty of drainage, by cholecystostomy. Only recently I had from the operator an account of the case of a very prominent politician who, some months after an apparent recovery from typhoid, developed a grave cholangitis accompanied by intense jaundice and high fever. The condition of the patient was so very grave that the gall-bladder was simply incised and stitched into the wound. Typhoid bacilli were found in the bile evacuated at the operation, but no stones. Now, a year after operation, bacilli are still found in the bile from the fistula, which is not allowed to close, any attempt at closure being followed by a recrudescence of the old symptoms. In a similar case it would be better, if the condition of the patient admitted, to open the common duct, stitch in a large rubber tube, passed well up to the hepatic ducts; after tamponing for a few days the belly as a safeguard, irrigate the bile ducts with repeated irrigations of warm, normal salt solution. Kehrer, in his admirable clinical histories, repeatedly mentions removing in this way most offensive bile, with the result invariably of a marked diminution of sepsis. The neglected cases of gall-stone

disease, by reason of their complications, such as innumerable adhesions, fistulous communications with other organs, obstruction of the pylorus and duodenum by kinking, will demand the most resourceful and skilful surgery, and will even then have a high mortality. In addition with long-continued gall-stone disease, cancer is not infrequently associated, and then all efforts of relief are futile. However, we can in the present state of gall-stone surgery promise in uncomplicated cases almost certain cure; in cases of stones in the common duct, unless in persons with other complications, but a slightly increased mortality. While in the neglected cases, the cases in which patients and attendants have procrastinated and frittered away time and recuperative powers, the mortality will be high; how high one cannot say, but in Kehrer's cases this class gave a mortality of 47 per cent.

It therefore becomes our duty, when face to face with recurring severe gall-stone attacks which threaten to incapacitate or kill the patient, to urge early operation and let the patient bear the onus of the delay, if there is any.

Of forty-four gall-bladder operations which I have done, six have proved fatal, as follows: Of thirty-four uncomplicated cholecystostomies, one died. A young woman of 30 years of age, weighing about 240 pounds; she died on the third day, when the heart gave out. Only a partial autopsy was allowed, and no peritonitis or hemorrhage was found.

Two complicated cholecystostomies died; one a woman of 55, a sufferer for fifteen years, had vomited almost continuously for three weeks before operation. The stomach was very much enlarged and I intended to do a gastro-enterostomy, but after breaking up adhesions of the gall-bladder to the transverse colon, stomach and duodenum and removing thirty-five stones, the patient was so feeble that I had not the courage of my opinion, and the patient died fourteen days later, having repeatedly vomited retained food and occasionally blood, gradually becoming weaker. No autopsy allowed.

The second case was a woman 54 years of age, who had been ill five weeks before I first saw her, at which time she was deep-gold color, septic and constantly vomiting. I could feel an enlarged gall-bladder, which was very tender and contained stones which actually grated under my touch. Operation was urged and declined for three weeks. When I then did it I removed 115 gall-stones weighing exactly two Troy ounces. The patient's fever disappeared, the stools contained bile and appetite was reestablished, when she suddenly collapsed on the fifth day and died. A partial autopsy showed no hemorrhage or peritonitis.

In eight cases I have met with stones in the common duct; in five, stones were also found in the gall-bladder. In three of these cases I opened the gall-bladder, removing the stones by a cholecystostomy and crushing stones in the common

duct by fingers or padded forceps—all three recovered. In two cases I opened the common duct only; first finding from exploration through the common duct a rudimentary or contracted gall-bladder, and after draining the common duct with rubber drainage, both cases recovered.

In three cases I opened both the gall-bladder and common duct to remove stones. Two died. One, a woman 49 years of age, a sufferer for nine years, and intensely jaundiced for nine months before operation. Two stones were removed, one a centimeter in diameter from the gall-bladder, and one slightly larger from the common duct. The common duct was drained, but the patient died from cholemic hemorrhage the second day.

The second death was in a feeble Armenian, 39 years of age, who had suffered fifteen years and had been deep-bronze color for months. I removed from him also one stone from the gall-bladder and one from the retroduodenal portion of the common duct. During the month he lived after operation his temperature remained normal, or slightly below, and on the thirtieth day he suddenly died from heart collapse, due as much to innutrition as anything. The autopsy showed no peritonitis or hemorrhage, but great wasting of all tissues.

Of two cholecystectomies which I have done on patients who had suffered from gall-stones, one died. The patient was a man 55 years of age whom I saw in consultation eight years ago, at which time I urged him to have an operation. At that time the attacks of pain were of great severity and recurred very frequently, but he would not entertain the thought of operation. During the eight years which elapsed he was frequently incapacitated by pain and jaundice from labor, and increasing doses of morphine became necessary to give him any comfort. Just before operation he had required one-half-grain doses of morphine every three or four hours. I urged operation and removed a gall-bladder, pear-shaped, about six inches long. The gall-bladder contained no stones, but its walls were very much thickened and the mucous membrane very much thickened, inflamed and in some places necrotic. No stone could be detected in the common duct. The cystic duct was ligatured and overcast and the abdomen tamponed. His vessels were sclerosed. During the ten days he lived he had with increasing frequency attacks of lividity of hands and weak pulse, but practically a normal or slightly subnormal temperature. The stools, previously white, became normal after operation and he had absolutely no pain. His appetite was fickle and death came with a collapse. No autopsy allowed.

DISCUSSION.

Dr. R. H. Gibbons said that it was important to make surgical explorations more often than was done before the physician had carried out any prolonged treatment, in order to determine whether or not there is some gall-stone obstruction which might eventually lead to malignant disease.

Only recently a medical friend sent for him as a surgeon. He had had several marked attacks of gall-stone colic, and had never fully recovered from jaundice. Operation was advised, and at the operation, done by Dr. E. Laplace, in Philadelphia, it was found that he had malignant disease of the pancreas and duodenal end of the stomach and of the liver. The speaker said he had also seen a physician who recently died from a tumor supposed to be connected with the pyloric end of the stomach. He had recommended that Dr. Weir see the case, and this gentleman, examining under ether, came to the conclusion that it was not a tumor of the stomach. Operation showed that the tumor was one of the pancreas. Dr. Seymour should receive the thanks of the Association for having reported his failures as well as his successes.

Dr. Seymour, in closing, said he hoped the profession would soon recognize the importance of gall-stone surgery, and would consequently no longer permit the unnecessary complications to occur that had been observed in his bad cases. The procrastination of surgical treatment, he was sorry to say, was largely attributable to the attitude of the medical attendants.

PRINCIPLES INVOLVED IN THE REPAIR OF LACERATIONS OF THE PELVIC FLOOR.¹

BY JAMES HAWLEY BURTENSHAW, M.D.,
New York.

BARELY twenty years have elapsed since preconceived ideas regarding the function of the so-called perineum or perineal body began to undergo radical change. Previous to the publication in this country of the classic paper by Emmet, and of that in Germany by Schatz, it was generally conceded that on the integrity of the perineum depended the maintenance of the normal positions of the organs of the pelvis. Even in 1890, Goodell taught that "the sustaining power of the vaginal column depends on the integrity of its perineal abutment," and Thomas and Mundé, in 1891, that "upon the posterior vaginal wall rests the anterior, upon this the bladder, and against the bladder the uterus, all of which depend in great degree for support on the perineal body." This perineal body was defined then, as it is today, as "a triangular wedge composed of muscles, fascia, and areolar tissue which fills the space intervening between the backward curve of the rectum and the forward curve of the vagina." It is now accepted as a fact that this perineal body does not enter into the formation of the muscular floor of the pelvis, but lies wholly beneath it; that its function is solely to give needed support to the curve of the rectum during the expression of intraabdominal force, especially in defecation. From the position of the perineal body between the vaginal and rectal orifices it is not difficult to discover the source of error as to its physiolog-

¹Read before The New York State Medical Association at its Nineteenth Annual Meeting, held in New York, October 20, 21, 22, 1902.



FIG. 1.—The levator ani muscle, covered by its fascia, as seen from below (Weisse).

ical function, but the deductions of the older anatomists, in some respects, closely approached the truth, and if one will substitute the term "pelvic floor" for "perineum," certain of their arguments, in the light of present-day knowledge, will be found to be unassailable. But, in view of the fact that to "laceration of the perineum" is attributed such a train of pathological symptoms, and because of the entirely erroneous conception of the physiology of this structure, it would seem to me better had the terms "perineum" and "perineal body" never been invented.

The various structures entering into the composition of the pelvic floor are still a subject of dispute. This paper has to do only with the admittedly most important muscles of the floor and their aponeuroses, namely, the pubococcygeus and the puborectalis, which unite to form the levator ani. It is extremely difficult to obtain even a moderately correct notion of the attachments of this muscle, except by a careful dissection. Drawings and printed descriptions, even when of the best, are apt to be confusing. I shall not weary you with unnecessary anatomical details, but a brief *résumé* of the origin and insertions of the levator ani is necessary in order to appreciate its important function. Remove the skin, fascia, and certain muscular structures over the area bounded by the pubes, the ischial rami, and the coccyx, and a portion of the levator ani will be exposed to view, a more or less apronlike muscle when seen from this position which encircles the

urethral, vaginal, and rectal orifices. This is shown in Fig. 1, the superficial layer of the triangular ligament (see Fig. 3) having been removed.

The levator ani on each side is attached to the horizontal ramus of the os pubis, to the inner side of the spine of the ischium, and to the fascia extending between these points (Fig. 2). The insertions of the muscle are many. "Stretching down and back, the fibers divide into unequal portions, of which one passes to the anterior aspect of the rectum, another to its posterior and lateral surfaces, while the fibers attached to the pubic bone extend along the vagina, with which they are united by strong connective tissue, but do not terminate within its walls. The belly of the muscle sweeps backward, almost horizontally, surrounding the rectum" (Piersol). In Fig. 2 these points of attachment are particularly well shown. It would seem that this dissection should convince those who are averse to attributing sustaining function to the pelvic floor that every anatomical detail of the parts tends to uphold the theory.

Of very great importance is the fascia which covers the several portions of the levator and enters largely into the structure of the pelvic floor. Without entering into details, it may be said that the posterior or outer aspect of the muscle is covered, from the rami of the pubes to the ischia and coccyx, by a dense fascia, the levator, which, a short distance above the external anal sphincter,



FIG. 2.—The attachments of the levator ani muscle to the pelvis, showing the rôle of this muscle in supporting the pelvic viscera (Dickinson).

unites with the deep layer of the triangular ligament (Figs. 1 and 3). The rectovesical fascia (Fig. 3) I consider the most important fascia of the pelvis, as it undoubtedly is the prime factor in enabling the pelvic floor to withstand intraabdominal pressure at the pelvic outlet. It has its origin from the parietal or main layer of the pelvic fascia along the so-called "white line," which extends from the lower part of the posterior surface of the symphysis to the spine of the ischium, and covers the inner or upper surface of the levator ani as far as the rectum, where it divides into four layers—the vesical, the vesicovaginal, the rectovaginal and the rectal. Of these, the rectovaginal covers the fibers of the levator which pass between the vagina and lower part of the rectum, while the rectal layer extends behind the rectum and is attached to its walls.

I do not propose to enter into the subject of the dynamics of the pelvis. There can be no doubt that the function of the pelvic floor, as a whole, is to support the superimposed viscera, which is accomplished mainly by the inherent strength of the fascia and connective tissue. The principal function of the levator ani muscle is to support and hold in position the rectum, vagina and urethra. As Kelly says,² "It is apparent that the vaginal outlet has no direct means of closure such as would be afforded by a powerful sphincter muscle, but depends for its support upon the indirect action of the levator muscle. For by the contraction of this muscle the lower end of the rectum is tightly lifted up under the pubic arch and the vagina flattened out and held up between the two."

Emmet, in 1883, in support of his argument

against the undue importance attributed to the perineal body, drew attention to the fact that laceration through the sphincter ani might occur without subsequent descent of the pelvic organs, provided there was no accompanying laceration of the pelvic floor. It is not my intention to detail the injuries that may occur to this floor, or the symptoms arising therefrom, but rather to discuss the principles involved in efficient repair; and with this object in view I draw attention once more to the position of the levator ani muscle and its superior and inferior layers of fascia as they surround the vaginal canal (Figs. 3 and 1). It is to be remembered that the direction of the normal vaginal canal, for a distance of from one-half to three-quarters of an inch within the line of the hymen, is upward and backward, and from this point, the so-called perineal angle, almost directly backward (Fig. 3). It is at this perineal angle that the levator and its layers of fascia lift the canal forward or upward, and it is at this point also that separation of the muscle and of the fascia usually occurs.

The train of symptoms following this accident I need not refer to here. The diagnosis is easily made. If a normal rectovaginal septum is examined by means of one finger in the vagina and another in the rectum, the edges of the levator ani may be felt through the lateral walls of the vagina; if separation of the muscle has occurred, the anus is not directly forward, the vaginal outlet is relaxed, and, in a majority of cases, digital examination readily detects the lesion.

Long before the days when the practice of gynecology was set apart as a specialty by itself, the morbid effects of these lesions on the health of women were recognized, and more or less well-

²*Operative Gynecology.*

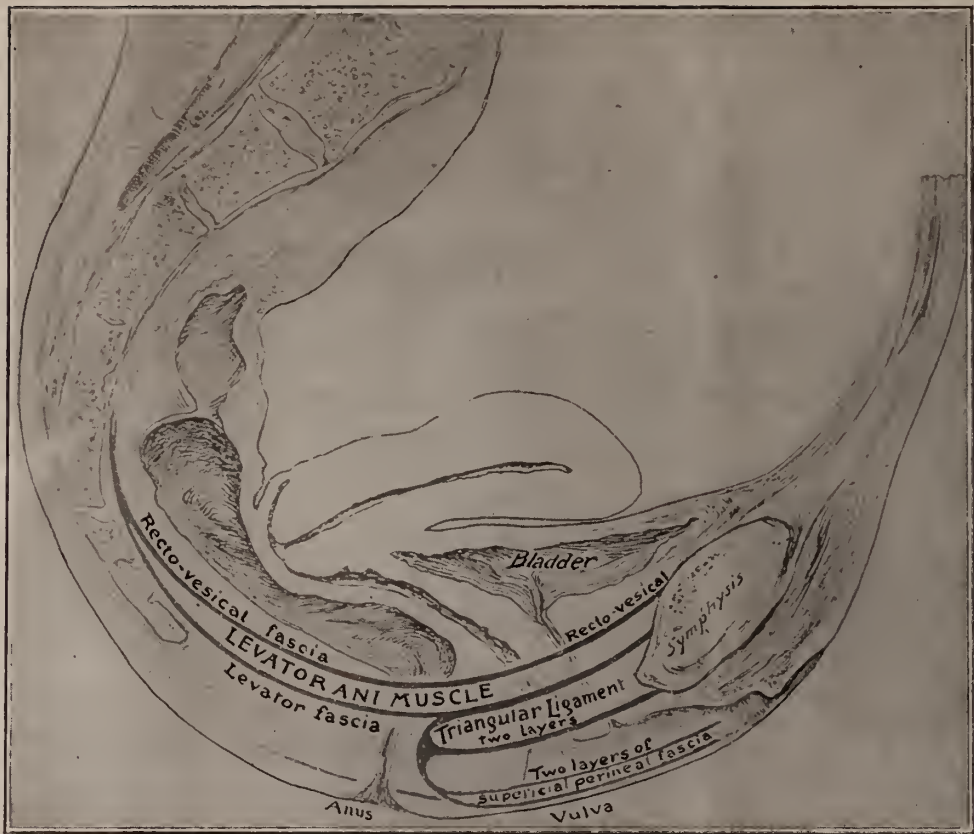


FIG. 3.—Mesial section showing the levator and muscle and its enveloping fascia (Dickinson).

directed efforts were made by surgeons toward effecting a cure. Portions of the vaginal floor were denuded, the areas of denudation being of various shapes and sizes, and the edges of the wound were approximated by sutures introduced in various ways, but not until Emmet so clearly demonstrated the function of the pelvic floor and its pathology did surgeons appreciate the principles underlying operation.

And now this question intrudes itself: Do a majority of the modern operations of perineorrhaphy and colpoperineorrhaphy actually restore the pelvic floor to its normal condition? To this question I think there is but one answer—No. In but one or two of the many text-books on gynecology now in general use are these operations on the posterior wall described in sufficient practical detail, nor are the generality of operators at clinics more precise in their technics. Especially is this true with regard to the denudation of the tissues. The would-be operator or the student is directed to outline the area to be denuded, and then simply to *denude* it, taking care to remove all scar tissue, if such is present. Except in connection with the latter, no direction is given about the amount of tissue that should be removed; in other words, whether the denudation should extend through the mucous membrane only, or into or through the vaginal wall. As a matter of fact, until very recently, most operators have endeavored to save as much tissue as possible, and

the flaps or strips removed have consisted of but little more than the mucous layer.

It stands to reason that here, as elsewhere in the body, in order to close a muscular rent, the edges of the muscle or muscles must of necessity be raw, and must be closely approximated and so held until union has ensued. By far the greater part of posterior-wall plastic surgery does not expose the levator ani muscle and its enveloping fascia at all; the muscular wall is partially denuded, and, by the help of sutures, is backed up against itself, in which position the surfaces unite. Such an operation is that known by the name of Hegar, pictured in Fig. 4. I willingly grant that, in a majority of instances, such an operation fulfils all necessary indications, as far as reducing the lumen of the canal and partially closing the outlet is concerned, but I do not admit that it repairs the laceration of the pelvic floor. The edges of the separated muscle and its fascia undoubtedly are brought closer together by the approximation of the immediately overlapping tissue, but the rent remains. Many operators have appreciated this defect, and have evolved special methods for the suturing of these superficially denuded areas, the professed object of the sutures being to draw the separated muscles and fascia together, but I fail absolutely to discover how this closure can be made permanent unless muscles and fascial edges themselves have been freshened, or, perhaps, the



sutures are removed? This being granted, I cannot see that anything more is accomplished by this operation than by those of Hegar, Martin, Bischoff, Freund, Dudley, Edebohls and a score of others. If the denudation in the Emmet operation were to extend through the thickness of the vaginal wall, as in Kelly's method, it seems to me that the permanent results might be more in accordance with his claims.

I do not for a moment deny that a woman suffering from pelvic floor laceration will be immensely benefited by the performance of one of these plastic operations; I simply fail to convince myself that the parts can be restored to their *normal* condition, the condition in which they were previous to the injury, unless the ruptured muscles and fascia underlying the floor of the vagina are individually freshened and individually sutured.

It would appear that, so long as good results are obtained from these operations, it is unnecessary to strive for a higher degree of excellence in technics; that more elaborate and time-consuming procedures are uncalled for. This may well be; but advanced surgeons doing scientific work will ever endeavor to base that work on sound anatomical and physiological principles, and will not rest satisfied until that end has been attained. It is for this reason that new operations and modifications of old ones are constantly being brought forward.

In carrying these principles into effect it is

suture has been of non-absorbable material and buried.

It would appear, in this connection, to be rank heresy to question the teaching of such an eminent authority as Thomas Addis Emmet, but I confess that during an active experience covering nearly ten years in the teaching of operative gynecology the conviction has grown upon me that the operation devised by him for the cure of relaxation of the pelvic floor does not accomplish what he alleges for it. By means of a gutter-shaped, triangular denudation on each side of the vaginal canal, which denudation extends only through the mucous membrane, and by the introduction of three separate sets of sutures, "the slack of the retracted fascia is taken up throughout the pelvis, the posterior vaginal wall is lifted upward and forward in contact with the vesicovaginal septum, the everted tissues at the vaginal outlet are rolled in, and the separated levator ani muscles are brought together so that the woman becomes apparently perfectly normal." I grant that all this *may* be perfectly true, and that all that is claimed for the operation may be accomplished—*just so long as the tightly drawn sutures remain in place*; but neither the levator itself nor its fascial coverings have been freshened and directly united, and being held in their normal positions only by the sutures, is it not reasonable to suppose that they will retract to a certain extent as soon as the



FIG. 5.—First step in suturing of the separated levator ani muscles (Reed).



FIG. 6.—Second step in suturing of the separated levator ani muscles and vaginal incision (Reed).

necessary to bear in mind certain additional facts in connection with the physiology of the pelvic floor. The first and most important of these is that the strength or sustaining power of the floor does not lie in the levator muscle itself, but in the fascia which envelops it. The conditions here are analogous to those which obtain in connection with the muscles and fascia of the anterior abdominal wall. Every operator is fully alive to the necessity of carefully approximating the edges of the rectus fascia if he would prevent the subsequent occurrence of ventral hernia. The stitching together alone of the muscle edges will not prevent hernia through the abdominal wall, nor will a like operation on the levator restore the lacerated pelvic floor. In every case the fascia itself must be united.

During the past year or two the technic of pelvic-floor repair has been greatly improved by a number of operators, notably by Harris, Reed, Noble and Stone. Two of the steps in Reed's operation³ are shown in Figs. 5 and 6. Briefly, this operation is as follows: After dissecting up a flap of the vaginal wall, the levator ani on each side is hooked forward. If the fascia underlying the muscle (the levator) has been ruptured, its edges are freshened and united by interrupted catgut sutures. The redundancy of the vaginal wall is then excised, and the separated levators, the rectovesical fascia, and the edges of the vaginal wound are brought together by deep

sutures of silkworm gut, introduced in a manner original with the author of the method (Fig. 6). Modified in some minor details, this operation impresses me as being an ideal one for the purpose for which it was designed—to restore the pelvic floor.

It is true that in many cases in which the lesion is of long standing, especially if the woman is poorly nourished, the rectovaginal septum near the outlet will be so thin that a search for the separated levator edges cannot be carried out without danger or injury to the bowel. It is in this class of cases also that it frequently is impossible to recognize and isolate the levator, to say nothing of its fascia, and the operation that will give satisfactory results under these circumstances will be of the Hegar type, mentioned above.

Conclusions.—These may be summarized briefly, as follows:

1. The rôle of the pelvic floor in sustaining the pelvic viscera being acknowledged, a laceration of the muscles and fascia composing the most important section of the floor should be repaired in order to restore the natural equilibrium of the pelvis.

2. While a majority of the plastic operations on the vaginal wall restore the natural curves of the vagina and rectum and reduce the size of the vaginal outlet, in order to restore the pelvic floor to a normal condition, approximation and suturing of the edges of the levator ani muscle and its fascia are imperative.

DISCUSSION.

Dr. E. D. Ferguson, of Troy, spoke of the principles underlying these operations. In every operation, he said, done by through-and-through suturing, there was an error with regard to the restoration of the parts to their natural condition. When these sutures were tightened they were thrown into a circle, and consequently the tissues which were retracted were not brought together, particularly in the center. They were only united by scar tissue, and such tissue would always give. There should be absolute and complete exposure of all parts, and this should be accomplished by proper dissection and making of flaps. Then came the question as to the recognition of the levator ani and the differentiation of the different layers of retracted muscle and fibrous tissue. He had not always found it possible to do this in actual practice. If the pelvic fascia were brought together with any kind of suturing, and the best of all, he believed, was the cobbler's stitch, the fibrous and muscular tissue would be brought together and there would probably be good union. Unless this tissue was brought out from the sulcus on each side and built up into the fibro-muscular floor which formerly existed, the operation would not be successful. In all other methods the scar would yield, and therefore there would ultimately result "a skin perineum." This principle of closing this part

³Journal of the American Medical Association, August 30, 1902.

by itself was most important; the rest of the wound could be closed in various ways.

Dr. Frederick Holme Wiggin said that his experience coincided with the remarks of Dr. Burtenshaw and of Dr. Ferguson. Many years ago he had become dissatisfied with the method of operating upon the perineum, and had discovered the necessity of bringing together the muscles which separate on the perineal floor. An external tear of the perineum did not amount to anything practically; it was only when the muscles separated and allowed the rectum to prolapse and form a rectocele that the result was serious. As soon as the rectocele formed there was another train of symptoms developed. The force required for defecation was exerted in the wrong direction, *i. e.*, forward instead of downward. The important thing was to bring together these separated muscles and hold the rectum in place. If this were done the woman would be very much benefited. He had been in the habit of making an incision at the junction of the mucous lining of the vagina and the skin and separating the mucous membrane from the deeper tissues to the highest point of the rectocele. Having raised the flap it would be found that the rectum could be pushed back into place and the outline of the muscles could be felt. No fine dissection was required. The parts were then brought together with buried sutures of catgut or kangaroo tendon. The perineal body became thickened as the operation progressed. Finally the mucous membrane was closed so as to avoid infection. For years he had been in the habit of allowing the woman to pass her own urine, and applying a little iodoform and ether solution to the wound. The results had been uniformly satisfactory, not only to himself, but to the woman and her husband.

Dr. Gibbons said that there were two forms of injury in these cases which should be recognized. If there were merely a laceration of the fascia, which is practically the sheath of the muscle, nothing more was necessary than to expose the fascia and dissect out the cicatricial tissue or cut away the overstretched part of the fascia. Then the fascia and needle are brought up back toward the median line according to the method of Emmet. The Creator never placed the muscle where Reed attempted to place it. Howard, of Chicago, first dissected out the cicatrix in the muscle itself, and brought the muscle together. Goldspohn, of Chicago, recommended a lifting up of the flap anteriorly and beginning high up and building up toward the front. This, the speaker said, was an excellent idea. The operation of Emmet, if properly done, with complete denudation—not merely snipping off the mucous membrane—brought the parts to where they had been originally. This should be done on each side if the laceration were bilateral. If the muscle itself were torn, one treatment was appropriate; if the fascia were merely overstretched or torn, another method should be employed. Emmet provided for this by exposing the

muscle. In operating for hernia the same thing was done, and the muscles came together and united.

Dr. Eden V. Delphay said that so far only one class of lacerations had been referred to, *i. e.*, on the antero-posterior line. In some cases there was external evidence of laceration; in others the skin was intact. By inserting the finger into the vagina laterally one should determine whether there was resistance toward the ischium; if not, then the laceration was quite serious, because the levator ani was torn through from one border to the other. Here, the denudation should be carried well down to the muscle and all cicatricial tissue removed. The ends of the muscle were then brought together. The effect of the tear in the levator ani was to cause retraction of the posterior fibers of the muscle and greatly impair the support to the pelvic organs.

Dr. David P. Austin, of New York, said that better than waiting, as in the majority of cases physicians do wait, for perineorrhaphy, was the performance of the operation immediately after delivery. At that time the parts that had been torn asunder could be more easily and thoroughly brought together than afterward. According to his experience, even cases in which the laceration had extended into the rectum could be better treated immediately after delivery.

Dr. Theodore P. Simpson, of Beaver Falls, Pa., said he had been very much interested in the paper, and had done this operation twice in the last three days. He felt with the reader of the paper that there was something lacking in the operation as ordinarily performed, especially by those who are not specialists. In all cases there was a rectocele and a vaginocoele, and in order to return the parts to their normal shape as well as condition, the extension, so to speak, of the floor of the vagina must be removed—in other words, the redundant mucous membrane must be taken away. In the operation of Kelly, provision was made for a tongue of mucous membrane, three-quarters of an inch wide, toward the vagina, and an incision was made on either side down to this tongue. When the parts were brought together, after sufficient denudation to take in both mucous membrane and muscular tissue, the muscular fibers are brought together quite perfectly, being attached not only from side to side, but to some extent also from end to end. In this way the natural curvature of the vagina was replaced.

Dr. J. Riddle Goffe thought all this question of operating upon the floor of the pelvis had been made unnecessarily complicated and the general practitioner had been thereby confused. He believed the correct idea was that embodied in the operation devised by himself, which, as the stitches are tied, tended to constantly elevate the depressed structures. The old operation was very defective because it produced exactly the opposite effect, *i. e.*, it dragged the tissues downward. Two sutures properly applied would usu-

ally carry the whole rectocele up into the vagina out of the way of the torn ends of the transversus perineal muscles, which are then sutured together. Dr. Goffe's plan was to bring together the parts by a single line of sutures extending from the highest point of the rectocele above to the caruncle laterally. He had practiced this operation for a considerable time and had found it simple and entirely satisfactory.

Dr. Burtenshaw said that a good deal of the discussion on his paper had been like the man walking around Robin Hood's barn. He admitted that many of the operations already devised fulfilled the indications, but he thought the proper principles were not involved in them. There was no question that a good deal of difficulty was experienced in dissecting out the levator ani muscles. In many cases it was impossible to find the fascia. He did not think that Dr. Gibbons had answered the question at all. If muscles were to be brought together the edges of the torn muscles must be freshened or the fascia must be brought together. As the parts were ordinarily stretched they must be partially excised in order to secure proper coaptation. He claimed that the pelvic floor was not restored to its normal condition by the usual operations. It was not denied that the immediate operation was not better, but this did not come within the field of the paper. Kelly's operation was nothing more than the Emmet operation, except that Kelly laid stress upon cutting a section out of the posterior vaginal wall. The operation was an excellent one, but he did not think it accomplished any more than the old Hegar operation. In the method employed by Dr. Goffe little consideration was given to the fact that the vaginal wall was firmly anchored under the pubic arch. The yield of the vaginal wall was all from the direction of the cervix. He claimed that the effect of the sutures in that method was that the parts were drawn down.

UNRECOGNIZED TOXIC INSANITIES.¹

BY T. D. CROTHERS, M.D.,
Hartford, Conn.

RECENTLY, the term Toxic Insanity has come to represent a form of mental disease in which the exciting and predisposing causes are alcohol, opium and its alkaloids, also arsenic, lead and other minerals, together with toxins and bacterial products formed within the body. The symptoms include delirium, mania, melancholia, delusions and hallucinations, associated with local inflammations of glandular organs and nerve fibers. During the year 1901 over 700,000 persons were arrested in this country for intoxication from alcohol and crime associated with it.

These were cases of toxic insanity with symptoms of both mental and physical disease. This army of toxic insanities is increasing, and one

of the prominent causes is the legal effort to cure by fine and imprisonment, which not only intensifies the disease, but makes it more incurable. The medical profession are indifferent to the influence of alcohol in the production of disease and its consequences, and by silence consent to the application of injurious legal penalties which are practically fatal to the victim.

My purpose in this study is to point out an unrecognized class of persons who suffer from these toxic insanities and who are not considered as mentally diseased, but whose disorders are regarded as moral lapses without medical significance. These persons are found in every community, and are not the chronic inebriates who frequent saloons, and appear intoxicated on the streets, or in police courts, where they are accused of petty crimes resulting from insane conditions, but are the men and women who often occupy places of respectability in social, business and professional circles, and are active workers in many ways in the community. Their lives are irregular and not along healthy, normal lines, and their pursuit of pleasure, business or public ambition is marked by recklessness, either of morbid intensity or stupid indifference, while frequently they startle their friends by some extreme and injudicious act.

Spirits and drugs are used by them either in so-called moderation continually or at periodic intervals, but the practice is concealed or only known by their intimate associates. Such persons make strange failures in business, professional and social circles, and seem beset with trouble, and are often opposed to the established order of society and its institutions. They are also continually out of harmony with their environment, and act strangely, exhibiting unaccountable suspicion of the acts of their associates, or credulous faith in impostors. Where crime is committed, it is marked by childish impulsiveness and stupidity, and their conduct and habits are often unusual and unexplainable. Such persons are called irregulars, cranks, extremists, paranoics and fast livers, and are apparently most of the time on the frontiers of insanity. They exhibit degrees of criminality with mental and moral pauperism, although occasionally they show signs of genius, and some intellectual vigor and strength.

Often they are leaders in certain circles, and their weakness is considered to be the low instincts and passions of the natural man. The form of insanity is of the paretic and auto-toxic type, and clearly traceable to the special toxic drug used. The clinical symptoms are uniform and characteristic, and point to psychopathic disease. Many of this class, although using spirits and drugs continually, carry on business and perform the ordinary duties of life, but when studied show symptoms of marked aberrations of intellect and character.

They are usually unreliable and untruthful, and exhibit decided declensions from their early am-

¹Read before The New York State Medical Association at its Nineteenth Annual Meeting, held in New York, October 20, 21, 22, 1902.

bitions and purposes of life. Their view of duties, obligations and the relations to their families and society is changed. Their pride in personal appearance and character is lost. Mentally, they are irritable, and either suspicious or extremely credulous and often unable to discriminate between cause and effect in ordinary events. They draw conclusions from the most imperfect impressions and trust implicitly to the senses, which are always unreliable. Usually they are hyper-sensitive and emotional, sometimes in the opposite state of stupor and indifference. This mental deterioration exhibits itself in delusions, hallucinations, both concealed and open, and morbid impulses which are seldom corrected or recognized by themselves. These symptoms of disease follow definite lines, either of general skepticism of the purpose and motives of others, or of extraordinary precautions taken to avoid possible injuries that would result from fancied plots of others to injure them, or of expansive delusional states with dreams of wealth, honor and aggrandizement. They are either alarmed at the treachery and dishonesty of their family and friends, or are exulting in the consciousness of personal ability to control events and turn them to their own comfort and progress.

Physically, the senses are impaired. Their powers of sight, hearing, taste, smell and touch are lowered, and their acuteness lessened. The coordination is disturbed, and palsy of the muscles with tremors are often marked. The facial muscles are anesthetic and do not respond to the play of thought, or are hyper-esthetic and quiver with every emotional change. The tone of voice is altered, and thoughts are uttered either in a quick and jerky way or in a slow, measured manner. There is one peculiar symptom common to these toxic insanities, namely, the diseased person has the delusion of ability to control, and believes he has power to stop the use of spirits and drugs at any time. This delusion of free will often grows with increasing intensity down to the last moment of life. The continuous failures, and the experience of years without a single success, or instance of ability to change at will, leaves no impression on the mind of the drinker or drug user. On all other topics there may be a general recognition of cause and effect, and the value of the teachings of experience, but concerning drink and drugs the delusion of control never ceases. The failure to confirm the delusion of free will taxes the mind for explanations which are only clear to the victim. This delusion of strength and ability to abstain at any time is encouraged by the friends of the victim, followed by condemnations for his failure. No matter what conditions or necessities may exist to demand sobriety and abstinence from the use of spirits, the patient insists that he can abstain at any moment, and cares neither for the taste nor the effects of spirits.

This belief is sincere and emphatic, and should a free interval occur in which no spirits are taken, this is considered evidence of the power of the

will to stop at any time. The use of spirits during conditions where personal interest and that of the patient's family suffer, and where the indulgence is practically suicidal, is explained as a mere lapse which could have been prevented by an act of the will. This delusive state is unknown by the promoters of the ordinary revival movement, and temperance efforts in which the central object is to awaken the powers of the will supposed to be dormant. In many instances, these efforts intensify and fix the delusion of free will, making recovery more and more uncertain. It is a curious fact that this peculiar symptom, which is seen in every day's experiences, of the failures of inebriates to abstain should not be recognized as a disease. Another symptom, more apparent in the latter stages, is the frequent suspicion of the infidelity of the wife and friends, with pronounced suspicions that their conduct and acts are intended to harm. Other symptoms are present which seem to depend on the idiosyncrasy of the patient, which are significant of brain failure.

Often these are manifested in extreme credulities and strange delusions of the most absurd character without reason or justification. Deliriums are frequently followed by sense hallucinations. These change rapidly from one condition to another and are concealed by the patient, who at first doubts their reality, then finally comes to accept them as facts. When the patient drinks steadily, the mental failure is often manifested in extreme exaltation and delusional confidence in his capacity and strength.

Where the drinking is in short paroxysms, convulsive conditions follow in which the brain acts with great intensity for a time. A steady decline in both physical and mental vigor is apparent, in conduct and thought. There are many persons in this condition who are regarded by their intimate friends as odd and peculiar. Others in this state become bold and self-assertive, and seek to attract public attention by their peculiar conduct, then later become exhausted and collapse. Symptoms of mania, delirium and melancholy are frequent; homicide and suicide may follow each other. Criminal impulses to take advantage of or injure some one bring these toxic insanities into prominence and are evidently due to the toxins arising from alcohol or drugs, breaking up the metabolism of the body, diminishing its nutrition, favoring the growth of other toxins, and centers of bacteria poisoning, and are not only protoplasmic poisons, but irritants to the higher brain centers. Such insanities are seldom or never recognized, except when some extraordinary change or strange conduct attracts scientific attention. These insanities when studied clinically merge into groups in which some special symptoms become prominent; one of these groups show marked paretic symptoms, another mania, or melancholy or dementia, with various forms of mental disturbance.

These symptoms are often masked, though

sometimes clearly seen by intimate associates, and on some unusual occasion of strain or stress. A grouping of these obscure cases in classes, according to the occupation and surroundings, brings into prominence many clinical symptoms and distinct types that are practically unknown. The first group of toxic insanities which I shall describe will be those found among business men. Such persons are known as moderate drinkers and only occasionally seen obviously under the influence of spirits or drugs. In business circles they are regarded simply as persons who occasionally drink too much, either when in company or from some special cause. Among the first symptoms of mental change are business complications, and failures through bad judgment and want of caution, with credulity in business matters and suspicious of their associates. They neglect their families early in their career and spend their evenings in clubs and theaters, showing great interest in unimportant matters foreign to their life and interests. Frequently, if able, they possess fast horses or yachts, and join in outdoor sports to the neglect of their business, always craving excitement and dreading monotony. They are alternatively severe and lax in their business habits, making strange friends and ignoring old companions, and are boastful and arrogant in their treatment of associates, and when intoxicated are delirious and irritable. When sober show great desire to conceal their lapses or explain the special causes of their failures.

After a time these men become alarmed at their condition and consult physicians, and when able employ a family physician to be with them all the time. The physician may be ignorant of the real causes and diagnose some organic disease, and so minimizes the effect of alcohol and thus injure the patient rather than help him. Then the personal habits change and also the appearance and manner of the man. His use of spirits increases, until finally he becomes bankrupt, then is forced to begin life again in a lower position. In this condition he often becomes a criminal, frequently a defaulter, and dies in prison. During all this time he is suffering from toxic insanity never recognized or properly treated. Numerous examples are seen in every town and city where persons of wealth and position show decided change of character, and become patrons of gambling houses and race courses. They neglect business, desert their families, become changed in habit and yet are rarely seen openly intoxicated. Some of these cases show hysterical fear of death and employ many physicians, concealing their use of alcohol beyond that of wines at the table. Two such cases under my observation were as follows: Both were active business men of previous good judgment and excellent character. Both used spirits and drugs, secretly and openly, and both pursued a course of dissipation and reckless business conduct. One was passionate and delirious at times. He was examined by two experts, who

found no symptoms of insanity, yet two weeks after, without any unusual symptoms manifested, he attempted to kill his wife and, supposing he had done so, shot himself. The other case was treated by his family physician and many experts for malaria and nervous exhaustion, and was considered competent to take care of himself, although manifesting great inconsistencies in conduct, and defending strange theories.

Finally, he died suddenly, and was found to be a bankrupt. It appeared that he had been supporting two distinct families, each in ignorance of the other, and living for years a life of great deception and fraud. Speculators, whose occupation usually induces much irregularity of living and great mental strain, are often types of this form of insanity. At first, they begin to drink in company for sociability, then later when depressed or unduly excited use spirits, either to give boldness and courage, or to steady the nervous system. Such persons are noticeable for their egotism, dishonesty, untruthfulness and reckless conduct, and unstable judgment.

Frequently, they become gamblers, continually discounting the future and taking risks and wild chances. As plungers, their impulsive and insane conduct always ends in disaster and ruin. Spirits are used with increasing frequency, and family and social relations are disturbed, and they live mainly in hotels, clubs and lodging houses. The mind is in a continuous state of mania and delirium, and in their work they are audacious, unreasonable and uncertain, always lacking steadiness and persistency. They are not called drunkards, but are regarded as fast men, living at high pressure. Paretic delusions of grandeur and power appear, giving a certain mental force that is delusive, which alternates in the extremes of success and failure, frequently ending in death from hemorrhage or acute inflammations. Toxic insanities are often seen among politicians. Their career is usually shorter than that of merchants or speculators, but is more strongly marked with symptoms of insanity. The mania for office and political power usually appears in poor lawyers and unsuccessful business men. Usually they are beer or spirit drinkers at the table, are dissatisfied with their present condition, and therefore seek office and power. In their life marked decadence is apparent.

They associate with low, barroom voters, spending their time in saloons, catering to spirit drinkers, brewers and ward heelers. Like others of this class, they neglect their families and join clubs. In election campaigns they are intensely excited and are constantly engaged in intrigues and plots. The judgment becomes feeble and is always controlled by others. The moral sense of right and wrong is weakened, and they only do right under compulsion. They show low cunning and delusional persistency in following lines of conduct planned by others. When given office, they are purchasable and open to any malign influence. Their career as office holders is short,

except under peculiar circumstances where they are supported by their superiors for some particular purpose. Such men drink constantly, yet are seldom intoxicated, but always show parietic signs which are not generally recognized except as weak, vicious impulses.

These insanities are common. Toxic insanities among professional men have also, unfortunately, many examples. The resignation of a clergyman and his disappearance in private life, after a short career of irregularity in conduct and pulpit administration, is an example of such cases. Some strange unreasoning conduct, and defense of wild theories, alternating with credulity and skepticism, are also common symptoms. Among lawyers, some unusual act or strange defalcation or a foolish effort to take advantage of opportunities to secure wealth by fraud are characteristic signs.

Among doctors who are so-called moderate users of spirits a symptom is the rupture of family relations, with social scandal, or foolish contentions with brother practitioners, or indorsement of some extraordinary theory, and unusual conduct. These are frequently symptoms and are indications of insanities seldom recognized. Many instances are on record where professional men, after a career of eccentricity, suddenly developed mania and delirium, which ended fatally; later it is found that spirits and drugs have been used secretly for years.

The insane conduct was specifically due to the spirits and drugs taken. The following are examples: An eminent physician died recently in a private sanitarium and the cause of death was said to have been cerebral hemorrhage. For ten years this man had been insane, although practicing his profession up to within a few months before death. Twelve years ago he began to use spirits to excess and a year later obtained a divorce from his wife, broke up his family home and had since lived in a hotel, leading an erratic life. He had delusions first of his wife's infidelity, then of persecution by his family, and was continually distrusting his fellow-practitioners, sometimes slandering them with great acerbity, then would show inordinate credulity, going from one extreme to the other, and at the slightest provocation engaging in legal contests, in which he was always beaten.

He has been a speculator, a gambler, a libertine and a low politician at times, and been detected in trying to take advantage of his patients and forced to make restitution. During these years he has drunk continuously and was intoxicated at intervals. He spent a large fortune and has twice been convicted of criminal assault while under the influence of spirits. No effort was made to restrain him, his friends regarding his condition and conduct as vicious, and the community tolerated his presence and permitted him to imperil the interest of his friends and the society in which he moved.

The death certificate was accurate, but the toxic insanity was unrecognized. A doctor who drinks

steadily and shows great eccentricity of conduct and profound deterioration of general morals is always a dangerous man, not only in his personal influence, but in his inconsistent delusional mentality. Examples of lawyers, teachers and others of this class will occur to the minds of every one. One such man, who recently died, was a violent defender of the use of alcohol as a stimulant and brain and nerve tonic. Another denounced all religion as destructive to civilization, a third was a rank socialist who would like to have society all on a level. Lawyers who have suffered from this disease have nearly always lost influence, and their career has terminated early in physical and mental bankruptcy. Occasionally, a clergyman gives unmistakable evidence of toxic insanity by his strange and unreasonable theories or his strange principles.

The contrasts in both the lawyers and clergymen of this class with their compeers are not always clear, and yet their position and conduct indicate some change which cannot be mistaken. In business and social circles the means for judging similar conditions are more difficult, hence cases are overlooked.

Toxic insanities among literary men have many striking examples, particularly among journalists. Alcohol taken continuously, even in moderation, very soon impairs the capacity to do anything but inferior journalistic work. Opium and cocaine takers frequently write books, pamphlets and sensational novels. Cocaine users particularly manifest word manias and delusions of great mental capacity, both in visionary reasoning and turgid imagination. In the opium takers, the mind efforts are so erratic and peculiar as to point to the real conditions, particularly in the uncertainty and vagueness which an expert is able to trace. In all cases, the higher moral faculties of consciousness, truthfulness and sense of right and wrong disappear early. The writings of drug users who magnify the faults and weakness of society, and proclaim the hollowness of family life, indicate drug psychoses. The vague character of writing and the grotesque and startling sensationalism are also unmistakable signs. In the lower walks of literary life there are many persons of this class who live most dramatic and sensational lives and pose as the victims of wrongs done by others. Literature is full of psychological symptoms of the toxic insanity of authors; both books, papers and controversial pamphlets, in political and religious circles, attest this fact.

In society circles the toxic insane frequently appear, particularly among persons who have inherited wealth, using spirits at their tables and have wine suppers at night. Such persons are noted for strange, erratic acts and delusions of superiority. They follow fads and whims of fashion up to the verge of absurdity. Often they display conduct almost criminal in its neglect of common sense and the rights of others. They ignore all society but their own, grow more and

more selfish, hold doubtful family relations, and lose respect for right morals and good citizenship. These victims of toxic insanities are often drug maniacs and support opium dens, and are users of highly flavored wines and spirits. Their lives are marked by great irregularity and an apparent pursuit of pleasure. They patronize physicians who humor their whims and leave them worse than before. In many respects they are a greater menace to society than persons of similar habits' lower down in the social scale.

The so-called fast set, in the circles of wealth and active business life, contain many examples of toxic insanity whose symptoms point unmistakably to degenerate psychosis. The immoral conduct, the unreasonable delusions, the extravagant expectations and changeable, erratic manners and habits can only come from a brain made altogether unstable by the anesthesia of alcohol. Such persons go from one extreme to another, appearing at dinners, balls, theaters, watering places, patrons of this or that extravagance, pursuing fads, traveling from place to place, developing egotism and contemptuous superiority for persons not in their class, and at the same time drinking steadily, often to great stupor, then making ineffectual efforts to recover, only to relapse. These are all signs of toxic insanity. Some people of this class become maniacal and have parietic symptoms and live on a plane of intense excitement and exaltation. Others become melancholy and have religious delusions, promote and foster all kinds of strange and extraordinary philanthropic measures. They are always interested in affairs far away and never in those near at home; others have delusions of wealth and go into the stock market with a fascination that is thoroughly insane.

A few manifest miserly impulses or deliriums for political promotion, or strive to become famous as travelers and leaders in new enterprises, starting with great expectations, but changing suddenly and unexpectedly to some other purpose of thought or action. Often these insanities have a limited influence and die a violent death, only a few of them ever going to insane asylums. Some of the facts to be emphasized from this clinical study are:

1st. Toxic insanities, particularly from spirits and drugs, are increasing. This is apparent not only from the records of courts and hospitals, and among the lower and more degenerate classes, but from the unusual conduct and acts of persons high in the domain of active life, together with strange, unexpected crime and social changes and revolutions, which startle society and disturb business; when such persons are studied they are found to be largely associated with spirit and drug taking.

2d. A closer study reveals a distinct origin, progress and development of a psychosis and progressive disease and degeneration of the brain and nerve centers, called toxic insanity.

3d. The paralyzing anesthetic action of alcohol,

first on the sensory, then on the higher coordinating centers, is one of the most distinct of all the psychoses, because traceable from cause to effect.

4th. It is beyond question that a large percentage of all the insanities occurring in the higher levels of business, literary, professional and social circles are both directly and indirectly the result of the use of alcohol and drugs.

5th. These causes are largely unrecognized except in the later stages, and then do not attract attention beyond that of contributory conditions and accidental causes.

6th. Finally, changes of conduct, character, habits and manners in persons who use spirits and drugs can only be explained as true psychoses and insanities, which demand medical study and treatment.

7th. It is said that fully one-fourth of the medical practice in this country among the better classes of society is directed to correct the injuries which follow from the toxins of alcohol and drugs. There are medical men in every large city and hotel physicians who are constantly employed in the care of persons in toxic states from alcohol or drugs. The actual psychopathic condition is unrecognized and unknown. While in the lower classes it is certain that the largest proportion of crime and poverty is due to the same causes.

THE MANAGEMENT OF HEMORRHAGE.

At the last meeting of The New York State Medical Association, in discussing the remarks made by Dr. R. H. M. Dawbarn on the subject of the Management of Hemorrhage, Dr. F. W. Higgins, of Cortland, said that the author had mentioned several valuable remedies, each one of which, it seemed to him, might be useful in hemoptysis. He believed that adrenalin would be helpful in such cases, as he was very sure that gelatin, when given internally, was valuable in cases of hemoptysis of not a very urgent character. He would give the gelatin by mouth, because there was some danger of tetanus in the hands of the general practitioner if administered hypodermically. Oil of erigeron had not been mentioned, yet it had served him so well that he thought it should be referred to. Nasal hemorrhage seemed to him even simpler than appeared from the paper. He had never seen a case in which plugging of the posterior nares was necessary. Any one familiar with nose and throat work could generally pack the bleeding nostril full of plain gauze from the front, beginning well back toward the posterior nares. This, assisted by slight pressure upon the anterior nares, had controlled severe hemorrhage in his experience. Most nasal hemorrhages come from a spot situated about one-third of an inch from the anterior nares. The hemorrhage, if from this situation, could often be controlled by pressure with the finger on this point.

Dr. Homer Wakefield, of New York, said that

in pulmonary hemorrhages, especially of cardiac origin, the inhalation of pure nascent oxygen gas had, in his experience, been the nearest to a specific of anything he had ever tried. He believes the oil of erigeron acts as an oxygen carrier in the blood, because it is known that a physical property of all terpenes and analogous agents is the absorption of oxygen, and that when they become impregnated with oxygen before being therapeutically administered, they lose this valuable medicinal property. In internal hemorrhages, especially uterine and renal hemorrhages, and when there is marked anemia, with decided reduction of hemoglobin and leucocytosis, it is of greatest value.

Dr. Bangs, of New York, asked the reader of the paper whether there would be any advantage in placing the posterior plug directly in the posterior nares rather than in the nasopharynx. He had attended last spring a case of very profuse nasal hemorrhage, and found it impossible to control the hemorrhage by the injection of a 40 per cent. solution of antipyrine, or even by the injection of a strong cocaine solution. The bleeding point could not be located by examination from the anterior nares. He had made use of the catheter in the manner described in the paper, and had introduced the posterior plug, made of the shape of the posterior nares. The plug did not fit at once into the posterior nares, but by drawing on the thread in the mouth the plug was brought back, and then with the finger guided up into the posterior nares, traction, of course, being made on the string through the nose. No more blood could then be seen running down the posterior pharynx, whereas before that a steady stream of blood had been passing into the pharynx. The hemorrhage through the anterior passage, of course, increased then, and consequently a number of antiseptic tampons were placed anteriorly to control this.

Dr. W. G. Schauffer thanked the author for the explicit and careful directions given in the paper, for this was just what was wanted by the general practitioner. He did not at all agree with the gentleman who had spoken a few minutes ago, and expressed the opinion that all nasal hemorrhage could be controlled by direct pressure. The technique of controlling internal hemorrhage by bandaging the limbs was well known to many of us, and yet the exact mode of procedure was not generally known. He would like to inquire if Dr. Dawbarn made use of cold and other measures.

Dr. W. E. Swan asked regarding the saturation of the plugs with persulphate of iron or some other styptic solution. He had treated a number of hemorrhages of the nose. His plan formerly had been to cleanse the nose and then introduce the persulphate of iron on a feather, and the method had proved successful in a majority of cases. More recently he had used a spray of adrenalin solution, and had never had it fail. Where it should do so he would, of course, plug

the posterior nares. It was quite important to draw the palate forward, as described by the author.

Dr. Fitzgerald referred to a case of epistaxis, in which he had plugged both the anterior and posterior nares, thus checking the hemorrhage, but this had been followed immediately by bleeding on the other side. The patient's gums then began to bleed, and purpuric spots appeared on the body. The patient died, and at the autopsy it was found that the spleen weighed fifteen pounds, and the patient was greatly emaciated.

Dr. Stern asked if Dr. Dawbarn had had any experience with stypticin.

Dr. T. P. Simpson, of Beaver Falls, Pa., said that one form of hemorrhage had not been alluded to, although of a very serious character and difficult to control. He referred to intestinal hemorrhage, and particularly that variety occurring in typhoid fever. He would like to know how the author of the paper would control this. A recent method of treating such hemorrhage was by the use of 1-1,000 solution of adrenalin chloride internally.

Dr. A. J. Ochsner said that the great merit of the paper was its simplicity and practical nature. He had tried some of the methods there described, and could say that they were thoroughly reliable and of great value. In hemophilia a form of treatment that had not been published as yet consisted in giving the patient albumin in the form of whites of eggs. The whites of four to six eggs were given three times a day, and seemed to have a very definite effect upon the blood in hemophilia. Dr. Mayo Robson had prescribed drachm doses of chemically pure chloride of calcium, largely diluted, three times a day, or as an enema every four hours, for four days in cases of hemorrhages accompanying cholemia.

Dr. William J. Mayo said that he had been very glad to hear this very practical paper of Dr. Dawbarn. He would like to hear from him further regarding a bloodless method of removing the tonsils, to which he had made reference. With regard to operations on hemophilia, the speaker said that these cases were frequently encountered quite unexpectedly, and it was well to learn all that one could concerning the treatment of these troublesome cases. He knew that cases of cholemia showing purpuric spots invariably die from hemorrhage if operated upon. He had been very much interested in the use of chloride of calcium because he had tried this in cholemic cases, and since doing so had not seen any severe hemorrhages, although he would admit that he had been very careful about operating on the purpuric cases. He also said that Mr. Robson had tried the experiment of feeding chloride of calcium to a dog for several days, and keeping another dog as a control. He then cut the jugular vein of each dog, and noted that the control dog, the one that had not had any chloride of calcium, succumbed very quickly, while the other

dog did not. Continuing, Dr. Mayo said that while preparing to tampon the nose for hemorrhage it was well to instruct the patient to tightly hold the nose with the fingers, for often by the time the surgeon was ready to insert the tampon it would be found that the bleeding had been checked. It was the passage of the air through the nose that broke up the fresh clot.

Dr. Dawbarn closed the discussion. He said that Dr. Higgins had been especially fortunate in finding nasal hemorrhage so easily controlled, and he would probably eventually meet with cases which would not yield to such simple treatment. Every year in this country there were several hundred recorded cases of death from epistaxis. In these fatal cases there were usually several recurrences of the epistaxis, and finally syncope and death because of the acute anemia. In packing the nose from in front, unless the gauze happened to rest upon the bleeding point, it was quite probable that the packing would be valueless. In a case of epistaxis that he had seen the hemorrhage had been checked by a tampon, but the gauze had caused irritation and hawking, and had finally dropped down into the pharynx and had been swallowed. A simple method sometimes useful was the introduction of an oiled handkerchief into the anterior nares, and filling the pouch so formed with gauze. This was not nearly so comfortable as the method he had described. He had not attempted to mention the various drugs that had been used for the control of hemorrhage. He did not use persulphate of iron or tannin, or any other similar styptics, as they were capable of causing irritation and forming by coagulation balls upon the hairs in the nose. It was a very objectionable method. He had intended to make clear the method of introducing the posterior tampon. The usual way was to cut the tampon to fit this part, but the attempt to do this almost always resulted in leakage, and for this reason he preferred to use a large cotton ball. He had only referred to measures which were especially useful in very urgent cases of pulmonary hemorrhage. The object of the method he described was to accumulate sufficient blood in the extremities to cause the patient to feel faint and to break out in a cold sweat. This naturally assisted the formation of a clot and the checking of the hemorrhage. For example, in a case of hemorrhage from the bowel in typhoid fever, if the heart were not too weak, it was wise to accumulate blood in the extremities and diminish the pressure at the point of bleeding. It often required a great deal of courage to do this, and many practitioners would do exactly the opposite, *i. e.*, give whisky. He thought the ice bag should not be used on the abdomen. Instead, the patient should be inverted and very hot water should be injected into the rectum. In most cases of typhoid hemorrhage there was a marked subnormal temperature. After having introduced about one gallon of hot water, the usual capacity of the colon, it would be found that this increased bulk

tended in itself to check the hemorrhage from the bowel.

With regard to his bloodless method of performing tonsillotomy, the speaker said that the cases likely to cause hemorrhage after tonsillotomy were not in children, but in adults in whom the tonsils contained much connective tissue. His method was to pass a purse-string suture around the tonsil before doing the tonsillotomy in the adult. A mouth gag was introduced, and the first of the four sutures passed beneath the tonsil and out at the back, using stout pedicle silk. Then it was reintroduced where it came out, and in this way three loops were finally made, which, when drawn upon, absolutely controlled the tonsil. It was not necessary to tighten the ligature until it was found necessary to control hemorrhage. He had used the method upon a very anemic man. It was a fact that deep breathing would often be effectual in controlling nasal hemorrhage.

EARLY CANCER OF THE TONGUE.

Now let me lay down certain rules for your guidance in regard to these matters. In the first place, if you are consulted about warts and warty growths, particularly on tongues which are the seat of one of these predisposing conditions, see that no time is lost in removing them. This should be done by two elliptical incisions which include the healthy tissues around the wart into the muscular substance. The edges are brought together and the wound is healed in four or five days. In the second place, in regard to indolent ulcers upon the surface or under the border of the tongue, which are ascribed to the rubbing of a tooth, see that the cause of the irritation is removed at once. And if, at the end of a week or ten days from that time, the ulcer is not well or healing rapidly, cut it out in precisely the same fashion. Do not hesitate for a moment. The operation is trivial, and may save the patient from great misery, and often from a horrible death. If white patches or plaques become thicker, and if they become a little more prominent, and particularly if they show a tendency to break down in the center or soften, let them be cut with as little delay as possible. Of late years I have gone further than this and have advised patients suffering from bad superficial glossitis, where the tongue is constantly irritated, where the patient consequently is always suffering and always in dread and danger of cancer, to have that portion of the tongue removed, even when there is no sign of cancer or of a precancerous condition. I have given that advice particularly when the under surface is in a healthy condition, so that the mucous membrane can be turned up to make a good covering for the stump. It is very difficult indeed to persuade patients to undergo an operation of that kind. But such patients are infinitely better off and happier for the operation. They speak well enough to carry on their business and to go about like other people, so well that few people would have the least notion that an operation had been performed upon them. They are relieved not only of the fear, but of the danger of cancer; and they are able to take all kinds of food.—BUTLIN, *British Medical Journal*.

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Byron C. Cheeseman.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornbergr.
Vice-President—Frank S. Jennings.
Secretary—H. S. Bramer.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Horace L. Hulett.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutter.

SENECA COUNTY MEDICAL ASSOCIATION.

President—William Austin Macy.
Vice-President—George O. Bellows.
Secretary—J. Spencer Purdy.
Treasurer—Carroll B. Bacon.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davis.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Albert E. Woehner.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stockschlaeder, James C. Davis.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer
Vice-President—William O. Huggins.
Secretary—Alva Le Roy Chapin.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Connor, Middletown.
Secretary—Ernest Valentine Hubbard, 114 West 70th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeKoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.
Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.
Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.
Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.
Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.
Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.
Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.
Secretary—Ogden C. Ludlow, 234 West 135th street, New York.
Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.
Treasurer—Charles Ellery Denison, 68 West 71st street.
Executive Committee—Frederick Holme Wiggan (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).
Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdman, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.
Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.
Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

Treasurer—Frank Guillemont.

Executive Committee—F. J. Baker, E. E. Campbell.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Howard A. Maynard.

STEBUN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Kogle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Treasurer—Charles W. Piper.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Charles W. Piper, Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New

York State Medical Association.

COMMITTEE ON PUBLICATION:
CHARLES E. DENISON, M.D., Chairman, New York.
John W. S. Gouley, M.D., New York.
Thos. F. Reilly, M.D., New York.
L. C. Ager, M.D., Brooklyn.
John J. Nutt, M.D., New York.



PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 10.

OCTOBER, 1903.

\$1.00 PER ANNUM.

ANNUAL MEETING.

Members will please note that the annual meeting of **The New York State Medical Association** will be held on October 19-22, 1903, at the New York Academy of Medicine.

DIRECTORY FOR 1903.

The *Directory* for 1903 is in the hands of the binders and will be issued in a few days. The delay in issuing this volume has been due to the fact that the publishers and binders have been seriously interfered with in their work in the last few months by the building strikes.

THE NEW YORK STATE MEDICAL ASSOCIATION.

When referring to the manifold advantages of membership in The New York State Medical Association, attention should be called to the following facts:

That The New York State Medical Association does not exist as an entity, but is composed of the united County and District Branch Associations. That membership in a regularly chartered County or District Branch Association carries with it membership in the State Association.

That The New York State Medical Association is the legal representative and only affiliated branch in New York State of the American Medical Association.

That it is only through membership in The New York State Medical Association that physicians residing in New York State can become members of the American Medical Association.

The New York State Medical Association will assume the defense of suits of alleged malpractice brought against members.

THE TWENTIETH ANNUAL MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The sessions of the Association will be held at the New York Academy of Medicine, 17 West 43d street, October 19th to 22d, inclusive.

The program for the four days is as follows:

First Day, Monday, October 19th.

Meeting of Nominating Committee, 9 A. M.

Meeting of the Council, 10 A. M.

LUNCHEON, 12.30 P. M.

Meeting of the Council and Fellows, 1.30 P. M.

ORDER OF BUSINESS.

1. Calling the meeting to order.
2. Roll-call by the Secretary.
3. President's report on the needs of the Association.
4. Annual report of the Council.
5. Report of the Treasurer.
6. Reports of Standing Committees.
7. Reports of Special Committees.
8. Unfinished business.
9. New business.
10. Report of Nominating Committee.
11. Election of officers.
12. Reading of the minutes and action thereon.

Members, Fellows, Delegates and guests are invited to attend the meeting of the New York County Medical Association, to be held in Hosack Hall at 8.30 P. M.

Second Day, Tuesday, October 20th.

MORNING SESSION, 9.30 A. M.

ORDER OF BUSINESS.

Calling the Association to order.

Address of welcome by the Chairman of the Committee on Arrangements.

Special report from the Council and Fellows.

Reports of Special Committees.

The reading and discussion of papers.

1. "Sea Bathing in Some Forms of Skin Diseases." By DR. R. ABRAHAMS, New York City.
2. "Treatment of Compound Fractures." By DR. V. D. BOZOVSKY, Dunkirk, N. Y.
3. "Stab Wounds of the Abdomen." By DR. F. J. DOUGLAS, Utica, N. Y.

"The Relation of the Municipal Milk Supply to the Health of Children." By DR. GEORGE W. GOLER, Rochester, N. Y.

4. "The Surgical Treatment of Hemorrhoids." By DR. C. S. PARKHILL, Hornellsville, N. Y.

5. "The Causes of Failure After Operation for Nephroptosis." By DR. AUGUSTIN H. GOELET, New York City.

6. "Results from Operative Treatment of Cancer of Rectum." By DR. JAMES P. TUTTLE, New York City.

Second Day, Tuesday, October 20th.

AFTERNOON SESSION, 2 P. M.

7. "Extradural and Mastoid Disease." By DR. SEYMOUR OPPENHEIMER, New York City.

Discussion by DR. A. B. DUEL, New York City.

8. "One of the Dangers in the Surgery of the Biliary Passages." By DR. E. D. FERGUSON, Troy, N. Y.

9. "School Hygiene and the Great Need of Regular Medical Supervision in Schools." By DR. H. ERNEST SCHMID, White Plains, N. Y.

10. "Relation of Vertigo and Headache to Gastro-Intestinal Disorders." By DR. ALLEN A. JONES, Buffalo, N. Y.

11. "Bacteriology and Pathology of Dysentery in Children." By DR. WILLIAM H. PARK, New York City.

12. "Clinical Aspects of Ileocolitis in Children." By DR. THOMAS M. ROTCH, Boston, Mass.

13. "Colon Bacillus Infection of the Female Genito-Urinary Tract." By DR. ALBERT H. ELY, Southampton, N. Y.

Discussion of Nos. 11, 12 and 13 by DR. W. P. NORTHROP, DR. L. E. HOLT, DR. J. E. WINTERS, DR. C. G. KERLEY, DR. R. G. FREEMAN, New York City; DR. F. W. SHIPMAN, Mount Vernon, N. Y.

14. "Some Less Usual Causes of Post-Operative Elevations of Temperature." By DR. MARTIN B. TINKER, Clifton Springs, N. Y.

Second Day, Tuesday, October 20th.

After careful deliberation the Committee on Arrangements has considered it advisable to omit a program for Tuesday evening, thus leaving the evening free for social engagements.

Third Day, Wednesday, October 21st.

MORNING SESSION, 9.30 A. M.

15. "Ergot in Alcoholism and Morphineism and the General Class of Drug Habit Cases." By DR. ALFRED T. LIVINGSTON, Jamestown, N. Y.

16. "Laboratory Aids to Diagnosis for the General Practitioner." By DR. V. A. ROBERTSON, Brooklyn, N. Y.

17. "Puerperal Sepsis." By DR. JAMES H. BURTENSHAW, New York City.

18. "When and How to Operate for Gall-Stones." By DR. IRVING S. HAYNES, New York City.

19. "The Typhoid Epidemic in Ithaca, with Special Reference to Causation, Prevention and Treatment." By DR. CHAUNCEY P. BIGGS, Ithaca, N. Y.

20. "Typhoid Delirium with Cases." By DR. EDGAR H. DOUGLAS, Little Falls, N. Y.

21. "Sewage Disposal as a Means of Purifying the Water Supply of the Cities and Towns of the State." By DR. CHARLES B. TEFFT, Utica, N. Y.

Discussion.

22. President's address.

Third Day, Wednesday, October 21st.

AFTERNOON SESSION, 2 P. M.

23. "Presentation of a Patient from Whom the Superior Maxilla, Left Side, Was Removed and the Bone Removed. Operation on May 4, 1870." By DR. D. P. AUSTIN, New York City.

Discussion: By DR. JOHN W. GOULEY, DR. CHARLES N. DOWD, DR. WILLIAM A. EWING, New York City.

24. "Suggestions for Examination of the Presumably Insane." By DR. R. H. HUTCHINGS, Ogdensburg, N. Y.

Discussion: By DR. WILLIAM MABON, New York City; DR. C. E. ATWOOD, White Plains, N. Y.; DR. E. D. FISHER, New York City.

25. "The Treatment of Pneumonia." By DR. DELANCEY ROCHESTER, Buffalo, N. Y.

Discussion: By DR. W. GILMAN THOMPSON and DR. A. ALEXANDER SMITH, New York City.

26. "Arterio-Sclerosis and Its Bearing on Certain Lesions of the Retina and Optic Nerve." By DR. CHARLES STEDMAN BULL, New York City.

27. "Dysmenorrhea." By DR. CHARLES BONIFIELD, Cincinnati, O.

28. "Properties of the Blood Serum as Illuminated by Ehrlich's Researches." By DR. RICHARD C. CABOT, Boston, Mass.

Discussion: By DR. E. K. DUNHAM, DR. JOHN S. THACHER, DR. JAMES EWING, New York City.

29. "Minus Cylinders: Those Who Prescribe Them and Those Who Wear Them." By DR. F. W. HIGGIN, Cortland, N. Y.

Third Day, Wednesday, October 21st.

EVENING SESSION.

Annual banquet at the Hotel Manhattan, Madison avenue and 42d street, at 7.30 p. m.

Fourth Day, Thursday, October 22d.

MORNING SESSION, 9.30 A. M.

30. "Diphtheria in the Country: Its Diagnosis and Management." By DR. J. R. STURTEVANT, Theresa, N. Y.

31. "Some Features of the Epileptic Attack." By DR. B. ONUF, Sonyea, N. Y.

32. "The Influence of Oxygen Taken by Full Normal Respiration, or Chemically Pure, as a Means of Sustaining and Increasing Mental, Nervous and Physical Energy." By DR. CORDELIA A. GREENE, Castile, N. Y.

33. "Knowledge of the Eye That Is of Use to the General Practitioner." By DR. S. BUSBY ALLEN, New York City.

34. "The Early Diagnosis of Tuberculosis." By DR. J. J. WALSH, New York City.

35. "Treatment of Septic Affections by the Intra-Venous Injections of Ccllangol." By DR. GEORGE TUCKER HARRISON, New York City.

Fourth Day, Thursday, October 22d.

AFTERNOON SESSION, 2 P. M.

"Peculiar Symptoms Following Radical Operations." By DR. G. F. COTT, Buffalo, N. Y.

36. "Acute and Chronic Cholecystitis." By DR. J. H. MUSSER, Philadelphia, Pa.

Discussion: By DR. ROBERT J. MORRIS, DR. FRANCIS H. MARKOE, DR. EGBERT LEFEVRE, New York City; DR. W. Q. HIGGINS, Sanborn, N. Y.; DR. ALEXANDER LAMBERT, New York City.

37. "The Etiology and Pathology of Salpingitis." By DR. EDWARD J. ILL, Newark, N. J.

38. "Surgical Treatment of Salpingitis." By DR. HENRY C. COE, New York City.

39. "The Non-Operative Treatment of Salpingitis." By DR. W. TRAVIS GIBB, New York City.

Discussion: By DR. WILLIAM M. POLK, New York City; DR. S. C. GORDON, Portland, Me.; DR. W. GILL WYLIE, New York City; DR. L. GRANT BALDWIN, Brooklyn, N. Y.; DR. C. C. FREDERICK, Buffalo, N. Y.; DR. J. R. GOFFE, New York City.

40. "A Report of Twenty-five Prostatectomies." By DR. PARKER SYMS, New York City.

Delegates to the Medical Society of the State of Pennsylvania, held at York, September 22d-24th, Julius C. Bierwirth, Ramon Guiteras and Frederick Holme Wiggan.

MEDICAL DIRECTORY.

The Committee on Publication of The New York State Medical Association beg leave to present the fifth volume of the *Medical Directory of New York, New Jersey and Connecticut* to the members of the Association.

In compiling the list of physicians the same general order has been followed as last year, giving membership in all societies having a recognized standing in the profession, hospital and dispensary appointments, with residence, office hours, telephone call and college and year of graduation.

No change has been made in the use of tinted paper, it having been found to be of great practical value and meeting with high commendation.

The list "received too late for classification" may appear unduly large, but in order to increase the usefulness of the book it became necessary to add changes of address received after the page proof had been returned to the printer, as well as the physician registering at a late date with the county clerk.

The committee have added a list of medical libraries in the three States, which makes a very useful reference to the physician.

Our endeavor to make the *Medical Directory* the best reference book for the profession can be furthered by the members assisting your Committee on Publication in notifying us of errors and omissions, and securing subscriptions from your friends by showing them a copy and pointing out the value it has been to you and the great usefulness it may be to others.

In a letter to the chairman of the Committee on Publication by the editor of a new medical publication, the statement is made that out of 13,364 names to whom letters were sent, the postal authorities had returned only twenty-five letters. He says: "Permit me to offer you my congratulations on the extraordinary accuracy of the *Medical Directory of New York, New Jersey and Connecticut*. Your achievement is all the more wonderful when it is understood that I refer to the edition published last year (1902).

"If your committee would publish a directory of the physicians of the United States our company will pay willingly \$1,000 for the first copy issued, and if it at all approaches your local directory in clearness and correctness, our expenditure would be safeguarded by the immense saving which would be effected from loss of stationery and postage stamps (there were seventy-five letters returned to us from the city of Baltimore alone) and with assurances of our admiration and thanks."

TO THE COUNCIL.

Next meeting third Monday in October (19th). The officers of the State Medical Association form the Council of the Association, and as such the Council is the Executive Board of the Association. They appoint delegates to the societies of other States. They employ an attorney for all legal matters. They have authority to institute defense in suits for alleged malpractice, to take action in violation of the laws of medical practice. Questions of ethics and discipline, on appeal from decisions of District Branch Associations, are adjudicated by the Council.

TO THE FELLOWS.

Next meeting third Monday in October (19th), after the meeting of the Council.

The Council and Fellows, having the superintendence and management of The New York State Medical Association, have the power to make and prescribe by-laws, to establish the conditions of admission, dismissal and expulsion of its members; to determine the amount of annual dues.

SUITS OF ALLEGED MALPRACTICE AGAINST MEMBERS DEFENDED BY THE STATE ASSOCIATION.

By-Laws of The New York State Medical Association.

ARTICLE II, SECTION 7.

The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association. A member desiring to avail himself of the provisions of this section shall make application to the Council through the Secretary, shall sign a contract renouncing his own and vesting in the Council sole authority to conduct the defense of said suit or to settle by compromise, and shall make such other agreements as the Council may require. The Council shall thereupon contract with said applicant to take full charge of said suit, to furnish all necessary legal services, to pay all necessary expenses and not to compromise said suit without consent of the accused, but the Council shall not obligate the Association to the payment of any damages awarded by decree of court or upon compromise.

THE STATE ASSOCIATION.

The editorial from the *Kentucky State Medical Association Bulletin* so clearly states the particular reasons why the physicians in New York State should be a homogeneous body, it seems a waste of good language not to repeat it, and we urge every member to tell us what you are doing in your county:

This, the second number of the *Bulletin of the*

Kentucky State Medical Association, published and owned by the Association, and devoted to the medical interest of the people and medical profession in the State, comes to you, doctor, not asking you to scan its pages in cold criticism, but as bone of your bone and flesh of your flesh. You are one of the owners of it. Each of its readers may find in it one of those links which bind each of them more closely to one another, and weld all of them into one common association, so that each doctor may have not only his own influence, but that of all his fellows in all that is good. This is the organ of the whole profession of the State, is owned and run by them, and its success will be in proportion to the interest in its welfare displayed by each man to whom it comes.

First, let us together think of medical organization, what it has been in Kentucky in the past, what it now is, and what it may become if wisely conducted. The State Association is nearly fifty years old. During those years its membership varied from one to 400, and its rolls contained many of the best physicians in Kentucky. The average attendance on its annual sessions was about a hundred. Every man who had the privilege of attending these sessions will always be thankful for it. Renewing annually the pleasant knowledge of one another, and hearing and admiring each the other's annual views on current topics, these sessions were delightful, instructive, entertaining—all that could be desired, except this: That little over one-tenth of the doctors in the State ever knew or cared when or where the society was to meet, or had met, and, as a general rule, only one-thirtieth to one-twentieth of the medical men of Kentucky took part in its deliberations. In the State there were twelve county societies, and three of them held regular meetings. There were a number of district societies that acted as preparatory schools, in their small circles, for the State Association. About eleven months after each annual session a beautiful red-bound "Proceedings" was published, a silent monument to the real value of the meeting. The expense of issuing these was just enough to use up all the society's funds and keep it on the verge of debt. Let no one minimize the influence for good of this honored body. Small, membership scattered, unbusinesslike in its methods, harassed by medical politics of the worst sort, many of its members personally inimical to one another, without adequate funds for any purpose but the publication of the volume of transactions already obsolete before publication, yet this society and its influence brought some order out of the medical chaos following the war. Taking advantage of the sentiment created by the yellow fever epidemic of 1878-9, it helped in having the Legislature establish the State Board of Health. Following this it has perfected very effective statutes for the protection of the ignorant and credulous from charlatanism and quackery. If it has accomplished this much, what can be done by the

entire profession of the State in a compact, homogeneous organization? Already county societies have been organized in more than 75 of 119 counties in the State, and the membership of the State body has passed the 1,500 mark. Under the new constitution of the State Association the county society is the unit, and upon the success of each county society does it depend for its stability and influence. No doctor can belong to other medical organizations affiliated with either the American Medical Association or the State Association unless he first joins his county society. Active county societies will bring the doctors of small sections into pleasant social contact with their fellows and compensate them for the professional isolation, which is the greatest danger to every individual doctor. Going from home to home of his own friends and clientele, feeling that this and that person owe their lives and health to his administration, frequently being called upon to relieve diseases where others have failed, and too frequently forgetting that like services are being rendered by others for his failures, the doctor gradually becomes self-sufficient. Two men developed under these same conditions come into opposition, and the backbiting and rivalry begin and get worse and worse as time rolls on. In Kentucky this picture could almost be multiplied by the number of doctors in it; and yet, in almost every instance, each of the parties to these quarrels is as honest, as competent, and as well equipped as the other. If, then, these two men can gradually be brought together in a small society and it can gradually dawn on each of them that they are mutually honest and praiseworthy, having the same aims, hopes and aspirations, and that they can help and be helped by their neighbors to do better work in the common battle against disease and suffering, that the motto of this Association and of this grand old State, "United we stand, divided we fall," is an actual truth to be lived up to, will not that day when professional unity is a fact and not a dream have begun to dawn?

What is your county society doing? Is it helping you? Is it in better condition than when it was organized? If your answer to these queries is "No," then be honest with yourselves and say it is your own fault. Each individual member of each county society will reap benefit from it in exact proportion to the amount of work he does for it. If you have not been working, go to work to-day and help the next meeting to be the best, biggest, most interesting, most helpful and most fraternal that you have ever held.

Here's to you two and we two.
 If you two like we two
 As we two like you two
 Then here's to us four;
 But if you two don't like we two
 As we two like you two
 Then here's to we two and no more.

Association News.

MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The twentieth annual meeting of The New York State Medical Association will be held at the Academy of Medicine, 17 West 43d street, New York City, on the 19th, 20th, 21st and 22d of October. You cannot afford to be absent. Be sure to come early and bring your friends.

PROGRAM OF THE MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The program of the twentieth annual meeting of The New York State Medical Association, to be held October 19, 20, 21 and 22, 1903, is published in full in this number of the JOURNAL. The Committee on Arrangements will send to each member a program of the meetings and are prepared for a large attendance. Come early and stay late.

ANNUAL DINNER OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Arrangements have been made for the annual dinner of The New York State Medical Association on Wednesday evening, October 21st, at Hotel Manhattan.

The request for contributions is made by the chairman of the Committee on Arrangements, Dr. Samuel A. Brown, of 23 East 44th street. As money to be expended for such entertainments can be better met by voluntary contributions the chairman finds it necessary to make and complete arrangements at an early date, and as he is very anxious to have a large attendance he would appreciate it if you give this matter your early and favorable attention.

REDUCTION OF FARE FOR THE NEW YORK STATE MEDICAL ASSOCIATION.

The Committee on Arrangements have secured a reduction of fare on the certificate plan for those attending the meeting of the Association, to be held in New York City, October 19, 20, 21, 22, 1903.

When purchasing your ticket be sure you request a certificate.

On your arrival at the meeting, present your certificate at time of registration.

Register at the place of meeting, Academy of Medicine, 17 West 43d street, as soon as you arrive in New York.

The special agent of the Trunk Line Association will be in attendance to validate certificates on October 20th and 21st.

You will be entitled to a continuous-passage ticket to your destination by the route over which you make the journey, at one-third the limited fare.

You can secure certificates for members of your family on the same terms.

Even if you do not wish to return by the same route, ask for a certificate, as by so doing you can help your fellows, as a contingent of not less than 100 persons holding certificates showing payment of not less than 75 cents is enforced by the Trunk Line Association.

When you register, state if you have a round-trip ticket, as this also counts as one certificate.

MEETING OF THE COUNCIL AND FELLOWS.

A special meeting of the Council and Fellows of The New York State Medical Association, held at the New York Academy of Medicine, New York, October 1, 1903, was called at the request of the Council by the president of The New York State Medical Association, the object of this meeting being to receive a communication from the Medical Society of the State of New York, that additional conference be instituted for the unification of the Medical Society of the State of New York and The New York State Medical Association. The meeting opened promptly at 2 P. M., being called to order by Dr. Frederick Holme Wiggin, president of The New York State Medical Association.

The secretary read the following communications from Onondaga County and Cortland County:

Resolved, That the Onondaga County Medical Society, which has always remained loyal to the State body, because of the recent action of the American Medical Association paving the way to unification of the regular medical profession of this State, believes that the time has come when the two State bodies shall become united in a single body, and that the Medical Society of the State of New York; that both the Society and the Association shall at once approach this scheme in a spirit of conciliation, willing to make such concessions as each body can consistently make, and that a copy of this resolution be forwarded to the president of the Medical Society of the State of New York, the president of The New York State Medical Association and to the Committee on Conference.

(Signed) A. S. HOTALING, *Secretary*.

Dated,
SYRACUSE, N. Y., June 2, 1903.

At a meeting of committees from the Cortland County Medical Society and Cortland County Medical Association, held at the office of Dr. Higgins on Friday, September 4, 1903, the following resolution was adopted:

Resolved, That as about 35 or 40 per cent. of the members of the Cortland County Medical Society are members of both the Society and Association;

That we believe we express the sentiment of nearly all the profession of the county in the desire for the harmonious union of the two medical organizations of the State, since we believe our influence and power in the State in obtaining needed legislation and preventing the enactment of harmful laws would be greatly enhanced thereby, and we recommend that all proper measures be taken to bring about this end.

F. W. HIGGINS,
H. T. DANA,
J. W. WHITNEY,

Committee for Society.

S. J. SORNERBERGER,
C. D. VER NOOY,
F. D. REESE,

Committee for Association.

The following letter, signed by four members

of the Conference Committee of the Medical Society of the State of New York, was read:

SYRACUSE, N. Y., May 28, 1903.

TO DR. F. H. WIGGIN,

President of The New York State Medical Association.

My Dear Doctor—At the last meeting of the Medical Society of the State of New York the Committee on Conference appointed to confer with a similar committee of The New York State Medical Association, after making its report, was continued and instructed to await the action of the American Medical Association at New Orleans before considering further the methods of amalgamating the regular profession of the State of New York.

At a recent meeting of the American Medical Association radical action was taken removing the obstacle which prevented unification. Appreciating the fact that no further barrier stands in the way of unifying the profession of the State of New York into a single State society, the committee representing the Medical Society of the State of New York would respectfully ask The New York State Medical Association that further conference with its representatives be arranged, with the object of speedily settling upon a definite plan which shall form the basis for amalgamation of the two existing bodies. In making this request the committee representing the Medical Society of the State of New York assures the Association of its earnest desire to increase the influence of the State profession by the action suggested; that it would further state to that body that it is ready to suggest to the Medical Society of the State of New York that it amend its charter to continue, consolidate and amend Chapter 138 of the laws of 1806, Chapter 94 of the laws of 1813 and Chapter 452 of the laws of 1900 for the purpose of cultivating and advancing the science of medicine, the promotion and protection of public health and the establishment of a death benefit fund for the dependents of the members of the Medical Society of the State of New York; that it feels justified still further in assuring the Association that it will recommend to the State Society the method of organization founded upon the plan suggested by the American Medical Association and considered by the joint conference when in session in April, 1902, and that all other matters of detail which must be considered before final action can be taken by the respective societies must of necessity become subjects for conference.

The committee asks for careful deliberation in conference that both the Society and the Association may in the near future be able to present completed and satisfactory plans to the State bodies for ratification.

Respectfully,

(Signed) HENRY L. ELSNER, Chairman;

A. JACOBI,

A. VANDER VEER,

GEORGE R. FOWLER,

Committee.

Voted to receive and place on file.

The secretary then read the answer of the president:

—, June 10, 1903.

DR. HENRY L. ELSNER,

Chairman Committee on Conference, Medical Society of the State of New York, Syracuse, N. Y.

My Dear Doctor—I have received your communication of the 28th requesting the appointment by our Association of a committee to confer with your committee relative to plans for uniting our State bodies, signed by yourself, Drs. A. Jacobi, A. Vander Veer and George R. Fowler, and I shall take pleasure in presenting it to our Council at the earliest practical moment for consideration and such action as they may see fit to take on it, as under our Constitution and By-Laws matters of importance are so referred.

Respectfully yours,

(Signed) FREDERICK HOLME WIGGIN,

President.

The following resolutions, offered by Dr. Joseph D. Bryant and seconded by Drs. John A. Wyeth and E. D. Ferguson, were passed unanimously:

WHEREAS, The members of The New York State Medical Association desire a union of the medical profession in the State of New York; and

WHEREAS, It is deemed expedient for the attainment of this purpose to make further effort to bring together The New York State Medical Association and the Medical Society of the State of New York under the name of "The Medical Society of the State of New York";

Resolved, That a committee of five be appointed by the chair, and said committee is hereby empowered to do whatever is necessary and expedient to bring about such a union in a just and equitable manner; and

Resolved, That the committee so empowered may confer, cooperate and unite with a committee of the Medical Society of the State of New York for the purpose of forming said union of the two medical organizations; and

Resolved, That a copy of these resolutions be transmitted to the secretary of the Medical Society of the State of New York, with a request that their Conference Committee be granted similar powers.

Committee appointed in accordance with the above resolution:

E. ELIOT HARRIS, Chairman;

JULIUS C. BIERWIRTH,

ALEXANDER LAMBERT,

PARKER SYMS,

WISNER R. TOWNSEND.

List of those present at the special meeting of the Council and Fellows of The New York State Medical Association, held at the New York Academy of Medicine, on October 2, 1903:

Dr. Frederick Holme Wiggin, Dr. Guy Davenport Lombard, Dr. Eliot Harris, Dr. John Shrapy, Dr. Charles E. Denison, Dr. J. Riddle Goffe, Dr. David P. Austin, Dr. Smith Ely Jelliffe, Dr. H. S. Oppenheimer, Dr. Thomas F. Reilly, Dr. Montrose R. Richard, Dr. S. Busby Allen, Dr. Nathan E. Brill, Dr. Joseph D. Bryant, Dr. James H. Burtenshaw, Dr. Robert J. Carlisle, Dr. L. W. Zwisohn, Dr. Edmund L. Cocks, Dr. Robert N. Disbrow, Dr. Henry A. Dodin, Dr. Daniel S. Dougherty, Dr. Louis R. Eichberg, Dr. John A. Fordyce, Dr. W. Travis Gibb, Dr. Robert H. Green, Dr. Frederick P. Hammond, Dr. Neil J. Hepburn, Dr. Irving S. Haynes, Dr. Lucius W. Hotchkiss, Dr. Richard Kalish, Dr. J. B. Leo, Dr. William M. Leszynsky, Dr. Frederic W. Loughran, Dr. Wilbur B. Marple, Dr. Emil Mayer, Dr. William H. Luckett, Dr. William G. Le Boutilier, Dr. Harry R. Purdy, Dr. Robert Abrahams, Dr. Adolph Rupp, Dr. Harry H. Seabrook, Dr. Henry M. Silver, Dr. Wisner R. Townsend, Dr. John Allan Wyeth, New York; Dr. J. Scott Wood, Dr. G. F. Maddock, Dr. Hubert Arrow-smith, Dr. Louis C. Ager, Dr. Arthur C. Brush, Dr. Martin Linderoth, Dr. Leonard C. McPhail, Dr. John O. Polak, Dr. Frank C. Raynor, Brooklyn; Dr. William Harvey Thornton, Buffalo; Dr. J. Orley Stranahan, Rome; Dr. Everard D. Ferguson, Troy; Dr. Frank W. Higgins, Cortland; Dr. Joshua William Morris, Jamestown; Dr. John U. Haynes, Cohoes; Dr. George F. Comstock, Saratoga Springs; Dr. C. D. Kline, Nyack; Dr. Albert C. Way, Perry Center; Dr. Irving D. LeRoy, Pleasant Valley; Dr. Mary Gage-Day, Kingston.

MEETING OF THE COUNCIL.

At a meeting of the Council of The New York State Medical Association, held October 1, 1903, Dr. Edward H. Squibb resigned as treasurer of the Association. Dr. Wisner R. Townsend was elected treasurer to fill the vacancy.

COUNTY ASSOCIATION MEETINGS FOR OCTOBER.

Erie County.—Monday, October 5th.
 Cattaraugus County.—Tuesday, October 6th.
 Rensselaer County.—Tuesday, October 6th.
 Kings County.—Tuesday, October 13th.
 Niagara County.—Tuesday, October 13th.
 Sullivan County.—Tuesday, October 13th.
 Tompkins County.—Tuesday, October 13th.
 Wyoming County.—Tuesday, October 13th.
 Orleans County.—Wednesday, October 14th.
 New York County.—Monday, October 19th.
 Orange County.—Wednesday, October 21st.
 Rockland County.—Wednesday, October 21st.
 Cortland County.—Friday, October 23d.
 Lewis County.—Tuesday, October 27th.
 Monroe County.—Tuesday, October 27th.
 Dutchess County.—Wednesday, October 28th.

was there any apparent reaction of any kind. The patient had also enormous doses of chloral bromide, and the query arises, If any part of the treatment was beneficial, which was it? The only thing clearly proved is the contention of the State Board of Health that the antitoxin is harmless.

Wayne County Association.—The regular meeting of this Association was held at Clyde, on September 1st, and the following papers were read: "The Medicinal Treatment of Chronic Diarrhea," by Dr. Allen A. Jones, of Buffalo; "Pelvic Abscesses," by Dr. J. F. Myers, of Sodus; "Friedrich's Ataxia," by Dr. M. A. Brownell, of Newark; "Cerebral Thrombosis," by Dr. T. H. Hallett, of Clyde; "Some of the Difficulties of The New York State Medical Association During Its Earlier Career," Dr. Darwin Colvin, of Clyde.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FOURTH DISTRICT BRANCH.

Wayne County.—Reuben A. Reeves, Macedon;
 Andrew F. Sheldon, Lyons.

OBITUARY.

Dr. Robert Newman, of New York City, born in Koenigsberg, Germany, died on August 28, 1903, at the age of 72, at Monument Beach, where he had been since early in the summer. He was a graduate of the Long Island College Hospital in 1863, and the Bellevue Hospital Medical College in 1869. During the civil war in 1863 he went to the front as State's volunteer surgeon. He was a member of the American Medical Association, The New York State Medical Association, American Electro-Therapeutic Association and the New York Pathological Society. He was Consulting Surgeon to the McDonough Memorial, Hackensack and Bayonne Hospitals, and the Home for Aged and Infirm at Yonkers, N. Y.

Dr. Daniel B. Howard, of Warrensburg, N. Y., died at his home on Monday morning, September 21st, from angina pectoris. He suffered an attack of la grippe some six years ago, since which time he has had several attacks of neuralgia of the chest.

Dr. Howard was the son of the late Dr. Eliakim W. Howard, who was a prominent physician for sixty-four years in Warren County, N. Y. He was born at Warrensburg nearly sixty-three years ago. He graduated with honor from the Albany Medical College in 1867, and at once entered actively upon the practice of medicine with his father. He became one of the foremost and best beloved physicians of the county. He was a member of The New York State Medical Association and of his county societies. In the community in which he lived he was a power for all that was good for its best interests.

Saratoga County Association.—A regular meeting was held at Worden Hotel, Saratoga Springs, Tuesday, September 22, 1903. The program was a Symposium on Typhoid Fever—"Etiology and Pathology," Dr. G. Scott Towne; "Symptoms and Early Recognition," Dr. Amos W. Thompson; "Complications and Prognosis," Dr. George F. Comstock; "Medicinal Treatment," Dr. John F. Humphrey; "Hydrotherapy," Dr. Frederick J. Resseguie; "Report of a Case of Tetanus," Dr. Douglas C. Moriarta.

In the symposium on typhoid all the old lines of treatment were reviewed, but especial interest was centered in the subjects of hydrotherapy and diet. The writer of the paper upon hydrotherapy, after discussing fully the satisfactory results, epitomized the whole subject as follows: "Water externally, water internally—more water." Regarding diet there seems to be an increasing tendency to break away from the old traditions in favor of greater liberality. A considerable series of cases of typhoid were reported, in which no departure whatever had been made from the patients' accustomed diet during health, and no change made in case of hemorrhage or other complications. The history of the cases upon this unrestricted diet shows that they do better all through the course of the disease than did those upon the old "milk and liquid" diet, and get up in far better flesh and strength, thus materially shortening the period of convalescence.

The case of tetanus reported was of interest, in that the patient recovered, but did not throw much light upon the problem of the value of the tetanus antitoxin; for while enormous doses were administered, covering a period of several days, there was no appreciable effect upon the frequency or severity of the convulsive attacks, nor

PERSONAL.

Dr. John Joseph Tierney, of New York, was married to Kathryn C. Mullane, September 16, 1903, at Holy Trinity Chapel, by Rev. M. A. Considine.

Dr. William A. White, of Binghamton, has been made superintendent of the Government Hospital for the Insane, Washington, D. C.

Dr. and Mrs. John A. Fordyce have returned, having spent part of the summer at Spring Lake, Mich.

Dr. E. H. Squibb, treasurer of The New York State Medical Association, resigned October 1, 1903.

Dr. J. N. McCormack, of Kentucky, chairman of the Committee on Medical Organization of the American Medical Association, made a brief visit in New York last week.

We are very happy to hear that Dr. George Blumer, of Albany, is making a rapid recovery from his recent attack of appendicitis.

AUTOMOBILE ACCIDENT.

Dr. Edward C. Rushmore, of Tuxedo, a prominent and active member of the Orange County Medical Association, was seriously injured in an automobile accident at Arden, N. Y. While going up a steep incline the power gave out and the machine started backward and toppled over a rock embankment. His niece, Miss Herrick, was killed instantly. Dr. Rushmore had his pelvic bone broken, and is in a very grave condition.

LEGAL NOTES.**Death Discharges Illegally Practicing Druggist.**

A rather pathetic incident occurred the first week of the month, during the prosecution of a druggist on First avenue. Mr. Conway, the inspector of the Association, and Mrs. Hughes, one of the detectives, secured evidence against one William Welterwitz, of 110 First avenue, it being a flagrant violation of the law in his having prescribed medicine for the commission of an unlawful abortion upon the detective.

When the case was called before Magistrate Cornell, in the 57th Street Court, the defendant, on leaving the court house, told the witness, Hughes, to take a good look at him, as it would be the last time she would see him, but she paid no attention to his remark, until the day following there appeared in the papers an account of his having returned to his drug store and taken a large dose of chloral.

He was subsequently taken to Bellevue Hospital, and every attempt made to save his life, but all the remedies failed, and he died. He was officially discharged by Magistrate Cornell on September 8th.

Albert W. Schaefer, druggist, of Avenue B and West Tenth street, was held in \$500 bail by Judge Cornell on September 17th for practicing

medicine without registration, and will be tried in the Court of Special Sessions. The evidence in the case showed that he had prescribed the use of an abortive agent.

Augusta Dudek, of East 78th street, was held for trial by Judge Zeller in the Harlem Court in \$100 bail; she claimed to have relatives who were well-known physicians, and claimed that she could practice medicine without fear of arrest because her friends were doctors.

Cynthia Jane Warburton was arrested and taken before Judge Barlow in the 54th Street Court, charged with practicing medicine without registration, and when the case was called the defendant produced a diploma and evidence of registration, though under the name of Cynthia Jane Wade; she also produced a marriage certificate showing that she had been married to Mr. Warburton. When she was asked how she signed her death certificates and birth certificates, she replied that the Health Board took it "C. J. Warburton, M.D." There is, of course, no such physician registered as "C. J. Warburton," and the Judge instructed her that she must immediately correct the records both in the County Clerk's office and in the Department of Health, as practicing under a false name was a felony.

Catherine Seifts, of 1155 Third avenue, was taken before Judge Cornell on a summons during the month, and was discharged with a warning on motion of the counsel for the Association. She is a woman 70 years of age, and the warning of the Magistrate is expected to be a sufficient deterrent.

In Clinton County a member of the Association has been sued for alleged malpractice. The plaintiff claims the defendant was to cure an ulcerated leg and tuberculosis of the knee; to faithfully, skilfully and diligently attend to and care for. Judgment is demanded for the sum of \$600.

This question has already been asked more than once, and it is, therefore, deemed wise to give it an early answer here. According to the articles of organization adopted by the State Association and the various county societies, a physician necessarily becomes a member of the State Association when he joins his county society. The county society is indebted to the State Association for each member on its roster, and necessarily takes upon itself the burden of collecting this annual due fee and turning it over to the treasurer of the State Association.

It is perfectly clear that the meaning of this is, that it is impossible for component county societies to have two varieties of members, one variety in affiliation with the State Association and the other not in affiliation. The sooner this is clearly understood, and the sooner county societies build up their rosters accordingly, the better it will be for the simplification and strengthening of organization.

News Items.

TRANSACTIONS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Vols. I and II.

The plates for Vols. I and II of the Transactions of The New York State Medical Association having recently been found, it will be possible to furnish members having sets of transactions which are incomplete, on account of the absence of these numbers, with either of them at an expense not to exceed \$5 per volume, provided a sufficient number of members signify, within a reasonable time, to the President, Frederick Holme Wiggin, 55 West 36th street, New York City, their wish to obtain Vol. I or II, or both of them.

There are still a few sets of the Transactions of the old State Association, Vol. III to XVI, in the hands of the Committee on Publication, and they will be furnished while they last to members of the Association who have not already a set, if they will send word to Dr. Charles E. Denison, Chairman, Committee on Publication, 64 Madison avenue, New York City, that they would like to have them and are willing to pay the express charges for the delivery of the books, which charges average less than \$1; they will be forwarded them at once.

MORAL AND LEGAL ASPECT OF ABORTION.

Criminal abortion is so repugnant to the true and conscientious physician, so detestable to the spirit of morality and Christianity, so abominable to the lofty and nobler instincts which control our moral being, that it has no justification whatsoever in law or morals. It destroys the honor of the profession, violates the sanctity of the home and relegates Christianity to the days of barbarism and infidelity. Notwithstanding its hideous loathsomeness, sad indeed it is to contemplate that we have individuals in this State, yea, even perhaps in this society, who prostitute their honor, sacrifice their manhood, and who hesitate not to insult God himself, by engaging in this damnable work, and yet, cowardly assassins that they are, their hearts calloused by their crime, they have the hardihood to raise their hands, dripping with the blood of the innocents, and proclaim to the public, the poor deluded public: We are physicians! We are members in good standing in our medical societies!

Members of this society, we know these facts to be true; we realize it, we feel it; it insults, it humiliates; we condemn it, we war against it, and after all we are in a measure helpless. This brings us to the question of legal abortion, or abortion permitted by law under certain qualifications, and for the specific purpose of protecting and saving the mother's life. This at once suggests the question, Are there any cases in which a physician is justified in bringing about an abortion or prescribing treatment from which he knows an abortion is likely to result? Our conduct should be guided in this matter in accordance with these principles: 1st. That we do not wish evil itself, but make all reasonable effort to avoid it. 2d. That the immediate result we wish to produce is good in itself. 3d. That the good effect intended is at least as important as the

evil effect permitted. 4th. That the evil is not made a means, used to obtain the good effect.

Coppens applies these principles as follows:

1st. If the medicine is necessary to save the mother's life and it is not certain to bring an abortion, though it is likely to do so, then the good effect is greater than the bad effect. You may therefore give the medicine to save the mother and permit the probable death of the child.

2d. If the medicine is not necessary to save the mother's life, though very useful for the sake of such an advantage, you cannot justly expose the child's life to serious danger.

3d. If the danger the child is exposed to is not serious, and the remedy, though not necessary, is expected to be very useful to the mother, the remedy may be given.

4th. If the drug is necessary to save the mother, and is as dangerous to the child as it is beneficial to her, can you give the remedy? No, you may not injure the child directly to benefit the mother indirectly; that would be using a bad means to obtain a good end.

This last principle applies to the case of a pregnant mother who has unceasing attacks of vomiting, so much so that if not relieved she will die. The attending physician and consultant agree that there is no way of relieving the vomiting except by emptying the uterus of its living burden. Abortion then is the means used to stop the vomiting. Can you do it? No, because the abortion directly and surely kills the child, as you would a man by driving a dagger through his heart: You can never do evil that good may come.

The only case that it would be permissible to destroy the child's life to save the mother's is when the child is an unjust aggressor, but the child can never be an unjust aggressor as against the mother. Who put it there? God, through the agency of its parents. The child is passive from conception to birth; at most, therefore, it can be but an innocent aggressor.

It is sometimes pleaded in justification of abortion that the mother's life is more valuable than the child's. Her social position, her duty to her family and husband, her age and accomplishments all combine to make her life more valuable; but who is to judge of the value of a life? Shakespeare tells us "Macduff was from his mother's womb untimely ripped." Admit the principle and you cannot destroy or kill an innocent aggressor except in self-defense. It at once prohibits the destruction of the fetus at any period of gestation. In many of the United States the law protects an unborn infant from its first stage of ascertainable existence; hence no matter what may be the period of gestation, an indictment lies for its wilful destruction. (Wharton Stille, 861 P.) That the law does guard its interests is shown by the fact that a child born at the extreme limit of gestation, after its father's death, is capable of taking by descent and being appointed executor.—F. J. WELSH, *Journal of Michigan State Society*.

MEDICAL CHARITY.

Doctors give away more than any other class of men on earth. It is stated that gratuitous services of physicians last year to one large Philadelphia hospital amounted to over \$500,000 at ordinary fees. If any individual or any society had given a half million dollars to any cause the fact would have appeared in all the dailies with large headlines, but this free work of physicians has come to be considered as too common for notice. And this was only one hospital in one city. How enormous this free work in the whole country must have been last year! Much of this free work was necessary and commendable and much of it was not.—*Wisconsin Medical Recorder*, June, 1903.

The Adulteration and Substitution of Drugs.

Mr. Bostwick's Assembly bill, to amend the Penal Code of New York State by adding thereto new sections relative to the manufacture, sale, adulteration, deterioration or substitution of drugs, if it becomes law will tend to prevent the increasing and prevalent pernicious custom on the part of manufacturers and druggists of foisting upon the public drugs which are either adulterated or not up to the proper standard. The bill in question requires that all manufacturers or importers of drugs must affix to all packages containing the same a certificate in writing which shall indicate the purity, strength and genuineness of such drugs and their ingredients, and in case of drugs which are liable to deterioration through lapse of time, said certificate shall furthermore state the date after which such drugs will deteriorate, and after which they shall not be sold, and in all cases said certificates shall state the date of manufacture or of importation and also the date of the sale thereof. Any manufacturer or importer, druggist or dealer in drugs, or other person who shall sell, offer, or expose for sale, dispense, or give away any drug which shall not have affixed to it, or to its wrapper or package, the certificate or certificates above mentioned, shall be guilty of a misdemeanor and liable to a heavy fine and imprisonment.

The clause of the bill dealing with substitution reads as follows: "Any druggist or dealer or other person who shall sell a drug not demanded by the buyer in place of that so demanded, or substitute any drug not required, for another, without the knowledge or consent of the buyer, shall be guilty of a misdemeanor and liable to a heavy punishment."

The fact has been obvious for a considerable time that a law of the nature referred to above is badly needed, not only in New York State, but throughout the whole country. The adulteration of drugs is a very serious matter, and may be placed almost in the same category as that of food. Both are in a way worse than stealing, for whereas filching a man's property only injures him materially, adulterating food or drugs hurts him physically. One affects his pocket, while the others menace—what is far more important—his health.

As to substitution, it has been proved up to the hilt that the practice is largely resorted to by New York druggists. The custom from every point of view is most reprehensible. The patient, the physician and the manufacturer are all sufferers by the druggist substituting another drug than that ordered. The patient because he does not receive the therapeutic treatment which the physician judges to be most suitable for his complaint, the physician because the patient does not respond to treatment in the manner anticipated, and the manufacturer because his medicine may gain an undeserved bad name through the substitution of an inferior article. Adulteration of all kinds, whether of food or drugs, and substitution, should be prevented by the strong hand of the law.

THE PHYSICIAN'S PROFESSIONAL RIGHTS AND DUTIES.

The usual rights are not granted him arbitrarily by the crown; they are founded in natural justice, but made definite and enforced by human legislation. *Take, for example,* his right to receive due compensation for his services. *This right was not recognized by the old Roman law in the case of advocates and physicians,* nor by the common law of England until the passing of the Medical Act in 1858. Surgeons and apothecaries could receive remuneration for their services, but not physicians. These were presumed to attend to their patient for honorarium or honorary; that is, a present given as a token of honor.

Certainly, if doctors by common agreement waived their right to compensation, or agreed to be satisfied with any gift which the patient might choose to bestow, they would be entitled to honor for their gener-

osity; but they are not obliged to such conduct on the principle of natural justice. For by nature all men are equal, and therefore one is not obliged under ordinary circumstances to work for the good of another. If he renders a service to a neighbor, equity or equality requires that the neighbor shall do a proportionate good to him in return. Thus the equality of men is the basis of their right to compensation for services rendered. The physician's right to his fee is a natural one, and on his patients rests the natural duty of paying it. Not to pay the doctor's bill is as unjust as any other manner of stealing.

Gentlemanliness has much to do with every one's success in life, and in particular with a doctor's success. It is especially when we are sick that we are sensitive to everything displeasing in the conduct of others. It is not then the bold thinker or the extensive reader that is the acceptable visitor to the sick room, but the gentlemanly consoler who says the right thing at the right time, whose very eye expresses and whose countenance reflects the thought and sentiment most appropriate on the occasion.

There are most able physicians who are not gentlemen, and there are in the medical profession gentlemen who are rather poor physicians; but as a rule, I believe, the gentleman will thrive where the genius will starve. It is more or less the same in other professions. I know learned lawyers to-day who are far from prosperous, while men ten times their inferior in learning are getting rich. I remember a most skilful physician, now no more on earth, who was a very genius in the science of medicine, but he was so filthy in his habits that many dreaded his visits and would sooner have a man of less ability and gentler manners as their family physician.

Gentlemen, habits good and bad cannot be put on and off like a dress coat. They are lasting qualities, the growth of years, the result of constant practice and self-denial or self-neglect.

Uniting the external decorum of a gentleman with a thorough knowledge of his profession, and with what is still more important, the virtues of a conscientious man and sincere Christian, ever true to the sound principles of mortality, you will be an honor to yourselves, an ornament to your noble profession, a blessing to the community in which Providence will cast your lot as the dispensers of health and happiness and length of days to your fellow-men.—C. R. SHAUGHNESSY, *Maritime Medical News*.

MAY A HOSPITAL STEAL?

A certain large corporation has for some years had an arrangement with a physician to care for its injured employees and has paid him liberal fees for his services. The case in point was one of bone injury and the physician said an operation was necessary, stating the fee that he would ask. There was some question in the minds of the company's officers as to the necessity for the operation, and the manager of the concern related the circumstances to his personal physician, who is a visiting physician to the hospital in question. Remembering that the hospital was in need of cases and of revenue, this physician suggested that the case be put in a ward at the hospital where the best treatment could be had. The ward fee was to be \$7 a week, and nothing was said about the fee for the surgeon. The company sent the man to the hospital, where he was operated on as a clinic case with entirely satisfactory results, by a leading surgeon, whose personal character and professional standing are a sufficient guarantee that he was an entirely innocent participator in

this pretty plain instance of medical highway robbery.

What has been the result? The manager of this rich corporation is telling the officials of other corporations how he evaded the payment of a surgeon's fee in an unpromising case, and how light the total cost of this case was. Another corporation abundantly able to pay good fees has thus found a way of entirely circumventing the demands of a physician to be paid for his work, and another physician has lost a valuable portion of his practice. A most aggravating feature of the case is the fact that it is physicians of unimpeachable character who, finding unconscious refuge behind the impersonality of an "institution," thus rob their fellow-physicians of their practice and their income.

This sort of occurrence, now so frequent all over the country, will inevitably disorganize the profession or else cause it, through its medical societies, to begin an open and bitter warfare against the hospitals, unless the hospitals themselves at a very early day adopt a system which will entirely prevent their stealing cases from the individual physician who has no hospital. The members of hospital staffs must at once look into the system of receiving cases under which they work, and must provide for a careful investigation of the social origin of cases, or else they must prepare to hear from the medical societies in terms that will be very definite.—*Forshay Bulletin Academy of Medicine.*

QUACK CONSUMPTION-CURE COMPANIES.

With the professional crusade against pulmonary tuberculosis there have arisen a number of fraudulent "cures" which should receive the attention of city and State governments. Medical societies should institute suits and "clean the rascals out" wherever it is legally possible to prosecute them, for hardly any crime is more heinous than to defraud the ignorant poor as these scoundrels are doing. There is said to be at least a dozen of these large "absolute consumption-cure" concerns in New York City. Every trick of the quack scamp is skilfully carried out to deceive the unwary, and as money is easily got by them it is freely spent to fleece the unfortunates. The worst feature of many of these companies is a skilful use of the names of eminent physicians and scientists in such a way that it becomes difficult to trap the rogues, and the cheap newspapers become *particeps criminis* by publishing their shameless advertisements. We have previously published an account of the exposure of one advertiser who deliberately adopts and trades upon the name of a great authority upon tuberculosis. The New York Charity Organization Society, through a committee, is seeking to restrict the operations of these nefarious firms, and should receive the help of the profession and of all good citizens. So far this committee is able only to advise. It has printed for general circulation

resolutions it recently adopted, declaring that there is no special medicine for pulmonary tuberculosis known; that the so-called cures and specifics, and special methods of treatment widely advertised in the daily papers, are, in the opinion of the committee, without special value. "These 'cures,'" the committee proceeds, "do not at all justify the extravagant claim made for them, and serve chiefly to enrich the promoters at the expense of the poor, and frequently ignorant or credulous consumptives." No cure, it is the committee's opinion, can be expected from any kind of medicine or method except the regularly accepted treatment, which relies mainly upon pure air and nourishing food. Physicians may aid by disseminating the circular and by asking the newspapers they take to warn their readers against the wretches.—*American Medicine.*

DIAGNOSTIC POINTS OF RENAL TUBERCULOSIS.

- 1st. The presence of tubercular disease elsewhere in the body.
- 2d. A previous trauma of the kidney.
- 3d. Hematuria, usually early.
- 4th. Frequent micturition at night.
- 5th. Polyuria, followed by a diminution in amount.
- 6th. Pain and tenderness in kidney region, with sometimes colic.
- 7th. A tumor on affected side.
- 8th. The characteristic fever of tubercular infection.
- 9th. Examination of the urine shows—
 - (1) Increased amount.
 - (2) Albumen absent, early, and may be present in small amount later.
 - (3) Tube casts as a rule absent.
 - (4) Acid reaction.
 - (5) The presence of pus.
 - (6) The presence of tubercle bacilli shown by tinctorial and inoculation methods.—I. D. THOMAS, *Virginia Medical Semi-Monthly*, July.

THE HEALTH DEPARTMENT.

A deep impression has been made upon people of the East Side by the activities of the Health Department. Dr. Lederle has been diligent in excluding from the school children afflicted with contagious diseases, but he has established a corps of trained nurses, who, when a child is excluded, go at once to the home and tell the parents how to treat the disease. These nurses go back to these homes every few days, and, as a result, the children return to school usually in a very short time. In the summer these nurses give free treatment to the sick infants of the tenements.

Dr. Lederle has established a branch of the Health Department on the lower East Side, where poor people can get immediate treatment. He organized a summer corps of physicians to give special service to children suffering from peculiar summer complaints. He established a trachoma hospital, and last year 50,000 children received free treatment there for this disease, and without which many of them were sure to go blind.—R. FULTON CUTTING, *New York Times*, September 11th.

PRIVILEGES OF MEMBERS.

By-Laws of The New York State Medical Association.

ARTICLE IX.

Sec. 4. Resident members shall have all the rights and privileges conferred by their respective County Associations and District Branch Associations. They shall be eligible to any office in the gift of the Association; shall be entitled to attend all meetings of the Council and Fellows, and shall receive all the protection, benefits and support conferred by the Association; but if a member's dues be unpaid at the time of the annual elections of his County Association or District Branch Association he shall not be counted as a basis of representation in this Association, shall not be eligible for election as a Fellow, shall not receive the publications of the Association or be included in its published list of members for that year, nor thereafter until he has discharged his indebtedness in full.

Sec. 9. No member shall be permitted to resign while owing dues or assessments or while he is under charges which may lead to his expulsion.

ASSOCIATION DUES.

By-Laws of The New York State Medical Association.

ARTICLE X.

Sec. 2. The annual dues of resident and non-resident members shall be six (6) dollars, but if such dues be paid within three months of the date of submitting the bill a rebate of one (1) dollar may be deducted.

Sec. 3. All dues shall be payable on the 1st day of January of each year.

Sec. 4. On the 1st day of July in each year the names of all those members who have failed to pay their indebtedness to the Association shall be dropped from the forthcoming list of members to appear in the *Medical Directory* for that year, and if these members shall further fail to pay their indebtedness by the close of the annual meeting of the Association of that year without satisfactory excuse their names shall be dropped from the official roll of members.

Why is it that so many of our general practitioners work so hard and receive so little compensation? Why should they make calls upon well-to-do people, charging \$1 a visit, when the prevailing charge is \$2? On such an income can they afford to visit the centers of medical learning? Are they able to take needed vacations or enjoy some of the many pleasures at hand that other men in similar walks of life enjoy? Is it necessary for a physician to be a slave to his profession? Do not the best people appreciate the fact that men who give time to self-improvement are worthy of better compensation

than those who continually drudge from early morn to late at night? Are the steady hand, the clear mind, the willing body found in the slave?

Has not the specialist, who does little or no general work, gained the confidence of the profession and people, given up many a dollar fitting himself to do better work? Is not many a day and week each year devoted to special study in connection with medical societies, among the poor at hospitals or in his office in order to increase his ability? In other words, in order to become possessed of most valuable assets he expends much capital expressed in terms of time and money. As a result he is called upon to do special work, for which in many cases he gets little or no reward, and in others large returns, depending on the ability of the patient to pay, the energy expended and responsibility involved.

It is these specialists who are sometimes asked to divide their fees. These requests do not come from physicians who appreciate the dignity of their calling, nor do they often come from the dishonest grafter, for there are few such in our ranks; but rather, let me suggest, as the result of thoughtlessness. This thoughtless doctor forgets that his patrons would willingly pay for his time and special attention given in the critical moment, when as their trusted family physician, looking after their interests, he considers it necessary, with them, to consult a specialist. He forgets that when he impresses upon them the worth of his time they hold his judgment in higher esteem and that when he gives them such time and advice, the value of both in their eyes will be much the same as that which he seems to place on it himself. He forgets that outspoken honesty of expression is in the long run appreciated by the people, and that nothing will so soon discredit a physician in a community as the feeling that he is indulging in sharp practice or betraying confidence. This thoughtless physician has for the time forgotten that his practice is much more substantial than that of the specialist and that he will be deriving an income long after that of the surgeon has dwindled. I think it can safely be asserted that ten general practitioners attain the age of 65 with a competency to one specialist who does the same thing.

The responsibility rests upon the surgeon to so regulate his charges in accord with the service rendered and the ability of the patient to pay that no physician calling him in consultation or to operate can truthfully say that the surgeon took the glory, the credit and the cash and left him only the drudgery and experience.

In conclusion let us remind ourselves that though the code of medical ethics has disappeared its principles remain, restated, modernized, re-enthroned. It rests with us as individuals to keep its spirit ever to the front and thus, American medicine in the future, as it has been in the past, shall be our glory.—T. W. ROBBINS, in *Journal of the Michigan State Society*.

MEDICAL ETHICS IN CANADA.

Our noble calling is marred by our one besetting sin, the bane of professional, as well as of social, life—*jealousy*, a spirit most vitiating to our manhood; and so long as this spirit exists, just so long will people withhold the respect to which our profession is otherwise entitled.

If we would have the public mind regard the dignity and worth of our profession, we must show to them by our daily walk and conversation that our chief delight is to uphold its honor. We must cultivate a fraternal spirit among ourselves, and carry out the great moral precept, "Whatsoever ye would that men should do to you, do ye even so to them." And let us while mindful of our own uphold the reputation of our friends and competitors in our profession. As it is only natural for one to make mistakes, I do not claim that there is any of us who never err in our conduct toward our professional brethren, for all must have at some time come short of the glorious precepts of the Golden Rule. But I do insist that each and all should strive to attain a state of perfection in our professional conduct toward each other. Too often we allow the laity to cause us to break every rule of etiquette. They will come to us seeking our opinion of a case that a fellow-practitioner has been treating, or they will ask us to visit and treat a patient that another physician has been attending without informing us of the fact, and if we do not question them on the matter we may cause ourselves no little mortification by visiting another physician's patients.

The idea is prevalent in the popular mind that they may call a second or even a third physician to the same case without the consent or knowledge of the first, or without their having formally discharged their former attendant. If the latter is done, or the first physician, for reasons of his own, declines continuing the case, I think it is the duty of the second to attend when called upon; but if people request us in the absence of their regular attendant to treat them, we should walk warily lest we encroach on another's rights. We have no more cause to interfere with another practitioner's patients without his knowledge or consent than we have to meddle with their private property; and it is our duty to endeavor to educate the laity to the fact that physicians have rights which must be respected, both in their relations to each other and to their patients.

Another source of misunderstanding among ourselves, and between the profession and the laity, is our scale of fees. I know of instances

in which the minimum fee is not asked; especially is this so in obstetric cases, and where another charges according to our scale of fees he is looked upon as an extortioner.

When approached by the laity in regard to our fee for an operation for a case of confinement, it would be well to state both minimum and maximum fees—explaining that it depended upon the time occupied and the amount of work involved.

Take an example: We are approached and asked, it may be, what do we charge for attending a case of confinement. Probably we may answer, "\$8" or "\$10"; whatever our usual fee in uncomplicated cases is. Perhaps another physician had attended a case for that individual, which involved a wait of eighteen to twenty-four hours, instrumental delivery, and stitching a torn perineum or cervix, and charged for these services \$25. Our answer would give the questioner the impression that he had been overcharged. Whereas, if we said our charge was from \$8 to \$30 he would have no reason to be disappointed with his attending physician's rates. I do not know of anything that cheapens our profession like reducing our rates in the spirit of opposition like so many second-hand dealers. Societies and insurance companies seem to have us at their mercy. Just think of making a physical examination, and testing for albumin and sugar in the urine, for \$3. It is pretty much in medicine as in everything else; we must keep our rates up to a certain standard if we are to do ourselves and our patients justice.

Another drawback to our profession is the lack of social principles, and our inclination to consider our individual interests, regardless of detriment to the profession at large. Such tendencies are best overcome by habits of association and mutual intercourse, which scientific and social meetings are calculated to engender. It would be a proper movement, at least in my opinion, for every society, such as ours, to adopt a code of ethics, and there are none of us but who would be the better for an occasional brush up on the etiquette of our profession, more in the way of a prophylactic than as a necessary course.

We owe it to our profession to promote its best interests, not only by scientific research, but by a feeling of brotherhood and of mutual support; so that the popular mind may entertain the idea which is well expressed in the words, "Behold how good and how seemly it is for brethren to dwell together in unity." We should as far as it is in our power live at peace with all men, but more especially with professional brethren.

There are certain rights and privileges to which a physician's professional standing entitles him. He would do well to assert them; in fact, it is his duty to do so. His talents and skill are qualities of which he is a steward, and should be used for the best general good, and are not to be wasted either by his own carelessness or by the selfishness of others.

When called to attend a case he should be

allowed the free use of his faculties, and not be deterred from doing what in his opinion is necessary, either by the solicitations of the patient or of anxious friends. In our relations with the sick we should exercise kindness and forbearance, making due allowance for their irritability and peculiarities, and at the same time endeavor to elicit such information as is essential for a proper diagnosis of their condition.

It should be beneath the dignity of a physician to misrepresent the gravity of a case, leading the patient or friends to think it more serious than it really is, and thus be tendered an exalted estimation of his services, to which he is not entitled. Nor should he involve a patient in unnecessary expense, by needless visits or by costly appliances.

Another error we are liable to fall into is allowing admiring friends to publish in the press our successful treatment of them or their relatives. This is an unethical method of advertising; we should be content with the successful issue of our efforts without sounding a trumpet.

In their intercourse with each other, physicians will best conserve and secure their own self-respect and that of society at large by a courteous conduct toward their professional brethren. Differences not infrequently arise from want of candor, a suppression of the truth, if not actual falsehood, on the part of parents or friends, and these false statements probably constitute the most fruitful source of jealousies and ill-feeling, which so often mar the fellowship and good feeling of our profession. We cannot be too cautious how we receive and act upon such statements *said* to have been made by a professional brother. It is among these snares that we must be "as wise as serpents," and "walk circumspectly."

We should as medical men and preservers of the public health bear testimony against quackery in all its forms, whether it appears with its usual bold front, or under the pretense of philanthropy or of religion.

Although the laws of our land are stringent for the suppression and punishment of fraud in general, yet fraud in medicine flourishes wholesale, and our only remedy would be to bring, as a united body, pressure to bear on the legislature to enact laws for the suppression of such practices. The press is the greatest source of help to promote the use and sale of quack medicines. In every newspaper and magazine, without exception, the virtues of some particular nostrum are set forth. Even our medical journals are often more than half taken up with advertisements that to say the least are not strictly ethical. Judging from the matter contained, a great many so-called medical journals exist solely for the purpose of advertising certain remedies which are generally indorsed with physicians' names. Neither will stand the straight rule of medical etiquette.

Another class that lend their influence to encourage the use of "secret nostrums" are members of the learned professions. It is annoying to see their names to an article declaring that a

certain patent medicine cured them, after the doctors had given them up, whereas if the truth were known, probably their trouble existed only in their imagination.

The pharmacist also contributes no small aid to the widespread use of questionable remedies, and gives them the advantage of space and place in his store. To-day we are more or less at the will of the pharmacist. He indirectly dictates to us what remedies we shall use, compounds our mixtures wholesale, and suggests to us for what and how to use them, and has his bottles labeled so that "a wayfaring man though a fool" might use them intelligently.

Lastly, and worst of all, we find that some practitioners do not hesitate to recommend some patent medicine, which fact at once commends the system in general, and that remedy in particular, to the popular mind.

It is also opposed to medical ethics to countenance the popular delusion of extravagant cures, or the prolongation of life beyond its natural limits, by means of some health-restoring extract, or an infallible system of medical practice—the faith in which among the deluded believers is in inverse ratio to the amount of common sense they possess. It is the duty of the physician to discountenance all such shams and to endeavor to set before people the true principle upon which curative medicine is founded.

Unless we be true to ourselves, and to the ethics of our profession, it will be vain to appeal to other learned professions, or to the laity for a proper recognition of our abilities, and of our general standing.

To uphold so honorable a position we must, to begin with, have the requisite knowledge of our profession, and as I mentioned at the first, a gentlemanly demeanor, and should fulfil our duties with kindness, and with courtesy, and with a just sense of true dignity engendered of self-respect.

Our manner or professional deportment, to be perfect, must be sincere, and actuated by a sense of regard for the feelings of our patients. It is certain that no generalized or artificial manner can fail, sooner or later, to betray itself. It is likewise impossible to have one manner for rich patients and another for poor patients. In this respect we should imitate the eminent physician who, when requested by the Archbishop not to treat him as he would a Whitechapel patient, replied: "Your Grace, I treat Whitechapel patients as if they were the Archbishop."

Professional morals are an important part of medical education, and it is as much our duty to acquaint ourselves with the precepts of the ethics of our profession as it is to study scientific truths.

I would again suggest the adoption of a medico-ethical code, and at the same time repeat that no laws, however stringent, will make a man.—W. R. DUNBAR, *Maritime Medical News*.

Book Reviews,

MANUAL OF THE DISEASES OF THE EYE FOR STUDENTS AND GENERAL PRACTITIONERS. By Charles H. May, M.D. Third edition, revised, with 275 original illustrations, including 16 plates and 36 colored plates. New York: William Wood & Co.

To this third edition of a valuable work the author has made a considerable number of additions and such alterations as to bring the subject up to the present date. The volume is full of good illustrations, many of them original and exceedingly clear and precise. As the author truly says, the eye must not be regarded as an isolated organ; a knowledge of the condition of the system is valuable in diagnosis and successful treatment. The first three chapters enter fully, yet concisely, into examinations, external subjective and objective, of the eye. In following seventeen chapters, while giving the facts necessary to an understanding of the diseases of the eye, the author gives all that is essential in ophthalmology to the general practitioner. Five chapters are devoted to optical principles and the last chapter to ocular therapeutics.

A THESAURUS OF MEDICAL WORDS AND PHRASES. By Wilfred M. Barton, M.D., Assistant Professor of Therapeutics and Materia Medica and Lecturer on Pharmacy, Medical Department, Georgetown University, and Walter A. Wells, M.D., Demonstrator of Laryngology, Washington Post-Graduate School; Fellow of the American Rhinological, Laryngological and Otological Society, etc. Philadelphia: W. B. Saunders & Co., 1903.

This extensive collation of medical terms cannot fail to be of the greatest value to students and to writers on medicine. It aims, as the authors announce in the introduction, to perform for medical literature the same services which Roget's "Thesaurus of English Words and Phrases" has done for literature in general; that is, instead of supplying, as an ordinary dictionary does, the meaning to given words, it reverses the process, and when the meaning or idea is in the mind it endeavors to supply the fitting term or phrase to express that idea. It aims especially to give the technical equivalents of vernacular or vulgar medical words and under appropriate headings to present all the technical words associated with a given subject.

The authors, surely not without much labor, have included in the long list the designations of more than two hundred diseases, organs and tissues which bear the names of their discoverers, doubtless with intent to remedy this perplexing nomenclature by appending to each faulty term its right name based on its true nature. This nice bit of work greatly enhances the value of the Thesaurus, the artistic part of which is so creditable to the authors and publishers.

VEASEY'S OPHTHALMOLOGY. A Manual of Diseases of the Eye for Students and General Practitioners. By Clarence A. Veasey, M.D. Philadelphia and New York: Lea Bros. & Co., 1903. Cloth, \$2 net.

Is a very convenient manual of practical ophthalmology for the student and general practitioner. The author has shown excellent judgment in what to include and what to omit, as exemplified in the systematic and concise manner which he presents his facts. The book is further embellished with 10 colored plates and a clear text.

BOOKS RECEIVED.

MANUAL OF THE DISEASES OF THE EYE, FOR STUDENTS AND GENERAL PRACTITIONERS. By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, New York, 1890-1903; Ophthalmic Surgeon to the French Hospital, New York; Consulting Ophthalmologist to the Red Cross Hospital, New York; Adjunct Ophthalmic Surgeon to Mount Sinai Hospital, New York, etc. Third edition,

revised, with 275 original illustrations, including 16 plates, with 36 colored figures. New York: William Wood & Co., 1903.

SEVENTEENTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH AND VITAL STATISTICS OF THE COMMONWEALTH OF PENNSYLVANIA. Vol. 2. Transmitted to the Governor November 30, 1901. William Stanley Ray, State Printer of Pennsylvania, 1903.

A COMPEND OF HUMAN ANATOMY. By Samuel O. L. Potter, M.A., M.D., M.R.C.P., London. Formerly Professor of the Principles of Medicine in the Cooper Medical College of San Francisco; Author of the "Hand-Book of Materia Medica, Pharmacy and Therapeutics," "Quiz-Compend of Materia Medica," "Index of Comparative Therapeutics" and "Speech and Its Defects"; Late Major and Surgeon of Volunteers, U. S. Army. Seventeenth edition. Revised and enlarged, with 138 wood engravings; also numerous tables and 16 plates of the arteries and nerves. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

TRANSACTIONS OF THE MISSOURI STATE MEDICAL ASSOCIATION at its Forty-sixth Annual Session, held at Excelsior Springs, Mo., April 21 to 23, 1903. St. Louis: The Nixon-Jones Printing Company, 1903.

A COMPEND OF DISEASES OF THE SKIN. By Jay F. Schamberg, A.B., M.D., Professor of Diseases of the Skin, Philadelphia Polyclinic and College for Graduates in Medicine; Fellow of the College of Physicians of Philadelphia. Third edition. Revised and enlarged, with 106 illustrations. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

A HANDBOOK OF THE DISEASES OF THE EYE AND THEIR TREATMENT. By Henry R. Swanzy, A.M., M.B., F.R.C.S.I., Surgeon to the Royal Victoria Eye and Ear Hospital, and Ophthalmic Surgeon to the Adelaide Hospital, Dublin; ex-President of the Ophthalmological Society of the United Kingdom. Eighth edition. Revised, with 168 illustrations and zephyr card of Holmgren's tests. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

REPORT OF THE TESTS OF METALS AND OTHER MATERIALS FOR INDUSTRIAL PURPOSES. Made with the United States testing machine at Watertown Arsenal, Massachusetts, during the fiscal year ended June 30, 1902. Washington: Government Printing-Office, 1903.

PROCEEDINGS OF THE CONNECTICUT MEDICAL SOCIETY, 1903. One hundred and eleventh annual convention, held at Hartford May 27th and 28th. Published by the Society. Gould A. Shelton, Samuel B. St. John and N. E. Wordin, Publication Committee.

A SYSTEM OF PHYSIOLOGIC THERAPEUTICS. A practical exposition of the methods, other than drug-giving, useful for the prevention of diseases and in the treatment of the sick. Edited by Solomon Solis Cohen, A.M., M.D., Senior Assistant Professor of Clinical Medicine in Jefferson Medical College; Physician to the Jefferson Medical College Hospital and to the Philadelphia, Jewish and Rush hospitals, etc. Vol. 8. Rest, Mental Therapeutics, Suggestion. By Francis X. Dercum, M.D., Ph.D., Professor of Nervous and Mental Diseases in the Jefferson Medical College of Philadelphia; Neurologist to the Philadelphia Hospital; Consulting Physician to the Asylum for the Chronic Insane at Wernersville; Consulting Neurologist to the St. Agnes Hospital; Consulting Neurologist to the Jewish Hospital, etc., etc. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

ELEMENTARY BACTERIOLOGY. By M. L. Dhingra, M.D., C.M., Edinburgh, Diplomat in State Medicine, University of Cambridge; Member of the Sanitary Institute, etc. With colored frontispiece and illustrations in the text. New York and Bombay: Longmans, Green & Co., 39 Paternoster Row, London, 1903.

THE PRINCIPLES AND PRACTICE OF SURGERY. Designed for Students and Practitioners. By George Tully

Vaughan, M.D., Assistant Surgeon-General, Public Health and Marine Hospital Service of the United States; Professor of the Principles and Practice of Surgery, Georgetown University, Washington, D. C. Philadelphia and London: J. B. Lippincott Company, 1903.

A DICTIONARY OF MEDICAL SCIENCE. Containing a full explanation of the various subjects and terms of anatomy, physiology, medical chemistry, pharmacy, pharmacology, therapeutics, medicine, hygiene, dietetics, pathology, bacteriology, surgery, ophthalmology, otology, laryngology, dermatology, gynecology, obstetrics, pediatrics, medical jurisprudence, dentistry, veterinary science, etc. By Robley Dunglison, M.D., LL.D.: Late Professor of Institutes of Medicine and Medical Jurisprudence in the Jefferson Medical College of Philadelphia, etc. Twenty-third edition, thoroughly revised, with the pronunciation, accentuation and derivation of the terms. By Thomas L. Stedman, A.M., M.D., Fellow of the New York Academy of Medicine. Philadelphia and New York: Lea Bros. & Co., 1903.

TWENTY-SECOND ANNUAL REPORT OF THE STATE BOARD OF HEALTH OF THE STATE OF RHODE ISLAND for the year ending December 31, 1899, and including the report upon the registration of Births, Marriages and Deaths in 1898. Providence, R. I.: E. L. Freeman & Sons, State Printers, 1903.

CLINICAL EXAMINATION OF THE URINE AND URINARY DIAGNOSIS. A Clinical Guide for the Use of Practitioners and Students of Medicine and Surgery. By J. Bergen Ogden, M.D., New York, N. Y., Late Instructor in Chemistry, Harvard University Medical School; Assistant in Clinical Pathology, Boston City Hospital; Medical Chemist to the Carney Hospital; Visiting Chemist to the Long Island Hospital, Boston. Illustrated. Second edition. Thoroughly revised. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF CLINICAL ANATOMY, FOR STUDENTS AND PRACTITIONERS. By Daniel N. Eisendrath, A.B., M.D., Professor of Clinical Anatomy in the Medical Department of the University of Illinois (College of Physicians and Surgeons); Attending Surgeon to the Cook County Hospital, Chicago; Professor of Surgery in the Post-Graduate Medical School, Chicago. Beautifully illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF OPERATIVE SURGERY, covering the surgical anatomy and operative technic involved in the operations of general surgery. Written for students and practitioners. By Warren Stone Bickham, Ph.D., M.D., Assistant Instructor in Operative Surgery, College of Physicians and Surgeons, New York; Late Visiting Surgeon to Charity Hospital, New Orleans; Late Demonstrator of Operative Surgery, Medical Department, Tulane University of Louisiana, New Orleans. With 559 illustrations. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF OBSTETRICS. By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania; Gynecologist to the Howard, the Orthopedic and the Philadelphia Hospital, etc. Fourth edition. Revised and enlarged, with 746 illustrations, 39 of them in colors. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF OBSTETRICS. By J. Clarence Webster, M.D. (Edinburgh), F.R.C.P.E., F.R.S.E., Professor of Obstetrics and Gynecology in Rush Medical College, in Affiliation with the University of Chicago; Obstetrician and Gynecologist to the Presbyterian Hospital; Obstetrician to the Chicago Lying-In Hospital and Dispensary; Consulting Obstetrician, Chicago Maternity. Three hundred and eighty-three illustrations, 23 of them in colors. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF DISEASES OF WOMEN. By Barton

Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania; Gynecologist to the Howard, the Orthopedic and the Philadelphia Hospital. With 655 illustrations, many of them in colors. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF PATHOLOGY. By Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania; Physician to the Philadelphia Hospital; Physician to the Pennsylvania Hospital, Philadelphia, etc. With 394 illustrations in the text, many of them in colors, and 7 full-page chromolithographic plates. Fourth edition. Thoroughly revised. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

NERVOUS AND MENTAL DISEASES. By Archibald Church, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence in the Northwestern University Medical School (the Chicago Medical College), Chicago; Late Professor of Neurology in the Chicago Policlinic; Neurologist to St. Luke's, Wesley, Mercy and Chicago Hospitals; Consulting Neurologist to the Home for Destitute Crippled Children, Chicago, etc.; and Frederick Peterson, M.D., President of the State Commission in Lunacy, New York; Chief of Clinic, Department for Nervous and Mental Diseases, Columbia University; Instructor in Mental Diseases, Columbia University; ex-President of the New York Neurological Society; General Consultant to the Craig Colony for Epileptics. With 338 illustrations. Fourth edition. Thoroughly revised. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK UPON THE PATHOGENIC BACTERIA, FOR STUDENTS OF MEDICINE AND PHYSICIANS. By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College, Philadelphia; Pathologist to the Philadelphia Hospital and to the Medico-Chirurgical Hospital, Philadelphia; Fellow of the College of Physicians of Philadelphia, etc. With 153 illustrations, a number of them in colors. Fourth edition. Rewritten and enlarged. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. By James M. Anders, M.D., Ph.D., LL.D., Professor of Clinical Medicine at the Medico-Chirurgical College; Physician to the Medico-Chirurgical Hospital; formerly Physician to the Philadelphia and to the Protestant Episcopal Hospital, Philadelphia; Fellow of the College of Physicians; Member of the Academy of Natural Sciences, Philadelphia, etc. Illustrated. Sixth edition. Thoroughly revised. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

AN AMERICAN TEXT-BOOK OF SURGERY, FOR PRACTITIONERS AND STUDENTS. By Phineas S. Conner, M.D.; Frederic S. Dennis, M.D.; William W. Keen, M.D.; Charles B. Nancrede, M.D.; Roswell Park, M.D.; Lewis S. Pilcher, M.D.; Nicholas Senn, M.D.; Francis J. Shephard, M.D.; Lewis A. Stimson, M.D.; J. Collins Warren, M.D., and J. William White, M.D. Edited by William W. Keen, M.D., LL.D., F.R.C.S. (Hon.), and J. William White, M.D., Ph.D. Fourth edition. Thoroughly revised and enlarged. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. A new and complete dictionary of the terms used in medicine, surgery, dentistry, pharmacy, chemistry and the kindred branches, with their pronunciation, derivation and definition, including much collateral information of an encyclopedic character. By W. A. Newman Dorland, A.M., M.D., Assistant Obstetrician to the University of Pennsylvania Hospital; Editor of the American Pocket Medical Dictionary; Fellow of American Academy of Medicine, together with new and elaborate tables of arteries, muscles, nerves, veins, etc.; of bacilli, bacteria, diplococci, micrococci, streptococci, ptomaines and leukomains, weights and measures; eponymic tables of diseases, operations, signs and symptoms, stains, tests, methods of treatment, etc. Third edition. Revised and enlarged. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

Original Articles.

FOREIGN BODY IN A BRONCHIAL TUBE—RECOVERY.¹

BY THOMAS A. MCGOLDRICK, M.D.,
Brooklyn, N. Y.

C. McN., aged 23, born in Ireland, presents a family history free from tendencies to pulmonary disease, and a previous personal history blemished only by an occasional attack of tonsillitis.

On June 6, 1898, while holding a common bone collar-button in his mouth he indulged in a hearty laugh. The deep inspiration drew the button from his mouth into his larynx. He was immediately seized with a choking sensation—a feeling of suffocation—which, with spasmodic cough, persisted for more than five minutes. Emetics were at once administered, and though successful in emptying the stomach, brought forth no button. For the ensuing three days the feeling of an obstruction to the ingress of air increased in severity and he entered the hospital.

The clinical history of his stay there has not been obtainable, but the patient reports that he remained twenty-nine days, twenty-one of which he spent in bed; that he was suffering from an attack of pneumonia, and at the same time an acute specific urethritis; that his temperature was as high as 106° F., and that no attempts at laryngeal examination nor operation were made. At the time of his discharge he suffered from cough, profuse fetid, muco-purulent expectoration and dyspnea. His after-treatment was continued under varying physicians until January, 1900, when he came under my observation.

The cough and expectoration had become most distressing; for six months preceding he had profuse sweats nightly; his weight, 150 before the accident, had decreased to 106; the appetite was poor; vomiting daily had persisted for three months, and the bowels were irregular in action. His temperature was 101° F. Physical examination showed marked emaciation; on the left side of the chest diminution of the respiratory movements, and increase in their rate (26); cardiac impulse in normal position. On percussion there was flatness from the left supra-clavicular space to third rib anteriorly, and for the remainder of the anterior part of the left side, decided dullness. Posteriorly, it corresponded to the front, the dullness extending to the level of the eighth rib in the scapular line. The right lung was hyper-resonant throughout. Auscultation: *Diminished* breathing sounds over entire area described as dull. The sounds heard, however, were bronchial in character—*i. e.*, high-pitched, with prolonged expiration—and at the apex were louder in intensity than over the remaining part of this area. At the junction of the third intercostal space and the parasternal line (left) a high, shrill-whistling

râle was heard, which persisted almost constantly until the foreign body was expelled. Over the right lung the breathing sounds were slightly emphysematous in type. Many large and medium-sized moist râles were heard over both sides of the chest.

On examination with the X-ray, the consolidated portion of the left lung was revealed, but neither at this nor at subsequent examinations with the fluoroscope and radiographs was there seen any trace of a foreign body. Although examined many times, no tubercle bacilli were ever found in the sputum.

Under treatment there was immediate and continuous improvement. Fever disappeared, night sweats and vomiting ceased, digestive functions returned to normal. The cough grew less, but has never disappeared; the sputum lost its purulent character and fetid odor, and diminished in amount. The weight steadily increased, on May 21, 1901, sixteen months after his first visit, being 126 pounds, and on October 4, 1901, 146 pounds, which he has since held.

On August 8, 1902, during a mild spell of coughing, the patient expectorated the button, which, save a slight staining, was unchanged. Since its expulsion the physical signs have undergone but slight modification, the entire upper and part of the lower lobes of the left lung presenting a chronic fibrosis, which has undergone some contraction. For a small area posteriorly—the sixth to eighth ribs—the breathing sounds have become louder in intensity. The left half of the chest is, in circumference, one and one-half inches in antero-posterior diameter, one inch smaller than the right. The heart is drawn to the left, the impulse at the apex being in the fifth interspace, just outside the nipple. There is still considerable cough and expectoration, but the patient has retained a good weight—146 pounds, for 5 feet 7 inches—is earning his livelihood and feels well.

SOME PECULIARITIES OF THE PULSE IN TYPHOID FEVER.¹

BY J. N. BASSETT, M.D.,
CANTON, N. Y.

TYPHOID fever presents a greater variety of conditions than almost any other disease with which I am acquainted. It attacks every organ and disturbs every function of the human system. Its leading characteristics in each case depend upon the idiosyncrasies of the patient and the virulence of the specific poison. Disease is said to present two pictures, the one a composite, or text-book, picture; the other clinical, or bedside, picture. The one is a description of the general features and leading symptoms of the morbid condition. The other is the individual picture, with its personal lines and features that distinguish one individual of a class from others of the same class. We fre-

¹Read before the Kings County Medical Association, June 5, 1903.

¹Read at the annual meeting of the First District Branch of The New York State Medical Association, Watertown, N. Y., May 26, 1903.

quently meet unusual symptoms in a disease with whose symptoms we think ourselves perfectly familiar. These symptoms are sometimes difficult to explain to our satisfaction. Such were the conditions of the pulse in two cases of typhoid fever that I was called to care for during the past season. The infrequency of the symptom is the only excuse I offer for presenting this paper.

Case No. 1.—Mrs. D. R. Residence, Russell, N. Y. Age, 62. Housewife. A large, stout-built woman, weighing 160 pounds. I first saw her the morning of October 17, 1902. There had been two undoubted cases of typhoid in the house during the previous three months. There had also been three other cases among persons who had been living at R's., and assisting them during their illness. Among these cases there had been one death. Mrs. R. was very sick, and naturally very much depressed. She persisted that she would not have typhoid fever, and was inclined to resist all methods of treatment. The interesting features of the case were the low pulse during the height of the fever and the rise in pulse-rate as convalescence became established.

The following is the temperature and pulse-rate, the pulse usually taken at about 4.30 P. M.:

Date.	—Temperature—		Pulse.
	A. M.	P. M.	
October 17th....	102 2-5		84
October 18th....	101 1-2		76
October 19th....	102 2-5	102 3-5	72
October 20th....	102 3-5	102 3-5	72
October 21st....	101 2-5	101 2-5	72
October 22d....	101	103	72
October 23d....	101 3-5	101 3-5	66
October 24th....	102	102 4-5	66
October 25th....	102 4-5	103	72
October 26th....	102 1-5	101	72
October 27th....	102 4-5	103	66
October 28th....	102	102 4-5	66
October 29th....	102 2-5	102 4-5	66
October 30th....	101	101 3-5	64
October 31st....	101	102 3-5	66
November 1st....	101 3-5	102 3-5	68
November 2d....	100 2-5	101	68
November 3d....	100 2-5	101 3-5	64
November 4th....	99 3-5	101	72
November 5th....	101 2-5	102 2-5	72
November 6th....	101 2-5	102 1-5	64
November 7th....	98 2-5	101 3-5	64
November 8th....	101		72
November 9th....	99 2-5	100	76
November 10th....	99 4-5		84
November 11th....	99 4-5	100	84
November 12th....	99 4-5	100	72
November 14th....	99 2-5	100	72
November 15th....		99 2-5	80
November 20th....		99	80
November 25th....		99	80

Convalescence was now established and uneventful. The remedies employed were acetozone, tannalbin and calomel as conditions seemed to indicate.

Case No. 2.—W. H. T. Farmer. Age, 73.

Never confined to bed by sickness in his life. Called at my office October 27, 1902, complaining of severe pain in head and through his back. October 29th was called to see him at his home. Found him with intense headache, face flushed, eyes suffused and congested. The following are the pulse-rate and temperature from then on:

Date.	—Temperature—		Pulse.
	A. M.	P. M.	
October 29th....		103 4-5	126
October 30th....	102 1-5	103 4-5	72
October 31st....	102 1-5	102 2-5	60
November 1st....	101 2-5	102 2-5	60
November 2d....	101 2-5	103 2-5	72
November 3d....	101 2-5	101 2-5	72
November 4th....		102 2-5	72
November 5th....	102 2-5	101 2-5	72
November 6th....	102	102 3-5	64
November 7th....	100 4-5	101 3-5	72
November 8th....	101	100 3-5	72
November 9th....	99 3-5	101 3-5	72
November 10th....	99 3-5		72
November 11th....	99 4-5	102	72
November 12th....	99 4-5	101 2-5	72
November 13th....	99 3-5	101 4-5	80
November 14th....	100		72
November 15th....	99 3-5		80
November 16th....	99 3-5		80
November 19th....	99		84

From this time on the temperature came to normal and the pulse remained at 84 until convalescence was well advanced. The remedies employed in this case were a solution of acetozone and a little laxative or stimulant, as seemed necessary on occasion. The low pulse is the more remarkable, as the fever seemed very severe at the start.

In regard to the pulse, Osler says, page 17, "Principles and Practice of Medicine": "The pulse in typhoid fever presents no especial characteristics. It is increased in frequency in proportion to the height of the fever. As a rule, in the first week it is above 100, full in volume and often dicrotic."

Struppell says, "Text-Book of Medicine," page 15: "The pulse is almost always rapid, although often not so much so as the height of the fever would lead one to expect. When it keeps to 140 or higher, in adults, it is always an unfavorable symptom. Temperature and pulse do not correspond in all cases. Sometimes the pulse will have a normal or subnormal frequency, even throughout the entire attack, despite the fever."

Hutchinson, page 270, "Pepper's System of Medicine," says: "The circulation is usually accelerated from the beginning of an attack of typhoid fever. The degree of acceleration is commonly proportioned to the severity of the other symptoms, and especially to the elevation of the temperature, and is generally more marked in the evening than in the morning."

Wilson, page 161, "Continued Fevers," says: "The pulse is increased in frequency. This increase is directly and chiefly, in enteric as in other

febrile diseases, dependent upon the rise in temperature. There are, in fact, some cases in which, although high fever is present, the frequency of the pulse does not, for some part of the time, exceed that of health; and in the mildest cases of enteric fever, and in cases of intestinal catarrh without fever, due to the cause of enteric fever, the pulse is sometimes less frequent than in health. During the period of the pyrexia the pulse does not usually rise above 120, and in many cases does not exceed 100 during the whole course of the disease. In 100 cases, Murchison ascertained that it exceeded the normal standard, at some time of the fever, in all but one; in 97 cases it exceeded 90; in 85 cases it exceeded 100; in 70 cases it exceeded 110; in 32 cases it exceeded 120; in 25 cases it exceeded 130; in 10 cases it exceeded 140; in 2 above 150. In 6 cases of 100 the same observer found the pulse to fall to 60; to 56 in 2; and in a single case to 52. In 1 case under observation the pulse fell to 37, and never throughout the whole course of the disease exceeded 56, but rose with convalescence to 66. In severe cases the pulse is apt to be frequent; and where in the adult it continues steadily above 120, the prognosis is, *pro tanto*, unfavorable. Cases, however, occasionally prove fatal in which the pulse does not exceed 100."

RECAPITULATION.

Case No. 1.—Fever continued 35 days. Pulse on first day of observation was 84, and not as high again until the twenty-ninth day. During 25 days the temperature was above 101. During 21 days the pulse-rate was not above 72, and some of the time as low as 64.

Case No. 2.—Fever continued 27 days. Temperature on first day, 103.3-5; pulse 128. Second day, fever the same; pulse 72, and did not again reach 80 until the sixteenth day, although the temperature continued above 101. On the twenty-second day the pulse reached 84, and convalescence was gradually established without marked interest.

CONCLUSION.

The pulse does not follow the temperature in all cases of typhoid fever.

The rate of the pulse does not indicate the severity of the disease. Cases in which the pulse-rate was at no time in the course of the fever above 100 have proved fatal.

Slow pulse occurs with high temperature so seldom in typhoid fever that the fact is not mentioned by some authors.

CAUSES.

Two theories have been advanced to account for this phenomenon. One, that the condition is due to the direct action of the typhoid bacilli upon the inhibitory nerve centers of the heart. The other, that a poison or ferment is produced by the action of the bacillus in the glands of the intestine; that this ferment passing into the circulation acts upon the inhibitory nerve centers of the heart. Which of these theories, if either, is correct is yet to be determined.

SPORADIC CRETINISM, WITH REPORT OF THREE CASES.¹

BY HERMON C. GORDINIER, M.D.,
Troy, N. Y.

SPORADIC cretinism, or infantile myxedema, is a chronic disease, closely allied, if not identical, with myxedema and the endemic form of cretinism. It is characterized by a lack of bodily and intellectual development, as shown by the general dwarfism, the thick, dry skin; the coarse, sparse hair; the peculiar facies, the idiotic expression and the disproportionate bodily development. It is due either to congenital absence of the thyroid gland, or an absence of its proper secretion, from an acquired atrophy of that body. When not congenital, it may develop any time after birth, up to puberty. When the condition comes on after puberty, it is designated myxedema.

This disease was not differentiated from the endemic form until 1871, when Hilton Fagge stated that: "In England a form of cretinism occurs which bears a close relation to affections of the thyroid body, but which is not peculiar to one part of the country rather than to others." In this form of the disease, which he called sporadic cretinism, there seems never to be a large goitre, but sometimes a slight swelling can be detected, or, as in a small boy who came to Halden, in Kent, a near relative may have a goitre. In the great majority of cases, the thyroid body is entirely absent, and no trace of it is discoverable on dissection. In almost every other respect sporadic cretinism is identical with the endemic form.

A study of the literature of this disease in America shows that it is comparatively rare. Up to the time of the publication of Osler's classic article, in 1893, but three cases had appeared in literature. Those cases were published by Jacobi, Townsend and Lloyd. Osler, in his monograph, collected five others, which, with three of his own, increased the number to eleven. In 1897 Osler collected sixty cases, including those already referred to, twenty-seven of which had been published, and the remainder furnished by physicians throughout the country. Since this publication cases have been reported by Bullard, Booker, Northrup, Rotch, Koplick, Patterson, Engleman and others, so that at present about one hundred American cases have been reported.

Etiology.—Both the sporadic and the endemic forms of cretinism are due to a loss of the secretion of the thyroid gland, the result of an atrophy of its proper secreting structure, or, rarely, from a congenital absence of that body. Reverdin, Kocher and others have shown that total excision of the thyroid gland in man is followed by a characteristic group of symptoms, inseparable from those of cretinism or myxedema. This condition they have named

¹Read at the Nineteenth Annual Meeting of the Second District Branch of The New York State Medical Association, at Hudson, N. Y., June 4, 1903.

"cachexia strumi priva," or operative myxedema. A similar condition has been observed by Victor Horsley, after ablation of the thyroid gland in monkeys. Horsley also found that, in animals so treated, there was an accumulation of mucin in the subcutaneous tissues and elsewhere, thus definitely correlating their conditions with that of myxedema by Gull and Ord. Of the sixty cases cited by Osler, goitre was present in 17 per cent.; the gland was said to be normal in 16 per cent., and no note was made in 20 per cent. In cretins, 25 per cent. have no thyroid, or it is replaced by connective tissue; in the remaining 75 per cent. the function is suppressed, a result of degeneration of the gland. In these cases, according to Kocher, there is often a colloid goitre. Kocher, in referring to heredity in the endemic type, finds that strong, healthy parents, who have begotten normal children while living in regions free from cretinism, produced cretins after moving into cretinoid districts. In these cases, however, the parents, one or both, had, previous to the birth of a cretinoid child, developed goitre. Such parents, on returning to their former homes, begot healthy children. According to Kocher, whenever goitre or cretinism appears in children, one of the parents will be found to have goitre. Goitre is the first stage of endemic cretinism, either in the individual or through parentage. He further states that congenital or inherited cretinism is derived from the mother alone, while inherited cretinism appearing, after a lapse of a few months or years, is derived from the father alone. This he explains by the fact that the fetus is supplied with normal thyroid conditions through the mother, if she be not in an atrophic state, and the inherited condition from the father may thus be corrected during intra-uterine life and during lactation from the mother, the disease only developing after the normal source of thyroid function is cut off.

Several ingenious theories have been advanced explanatory of the effect of the presence or absence of the thyroid secretion on the body metabolism. The most probable ones are advanced by Semon, Mendel and Patterson. Semon believes the removal of the thyroid gland produces an interference with the full chemical development of the constituents of connective tissues, so that these take on an embryonic character; and it is well known that excess of mucin occurs in embryonic tissues. Mendel believes that, normally, the thyroid secretes a substance which neutralizes certain toxins existing in the blood, and when the secretion is suppressed the toxins accumulate and thereby excite the symptoms of the disease. Patterson has developed two theories. The first is to the effect that the gland secretes a substance which is essential to the healthy and harmonious activity of the central and peripheral nervous systems. By the want of this substance the nervous mechanism is deprived of a body which regulates the forma-

tion and disposition of mucin products, so essential a feature of cretinism and myxedema. The other theory is that the gland excretes from the blood some material formed in the body metabolism which, by its retention, causes a form of toxemia, affecting, principally, the cerebral centers and the nervous mechanism concerned in mucin metabolism. He believes that the thyroid is an antitoxic gland, whose function is to destroy or modify, by rendering innocuous some toxic substance resulting from the digestion of certain albuminoid bodies. He believes that in utero, and up to a certain period after birth, the thymus acts vicariously as an antitoxic agent, when the thyroid is absent or diseased, and only when the thymus begins to atrophy do the symptoms of sporadic cretinism develop. Marie observed a case of congenital myxedema in which the thymus gland was hypertrophied. That a correlation of function probably exists between the thyroid, thymus and pituitary bodies seems proven both by clinical and pathological observations. Ponfick believes that the hypophysis cerebri acts compensatorily in diseases of or in absence of the thyroid gland. In many cretins this body has been found hypertrophied, while in some cases the thymus gland, the hypophysis and the thyroid gland have all been found atrophied. Of much interest in this connection is the observation, before mentioned, of Marie, in which the thymus gland was much enlarged in a case of congenital myxedema. Some cases of myxedema are cured only by the administration of both thyroid and thymus gland extracts.

The possibility of an acute infection of the thyroid body, a view promulgated by Siegert, is not to be lightly passed over as an etiological factor of much import in the production of sporadic cretinism, since cases of myxedema have followed the wake of several acute infections, as typhoid, rheumatism, syphilis and erysipelas.

Dr. C. G. Seligman, in a paper on congenital cretinism in calves, before the Pathological Society, of London (May 5, 1903), states that in every herd of Dexterkerry cattle which had been under observation in that country, it had been noted that a considerable number of monsters, showing a constant type of deformity, was born. These were, in fact, cretins, and the interest lay in the facts (1) that they were practically limited to the breed mentioned; (2) that the condition arose in fetal life; (3) and that it was associated with a diseased condition of the placenta in the parent cow. Of eighty-two calves born in two herds, nineteen were of this type and showed the characteristic short bases crania, very short limbs, foot-pads, etc. The thyroids of all such calves examined showed absence of colloid, and the usually malformed or ill-developed vesicles of the gland were choked with spheroidal cells. Clinically, the pregnancy of a cow about to produce a cretin showed a

marked deviation from the normal, and in the placenta examined there was a myxomatous and edematous change affecting many of the cotyledons.

Symptoms.—The symptoms of sporadic cretinism, while varying in their intensity, are so constant and characteristic that, in a well-marked case, it would be almost impossible for the physician to mistake it. The head is usually brachycephalic, the hair coarse and sparse, and the scalp is often covered with a seborrhea-like deposit; the fontanelles remain open long after the normal time of closure, the skin of the face and neck is thickened and often wrinkled, the eyelids are so infiltrated and swollen that the palpebral fissures are much narrowed, and the whole facial expression is like that of the Mongolian type. There is usually a distinct flush over each malar bone. The nose is retracted at its base, and the alenasi are thickened. The lips are much thickened and everted. The ears are enlarged, thickened and widely separated from the head, thus giving them an ungainly appearance. The tongue is large, flabby and protuberant. The teeth are carious and ill-developed. The lower jaw often projects beyond the upper. There is a universal thickening of the skin, which is of a dull yellow appearance, and often presents a fine or coarse desquamation. There is no edema or pitting of the skin, and it is not glossy, as it is in general edema from renal or cardiac diseases. The hands are spade-like, shortened, held stiffly and are very puffy, especially on their dorsal aspects. The nails are brittle and striated either transversely or longitudinally. The abdomen is protuberant and pendulous, and usually presents an umbilical hernia. The supra-clavicular fossae are very prominent, due to tumorous-like deposits of fat. These fatty tumors are said not to be present in the endemic form of the disease, and hence may form a distinguishing feature between the sporadic and endemic forms. The thyroid is small or absent and is usually not palpable. Goitre is very rarely present. The genitals are often but slightly developed. Hair rarely grows in the usual positions for it at puberty. The long bones are shortened and curved, thus producing the general dwarfism which is so characteristic of the disease. Cretins are usually anemic, their temperature is subnormal, perspire but rarely, even in the hottest weather, and their skin is very dry and harsh. Winter brings with it much discomfort, because of being so sensitive to the cold. The gait is slow, waddling and ungainly.

The mental changes are as constant as the physical. They are apathetic, stupid, apparently lazy and often look decidedly idiotic, although usually good-tempered, rarely cry or make faces, or have epileptiform or convulsive movements. Their expression is immobile, they walk very late and make no attempt to learn and are unable to read or write. Their voice is

hoarse and squeaky, and their speech is slow and monotonous. In marked cases of cretinism they merely vegetate and some are deaf and dumb. In the milder types of the disease they learn to walk and talk, and show much more evidence of intelligence, and are, to a certain extent, teachable. They are slow in their movements, very forgetful and apparently take little or no interest in their surroundings. There is nothing characteristic in the internal organs, save a general hypoplasia. The urine sometimes contains a trace of albumen and a few hyaline or granular casts. The blood shows the changes of anemia. A sign which Koplick has described, and which, he declares, is diagnostic, is an excessive prominence of and over the pisiform bone, separating the wrist crease from the antithenar prominence. The hypothenar eminence is thick, square and hypertrophied, as in the lower animals. Koplick states that the disease may develop in utero or at any time after birth. Fully half the cases develop before the eighteenth month. He has published cases that have developed the disease within a month or a few weeks after birth.

Pathology.—Cushing, in 1850, was the first to describe two cases of sporadic cretinism with the absence of the thyroid gland. Bramwell, in 1892, found ten autopsies in literature, in nine of which the thyroid gland was absent. Of the 160 cases of sporadic cretinism collected by Fletcher Beach, the thyroid was not palpable in seventy-three, palpable in eleven and enlarged in seven. Of the sixteen autopsies in his series, the thyroid was absent in fourteen, and the seat of bronchocele in two. The changes in the skull, in sporadic cretinism, although not constant, resemble those found in the endemic form. To Virchow belongs the credit of being the first to describe these bone changes. He termed this condition a premature ossification of the sphenobasilar bone. This bone in the fetus consists of three parts, the pre-sphenoidal, the post-sphenoidal and the basilar process of the occipital bone. All of these are separated by disks of cartilage. The segments of the sphenoid begin to coalesce at birth, and some bony union has occurred, but the sphenoid and basilar bones should remain ununited until about the fifteenth year. The case examined by Virchow presented complete coalescence of these three bones, no trace of the separation being visible. The result of such early union is that the base of the skull does not grow antero-posteriorly, and there is a very distinct deformity of the internal base due to the narrowing of the sella turcica and increase of the angle between the clivus and the posterior clinoid process. This lack of development hinders the growth of the base of the brain and doubtless assists in producing the change in the shape of the skull as well as the form of the face, which, with the edematous condition of the skin, occasions the peculiar physiognomy.

All the bones, with the exception of the clavi-

cles, are shortened. In the fetal bones, the femur may measure but an inch or two, and the other long bones are from a third to three-fourths of an inch in length. The epiphyses are greatly enlarged and may constitute three-fourths of the length of the bone. All the bones are thick and, usually, present curvatures, exaggerations of those which are normal. The scapulæ and ribs are often thickened. The latter are thickened at their costal and vertebral extremities.

The histological study of the long bones in cretinism shows that the arrest of development in length is due to vascular fibrous offshoots from the periosteum insinuating themselves between the cartilaginous epiphyses and the shaft. The cartilage is not really diseased; its cells, however, fail to proliferate and the matrix does not calcify. His and others have shown that these changes are not confined to the long bones, but that ossification in the pre-existent cartilaginous structures of the rest of the skeleton is delayed in all its phases.

The central nervous system has been examined so infrequently that nothing positive can be said of the changes present. It is desirable, in the future, to make careful studies of this system, in the hope that some light may be shed in regard to the etiology of sporadic cretinism. In the brain of the fetal cretin examined by Barlow, the crus cerebri, pons and medulla were more vertical than normal, and the pons was laterally compressed. The cerebellum was more in an upward direction than natural. All these changes Barlow ascribes to the basal changes in the skull.

The chief interest in the pathology of sporadic cretinism centers in the changes found in the thyroid gland. The change found has been described as a chronic interstitial thyroiditis, particular emphasis being laid on the secondary changes in the parenchyma, the result of atrophy of the secreting cells and colloid due to compression of the blood vessels by the new-formed connective tissue. The careful study of a fatal case of sporadic cretinism by Barker, and the interesting studies of the pathology of the thyroid gland by R. G. Murray, support the statement that the primary change in the thyroid gland is in the cellular structures due, as Murray believes, to the action of some toxic agent, and that the fibrosis is only a replacement fibrosis, such as occurs in the spinal cord and elsewhere, after the more highly organized structures have been destroyed.

Barker's case showed the following changes: With the low power, there was a marked increase in the connective tissue separating the lobules, and the acini were very distinct from one another. The individual acini were almost solid, except that here and there were single cyst-like dilatations filled with colloid. The high power showed the most marked atrophy of the gland and certain remarkable transformations in the epithelium. The cells lining the acini were

so changed that one not knowing the specimen would not recognize it as thyroid. The cell bodies varied a great deal in size, from small cells to actually large, flat, giant cells. The lumen of the acini varied greatly in size; some of the alveoli possessed no lumen; extremely few contained any colloid. The colloid varied decidedly in its staining reaction. It was absent from most of the lymph spaces and was not found in the blood vessels.

To summarize the pathology of sporadic cretinism, the changes consist of an absence of proliferation of cartilage cells throughout the skeleton, with defective ossification of the same, together with primary degeneration of the true secreting epithelium of the gland, a marked loss of the colloid substance, and secondary sclerotic changes resulting in a marked atrophy of the whole gland, with thickening of the skin and subcutaneous tissue and the deposition of mucin therein.

Diagnosis.—It is remarkable that a disease with such an array of characteristic symptoms should have been so commonly overlooked in this country, both by the general practitioner and the asylum physician, until the appearance of Osler's monograph, in 1893. The diseases most resembling sporadic cretinism are rickets, infantilism, ordinary idiocy, achondroplasm or fetal rickets. Cretinism, while bearing only a superficial resemblance to rickets, is most often mistaken for it. This error can only be made by those unfamiliar with the clinical history of each disease. The peculiar physiognomy, the mental changes, the marked dwarfism, thickened skin, the supra-clavicular fatty tumors, the spade-like hands, the absence of sweating and the sub-normal temperature of sporadic cretinism are in contrast to the characteristic symptoms of rickets, *i. e.*, the prominent frontal bones, block-shaped head, the soft, pliable skin, the marked perspiration, the beading of the ribs, the pigeon-shaped breast and the enlargement of the epiphyseal ends of the long bones and the characteristic rachitic curvature. Most rachitic children early become precocious.

There is a form of infantilism described by French authors as myxedematous infantilism that seems to be intermediate in character between sporadic cretinism and myxedema. The patient preserves the physical and mental attributes of a child of ten, up to the age of thirty. The sexual organs are undeveloped and secondary sexual characteristics fail to appear. Careful inspection elicits slight signs of myxedema, and the disease is improved or cured by thyroid feeding. There is a form of infantilism, however, not affected by thyroid feeding, in which the adult presents the exterior of a dwarf and the facial expression of a child, in which no myxedematous change is present. The mental change is that of mild idiocy. Obesity sometimes develops.

Fetal rickets, or achondroplasm, cases of

which have been reported by Jacobi, Smith and Townsend, has been classified by Horsley and Barlow with sporadic cretinism. On the contrary, Osler, Koplick and Rotch state that this condition presents nothing in common with rickets or cretinism. Koplick says: "They are far from being idiotic or presenting any of the symptoms of myxedema. Some of these dwarfs who reach adult age are exceedingly clever. Many of them are performers in museums and are above the average intelligence. Ordinary idiocy can hardly be mistaken for cretinism. The head in these cases is usually microcephalic or hydrocephalic; the general growth is, ordinarily, not interfered with; their mental defect is often more extreme; there is motor unrest, and they manifest none of the characteristics in the skin found in cretins."

Treatment.—One of the most brilliant therapeutic achievements was the introduction of thyroid feeding for the cure of myxedema and sporadic cretinism. To Schiff and Victor Horsley most of this credit is due. Schiff, as far back as 1884, introduced the thyroid gland either subcutaneously or in the peritoneal cavity, and observed that in thyroidectomized animals all the symptoms thus induced were averted and the animals recovered. Later, Victor Horsley, carrying out a similar line of research, suggested very strongly the use of the gland for the cure of myxedema. Thyroid therapy, however, was first introduced for the cure of myxedema in man by Dr. George Murray, in 1891. He used it hypodermatically. In March, 1892, Dr. Howitz, of Copenhagen, and in October, 1892, Drs. Mackenzie and Fox introduced the method of thyroid feeding, a great advantage over the subcutaneous method. Since its introduction, a little over a decade, abundant clinical evidence exists of its specific therapeutic effect in the cure of the adult, the infantile and the operative forms of myxedema.

The active principle of the thyroid gland is a globulin which resides in the colloid substance of the glandular follicles. It is called thyreoglobulin. It belongs to the class of proteids and contains about 1.5 per cent. of iodine. Bauman's detection of this element in the thyroid gland was the first intimation that it existed in the tissues of the higher animals and man. When thyreoglobulin is subjected to artificial digestion it forms albumoses and an insoluble non-proteid substance, to which Bauman has given the name of iodothyryn, which contains most of the iodine of the gland, the amount varying from 4 to 14 per cent. This substance is said by the experimental therapeutists to possess the same specific therapeutic effects on induced or acquired myxedema as does the powdered gland substance or the various thyroid extracts. In reference to the treatment of sporadic cretinism the same principle applies as in the adult form of myxedema, namely, that the thyroid extract be administered in large doses until the symp-

toms of the disease are in abeyance, and then the treatment to be continued, but in smaller amounts, over an indefinite period, in order to prevent relapses.

I will not detain you with the recital of the clinical histories of the three cases of sporadic cretinism which have been, for three years, under my personal observation, but will present the photographs for your inspection. They show better than verbal description the exact conditions before and after treatment.

Case 1.—A lad, aged nine years, is cured. He has shown no evidence, either mentally or physically, of the disease for over eighteen months.

Case 2.—A boy, aged seven, who has been under treatment, more or less continuously, for a year. His improvement is marked, physically, but less so mentally.

Case 3.—A girl, aged twenty, whose condition was diagnosed more than ten years ago by Dr. Stephen A. Webster (now deceased). She had received no treatment for several years until last winter. Since then she has improved in a remarkable way, both mentally and physically.

SPURIOUS GASTRIC SYMPTOMS.¹

BY ALLEN A. JONES, M.D.,
Buffalo, N. Y.

BY the term spurious gastric symptoms reference is made to symptoms that are apparently due to some disease of the stomach, but in reality are caused by disease elsewhere. Some symptoms stand out prominently and are more commonly encountered as false manifestations than are others. The first in importance is pain, which is often located exactly in the region of the stomach, but yet is not occasioned by anything whatever wrong with the stomach. Many minor stomach symptoms are also not infrequently false and misleading; such, for instance, as eructation, regurgitation, sensation of burning, coldness, etc. It may be contended that these are real stomach symptoms, whether or not they arise from disturbance elsewhere, and that they occur because of disturbance of the innervation of the stomach. There is truth in the contention, but for the sake of clearness in our understanding the nature and significance of gastric symptoms it is better to regard purely nervous manifestations as spurious when they are proven to depend upon some definite disorder in some other organ. It may be said, then, that all symptoms of the gastric neuroses are spurious, and inasmuch as most of the gastric neuroses are secondary to reflexes, toxemias, psychoses, or influences leading to general or special nerve exhaustion, it is safe to look upon them as secondarily spurious. True and false stomach symptoms are quite frequently associated. An instance of this may be found in chronic gastritis, due to chronic nephritis; distress after eating may here depend upon the gastritis, while

¹Read at the Nineteenth Annual Meeting of the Fourth District Branch of The New York State Medical Association, at Buffalo, N. Y., June 19, 1903.

belching, nausea and vomiting may as likely result from uremia as from the affection of the stomach. From these considerations it seems reasonable to infer that at a last analysis pain is the most important of all spurious symptoms. The chief causes of pain in the epigastrium that is not located in the stomach are, first, gall-stone disease; second, appendicitis or its results; third, pancreatic disease; fourth, disease of the peritoneum; fifth, disease of the heart or pleura; sixth, *tabes dorsalis*.

In all cases of *gastralgia* we must make a differential diagnosis between the rare disease essential *gastralgia* and *cholelithiasis*. No more frequent mistake is made than that of calling pain that is really due to gall-stones a *gastralgia*. This error is committed less frequently than was the case a few years ago, but yet too frequently. It is best to be extremely cautious about making a diagnosis of *gastralgia*. In one case who had had many attacks of so-called *gastralgia*, I later found jaundice and gall-stones, and in another who had been treated for *gastralgia* I found a serious attack of *appendicitis*. If it is borne always in mind that *cholelithiasis* may be attended by pain referred wholly to the left of the median line and high in the epigastrium, and that there may be no complaint of pain in the immediate region of the gall-bladder, the mistake is less likely to be made. In a case of *cholelithiasis* seen recently the pain at one attack was confined to the region of the ensiform and lower part of the sternum to the left, and misled the patient, who had passed many gall-stones, into thinking all her trouble was this time in the stomach. In a couple of days, however, she brought me three large gall-stones, recovered by sifting the stools, and her gastric pain had quite ceased. Nor is it necessary that gall-stones should pass through the ducts to cause referred gastric pain; it is sufficient that they should exist in the gall-bladder.

Not infrequently the gastric chemistry is altered in cases of *cholelithiasis* and a temporary *hyperchlorhydria* may mislead one into thinking that the cause of the pain. The motion of the stomach may also be retarded, and an abundance of gastric contents may be vomited or washed out several hours after eating. These, however, are spurious effects and should not be allowed to confuse the diagnosis.

We all realize that in the presence of jaundice and other common symptoms of biliary colic, the gastric disturbance will be easily relegated to its proper place, but in the absence of symptoms and physical signs of gall-stone colic, other than pain referred to the stomach, the diagnosis is not so readily made.

As with pain, so it is with vomiting. In a case I once saw in consultation, an old woman vomited almost constantly for several weeks, and, finally, at autopsy, no adequate cause of the condition was found except *cholelithiasis*, with an irregularly contracted gall-bladder and dilatation of the cystic duct. The patient had never been jaun-

diced, had no pain, gave no history of gall-bladder trouble and was reasonably thought to have concealed malignant disease. As with other symptoms so with vomiting; some people tolerate pronounced *cholecystic* disease without vomiting, while, for some unexplained reason, others suffer aggravated nausea and vomiting from apparently quiescent gall-bladder disease. Given a case of unyielding or recurrent vomiting in an adult which is not explained after exhaustive study and exclusion, the gall-bladder may be reasonably suspected.

To turn now to a second important cause of false gastric symptoms, *appendicitis* in its various phases and effects commands attention. At any time we are likely to see cases of so-called gastric pain, with or without vomiting, caused not by any actual disease of the stomach, but occasioned entirely by appendix disease, which may be acute or chronic; may reveal itself frankly later in the case, or remain masked. There may be no tenderness, no swelling, nor other local signs in the region of the appendix; no rise of temperature and no disturbance of the pulse other than that incident to pain or possibly vomiting. It may be objected that this statement is too sweeping and that in these cases upon proper examination there will always be elicited some local evidence of appendix disease, but there are, notwithstanding, cases in which the disease is so insidious, so masked, so hidden that the greatest difficulty attends its detection. There are, however, not a few cases in which the local evidences of *appendicitis*, though not prominent, are yet so well defined that by careful scrutiny they may be definitely determined. Here again we see instances of a reflex *hyperchlorhydria* confuse the diagnosis, and in one case, recalled as the subject is considered, several attacks of severe pain, apparently in the stomach, accompanied by temporary *hyperchlorhydria*, and apparently relieved by alkaline gastric sedatives, were followed by a fatal attack of *fulminating perforative appendicitis*.

A warning at this point, however, against the thoughtless, careless and indiscriminate diagnoses of *appendicitis* in cases of gastric disorders may not, I trust, be out of place.

While pancreatic disease is relatively uncommon, there are, nevertheless, some cases of chronic interstitial pancreatitis and pancreatic colic presenting epigastric pain that is apparently located in the stomach. In two cases of the former coming under our observation, and in which the nature of the disease was proved by autopsy, the pain was more or less paroxysmal, and was apparently in the stomach. Pancreatic hemorrhage is also accompanied by severe gastric pain and usually by vomiting. As is well known, the disease simulates perforative gastric ulcer quite closely sometimes and offers considerable difficulty in diagnosis.

Under the fourth heading, disease of the peritoneum, it is desirable to call attention to the cases of obscure tubercular peritonitis that occasions no tumor nor other gross anatomical

changes, but in which the gastric symptoms surmount all others, and rigid exclusion of definite painful disease of the stomach is in order. In a case of this kind recently studied the stomach was apparently the origin of the trouble; all food caused gastric distress, and at autopsy tubercular peritonitis was revealed. Some years ago two cases came under our observation that illustrated well how rupture of the heart may closely simulate gastralgia. In one of these cases, a woman of somewhat advanced age, the first symptom was pain in the epigastrium. This was severe in type and was soon accompanied by vomiting and retching. The pain was relieved for several hours by morphine, but later became extreme, was associated with manifestations of heart failure, but it took several hours for complete rupture to occur. The postmortem revealed a normal stomach and a tear in the left ventricle about three-quarters of an inch long, near the interventricular septum and the apex. This case was, I think, under the care of Dr. Rochester.

Angina pectoris, as is well known, sometimes simulates gastralgia, and this should be borne in mind when it is found that the gastralgia yields promptly to the administration of nitroglycerine. The dependence of so-called gastralgia upon arterio-sclerosis, arterio-spasm and syphilis is emphasized by the prompt relief following the exhibition of iodides in some of these cases. We are reminded, however, that occasionally there is found sclerosis of the arterioles, causing ulcer of the stomach, and thus in some of these instances the symptoms may be truly gastric, as Prof. H. U. Williams, University of Buffalo, has shown.

The reflection of the pain of acute diaphragmatic pleurisy to the gastric region is an occurrence not uncommonly observed. Some of these cases complain at the onset only of gastric pain and their true nature is to be discovered only by subsequent study.

It is unnecessary to mention further the false stomach symptoms that may occur with disease of the spinal cord.

In our experience, pain in the stomach is a very rare result of pelvic disease, while vomiting is notably a common result. Disease of the pelvic organs constitutes one of the causes of spurious gastric symptoms. I would not mention pregnancy as a cause of spurious nausea and vomiting were it not to make the presentation of the subject more complete; but we should ever be on the lookout for the more rare or obscure pelvic conditions that may elude a superficial examination. So also is eye strain to be considered a cause of false stomach symptoms, but pelvic disease and eye strain usually give rise to gastric symptoms as a part only of a general disturbance of the nervous system or neurasthenia and may, as a rule, be accounted causes of the latter, not of the former, with the exception of a few cases in which a pronounced gastric symptom is the only expression of disturbance and is relieved by correction of its cause in one of these distant organs.

OCULAR INCOORDINATION AND CEREBRAL REFLEXES.¹

BY F. PARK LEWIS, M.D.,
Buffalo, N. Y.

DURING the last few years the joint experience of the ophthalmologist and of the general practitioner has demonstrated a relationship between the eyes and the brain of so intimate and essential a character that a large group of morbid phenomena have now been definitely shown to be dependent upon a disturbance of the harmony existing between these organs.

The character of the functions performed by the eyes is at once psychic, nervous and mechanical; and the disturbance resulting from their incoordination may affect the mind, producing psychopathic conditions, of a degree varying from mere irritability or peevishness to mental fatigue or even melancholia; they may so disarrange the functional working of the brain as to cause neuro-pathic states as shown by involuntary motions or neuralgia, or by continued strain so profoundly affect the trophic influences as to disturb the nutrition of the lens, choroid, retina or extra-ocular tissues and not infrequently develop organic changes in structures other than the eyes themselves.

All of these phenomena have been broadly described under the general term of "reflexes," but an anatomical or physiological explanation of the manner by which these reflex nervous activities are produced has not been demonstrated, nor has a description been given of the channels through which these impulses are carried to the centers involved, and transmitted thence to the part in which the abnormal innervation is excited. The mechanism is so beautiful, however, and the process can be so clearly shown, that it may be of interest to sketch them in outline in the present paper.

In order that the ciliary muscle shall work smoothly and that it shall contract equally in every meridian at the same instant it is necessary that the rays of light shall fall upon the segment of a perfect sphere; but if the image, as it passes through the lens to the retina, is disturbed by reason of the fact that the radii of corneal curvature are unequal, the sensation of the imperfect visual impression conveyed to the brain is so unpleasant that instantly and automatically an efferent impulse is sent back from the brain, through the ciliary nerves, and an effort is made to correct the excessive curvature in the cornea by a reduction of the curvature in the symmetrical meridian of the lens.

Of the nerves governing the action of the ciliary muscles, about twenty pierce the sclerotic around the optic nerve entrance. These are subdivided when they reach their ultimate destination until a multitude of delicate sensitive neurons supply the muscular fibrillæ by which these changes in curvature are governed.

¹Read at the Nineteenth Annual Meeting of the Fourth District Branch of The New York State Medical Association, at Buffalo, N. Y., June 16, 1903.

Not alone may the departure from a normal type lie in the cornea. The eyeball may be organically and congenitally misshapen.

It may be too flat or too deep. In hyperopia, if, as rarely happens, the curvature of the cornea is regular, an even, but excessive strain is constantly thrown on the overburdened ciliary muscle.

If, as is frequently the case, there exist organic defects of both eyeballs as wholes and of the cornea, we have the torsion strain, the whole muscle being abnormally taxed, while the segments of one meridian are even more tense than is the remainder of the muscle.

Moreover, in order that there be no waste effort, there must be perfect synchronism of action between the mechanism of accommodation of both eyes.

Not only may the focal abnormalities described in one eye be found in the other, but in different degrees and in asymmetrical meridians; the right eye may have an axial diameter that is too short and its fellow too long; with this may be an excessive corneal curvature in the vertical meridian of the right, and a deficient corneal curvature in a diagonal meridian of the left. The effort to make the cerebral picture clear and definite is automatic and constant; hence, the impulse sent through the hundreds of filaments to the ciliary fibers, with the ever-changing focus, becomes almost vibratory.

It is not then surprising that under such a condition the head reels and aches, the eyes water and blur, light becomes painful, life becomes a strife, "and the grasshopper a burden."

But even now the story is but half told. Assuming that there are no focal irregularities or abnormalities, or that they have been properly corrected, it is still a prerequisite for clear and comfortable vision that the image in each eye shall fall upon symmetrical portions of the retina. To accomplish this the visual axes must lie in the same vertical and horizontal planes.

Asymmetry of the two sides of the body is the rule rather than the exception. The two halves of the face rarely correspond. The nose is on one side more than the other. The orbital cavity is higher on one side or more deeply placed. The eyes set in cavities that are not commensurate, are often, in consequence, uneven in their geometry. The plane of one is above or to one side of the plane of the other, or there may be muscular abnormalities causing false torsion of the eyeball.

The picture found upon the retina must be stereoscoped upon the cortex of the cuneus. The images must be merged in the brain picture. An efferent impulse must be sent to a weak or wrongly attached muscle to compel it to drag the eye in line so that the images may fall on symmetrically placed parts of the retina. This condition so distresses the nerve centers that co-ordinate physical or mental action is impossible and epilepsy or mental confusion or excitement may follow.

When we have the added complexity of irregularities of focus differing in amount and position in the eyes, together with difference in the axial planes, the resultant almost inevitably means serious disaster to the brain structures themselves.

An approximation of this may be appreciated by the normal eye when it encounters a newspaper page that has received a second impression slightly to one side and a little above the original. It is shown in the well-known bicycle advertisement seen in our street cars in which a rider is jogged over a rough road on a springless wheel. It is demonstrated by the rapidly moving kinoscope, demanding, as it does, a rapidity of accommodative effort that has in some cases resulted in intraocular hemorrhage.

In a word, it is the most painful and distressing strain that comes from the endeavor on the part of highly organized and sensitive muscle fibers to adapt themselves to quickly changing conditions for which they are unsuited.

The higher qualities of the brain are brought into play in the attempt to merge the cerebral images, and the mind is taxed and tired.

The trophic relationships are directly connected with the muscular activities. It is a common observation that paralysis of the facial nerve is followed by an abnormal smoothness of the skin, the structures of the face lose their fulness and cease to be well nourished. So an abnormal tonus may unduly develop the structures to which the nervous energy is directed. Hence a functional disturbance of the ocular muscle will, if continued long enough, produce a hypertrophy of the muscle fiber and the squint resulting from the continued contracting of the internal rectus gives ultimately a body of tissue so strong and thick that it refuses to relax when the strain is removed, and in consequence the tendon must be divided to restore the necessary balance.

Therefore it is that the most delicate, the most important and the most essential of the automatic nervous functions performed by the human organism is that governing control by which the various independent elements are made to work in harmonious accord.

It is as though another intelligence were directing the individual energies to produce the "team work" so constantly but so unconsciously present in health to maintain the perfect poise, the exact balance that enables a man to stand, and walk, to sit and bend without loss of equilibrium.

This absolute control is not an innate quality; it is the result of development and training. The infant possesses it only in *posse*; he can, only after much practice, maintain his balance. The idiot, through structural deficiency, may never acquire it, while it is temporarily lost through special toxic influences and permanently in certain forms of disease.

Nervous incoordination means muscular insubordination, while muscular revolt produces anarchy in the nerve centers, thus completing the vicious circle. It is the purpose of this paper to

outline the relationship of the eyes to the centers governing coordination; of the anatomical bearing of the nuclei of the ocular nerves to each other, to the other cerebral nerves and to special portions of the cortex; and to illustrate the disturbing effects that follow incoordination activities on the part of the intrinsic and extrinsic muscles of the eyes.

The process by which we become conscious of a visual impression involves the properties of physics, of psychology and physiology. The light impression of the inverted image focused on corresponding portion of the retina excites an impulse in the receptive elements in symmetrical parts of the cerebral cortex. The crossing of the optic nerve fibers causes the impression received by each eye to be carried to both sides of the cerebral visual centers, which is pretty definitely located in the cortex of the cuneus in the occipital lobe. Now, if we understand that for every terminal element in the retina is a corresponding nerve cell in the cortex, and the microscopic structure is analogous, coincidently with the development and perceptive acuity of the retinal rods must be a corresponding keenness of sensation in the cortex neurons. It follows, therefore, that as in normal eyes symmetrical segments of the retina correspond in their functional activities, so in the cortex, nerve cells related to these segments are excited coincidently.

In order that the psychical impression of the retinal image be clear and definite and not blurred and indistinct, it is essential that one picture in each hemisphere shall be exactly superimposed on the other. As in each eye is a center of greatest visual acuity from which the keenness of perception rapidly diminishes until it is lost at the marginal border of the retina, so there must be a macular region in the cerebral cortex which is the visual center of the brain.

The combination of two visual pictures into two corresponding psychical impressions is analogous to the blending of two stereoscopic pictures into one double binocular view. It will be evident, therefore, that a prerequisite for the proper performance of this function is that the refractive elements in each eye shall be focally correct, and that the position of the eyeballs in the orbits shall be relatively the same, and that the optical and visual axes shall have the same proportionate angle.

It will be seen, then, that uncorrected astigmatism of the eyes means astigmatism of the cuneus cortex; that anisometropia gives unequal psychical impressions, and especially that differences in the planes of the eyes as a result of muscular imbalance in which one eye is higher than the other, or in which the optical axis tends abnormally to the nasal or temporal side of its fellow, are profound sources of nervous or mental disturbances.

It is understandable that under such conditions the psychical effort of blending unlike impressions may result in psychical disturbances, while the nervous strain, as we shall see, may produce

nervous efforts widely remote from the structures directly involved.

The nerves by which the muscles of the eyes are energized are the third, the fourth and the sixth, a sensory branch from the fifth, and fibers from the sympathetic.

The third, it will be remembered, is practically a group of nerves, having different nuclear origins and a different distribution.

By this nerve, through its various branches, all of the eye muscles, extrinsic and intrinsic, are energized, except the external rectus, supplied by the sixth (the abducens), and the superior oblique by the fourth (the trochlearis).

In the gray matter directly below the fourth ventricle is the nuclear origin of the first of the cerebral spinal motor nerves, the third.

This nucleus, which has been most carefully studied, consists of distinct groups of cells having special characteristics.

Of these, the most anterior, small-celled nuclei give rise to the nerves governing the intrinsic muscles of the eye.

The most recent results, those obtained by Kahler, are given below, from before backward:

Sphincter iridis	Musc. ciliaris
Levator palp.	Rectus int.
Rectus sup.	Rectus inf.
Superior oblique	

In this same region, arising, indeed, below the deeper nuclei of the third, is the origin of the fourth, and more posteriorly still the group of cells from which arises the sixth. From the beautiful picture in Jacob's Atlas the relations of these and of all the other cerebral spinal nuclei will be readily seen.

There is now no doubt that a large number of the fibers which constitute the anterior quadrigeminal bodies are the end stations of the optic nerves.

It will not be forgotten that many fibers of the posterior commissure curve backward. These form a bundle gradually increasing in size and known as the long posterior fasciculus. There are added to it numerous fibers from the oculo motor, and "as it projects further back than the nucleus of the abducens it is probable that the fasciculus longitudinalis posteriorus not only contains the fibers of communication of the ocular muscles, but that it also contains fibers reaching back to the cells of origin of other cranial nerves."

In the neighborhood of the posterior quadrigeminal body there is an exchange of fibers between the fasciculi, thereby establishing communication between the third and superior oblique on the one side and the abducens on the other (Edinger). It is thus evident that the most perfect interrelationships are established not only between the optic and all of the other nerves of the eye, but as well between these and all of the cerebro-spinal nerves.

Edinger has shown that the optic nerve rises from the pulvinal thalamus, the lateral geniculate

bodies, the tuber cinereum and mainly from the corpora quadrigemina.

From the quadrigeminal bodies fibers seem to make for the nuclei of the third and fourth nerves.

Through the thalamus the radiating fibers reach out to the cortex of the cuneus, and from the cuneus again association fibers bring into relationship practically the entire cortex.

It is possible, therefore, to understand how profound may be the involvements dependent upon ocular incoordination and how psychic, nervous and nutritive disturbances may follow the effort to unite images produced in eyes having organic or focal disparities in appreciable degree.

As the interrelationships are intimate between the nuclei of the eye muscles, so that same relationship exists between the extrinsic muscles and the ciliary.

The anatomical distribution to the ciliary indicates a probable segmentary action of that muscle. The ciliary center, therefore, is not a single point, but as there is a cortical visual field corresponding to that of the retina, so there must be a series of ciliary centers corresponding to the ciliary nerve endings.

As there are about seventy nerves, therefore, splitting up into an almost infinite number of fibrillae controlling the ciliary fibers, the origin in the gray matter below the aqueduct of Sylvius might be represented diagrammatically by a number of nuclei having an equal number of neurons with the muscular fibers supplied.

A study of the pupil shows that these fibers are not innervated at once, but contraction of the pupil is effected in a wave-like form. The nerve supply of the cornea comes also from the ciliary branches; that it is studded with neurons its extreme sensitiveness demonstrates.

The function of accommodation is produced by the coordinate action of all of the extrinsic and intrinsic muscles. This is shown by the fact that strabismus is the result not infrequently of the abnormal innervation or disparity in efficiency of the superior recti.

So many cases have been recorded as to make further illustration unnecessary, showing that excessive convergence disappears when through prismatic or surgical correction this disparity is overcome.

Three propositions will be readily accepted:

1st. Among infants born into the world there are those whose eyes are unlike in size and in contour, constituting a class of congenital anisometropes.

A second class, with normally formed eyes as a birthright, progressively develop symmetrical departures from the normal.

A third class, with eyes of equal focal possibilities, develop unequally with corneae of unequal radii unsymmetrically placed; and in occasional cases, at least, probably in a majority,

A HITHERTO UNRECOGNIZED FORM OF ASTIGMIA exists, which is situated in the posterior scleral pole.

The reasons for this belief are that it is a fact of common experience to all observing ophthalmologists that the total amount of corneal astigmatism, as determined by the ophthalmometer, is found lesser or greater by actual test than the measurement would indicate. It is our custom to ascribe this difference to the lens, but there is no more reason to believe that every staphyloma posticum is a segment of a perfect sphere than there would be to look for keratoglobus where we now find corneal astigmatism.

Indeed, the demonstration was completely proven when, at a recent meeting of the Buffalo Ophthalmological Club, a case was presented of congenital choroidal coloboma in which the scleral differences of curvature were so great that while one portion of the fundus could be distinctly seen with the unaided ophthalmoscopic mirror, at another was a cup twelve dioptries in depth. There is every reason to believe that gradations in curve which have been broadly assumed to be corneal are, in fact, due to unequal scleral radii.

If marked abnormalities of curvature occur in the posterior pole of the globe, there is every reason to believe that slighter ones commonly present themselves and that sclerotic astigmatism is as definite and as tangible an entity as is that of the cornea or lens.

The nerves of the ciliary body, the iris and the cornea are the same. There are at least as many individual fibers in the iris terminating at the pupillary margin as there are degrees in a circle.

Electric stimulation over the sclera in the ciliary region causes contraction of the individual iris fibers corresponding to the meridian at which the stimulus is applied, demonstrating sectional action of the iris structures.

The same nerve current that supplies the ciliary and iris also supplies the cornea. Now, it is quite conceivable that if the innervation is irregularly supplied the nervous energy causing a meridional action of the ciliary muscle will carry a diametric instead of a circular nerve supply to the cornea, or indeed to the posterior polar region of the globe, producing functional and later organic differences in curvature in surfaces originally constituting a segment of a perfect sphere.

It has been shown that rabbits kept in dark hutches become myopic. The ciliary nerves, wearied with their effort to adjust themselves to imperfect focal conditions, lose their control over the tissues supplied, and ectasia, meridional or general, corneal or sclerotic, results.

It is by no means improbable that an undue nervous stimulus, on the other hand, may not cause reverse conditions. In the hyperopia the same ciliary effort is resisted by the general stability of the eye, but where the meridional spasm flattens one section of the cornea it permits a corresponding expansion of the lens. This is maintained in the cornea by the coordinate actions

of the external muscles, which receive the same nervous impulse.

Ultimately the muscles grow weary under the continuous effort, and, as Risley has shown, "hyperopic astigmatism is the turnstile leading to myopia." In like manner the ciliary arborization supplying the sclera no longer maintain a normal tonus, and a general or sectional scleral ectasia is produced.

The relation of the extrinsic muscles to these corneal changes is shown in the remarkable case recently reported by Bull, of Paris, in which a tenotomy of the externus was followed by the disappearance of a compound myopic astigmatism "against the rule," or, as Bull prefers to say, "inverse." There seems to be little doubt that muscular pressure has much to do with corneal curves.

I have seen the disappearance without tenotomy in small degrees of myopic astigmatism by the employment of weak prisms with the apices directed toward the weak muscle, as described in an article in the *Ophthalmic Record*² for February, 1902.

There is no question whatsoever that our knowledge of the etiology of progressive refractive changes is still exceedingly indefinite, and to no department of research can the efforts of the profession be more advantageously directed.

DISCUSSION.

Dr. Hubbell said that as the hour had arrived for adjournment he would say but a few words. Dr. Lewis' paper gave an excellent résumé of the mechanism and effects of eye strain, and in the main he accepted and commended its sentiments and conclusions. While, however, eye strain was an important factor in causing nervous disorders, it ought not to be forgotten that there are many other reflexes which are equally important, and that these should be looked for and studied in determining the etiology of disease. Neither the ophthalmologist nor general practitioner could afford to be one-sided or to be dominated by one idea in seeking to relieve his patient.

SMALLPOX.¹

BY WILLIAM A. MACPHERSON, M.D.,
LeRoy, N. Y.

S MALLPOX is one of the oldest diseases known; it existed in China and Hindustan more than 1,000 years before the birth of Christ. After a long period of time it appears to have made its way into Arabia, and to have shown itself in the Arab host at the siege of Mecca, in the year of the birth of Mahomet, 569. Pursuing the track of armies, we find it raging in Egypt in 640, and subsequently following the victories of the Saracens in the eighth

century through Italy, France and Spain. By the Saracens it was communicated to the Crusaders, and the latter caused its rapid spread throughout Europe. There was no smallpox in America prior to its discovery by Columbus, 1492. In 1517 the disease was imported into St. Domingo. Three years later, in one of the Spanish expeditions from Cuba to Mexico, a negro covered with the pustules of smallpox was landed on the Mexican coast. From him the disease spread with such desolation that, within a short period, over three million and a half of people were destroyed in that kingdom alone.

It was introduced into Iceland in 1707, when 1,600 persons were carried off by its ravages; or more than one-quarter of the whole population.

It reached Greenland still later, appearing there for the first time in 1733, and spread so fatally as to almost depopulate the country.

The southern countries of Europe furnish the largest annual contingent to the total mortality from smallpox, Rome showing, in 1887, a rate of 35 per 1,000, and Lisbon, 65 per 1,000. Rio Janeiro, for 1887, shows a mortality of 22 per 100 deaths from all causes. Prior to vaccination, it was universally regarded as the greatest scourge to mankind and was estimated as causing one-tenth of all the deaths among the human race.

The cause of smallpox is a specific animal poison. In the winter, '98 and '99, our country was visited in various parts of it, almost simultaneously, by mild epidemics of smallpox; the cause of such invasion was undoubtedly due to the return of our American soldiers from countries infected with that disease.

The disease invading localities in a mild form only, followed its usual course in all the older countries, and in its previous attacks upon this country. The history of these attacks has always been in a mild form, gradually assuming severer forms as it becomes acclimated, or growing in virulence as it passed from one culture media to another from year to year. The past year was noted for increasing severity, the death rate being considerably increased over the previous years since '98. In that year and '99 our town was visited by fifty to seventy-five cases, nearly all of a mild type. I was very much struck with its similarity to la grippe in its prodromal symptoms (viz., headache, backache, pain in loin, sometimes vomiting, high fever, 103 and 104 degrees, but presenting this characteristic, that none of the grip remedies which usually modify the fever upon the second visit had any effect upon the disease; the temperature usually rose higher and higher, until the appearance of the

²A New Use of Prisms in Heterophoria, by F. Park Lewis, M.D.

¹Read at the Nineteenth Annual Meeting of the Fourth District Branch of The New York State Medical Association, Buffalo, N. Y., June 19, 1903.

eruption, when it suddenly became normal, and the patient felt well). The first appearance of the eruption was miliary, characterized by redness, and felt like a millet seed beneath the skin; it was invariably seen upon the palms of the hands and soles of the feet. Upon the second and third days they became well-marked vesicles, and it was at this stage that the differential diagnosis became difficult to those who did not observe it through the primary fever; or, where the history of fever was not present, and the physician was not called until the vesicular stage, he was at first prone to call it a case of chicken-pox—one could not quite believe that he had a case of smallpox to deal with; but, from the third to the sixth day, the vesicles became pustular, and it is here that the physician, who still felt that he had chicken-pox to deal with, made his blunder, as it is not characteristic of the chicken-pox to pustulate; the vesicles begin to-day and do not pustulate unless they are disturbed or ruptured and infected. Nearly all cases began to dry and crust by the eighth day, and by the eleventh day were falling off, the process of desquamation being nearly completed by the fourteenth day. As regards the most contagious period, I believe it to be late in the disease. In not one did I observe infection to occur where persons were exposed during the initial fever up to the stage of eruption, but in several instances I observed infection taking place where those who had mild attacks mingled with non-immunes after the fourteenth day and up to the twenty-first day after the eruption. In one instance I observed the initial fever of four days' duration suddenly becoming normal without eruption, in one who had been vaccinated. In July, '02, I had one case of varioloid characterized by a well-marked discreet eruption of a severe type, where the prodromal fever was absent. The young lady attended Buffalo Bill's circus in Batavia with a party of friends the day before the eruption appeared, said she felt perfectly well, apparently had no fever, but the weather being very warm she may not have noticed it. This case I treated with the red lights after Finsen's suggestions, with very satisfactory results, as there was left but one slight scar where a pustule had been ruptured. In this case the eyes suffered severely, as the lids were pustular, seven pustules upon one eye and six upon the other. I kept the whole face covered with a light covering, excluding light entirely, which may have aided in the good results, as I believe it has been generally observed that covered surfaces of the body do not pit as do the exposed surfaces. Not one other of the party became infected from the exposure at the circus.

As regards vaccination, there is no other means of immunity aside from having the disease. And I observed vaccination work well upon children who had the disease. As a proof that it undoubtedly was smallpox, I observed a mother,

who had never been vaccinated, with the disease in a severe form, and her little boy of three years. The child had been vaccinated when eight weeks old; he slept with his mother and played in the same room and *lived* with her during the whole stage of the disease, yet remained perfectly immune. I believe that there is absolutely no danger from vaccination properly done with scrupulous cleanliness. We as physicians are to blame for troubles arising from vaccination. The patients ought to return at stated intervals for observation of the progress of vaccination; it ought to be treated as a surgical wound. The physician does not introduce poison at the time of vaccination, but it is introduced, perhaps, days afterward by the patients themselves, by their misunderstanding the care of the arm. I venture to say that if 3,000 children received a pin scratch upon the arm upon the same day, without the introduction of vaccine, there would be two or three deaths inside of two weeks from blood-poisoning. It is true that severe vaccinations, where the arm becomes painfully swollen and the period of healing is prolonged past twenty-one days, do not (as most people suppose) confer the immunity that the perfect vaccination, which is characterized by the smaller vesicle passing through the various stages and falling off upon the fourteenth or eighteenth day, does. In the latter case vaccine alone operated; in the former mixed infection resulted to produce the severer symptoms. Gentlemen, there is nothing like an epidemic of smallpox to convince one of the efficacy of vaccination. The following are the conclusions of the Commission of Vaccine on vaccination performed in France during the year 1839:

1.—That the simultaneous vaccination of the masses instantly arrests the progress of the variolous epidemic.

2.—That if vaccinia be not an absolute and infallible preservative against variola, it is at least the most certain, and the most exempt from danger.

3.—That varioloid, in the majority of cases, is the only inconvenience to which the vaccinated are exposed.

4.—That there seems no reason for the belief that the long vaccinated are not as surely preserved at the present day as they have hitherto been; nor that the recently vaccinated have received less security than those who preceded them.

5.—That the complete success of revaccination affords no proof that the individual had ceased to be protected by vaccination, and that he had again become susceptible to variola.

6.—That a second vaccination does not appear to possess the power, any more than the first, of protecting all persons indiscriminately from the risk of a future attack of variola.

7.—That a total extinction of variola is to be effected by the universal adoption of vaccination.

INTESTINAL OBSTRUCTIONS.¹

BY W. C. PHELPS, M.D.,
Buffalo, N. Y.

IN the older tables of the statistics of this condition the mortality is given as 95 per cent. Later reports make the percentage 45 per cent. This gratifying result has been due to early diagnosis and prompt exposure and treatment of the disease by laparotomy. Having had some experience, a brief recital of which may be of interest, and the fearful mortalities of this disease, are the reasons of my choice of intestinal obstruction as a subject for a paper.

Treves, in the last edition of his book on this subject, gives the following anatomical varieties:

First, strangulation by bands, or through apertures;

Second, volvulus;

Third, intussusception;

Fourth, obstruction by foreign bodies;

Fifth, stricture;

Sixth, obstruction by growths from the bowel wall;

Seventh, obstruction by growths outside the bowel;

Eighth, fecal accumulation.

The relative frequency of these forms is: First, fecal accumulation; second, stricture of the large intestine; third, intussusception; fourth, strangulation by bands; fifth, blocking by foreign bodies; sixth, all the forms which are rare.

Obstruction by bands and hernias involve the small intestine; volvulus, the sigmoid; intussusception, the ileo-cecal region, strictures, the large intestine; foreign bodies, the jejunum and ileum, while fecal accumulation is found only in the large intestine. When the occlusion is sudden and complete, the effect on the patient as regards pain will vary, depending on the portion of bowel involved. If it is a coil of small intestine, the pain will be more severe than when the large gut is constricted. This is due to the walls being thinner, with a greater supply of nerves, especially the vaso-motor. For this reason, also, the change from the normal appearance will be quicker and gangrene produced in a few hours. In a case of strangulated femoral hernia I found gangrene, or a condition which rapidly passed into gangrene, in twenty-four hours. The patient was sent to the hospital by her physician as soon as he saw her, which was a few hours after the first twinges of pain were experienced, but which rapidly became excruciating, with a condition of severe shock. On exposing the bowel, its color was rather more than brown, not exactly black, and its luster much dimmed. Being too suspicious to return, after the constriction was freely removed, the loop was drawn out till sound gut was visible, and the mass, enveloped in an antiseptic dressing, was left outside of the abdomen for in-

spection. In forty-eight hours the gangrenous portion ruptured. The general condition of the patient went on to normal about as fast as the constricted bowel did to destruction, and on the third day I made a resection of about eight inches, uniting the bowel by circular enterorrhaphy, and returned it to the abdominal cavity, with provision for free drainage. Recovery was perfect, though for ten days acute surgical mania, requiring the restraining sheet, was present.

I have had a case also which illustrates the lesser degree of pain where the large intestine is involved, and relate it, for the additional reason, that the location of the constriction may sometimes be indicated by the kind and amount of pain and shock. The patient, a man in middle life, entered the medical ward of the Buffalo General Hospital for a tumor, somewhat painful, in the right hypochondriac region. It was at first thought to be a floating kidney. In a few days severe constitutional symptoms with pain developed, and he was transferred to the surgical ward. His condition had become desperate, and an exploratory opening of the abdomen was made. The tumor proved to be an intussusception of the cecum, which dragged along with it some ileum into the ascending colon, with gangrene of the anterior wall and perforation. The severe pain came on late and was due to peritonitis following gangrene and perforation, and not to the distension and occlusion of the colon, which had existed some days. The mass was resected and the ileum united with the Murphy button to the closed colon. The patient died a few hours after. Lavater, quoted by Treves, states that the bowel above the constriction grows red, below it the bowel grows white, and the portion involved grows livid and purple. The tint of red is due to congestion, and the vessels may be seen engorged below the peritoneal coat. There is more or less distension by gas and fluids, and on this account it becomes thin, and if the distension be great, the blood will be forced out of the vessels and it will become pale. On opening it, the mucous membrane is found congested, and gangrenous spots may form if the occlusion has lasted some hours. Below the constriction, as before stated, the gut is pale and empty. Occasionally, however, an enteritis is found. The strangulated portion shows the redness of congestion, or is purple or black, depending on the length of time. For a while it retains its sheen, but this soon disappears, and it becomes dull and softened, and it may have on it layers of lymph. If not relieved, it becomes gangrenous, with the nauseating odor peculiar to that condition. Under the point of constriction the process of destruction is more rapid, but, contrary to what would be expected, the mucous membrane first dies, then the muscular and cellular, and, last of all, the serous coat. It is not easy, and no absolute rule is given by which one

¹Read at the Nineteenth Annual Meeting of the Fourth District Branch of The New York State Medical Association, Buffalo, N. Y., June 19, 1903.

can say whether the gut will live or not. If any circulation can be demonstrated in it by stroking the vessels or by pricking them, there is a chance of living, but if this is gone together with its luster, and the gangrene odor is present, there is no chance. I have used the peroxide of hydrogen for determining the condition of the bowel, and think it of value. It is to be poured freely over the part, and if alive a red, healthy color will be produced, and if dead, no change will occur. The pathology of the distension of the whole alimentary tract above the constriction is not well understood. It is not wholly due to accumulation of gas normally formed from the process of digestion, as was formerly supposed. It seems to be shown by late experiments on animals that a large part is due to decomposition of the bowel contents, which were imprisoned when the occlusion occurred. It has been learned clinically that the distension is greatest when the blood supply through the mesenteries is cut off by the constricting agent, and when peritonitis is present. Thrombi forming in the mesenteric vessels produce the same effect, which is supposed to be a paralysis, allowing the gut to become inflated.

The attack of acute intestinal obstruction is sudden. The pain may at the very beginning be like that of the severest form of colic, or it may begin with considerable severity, and afterward become excruciating, continuing so until the collapse which precedes death. Its location is referred to the region of the umbilicus, although the point of obstruction may be at the other extremity of the abdomen. No explanation of this has been given. In some of the most severe cases of appendicitis I have noticed that the pain was referred to this same locality. Obviously, then, the location of the pain by the patient is of no assistance in locating the obstruction. Vomiting is always present, and, like the pain, continues to the last. At the beginning it is green or yellow, and then becomes stercoraceous.

In a case of obstruction from strangulated hernia, while on the operating table and before completion of the anesthesia a renewed attack of vomiting occurred, and the patient was at once suffocated, being drowned in his own vomit. It came as a continuous stream from the mouth and nose, and ceased only with death. Because of this experience I am always glad to have the stomach washed out before beginning the anesthetic, and I think a stomach tube should be included in the list of appliances to be provided in all cases of laparotomy for acute obstruction.

Constipation is always present, and if any fecal matter or flatus is passed, it must come from below the constriction.

In many instances enemata have been given, and the statement will be made that the bowels moved. Careful inquiry will establish the fact that the amount was small, and perhaps com-

posed of only hard sybulous masses from the large intestine. A small amount of flatus may be passed from the same locality. The pulse is small and rapid, and the temperature subnormal. Thirst is a prominent symptom, and the fluids are taken only to be soon vomited. The cause of death is collapse, if it takes place quickly, as it has been known to in from ten to twenty-four hours; peritonitis, if life is longer spared, due to perforation; septicemia, however, kills the majority. It is an auto-intoxication from the decomposed contents of the bowel.

Bands have been the cause of obstruction in three cases that I treated, and which have never been reported, two of which I will, therefore, now briefly mention. D. S., a young man, aged 21 years, entered the Buffalo General Hospital, March 25, 1900, having very severe pains over entire abdomen. These became worse, and on the next day localized in the appendicular region, with the other symptoms usual in appendicitis. At 5 p. m. was operated by Dr. E. J. Meyer, in absence of Dr. Park. Lymph was present; the appendix was removed; the abdomen was washed out with salt solution and drained through the wound, and posterior drainage through the loin. I came on duty April 15th and found him a convalescent ward patient, reported to me as about ready to be discharged, cured. On the early morning of the 22d of April, one month after his admission, and the day on which he was to be discharged, he again was seized with severe pains in the abdomen and by noon they had become so severe that his cries disturbed the whole ward. Morphine hypodermically was given, but I was not notified, because the resident surgeons thought that he was again exaggerating his pains, as he was prone to do when his wound was dressed. At 3 p. m., however, I received an urgent call and found him in a condition of collapse. A tumor had developed in the left umbilical region. I at once had preparations made for a laparotomy. I did not know what caused the tumor which had so suddenly appeared. Hydronephrosis, wandering spleen, and bowel obstruction were thought of. Incision in median line from umbilicus downward was made. By this incision the tumor could be palpated, but not seen. An exploring aspirator needle was inserted, and a straw-colored, clear fluid withdrawn. One of the residents, fresh from the college laboratories, hastily made the silver test, and said that the fluid was urine. A suddenly developed hydronephrosis was, therefore, the diagnosis made. The incision was enlarged upward, passing on the left of the umbilicus, till the tumor could be seen, as well as felt, when it was found to be black, dull, sticky, of bad odor and was gangrenous bowel, and not kidney. In delivering it through the wound considerable force was necessary, as it seemed to be held by something which was attached to the right side of the abdomen. Under

this traction the constricting band gave away, and the tumor was delivered, and was as large as a new-born child's head. Inspection showed the linear gangrene produced by the band which had constricted it; sixteen inches of bowel were gangrenous. There was nothing to do but to remove it, and as quickly as possible on account of the desperate condition of the patient. A Murphy button was, therefore, used to make the anastomosis.

The only after-treatment that he received was morphine hypodermically and salt solution by the rectum for six days. Then fluids, followed by fluid diet. The button came away on the eighteenth day. He had no fever and pain was abolished by hypodermics of morphine, given every four hours. He was absolutely comfortable and did not complain of being very hungry till the sixth day, when we, too, thought perhaps he was getting hungry. He has since been in good health, and follows his usual occupation.

As surgical cases are apt to come in groups, about this time I was called by Dr. Lake, of Gowanda, to see a patient with acute obstruction. I found a man of middle life, very thin in flesh, the walls of the abdomen being so thin that the distended coils of intestine could be plainly seen and also the intestinal peristalsis, which came on in paroxysms, attended by most excruciating pain. With his consent, preparations were at once made for a laparotomy. The history gave nothing to base a diagnosis on, as to the kind or location of the obstruction, for he assured me that he had never been sick in his life. He must have been delirious, for I afterward learned from Dr. Tuttle, of Cattaraugus, that he had been a patient of his some years before, with a most severe attack of peritonitis. I had no trained nurses this time, no porcelain dishes, nor nicked sterilizers, nor hospital assistants, perhaps fresh from the dressing of a pus wound, but instead, a small house among the hills, half rebuilt after a fire, some milk pans and table dishes, together with a smart wood fire in the kitchen stove. The abdomen was opened in the median line, and the first thing encountered by the hand inserted were three round cord-like strings. These proved to be attached to the omentum like long fringes by one end, and after encircling adjacent coils were attached by the other end to some part of the posterior abdominal wall which was not determined. The largest was the size of the little finger. These were divided, but only one seemed to hug the bowel closely, and that not enough to cause much obstruction. A further search was made, and following up the collapsed bowel my finger came to another band, very tightly drawn around it, which could not be exposed to view on account of its depth and the large size of the distended coils. It was divided, and gas immediately filled the bowel. The wound was now closed. He made an uninterrupted and perfect recovery. The operation proved to be an

aseptic one, notwithstanding the rather forbidding conditions under which it was made.

These two cases were the result of previous peritonitis, which left bands of adhesion. If the band in the first case was formed as a result of this one attack of appendicitis, and not due to previous recurring ones, it was a sequela of this disease which I have never before met.

The second one was, I think, the result of a previous severe peritonitis of unknown origin. The bands are probably always caused by peritonitis, so that, if the history of a case shows previous peritonitis, bands may be strongly suspected.

The time allotted will not allow an extended report of other cases, and I will, therefore, very briefly note them.

Two cases of intussusception, one in a child and one in an adult, both of which died after operation. One of strangulation of the transverse colon by being forced through a rent in the gastro-hepatic omentum, died after operation. One curious case of a band contracting the bowel into a knuckle with rupture of all but the peritoneal coat by the force of peristalsis. Patient a boy of 14 years, who died after operation. One case of obstruction by a foreign body—an enterolith of large size—this case has been reported—recovered. One of rectal impaction by seeds. This patient, a boy, was in collapse when first seen, but quickly recovered on removal of the cause. One due to a sharp bend at the splenic flexure of the colon, caused by the transverse colon dropping down into the pelvis, three days after an operation for removal of a pus kidney of the right side. Died after laparotomy.

One of carcinoma of sigmoid and upper rectum, causing complete obstruction for ten days—laparotomy with inguinal colotomy, followed by death. The patient was a woman of 45 years. The cause of the obstruction was not known till laparotomy was made.

On May 23d last saw a case in consultation, of acute obstruction of three days' duration. Patient aged 69 years. The attending physician had used the various approved methods faithfully, with no result. Laparotomy was urged as the only hope for him, but he refused and died on the third day after. Duration of illness—six days.

As in strangulated hernia, the matter of time is of vital importance, so it is in internal intestinal obstruction. I think some of these fatal cases might have recovered if an early laparotomy had been made.

Septicemia is the cause of death in the majority of cases. To prevent this, early removal of the cause is necessary. The bowel should be released, and if small intestine, washed through an opening made for the purpose, unless obstructed near the stomach. If too long delayed, operations are useless. Diagnosis is confessedly difficult in many cases, but as in

appendicitis, it would be better to err occasionally than to habitually delay operative measures until it is too late.

DISCUSSION.

Dr. Zera J. Lusk, of Warsaw, said:

"I have been interested in the manner in which Dr. Phelps has treated the subject in his excellent paper.

"He is a surgeon, and has considered it from that standpoint, leaving little to add, excepting, however, the manner of treatment, which should receive greater emphasis. Experience, observation and results prove that it is *surgical* and *not medical*.

"I was convinced of this fact very early in my professional life. My knowledge was obtained by very dear experience, but never forgotten.

"The case was one of obstruction due to fecal impaction, and the result of the treatment of the old doctor who was called in consultation, which was 'high-up enemas,' as he termed it, of 'soapsuds and glycerine,' 'alkaline solution to be followed with an acid solution,' 'ox-gall,' sweet oil, *et al.*—continued until we were exhausted and the poor patient relieved of his torture and agony by collapse and death. Before death, however, the old doctor gave him the 'last resort'—liquid mercury. When surgical aid was suggested by me in the early treatment, the reply came quickly: 'Oh, no; not until every effort is first made. Under the knife he will die anyway.' That the patient's friends bore the same opinion was readily seen.

"Unfortunately, relief has occasionally followed this method of treatment. I say unfortunately because the physician who has treated a case with success will be led to advocate and apply the same measures when subsequent opportunity offers, with probably fatal result, but whose opinion will carry great weight in the family, because he can 'back it up' by '*my experience*.'

"I know of three families made to mourn the loss of loved ones within the last two years, when the physician in each case claimed the treatment pursued had been previously followed with success.

"I will briefly refer to one case which occurred in a city of nearly 400,000:

"It was a case of strangulated hernia in a male; age, 32; married; wife and three children; worked at harness-making. The attending physician, with his assistant, failing to reduce by taxis under an anesthetic, gave large doses of opium and applied hot fomentations. After thirty-six hours of this treatment surgical aid was called, but came too late. The man died while preparations were being made to operate. The doctor acquitted his conscience, claiming to have had two previous cases who had recovered under this treatment.

"This class of dangerous practitioners are too numerous and need to be taught that a 45 per cent. death rate under surgical is 50 less than a 95 per cent. and under medical treatment."

THE CURE OF HERNIA.¹

BY GILBERT D. GREGOR, M.D.,
Watertown, N. Y.

Mr. President and Gentlemen of the Association:
THROUGH a misunderstanding with your honored president, the title of my paper appears in a different light than I intended that it should. The "Surgery of Hernia" would undoubtedly make an excellent subject, but before an association composed in the most part of general practitioners, I deem it less attractive than though it read "The Cure of Hernia." It is along the line of the cure of hernia, whether by surgery or mechanical means, that I propose to say a few words.

I take this subject, not because I have any treatment to offer, other than that with which you are all more or less familiar, but to urge upon you a more efficient use of the means already at hand.

During a residence in this section of something like five years I have been much surprised with what neglect the profession in general treated the subject of the cure of hernia, and with what vigor it was followed by the charlatan. My observation leads me to believe that the great majority of ruptures in this vicinity are being treated by the advertising class who promise a cure by truss, embrocation or injection. For this condition of affairs the profession is not entirely guiltless. For the family doctor to make the diagnosis and then to dismiss the case with the advice that a truss be worn does not end his responsibility in the matter, nor is it satisfactory to the patient. The nature of the trouble should be explained to him. He should be warned of the dangers of strangulation. He should be told of the benefits to be derived from a truss and finally the probability of a cure by operative methods. If the patient elects to wear a truss, as he probably will, the doctor should get the truss and not only put it on, but fit it on him. He should see that the truss is worn with comfort, that it performs the functions expected of it, and then if the time comes when the patient is tired of his truss he will seek radical relief through legitimate channels.

It is not my purpose to enter deeply the subject of hernias and what I do say will be from the standpoint of abdominal hernia, and unless otherwise designated, I mean inguinal hernia, so that the term here used is synonymous with rupture in its most restricted meaning.

Surgically, we speak of a hernia as consisting of a sac, the coverings of the sac and its contents. The sac is a protrusion of parietal peritoneum. If the hernia be of some size the lower portion of the sac we call the fundus and that portion lying in the opening through which the hernia first escaped, which usually is much smaller than the fundus, we call the neck. The coverings of the

¹Read at the Annual Meeting of the First District Branch of The New York State Medical Association, Watertown, N. Y., May 26, 1903.

sac are the tissues lying between it and the surface of the body and are of more interest anatomically than surgically. The contents of the sac vary, usually it is omentum or bowel or both. However, nearly every abdominal organ, with, perhaps, the exception of the pancreas, has been reported at one time or another as having been found in a hernial sac.

The point of exit of a hernia from the abdominal cavity is through some naturally weak point in the abdominal wall. These points are the so-called inguinal canal, the femoral opening and the umbilicus. The frequency of hernia through these openings is in the order named. Abdominal sections, making an artificially weak point in the abdominal wall has added another variety to our list, viz., the ventral. At the present day I believe ventral hernia to be as frequent as umbilical.

The treatment of hernia will depend upon the age of the patient or the condition of the hernia. In children to the age of 5 years, we can go back to an ancient form of treatment, namely, that by mechanical means, or, in other words, by a truss. Both Celsus and Galen mention the cure of hernia in children by mechanical means, though the spring truss was not perfected until the seventeenth century. For cure in children and comfort to adults the truss unquestionably has been of more value than all other methods combined until the introduction of the modern operation under aseptic conditions.

Then in a child a properly applied spring truss, to which adequate attention can be given both by the physician and the parents, will cure most cases of inguinal hernias. The younger the child the better the prospects of a cure. The pad should be of hard rubber and be worn over the internal ring. A common mistake in fitting a truss is to try to adjust the pad over the external ring, with the result that the pad for the most part rests upon the pubic bone. This allows the protrusion of bowel or omentum to enter the internal ring, and it is then soon through the canal and under the pad, where it immediately causes trouble. The spring must be made to fit the body comfortably and smoothly, while the amount of pressure must be carefully adjusted. You want just enough pressure to keep the inguinal canal closed, no matter what the position of the patient. Too much pressure, especially in infants, is liable to cause sloughing of the skin. It is no great trick to adjust the pressure of these steel spring trusses when once you have tried it; bending it with the hands in the proper place will increase or diminish the pressure as you increase or diminish the curve of the spring. The whole process of fitting a spring truss is simply a little study in mechanics. When once the truss has been properly fitted it should be worn night and day.

Instruct the mother or those in charge of the child's bodily comforts how to apply the truss, and then they can remove it for a few moments

while the child is in its bath or to care for the skin underneath the pad. The patient should be kept in the recumbent position when the truss is off. It should be thoroughly impressed upon the attendants that with care and watchfulness the hernia can be cured, almost certainly so if the patient is under 5 years of age, but that one-half day's carelessness on their part may undo six months' intelligent treatment. In children over 5 years of age the chances of cure are not so good, though I believe a truss should be tried up to the period of puberty, with the idea of curing the hernia. The younger the child the better the prospects of a cure, and the shorter the time that it is necessary to wear a truss. I never feel safe in removing a truss within a year after the time when the hernia was last seen.

In children over 5 years a longer time should be allowed, say two years.

Occasionally a case will be met with where for no apparent reason every effort to retain the hernia by a truss will be defeated. I recall two such cases in my own practice; not that two have been my only failures in treating hernia in children, but these two were cases where every effort on the part of the parents and myself was unavailing. Both cases had to be operated before a cure was effected, one at the age of 30 months and the other at 6 years.

After puberty the truss is simply a palliative method of treatment, but should always be worn by a patient having a hernia who refuses radical treatment.

Two years ago, in a paper before the Jefferson County Medical Society, I said that I never had known, personally, of a hernia being cured on an adult by a truss.

Less than a year ago a patient came to me wearing a double truss. In examining him I found a good-sized hernia on the right side, but on the left side I could get no protrusion. He said that for several months the hernia on that side had not been down, but he wished both sides operated.

After doing the hernia on the right side I cut down on the inguinal canal on the left side and was able to demonstrate to the physicians present an obliterated hernial sac. Here was a case where the truss had effected a cure, temporarily at least. The patient was, however, but 17 years old, though man grown.

When a portion of the omentum or a bit of bowel becomes adherent to the sac it produces the condition known as irreducible hernia. In such cases the ordinary truss is useless. Here I always urge the radical operation, and, in fact, it is just this inability to wear the ordinary truss that drives a goodly number to seek relief by operation. All you can do in a mechanical way in these cases is to fit a truss with a concave pad, with the idea of preventing the hernia from growing larger.

The operative treatment is applicable to all cases of reducible or irreducible hernias unless they

be very large or the age or general physical condition of the patient prohibits operative work of any kind. The patients that give the best results are children or young adults. Most authorities give the age of 50 as the limit for an elective operation, but I think that a mistake; however, beyond that age we should be more guarded in promising a cure.

Within two years I have operated cases at 54, 59, 65 and 71. All made excellent recoveries, and up to the present time all have remained cured. The one of 59 had the largest hernia I ever operated. The patient was a very large, powerful fellow, a blacksmith by occupation. The hernia was not only large, but partially irreducible, and at the operation a mass of adherent omentum, as large as two fists, had to be tied off. Two months after his operation he, in one day, put on 120 horseshoes without suffering any inconvenience or showing any indications of a relapse.

There are a good many operations for the radical cure of hernia, but at the present day they follow a few general principles. These are: The ligation and extirpation of the sac, the transplantation of the spermatic cord and the closure of the inguinal canal by suture.

It is not my purpose to describe to you the different methods of operation, but simply to say a few words regarding the method that has always served me a good purpose. This method is generally known as Bassini's operation and probably, in the hands of all classes of operators, has given better results than any other method.

In this operation the skin incision extends from the spine of the pubes, parallel to and from one-half to one inch above Poupart's ligament, to an inch beyond the internal ring. This incision is deepened until the aponeurosis of the external oblique is reached. A grooved director is passed through the external ring under the aponeurosis and this is split up to correspond with the skin incision, care being taken not to get too close to Poupart's ligament. The flaps of the aponeurosis are dissected back, on the inner side, to the rectus muscle; if necessary, on the outer side to the shelving portion of Poupart's ligament.

The contents of the inguinal canal are now lifted up by blunt dissection, usually with the fingers, and if the sac is not readily recognized the elements of the cord are teased free, when the sac will come into view. It is freed by its distal extremity and then well into the internal ring. It is now opened, the interior inspected, a ligature applied high up and the sac excised below the ligature. As soon as this is done the stump of the sac disappears within the abdomen. The inguinal canal is next closed by five or six interrupted sutures of kangaroo tendon.

Begin the first suture above the internal ring. Gather up a considerable bundle of muscular tissue on the inner side and pass the needle out through the lower edge of Poupart's ligament. This suture is not a part of Bassini's operation, but has been taught by Coley. Its purpose is

simply to thicken the tissues above the internal ring. The next stitch is placed below the internal ring and close to it. This suture is passed first through the internal oblique and transversalis muscles and transversalis fascia on the inner side, the spermatic cord is lifted out of the way and the needle is passed through the lower shelving portion of Poupart's ligament on the outer side.

Three or four more sutures will be sufficient. These sutures are then tied by lifting up the spermatic cord and passing one end of the suture beneath it. When all are tied the inguinal canal is securely closed and the cord lies on top of it. The divided edges of the external oblique aponeurosis are next brought together with a running suture of kangaroo tendon and finally the skin incision is closed by any method that suits the fancy of the operator and a light dressing applied.

The success of this operation depends, in a great measure, upon a perfect aseptic technique and the use of a proper suture material. In properly selected operations the relapses that have occurred have been in those cases where suppuration took place. Suppuration does not necessarily mean relapse, but it is more liable to occur than though healing had been by primary union.

In my own experience I have had three cases go septic. Two of these occurred in operations done in private houses and undoubtedly depended upon imperfect technique in the preparation of the patient.

The other one occurred in a hospital case, but was an emergency operation, as the hernia was strangulated and he was taken directly to the operating room. In none of these cases was the infection severe, resulting simply in a small mural abscess, which healed promptly as soon as the pus was evacuated. In none of these cases has a relapse yet occurred, though it is now eighteen months since the last one was operated. One who is accustomed to operative work is really surprised at the regularity with which primary union occurs in these operations. The handling of the tissues made necessary in the removal of the sac and the transplantation of the cord would naturally predispose any slight infection to become active, but apparently the vitality of the parts is such that they are able to overcome anything but a serious insult. No doubt but rubber gloves are an element of safety here, as there is not the injury done to the tissues as when the bare hands are used.

The suture material to use in closing the inguinal canal and the aponeurosis of the external oblique should be kangaroo tendon. Silver wire, silk-worm gut, silk and chromatinized catgut have their advocates. The first three are liable to lead to sinuses and prolonged suppuration, while the catgut is not as reliable as the tendon.

I once buried some silk-worm gut in an attempt to do a radical operation after relieving a strangulation and for four months thereafter I

had an occasional job in picking out my suture through a suppurating sinus. This was long before I had heard of the Bassini method or kangaroo tendon.

There may be better methods of operating than the one I have described to you and there may be better suture materials than kangaroo tendon, but as both have given me perfectly satisfactory results I shall continue to use them.

The dangers of this operation under proper conditions and in properly selected cases are simply the dangers of the anesthetic, and there should be at least 98% of cures. The contraindications are age or a general debility, and very large hernias, especially large, irreducible hernias. In these cases, when operative work has been attempted the mortality has been very high and the recovered cases have nearly always relapsed.

My experience with hernias in the female has been different from what I anticipated from my study of the literature of the subject. That is, I have seen but a few cases of femoral hernia, nearly all being of the ordinary inguinal type and the proportion being about in the same ratio as in the male. The treatment is the same. In the operation, however, it is not necessary to transplant the round ligament as we do the spermatic cord. In separating the sac I usually have lifted the round ligament out of its bed, but after the sac was ligated have allowed it to drop back into its place again and passed the suture over it. This operation has given me perfect success.

Perhaps I should devote a moment or two to the subject of strangulated hernia. By strangulation we mean the constriction of the loop of bowel in the hernial sac so that the fecal current is obstructed and the circulation more or less interfered with. This condition is produced suddenly by lifting, straining or coughing, and is quickly followed by pronounced symptoms. These are pain, referred to the now irreducible tumor at the hernial orifice, and vomiting. The hernial tumor becomes large and tender. The vomiting is the most persistent symptom and consists first of the contents of the stomach and later becomes stercoraceous. Constipation is usually complete. Occasionally the pain is referred to the navel or epigastrium. In one case I overlooked a strangulated hernia on my first visit, as the pain was all referred to the stomach, and the patient felt delicate about calling my attention to the tumor in the groin. In another case the hernia became strangulated synchronously with its development.

The treatment of strangulated hernia is reduction by taxis or, failing in this, by operation. In following out the method by taxis, the hips should be elevated, an opiate or general anesthetic given, the hernial tumor drawn down as much as possible at first, and then grasping the entire tumor in one hand, and making upward pressure, the fingers of the other hand can manipulate the bowel through the constriction. Force is to be avoided on account of the danger of injury to or

even rupture of the bowel. If these manipulations are not successful after thirty minutes' efforts, I advise immediate operation. In cases far from surgical aid an ice bag may be applied and after waiting a few hours the same method be repeated. Failing a second time, surgical aid must be obtained. The length of time that, with safety, a hernia can be left in this condition will depend upon the tightness of the constriction, and that is a question that we are not always able to decide intelligently from external appearances. My own experience leads me to think that the smaller the hernial tumor the tighter the constriction, and, consequently, the poorer the prospect of reduction by taxis. One practitioner recently told me he never hesitated to wait twenty-four hours before asking help, and that he never lost a case.

That he has not done so is his good fortune, as gangrene of the bowel has been known to occur within four hours after strangulation. By operating when the bowel is in good condition, and the patient's strength has not deteriorated, we can operate not only with the idea of relieving the strangulation, but of curing the hernia. In doing this we make the same incision as for the Bassini operation, except that its lower extremity extends on to the scrotum and the sac is opened and its contents reduced before it is dissected out. Otherwise the operation is the same as I have described to you.

Femoral hernia gives equally as good results in the operative treatment as inguinal. The same principles are carried out, viz.: High ligation of the sac and its removal followed by closure of the saphenous opening either with a pursestring suture, as advised by Coley, or by interrupted sutures, as done by Bassini.

Umbilical and ventral hernia give less satisfactory results by operation, especially in cases of pendulous bellies with much fat and little muscular tissue.

This, then, gentlemen, is a brief review of our attitude toward the cure of hernia, and while I have offered you nothing new, I do hope that the object of the paper will in a measure be fulfilled by stimulating you to look more carefully after your cases of hernia and to hold them within the legitimate field of the medical profession.

A STUDY OF CANCER MORTALITY.

A summary of results seems to me to lead to the following conclusions as regards cancer in the city of Dundee:

1. That the death-rate from cancer as a whole, during the twenty-five years under review, has more than doubled, having increased from 7.27 to 16.92 per 10,000 of the population over the age of 20.
2. That this increase is greatest at ages over 45, is common to both sexes, but more marked in the male sex, though the actual mortality is higher among females.
3. That in females this is chiefly due to an increase in malignant affections of the abdominal viscera.
4. That uterine cancer and cancer of the breast in

females have increased, though not in any marked degree.

5. That cancer of the rectum also shows a slight increase in both sexes.

6. That in males the highest mortality is from cancer of the abdominal viscera.

7. That in males cancer of the mouth and upper digestive tract has also greatly increased.

8. That therefore cancer of regions which may be described as "accessible" has increased, as well as that of parts which are not so accessible, and where the diagnosis is more difficult, but the increase in the latter is out of all proportion to that in the former class.

9. That during the same period there has been a great improvement both in clinical and pathological diagnosis, as well as in death certification, and consequently a considerable diminution in returns from such indefinite conditions as "old age" and "disease" of the various organs (without any specification of its nature).

10. That this must, to a considerable extent, have helped to swell the returns of death from "cancer."

I am of opinion, however, that this is by no means sufficient to account for the great increase in cancer mortality, and that this increase is a real and substantial one, though by no means so great or so alarming as the general public believe or as a superficial glance at statistics would seem to indicate.—CHAS. TEMPLEMAN, *British Medical Journal*.

LOCAL ANESTHESIA.

Following the remarks of Dr. John A. Bodine, on the subject of Local Anesthesia in Herniotomies, at the nineteenth annual meeting of The New York State Medical Association, Dr. John A. Wyeth, of New York, said that from the very introduction of cocain into surgery he had been an earnest, and perhaps an enthusiastic, advocate of this form of anesthesia; hence, it was a great personal pleasure to him to find that one of his old pupils had become so proficient in its use, and had been able to advance such strong arguments in favor of its use in the operation of radical cure of hernia. It was peculiarly well adapted to this operation, which was no doubt done under modern technique with very little risk. He thought that probably 50 per cent. of cases of hernia in his own experience refusing operation did so because of their fear of narcosis. With a weaker solution of cocain one must use a wider circle of infiltration. One of the objections to the infiltration method was the traumatism which the cocain itself inflicts upon the tissues, and the greater the distention the greater the pressure upon the weakened tissues. He had never been able to attain that perfect and satisfactory degree of anesthesia in the skin with these weaker solutions. He had tried them upon himself and upon many patients during the past fifteen years or more. He was of the opinion that a 1 per cent. solution ordinarily, and a 2 per cent. solution in certain hyperesthetic persons, was weak enough for the skin. The injection directly into the integument was essential, and with this strength there could be no danger of toxemia. By injecting two or three drops and then incising, the excess of cocain is allowed to escape, and the anesthesia is almost instantaneous. It was his custom to infiltrate the nerves as soon as recognized. In his opinion, cocain anesthesia

should not be used in difficult hernia cases; it was more satisfactory to the surgeon and to the patient ultimately to have the benefit of complete narcosis by ether or chloroform. It was important that the solution should be sterile; it should be fresh for each case operated upon. He could not recall a single case that they had done together in which suppuration had occurred from the cocain. The surgeon should not be discouraged if he does not secure perfect anesthesia in his first attempts, for there is a good deal to be learned with regard to the details of the technique.

Dr. E. D. Ferguson said that he had had no personal experience with cocain in hernia cases, though he had used it a great deal in minor surgery. However, for some time past he had been considering the question of using it more extensively. There was a class of cases in which he could not see his way clear to using it. In a simple hernia in which the incisions could be readily completed and the manipulations carried out without any special difficulty, the hernia being easily reduced, it was desirable to use cocain; but in some of the old herniæ, the very large hernia, which had been retained in the scrotum along with a considerable portion of the abdominal contents for many years, could not be replaced, and it seemed to him that, in justice to the patient and kindness to the operator, the operation should be done under general narcosis. Some patients might allow themselves to be tipped into the Trendelenburg position and submit quietly to the separation of the adhesions, but such patients were decidedly exceptional.

Dr. Alexander Lyle said that his experience in the use of cocain in herniotomy had not been so extensive as that of the reader of the paper, but he had done thirteen of these operations under cocain anesthesia. His plan was to inject a $\frac{1}{2}$ per cent. solution into the skin instead of a $\frac{1}{4}$ per cent. solution. This was done because, on attempting to suture the skin after an hour, there was some pain with the weaker solution which was not observed with the $\frac{1}{2}$ per cent. solution. Again, it should be remembered that in morphine one had a perfect physiological antidote to cocain, and hence it was safe to use the stronger solution of cocain. Some had claimed that under cocain anesthesia proper relaxation of the muscles could not be secured, but this opinion he did not share. It was, of course, important to secure good relaxation of the internal oblique. Of his thirteen cases the three nerves were found in seven cases, and in the other six cases both the inguinal and the iliohypogastric nerves were recognized. He thought it was very important to have the cocain solution hot, as much less of the solution was then required. In the treatment of the sac, Dr. Bodine excises the sac, but the speaker said he had dissected up the sac and folded it up with a purse-string suture, following the MacEwen method, so as to produce an additional barrier at the internal ring. Unless the

sutures were fastened too lightly there would be no sloughing. In none of his cases had it been necessary to tie a single blood vessel, and in none had there been any suppuration. He had taken pains to push the ilioinguinal nerve to one side after cocainizing it, so as to avoid catching it in the sutures uniting the internal sac to Poupart's ligament. By so doing the patient would be spared considerable after-pain.

Dr. A. J. Ochsner, of Chicago, said that personally he had had no experience with this method, but he intended to put it at once to a practical test.

Dr. William J. Mayo, of Rochester, Minn., said he had had very little experience in this particular field, but the paper had cleared up little points in his own mind with regard to the surgical use of cocain, and perhaps explained why he had not been entirely satisfied with its use in surgery.

Dr. John B. Harvie, of Troy, said he did not think the value of the local use of cocain in hernia cases was sufficiently recognized generally by the profession. In cases in which there was devitalized bowel in the sac the administration of a general anesthetic unfavorably influenced the mortality. Within the last year he had had an opportunity of using cocain locally in cases of strangulated hernia, and the results had been infinitely better than the general use of an anesthetic. He thoroughly agreed with the reader of the paper as to the admirable results that may be obtained from the injection of cocain. He had not succeeded in cocainizing the trunks of the nerves so successfully as had Dr. Bodine; nevertheless, he had secured very satisfactory anesthesia, as instanced by the fact that traction on the intestine was not associated with special discomfort. A case was recalled in which several inches of the intestine were resected under cocain anesthesia because general anesthesia was undesirable.

Dr. Edward Wallace Lee, of New York, asked the reader of the paper with regard to the details of the technique. In making the injections he would like to know whether a number of punctures are made with a very small amount of infiltration at each puncture, or whether the needle was inserted a considerable distance and the infiltration made on the withdrawal of the needle. He would also like to know if the author had ever noticed any tendency to sloughing in and about the sites of the punctures. In regard to the sensitiveness of the peritoneum, the speaker said he had done appendectomies under cocain infiltration, and had noticed that when either the visceral or parietal peritoneum was not inflamed it was not especially sensitive.

Dr. R. H. Gibbons, of Scranton, Pa., said he had witnessed a number of Dr. Bodine's herniotomies under cocain anesthesia, and he wished to emphasize the importance of carrying out his recommendations. The position of the incision was of great importance, as it avoids hemorrhage. The infiltration of the nerve sheaths was also im-

portant, and the smaller the quantity of the cocain solution used the better. The speaker said he had begun the use of cocain when it was first introduced by Dr. Carl Koller, and at that time even a 20 per cent. solution was employed. He now could shrink the tissues of the nose just as surely with a $\frac{1}{4}$ per cent. solution. Dr. Bodine's recommendation not to use gauze in carrying the cord out of the way was a good one. Traction on the omentum could only be made painlessly if done toward the line of the adhesions; if made from the visceral end of the omentum there would be not only pain but intense shock. It had been pointed out by Dr. Harrison Cripps that traction on the omentum was very dangerous. In separating the adhesions the method of lifting the omentum with the fingers at the point of the adhesions was dangerous; traction should be made and the separation effected from the attached end of the omentum and the visceral attachment should never be pulled upon.

Dr. A. Ernest Gallant, of New York, believed Dr. Bodine's success was attributable to his method of introducing the cocain into the skin. The speaker said he could usually do as well with one drop of a solution as most operators did with ten, and this was because he made it a point to put the cocain underneath the epidermis, injecting drop by drop instead of spreading a quantity of the solution. Dr. Bodine's experience differed entirely from that of most users of cocain with regard to the employment of fresh solutions. Last year one investigator had studied the question as to why an acid solution of cocain was stronger in its anesthetic action than others. If one grain of boric acid were mixed with one ounce of a solution of cocain, it could be kept almost indefinitely. He now has such a solution which is almost two years old, and although it was in a clear bottle and not protected from the light, it contained no fungus and exhibited no evidence of deterioration. The use of cocain in the wound in herniotomy was not what was desired; the cocain was used in the skin and the rest of the work was done practically without cocain.

Dr. Bodine closed the discussion. With regard to Dr. Wyeth's criticism, that traumatism was inflicted by the use of a considerable quantity of the infiltration fluid, he said he would accept this criticism tentatively at the present time. The injection should be intradermic rather than hypodermic. The method of introduction produced edematization and acute anemia, and by this method the anesthesia would last for an hour and a half. Even though it was true that morphine might be an excellent antidote for cocain, there was no occasion for using any larger quantity of this drug than was actually necessary. He had never observed even the mildest symptoms of cocain toxemia in his cases. He recognized the limitations of cocain in this work, and none of his forty-eight cases were especially difficult ones. The great value of the method was that many persons suffering from hernia, if they knew that

they could be operated upon so easily, would come earlier for operative treatment. The pain from working in the peritoneal cavity arose from tension and stretching. Pulling on the omentum caused intense pain and shock. Hilton, in his book on "Pain," emphasized the relation of the peritoneum to the overlying nerves. It had, therefore, seemed to him that this might be retroactive, and that a sedative effect might possibly result from cocainization of the overlying nerves. It was certainly true that one surgeon could be successful in cocain surgery and another could not. In other words, the personal equation was a powerful factor. If the patient were assured that he would experience no pain, and then at the outset, in the presence of the still doubting patient, the surgeon carelessly asked the assistant for a knife, the patient would become at once utterly demoralized, and could not then be anesthetized, even by strong solutions of cocain.

THE TREATMENT OF OBSTINATE VOMITING.

Four plans of treatment are available:

1. To reduce the quantity and quality of the food to that point which will be retained, and gradually increase.
2. To influence the stomach by drugs administered by the mouth.
3. To reduce the general nervous irritability by massage and the rest cure.
4. To reduce the nervous irritability by nervous sedatives administered by hypodermic injection and rectal injection, at the same time pushing the food to a little above the limit of tolerance.

The first plan of treatment is the oldest; is good, but too slow; too much time is lost in patients already too much reduced, and in danger of death from exhaustion.

The second treatment is irrational, as the stomach itself is not diseased. It is rarely successful, though it may be consoling to the physician to say to himself, or consultants, that he has used every drug recommended. Excepting a starting dose of calomel, to cause moderate purgation, I think all stomach medication is to be condemned.

Massage and the rest cure will succeed in a greater number of cases than any other treatment. It is the ideal treatment for those who will allow it and are able to pay for it; these we, unfortunately, find in the minority.

The fourth plan of treatment I find to be nearly as successful as the third, with the advantage that it can be applied to all classes easier than the rest cure and massage.

To go into detail, it is the use of bromide of potash, chloral and valerian, singly or variously combined, by rectal enemata exclusively; 60 or 90 grains bromide, with 20 to 30 grains chloral, are given in the twenty-four hours, divided into two or three doses; this is continued after the vomiting is checked, to keep down the increased amount of food which is allowed, which I find it will do

with almost mathematical certainty. I give any kind of solid food, with the only proviso that it be finely divided, peptonized milk, buttermilk or koumiss, meat chopped *after being cooked*, toast, crackers, hard bread. As these patients have a great thirst, for the first week most of the water allowed should be given by enemata. On this general plan of treatment I rarely fail to check at once long-continued exhausting vomiting of any reflex variety, whether it be central from brain disease, puerperal, or hysterical and neurasthenic. Under the tolerance of food induced by the continued use of the sedatives mentioned, nutrition improves rapidly, the debility passes away, and on the suspension of the medicines the vomiting does not recur.

I have in several cases used 10 or 13 grains chloral and 30 grains bromide of potash twice a day by enema for thirty days, with satisfactory nutrition at the end of that time. Chloral is very irritating in a suppository, somewhat less so in enemata of 2 or 3 ℥ of mucilage; and to cause them to be retained, it is often requisite to give a preliminary enema of 5 to 8 ℥ of tr. opii in ℥ ii water.

Morphine hypodermically will arrest most kinds of vomiting for a short time; but it has the objection that it impairs digestion, produces hyperchlorhydria, and also arrests the normal bowel peristalsis; this is often sufficient to cause vomiting.

The deprivation of water from the vomiting produces a great disorder of the nervous system; an important part of the treatment is to supply water by large warm saline enemata, given in the intervals of the sedative enemata.

The histories of typical cases of each variety of reflex obstinate vomiting I read to your society, but forbear to burden this article with their publication.—A. W. PERRY, in *The American Therapist*.

A SUBSTITUTE FOR SKIN GRAFTING.

Following the suggestion of Hamilton that granulations might be induced to spring up about a piece of sponge, it was decided to try it in the following case:

W. G. —, age —, was burned on May 5th on both feet by a hot-water bag. The left foot was burned along the outer side and also on the heel, but with the exception that the heel was only slightly injured. The right foot from the toes to the ankle was badly burned, the parts sloughing and coming away. Before I saw the case soda had been applied, also carron oil with carbolic acid in it. The usual treatment for such injuries was adopted and continued until June 18th. The wound seemed to remain exactly in the same condition up to this date. No volunteer coming forward to enable me to perform skin grafting, I determined to fall back on what had several times helped me before, namely, sponge grafting. I procured a fine sponge, and

having removed all siliceous and calcareous salts and rendered it aseptic, as also the wound, I carefully adjusted it to the parts. I then covered it with protective tissue, and covered this with lint soaked in 1-20 solution of carbolic acid in glycerine, and this with a pad of boracic lint and a bandage. The following day I found a considerable amount of purulent discharge, but no odor. I dressed it as before. Four days after the application of the sponge I found it adhering at the edges and flattening in the center and infiltrated with blood and new tissue. Removing a small portion from the surface of the center, blood oozed out. The process of clipping out the portion of sponge gave no pain, showing that as yet nerves had not found their way into the new mass. By the tenth day the sponge seemed to be quite adherent all over the wound, and when touched rather roughly it bled. The discharge from the wound was quite copious and of pale color, but kept entirely free from odor. The sponge, as soon as it became vascular, filled with embryonic cicatricial tissue and gradually disappeared, leaving a rather hard mass of tissue, without any contraction. By July 30th the hardness had disappeared and the part felt soft and natural.

I have already stated why sponge is the best dead tissue to use. Charcoal and calcined bone might also be utilized in cases where a strong framework was desirable in order that contraction may be avoided, but in the cases in which I have made use of sponge, such as burned tissues near a joint, and where there is often considerable contraction if skin grafting is performed, I have found little or no contraction where the sponge was used. It should only be applied where a vacuity is to be filled. Hamilton's experiments have shown that if it is forced between two portions of a muscle, without a portion of the muscle excised, organization does not proceed nearly so equally as where a piece of tissue is removed and the sponge takes its place. The reason of this is obvious, as it merely presses against blood vessels and obstructs circulation, causing inflammation. Finally, to be successful with this treatment, a sepsis must be rigidly enforced. The wound must be made thoroughly aseptic, also the sponge. There is no reason why a patient should not be allowed to move about if practicable, after the sponge is firmly fixed, which will be about ten days. I have found, however, that some parts of a sponge become organized more quickly than others. This the surgeon must carefully watch, as, if too free movement is allowed before the whole sponge becomes organized, bleeding is apt to take place, which is to be guarded against.

The process is a long one, but, in my opinion, the results far outweigh the disadvantage of delay. I should strongly advise any of you who have an intractable ulcer or much loss of tissue, especially near a joint, to give this process a careful trial.—*Proteus in American Therapist.*

RECURRING SUBCONJUNCTIVAL HEMORRHAGES A SIGN OF CHRONIC RENAL DISEASE.

In a paper upon the ocular manifestations in chronic Bright's disease (*Am. Medicine*, December, 1902), Dr. G. E. DeSchwienitz emphasizes the fact that while it is known that recurring subconjunctival hemorrhages may be a sign of chronic renal disease, yet the manifestation has not received the place it deserves among the ocular signs of nephritis. Dr. DeSchwienitz says: "In my experience these subconjunctival ecchymoses have occurred in persons past 40, and usually during sleep, the patient being surprised on waking in the morning to find a more or less extensive subconjunctival extravasation, most frequently, I think, in the left eye. In one case they may occur at comparatively short intervals; in another the periods between the attacks may comprise several weeks or even months. In five cases seen recently, three of the patients having died, the ages were in two between 40 and 45, in one between 50 and 60, and one between 60 and 65. The fatal issue occurred within three years after the first subconjunctival hemorrhage was noted, and these hemorrhages were the first sign which called attention to the chronic contracted kidneys from which they all suffered.

"If this association of Bright's disease and recurring subconjunctival hemorrhages is a matter of common observation, as indeed it may well be, at least the fact has not been emphasized, and the simple rule to examine the urine carefully in each such case may lead to the discovery of a serious renal disorder, which, as William Osler has said, is frequently latent; and even in an advanced grade may be compatible with great mental and bodily vigor.

"Of course, hemorrhages of this character occurring in elderly people are indicative of ordinary arteriosclerosis, and are only one of the many signs of this condition, but what I wish to point out is that they are not confined to the eyes of old people, but may be seen, as I have just quoted, in those not much over 40, and in subjects, moreover, in apparently perfectly vigorous health, and when signs of arterial degeneration are not evident in the radials or temporals. One patient to whom I have referred scouted the idea of the necessity for urine examination, although within three months he had three spontaneous subconjunctival hemorrhages, none of them very large, and all of them disappearing quickly, a peculiarity which, if anything, enhances the significance which I have given them. They are the little leaks announcing that a greater break is not far off."

INVESTMENTS FOR PHYSICIANS.

It is a matter of common remark among bankers and business men that physicians, more than members of any other profession, unless it be the clergy, are prone to make unwise investments of their savings. Medical men, it is true, are among the most far-seeing of individuals, as far as the judgment of the character of their fellow-man is concerned; in general, they are noted for the common sense they display in the ordinary dealings of life. Too often, however, the sense of proportion seems to abandon them when it comes to matters relating to their financial welfare. The reason is largely, in our opinion, to be found in the widespread misunderstanding which exists among members of the profession regarding the fundamental principles underlying investments. How often in moving among medical men do we hear comments on "investments" in mining stocks, in oil wells, in rubber plantations or in industrial companies of various types. It is no unusual occurrence to be recommended by a friendly disposed fellow-practitioner to remove our accumulated little surplus from the savings bank and to buy ignis fatuus oil stock that is paying 12 per cent. dividends, or to sell our Chicago and Northwestern Railway bonds and purchase Guatemala rubber and coffee stock at 50 cents per share because it is announced that the price will be

advanced to 75 cents next month. The promoters of these will-o'-the-wisp concerns are only too well aware of the ease with which large numbers of medical men can be induced to venture in them; that they make good use of medical directories the daily mail of every medical man in the country attests.

It is doubtless to the credit of the majority of medical men that they are ignorant of the details connected with the selling of stock and bonds, that they know nothing of "puts" and "calls," and that the "short interest" and "stop-loss orders" are terms which are mysteries to them. A man to be well versed in all the minutæ of Wall Street or La Salle Street should give his whole time to the occupation and he will be fortunate then if he learns how to trade with profit. The physician who is to be a success in his profession and an honor to it must give as much time and thought to that profession as old John Graham advised his son to give to pork. If he attempts to speculate in stocks and to practice medicine at the same time he may not be the most closely shorn of the "lambs" in the Street, but he will almost certainly deteriorate as a physician in the homes of his patients.

It is important to distinguish between "investment of savings" and "investment for large profits." In the latter instance overambition is likely to lead to indulgence in semi-speculative investments or to the yielding to pure speculation in so-called securities which are really nothing more nor less than gambling counters.

If Simeon Telya, of the Province of Moncostenango, in Guatemala, were to write to 1,000 physicians and ask each to lend him \$100, it is very improbable that he would receive favorable answers to his request; at any rate, before loaning the \$100 to a man unknown to him and living so far away, inquiry would first be made as to the reliability of the man and the security of such a loan. But let Simeon Telya stake out a few acres of Guatemala highlands or marsh, and, with the help of an enterprising American promoter who has a couple of hundred dollars with which to begin a new scheme, organize a company with \$3,000,000 capital, advertise broadcast that rubber trees which have been planted are rapidly developing, and that meanwhile the yield of coffee will speedily make dividends possible, send printed prospectuses to physicians stating that this month is the last opportunity to secure "treasury stock," and that next month the price of each share will be doubled, and it is surprising how many "conservative" men, without investigating in the slightest way Simeon or his plantation, will mail their checks for the stock.

Now there can be no doubt that some rubber plantations are exceedingly profitable, and that there have been mines and oil wells which have turned small investments into great fortunes. Many of the ventures exploited represent opportunities of actual value; more of them have an honest purpose behind them, but ultimately prove unprofitable, but those who have watched the course of such concerns most closely tell us that a "large proportion of such offerings afford little or no return to the public who risk their money in the scheme."

Safety of the principal is of much greater importance than large dividends or a high rate of interest. Rather than run any large risk it is better to be satisfied with the small rate of income which pertains to the so-called "widows' and orphans' investments," such as are provided by savings banks, Government and conservative municipal bonds, endowment insurance in first-class companies, or first mortgages on real estate worth twice the face of the mortgage, and which is producing income considerably in excess of the interest on the mortgage and is owned by some one who has other property than that on which the mortgage is held.

Certain bonds and stocks can be purchased with safety; others are risky. One of the most important principles which should be grasped is this: It is never wise to invest in securities of which one cannot have full knowledge. This is why it is better to invest in the securities of local companies which serve essential local needs, like light, water and transportation, for the phy-

sician, if he invests in his own town or city, ought to be better able to make sure whether or not the companies whose bonds he purchases are honestly and economically managed than if he buys the bonds of companies operating in distant cities. He should study the company's reports, be sure that he understands what every item means, keep in close touch with the officers thereof and know as much as possible of the nature of the business. The advantages of seeking all one's business profits within the range of his own immediate and more or less expert observations can scarcely be overestimated. The securities of companies, and especially of industrial concerns, which avoid publicity, and of which no adequate account of resources and liabilities, of relation of fixed charges to net earnings, and of relation of dividend distributions to surplus earnings can be obtained should be shunned as assiduously as the substitution of morphine for quinine.

A second fundamental verity with regard to investments is to be found in the fact that "the return on a security always indicates the measure of the risk." An examination of the yield of different classes of bonds will show that Government bonds return about 2 per cent., high-class municipal bonds about 3 per cent. and railway bonds of the best class from 3.25 to 4.5 per cent. If on inquiry a bond or stock be found to be selling at a price which permits of a net yield of over 5 per cent., it is either because there is a limited market for the security or the investing public doubts the stability of the return. Occasionally there is to be picked up a really safe security which yields more than 5 per cent. net return, but this is rare, and there is always some special reason to account for its cheapness.

A third law of investments is this: A large proportion of new business undertakings fail; it is therefore rarely wise to put money into any new enterprise. Such a disposition of money must be looked on as speculation rather than as an investment. It is much safer to limit one's purchases to the bonds, for example, of railways and corporations, which, through a series of years (including a period of hard times), have demonstrated their ability to pay all their fixed charges with 60 per cent. or less of their net earnings. If the stocks of first-class railroads are ever purchased (and they are, of course, always much less safe than the bonds of the same roads) the investor should first make sure of the margin of safety of surplus earnings over dividends; if, after all fixed charges have been paid, more than 60 per cent. of the surplus earnings have been distributed as dividends at any time during the preceding five or ten years, the stock should not be bought as a prime investment.

Fourthly, a physician should never intrust money for investment to any person or company who offers to place great skill in reading the markets at the disposal of the investor in exchange for a practical part of the large profits promised. Discretionary pools, trading syndicates and all such "*get-rich-quick*" concerns are to be avoided as one would the arch enemy. Promises of 10 per cent. return or more monthly are to be regarded as opportunities for falling into a snare, and the snare is very often a tangle which ends in disgrace. If discretionary pools had that clairvoyant knowledge of the immediate movements of the market which would permit them to make the money for their clients that they claim, they would be in the market entirely on their own account, and not be wasting time working on small commissions for other people. Fortunately, the postal authorities are ridding the country of the worst of these pests as fast as their attention is called to them.

In conclusion, if medical men would learn to follow the advice of a sage counselor and "lend no money as a favor to any one unless you are willing and able, if need be, to give the money outright; to have no business dealings with your relatives in which business and sentiment are mixed up; sign no notes and assume no financial responsibilities for other people * * * and never put a large part of your savings into any one investment," there would be many fewer heart burnings in old age and many happier physicians' families than there are to-day.—*Journal of the Am. Med. Assn.*

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Byron C. Cheeseman.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberger.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutler.

SENECA COUNTY MEDICAL ASSOCIATION.

President—William Austin Macy.
Vice-President—George O. Bellows.
Secretary—J. Spencer Purdy.
Treasurer—Carroll B. Bacon.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Horace L. Hulett.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davs.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Albert E. Woehner.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Blecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stocksclaeder, James C. Davis.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer.
Vice-President—William O. Huggins.
Secretary—Alva Le Roy Chapin.

Treasurer—Frank Guillemont.
Executive Committee—F. J. Baker, E. E. Campbell.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Howard A. Maynard.

STEBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Koyle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Conner, Middletown.
Secretary—Ernest Valentine Hubbard, 138 West 74th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.

Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.

Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.

Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.

Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.

Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.

Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.

Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Wilbur B. Marple, 35 West 53d street, New York.

Second Vice-President—Frederick P. Hammond, 129 East 116th street, New York.

Secretary—Ogden C. Ludlow, 234 West 135th street, New York.

Corresponding Secretary—Frederic W. Loughran, 744 Prospect avenue, New York.

Treasurer—Charles Ellery Denison, 68 West 71st street.

Executive Committee—Frederick Holme Wiggin (1 year), Charles S. Benedict (2 years), Parker Syms (3 years).

Committee on Public Health and Medical Charities—Robert J. Carlisle, chairman, 44 West 48th street, New York; John F. Erdmann, Charles G. Kerley, Joseph D. Nagel, Edward L. Keyes, Jr.

Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 30th street, New York; William G. Le Bottillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.

Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hovenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:

CHARLES E. DENISON, M.D., Chairman.
Charles G. Childs, Jr., M.D.
Arthur R. Duel, M.D.
Frank S. Fielder, M.D.
Thomas F. Reilly, M.D.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE,
MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND
CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. NO. 11.

NOVEMBER, 1903.

\$1.00 PER ANNUM.

STATE DINNER.

The annual dinner of The New York State Medical Association was held on Wednesday evening, at the Manhattan Hotel. Covers were laid for one hundred and sixty-five, of which about thirty were ladies. At the close of the dinner Dr Wiggin arose, and in a short address related how his attention was drawn to the subject of medical unity during the early days of his practice, and how the plan of gradually bringing about medical unity was evolved by Dr. Harris and himself after six years of steady effort. After thanking the members and officers for their unflinching support during all this time, he introduced Dr. Bristow, president Medical Society of the State of New York. Dr. Bristow preached the gospel of peace and unity among all, and was warmly applauded.

Rev. Mr. Wright, in a witty and pleasing manner, showed us how we appear to the clergy. Incidentally he awoke considerable interest by advocating euthanasia for hopelessly incurable cases.

By far the most entertaining speaker of the evening was ex-Senator John S. Wise, who held the audience spellbound for more than half an hour. Dr. John H. Musser, president of the American Medical Association, and Dr. Simmons, secretary of the same organization, expressed their satisfaction at the outcome of the conference on medical union. Drs. Ferguson, Didama, Jacobi and Fairbairn also spoke. The general trend of all of the speeches was that we should let

“bygones be bygones,” and that, like the North and the South since the war, we should present an undivided front, to fight shoulder to shoulder in the new organization against all enemies of the public weal.

Taken as a whole, the addresses were superior to most post-prandial oratory, and no one tired of listening to the words of peace and of goodwill spoken by the aged gladiators of the past.

It will long be remembered as the medical love feast of 1903.

TWENTIETH ANNUAL MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The twentieth annual meeting closed on Thursday, October 22d, having been one of the most successful in the history of our organization. The attendance was large at all the meetings, especially the last afternoon, when the audience was larger than at any of the previous sessions. Our registration numbers as large as any previous year. The proceedings were carried on very promptly and the readers of the papers responded to the order of the program. Of the forty-two papers on the program thirty-nine responded. The papers were exceedingly good, showing a high order of scientific work. The association was honored by several visitors, who contributed papers—the president of the American Medical Association, Dr. J. H. Musser, of Philadelphia; Drs. Thomas A. Rotch and Richard C. Cabot, of Boston, and Dr. Charles L. Bonifield, of Cincinnati. The President, Dr. Frederick Holme Wiggin, delivered an interesting address to the Fellows and Council, giving a history of medical societies; also an address on the duties of the President. Both addresses are printed in full in this number of the JOURNAL.

DEFENSE OF ALLEGED MALPRACTICE SUIT AGAINST A MEMBER AND PROSECUTION OF ILLEGAL PRACTITIONERS.

The following correspondence in connection with this subject is of interest:

"DR. FREDERICK HOLME WIGGIN,

"55 West 36th Street, New York:

"Dear Doctor Wiggin—Nearly two and a half years ago I became the defendant in a malpractice suit, the grounds for which were caused by no fault of my own. As yet the case has never been tried, but has been ably looked after in its minor details by my lawyer here.

"Since I was sued The New York State Medical Association has instituted a new protection for its members whereby they are defended in such suits. How can I, without putting my case entirely in the hands of the association, or asking it to assume my defense, still in some way have its cooperation, and as such being known, lend its additional strength and support to my defense?

"I have been a member of the association some ten years.

Very truly yours,
"_____."

"My Dear Doctor—Your letter to Dr. F. H. Wiggin, president of the association, he has just forwarded to me.

"As you know, the defense of members of the association in malpractice suits was begun at the close of the meeting in October of last year. This applied, of course, to actions brought after that date, and as your action is somewhat older there is no duty resting upon the association with reference to your defense, except a fraternal one.

"However, if I can be of any service in cooperating with your attorney by way of suggestion, though it is entirely outside of my employment, I should be very glad to help, and you may rest assured that you have the added strength which goes with the support of this great organization.

"I am sure that your case is in good hands, and shall expect a successful outcome. If in future you are attacked you have only to send your papers with a statement of the case to the Medical Association, and your defense will be conducted without expense to you.

"With kindest regards, Very truly yours,

"(Signed) JAMES TAYLOR LEWIS,

"Counsel for The New York State Medical Association."

"FREDERICK HOLME WIGGIN, M.D.,

"President The New York State Medical Association,
"55 West 36th Street, New York:

"My Dear Doctor Wiggin—I wish to bring a little matter before you for advice, which you can either tell me about, or, possibly, you will refer my letter to the counsel for the association, so that I may be properly advised.

"We have in this district one _____, who is openly practicing medicine without having any legal qualifications whatever to do so. He has a large sign hung up outside his premises, and he pretends to people in his immediate locality that he is practicing under a diploma issued by the Medical Department of the University of Michigan, Ann Arbor, although this is not the case, and they have notified us and others that no diploma was ever issued to him. He has further stated, and I hold a rough copy of the affidavit that he made in the case that his diploma was indorsed by the University of Syracuse, and upon an affidavit to this effect he was able to secure the registration of this diploma in Yates County, N. Y., and upon the paper given him by the County Clerk of Yates County he afterward had his diploma registered in Seneca County. I have communicated with the two County Clerks referred to, and also with the Secretary of the State Board of Regents, and I find that upon the advice of the State Board of Regents the registration in both counties has been canceled, consequently the said _____ has nothing more to stand upon in either case.

"Now, I have been informed by the State Board of Regents that under Chapter 661 of the Laws of 1893, as amended in 1895, 1896 and 1901 and 1902, the initiative in prosecuting a case of this kind is left to the local county society. Whether there is any other means by which we could have this matter followed up through the District Attorney of the county or not I do not know. I presume that there is some chance that either the University of Michigan or the Syracuse University might take the initiative in this case, and I am bringing the matter before them to see what they would be willing to do under the circumstances.

"As to the county society taking the initiative, we are in the position of being a very small body, and with very little money readily available for any purpose like the above. Besides this, there is possibly a natural apprehension on the part of most, if not all, of the members that should the county society undertake to prosecute in this case that the friends of this man might readily retaliate against them as individuals in this way, and I am afraid it would be very hard to get anything started, unless one or two of us take hold of the matter personally, and I therefore would like to know whether there is any other way of getting it.

"Thanking you for any advice that you can give me,
Very truly yours,

"President _____ County Medical Association."

The following answer was sent to the above letter:

"My Dear Doctor—A copy of your favor of September 5th to Dr. F. H. Wiggin has been referred to me.

"It would seem from your letter that the facts are that at present _____ is not a registered physician of _____ County, and if you will send me his address I will write him to the effect that he will be arrested unless he stops practicing medicine without registration and proceeds to pass the examination required by the Regents, as others are required to do.

"That may have the desired effect of getting rid of him from your community at least, and if not, then I will proceed to have him arrested as the law requires, and I will keep you advised of what is being done.

"The procedure will be about as follows: It will be necessary for you to employ some responsible person to go to this doctor and feign sickness, and get a prescription from him; then let this person send to me a full, complete and accurate statement of the entire conversation which took place when he called on _____, together with the prescription which he received, and I will prepare these papers from his statement. I would send to the County Clerk for a search of the record, which would be evidence that he was not registered, and when I had the papers completed, would send them all, together with a proposed warrant, to the District Attorney of your county, who would then be compelled to proceed to prosecute this man, and if you will kindly send me the address of _____ I will take the first step at once.

Very truly yours,

"(Signed) JAMES TAYLOR LEWIS,

"Counsel for The New York State Medical Association,
180 Broadway, New York."

Professional union in New York City seems now inevitable. Two committees, each of five members, have been appointed by the Medical Society and by the Association, and have been given full power to make arrangements for unification. It therefore appears impossible that any unforeseen difficulty or opposition can arise which would prevent the extinction of the unfortunate differences which have so long kept the physicians of New York from unity. There will be delight not only in New York but in the whole nation at this victory of a united profession over schisms, cliques, parties, schools, reactionaries and demagogues.

Association News.

COUNTY ASSOCIATION MEETINGS FOR NOVEMBER.

Kings County—Tuesday, November 10th.
 Otsego County—Tuesday, November 10th.
 New York County—Monday, November 16th.
 Onondaga County—Monday, November 16th.
 Ulster County—Monday, November 16th.
 Orange County—Wednesday, November 18th.
 Cortland County—Friday, November 20th.
 Lewis County—Tuesday, November 24th.
 Monroe County—Tuesday, November 24th.
 Westchester County—Thursday, November 26th.

THE NEW YORK STATE MEDICAL ASSOCIATION COUNCIL, 1903-1904.

Elected at Annual Meeting, October 19, 1903.

President—William Harvey Thornton, Buffalo.

Vice-President—Charles S. Payne, Liberty.

Vice-Presidents, ex-officiis—J. Orley Stranahan, Rome; Everard D. Ferguson, Troy; Frank W. Higgins, Cortland; Joshua William Morris, Jamestown; Julius C. Bierwirth, Brooklyn.

Secretary—Guy Davenport Lombard, 12-16 East 31st street, New York City.

Treasurer—Frederick A. Baldwin, New York City.

Committee on Arrangements—Samuel A. Brown, New York City.

Committee on Legislation—E. Eliot Harris, New York City.

Committee on Library—John J. Nutt, New York City.

Committee on Public Health—Louis C. Ager, Brooklyn.

Committee on Publication—Charles E. Denison, New York City.

Committee on Nominations—Wisner R. Townsend, New York.

FIRST DISTRICT BRANCH.

Report of Executive Committee of First District Branch.

The following letter was submitted to the Council at its meeting of October 19th, having been received by the secretary of the State Association:

LITTLE FALLS, N. Y., Sept. 5, 1903.

To the Council of The New York State Medical Association:

Whereas, at a regular meeting of the First District Branch, New York State Medical Association, Drs. A. H. Crosby and Charles E. Douglass, of Lowville, requested that an investigation be made in regard to charges and statements that they had been interested in encouraging a suit for malpractice against a brother practitioner, and at this meeting held in Watertown,

May 26, 1903, the matter was referred to the Executive Committee.

The Executive Committee of the First District Branch respectfully report that, after a close investigation of the case and a study of the papers, in the opinion of the committee there is no ground for any such charge against the gentlemen above named, and recommend that no further action be taken.

J. O. STRANAHAN,
 CHARLES B. TEFFT,
 B. C. CHEESEMAN,
 JOHN N. BASSETT,
 EDGAR H. DOUGLAS,

Members of Executive Committee, First District Branch, The New York State Medical Association.

Broome County Association.—The semi-annual meeting of this association was held at Dr. Orton's office, Binghamton, October 13th, at 3 P. M.

The meeting was called to order by the president, Dr. Farnham. The secretary read the minutes of the previous meeting, which were approved. Drs. Orton, Farrington, Martin, Quackenbush, Curran, May, Michael, Allen, Kelly, Stearns, Farnham and Greene were present.

Dr. John D. Curran read an excellent paper on "Vomiting After Etherization." The paper was discussed by most of the members present. Dr. Orton moved a vote of thanks to Dr. Curran for his valuable paper, which was carried unanimously.

Dr. Kelly presented a paper of much interest on "Puerpura Hemorrhagia." Dr. Quackenbush reported some interesting cases of asthma.

Dr. Martin was elected vice-president in place of Dr. William A. White, who has moved to Washington, D. C.

Dr. Orton offered the following resolution, which was unanimously adopted:

"WHEREAS, Since the last meeting of this association, our esteemed vice-president, Dr. W. A. White, has been called to fill a position at once one of the most responsible and honorable for an alienist to occupy in this country, namely, Superintendent of the Government Hospital for the Insane, at Washington, D. C., we desire to place on record our high appreciation of Dr. White's eminent fitness and abundant ability, both by education and experience, to do credit to himself and his profession, and likewise subserve an invaluable addition for the promotion of the cause of science and humanity."

On motion Dr. White's name was transferred to the non-resident membership list.

C. W. GREENE, Secretary.

* * *

Cattaraugus County Association.—The regular semi-annual meeting of this association was held at Salamanca, on October 6th. The program was as follows: Paper, "The Surgery of the

Prostate Gland," by Dr. Charles P. Knowles, of Olean, read by Dr. Jacob E. K. Morris, of Olean, as Dr. Knowles was unable to be present. Discussion of rational treatment of gonorrhoea, by the members present, led by Dr. J. Sutherland Wright, of Little Valley.

Report of cases by Dr. Carl S. Tompkins, of Randolph.

C. S. TOMPKINS, Secretary.

* * *

Chautauqua County Association.—The regular semi-annual meeting of this association was held in Brocton, September 29, 1903.

The meeting was called to order by the president, Dr. O. C. Shaw, of Cassadaga. The following members were present:

Dr. H. C. Eastman, Jamestown, secretary; Drs. William M. Bemus, Morris N. Bemus, W. W. Hotchkiss, Albert T. Livingston, J. W. Morris, E. M. Scofield, L. H. Snow and W. D. Wellmen, of Jamestown; H. F. Hunt, Dewittville; E. A. Scofield, of Bemus Point; Thomas D. Strong, Westfield; V. D. Bozovsky, John A. Weidman, Dunkirk; A. F. Soch, Fredonia; C. A. Rood, B. S. Swetland, Brocton. Drs. D. M. Hall, Westfield, and A. E. Dean, Brocton, were admitted as new members.

An interesting paper upon "Plastic Iritis" was read by Dr. W. W. Hotchkiss, of Jamestown, which was fully discussed, after which Dr. Morris reported "an interesting case of chorea." After the discussion of this case, an adjournment was taken for dinner.

During the intermission the doctors and ladies visited and inspected the Brocton wine cellars and were each presented with a bottle of wine as they left the office.

An excellent dinner was served at the Brocton House, and then they were all photographed by Cotter.

The afternoon session was called to order at about 2 o'clock and listened to a paper by Dr. Henry C. Buswell, of Buffalo, upon "Acute Cardiac Dilatation." This paper was well received and fully discussed, and the doctor received a vote of thanks.

After voting to hold the January meeting in Jamestown, the meeting adjourned.

While the doctors were holding their afternoon meeting the ladies of the party—Mrs. T. D. Strong, Mrs. W. M. Bemus, Mrs. Morris N. Bemus, Mrs. Hotchkiss, Mrs. Snow, Mrs. Hatch, Mrs. Swetland, Mrs. C. A. Rood, Mrs. E. Rood and Miss Field—drove to Spring Lake farm, the home of W. H. Becker, and were well entertained. They then joined the physicians at the Brocton House at 3 o'clock for a drive, which was taken to Vine Cliff, the summer home of C. A. Wenborn, the former home of Thomas Lake Harris, the founder of the "Community of the Brotherhood of the New Life," which flourished here thirty-five years ago.

From Vine Cliff they went along the Lake

road to the Eagle Tree fruit farm, the homes of L. H. Corell and son James, where they were all invited to alight and pick a basketful of grapes. When each had filled a basket with fine Niagara or Concord fruit they were hurried into the wagons and driven to Portland Center and treated to some of the choice wines in the Portland wine cellars of Fuller & Skinner.

As it was nearing train time a proposed drive through the dense vineyard section of the South road was postponed.

They returned down the Main road and over the new bridge that crosses the Pennsylvania Railroad.

All were well pleased with their day's recreation, and profusely thanking the Brocton physicians for their entertainment and hospitality, they departed for their homes better prepared to respond to the calls of the sick and suffering.

* * *

Kings County Association.—The regular monthly meeting of this association was held at 315 Washington street, Brooklyn, on Tuesday, October 13th, at 8.30 p. m. The president, Dr. George H. Treadwell, was in the chair, and about fifty members were present. Dr. George S. Hopkins read a paper on "The Spectroscopic Elements of Light as Therapeutic Agents," upon which a discussion followed by Drs. Andrew H. Smith, William James Mortimer and A. D. Rockwell. In executive session two new members, Drs. Leon Louria and Willis Cummings, were elected to membership. The meeting adjourned at 10.30, and the usual collation was served.

* * *

New York County Association.—This association held its stated meeting October 19, 1903.

Dr. Frederick Holme Wiggin presented the following specimens:

Presentation of a Patient Five Years After Resection of Rectum and Sigmoid Flexure for Carcinoma.—The patient had come to him with a diagnosis of hemorrhoids. On attempting to do an excision the gut parted, necessitating a laparotomy. On opening the abdomen it was discovered that the disease involved the sigmoid flexure and a part of the descending colon, and had already infected the adjacent glands. There seemed to be but little hope of the patient's surviving, so it was thought proper to take the additional risk of doing a radical operation. Contrary to expectations, the woman made a good recovery, and had remained well until a few months ago, when the parts around the artificial anus became tender and infiltrated.

Drs. Parker Syms and J. Riddle Goffe reported that they had examined the woman and could find no evidence of a recurrence.

Contents of Axilla.—This specimen was removed from a case of recurrent carcinoma of the breast. There was no evidence of inflammation of the scar of the first operation.

Loose Fibroids.—These were entirely inde-

pendent of the uterus, and had been nourished from the mesentery.

Fibroids Removed by Hysterectomy; Unusual Symptoms.—In this case the operation was done because of the presence of grave mental symptoms. The vaginal route was selected. The day after the operation there were nausea and abdominal distention, which were temporarily relieved by lavage of the stomach and the use of saline infusion. A few hours later the patient suddenly developed severe precordial pain and dyspnea, and died with symptoms pointing to occlusion of the coronary arteries.

Specimens of Appendicitis.—Several such specimens were exhibited.

Adenocarcinoma of the Sigmoid.—Dr. James P. Tuttle exhibited a specimen of adenocarcinoma of the sigmoid flexure that he had removed by operation a few hours before. As there was a history of syphilitic infection many years before, the man had been subjected to a course of active anti-syphilitic treatment, and while his general condition had materially improved, the tumor had not diminished and the stools regularly contained blood and mucus. A microscopical examination of a specimen removed by forceps also failed to show the presence of malignant disease, but the exploratory operation led to the removal of an adenocarcinoma situated within one inch of the descending colon in the sigmoid flexure.

Ectopic Gestation.—Dr. J. Riddle Goffe exhibited this specimen, which had been removed from a woman who had had an irregular "spotting," instead of the regular period on October 8th. This bleeding and the occurrence of three attacks of abdominal pain had led to the operation. A small ectopic gestation was found in the right tube.

Gangrenous Dermoid Cyst of the Ovaries.—Dr. Parker Syms presented this specimen, which he had removed from a girl of 16. A dermoid cyst was found in each ovary, the one of the left being the seat of gangrene, the result of a double twist in its pedicle.

President's Address—"Physiologic and Therapeutic Action of Alcohol."—Dr. Alexander Lambert. Address on page 436.

* * *

Orange County Association.—The regular meeting of this association was held at Middletown, Wednesday, September 16, 1903, at 2 P. M. There was not the usual number present on account of a severe storm. In the absence of the president, Dr. W. E. Douglas, vice-president, presided and called the meeting to order. Owing to the small number present it was thought advisable to postpone the scientific papers until the next regular meeting. The business session was then held and matters of some importance were discussed.

Dr. F. W. Dennis, of Unionville, made a motion that a committee of three be appointed by the chair to draft resolutions regarding the re-

cent serious accident to Dr. Rushmore, of Tuxedo.

The motion was seconded and carried. The committee drafted the following:

"WHEREAS, Our fellow-member, Dr. Edward C. Rushmore, was seriously and almost fatally injured in his recent automobile accident, and is now confined in bed by reason of the injuries thus sustained, and

"WHEREAS, By the same accident, an all-wise Providence saw fit to remove by death a dear relative;

"Resolved, That the sincere sympathy of this association is hereby extended to Dr. and Mrs. Rushmore in view of the doctor's serious injuries and the extremely sad bereavement which they have suffered, trusting that in due season the doctor may be restored to his usual health and strength, and it is further

"Resolved, That a copy of these resolutions be spread upon the minutes of this meeting of the association and copies sent to Dr. and Mrs. Rushmore, and the daily papers of the city of Middletown. "Signed.

"H. E. WISE, Turner, Chairman.

"F. W. DENNIS, Unionville.

"C. I. REDFIELD, Middletown."

There being no further business before the association, adjournment was made until Wednesday, October 21st.

C. I. REDFIELD, Secretary.

* * *

Rockland County Association.—The regular quarterly meeting of this association was held at the United States Hotel, Haverstraw, on Wednesday, October 14th. There were present Dr. George A. Leitner, Piermont, vice-president; N. B. Bayley, Haverstraw, treasurer; Dr. S. W. S. Toms, Nyack; Dr. W. R. Sitler, Suffern; Drs. Alexander Lyle and J. B. Walker, of New York City, and Dr. F. Levassur, Haverstraw.

Dr. Lyle read an extremely interesting paper upon the local use of cocaine in the obtaining of anesthesia in the area of surgical work by hypodermic infiltration and injection into the nerve trunks on the proximal side of the incision. The paper was illustrated by cases of inguinal hernia and appendectomies.

Dr. J. B. Walker read a clear and concise paper on appendicitis, in which the relative value of the signs and symptoms of disease on the right side of the abdomen were compared and deductions drawn from them as to the most advantageous period for operating. While he was in unison with all good surgeons that appendicitis was a surgical affair, cases did occur where the exigencies of the case justified medical treatment, and it was a satisfaction to know that skilled medical treatment was justified in the proper class of cases.

The next meeting (the annual) will be held at Piermont, January 20, 1904.

N. B. BAYLEY, Secretary.

Steuben County Association.—The regular quarterly meeting of this Association was held at Liberty Building, Hornellsville, on Wednesday, October 21st. The following papers were read: "Melancholia and a New Treatment for Same," by Dr. Floyd S. Crego, Buffalo; "Cause and Cure of Backwardness in Children," by Dr. Frank H. Koyle, Hornellsville; "Technique of the Pasteur Treatment Against Hydrophobia," by Dr. M. Estromer, Baltimore; "X-ray and Other Lights as a Therapeutic Measure," by Dr. John D. Mitchell, Hornellsville; "Management and Treatment of Typhoid Fever," by Dr. B. R. Wakeman, Hornellsville.

York; Lyman A. Cheney, New York; Albert H. Ely, New York; Henry W. Frauenthal, New York; Alfred Freundlich, New York; P. William Nathan, New York; Louis Peiser, New York; Bernard Scheinkman, New York; E. H. M. Sell, New York; George J. Seufert, New York; Carl F. Siefert, New York; Thomas A. Smith, New York; Henry J. Wackerbarth, New York.

Queens County—Archer W. Jagger, Flushing.

Sullivan County—Henry Levien, Liberty; George F. Rice, Jeffersonville; Alford B. Sullivan, Liberty; Stephen W. Wells, Liberty.

Ulster County—James L. Preston, Kingston.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

SECOND DISTRICT BRANCH.

Saratoga County—William S. Donnelly, Ketchums Corners; George Hudson, Stillwater; John R. McElroy, Jonesville; Frederick J. Resseque, Saratoga Springs.

Washington County—Alfred M. Young, Salem.

THIRD DISTRICT BRANCH.

Broome County—Frank L. Allen, Binghamton; John S. Kelley, Binghamton; James V. May, Binghamton; Francis M. Michael, Binghamton.

Chenango County—James B. Drake, Norwich.
Seneca County—Charles S. Barnes, Ovid.

Tompkins County—Richard Cornell Warren, Ithaca.

FOURTH DISTRICT BRANCH.

Chautauqua County—Albert Edward Dean, Brocton; Dupree Meriwether Hall, Westfield.

Erie County—James P. Barr, Buffalo; Prescott Le Breton, Buffalo; Frederick Carl Busch, Buffalo; Pierce J. Candee, Buffalo; William J. O'Donnell, Buffalo; William Hobson Heath, Buffalo; Irving W. Potter, Buffalo; Lilian C. Randall, Buffalo; Henry E. Stadlinger, Buffalo; George B. Stocker, Buffalo; Edward Tweedy, Buffalo.

Livingston County—James E. Crisfield, Dansville; James A. Jackson, Dansville; James H. Jackson, Dansville; Charles V. Patchin, Dansville.

Monroe County—George W. Goler, Rochester.

Niagara County—E. O. Bingham, Niagara Falls; W. J. Faulkner, Youngstown; Edward P. H. Griswold, Niagara Falls; A. J. Lawler, Niagara Falls; Frederick R. McBrien, Niagara Falls; Norman W. Price, Niagara Falls.

Wyoming County—Sewell A. Brooks, North Java; William Nelson Martin, Cowlesville; Marion Eugene Martin, Bennington.

Yates County—J. H. Wilkin, Rushville.

FIFTH DISTRICT BRANCH.

Kings County—Willis Cummings, Brooklyn; Leon Louria, Brooklyn.

New York County—Edward F. Brennan, New

OBITUARY.

David Franklin, M.D.

Dr. David Franklin, of New York City, died at his residence on October 6, 1903, of appendicitis, at the age of 48 years.

Dr. Franklin was born in New York City, was a graduate of its public schools and of the College of the City of New York, and in medicine in 1878 in the medical department of the New York University. He subsequently entered Bellevue Hospital by competitive examination and remained there through the full term of service. He then went to San Francisco, practicing medicine there, returning to New York City two years later, where he located in the upper portion of the city, known as Harlem.

Soon thereafter he was appointed to the position of house physician to the Hebrew Orphan Asylum, which position he held until his death, a period of over twenty years. He was a member of the American Medical Association, of The New York State and County Medical Associations, of the Harlem Medical Association, and of the Alumni of Bellevue Hospital. He was married to Miss Belle Becker, who died three weeks before her husband. Three daughters survive him.

The following preamble and resolutions were sent to his family and placed on the records of the Harlem Medical Association:

In accordance with a resolution unanimously passed at a meeting of the Harlem Medical Association on October 7, 1903, the undersigned respectfully present the following preamble and resolutions on behalf of the Harlem Medical Association:

WHEREAS, By the inscrutable ways of a Divine Providence we have lost by the death of Dr. David Franklin one of our most loyal, conscientious and faithful members, for many years the treasurer and a trustee, and at one time president of the Harlem Medical Association; therefore be it

Resolved, That we enter upon our records this minute of our lasting regret at his untimely death, and our deep appreciation of the many traits of his character which endeared him to all.

Dr. Franklin was known to us as a model of quiet patience, perseverance and determination of character, and as one of Nature's noblemen,

a skilful physician, a cheerful counselor and a loyal friend.

As a physician he was thorough, clear-headed and scientific, studying each and every case intrusted to his care with the patient minuteness of detail so requisite, and his large and successful practice bears every evidence of the success that follows such painstaking attention.

His faithful service as a physician to the Hebrew Orphan Asylum for twenty years abundantly shows his unswerving attention to duty.

Not only were his services eagerly sought by those suffering, but he became endeared to those who knew him, and his counsel was often asked and as eagerly accepted, as it was cheerfully given.

As a friend he was all that the name implies—ready to respond to any call made upon him, self-denying and self-effacing, tried, faithful and true. Although taken from those who loved him, at the very zenith of his career, when there was every reason to believe that there was a future of happiness and of fame awaiting him, his all too short life brings to us all a lesson we may profit by.

We shall ever bear him in fond remembrance and place this record of his manly, loyal, consistent, gentle and true character upon our records, as they are engraven in our memories.

EMIL MAYER,
RICHARD VAN SANTVOORD,
MONTROSE R. RICHARD,
Committee on Resolutions.

* * *

Dr. Jean F. Chaveau died at his residence, 31 West 60th street, New York City, on October 17th. The doctor was a graduate of the Geneva Medical College, class of 1853. He was a member of The New York State Medical Association, Neurological Society, New York Academy of Medicine, Medical Society of the County of New York, Physicians' Mutual Aid and the Medical Association of Greater New York.

PERSONAL.

Dr. Douglas C. Moriarty, we are very sorry to learn, was unable to attend the recent meeting of The New York State Medical Association, on account of the death of his daughter.

* * *

Dr. William Van Valzah Hayes, 10 East 43d street, married Miss Mary Caulbourne Conner, of Altoona, Pa., September 9th.

* * *

Dr. Arthur J. Benedict, whose wife, Marion Wilcox, died at her home in Phœnicia, October 23d, has our sympathy in his sorrow.

LEGAL NOTES.

Another Member Defended in Malpractice Suit in Queens County.

The Counsel of the State Medical Association was again called in in the defense of a very well-known member of the Association, who was sued in the County of Queens, Long Island, on account of the death of an 11-year-old child operated upon, who died from the effects of the chloroform.

The action had been tried once, before Mr. Justice Garretson and a jury, at which trial the jury disagreed. On the present trial, which was held before Mr. Justice Marean, the jury brought in a verdict for the defendant. The learned Judge, in charging the jury, stated the case in a wonderfully scholarly manner, and followed the rules laid down in the well-known case of Carpenter vs. Blake, which holds in effect: First, that if the jury concludes that the defendant in the case possessed that reasonable degree of skill and learning which is ordinarily possessed by professors of the same art and science; second, if he used reasonable and ordinary care and diligence in the exercise of his skill and the application of his judgment to accomplish the purposes for which he is employed, and, third, if he used his best judgment in the execution of his skill and the application of his judgment, then the verdict must be for the defendant.

The rule of reasonable care and diligence does not require the exercise of the highest possible degree of care; to render a physician or surgeon liable it is not enough that there has been a less degree of care than some other medical man might have shown, or even less than he himself might have bestowed, but there must be a want of ordinary and reasonable care. There is no liability for error of judgment.

Almost every phase of this alleged malpractice has been covered by decisions now, and if the members of the Association would but continue to stand firm and to assert their rights, the public would come to realize that the medical profession had become no longer a subject for attacks of unscrupulous litigants.

* * *

Thomas E. Conway, the prosecuting inspector of New York County Association, has undergone quite a serious surgical operation, and is on the road to a complete recovery.

* * *

It seems almost incredible, but it is a fact that the counsel has just been asked if it is true that members of the Association are defended in malpractice suits; certainly there has been much said on the subject, and why the members do not know that such is the fact it is impossible to understand. It must be that they do not read their JOURNALS each month and keep up with the progress of events.

ATTACKS ADVERTISING QUACKS.

James Taylor Lewis, of this city, counsel of The New York State Medical Association, said, with reference to Justice Mayer's remarks before the Medical Jurisprudence Society, on Monday evening:

"The justice was doing much by such a statement to educate public opinion to a point where it would demand the withdrawal by some of the daily papers of New York and other cities throughout the State of all advertising on the part of irresponsible and fraudulent astrologers, midwives, fortune-tellers and quacks who are so openly advertising their wrongdoing in the columns of some of the great dailies. If the justice would take a step further in practice, and for the ensuing six months would imprison every case brought before him where the defendant was convicted of practicing medicine illegally, instead of imposing a small fine, he would assist the medical profession in this State to the greatest degree in stemming the increasing wrongdoing of these medical mountebanks.

"The Court of Special Sessions, in that direction, has almost unlimited power, and I believe that the imposition of small fines, to which there is at present no minimum, actually tended to an increase of these practitioners, rather than as a deterrent, because the defendants have come to the belief that no imprisonment will result from their wrongdoing, and that they will be simply called on to pay a small fine, which they can well afford to do, and immediately return from the courthouse to their offices. It is only a short time ago that my inspector secured the conviction of a quack who was practicing under the name of an advertising registered physician, where it was discovered that not only was the person examining and prescribing not a physician, but the alleged pharmacist who put up the physician's prescriptions, and was only an adjunct to the office of the doctor, was not a pharmacist at all, but a former ball player.

"I believe the profession looks on these quacks as, perhaps, the greatest menace to the public health to-day. The advertising midwives, while their advertisements are usually for an apparently lawful purpose, are well known to be wholly improper and criminal."

FOR UNION OF THE PROFESSION.

A special meeting of the Medical Society of the State of New York was called on Tuesday, October 13, 1903, to consider the communication from The New York State Medical Association to the Medical Society of the State of New York that a committee be appointed to promote unification of the two medical organizations in New York State. Dr. D. B. St. John Roosa presented the following preamble and resolutions, seconded by Dr. Willis G. MacDonald, and without discussion were carried unanimously:

WHEREAS, The New York State Medical Asso-

ciation, at a recent special meeting duly assembled, has, by unanimous vote, appointed a committee with full power to meet with the similar committee of the Medical Society of the State of New York to arrange for the unification of the two organizations under the corporate name of the Medical Society of the State of New York; therefore be it

Resolved, That the Committee of Conference of the Medical Society of the State of New York, already appointed, be given power equal to and commensurate with the powers recently granted the committee created by The New York State Medical Association for the purpose of unifying the two State medical societies into the Medical Society of the State of New York.

The joint Committee of Conference is now composed as follows:

For the State Association—E. Eliot Harris, chairman; Julius C. Bierwirth, Alexander Lambert, Parker Syms, Wisner R. Townsend.

For the State Society—Henry L. Elsner, chairman; A. Jacobi, A. Vander Veer, George Ryerson Fowler, Frank Van Fleet.

The ninetieth annual meeting of the Vermont State Medical Society was held at Bellows Falls, October 15th and 16th. William Watkins Seymour, of Troy, N. Y., a member of this association, read a paper entitled "Treatment of Effusions of the Chest and Their Consequences."

Book Reviews.

TUBERCULOSIS: Recast from Lectures Delivered at Rush Medical College, in Affiliation with the University of Chicago. By Norman Bridge, A.M., M.D., Emeritus Professor of Medicine in Rush Medical College; Member of the Association of American Physicians. Published by W. B. Saunders & Co., 1903. Cloth, \$1.50.

This little volume consists of a series of lectures delivered by the author to the students of Rush Medical College. It is not intended to be an exhaustive treatise on the subject, yet much of a practical nature is embodied in it. There is room for criticism in the author's classification of the various forms of pulmonary tuberculosis, but this is of minor consequence. The well-known views of the author on the value of securing rest for the affected lung by means of adhesive plaster strapping are clearly set forth. There is really very little new information to be found in the book, yet all of the well-known facts are stated in a pleasing and readable manner.

NERVOUS AND MENTAL DISEASES. By Archibald Church, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence in the Northwestern University Medical School; Late Professor of Neurology in the Chicago Polyclinic; Neurologist to St. Luke's, Wesley, Mercy and Chicago Hospitals; Consulting Neurologist to the Home for Destitute Crippled Children, Chicago, etc., and Frederick Peterson, M.D., President of the State Commission in Lunacy, New York; Chief of Clinic, Department for Nervous and Mental Diseases, Columbia University; Instructor in Mental Diseases, Columbia University; ex-President of the New York Neurological Society; General Consultant to the Craig Colony for Epileptics. Published by W. B. Saunders & Co., 1903. This is the fourth edition of this work. It has been

thoroughly revised and the subjects brought up to date in every particular. The subject of intermittent limping, now definitely known to depend upon a lesion of the posterior root ganglia, and herpes zoster have been given a section each. Another addition is the discussion of that form of epilepsy marked by myoclonus, furnishing the so-called combination disease. Further importance has been given to symptomatology and systematic disturbances, and the diagnostic value of astereagnosia and of Kernig's Sign has been elaborated.

The book consists of some 900 pages, with 338 illustrations. The typographical work is excellent and the paper good. The binding is well done and should be lasting. Not only do we recommend this work to those interested especially in these diseases, but also to every physician who desires to be broad-minded in his profession.

TEXT BOOK OF OBSTETRICS. By J. Clarence Webster. W. B. Saunders & Co.

If any one should say that he has read this book without admiration I would not believe him. So far as my personal opinion is concerned this work has been read from cover to cover with not only admiration, but with interest and with a little regret. Admiration is aroused by the good, clear, pithy common sense; by the condensed style, by the calm reasoning of the author, by the excellent work of the artist, and by the good taste of the printer and binder.

Interest is awakened by the outside view of obstetrics. It is so different from the standpoint of New York. Different often, but not always better. Regret begins with the title, "A Text Book of Obstetrics."

Now, a text book should be so clear that the student must understand it, and the very best way to test a text book is to take a certain portion and try it on some students. The treatment of puerperal eclampsia was selected. It may be imagined what ideas were conveyed by the following sentence: "Rectal administration of chloral is used by many authorities in addition to chloroform." One student had just been studying the administration of ether per rectum. Then, again, hot packs, rectal irrigation and various hyriatic measures are recommended. Not a word about temperature or technique, and the normal salt solution is advised, one pint every five or six hours, by the bowel. Two quotations from other authors may not be amiss. "Familiarity with technical details is as important to the skilful and effective application of water in disease, as it is in the technique of surgical procedures."—S. Baruch.

"At least two gallons, preferably six to eight gallons of water at 110° to 115°, give the best results."—R. Kemp.

No, it is not a text book, but it is most valuable to the practitioner. The only real fault seems to be that the author knows so much more than he tells that he gives the reader credit for more knowledge than a student possesses.

If, however, the book is over the student's head, it is exactly suited to the man in the heat and burden of the day. Possibly the idea is "strong meat is not for babes," and one student made the criticism that the book was "too meaty."

BOOKS RECEIVED.

THE PRACTICE OF OBSTETRICS. Designed for the use of students and practitioners of medicine. By J. Clifton Edgar, Professor of Obstetrics and Clinical Midwifery in the Cornell University Medical College, Attending Obstetrician to the New York Maternity Hospital. With 1,221 illustrations, many of which are printed in colors. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

TEXT BOOK OF THE DISEASES OF THE EYE. For students and general practitioners of medicine. By Howard F. Hansell, A.M., M.D., Clinical Professor of Ophthalmology, Jefferson Medical College; Professor of Diseases of the Eye, Philadelphia Polyclinic; Ophthalmologist, Philadelphia Hospital; Consulting Ophthalmolo-

gist, Chester County Hospital, etc., and William M. Sweet, M.D., Demonstrator of Ophthalmology, Jefferson Medical College; Assistant Ophthalmic Surgeon, Jefferson Medical College Hospital; Assistant Ophthalmologist, Philadelphia Hospital; Associate in Ophthalmology, Philadelphia Polyclinic; Consulting Ophthalmologist, Phoenixville Hospital, etc., with chapters by Christian R. Holmes, M.D.; Casey A. Wood, M.D., D.C.L.; Wendell Reber, M.D.; with 256 illustrations, including colored plates. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, ophthalmology, dermatology, otology, rhinology, laryngology, hygiene and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U. S. A., with the collaborations of William Osler, M.D., Baltimore; John H. Musser, M.D., Philadelphia; James Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; Thomas M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume III, Thirteenth Series. Philadelphia: J. B. Lippincott Company, 1903.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK FOR THE YEAR 1903. Published by the society, 1903.

NOSE AND THROAT WORK FOR THE GENERAL PRACTITIONER. By George L. Richards, M.D., Fellow of American Laryngological, Rhinological and Otological Society; Fellow of American Otological Society; Associate Editor of "Annals of Otology, Laryngologist and Rhinology"; Otologist and Laryngologist, Fall River Union Hospital, Fall River, Mass. Price, \$2. Published by the International Journal of Surgery Company, New York.

A MANUAL OF THE PRACTICE OF MEDICINE. Prepared especially for students. By A. A. Stevens, A.M., M.D., Professor of Pathology in the Woman's Medical College of Pennsylvania, Lecturer on Physical Diagnosis in the University of Pennsylvania, Physician to the Episcopal Hospital and St. Agnes' Hospital, Fellow of the College of Physicians of Philadelphia. Sixth edition, revised and enlarged. Illustrated. Philadelphia, New York, London: W. B. Saunders & Co., 1903.

THE FOUR EPOCHS IN A WOMAN'S LIFE. A short study in hygiene. By Anna M. Galbraith, M.D., author of "Hygiene and Physical Culture for Women," Fellow of the New York Academy of Medicine, ex-President of the Alumnae Association, Women's Medical College of Philadelphia; Attending Physician, Neurological Department, New York Orthopedic Hospital and Dispensary. With an Introductory Note by John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania. Second edition, enlarged and revised. Philadelphia, New York, London: W. B. Saunders & Co., 1903.

MODERN SURGERY, GENERAL AND OPERATIVE. By Chalmers Da Costa, M.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia; Surgeon to the Philadelphia Hospital and to St. Joseph's Hospital, Philadelphia. Fourth edition, rewritten and enlarged, with 707 illustrations, some of them in colors. Philadelphia, New York, London: W. B. Saunders & Co., 1903.

TRANSACTIONS OF THE CONNECTICUT MEDICAL SOCIETY. This volume of 460 pages contains the proceedings of the 111th annual meeting of this society. It contains a list of the 700 members of the society, together with thirty-six original papers. These papers are for the most part of a high order, and do credit to the State that has always stood in the front rank of American medicine.

REPORT OF THE TREASURER.

To the Council and Fellows of The New York State Medical Association.

Dear Sirs—I have the honor to present the annual report of Dr. E. H. Squibb, the late treasurer, whose resignation did not take effect until after the books of the year were closed. I also present a supplementary report of assets and liabilities, dated October 15, 1903.

It gives the treasurer great pleasure to congratulate the Association upon the excellent financial showing, and to bear testimony to the manner in which Dr. Squibb performed his duties. His books are marvels of neatness, and an expert accountant has verified all the vouchers and footings, and found them correct in every particular. The Association owes a debt of gratitude to the Doctor for his untiring efforts in its behalf.

Respectfully submitted,

WISNER R. TOWNSEND, Treasurer.

The New York State Medical Association, in Account with E. H. Squibb, Treasurer,
for the Year Ending September 30, 1903.

Dr.		Cr.	
To Business Office expenditures.....	\$2,444.50	By Arrears and dues collected.....	\$8,936.00
“ Treasurer’s Office expenditures.....	537.81	“ Interest on deposits and bank collection charges advanced, etc., credited to the Treasurer’s Office.....	19.98
“ Legal Department expenditures.....	59.65	“ Commission received for obtaining members for the American Medical Association.....	120.10
“ Committee on Arrangements expenditures.....	553.42	“ Initial dues overpaid through Dr. Dodin, treasurer Fifth District Branch Association.....	3.00
“ Committee on Legislation expenditures....	78.93	“ Clerical work, Business Office for districts and counties.....	58.68
“ Committee on Library expenditures.....	333.00	“ Loan.....	500.00
“ Journal account expenditures.....	3,756.67	“ Balance salary advertising agent returned.....	22.50
“ Directory account expenditures.....	5,624.79	“ Styles & Cash credit, for reason of overpayment.....	14.25
“ Interest transferred to Building Fund....	146.60	“ Journal advertisements.....	2,121.93
“ Storage on old transactions expenditures..	205.00	“ Sale of Journals.....	9.80
		“ Sight draft protest repaid.....	1.64
		“ Directory advertisements, 1902-1903.....	887.00
		“ Sale of Directories, 1901-1902-1903.....	999.25
“ Balance.....	725.55	“ Interest on Building Fund mortgage.....	73.12
		“ Balance brought over October 1, 1902.....	698.67
	\$14,465.92		\$14,465.92

E. H. SQUIBB, Treasurer.

Examined and found correct, October 10, 1903.

F. C. TOWNSEND, Certified Public Accountant, 31 Nassau street, New York.

JULIUS C. BIERWIRTH, }
WISNER R. TOWNSEND, } Auditors.

EXPENSES OF THE BUSINESS OFFICE.

Rent for rooms, arrears for 1902.....	\$50.00
Rent for rooms (share) for 1903.....	84.00
Fire insurance (share).....	20.00
Telephone service (share).....	67.29
Printing, stationery, etc., for the President...	294.88
Printing, stationery, membership certificates, etc., for the secretary.....	339.72
Printing, stationery, etc., for districts and counties.....	396.96
Printing, stationery and other incidentals for office proper.....	377.15
	\$1,630.00
For salaries.....	814.50
	\$2,444.50

EXPENSES OF THE TREASURER’S OFFICE.

Loan returned.....	\$500.00
Interest paid on same.....	2.08
Reprints of Article X of the By-Laws.....	2.25
Refund overpayment on dues of three members	3.00
	\$507.33
Direct working expenses of the Office.....	30.48
	\$537.81

EXPENSES OF THE LEGAL DEPARTMENT.

For legal services.....	\$50.00
For printing.....	9.65
	\$59.65

EXPENSES OF COMMITTEE ON ARRANGEMENTS.

Expenses paid for 1902 meeting.....	\$458.70
On account of 1903 meeting.....	94.72
	<u>\$553.42</u>

EXPENSES OF COMMITTEE ON LEGISLATION.

Mr. Cuyler, services at session of 1903.....	\$35.00
Printing and clerical work.....	43.93
	<u>\$78.93</u>

EXPENSES OF COMMITTEE ON LIBRARY.

Arrears for rent of rooms.....	\$25.00
Rent of rooms for 1903 (share).....	248.00
Fire insurance (share)	60.00
	<u>\$333.00</u>

DIRECTORY ACCOUNT.

On account of publication of Directory for 1902,	\$3,212.73
On account of compilation of Directory for 1903	1,542.75
Rent for rooms for 1903 (share).....	84.00
Cost of delivery, 1902 issue.....	259.99
Telephone service (share).....	56.40
New typewriter.....	110.00
Printing, stationery and other incidentals.....	388.92
	<u>\$5,624.79</u>
Total expense.....	\$5,624.79
Total receipts.....	1,886.25
Cost	<u>\$3,738.54</u>

OLD TRANSACTIONS ACCOUNT.

For storage of old transactions, arrears.....	\$100.00
For storage of old transactions for 1903.....	105.00
	<u>\$205.00</u>
On storage packed in boxes October 1, 1902,	
3,516 volumes.	
On storage packed in boxes October 1, 1903,	
1,782 volumes.	

EXPENSES OF THE COMMITTEE ON PUBLICATION—JOURNAL ACCOUNT.

Total expense of publishing the Journal.....	\$3,487.12
Rent of rooms for 1903 (share).....	84.00
Printing, stationery and other incidentals.....	185.55
	<u>\$3,756.67</u>

Total receipts..... 2,121.93

Cost \$1,634.74

BUILDING FUND.

Building Fund account, October 1, 1902.....	\$3,621.80
Interest received on mortgage.....	73.12
Interest received from savings bank.....	13.50
	<u>\$3,708.42</u>

Distributed as follows:

Investment in real estate mortgage.....	\$3,250.00
Investment in savings bank.....	458.42
	<u>\$3,708.42</u>

The present outstanding bills unpaid are:

Printing bill for September Journal.....	\$194.72
For storage on old transactions.....	30.00
Small bills to the amount of.....	99.38
	<u>\$324.10</u>

Bills due, but not yet in treasurer's hands:

Printing bill for October Journal and incidentals.	
Publisher's bill for Volume V of the Directory, to be issued October 10, 1903.	

E. H. SQUIBB, Treasurer.

SUPPLEMENTARY REPORT, OCTOBER 15, 1903.

ASSETS.

Cash in Long Island Trust Company.....	\$725.55
Cash in Lincoln Trust Company	
General Fund.....	98.37
Building Fund.....	531.54
Cash in Business Office.....	159.63
Bills receivable, advertisements in Journal....	256.97
Bills receivable, advertisements in Directory..	377.50
Bills receivable, orders for Directory.....	125.00
Bills receivable, dues in arrears, \$510.	
Building Fund, bond and mortgage.....	3,250.00
Inventory, office furniture and card catalogues, cost \$1,434, less 25 per cent.....	1,075.50
Library, over 10,000 volumes, original cost estimated by an expert librarian, \$30,000.	
*Directory, 1903, 800 copies unsold.	
State Transactions, 1,782 copies unsold.	
New York State Journal of Medicine, 1,000 copies unsold.	
Total	<u>\$6,600.06</u>

*Not yet delivered to the Association by the printers.

LIABILITIES.

Volume V Directory bill, not yet in treasurer's hands, as contract is not yet fully completed, estimated	\$3,000.00
Bills to October 15th, not due until November 1st, estimated	300.00
Bills of Entertainment Committee for meeting October 19th, estimated.....	200.00
Salaries	32.00
Total	<u>\$3,532.00</u>

WISNER R. TOWNSEND, Treasurer.

Original Articles.

PRESIDENT'S ADDRESS¹.

The Past and Present Needs of the Medical Profession.

BY FREDERICK HOLME WIGGIN, M.D.

Members and Guests of The New York State Medical Association:

AS your presiding officer it now becomes my pleasant duty to address a few remarks to you, and as the By-Laws of our Association require that at the meeting of the Council and Fellows the president shall report on the condition and needs of the Association, it seems to me fitting that at what may prove, in view of the probability of the amalgamation in the near future of our two State bodies, to be an epoch in the history of our profession, that some thought should be given to the needs of our profession as a whole, and for this reason I have chosen as the subject for my remarks, "The Past and Present Needs of the Medical Profession," and it will be my endeavor to contrast as briefly as possible the conditions that prevailed during the latter part of the eighteenth century with those of our own time.

Dennis, in an article entitled "The Achievements of American Surgery," calls attention to the fact that at the beginning of the Revolutionary War there was only one medical book, three reprints and twenty pamphlets by American authors; hence, it is not surprising to find that medical men in this country were at that time realizing their need for further intercourse with their fellow physicians, and had begun to bring this about in the only way that at that time was possible—namely, by the organization of societies, whose chief object was the discussion of practical and scientific medical subjects.

The first of these societies to be formed, whose organization has been continuous to the present time, was the Litchfield County Medical Association, organized in 1765, and of which the speaker was formerly president for several years. It is interesting to note that in initiating this movement American physicians were in the lead, as has often been the case in the past, for, according to Sir Victor Horsely, the first English medical society, the Leicester, formed for the discussion of practical and scientific medical topics, was not organized until 1800.

In this country the movement spread rapidly, and before the dawn of the nineteenth century we find that many of these new organizations, realizing the weakness of their independence, and also that in union there is strength, and that larger annual gatherings of medical men would afford opportunities for wider and fuller discussion, joined forces and organized State medical societies. According to Davis, these societies were formed in the following order: That of New Jersey in 1776, and in incorporated by the Legis-

lature in 1790; that of Massachusetts in 1781; that of New Hampshire in 1791; that of Connecticut in 1792; that of South Carolina in 1797, and the Medical Chirurgical Faculty of the State of Maryland in 1799. These several societies were, according to the same authority, sanctioned by acts of incorporation by the Legislatures of the several States in which they were located, "Their avowed objects being the promotion of friendly intercourse, the advancement of medical science, and the support of the usefulness and honor of the medical profession."

A few years later, in 1806, the members of the profession of this State, following the example of their brethren in the States already named, organized the Medical Society of the State of New York, the Society receiving a charter in that year from the Legislature of this State.

As has been stated, the chief object of these organizations in their formative period was the promotion of practical and scientific medical knowledge; but soon after the organization of the State societies some of them became more or less identified with the body politic, the Legislatures having given them the right to judge of the qualifications of and to grant licenses to practice to those physicians who desired to settle in their respective territories.

The development of the medical society in this country was largely limited to county and State bodies until 1846, when, at the request of the Medical Society of the State of New York, many of the existing medical societies, feeling the necessity of strengthening themselves by a union into a national organization, for the avowed purpose of raising the standard of medical education, sent delegates to a conference held in New York in May of that year, the result of which was the organization in Philadelphia, a year later (1847), of the American Medical Association, there being present representatives from a large majority of the permanently organized societies of the country.

As a result, undoubtedly to some extent, of these efforts to organize the profession for the discussion of practical and scientific medical questions, the achievements of American physicians began to make a lasting impression upon the world, and Dennis, in the course of the article already referred to, which was published in 1892, states that "When the nineteenth century dawned upon us in the long list of brilliant men who had made the surgery of the world famous the name of no American appeared upon that honor scroll; but from colonial days down to the present time the names of Americans shine forth in bold relief. * * * Who can estimate the value to mankind of the introduction of anesthesia and the conception and development of ovariectomy, to say nothing of the other medical discoveries which have been made by members of the medical profession of this country?"

In the meantime the country was developing, and the population and wealth were increasing at

¹Read at the Twentieth Annual Meeting of The New York State Medical Association, October 21, 1903.

a rapid rate, and it was but natural that under these conditions and the ease with which charters for medical colleges could be procured from the Legislatures of the various States, there should come the establishment in ever-increasing numbers of medical colleges. Davis states in his book entitled "The History of Medicine," that at the beginning of the nineteenth century there were only four medical colleges in the United States—namely, the medical schools of the University of Pennsylvania, Columbia, Harvard and Dartmouth colleges, the total number of graduates annually from these schools averaging less than forty. By 1850 the number of medical schools had grown to forty, and the average number of graduates annually, had risen to 1,000; while, as has already been stated, the early colleges were parts of universities, the later ones were proprietary institutions, and, according to Davis, were without pecuniary endowments, and consequently dependent upon the fees of students for their support. "An active competition for students began," continues Davis, "based not on an effort to see which college could give the most full and systematic courses of instruction, but rather which could confer the degree of M.D. at the least cost to the student of time and money. Under these conditions and tendencies the annual courses of medical college instruction were progressively shortened from six months, as required by the first colleges, to sixteen weeks or less, and all semblance of a requirement of suitable preliminary education was omitted." By thus nominally studying medicine three years the student could obtain a diploma, entitling him to practice, in an easier and more economical way than by studying with a preceptor for four years and then passing an examination before the censors of a county or State society."

The increased facilities for the dissemination of medical knowledge and the low standard of medical education required between 1840-1880 attracted large numbers of persons to the ranks of the profession, many of whom were but ill-prepared for their lifework. Under these conditions it is not to be wondered at that as time went on it became necessary for the State societies to relinquish the important privilege of granting licenses to practice and to seek for the establishment of State boards of medical examiners to pass on the qualifications and to grant licenses to physicians wishing to practice in their respective localities. The loss of the licensing privilege, coupled with the increased ease with which medical literature could now be obtained, manifested itself in the lessening importance to the individual physician of the county and State society, as shown by the gradual falling off of the ratio of their membership to that of the total number of physicians.

At the same time that the importance of the older societies was diminishing the unfortunate overproduction of physicians began to show itself in many ways, among which was the for-

mation for various reasons of many new organizations; one reason for which was that the plan of organization of the older society often allowed the control of it to rest in a few hands. Then followed a period of time during which the medical profession became weakened and disorganized.

The resulting discord was all the more disastrous to our profession because during this same time all other bodies of individuals having like purposes and engaged in similar pursuits were busy forming compact organizations for their own benefit and protection; in other words, outside of our ranks, the individual was being displaced as a unit by the organization.

During this same time, however, various efforts were made with more or less success, and especially in this State, to elevate the standard of medical education, but the unfortunate effects produced by the overcrowding of the profession, aided by the lack of foresight on the part of the medical leaders of the last half of the century, in splitting up the profession into numerous small and comparatively unimportant bodies, have of late years manifested themselves in many ways, but in none more markedly than in the growing evil at the present time, of contract practice in lodges and societies, contracts being made, it is said, to treat whole families for \$2 a year, the frequency with which unjust malpractice suits are being brought against reputable physicians, the grave existing abuse of medical charity, and the general lack of respect and influence accorded our profession as a whole. In connection with this subject, the following statement, made by a recent writer, is of interest.

"A physician can be Prime Minister of France or a Governor of Cuba, but not President of the New York City Board of Health."

The speaker, as well as other members of the Association, was made aware of the condition of the profession several years ago as a result of investigations made in connection with efforts to suppress the abuse of medical charity, and it seemed clear that the time had come when a new departure in medical organization must be made in this country, in order that our profession might be gathered into one fold and that through strong and powerful organizations, county, State and national, our profession might be placed in the near future in a proper position to look after its own interests and to regain and maintain the social position and influence to which it is justly entitled. The necessity for a change in the form and attractiveness of existing medical organizations, if it is desired to unite the members of our profession in a few strong and united societies, is made still more evident when it is recalled that, according to Simmons, there are about 77,000 physicians in the United States who are not at present members of any existing medical organization.

Sir Victor Horsely, in a recent paper, has well said: "Organizations, medical or otherwise, are

purely temporary; their only purpose is to meet the needs of the moment, and when those organizations fail to keep pace with the natural evolution of the circumstances under which we have to live, it is quite clear that we ought to reconstruct the various machines that we have in operation."

In the paper already quoted from, Sir Victor Horsely divides the requirements of the profession at this time under two heads—namely, social and scientific; and under the social requirements are placed the right to practice, defense from unjust attacks, and the enforcement of our rights by the prosecution of illegal physicians. Under scientific he says: "In order that we may practice our profession properly we require meetings for the discussion of practical and scientific medical subjects, and we require above all a system for the rapid diffusion of knowledge."

Before considering what must be done in order to remedy the existing evils, it is well to recall at this time that the primary causes of the various ills from which our profession is now suffering were the establishment by individual physicians during the nineteenth century of large numbers of medical colleges, having little or no capital or endowment, the competition between them for students resulting in the lowering of the standard of medical education, and this lowered standard in turn resulted in the graduation of large numbers of physicians, many of whom were but poorly qualified for their lifework. This in time led to the shameful abuse of medical charity, the great growth of contract practice in lodges and societies, frequent malpractice suits against physicians, the competition of illegal physicians and the publication of large numbers of journals, which are published solely for the purpose of making money from the sale of advertising space to all comers.

Fortunately for all concerned, at the present time, for various reasons, the medical colleges which are not departments of universities are rapidly disappearing.

Efforts are now being made on all sides to elevate the standard of medical education, and in connection with this subject the following statement made by President Eliot in his annual report to the Board of Overseers of Harvard College for 1901 is of interest:

"In the higher education of America there is no more important question than this: Shall the professional schools of the universities continue to be open to uneducated persons or persons of very slight education, or shall they all require for admission a preliminary degree in arts or science? Private-venture schools with low requirements for admission, or none, might still continue to exist. The important question is: What should the universities do in this matter? Harvard University has definitely determined to pursue the policy of requiring for admission to its professional schools a preliminary degree, and has already applied this policy to its schools." A further statement is made that since this policy was put into effect a

striking improvement in the work of the professional schools has become evident. "It stands to reason that much better instruction can be given to a class composed exclusively of college graduates than to any class in which there are many persons of inferior training. Since the wise and efficient conduct of American affairs, commercial, industrial and public, depends more and more upon the learned and scientific professions, the universities owe it to the country to provide the best possible preparation for all the professions. This best possible preparation can only be given to young men who, up to their twenty-first year, have had the advantage of continuous and progressive school and college training."

Sooner or later all universities of standing will undoubtedly adopt this same policy, and the result will be very beneficial to both the public and the medical profession, even though for a time the number of physicians who graduate annually would be somewhat lessened. Much benefit would result if the medical colleges would furnish lectures to their students, especially those of the first year, on the history of medicine and on the principles of ethics, as such instruction would tend to make the students more loyal to their profession and higher-minded in their relations with others. This was pointed out many years since by Dr. J. W. S. Gouley, who, in his review of Flint's book, entitled "Medical Ethics and Etiquette," said: "The rules of conduct adapted to the peculiarities of medicine constitute medical ethics. These rules have a moral weight. It would be a fortunate thing for the profession if medical colleges would establish a professorship of history of medicine and of medical ethics."

From what has been stated, it is evident that if we are in the near future to succeed in organizing the medical profession of this State and country into bodies of sufficient strength to look after their own interests and those of the public, we must in the first place be careful in the selection of our form of government.

The following statement in connection with this subject is of interest. Dr. Charlton T. Lewis, before the National Convention of Municipal Ownership, said: "The business of government involves the supervision of private actions and of private business, with just so much control of them as will prevent them from encroaching unjustly on other private actions and private business. It must prevent wrong, punish crime, suppress all nuisances."

The form of government for such an organization as we have in mind must be democratic in character, and one easily controlled by the majority. And as the first medical organization in this country was, as we have seen, a county association, so must the unit and important factor in our twentieth-century organization be the county society, which must be made the door of entrance and exit to all the higher bodies. These units must be grouped together through representatives into a State body, chartered by the Legislature, but of

which every member of a component county society shall, however, be a member, and entitled to all of its privileges, excepting that of voting on its business affairs.

It will be necessary for the State Association to see that all properly qualified physicians in its territory, who desire to do so, have the right to practice their profession; it must look after the public health, and it must be wise and powerful enough to prevent the further demoralization of the public by reason of the abuse of medical charity, and to accomplish this sooner or later the organization must insist on provision being made by those in control of public institutions, hospitals and dispensaries for compensation to physicians for professional services rendered to those unable to care for themselves. It must discountenance contract practice at ruinous rates. It must defend its members from unjust attacks relative to their professional honor and standing. It must, in order to prevent injustice being done to its members, have rules of conduct for the guidance of the committees on ethics and discipline of its component societies. It must establish circulating medical libraries and a bureau of information for the benefit of its members, as well as to make provisions for a death-benefit fund for their dependents. It must see that State laws regulating the practice of medicine are properly enforced. As has been said with much truth:

"It is well enough known that public officials in American States and cities are not remarkable for their ability or their inclination to make themselves work by taking the initiative in new undertakings. It has been pointed out by students of public affairs, and with special reference to municipal administration, that nearly all the reforms which have been accomplished up to date, and which have proved worth while, have been initiated by private or voluntary agencies—by citizens, either individually or organized in citizens' committees or associations, who are not paid for being reformers, and who often find it even a thankless task."

For the purpose of properly keeping its members up with the times in professional matters, it would be necessary for these various organizations to have meetings at short intervals at which separate sessions are held for the political and business parts, and for the discussion of practical and scientific medical topics; and in order that the members of these societies may be encouraged to do the best literary work of which they are capable, it is absolutely necessary that it be published, experience having shown that criticism and publicity are the greatest incentives a physician can have to do the best work of this kind of which he is capable. Hence it is necessary that the organization should have its own journal.

In order that the organization may carry on its work properly provision should be made for an ample annual income, as well as for a proper initiation fee. An organization such as has been described would require an office and a sufficient

force of clerks and stenographers to enable its business to be transacted in a prompt and orderly manner. In this office should be kept on file a brief medical history of all physicians residing within the State, in order that it may be easily known by the officers who are and who are not legally qualified physicians. This information can be utilized for the benefit of all of the members, by publishing it from time to time, in book form, as the members of our Association are well aware.

The State bodies, as herein suggested, must in turn be united through their representatives into a national organization, holding a special charter from the national Government, in order that dignity and importance may be added to our profession, and also that the national organization may have the right to finally and legally transact its business in any State where its meetings are held.

Nothing is more needed at the present time in a national way by the members of our profession than a national practice act, or, at least, medical reciprocity between the various States of this country, which would allow a physician who has been licensed in one State to legally practice in any other State of the Union.

The organization must be powerful enough to insist on our profession having a representative in the President's Cabinet; it must look after the health of the nation; it must see to the remedying of the abuse of the copyright law, which has of late years been very much abused by manufacturing pharmacists, who, instead of patenting their preparations, have been selling them largely under a copyrighted name, thus escaping the provisions of the patent law, requiring that a copy of the formula of their preparations be filed in the Patent Office.

Among the many abuses by individual members of our profession which must be rectified is that of freely prescribing medicines of unknown composition, a practice which is frequently indulged in at the present time. In an article on this subject, entitled "The Objections to Prescribing Medicines of Unknown Composition," by Prof. A. A. Eshner, of Philadelphia, the following statement is made:

"From the foregoing considerations it must be clear that the prescription of medicines of unknown or concealed composition is unscientific, unprofessional, unfair if not prejudicial to the sick, unprogressive and unstimulating, and, most of all, unnecessary.

"The remedy for the existing state of affairs is in the hands of the medical profession. The manufacturing pharmacists will not make preparations that they cannot sell, and if physicians will not permit the creation of an artificial demand for illegitimate preparations, and will cease to prescribe them, the manufacturers will soon discontinue their production. To this end it is the duty of all medical men having the interests of their profession and their patients at heart to confine

themselves to the employment only of such drugs or combinations of drugs whose composition is of public knowledge, and, further, is vouched for by some recognized authority."

The National Association, with its larger income, should supplement the work of its component State societies by publishing and distributing to the members a weekly journal, and it should from time to time publish a national medical directory, the data for which should be furnished without expense by the State organizations. Then the advantage to the profession of a well-ordered series of united societies, county, State and national, would be almost incalculable. There are also great dangers to be guarded against, the greatest of which would seem to be the possibility of the members of the various governing bodies, through inattention to their duties, allowing a well-organized minority to control the majority, and to manage the organization for their personal benefit rather than for the benefit of the medical profession. Abuse of political power, when it is obtained, must be carefully guarded against. Our organizations must be ordered, as President Roosevelt recently well said, in referring to our Government, with a "view never to wrong the weak, and never submitting to injury from the strong," and, in order that this may be done, we will need to select for our officers medical statesmen who will study the needs of the members, individually and collectively, and when they have found them, will endeavor to supply them. It is also necessary that the individual members should be taught to have greater personal regard and sense of responsibility for each other than they have had in the past.

It is said that "Cabet, the great socialist, when criticized because a book of his on Socialism contained no scientific theory of it, replied, 'If we are asked, What is your science? we answer, Fraternity; What is your principle? Fraternity; What is your doctrine? Fraternity; What is your system? Fraternity.'"

It has been my endeavor during the course of these remarks to show that the evils from which our profession is at present acutely suffering are the results of mistakes made by our predecessors, who sowed the seed, with the result that we are now reaping the whirlwind. It remains for us to find and apply the remedy, and it is the belief of many that a long step in advance has just been taken by the agreement of The New York State Medical Association and the Medical Society of the State of New York to join hands and form an organization worthy of the 12,000 physicians of the Empire State.

In closing I cannot do better than to leave in your minds the thought so well expressed in the words of Anne Reeve Aldrich:

I made the cross myself whose weight
Was later laid on me.
This thought is torture as I toil
Up life's steep Calvary.

To think mine own hands drove the nails;
I sang a merry song,
And chose the heaviest wood I had
To build it firm and strong.

If I had guessed—if I had dreamed—
Its weight was meant for me,
I should have made a lighter cross
To bear up Calvary!

ANNUAL ADDRESS OF THE PRESIDENT TO THE COUNCIL AND FELLOWS.¹

BY FREDERICK HOLME WIGGIN, M.D.

Members of the Council and Fellows of The New York State Medical Association:

NOTWITHSTANDING the recent action of our Association and that taken by the Medical Society of the State of New York, at their special meetings, in appointing Committees on Union, with power to arrange the details of the amalgamation of the two organizations, which must of necessity include a new constitution and by-laws, I have deemed it best to carry out the provision of our By-Laws defining the duties of the presidential office, compliance with which requires me to make a report to you upon the condition of the Association, and what in the light of experience its needs for the future seem to be. But, before doing this, allow me to express to you my sincere appreciation of the confidence which you have shown in me, by placing the supervision and management of the affairs of the Association in my hands during the past year, as well as the honor you have done me in making me your presiding officer at this, our annual meeting. I also desire to express my appreciation of the efforts to advance the interests of the Association made by the members of the Council and of the committees during the past year, and, in addition, I desire to thank those individual members of the Association who have aided me during my term of office by promptly and kindly complying with my various requests.

CONDITION OF THE ASSOCIATION.

The past year has been in many ways a most prosperous one for the Association, as is shown by the large number of new County Associations which have been organized since our last annual meeting, due largely to the efforts of the energetic president of our Fourth District Branch, Dr. Josiah William Morris, our component County Associations now numbering 35, as against 21 last year, an increase of 14. The growth in popularity of our organization with the physicians of this State as they have become better acquainted with its purposes is evidenced by the numerical increase in our membership, the names of 372 physicians having been added to the list of our active members, in addition to which we have restored to the list the names of 60 of our former members, who have made good their in-

¹Read at the Twentieth Annual Meeting of The New York State Medical Association, held at the New York Academy of Medicine, October 19, 1903.

debtedness, making a gross increase for the year in our active membership list of 432. Twenty-three of our members have joined the "majority" during the past year, as follows: Drs. George Beers, E. Miller Cameron, Jean F. Chauveau, Walker Curry, David Franklin, William C. Gallagher, Marcus K. Goldsmith, Isaac Newton Love, Robert Newman, William S. Whitwell, of New York City; John Byrne, Alexander Demby, Susan R. Pray, Earle Eugene Woolworth, of Brooklyn; Dwight S. Chamberlain, of Lyons; William C. Fritz, Buffalo; John Gillespie, Jr., Warrensburg; J. Ernestine Hills, Willard; Daniel B. Howard, Warrensburg; Jacob M. Kraus, Buffalo; Charles W. Piper, Wurtsboro; Monroe T. Pultz, Standfordville; Adam T. Van Vranken, Albany. Fifteen of our members have resigned and two have removed from the State. We must, therefore, deduct 40 from the gross increase, giving a total number of 1,757 active members. There are, unfortunately, included in this number the names of 95 members whose dues for 1903 remain as yet unpaid; at least they have not yet reached the State treasurer, and in accordance with the By-Laws, Article X, Section 4, if settlement of their indebtedness is not made by them before the close of our meeting, the officers of the Association will be obliged to drop their names from the roll of members, in which case the total number of active members, on which to base our representation in the American Medical Association, would be 1,662, which will entitle us to four members of the House of Delegates of the American Medical Association next year.

INITIATION FEE.

By some it has been thought that the change in our By-Laws, made at our last annual meeting, in regard to the dropping of the initiation fee, was the cause of the large increase in our membership which has taken place this year; but that this is not the case is evidenced by the fact that while the abolition of the initiation fee went into effect October 23, 1902, the large increase in our active membership which has taken place did not begin to manifest itself until the change in Article II, Section 7, referring to the defense of suits of alleged malpractice brought against members of this Association, had been spread broadcast, about March 1st, throughout the State. From this it would appear to be for the interests of the Association, if it is to continue as an entity, that the initiation fee be restored, for it seems only fair that when a physician wishes to join an association, having tangible assets, derived from funds and work, contributed by his predecessors, that he, desiring to share in this property, should in turn contribute something of value to the organization, besides the annual dues, in return for which he receives direct compensatory advantages. In addition to this ethical view of the matter, the payment of the initiation fee tends to prevent members from carelessly giving up their membership. Several times during

the past year members of the Association have stated to me that they thought that they would not pay their dues for 1903, but would resign, as they could easily rejoin at any future time without loss to themselves.

RECEIPTS.

The receipts of the Association, while less than those of last year, have still been adequate to meet the needs of the organization, and to enable us to carry forward a small balance to next year, after paying our legitimate expenses. Had not the By-Laws relating to the initiation fee been changed, the receipts would have been \$1,860 larger than they were.

Since the Association announced, about March 1st, through its officers, its readiness to comply with Article II, Section 7, "to assume the defense of suits of alleged malpractice brought against members of the Association," we have been called upon to defend in this way or aid in the defense of eight of our members. In the majority of these cases the plaintiff has dropped the suit as soon as it became known that our Association had taken up the matter and was ready to fight, showing the wisdom of the organization when it adopted the plan of looking after the personal interests of its members. For the successful carrying on of this part of the work the thanks of the Association are due to James Taylor Lewis, Esq., our Counsel, for his conscientious and faithful work, as well as for the liberal terms on which he undertook it.

JOURNAL AND DIRECTORY EXPENSES.

The question has frequently been asked of the officers of the Association why the Committee on Publication did not procure a sufficient number of advertisements to make the JOURNAL and the *Directory* self-supporting. In reply it is only fair to state that it is because the present committee, as well as former committees, have been sufficiently wise and high-minded to take the lead in the matter of ethical advertising, and have endeavored to accept only notices of "drugs or combinations of drugs whose composition is of public knowledge, and, further, vouched for by recognized authority." In connection with this subject a letter was recently received from a prominent and respected member of our Association, which is of interest: "We of New York can glory in the deficit of the *Directory* and JOURNAL of our Association, if it is the price of being clean and ethical. We can't be bought simply to show a profit for the year's advertising, and in time this will be recognized."

INCREASE IN MEMBERSHIP.

One of the chief needs of the Association, if it is to continue, is a large accession of new members who are willing to take an active interest in its affairs, thus preparing themselves for the important duties of official Association life. It would be a simple matter for each one of our 1,757 members to induce a personal friend to join

our organization during the year if he would but make the effort, thus easily doubling our membership, which would result in lasting good to the Association.

REVISION OF BY-LAWS.

There is need for the appointment of a committee to study and revise our By-Laws, in order that they may be harmoniously adjusted, as some of the changes made in various sections at our last annual meeting, apparently through an oversight, are in conflict with other sections relating to the same subject, and it should also be the duty of this committee to make the By-Laws conform, as far as practicable, to the Constitution and By-Laws for State societies, promulgated by the Committee on Organization of the American Medical Association. I would also respectfully suggest to such a committee, if its appointment should be authorized, the wisdom of changing the ratio of Fellows of the State Association from one in every ten of our membership to one for each one hundred, each County Association, however, having at least one representative. At the reorganization of our Association in 1900 the ratio of representation of Fellows to membership was fixed at one in ten because it was at that time the basis of the representation of the American Medical Association. The reason why this suggested change would be of benefit is that it has been found impracticable to find the needed number of members sufficiently interested in the Association's affairs to be willing to sacrifice the time and money necessary to attend to the duties of their office, by being present at the meetings of the Council and Fellows; another advantage of the proposed change would be that it would serve to increase the importance of the smaller County Associations, while diminishing somewhat that of the larger ones, making it more difficult than it is at present for the members of the larger component organizations to control the Association. Much confusion would be avoided in our list of members, as published in the annual volume of the *Directory*, if, when a member temporarily leaves the State for a year or more, his name was transferred at once to the list of non-resident members, the name being restored to the active membership list upon his return, without any other formality than his notifying the secretary of his Association of that fact.

NOMINATIONS.

A change should also be made in the By-Laws allowing the nominations for officers to be made by members of the Council and Fellows from the floor in addition to those made by the Nominating Committee.

I would also earnestly advise this committee to consider carefully the amending of the By-Laws so as to restore the initiation fee, as the change made last year abolishing it has made a difference, as has already been stated, in the receipts of the Association during the past year of something like \$1,860.

COLLECTION OF DUES.

One of the chief difficulties met with by the officers in the carrying on of the work of the Association is the irregular manner in which members still pay their annual dues, caused in part by the manner in which the treasurers of our County and District Branch Associations send out their bills. It would seem wise, in order to obviate this difficulty, to change the By-Laws, so as to allow of the reversal of the order of collecting these dues authorizing the State treasurer to collect all dues of the State, District Branch and County Associations, it then being his duty to transmit that portion of the money collected belonging to the local organizations to their treasurers on the first of each month. This work could easily be performed by the State treasurer without an undue amount of personal labor, as the clerical work could then be done under his supervision at the business office of the Association. This change would undoubtedly save the treasurers of the local societies a great deal of annoyance and work, and this is of importance, as they are busy men, already overburdened with their professional work. This change in the collection of dues would also enable the members to receive their annual certificates of membership much more promptly than is often the case at present.

DELINQUENTS.

In order that errors and omissions may be avoided in the published list of the forthcoming volume of the *Medical Directory*, it would be wise to provide for the publication in THE NEW YORK STATE JOURNAL OF MEDICINE, in the June number of each year, of the list of names of those members whose names are not at that time on the treasurer's books as having paid their annual dues.

NEEDED LEGISLATION.

I also desire to call the attention of the Committee on Legislation to the necessity of procuring a law requiring those bringing suits against physicians to be classed as infant suitors, and that they be compelled to give a bond, as unjust suits of this kind are generally brought by irresponsible persons.

The Committee on Legislation should further a law forbidding the practice of refraction by opticians. Under the Massachusetts laws those "opticians who advertise themselves as eye specialists are convicted of practicing medicine."

The following resolution is offered at the suggestion of Dr. Harry Hartshorne Seabrook:

Resolved, That the Committee on Legislation be requested to further a law making it a misdemeanor, punishable by fine or imprisonment, for men not graduates of medicine to advertise themselves as eye specialists, or for sellers of glasses to sell any pair of correcting lenses to persons when they are not able to raise the vision of each eye of the purchaser to 20/xxx Snellen except by the order of a legally qualified physician."

At the last meeting of the American Medical Association both the Ophthalmological Section

and the House of Delegates adopted a resolution concerning the examination of school children's eyes and ears, and it has been requested that The New York State Medical Association pass a resolution along the following lines:

"WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures, therefore be it

Resolved, That it is the sense of The New York State Medical Association that measures be taken by boards of health, boards of education and school authorities, and that needed legislation be secured, looking to the examination of the eyes and ears of all school children, that disease of these organs in its incipency may be discovered and corrected."

NATIONAL INCORPORATION FOR THE AMERICAN MEDICAL ASSOCIATION.

I would also respectfully advise that a resolution favoring national incorporation for the American Medical Association, along the following lines, be passed at this time:

"WHEREAS, It is the belief of The New York State Medical Association that reincorporation of the American Medical Association under a national charter would elevate the position and increase the dignity of the medical profession of this country, therefore be it

Resolved, That the American Medical Association be hereby requested to make application through its committee to Congress for a special charter permitting the Association to hold property and to meet anywhere within the territorial limits of the United States; and be it further

Resolved, That the members of the House of Delegates of the American Medical Association, representing this Association, are hereby instructed to favor and vote for such national incorporation for the American Medical Association, and the secretary is hereby instructed to forward copies of these resolutions to the president, the secretary and the chairman of the Committee on National Incorporation of the American Medical Association."

In connection with this subject, an editorial which appeared in the *New York Evening Post* on October 12th of this year is of interest. In the course of this editorial Judge Grosscup, of the United States Circuit Court is reported to have stated that "in his opinion a national incorporation law would be constitutional." While the right to incorporate companies is not one given to Congress by the Constitution, the Judge's opinion seems to be based "on the power of Congress to regulate interstate commerce; also on the fact that the power of incorporation was never in dispute at the Constitutional Convention; that in the right to enact a National Bankruptcy law the Central Government wields as drastic a power and one analogous to it; that the exercise of the incorporation by the several States might be called abso-

lutely and totally contradictory to a proper exercise by the nation of the power to regulate interstate commerce, for practically all companies do an interstate business. Canada, under this last principle, has practically asserted the right of national control over corporations. The Canadian Constitution no more gives that power specifically than does ours, but the Dominion Government has gradually assumed this power, in spite of the protest of the provinces."

The following letters received in connection with this matter, and which have already appeared in THE NEW YORK STATE JOURNAL OF MEDICINE, are of interest:

MAY 1, 1903.

My Dear Doctor—Your favor of the matter of a national incorporation for the American Medical Association at hand.

I should think such action would be desirable as a matter of policy for the Association if a national charter can be obtained. It is still an open question, I think, whether Congress has the power to grant charters under a national law.

There has been considerable discussion of this question for the past two or three years and in which eminent lawyers have disagreed. This discussion has been in the line of remedies for trusts. It has been maintained by some that an amendment to the Constitution would be necessary before action could be taken.

I think, however, that Attorney-General Knox is of the opinion that Congress already has sufficient power. I have never seen where he stated this in so many words, but I should regard it as a fair inference from what he has said while discussing the control of trusts.

The mere fact that such charters have been granted makes a strong presumption in their favor, but it is not conclusive, as Congress, like our State Legislature, sometimes passes laws which are afterward declared unconstitutional.

It is my own opinion that Congress now has such power. It has granted charters to railroads. One railroad was incorporated to build from Texas to the Pacific Coast, with authority to have an office in Philadelphia. It got into the courts of this State through the attempt to tax its property here on the ground of being a foreign corporation. Our courts held that, being incorporated by the General Government, it was not a foreign corporation, as it would have been if it had been incorporated by a sister State.

I apprehend that you would have trouble at this time to get such a charter. At least, there would be opposition on the ground of general policy. I think we are going through a transition period at this time so far as concerns the powers to be lodged in the General Government. Our expansion policy and laws about trusts are now bringing this matter to the front and are giving the General Government a somewhat different trend than it has maintained for the past twenty-five years or so.

To grant a charter to an association of the

standing of the American Medical Association would attract attention and would be deemed an important step in the general policy of the Government and it would be opposed on that ground.

I believe, however, that now is a favorable time to make such an attempt, if it be thought advisable.

However, the little State of Delaware will now give you almost any kind of a charter that you want, with the right to hold meetings and do business where you please.

(Signed) _____

NEW HAVEN, Conn., March 28, 1903.

Dear Wiggin—Your letter and enclosure received and read with care. I have been unable to see Judge Baldwin, but communicated with him by telephone, and he says that "The American Social Science Association has a special charter, which *will allow* it to hold meetings *anywhere* in the United States." He says that "any national association can petition for a *special* charter, and if there is a little influence can get one at Washington, which means that it need not comply with the laws of the District of Columbia or any other territory, and that such special charter can easily be legislated through by a man of influence, and a few influential doctors could make this go through Congress very easily, which *would then allow us to have an official regular annual meeting in whatever State the annual session was held.*"

Yours sincerely,

(Signed) OLIVER T. OSBORNE.

PHYSIOLOGIC AND THERAPEUTIC ACTIONS OF ALCOHOL.¹

BY ALEXANDER LAMBERT, M.D.,

New York.

WHEN the painstaking researches of modern scientific work bring out new facts on old subjects it is worth our while to reconsider our ideas and, if necessary, to rearrange them. I have, therefore, chosen the present subject for my inaugural address this evening. The use of alcohol in medicine is so widespread that the subject will be of interest to all, and an accurate idea of the physiologic effects will be of use to us in considering how and when to use it in our daily work. The toxic action and its pathologic results are too familiar to need any mention, and will therefore have no place in this paper. It is only the result of small, non-toxic doses in healthy persons that we will consider, as its physiologic action and the effects of therapeutic doses in its relation to disease. I think that most of us were taught that alcohol in moderate doses was a cardiac and arterial stimulant, increasing the force and frequency of the heart's action, and simultaneously by dilating the capillaries increased the flow of blood through them; that it was a cerebral stimulant; a stomachic; by many considered a tonic; that it was a food, supplying energy though

not stored up in the body; that it was a retarder of tissue changes, restricting waste and checking the secretion of nitrogen. There have recently appeared some new experiments and critical reviews of the whole subject which I think must force us to change some of these views. A most scholarly monograph by Rosenfeld, entitled "Der Einfluss des Alcohols auf der Organismus," and the experiments and critical reviews of the subject by Prof. R. H. Chittenden, Dr. John J. Abel and Prof. W. O. Atwater, in the report of the Committee of Fifty, entitled "The Physiological Aspects of the Liquor Problem," are those especially referred to, and they will repay a careful study. Meanwhile, I offer you a review of these monographs.

Let us consider first the action of moderate doses on the heart and circulation. On the heart itself, when all outside influences are removed and proper precautions have been taken against local irritation and movements of the body, in healthy subjects, alcohol in such amounts as are likely to be found in the blood in any condition far short of intoxication, does not show any appreciable action on the heart itself, either in the way of stimulation or depression. In very large quantities, as in helpless intoxication, alcohol is a direct and powerful cardiac depressant, weakening first the auricular and then the ventricular systole, causing more or less distension of both cavities, marked slowing of the movements and great diminution in the output of blood. Experiments on the pulse-rate confirm the above cardiac action, and we find that here also, when proper precautions were taken against local irritations and movements of the body, alcohol in moderate doses caused no increase in the pulse-rate, either in the case of unfettered animals or in man. This statement seems to hold good both for those accustomed to its use in moderation and also for abstainers. Many observers have, however, taken an opposite position, but careful consideration of their experiments will show that no precautions were taken to eliminate the influences of extraneous irritations or bodily movements. In its action on the vessels themselves alcohol in small and moderate doses has no direct action on the walls of the blood vessels, and it has in these doses no appreciable effect on the arterial blood pressure. When a change in this pressure is observed it is in the direction of a fall and not of a rise, and follows large dosage. For the action of alcohol on the circulation we must look to its action on the controlling nervous mechanism. The flushing of the face seen after moderate, or even small, doses takes place before there is much or any lowering of the blood pressure. It is only in a later stage, when the abdominal arteries are widely dilated, that a marked depression of the arterial pressure occurs. Kobert has shown that alcohol in moderate doses has no dilating action on the walls of the vessels, and Gutnikow has made it evident that even large doses do not paralyze the peripheral terminations of the vaso-constrictor

¹Inaugural address of the President of The New York County Medical Association, read at the stated meeting, New York, October 19, 1903.

nerves situated in the walls of the arteries, but that alcohol works through its depressant action on the vaso-constrictor centers in the medulla, their reflex excitability being decidedly lowered by fairly large quantities. But this depressant action on the nerve centers is only demonstrable when *large* doses of alcohol are administered, and consequently does not explain the primary flushing of the skin which is seen after small or moderate doses. It is evidently due to some action on the nervous system, but no depressant action on the vaso-motor centers can be shown when small doses are employed. It is usually assumed that some such action does occur, which is too small to lower their excitability in response to experimental tests. It is interesting to note that the same difficulty is encountered in explaining the vasodilation of amyl nitrite and nitroglycerine. Durdufi concludes from his experiments that these drugs neither depress the vaso-constrictor centers nor stimulate the vaso-dilator centers at a time when they cause considerable vascular dilatation. To explain the action of these two drugs he is obliged to fall back on the hypothesis that they annul the effect of the normal stimulus, whose action on the opposing nerve centers of the circulation is to maintain a normal blood pressure and an average caliber of the vessels. To the absence of this normal or physiological stimulus he ascribes the effects of amyl nitrite, such as the dilated vessels and the lowered blood pressure.

Meltzer, on the contrary, believes that the flushing of the skin "is due to either a stimulation of the vaso-dilators, or an inhibition of the tonus of the vaso-motor center; in either case it is the effect of stimulation of a normal function, and not a paralysis of a function." Meltzer further emphasizes the fact that under the action of alcohol the blood pressure is not the main consideration, but the change in distribution of the blood. The amount of blood remaining the same, when there is a vaso-dilatation of the peripheral vessels there is a corresponding vaso-constriction of the vessels of the splanchnic area. The blood pressure measured at this time will show no change, nor will it show the change in the distribution of blood.

We have so far been considering the action of alcohol on healthy individuals. That it will act the same in disease does not necessarily follow. Some recent work of Richard C. Cabot, of Boston, is interesting in this connection. He summarizes his results as follows: "In 41 patients, mostly cases of typhoid fever, 1,105 measurements of the blood pressure were made before, during and after the administration of alcohol in therapeutic doses. Neither the maximum nor the minimum blood pressure showed any variations that could reasonably be referred to the action of alcohol. So far as was determined by the methods and in the cases used in this research, the action of alcohol upon the circulation

was nil." The same neutrality and apparent inertness of therapeutic doses of alcohol were observed in relation to the pulse-rate of 309 patients suffering from a great variety of diseases. The results of observations of the action of alcohol on the circulation in disease agree with those made on healthy individuals, and we must therefore give up our previous ideas that alcohol is a direct cardiac or circulatory stimulant.

In considering the action of alcohol on the respiration, we must consider whether it stimulates the respiratory center directly or whether it is only an indirect stimulant, causing an increase in the intake of O₂ only because of increased demand in the tissues. Rosenfeld concludes that while the depth of respiration is undoubtedly increased, and more so in fatigued than in non-fatigued individuals, the intake of O₂ and output of CO₂ are not essentially increased. It, therefore, is only a purposeless exertion of the respiratory apparatus that is caused by alcohol. Abel's summary is slightly different, and is as follows: Alcohol is a respiratory stimulant of moderate power for human beings. During a period of an hour or more after its administration it causes an increase in the volume of air passing through the lungs and in the absorption of oxygen (3.5 per cent.). Highly flavored wines, brandy and other alcoholic beverages which contain large amounts of stimulating esters have a more pronounced action than ethyl alcohol. The stimulating action of alcohol and of alcoholic beverages is greater in the case of fatigued persons than in those who are in nowise exhausted. Increased heat dissipation always accompanies the above-named effects. The compensatory increase in heat production requires an increase in the oxidative processes of the tissues. The increased demand for oxygen is the direct cause of the increased activity of the respiratory center. Small or "purely exciting" doses of alcohol have also the effect of increasing the movements of the digestive tract and of causing a state of unrest and tension in the skeletal muscles, and thus further adding to the demand for oxygen. According to this view alcohol is an indirect stimulant of the respiratory center. It should be borne in mind that these physiological effects are less pronounced in man than in animals. Binz, on the other hand, believes that alcohol is a direct respiratory stimulant, acting on the nervous centers, this being most noticeable in men who were fasting or fatigued. Cabot, in noting the changes in respiration produced by alcohol, found that in 309 persons suffering with various diseases the respiration was raised over 4 periods in 24 cases, lowered over 4 periods in 30 cases and respiratory rate the same in 255 cases. Alcohol, therefore, as a respiratory stimulant in disease in human beings can be of but little use.

Digestion is both a process of secretion, chemical action and solution and also of absorption. In studying the effects of alcohol on digestion all the different processes must be separately con-

sidered. Beginning with secretion, we find that alcohol and alcoholic fluids, when introduced into the mouth, stimulate the flow of saliva and also the concentration and amylolytic power of human mixed saliva. This is purely a local reaction and necessarily of short duration, as it ceases when the alcoholic fluid is swallowed. Alcoholic fluids, when introduced directly into the stomach, do not reflexly or through the circulation stimulate the salivary flow. Upon gastric secretion alcohol and alcoholic fluids have a marked effect, increasing very greatly both the flow of gastric juice and also its content of acid and total solids, giving a gastric juice of strong proteolytic action. Further, this action is exerted not only by the presence of alcoholic fluids in the stomach, but also indirectly through the influence of alcohol absorbed from the intestine. Thus ordinary ethyl alcohol introduced into the empty stomachs of dogs with the duodenum ligated shows a marked stimulating action upon gastric secretion—as compared with the action of water under like conditions—increasing not only the volume of gastric juice very greatly, but also its acidity, content of solid matter, etc. Moreover, alcohol absorbed from the intestine, the latter being entirely shut off from the stomach, may likewise cause stimulation of the gastric glands, with a marked increase in the rate of secretion, etc. Whisky, brandy, sherry, claret, beer and porter all agree in producing stimulation of gastric secretion. Any direct influence of alcohol on the pancreatic or intestinal secretions must be small, because of the rapid disappearance of alcohol from the stomach by absorption through its walls. That the absorption of alcohol is rapid is well shown by the work of Chittenden and his associates, for in one experiment 50 c. c. of a 20 per cent. solution of alcohol were introduced into the stomach, and on withdrawing the stomach contents half an hour later no alcohol whatever was found in the 40 c. c. of fluid obtained; 200 c. c. of a 37 per cent. alcohol were introduced into the stomach with the duodenum ligated at the pylorus, and after three and a half hours less than 8 per cent. of the alcohol remained. Ogata states that when 6-8 grams of alcohol are taken into the stomach in the form of wine and beer 80-90 per cent. will disappear from the alimentary tract inside of half an hour. Considering next the action of alcohol on the chemical processes of digestion, Chittenden has found that pure absolute alcohol has no very marked influence on the digestion of farinaceous foods by the saliva. With active saliva not greatly diluted the presence of even 5 per cent. of absolute alcohol may lead to a slight increase in digestive power. Large quantities cause retardation of amylolytic action, but even 10 per cent. of absolute alcohol produces only slight retardation, hardly recognizable in the solvent action of the saliva, but showing in the amount of reducing sugar formed. Strong alcoholic beverages, as whisky and brandy, do not materially

retard salivary digestion; when present to the amount of 5 per cent. they may even stimulate amylolysis. The inhibition of amylolysis by these beverages is out of all proportion to their alcoholic content, and is due to the presence of volatile acid reacting bodies. Wines and malt liquors show a powerful inhibitory influence upon salivary digestion, due almost entirely to their acid properties. The influence of alcohol on the chemical action of gastric juice is nil when present in 1 to 2 per cent. Not until the digestive mixture contains 5 to 10 per cent. of absolute alcohol is the action of the gastric juice materially interfered with. In the presence of 15 to 18 per cent. of absolute alcohol digestive action may be reduced one-quarter, or even one-third. The extent of retardation by a given percentage of alcohol varies greatly with the strength or activity of the gastric juice. The weaker the gastric juice the greater is the inhibitory action of a given amount of alcohol. The action of whisky, brandy, rum and gin, ordinarily containing from 40 to 50 per cent. of absolute alcohol, is practically in ratio to their alcoholic content. The possible presence of so-called fusel oil in whisky cannot modify the action of this beverage on the gastric juice. The higher alcohols, characteristic of fusel oils, tend to increase the solvent action of the gastric juice when present in small amounts, and it is only when present in far larger amounts than would be possible when introduced as impurities in whisky that they show any decided inhibitory action. Sherry and clarets cause an inhibitory action on gastric proteolysis out of all proportion to the alcohol present, due to the solid matters contained in the wine. White wines of the Hochheimer type, containing about 11 per cent. alcohol, in small amounts tend to increase the rate of digestion, while in larger amounts, as 10 per cent., they have a slightly retarding effect, due almost wholly to the solid matters rather than to the alcohol or other volatile substances. With malt liquors, such as ale, lager beer, bock beer, stout and porter, having content of alcohol ranging from 1.5 to 5.5 per cent., the experiments lead to the conclusion that in small quantities they are without inhibitory influence on the digestive power of the gastric juice; small amounts show a tendency to slightly increase the rate of digestion. In larger amounts they give rise to an inhibition of proteolysis which is entirely unconnected with the small amounts of alcohol present, but directly traceable to the comparatively large amounts of extractives they contain.

Although the effect of alcohol is very marked on the chemical action of the pancreatic juice when tested *in vitro*, in life there seems to be but little chance that alcohol, when consumed in moderate amounts, reaches the digestion in the small intestine. We have seen the alcohol is too rapidly absorbed to have much effect on this form of digestion. Pancreatic juice, however, in its proteolytic action is more sensitive to pure

alcohol than gastric juice, 2 or 3 per cent. of absolute alcohol being sufficient to produce a distinct retardation of proteolysis. There are acid substances in brandy and rum, and especially in whisky, which cause small amounts of these beverages to have a detrimental action on the proteid digestion of the pancreatic juice, so that their action is out of proportion to the alcohol they contain. The acid clarets and white wines have a similar effect, and are more inhibitory than sherry, though the last contains twice their amount of alcohol. The solid and extractive matters in the malt liquors likewise exert an inhibitory action upon the pancreatic proteolysis, though far less pronounced than that exerted by wines. Many non-alcoholic beverages exert a similar effect, such as tea and coffee, and ginger ale may produce as great an inhibition of pancreatic proteolysis as a corresponding proportion of lager beer or Bass' ale. The amylolytic ferment of the pancreatic juice being similar to the salivary enzyme is affected the same, as we have seen in salivary digestion. In summing up the effect of alcohol on the digestive processes, we have an algebraic sum to consider. First, an increase of secretion due to alcohol; then, if the alcohol be present in sufficient amounts, a retardation of the chemical processes; but as the alcohol is rapidly absorbed this inhibition is removed, and again the reflex secretion into the stomach of a strongly acid and active gastric juice, and an increase in rapidity and power of digestion. In the mouth while the alcohol is present an increase in flow and improvement in the composition of active saliva. The stimulation and inhibition, therefore, tend to neutralize each other, so that the ultimate result is not materially modified from the normal. If the amount of alcohol consumed is not sufficient to cause inhibition of the chemical processes, a single dose of most alcoholic beverages may fairly be thought to improve the digestive processes. This is true for single doses, and not repeated consumption, for after the repeated consumption, as shown by experiments with gastric fistulæ, the secretory processes seem to be blunted and a diminution in the digestive processes takes place. It must also be remembered that with weak digestive juices the effects of alcohol are correspondingly increased in their inhibitory effects on the proteolytic action. Cabot, in his clinical observations, found that, in 294 cases, the food was taken better after alcohol in 64 cases, less well in 18, and the same as before the alcohol in 212 cases. Judging from the condition of the tongue he found it the same as before the alcohol in 213 cases, better in 42 cases, worse in 20, and moister and more coated in 6 cases.

Judging from the effect of alcohol on the absorption of food from the intestines, Rosenfeld compares the nitrogen outgo in the feces in certain metabolism experiments in which the income in the food and the output in feces and urine were accurately measured. He concludes that alcohol

produces a varying effect, sometimes increasing the absorption and sometimes diminishing it. He inclines to the belief that the influence of alcohol disturbs rather than aids intestinal absorption. This is undoubtedly true of toxic doses, but the experimental facts at our disposal when moderate doses were used show that there is a slightly greater absorption with alcohol than without it. This is more noticeable of the proteids than of the other nutrients. This is shown only of persons in health, and gives no indication of the action in people in whom the digestive powers are weakened.

Among the most interesting experiments yet performed are those of Atwater on the nutritive value of alcohol. In the completeness of their conception, and in the accuracy of their detailed execution, they have never been equaled. It is impossible in this paper to give the details of their methods; suffice it to state that the subjects of the experiments were healthy young men, two total abstainers and one used to alcohol in moderation. The amount of alcohol given in any one day was 72 grams in six doses, three with meals and three between meals, so that the effect of alcohol as a drug was never felt by any one of the subjects, except one at one time reported a slight tingling in the ears, so that the important difference of alcohol as a drug and alcohol as a food replacing an isodynamic amount of fats and carbohydrates was never lost sight of. The subjects remained day and night for a varying number of days in a copper-lined chamber, called a respiratory calorimeter. The total income of O_2 , H. C. and N. was accurately calculated of the air, water and food which went in to the subjects, and the total outgo of CO_2 , H. C. and N. in air and excreta from the subjects was also carefully computed. The temperature of the chamber was uniform, and the amount of heat generated accurately measured. In the rest experiments the subjects made no more exertions than were necessary for their existence, and in the work experiments the muscular work done was on a stationary bicycle, connected with a dynamo, so that the friction of the pedals and the energy expended were transformed into heat by an electric lamp, and were accurately measured. The total income and outgo were thus accurately measured in calories, or heat units, and the loss or gain of body weight, variations in body temperature, pulse, etc., were also noted.

The results of the inquiry are considered under the following heads: The effects of alcohol upon digestibility of food, which we have just mentioned; the proportion of alcohol oxidized and unoxidized; the effect upon the elimination of carbon dioxide and the consumption of oxygen; the metabolism of the energy of the alcohol; the protection of body fat and protein by alcohol; its effect upon the radiation of heat from the body and changes in body temperature; the rapidity of oxidation of alcohol in the body; and, finally, alcohol as a source of heat and of muscular energy.

The question of the amount of alcohol oxidized in the body has been answered with unusual unanimity by most observers. A few of the French experimenters have held that it was not oxidized, but was excreted unchanged; this conclusion has long since been disproved, and the more careful the experiments made the less has been the amount found of unoxidized alcohol excreted. Atwater has found that the amount of alcohol given off from the body ranged from 1.3 per cent. to 3.7 per cent., averaging in thirteen experiments 1.9 per cent. Hence it would seem that about 98 per cent. of the alcohol taken in moderate doses in health is oxidized in the body.

Two opposing theories have been held regarding the effect of alcohol on the consumption of oxygen and the production of carbon dioxide in the respiration, one theory being that alcohol prevented the normal action of oxygen in the body, and thus reduced the production of CO_2 ; the other being that the oxidation of carbon was increased, and with the production of carbon dioxide. The more recent experiments show that it is certain that the amount of CO_2 and O_2 after alcohol is not increased at all or only to a trifling amount. The former differences of opinion were due to a failure to appreciate that alcohol is oxidized in the body the same as the carbohydrates, fats and protein, and that the body uses its fuel as its needs require for warmth or work. Hence the quantity of O_2 used or of CO_2 given off in the respiratory products may be increased or decreased in a wholly natural way.

In studying the metabolism of the energy of alcohol and comparing the daily increase and outgo of energy with or without alcohol, we find when the diet contained no alcohol the total energy of the proteids, fats and carbohydrates burned in the body averaged 2,718 calories per day, and was thus practically identical with the energy which was given off by the body as heat or heat and (the heat equivalent of) external muscular work, and averaged 2,723 calories per day. When alcohol formed part of the diet the total energy of the proteids, fats and carbohydrates burned in the body, added to the energy of the alcohol, averaged 2,747 calories per day, and the energy given off as heat or heat and external muscular work averaged 2,752 calories per day. The total kinetic energy of outgo is equal to the total potential energy of income, whether it be with ordinary diet alone or with ordinary food and alcohol. The conclusions are therefore: 1. That the law of the conservation of energy obtained with the alcohol diet as with the ordinary diet. 2. That the potential energy of the alcohol oxidized in the body was transformed completely into kinetic energy, and appeared either as heat or as muscular work, or both. To this extent, at any rate, it was used like the energy of the protein, fats and carbohydrates of the food.

The belief that alcohol has a specific action in retarding the metabolism of the body material,

both fat and proteid tending to prevent waste, was formerly quite generally held, and is to-day a widespread opinion. The most recent experiments abroad, performed in many laboratories, as well as the experiments of Atwater, show conclusively that alcohol always protects the body fat, and is as efficient in this regard as the fats and carbohydrates of the food which it replaced. In respect to its protection of the body protein its effect is somewhat different. Sometimes it can and does protect the proteids, at other times it seems to cause an increased disintegration of these. Atwater's conclusions regarding his experiments express this most clearly, and the reviews of Roseman and Rosenfeld coincide with his views. The conclusions are as follows: 1. That the power of alcohol to protect the protein of food or body tissue, or both, from consumption is clearly demonstrated. Its action in this respect appears to be similar to that of carbohydrates and fats; that is to say, in its oxidation it yields energy needed by the body, and this saves other substances from oxidation. In this way alcohol serves the body as food. Just how moderate quantities of alcohol compare with isodynamic amounts of sugar, starch and fat in the power to protect protein from katabolism is not yet settled. Apparently it is in some cases equal, in others inferior, to these substances. It is by no means certain that the fats and carbohydrates are always equal to each other in this power. 2. Alcohol appears also to exert at times a special action as a drug. In large quantities it is positively toxic, and may retard, or even prevent, metabolism in general and proteid metabolism in particular. In small doses it seems at times to have an opposite influence, tending to increase the disintegration of protein. This action, though not conclusively proved, is very probable. It offers a satisfactory explanation for the occasional failure of alcohol to protect protein, the assumption being that the two tendencies counteract each other. The only justification for calling alcohol a proteid poison is found in this disintegrating tendency. This pharmacodynamic action of alcohol appears to be temporary and most apt to occur with people little accustomed to its use. The circumstances under which such action occurs cannot now be fully defined.

That alcohol in toxic doses increases the radiation of heat from the body has long been recognized as a fact, and in drunken persons exposed to cold, temperatures of 5 degrees or 6 degrees or more below normal have been observed. But in healthy men moderate doses only cause a slight fall, usually less than half a degree. In Atwater's thirteen experiments with and thirteen without alcohol, in which the number of calories taken in and given out are carefully measured, we find that with three different men, at rest and at work, in whom 72 grams of alcohol per day, taken in six doses and furnishing 500 calories of energy replaced the

isodynamic amounts of fats and carbohydrates, the alcohol caused no increase in the amount of heat radiated from the body.

The opinion that alcohol is more rapidly oxidized in the body than other substances as carbohydrates does not seem to be substantiated by experimental proof. In Chauveau's experiments on dogs, in which the dogs received rations containing meat, sugar and alcohol and were put to work on a treadmill shortly after, and the determinations of carbon dioxide exhaled and oxygen used were made, the respiratory quotients implied that carbohydrates, either glycogen or sugar, were the chief material burned during the one or two working hours. The respiratory quotients for the remainder of the day implied that the larger part of the alcohol was burned during the ten hours next succeeding the working period. In Atwater's experiments, three series of experiments in which the alcohol diet and ordinary diet are compared, and the evolution of heat for hourly periods noted between 7 P. M. and 7 A. M., there are no more irregularities or indications of disturbance in the alcohol than in the non-alcohol experiments. The night hours were chosen because the evolution of carbon dioxide and heat is much more regular by night than by day, and thus the more rapid oxidation of alcohol, if it occurred, would be more readily detected. From this it would seem that moderate doses of alcohol are not more rapidly oxidized than other fuel substances, and that the body uses what is most economical for its needs.

The question now arises, Is alcohol a source of heat to the body when oxidized? In the rest experiments the heat given off from the body was equivalent to the total potential energy of the materials oxidized. This was as true in the experiments in which alcohol made part of the diet as in those with ordinary food exclusively, hence alcohol must have contributed its full quota of heat as truly as did the starch or fat, and all its potential energy was converted into heat within the body. The same principle applies in the work experiments, and unless all the potential energy of the alcohol was transformed into the energy of internal work in the rest experiments and into that of internal and external work in the work experiments, certainly an improbable hypothesis, part must have been transformed directly into heat in the body. The question whether or not the energy of alcohol is used for muscular work is not definitely settled. There is no evidence that there is a difference in the energy or heat derived from alcohol and from the other nutrients, but there is no proof that such difference does not exist. It certainly seems most probable that such energy for muscular work is derived from the alcohol, but for a detailed consideration of this point I must refer you to Atwater's discussion of the question. What is of practical importance to us is the expressed opinion that the utilization of the energy of the whole ration was slightly less economical with the alco-

hol than with the ordinary diet, especially when the subjects were at hard muscular work, but the difference in favor of the ordinary food was very small indeed, hardly enough to be of practical consequence. From this it follows that the energy of the alcohol was utilized very nearly or quite as well as that of the other fuel ingredients which it replaced. The difference here referred to was the difference in some work experiments between 3,668 calories metabolized with the ordinary, and 3,698 with the alcohol ration, a difference of 30 calories, or .8 per cent. If the whole deficit is charged to the alcohol, it would be 30 calories, or 6 per cent. of the 500 calories supplied by the alcohol; that is, calorie for calorie, the alcohol in this case would be 6 per cent. less effective than the fats and carbohydrates it replaced. Even with the small doses of alcohol in these experiments, it was noticed that there were indications that the subjects worked to a slightly better advantage with the ordinary rations than with the alcohol. The possibility here shown of alcohol in moderate doses furnishing energy for muscular work is a far different question from the desirability of alcoholic beverages as part of the diet for muscular labor. General observations and the results of practical tests on a large scale show such beverages to be of doubtful value and often harmful. The most carefully conducted experiments on the effect of alcohol on voluntary muscular action show that it increases the power of fatigued muscles, though it does not restore to them the same amount of power as they possessed before they were fatigued, and this restoration of power is only temporary, and is of short duration. It also lessens the sensation of fatigue; that is, it also acts here in some measure through the nervous system. To non-fatigued muscles it gives only a temporary increase in work done. Abel and many other observers deny that alcohol has any direct dynamogenic power for muscular tissue. The scientific conclusions coincide with what has long been known empirically. Alcohol will enable a brief spurt to be made, but it will not give sustained muscular power, and is followed by a depression of energy to below the normal. Last of all, in its physiologic action we come to consider the effect of moderate doses on the nervous system. According to Lusana and Albertoni, alcohol induces cerebral changes that can be studied when the dose reaches .4 parts per thousand of body weight; that is, 9 ounces of 10 per cent. wine for a person of average weight. But to many persons unaccustomed to its use such an amount would be far beyond the limits of moderation, and much smaller amounts will cause distinct changes, appreciable to the consciousness of those unaccustomed to its use. Several well-known pharmacologists, as Smiedeberg and Bunge, deny absolutely that alcohol has any stimulative effect on the cerebral centers, its primary action being depressant on certain higher and more easily

influenced brain processes. That the stimulation of emotions and faculties is fictitious and is but the inhibition by paralysis of higher functions. Kraepelin holds that in the early stages of its action alcohol truly stimulates the motor functions of the brain. But the best criticisms of Kraepelin's experiments do not consider that Kraepelin is justified in drawing such conclusions from the facts which he presents. Small doses of alcohol do seem to shorten the simple motor reaction time, but this may be due to the withdrawal of some inhibition and not a true stimulation. All reactions requiring nicety of judgment are dulled by even small doses of alcohol. It does not increase the quantity or vigor of mental operations; it clearly tends to lessen the power of clear and consecutive reasoning and decidedly lowers the acuteness of the several senses. "In many respects its action on the higher functions of the mind resembles that of fatigue of the brain; though with this action is associated a tendency to greater motor energy and ease." As Abel expresses it, "it tends to turn the inhibitive type of mind into the hair-trigger type."

7 Considering the physiologic action of alcohol as a whole, the weight of evidence shows that it is less of a stimulant and more of a narcotic than was formerly believed. It is not a cardiac stimulant, and its action on the circulation as a whole is that of changing the equilibrium of the existing distribution of blood. How this is accomplished can only be explained at present by more or less probable hypotheses. Therapeutically this effect on the circulation may be useful or not, depending on circumstances. In fainting attacks, in some forms of shock or collapse, when the pale, cyanosed appearance of the patient shows the blood is gone from the periphery of the body and is overfilling the vessels of the splanchnic area, alcohol acts quickly and advantageously by bringing an increased amount of blood to the brain, heart and skin and reducing the internal congestion. After exposure to cold, and in some forms of intestinal colic, it has a similar rapid and effective action. It has a useful narcotic action when sudden illness brings worry and distress to the patient. The euphoria produced by the alcohol is of advantage to the patient. The dual action of alcohol as a food and as a drug places it in its therapeutic consideration in a position by itself. This is especially true in its use in the infectious diseases. Many of us have seen some individuals in certain conditions of grave illness consume enormous amounts of alcohol with apparent benefit and not the slightest toxic symptoms, when under ordinary circumstances the same amounts would have produced the most profound intoxication. Atwater quotes the case of a patient of Dr. S. L. Abbot, of Boston. The patient was a young girl suffering from double pneumonia, who refused all other nourishment and medicine, and lived on a pint and a half of whisky a day for seven days, and

made a rapid and complete recovery. Dr. F. C. Shattuck, of Boston, reports a case of a boy 17 years old, unaccustomed to alcohol, who took, when sick with pneumonia, a bottle of brandy and two quarts of champagne in twenty-four hours, with no more toxic effects than from so much water. Runge is often quoted for the enormous doses of alcohol he gave to women suffering from sepsis. To one woman he gave 7 c. c. per kilo daily for seven days, and the patient recovered. When we consider that 7.8 c. c. per kilo is given as the fatal dose of alcohol, we appreciate the amount consumed by this woman with apparent benefit. These are but examples that doubtless can be duplicated in your own experience. It is in the infectious diseases that many of our best clinicians hold that alcohol is a benefit and cannot be replaced by any other substitute. Osler expresses it in saying: "We are still without the agent which can counteract the gradual influence of poisons which develop in the course of acute febrile diseases, such as typhoid and pneumonia, * * * the chief effect of which is exercised on the circulation, increasing the rapidity of the pulse and inducing a progressive heart failure. To meet this indication the general experience of physicians still points to alcohol as the most trustworthy remedy. Although some hold that alcohol in this condition is not indicated, I believe that it is, in many instances, the only remedy capable of tiding the patient over the most dangerous period." The experimental data obtained from infection in animals after alcohol has been administered cannot help us in forming a judgment as to the value of alcohol in infectious diseases, because in the experiments which have so far been made the dosage of alcohol has varied from 5 c. c. to 10 c. c. per kilo of body weight, which is so near or above the fatal toxic dose of 7.8 c. c. per kilo that it only proves that large toxic doses diminish the resistance to infection in animals as they do in man. That alcoholization in man reduces the resistance to infection is a firmly established fact, and generally acknowledged. But the use of alcohol after infection has occurred is the question under discussion. Ott has recently shown that alcohol protects the body proteins in fever and is as effective as the isodynamic amounts of carbohydrates. It therefore protects the body waste in disease as it does in health. The effect on the circulation, as we have seen, is probably to bring the blood from the splanchnic area and distribute it more abundantly in the peripheral circulation of the skin, central nervous system and heart. Meltzer advances the hypothesis that alcohol "in a certain dilution and at a certain stage, when in contact with the nerve cells, either directly stimulates preferably some of the normal inhibitory mechanisms of the body or increases their irritability. In consequence of this stimulation, the perception for finer differences becomes decreased, the reaction time is prolonged, the formation of associations and the irradiation of stimuli within the central nervous

system become restricted. Also, the tonicity of all the muscles is reduced, and the execution of motion is rendered difficult. While such changes are surely undesirable in health, they are very beneficial and desirable in sickness." These explanations of Meltzer, it is true, are hypotheses, but the weight of clinical evidence bears them out.

My personal belief is that many patients suffering from infectious diseases do not need alcohol, and are better without it; certain patients need it under certain conditions, and are benefited by it. It is also my belief, founded on clinical experience, that because a patient has been accustomed to alcohol is not a sufficient reason for its administration in infectious diseases. Many alcoholics suffering from pneumonia will do better and recover quicker if deprived of alcohol than if given it.

When all is said concerning the value under certain circumstances of alcohol as a food, its use as such certainly belongs to its therapeutic place in medicine and not to its use in every-day life. Atwater correctly says that its place as a nutrient is where the user is unable, because of either debility or disease, to otherwise obtain fitting and sufficient nourishment from ordinary food materials.

Clinical experience is the final proof of the value of alcohol in disease, and though this experience has caused a lessening in its employment, compared with former times, and scientific research has proved its field of usefulness to be more restricted than was formerly accredited to it, alcohol remains a useful and beneficial drug. Like all our best remedies, it is a poison, and in its therapeutic use this fact should never be forgotten. Its abuse and its toxic action are probably the most widespread phenomena that come in the experience of physicians, but that action of alcohol does not come within the scope of this address.

EXPERIENCE IN THE MEDICAL USES OF OXYGEN.¹

BY C. A. GREENE, M.D.,
Castile, N. Y.

OXYGEN is the most abundant and important of all the known elementary substances. A pure atmosphere is one-fifth free oxygen.

Priestly, a celebrated English chemist, succeeded, in 1774, in isolating and holding oxygen in a glass or metallic retort. This element was named oxygen from two Greek words, meaning sour and generate; because for a long time it was believed to be one of the constituents of all acids.

Ozone is really condensed oxygen, three molecules of the ozone occupying the space of two of oxygen; the same elements taking on an allotropic form, having sensible odor and highly stimulating properties. Ozone may be produced in highly electrical states of the atmosphere, as well as in the chemist's laboratory.

Oxygen enters largely into all chemical, vege-

table and animal structures and is contained in a greater or less degree in all minerals. Not long after Priestly's demonstration of the combination of oxygen in almost all material substances and its specific action as an aid to ordinary combustion, oxygen began to be considered a therapeutic agent. It was used as an inhalant, often in an impure state, and lauded as a wonderful secret remedy—almost a sure cure for serious forms of pulmonary disease. In several cases its unguarded and excessive use in advanced pulmonary affections, where organic changes had taken place, induced violent hemorrhage, with fatal results. These accidents occurring with persons of high rank, brought oxygen as a remedy into ill repute.

Oxygen has been difficult to procure, as it has been rendered unsafe by the presence of chlorine. Careful washing three times through a mild solution of potassa and then pure water obviates wholly all danger of this kind. The cheapest and most convenient substance for the production of oxygen is the potassium chloride, mixed with about one-eighth of its weight of manganese dioxide. It is necessary to pulverize these elements so they may be finely and evenly distributed together, avoiding in the grinding or trituration the evolving of heat by attrition. Upon the application of heat, potassium chloride, without admixture of copper or ferric oxides, or manganese dioxides, becomes easily fused and pasty in consistency, and in this stage refuses to yield up its oxygen. Undoubtedly the effect of the dioxide of manganese is to give molecular application of heat and prevent the fusion of the salt.

For the last fifteen years I have seen the most marked favorable results in the daily use of oxygen in cases of bronchial irritation, with heavy expectoration, and evident abrasion of the mucous linings of the larger tubes. This has occurred in some cases where the habitual circulation was above 90, running to 105 or 108 toward evening. With most of these patients there existed defective nutrition and assimilation, and consequent depressed condition of the nervous energies.

In such instances deficient action in the air vesicles is quite common, particularly in the middle and lower lobes of the right lung and the lower lobe of the left. We never fail to find a low condition of the nervous system, and a lack of good general innervation where there is deficient vesicular respiration from any cause whatever. It is quite clear to the most casual observer that full nervous vigor depends nearly as much upon free blood and brain oxygenation as upon the normal manufacture and abundant supply of the circulating fluids.

The first effect of oxygen seems to be to stimulate the vaso-motor nerve centers, and acting through the pneumogastrics to their peripheral terminals, to have a direct, mechanical and functional influence upon the air cells.

Where there is an undilatable condition of the air cells or obstruction of the larger and more minute bronchial passages, the earliest inhalation

¹Read at the meeting of the Wyoming County Medical Association, at Castile, N. Y., April 21, 1903.

of oxygen should be made very slowly, but with persistence. The oxygen should always be retained as long as possible. In the course of a quarter or half a minute, the oxygen will be so far absorbed that very little will be expelled during the succeeding expiration.

The air being entirely fresh in the inhaling-room, the patient should be directed to make ten full nasal respiratory acts between each inhalation of oxygen, breathing more deeply each time. The effort of inhalation of oxygen should be made a little more intently, firmly and decidedly, until from ten to fifteen full inhalations are taken. After the patient has acquired the power to fill the air vesicles fairly well, eight or ten inhalations will be quite sufficient at one sitting. Consecutive inhalations of the pure oxygen cause undue cerebral hyperemia, nervous excitation, too rapid stimulation of the pulmonary capillary circulation, and would, I think, under favorable conditions, easily produce hemorrhage.

Using oxygen in the manner described always leaves the patient quiet nervously and disposed to be restful. The circulation is not particularly quickened, but the radial artery always shows a more full, even and stronger pulsation after the inhalation.

Enforced nasal respiration during at least two hours of the day, in the open air, is always earnestly enjoined upon all patients showing pulmonary or nervous weakness. Strong, decided nasal respiration has much to do in stimulating free arterial and venous circulation through the brain. I know of nothing which so gives power to the vaso-motor energies and the entire respiratory apparatus and so certainly insures normal cardiac action as abundant oxygenation of the blood and brain.

It's a fact beyond question that congestion or inflammation is most likely to arise in those portions of the lungs, indeed in all the organs and tissues of the body, that are kept still. It is almost axiomatic that normal action is life and stillness is death.

Pure blood and the free flow of the blood in and out of each organ are necessary to its healthful, functional action. This is especially true of the brain and lungs, and nothing can more surely accomplish this than the free use of oxygen.

In congestion from ordinary colds and in the more or less severe forms of lobular pneumonia, I know of nothing more effective than the careful, persistent use of oxygen. In pulmonary congestion little can be done if there is obstruction of the portal, renal or hepatic systems of circulation. Engorgement or arrest of functional action in these localities must be resolutely overcome before we can secure good circulation through the pulmonary and cardiac blood vessels.

In the case of a lady 80 years of age, with renal and hepatic complications, whose recovery was the best I have ever known in so severe a case of double pneumonia, we administered the oxygen every two hours. At first with most persistent

effort the patient could use only five gallons a day, but after a few days was able to double the amount. From that time her recovery was rapid and very favorable.

With persons of sedentary habits of life there is often a partial suspension of respiration from nervous preoccupation, resulting in scanty brain oxygenation. This gradually leads to neurasthenic conditions. Undue brain activity from intense currents of thought and feeling, with men or women who are not physically active, always induces nervous excitability and physical weakness. If the nervous force is used too largely in the brain, there is failure of innervation at the nerve terminals in the various organs, or at the extremities of the body.

With persons who have been subject to exhaustive labor, both mental and physical; with professional people, teachers, students, accountants and seamstresses, who have been without much physical exercise for a considerable time, there often arises a condition of nervous depression, causing great physical debility, with more or less extreme melancholia. The inhalation of oxygen in the pure air by full, normal respiration, or its guarded medical administration, as previously described, promotes sleep and compels equilibrium of the nerve currents.

I do not think oxygen affects particularly cases of tuberculosis or the changed structures occurring in fibroid phthisis.

I cannot refrain in this connection from referring to the value of oxygen in all cases of cerebral hyperemia, where there is a marked inclination to arterial or venous stasis. A livid, dusky or dark-brown color under the eyes, with or without puffiness, is always an evidence of a greater or less degree of passive congestion, often decided engorgement of the arterial circle of Willis and the large venous sinuses in the same locality. This appearance occurring either with men or women, young girls or children, indicates a more or less dilated and engorged condition of these important blood vessels. This change of circulation is always attended by disturbance of the cerebrum and all the functions sustained by the vaso-motor and sympathetic system of nerve distribution.

In any case of respiratory obstruction the value of oxygen is far greater than that of any form of alcoholics, for it stimulates the brain and respiratory functions normally. It is much safer to feed the brain with oxygen in the natural combination with nitrogen or in its chemical purity, rather than benumb that life center with the carbon of alcoholics.

For more than fifty years of constant, laborious, medical work there have come under my care many alcohol and opium habitués, principally women. I think the cure of alcohol habitués, even of those who have used the purest liquors in a limited way for a time at all extended, is quite as hard to make permanent as that of the opium unfortunate. I have never had the care of such a

patient where I did not find, in addition to irritation to the mucous linings, the altered and abnormal condition of the brain blood vessels described.

When the accustomed solace is withdrawn, in addition to abundant and easily assimilated nutrition, the guarded administration of pure oxygen is of great value in quickening the stagnant, venous and capillary brain circulation. I know of no medicament, not even our best tonics, which relieves the varying conditions of exhaustion, excitation and general malaise from which such patients suffer so fully as oxygen, especially during the earlier days or weeks of disuse of the discarded drug.

Some fourteen years ago a most interesting lady in high life, of fine presence, and 32 years of age, came under my care. During the last years of fashionable school life she had suffered from severe headaches, which occurred once in three or four weeks. By a physician's advice she had found relief by taking a couple of tablespoonfuls of the purest brandy. Profound sleep followed, from which she awakened after two or three hours, weary and exhausted, but free from pain.

It was natural she should persist in using so convenient and pleasant a remedy. Two or three years after her marriage her mother, sister and other friends coming to her home and finding her in a heavy sleep from alcoholics would remonstrate with her, but without avail. After six years the headaches came every two or three days, and the patient required increased doses to secure relief.

In spite of her protests, her husband and friends insisted upon her coming under my care. Hepatic, renal and cerebral congestion fully accounted for the morbid condition which had led her for more than a year to feel that her husband and all her friends were her worst enemies. A melancholy obstinacy was her prominent characteristic, and she stoutly resisted the idea of hygienic or medical care. Kind, firm, wise restraint and careful treatment to unload the oppressed liver, kidneys and brain gradually brought relief. It was a full month before her mind cleared sufficiently to enable her to realize her own condition. She then became willing to second wisely the efforts made for her recovery. The patient was placed upon a most nutritious diet, from which carbonaceous fluids were largely excluded.

Life in the open air, with abundant, enforced respiration and exercise, with full brain oxygenation, naturally and chemically, did much to clear up the old stagnant brain capillary circulation, and with it the cobwebs of morbid fancies, hatred of nearest friends, melancholia and suicidal inclinations. The treatment was continued for several months until the patient's general health and better life habits were quite firmly established. I am assured that without strenuous effort on the part of the patient and physicians and abundant, persistent brain oxygenation, this case must have resulted most seriously.

I cannot overestimate the value of normally and chemically administered oxygen in all cases of nervous depression connected with cerebro-spinal congestion, though in most severe cases every possible medical and moral aid must also be given the patient to insure recovery.

Almost every good thing, even the most skilled medication, may be overdone, but I have never known a man or woman who used too much common sense or breathed too freely pure, blessed, oxygenated air.

A LARGE DOSE OF CHLORAL HYDRATE.¹

BY THOMAS J. ACKER, M.D.,
Croton-on-Hudson, N. Y.

ON January 10, 1903, I was summoned to attend Miss A. C. N., a Swede, who was a visitor at the home of her friend, residing at Oscawana, N. Y. Age, 44 years. She was a dressmaker by occupation, except for the last three years of her life, which had been spent in giving massage treatment to many different persons.

Her general appearance was that of a person in good health; the menses were regular. An examination disclosed *acute mania*, superinduced by the loss of her money, being homeless and without a relative in this country. Her tendency was suicidal, as she deplored the idea of becoming dependent upon her friends for support. She was very nervous and restless, making the statement of not having slept for three consecutive days and nights.

Saw the patient next morning, January 11th. She was much better, after sleeping nearly all night. She took two doses of the bromidia, as directed. Ordered the same treatment to be continued, with plenty of good, nourishing food and out-of-doors exercise, and instructed her friend to take charge of the medicine and be careful to keep it out of the patient's possession, for fear she might take the bromidia to destroy her life, as she manifested a suicidal tendency.

At 8 o'clock P. M. on the same day, January 11th, a messenger came to my office and informed me that Miss A. C. N. had taken all of her sleeping medicine at one dose. I arrived at the bedside of the patient at 9 o'clock P. M., and learned from her friend that the patient had left her room on the second floor at 5 o'clock P. M., descending to the dining-room, securing the bottle of bromidia, and swallowed its contents—22 drams, which contained 330 grains of chloral hydrate, 330 grains of potassæ bromide, 2¾ grains of ext. cannabis indica, and 2¼ grains ext. hyosciami. This was done during the absence of the patient's friend from the house, which did not exceed ten minutes.

The patient's condition: Pulse, 62 per minute, and feeble; respiration, 14 per minute; pupils contracted, face flushed; extremities cold, and she was in a profound sleep, from which she could

¹Read at the meeting of the Westchester County Medical Association, March 26, 1903, at White Plains, N. Y.

be aroused by violent shaking, but could not articulate a word, but could swallow.

Treatment: First dose consisted of 5 drops of *tr. nucis vom.*, one teaspoonful of brandy and one-half a teacupful of hot, strong coffee, and bags of hot water applied to the extremities and continued until the limbs regained their natural temperature. At each subsequent hour 2 drops of *tr. nucis vom.* and all of the hot, strong coffee that the patient could swallow (about one teacupful) were ordered given. January 12th, at 9 o'clock A. M., I saw the patient. She could be aroused and speak. The same treatment continued. January 13th she had apparently recovered, without any bad effects. The treatment was discontinued, and other remedies prescribed. She soon left her friend's residence, and when last heard from she had been placed in an asylum.

We find on record where 10 grains of hydrate of chloral have produced death, and among cases where 350 grains taken did not result in the death of the patient.

PRESENT STATUS OF THE TREATMENT OF RETRO-DISPLACEMENTS OF THE UTERUS.¹

BY HARVEY P. JACK, M.D.,
Canistota, N. Y.

THAT any woman suffering from a persistent retro-displacement of the uterus is ever really well is now generally recognized among gynecologists as *not* possible. While in a few cases she will suffer little from the backache, bearing down and pains radiating to the vulva and down the thighs, the classical symptoms, in no case, I believe, is she free from some reflex disturbance, more or less severe in character. I have seen a persistent facial acne, accompanied by a gastric neurosis, recover after the replacement of a retro-displaced uterus, and the symptoms referable to a movable kidney disappear upon the introduction of a properly fitting pessary. Odon has shown that 14 to 17 per cent. of the gastric neuroses occurring in women are due to and are cured by relieving a retro-displaced uterus. He has made elaborate dissections showing the intimate connection between the sympathetic nervous system and the uterus. The above and the increased vulnerability of the organ, the disability for sexual intercourse, amounting in some cases to a dyspareunia; the greater liability to infection, extra-uterine pregnancy, sterility, and the intense suffering caused by the ever-recurring inflammations of the organ are urgent reasons why all possible should be done by the profession for these cases, and that so many mechanical contrivances have been devised and so many different operations have been originated, is the best of evidence that gynecologists have long recognized their responsibility in this respect, and the fact that many of them says that nowhere in gynecology do they do so

much good bears testimony to their satisfaction with this part of their work.

The treatment of retro-displacements of the uterus is: First, preparatory; second, curative; and curative may be divided into (a) cases that can be cured by mechanical means, and (b) cases that can only be cured by surgical means, and any knowledge that will help us to early say to which of the curative means our case should be assigned will be of value, and my chief reason for presenting this paper is to add my bit of experience to that already accumulated. The forces which nature has provided for holding the uterus in normal position are: (a) the dynamics of the abdomen; (b) the utero-sacral ligaments; (c) the broad ligament; (d) the utero-vesical peritoneal reflections; (e) the round ligaments and the cellular tissue. And an intact vagina prevents the drag of the bladder and rectum on the uterus.

Of all these I believe the first and the last, the intact vagina, together with the utero-sacral ligaments, are by far the chief forces operating to keep the uterus forward. I have many times examined women who, at the first examination, presented a retro-displacement, and at a second, a few days later, the uterus would be found in anteversion. Surely, if the round ligaments were the chief factor in retaining the uterus in position, as many gynecologists would have us believe, this could not be so, as they do not have the power of relaxation and contraction.

Besides, when I have opened the abdomen for other purposes (or for suspension), I have displaced the uterus backward, without any apparent pull on the round ligaments. If this be true, then those cases in which the abdominal dynamics have not become greatly impaired, cases in which there is little or no general enteroptosis, in which the vagina is nearly or quite intact, cases suffering with no other serious uterine or ovarian disease, will offer the best prospects for a radical cure by preparatory, followed, if need be, by mechanical, means. And this has been my experience. By preparatory treatment I mean rest in bed until the acute stage of inflammation is passed (though often this is not severe enough to be necessary), coupled with properly applied vaginal glycerine tampons of wool, and when the tenderness has subsided the replacement of the uterus and its maintenance in position by tampons, which from the first should be thoroughly saturated with glycerine, boroglycerate or ichthyol glycerine, and applied every two or three days and left in twenty-four hours. Then they should be removed and three or four hot douches, hot as can be borne, should be given, the patient being in the recumbent posture. The douches should be given at four-hour intervals. During all this treatment, which, as a rule, will not occupy more than two weeks, a cold bath, followed by brisk rubbing, should be given each morning, and these should be continued for months. Cold baths are the best means we pos-

¹Read before the Steuben County Medical Association, April 6, 1903.

sess of building up the tonicity of the abdominal muscles. In the treatment of retro-displacements enough attention has not been paid to strengthening the dynamics. They are our greatest forces in holding the uterus forward. To this end also strychnine and iron should be administered freely, and a full nourishing diet given, especially if the patient is much weakened, and she usually is both weak and nervous. After two to four weeks of this treatment moderate and systematic exercise should be insisted upon. The uterus may remain in position now without further treatment. If it show a tendency to drop back, a well-fitting Albert Smith, Hodge or Emmett pessary should be introduced—and to properly fit a pessary so it will do no harm often requires great skill and patience. After the pessary has been worn from six months to a year a cure will result in a large proportion, at least 50 per cent., of these selected cases, and a symptomatic cure in the remaining 50 per cent. Unfortunately, the number of cases to which this plan of treatment offers good prospects for a radical cure is not large as compared with the large number of women suffering from this ailment. Given a case, then, to which this treatment is applicable, and we should have one who is young, not over 35 years of age, one not suffering from general ptosis, whose general health is good, one with an intact vagina, one whose circumstances are not such as to compel her to work hard, one *not* suffering from hereditary retroflexion, and, finally, one who will consent to carry out to the letter the details of the instruction given and whose uterus is not too heavy and boggy.

The next class of cases we have to treat are those presenting the features of retro-displacement of the uterus, accompanied by a more or less pronounced degree of subinvolution of the organ, cases in women who have been bearing children rather rapidly, but whose musculature is normally strong. Now if in these cases, added to the above, we have a pronounced relaxation of the vaginal outlet we shall have a set of conditions that favor an incurable ailment without operation. But in quite a large proportion of these cases, by pursuing a rigid preparatory treatment, if they have not existed too long, and following this with a thorough curettage and packing of the uterus, and a thorough repair of the relaxed outlet, we are enabled to transfer them to the first class of cases, and frequently the displacement will be cured without going further, without the necessity of the use of any mechanical support. I can now recall from my experience several cases in which these operative procedures resulted not only in a symptomatic cure, but in an anatomical one as well, to the delight, it is needless to say, of both myself and the patient.

Now we come to a consideration of the third class of cases which presents itself for relief. Cases presenting a general abdominal ptosis, having a weak musculature, cases having a pro-

nounced relaxation of the vaginal outlet, with or without a cervical tear, and a pronounced subinvolution, accompanied with more or less endometritis and possibly cystic or other ovarian or tubal disease. Their nervous systems are exhausted, and the tone of their musculature naturally weak and poorly developed, and to these should be added all cases of hereditary retroflexion. The only hope of a radical cure in these cases is by means of a surgical operation, supplementing that on the cervix and outlet, which shall have for its object the maintenance of the uterus in anterior position. Of these a large number have been devised, the one most advocated being Alexander's operation. While my experience with this operation has been limited, never having performed it, I have examined several women from one to two years after the operation had been performed by good men. In all of them the uterus was either back or sagging, and all were women who had never borne children and with fair musculature, cases which would have stood an excellent chance for cure by a well-fitting pessary and the means outlined above. If this operation does not succeed in holding up a light uterus in a fairly strong and healthy woman, what can be expected of it in a relaxed woman, weak, nervous, and presenting general enteroptosis and a heavy, boggy organ?

That it has been quite generally disappointing is best evidenced as well by the confession of many operators as by the number of operations on the round ligaments, extra and intra abdominal, which have been devised. Most of these, as those of Mann, Wylie, Baldy, Ferguson, and lastly Noble, operate by suspending the uterus either to the abdominal wall by the round ligaments, as those of Ferguson and Noble, or by shortening intra-abdominally the strong or uterine end of the round ligament. Of the first two, it may be said that the uterus is practically and actually suspended to the abdominal wall by the round ligaments by a longer and more tedious operation than the suspension operation devised by Dr. Kelly. What its advantages over Dr. Kelly's operation are I am unable to see, and the experience with the cases following labor or at labor is too small to force a conclusion. It should not interfere, as the round ligaments undergo involution with the uterus, and so also do the ligaments formed by Dr. Kelly's operation, as observed by himself and Dr. Palmer Dudley by actually feeling them involute with the hand, introduced through an umbilical hernia.

In Dr. Mann's, Dr. Wylie's and Dr. Baldy's operations we have to reckon with the possibility of a lax abdominal ring, and consequent weak attachment of the ligament, or with the fact that the ligament beyond the uterine portion may be weak and attenuated, as it quite often is, and also with the fact that the insertion of the round ligaments is on a plane posterior to their attachment to the uterus. Consequently any pull forward exerted by them is at a disadvantage, as

they must necessarily pull the uterus downward and backward until the two superimposed planes are on a level. All of these operations necessitate the opening of the abdomen.

If any round ligament operation is to be chosen, I can see the least objection to the operations of Ferguson and Noble, but they operate in effect by suspending the uterus, using the whole or a part of the round ligaments to accomplish the results, and these operations are more tedious to perform, and possess no advantage over the suspension of the uterus, as devised by Kelly and later by Olshausen. This operation, to my mind and in my experience, comes nearest of any toward the ideal, and certainly the results are ideal. The only practical objection that has been urged against it is that it interferes with labor. Thousands of cases have now been heard from, and this objection has proved of little, if any, foundation. Occasionally we read a paragraph with the ghastly sounding and startling title of "Caesarean Section Made Necessary by Suspension of the Uterus." I have never yet read one that did not immediately describe, in giving an account of the operation, a fixation instead of a suspension, dilating on how dense and fixed the adhesions were. It is well known that the ligaments formed by a properly performed suspension are, after two or three months, from two to four inches in length, and allow free mobility of the organ in any direction except backward, and the persistence with which a part of the profession insists on calling a suspension a fixation is unaccountable. I believe that a properly performed suspension is as safe as any operation for the correction of this condition that has been devised, and certainly none has given so perfect results. As compared with Alexander's operation, if that operation ever succeeds, it would appear that it only succeeds in cases that would be as well or better treated by mechanical means, and in cases where an operation is needed excellent and safe results are secured by suspension by Dr. Kelly's method.

I have been expecting some one would soon report a series of successful cases by means of paraffin prothesis in the utero-sacral ligaments, but so far, at least to my knowledge, this procedure has not been tried.

The conclusions deducible from the above are:

First. That cases of retro-displacement of the uterus should be carefully studied and classified as to means for their cure in certain individual cases, and merit the benefit of trained opinion.

Second. That many cases, if seen early, are capable of cure without operation.

Third. That hygienic measures are of great importance in treatment.

Fourth. That in cases that can only be cured by operation, the great majority of all cases, suspension of the uterus offers us a safe, certain (in fact, the best) means of cure.

SYPHILIS AS A CONTAGIOUS AND INFECTIOUS DISEASE.¹

BY WILLIAM J. MEYER, M.D.,
White Plains, N. Y.

Mr. President and Gentlemen:

SYPHILIS is so widespread, its rapacity is so greedy, its influences on both health and disease are so evident, and its sequelæ are so often disastrous that I think we are more than justified in giving it at least a passing reference.

During the past eight years it has been my portion to meet this frightful scourge in each and all of its terrible forms, from its primary chancre to its final stage of almost complete physical dissolution. I have seen cases where its initial inoculation was apparently but slowly followed by the usual phenomena, thus leading its unfortunate victim into a false sense of security, and I have again seen it in all its repulsive aspects of complete incubation, and I have ever been of the opinion that far too little stress is placed upon the existence of syphilis.

My almost daily experience with syphilis since entering upon the practice of medicine has filled me with such a disgust for it as a disease, and with such a fear for its consequences upon careless, unthinking and ignorant humanity, that I cannot resist the temptation of voicing my sentiments with those who already protest against existing conditions.

We know only too well how universal is syphilis, and how inconsiderate it is in its choice of victims; it respects neither rank nor position, affluence nor poverty, infancy nor old age; it is acquired not only as a result of immorality, but the misfortunes of accident have only too frequently introduced it into the blood of the innocent and virtuous. Syphilis has at the present day reached such a condition of almost universal prevalence that none of us can ever feel free from the possibilities of an accidental inoculation. The colossal ignorance existing among the general public regarding syphilis and its easy modes of transmission forms one of the greatest dangers in connection with it.

Were syphilis a self-limiting disease, or one easily isolated or treated in isolation, we could look upon it with more or less equanimity; did syphilis exert its baneful influences only upon its original victim, it might be considered with less aversion; but, being subject to no isolation, and invading the blood of even unborn generations, its potentiality for disaster is unlimited.

My experience with syphilis has most probably been the experience of all general practitioners of medicine; still, that I may strengthen my position in thus presenting this subject to you to-day, I think it wise to mention a few cases which have impressed me:

Case 1.—In 1898 I was called to see Mrs. F., whom I found with a recently but very clearly

¹Read before the Westchester County Medical Association, May 28, 1903.

developed specific ulceration of the right leg. In consequence of two abortions, for which I had previously treated her, and which I had suspected of being of a syphilitic origin, I was little surprised at this new evidence of the disease, but there could be no doubt as to the moral integrity of Mrs. F., or to the truth of her denials regarding even the existence of such a disease as syphilis. When I found this ulceration of the leg I examined and cross-examined, until at last I obtained the history of a "sore" which had appeared on her genitals some six or seven years previous, which she, in her innocence, had looked upon as a "chafe," but which I succeeded in tracing to her husband, whose moral character was very lax, and who had developed a Hunterian chancre about that time. Mrs. F.'s family history was excellent, and nothing unfavorable could be discovered in that direction. She herself had six children, the youngest being, in 1898, three years of age.

Previous to 1891 (when she most probably obtained her chancre) Mrs. F. had given birth to four fine-looking, healthy and bright children. These children were actually attractive, and were charming specimens of youthful America. Since 1891 Mrs. F. had five pregnancies, two of which resulted in full-term confinements, the other three in abortions, ranging from two to four months. It was during two of these abortions she had been my patient. The two children born since 1891 were so evidently the victims of their father's immorality that it is with pity that I recall them.

The eldest was a girl four and a half years of age, and the younger a boy of three. The girl was much below the usual height of her years, being scarcely larger than neighboring children of three; her complexion was sallow, her hair thin and brittle, skin dry and wrinkled, limbs frail; her teeth were separated and plainly marked with Hutchinson's ridges; her lips were cracked and serrated by reason of old scars; her throat plainly demonstrated the existence of past ulcers, and her uvula was more than half destroyed. Mentally, she was so sluggish that future development was despaired of. She also showed signs of incipient epilepsy.

The boy was equally degenerate with the girl. His appearance was of the same withered, blighted character; he had the Hutchinson teeth and the same evidences of general malnutrition; he, however, had fresh mucous patches in his mouth and throat, and fissures around the anus which bled with every intestinal evacuation. He had a marked flattening of the nasal bridge, with a more or less muco-purulent nasal discharge. An ulcer of the soft palate threatened complete destruction of the tissues. Although both these children were at once placed on the iodides and mercurials, combined with outdoor exercise and the most nutritious diet, but little relief could be obtained. The mercurials were rejected by

the girl to such a degree that even their most cautious use produced salivation. In the boy's case it seemed that the more carefully we employed the mercury and iodides, the more aggravated the condition. The boy died at the age of three and a half in convulsions, which my confrères and myself diagnosed as caused by cerebral gummata.

This one case alone replete as it was, with such awful evidences of the insatiate character of syphilis, caused me to fear and detest the disease above all others, especially because of its devastating influences on the innocent progeny of the licentious.

The misfortune of Mrs. F. and her children presented to me two facts for consideration, *e. g.*:

First, the accidental and unconscious acquisition of syphilis under perfectly legitimate and virtuous conditions; second, the undeniable and repulsive evidences of the transmission of justly acquired syphilis, through the innocent medium of virtuous maternity, to the fetus in utero, resulting in either the death of the fetus or in the more or less complete destruction of the health of the live child.

Case 2.—Another unfortunate case of syphilis came to my attention during my service at Gouverneur Hospital. An Italian father brought his nine-year-old son to the hospital for treatment. Upon examination the boy presented a genuine Hunterian chancre on his lower lip, together with sub-maxillary glandular enlargements on the right side. The case, upon investigation, developed the following facts: The boy was a truant, and had for some time been running errands for a gang of laborers; his trips with a beer bucket to a neighboring saloon were occasionally rewarded with a drink from the bucket, and it was found that at least two of the laborers had mucous patches at the time of investigation. Whether or not one of these men had received his infection from the other by means of this bucket was a question left undecided, but it was established beyond peradventure that the boy owed his chancre to the use of said bucket.

This case is another illustration of the ease with which syphilis is transmitted to the innocent.

Our therapeutics and practices are so frequently embarrassed by the existence of syphilis as a complication that I think a case illustrating this phase of the disease is pertinent to this paper.

Case 3.—I was called to Mr. P., who had suffered a simple fracture of the upper third of the left tibia, about twenty-one hours previously. Mr. P. was known to be a specific with a syphilitic history of some nine years' standing. He had never accepted further treatment after the disappearance of his chancre, and when called to set his fracture I at once examined and searched for secondary and tertiary

manifestations. I found a general periostitis affecting all the long bones, including the fractured tibia, and warty growths behind both ears, which were diagnosed as syphilitic vegetations. The fracture was immediately set and placed in plaster, and strong doses of iodides and mercury given. After two weeks the plaster was removed, according to custom, and I then found that there were no indications of union. Under chloroform, the fractured ends of the bone were rubbed smartly together, reset and again put up in plaster. This second plaster dressing was removed in ten days, and when union was again found wanting I advised hospital care, with an operation—such as wiring. My patient strongly objected to hospital treatment, and since his surroundings did not permit of any operative interference at his home, I tried to content myself with the more palliative treatments. I reset that fractured tibia five times, using every dressing I ever heard of in the hope of obtaining union, from the plaster cast to the leather cast and fracture box. When I at last became desperate through failure to obtain union, my patient consented to submit to operation. While under treatment with me I pushed his iodides and mercury so strongly that when he passed from me to the hospital he was taking ʒss iodide potash daily, and gr. ss of bichloride. I had never pushed the iodides or bichloride to such an extent in any previous case, and I was sadly disappointed in their failure. Mr. P. had his tibia wired, but fully six months elapsed before he obtained a united bone even after operation. I do not think there can be any question as to the responsibility of his syphilis for this long-delayed result.

It is needless, I think, to cite further cases to prove the viciousness, treachery and awful sequelæ of syphilis. It is also, I fear, useless to expect any new or more efficacious line of treatment other than the one now employed, but I *do* think that stronger efforts should be indulged in to check, or to at least limit as far as possible the further and future spread and propagation of this disease. Considering the conditions attending syphilis, its almost unrecognizable prevalence, the insurmountable obstacles attending its isolation, the extraordinary ease and frequency with which it is introduced to the innocent, the secrecy with which the guilty one endeavors to hide his infection, and, above all, his utter ignorance regarding syphilis and its dangers, make it imperative that the medical profession take immediate and continued steps to eradicate at least some of the perils attendant upon it. Syphilis has for generations been considered solely as a venereal disease; it has for generations been classed among the unmentionable results of licentiousness, and it is now time for us to consider it in its true character. When first visited upon the human family, syphilis was most probably a venereal disease only, but through propagation,

production and reproduction, it has been manured and cherished, until it is now one of if not the most virulent of our infectious and contagious diseases. Progress in medical science compels us to acknowledge these conditions, and our own consciences should impel us to search for a remedy. If we begin, continue and end by educating the people regarding the highly infectious and contagious character of this disease, we have won the victory, for then, in self-protection, they will avoid its dangers. Educate the people regarding syphilis as a disease, its modes and ease of transmission; educate them regarding the dangers, the great dangers, incidental to a neglect of the laws of personal and public hygiene; educate the people as to the best and most efficacious manner of avoiding all infections and contagions, having ever in mind the existence of this one disease above all others.

Modesty cannot and must not justify us in neglecting our duty in this matter, and, if need be, we should insist upon the establishment of a course of hygiene in our schools, so that our children will at least know the elementary laws of that science and be able to protect themselves accordingly.

SOME REMARKS ON HEMOPHILIA, WITH A REPORT OF CASES.¹

BY J. C. HUTCHINSON, M.D.,
Troy, N. Y.

HEMOPHILIA is a hereditary disease characterized by excessive bleeding from even the slightest wound and sometimes occurring spontaneously.

Etiology.—Hereditv seems to be the principal cause. The disease is very rarely seen in females as compared with males. The sons of bleeders of the male sex very rarely have the disease. The daughters of bleeding fathers do not, as a rule, show any symptoms of the disease, even during menstruation and labor, but will become the mothers of sons, some or all of whom will have the disease.

The blood does not show anything characteristic. Cabot says the blood is slower than normal in coagulation, and that the blood plates are fewer. After a severe hemorrhage the blood shows the usual signs—nothing characteristic.

Osler says the nature of the disease is undetermined, and we do not yet know whether it depends upon a peculiar frailty of the blood vessels, or some peculiarity in the constitution of the blood, which prevents the normal thrombus from forming in the wound.

There is in the bleeders a peculiar condition of the joints. The joints become swollen and painful, resembling that which occurs in rheumatism—sometimes accompanied by a little elevation of temperature. The large joints, especially the

¹Read at the Nineteenth Annual Meeting of the Second District Branch of The New York State Medical Association, Hudson, N. Y., June 4, 1903.

knees, are usually affected. The joint trouble comes on as the result of traumatism, either external or from concussion of the opposed surfaces, as in jumping from a height. There is an effusion of bloody serum into the synovial sac. I shall have more to say on this point later, as to the priority of discovery.

Dr. Hayes Agnew mentions a case of a bleeder who had always bled from the neck up on the slightest bruise or cut above the neck, never from below. Large hematoma sometimes form under the scalp from an injury that would be trivial in a non-bleeder.

Blood may come from the nose, which is the most common of the spontaneous bleedings, or the stomach, bowels, urethra or lungs. Petechiæ are seen on the skin, like small effusions of blood, in size from a pinhead to that of a quarter or larger. In the further consideration of the subject I shall quote freely from a paper which I read at the meeting of the Medical Society of the State of New York for the year 1877, and published in the transactions of that year, page 268. My excuse for making this long extract from so old a paper is this, that it was read on the last day of the meeting when only a handful of members and delegates were present, and it was not published elsewhere than in the transactions of that year.

After the definition I say in part as follows: "Hemophilia, hematophilia and hemorrhagic diathesis are synonymous terms, according to Dunglison. I shall not speak of the causes, pathology, or treatment of this disease, but simply report a case which has at least one point which is possibly novel.

"Case.—Willie Clark is, at the present time, about 9 years old. When I first saw him he was just beginning to walk, and had fallen, striking on his head and causing an immense bloody tumor of the scalp.

"The mother told me that her father was a sufferer from hemophilia, and had, on more than one occasion, nearly bled to death from the extraction of teeth. She herself had no particular tendency to hemorrhage, even in confinement. She also told me that the boy had bled in an alarming manner on several occasions previous to my being called, whether spontaneously or not I cannot now state. I told her to let the tumor alone, and that the fluid would eventually be removed by absorption. Before this lump disappeared, the child again fell and bruised the other side of the head, making another swelling as large as the first had been. He had one or two other bumps before he got so that he could walk firmly, but all signs of effusion finally disappeared after disfiguring him for several months.

"In November, 1871, I attended Mrs. Clark in confinement. She had an easy labor with no hemorrhage. When the baby, which was a boy, was about 3 months of age the brother threw a piece of a broken slate at him, producing a scalp

wound from which he died in a few hours, in spite of all attempts to stop the bleeding. Mrs. Clark has since had two more children, both boys, who can wound themselves without producing any inordinate bleeding.

"To come back to the boy. He has always had frequent attacks of epistaxis. I have been called in on several occasions to arrest the hemorrhage from small wounds that would give an ordinary child no trouble. On one occasion he was brought to my office on account of bleeding from a small wound on the dorsum of the tongue, near the center. This had been bleeding for over two weeks, and the child was almost exhausted from loss of blood. On looking at the tongue I found a mere scratch, apparently, but the blood, now very thin, kept continually oozing from it. I tried various styptics with no success, on account of the movement of the tongue; also, the hot iron with like results. Pressure could only be made effective in one way, and that by the insertion of a pin through the edges of the wound and twisting a thread around the ends. This I succeeded in accomplishing with Dr. McLean's assistance, and the hemorrhage was finally arrested. He is also troubled with puffiness and tenderness of the joints, especially the knee joints, from the slightest blow. The joints are, in every respect, just as they are described by Wickham Legg and Sir William Jenner in connection with this disease. Sometimes the swelling seems to come on spontaneously from mere overexertion. About the middle of March, of the present year, I was at the house to see another member of the family, when I was requested to examine Willie's knee, which had been very much swollen and slightly painful and tender for a day or two. There was evidently fluid in the cavity of the joint, and I decided to find out its nature, if possible. I introduced the needle of a hypodermic syringe into the cavity of the joint, and drew the barrel of the syringe full of blood and serum. There was a great deal more blood than could have been produced by the wound of so small a needle in so short a time, so I unscrewed the barrel, leaving the needle in the wound, and emptied it, and drew out some more of the same fluid exactly like the first. I succeeded in getting about one-half an ounce, when the boy became uneasy, and I withdrew the needle. I am certain that the blood existed in the cavity before the introduction of the needle, and was not produced by the needle. The swelling all disappeared in a week or ten days, under the pressure of a bandage.

"I did not think anything more about this, until a week or so afterward I saw an article in the *American Journal of the Medical Sciences*, for January, 1877, which caused me to think this case worth reporting. The article referred to is on page 239, *et seq.*, and is quoted from the *Lancet* of November 18, 1876. It is a synopsis of an elaborate report of a case of hemophilia, read by Sir William Jenner, before the London

Clinical Society. After describing the case and the treatment, in his report of the autopsy he says: 'The left-knee joint was found to be full of purple blood and stringy synovia.'

"In his remarks upon the case he further said: 'The present was, he believed, the only case in which the cause of the swelling of the joints was found to lie in effusion of blood with excess of synovia. Dr. Legg (still quoting from the same article) was unable to find any such cause for the joint affection in any well-recorded case.'

"If Dr. Jenner is correct in his statement, and has been correctly reported, then the case I have just reported is the first reported case in which the cause of the swelling of the joints has been shown, in the living subject, to be effusion of blood.

"I have been able to come across only three references to the joint affection, in connection with hemophilia, besides Dr. Jenner's case.

"Dr. Wickham Legg (quoted in the number of the *American Journal of the Medical Sciences* for April, 1872, from St. Bartholomew's Hospital reports, Vol. VII) defines 'hemophilia' to be a hereditary disease, manifesting itself during the first years of life, attended by a hemorrhagic diathesis and tendency to swelling of the joints—this latter a very important feature of the disease.

"I will use his words in describing the swelling of the joints, as they will almost exactly describe my case: 'When 6 years old his left knee began to swell, and this joint has been swollen, off and on, ever since. The knee may keep well for three or four months; it then begins to swell, and will be painful and large for several months at a time, so that the boy is seldom free from some trouble with his joints. Sometimes, as the swelling is disappearing in the left knee, it appears in the right, and vice versa. Sometimes the ankles swell; but the left knee is the joint most commonly disabled. No difference has been noticed in summer or winter, or in cold or wet weather.'

"Dr. William M. Holton, in the *American Journal of the Medical Sciences*, speaks of a family of eight boys, seven of whom manifested hemophilia, and he says that most of them were subject to 'articular rheumatism,' as he called the joint affection. It was probably of the same nature as in the case above described. Neither Aitken, Flint nor Neimeyer speaks of the joint swelling in describing the hemorrhagic diathesis. Neither Trousseau, West, Meigs and Pepper, J. Lewis Smith nor Watson speaks of the hemorrhagic diathesis as distinct from purpura hemorrhagica or scurvy.

"Dr. Thomas read a paper before the East River Medical Association, January 4, 1867. I quote his words from the *Medical Record*, Vol. II, page 20: 'In some (patients) distinct periods of remission and exacerbation may be observed. At the latter times the patient is subject to frequent attacks of pain and swelling, with ecchymosis of the wrists, ankles and knee joints, attended with fever. These symptoms continue about a fort-

night, and then disappear with the subsidence of the swelling and removal of the ecchymosis.

"None of these gentlemen speaks of the effusion of blood into the joint itself, and, as far as I have been able to discover, Sir William Jenner's case is the first in which the hemorrhage into the joint is recorded, and that after death. And my case seems to be the first recorded case where the positive diagnosis of hemorrhage into the cavity of the joint in a case of hemophilia was made in a living subject.

DISCUSSION.

"Dr. Sherman, of Ogdensburg, referred to a case precisely of the same character as that reported by Dr. Hutchinson, in which a most profuse hemorrhage followed a slight abrasion of the frenum of the lip. There was precisely the same condition of affairs in the joints, and the patient was unable to move except upon crutches. The mother of the boy said that the grandfather suffered precisely in the same way, and died from hemorrhage following a very slight cut. The same diathesis had extended back in the members of the family for three or four generations."

I hope I have not worn out your patience with this long quotation, but, as I gave my reason for it, I hope that will be accepted as a sufficient excuse.

That the joint trouble is caused by effusion of blood into the joints is now accepted by most recent writers.

Immermann contributed 104 pages to hemophilia in *Zeimssens' Cyclopaedia*, on the volume published in 1878, a year after my paper was written. Concerning the joint disease he says: "These effusions are usually serous, but it is probable that they may also sometimes be sanguinolent, at least that is the opinion of Dubois, Cammon and Assman. Whether extravasations of blood ever take place into the cavities of the joints in these patients cannot be determined with certainty in the absence of autopsical results on this point. In the reported cases of this kind the diagnosis has rested merely on the clinical symptoms, such as the greater painfulness of the joints, the presence of cutaneous hemorrhages in the neighborhood and the palpatory evidence of solid masses in the fluid effusion."

Some of the cases have so-called muscular rheumatism. I do not think they deserve the name rheumatism any more than the joint affections do. To my mind the pains are due to pressure of blood, effused into the muscular substance, and caused in the same manner as the joint affections; that is, by external violence or by inordinate muscular action of muscles that have become atrophied by two causes, malnutrition from frequent hemorrhages and by non-use of the muscles on account of general weakness from some cause. These patients usually make blood very rapidly after a serious loss of blood.

I have a few more words to say on the question of heredity. In studying Immermann's statistics I think one would be warranted in drawing the

following conclusions, although the author referred to does not say so in so many words.

Where there is marriage of a man and a woman, both belonging to bleeder families, of course, it would be only following the usual course for the boys to inherit the disease in active form from the mother. This is not only so, but the girls also not only become mothers of sons who are bleeders, but they also, some of them at least, become bleeders themselves; also the girls in the third generation show a very much larger proportion of active bleeders than would the girls in whom the disease was inherited from the maternal grandfather alone. This may be explained by the double inheritance so increasing the tendency to bleed that the females not only bleed themselves, but, if they live long enough, may become the mothers not only of bleeding sons, but of bleeding daughters.

At the time the paper of mine quoted was written, Mrs. Clark's two younger boys were 5 years and $2\frac{1}{2}$ years of age, and up to that time the hemorrhagic tendency in them has not appeared, and I was informed many years afterward by Mrs. Clark that they were still free from the disease. Besides these three she afterward had three more boys. I attended her in confinement in November, 1877, December, 1879, and January, 1882, of boys each time.

When the boy born November, 1877, was about 5 years old he cut the frenum of the upper lip, and almost bled to death, and would have done so but for the untiring watching of his parents in preventing his removing the dressings by which constant compression of the lip was kept up for six or seven days. I tried styptics of all kinds without arresting it, the blood oozing out as soon as the pressure was relaxed. I finally succeeded in arresting the bleeding by putting a compress saturated with persulphate of iron between the maxilla and upper lip, pressing it well up against the frenum. Then I applied another compress on the lip externally and held it firmly in place by elastic rubber bands, passing back of the head and neck. He was restless and in spite of the watchfulness of the parents, who, by previous experience, were fully alive to the dangerous nature of the case, he succeeded in dislocating the dressing twice in the first forty-eight hours, with a return of bleeding each time. They did not care to have him restrained mechanically, so they held his hands constantly and so the bleeding was finally arrested, the compress being kept in place about a week. In this case it was possible to arrest the hemorrhage because the firm pressure could be made against the jaw. Her last child, when about 18 months old, cut the lingual frenum and bled to death in three or four days in spite of everything that was done. In making compression in these cases, care has to be exercised not to apply too great force, as gangrene has been known to occur from this cause.

Here in this family were eight children, all boys but the second, whom I have not mentioned,

and who died in infancy from something not at all connected with the family disease; there were four who had the disease in severe form, two of the four dying from it.

In regard to the nature of the disease, the underlying condition upon which the hemorrhages depend, it is pretty well agreed that we know nothing of certainty. If the women of bleeder families manifested the same tendency to hemorrhage as the men, the disease would die out in time, because few women would live through the first menstrual period.

The Medical Mountebank.—The doctor who begins by lying to his patients, if not rescued by the beneficent influence of a medical society, will invariably end by lying about his colleagues; and he who steals a colleague's reputation will not scruple at stealing his colleague's patients. The doctor who takes charge of a surgical case without the knowledge and consent of the attending surgeon, and with the sole object in view of aiding the patient in escaping liability for professional services, voluntarily puts himself under my heading—The Medical Mountebank—and is a highway thief minus a respectable thief's courage.

As a conscience-builder, if drifting along the seductive trail of irregularity, I know of nothing better, more elevating and instructive than the medical society. The nondescript myriads of medical knaves shun the medical society even as thieves shun the bright light of day. It is to the medical society we must look for relief from a mountebank-ridden profession. The quack advertiser will prosecute his nefarious barter in immoral suggestions and shameless indecencies just as long as we waste our ammunition on trivial rivalries. The charlatan will continue to dupe his victims with boastful promises and line his pockets with abstracted savings from the fool-fund while we cabal among ourselves and foster the junto of disorganization.—ELMER GREEN, in *Transactions of Wisconsin State Medical Society*, 1902.

THE LAW AND FAITH HEALERS.

A decision which is virtually opposed to faith healing to the exclusion of regularly admitted physicians was handed down in the Court of Appeals on October 13th. The decision was in the case of the people against J. Luther Pierson, of White Plains.

The trial court found Pierson guilty of neglecting his sixteen months old adopted daughter in not calling a physician to treat her for pneumonia, which resulted in her death. Pierson was convicted of violating Section 288 of the Penal Code by omitting, without lawful excuse, to perform a duty imposed upon him by law, the furnishing of medical attendance for the child.

In its opinion, written by Judge Haight, the Court of Appeals says:

We are thus brought to a consideration of what is

meant by the term "medical attendance." Does it mean a regularly licensed physician, or may some other person render "medical attendance"? The foundation of medical science was laid down by Hippocrates in Greece 500 years before the Christian era. His discoveries, experiences and observations were further developed and taught in the schools of Alexandria and Salerno, and have come down to us through all the intervening centuries; yet medicine as a science made but little advance in northern Europe for many years thereafter—practically none until the dawn of the eighteenth century.

After the adoption of Christianity by Rome and the conversion of the greater part of Europe, there commenced a growth of legends of miracles connected with the lives of great men who became benefactors of humanity. Some of these have been canonized by the Church and are to-day looked upon by a large portion of the Christian world as saints who had miraculous power. The great majority of miracles recorded had reference to the healing of the sick through divine intervention, and so extensively was this belief rooted in the minds of the people that for a thousand years or more it was considered dishonorable to practice physic or surgery.

At the Latern Council of the Church, held at the beginning of the thirteenth century, physicians were forbidden under pain of expulsion from the Church to undertake medical treatment without calling in a priest; and as late as 250 years thereafter Pope Pius V renewed the command of Pope Innocent by enforcing the penalties.

The curing by miracles, or by interposition of divine power, continued throughout Christian Europe during the entire period of the Middle Ages, and was the mode of treating sickness recognized by the Church. This power to heal was not confined to the Catholics alone, but was also in later years invoked by Protestants and by rulers.

We are told that Henry VIII, Queen Elizabeth, the Stuarts, James I and Charles I all possessed the power to cure epilepsy, scrofula and other diseases known as the king's evil; and there is incontrovertible evidence that Charles II, the most thorough debauchee who ever sat on the English throne, possessed this miraculous gift in a marked degree and that for the purpose of effecting cures he touched nearly a hundred thousand persons.

With the commencement of the eighteenth century a number of important discoveries were made in medicines and surgery, which effected a great change in public sentiment, and these have been followed by numerous discoveries of specifics in drugs and compounds. These discoveries have resulted in the establishment of schools for experiments and colleges throughout the civilized world for the special education of those who have chosen the practice of medicine for their profession. These schools and colleges have gone a long way in establishing medicine as a science, and such it has come to be recognized in the law of our land.

By the middle of the eighteenth century the custom of calling upon practitioners of medicine in case of serious illness had become quite general in England, France and Germany, and, indeed, to a considerable extent throughout Europe and in this country. From that time the practice among the people of engaging physicians has continued to increase until it has come to be regarded as a duty devolving upon persons having the care of others to call upon medical assistance in case of serious illness.

Formerly no license or certificate was required of a person who undertook the practice of medicine. A certificate or diploma of an incorporated medical college was looked upon by the public as furnishing the necessary qualification for a person to engage in the practice of such profession. The result was that many persons engaged in the practice of medicine who had acquired no scientific knowledge with reference to the character of diseases or of the ingredients of drugs that they administered, some of whom imposed upon the public by

purchasing diplomas from fraudulent concerns and advertising them as real. This resulted in the adoption of several statutes upon the subject.

The provision of the Penal Code under consideration was first adopted in 1881, following the statute of 1880, prohibiting the practice of medicine by other than a physician duly qualified in accordance with the provisions of the act. This, we think, is significant. The Legislature first limits the right to practice medicine to those who have been licensed and registered, or have received a diploma from some incorporated college conferring upon them the degree of doctor of medicine; and then the following year it enacts the provision of the Penal Code under consideration, in which it requires the procurement of medical attendance under the circumstances to which we have called attention.

We think, therefore, that the medical attendance required by the Code is the authorized medical attendance prescribed by the statute, and this view is strengthened from the fact that the third subdivision of this section of the Code requires nurses to report certain conditions of infants under two weeks of age "to a legally qualified practitioner of medicine of the city, town or place where such child is being cared for," thus particularly specifying the kind of practitioner recognized by the statute as a medical attendant.

The remaining question which we deem it necessary to consider is the claim that the provisions of the Code are violative of the provisions of the Constitution, Article I, section 3 (which provides for the free exercise of religious profession and worship).

The peace and safety of the State involve the protection of the lives and health of its children, as well as the obedience of its laws. Full and free enjoyment of religious profession and worship are guaranteed, but acts which are not worship are not. A person cannot, under the guise of religious belief, practice polygamy and still be protected from our statutes constituting the crime of bigamy. He cannot, under the belief or profession of belief that he should be relieved from the care of children, be excused from punishment for slaying those who have been born to him. Children when born into the world are utterly helpless, having neither the power to care for, protect nor maintain themselves. They are exposed to all the ills to which flesh is heir and require careful nursing, and at times when danger is present the help of an experienced physician.

But the law of nature, as well as the common law, devolves upon the parents the duty of caring for their young in sickness and in health, and of doing whatever may be necessary for their care, maintenance and preservation, including medical attendance if necessary, and an omission to do this is a public wrong which the State under its police powers may prevent.

We are aware that there are people who believe that the divine power may be invoked to heal the sick, and that faith is all that is required. There are others who believe that the Creator has supplied the earth, Nature's storehouse, with everything that man may want for his support and maintenance, including the restoration and preservation of his health, and that he is left to work out his own salvation, under fixed natural laws.

There are still others who believe that Christianity and science go hand in hand, both proceeding from the Creator; that science is but the agent of the Almighty, through which He accomplishes results; and that both science and divine power may be invoked together to restore diseased and suffering humanity.

But, sitting as a court of law for the purpose of construing and determining the meaning of statutes, we have nothing to do with these variances in religious beliefs and have no power to determine which is correct.

We place no limitations upon the power of the mind over the body, the power of faith to dispel disease, or the power of the Supreme Being to heal the sick. We merely declare the law as given us by the Legislature. We have considered the legal proposition raised by the record, and have found no error on the part of the trial court that called for a reversal.

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Byron C. Cheeseman.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberger.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Horace L. Hulett.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutler.

SENECA COUNTY MEDICAL ASSOCIATION.

President—William Austin Macy.
Vice-President—George O. Bellows.
Secretary—J. Spencer Purdy.
Treasurer—Carroll B. Bacon.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

CHAUTAQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davis.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics, Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Alvert E. Woehner.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Alvert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleecker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stockschlaeder, James C. Davis.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer.
Vice-President—William O. Huggins.
Secretary—Alva Le Roy Chapin.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Conner, Middletown.
Secretary—Ernest Valentine Hubbard, 138 West 74th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.
Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.
Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.
Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.
Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.
Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.
Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lanhert, 125 East 36th street, New York.
First Vice-President—Francis J. Quinlan, 33 West 38th street, New York.
Second Vice-President—S. Busby Allen, 53 East 86th street, New York.
Secretary—Ogden C. Ludlow, 234 West 135th street, New York.
Corresponding Secretary—John Joseph Nutt, 2020 Broadway, New York.
Treasurer—Charles Ellery Denison, 68 West 71st street.
Executive Committee—Charles S. Benedict (1 year), Parker Syms (2 years), Frederick P. Hammond (3 years).
Committee on Public Health and Medical Charities—Edward L. Keyes, Jr., chairman, 109 East 34th street, New York; John F. Erdmann, Charles G. Kerley, Joseph D. Nagel, Robert J. Carlisle.
Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 36th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.
Committee on Legislation—W. Travis Gihb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

Treasurer—Frank Guillemont.
Executive Committee—F. J. Baker, E. E. Campbell.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Howard A. Maynard.

STEBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Koyle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Farkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felner, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

The New York State Journal of Medicine.

Published Monthly by The New



York State Medical Association.

COMMITTEE ON PUBLICATION:

CHARLES E. DENISON, M.D., Chairman.

Charles G. Childs, Jr., M.D.

Thomas F. Reilly, M.D.

PUBLICATIONS:

THE NEW YORK STATE JOURNAL OF MEDICINE.

MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND CONNECTICUT.

Address all communications to the
EDITORIAL AND BUSINESS OFFICES,
64 MADISON AVENUE, NEW YORK.

VOL. 3. No. 12.

DECEMBER, 1903.

\$1.00 PER ANNUM.

STATE ASSOCIATION DINNER.

Among the letters of regret received from those who were unable to attend the dinner in connection with our annual meeting were communications from the President of Columbia College, Nicholas Murray Butler; Simeon Ford, and one from Dr. Henry L. Elsner, chairman of the Committee on Union of the Medical Society of the State of New York, which is as follows:

SYRACUSE, N. Y., Oct. 20, 1903.

My Dear Dr. Brown—It is a source of great disappointment to me to be unable to meet you and my many friends in the Association at your annual banquet to-morrow evening. I had looked forward to this occasion with great pleasure, but circumstances over which I have no control have arisen at the last moment which make it impossible for me to be with you. I wish, however, at this time to congratulate the Association and the profession of the State of New York upon the auspicious outlook for the future. I feel that at no time in the history of our State profession have we been more fortunately circumstanced than at present. The future is full of promise, the past has been forgotten and throughout this entire State men in the profession are eager and willing to shake hands with their colleagues; to join with them in the movement which has for its object not only the unification of the profession of this great State, but the advancement of our common interests and the ultimate strengthening of the national profession. Nothing that has transpired in the history of the American medical profession has done more to elevate our calling than the action recently taken by both State bodies. Reason must now prevail. Men must be willing to bury personal differences with but one object in view and that the good of all.

I feel that the work of the past two years which has at times appeared to some of us almost monumental and impossible of accomplishment has not been in vain; that we are soon to reap our harvest. I sincerely trust that you will express to those gathered about the festive board my great disappointment in being unable to meet with you, and that at the next annual meeting of the Medical Society of the State of New York there shall be gathered about the banquet table a united profession, looking to the future for the accomplishment of much that shall benefit mankind, making our calling more respected than ever before among men.

I am, with great respect and many assurances of friendly consideration,

Sincerely yours,

(Signed.) HENRY L. ELSNER.

COMMISSIONS FOR BUSINESS.

A physician, a member of our Association, was recently asked to see a patient in consultation by the latter's family physician, also a member of the Association. When the consultation was arranged for by the family physician, the consulting physician was requested to reduce his regular fee one-third.

A few days after the consultation, the consulting physician received the following letter:

Dear Doctor—Should any inquisitive friends of the patient to whom you were called in consultation by me recently call on you to find out the condition of the patient, etc., please simply give them the facts of her disease, or condition, prognosis, etc., mentioning nothing about the fee, as I had to charge a little extra to cover my expenses; you may not be approached, but as country people do queer things, I mentioned this beforehand.

Yours truly,

To this the following reply was sent:

Dear Doctor—I regret very much that I will be unable to comply with the request contained in your recent letter to me, namely, that I say nothing about my fee for services rendered to Miss _____ in case I am asked by her relatives what my charge for such services was.

You will probably remember that you requested me to reduce my fee one-third on account of the modest means of the patient's family, and I think you did wrong in adding anything to the sum you paid me for my services to your patient; I think, however, that you should have charged for your own services under your own name.

Yours very truly,

NEW YORK CITY.

Dear Doctor—I wish to inform you that I have recently opened a place of business for medicated baths (see enclosed card).

Should you at any time require such baths for your patients, I will appreciate very much if you send them to me, and I am willing to pay you a liberal commission for all business you might put in my way.

When patients desire to have massage treatment at their residences, I furnish competent male and female operators.

Thanking you in advance, and hoping to have your favorable reply, I remain,

Very truly yours,

PRESENT NEEDS OF THE MEDICAL PROFESSION.

In his address as the retiring President of The New York State Medical Association, delivered at a recent meeting of that body, printed in full in the November number of the *JOURNAL* of the Association, Dr. Frederick Holme Wiggin calls special attention to certain crying needs of the medical profession in our generation that must be attended to if there is to be any amelioration of evils long complained of, but still continuing.

He shows that although much has been done to organize the medical profession in this country there are still, according to the Secretary of the American Medical Association, more than seventy-five thousand physicians in the United States who are not at present members of any medical organization. If present-day evils are to be eradicated, more universal union of the profession is absolutely demanded. How this can be brought about remains one of the serious problems that those who have the best interests of the medical profession at heart must endeavor to solve.

Dr. Wiggin considers that it is evident that there is a necessity for a change in the form and attractiveness of existing medical organizations, if it is desired to unite the members of our profession in a few strong and closely allied societies. He quotes Sir Victor Horsley, M.D., who, in a recent paper, said: "Organizations, medical or otherwise, are purely temporary; their only purpose is to meet the needs of the moment, and when those organizations fail to keep pace with the natural evolution of the circumstances under which we have to live, it is quite clear that we ought to reconstruct the various machines that we have in operation." As Dr. Horsley has had very extensive experience in recent years as to medical organization, in various attempts to reorganize the British Medical Association in such a way as to make it effective for professional purposes, his words should go far in the matter.

He considers that at the present time there are two professional requirements—social and scientific. Under the social requirements are placed the right to practice, defense from unjust attacks and the enforcement of our rights by the prosecution of illegal physicians.

Here in New York much has already been accomplished beyond what has ever before been attempted as regards some of these social requirements. The defense of physicians against blackmailing suits for malpractice is now assumed by The New York State Medical Association for all its members, and already the rule is that, in most cases, suits never come to trial, for the plaintiff realizes the futility of fighting legally with a large and powerful medical association, and also feels that much of the sympathy that ordinarily goes out to the plaintiff on the part of the jury in these cases is neutralized by the fact that the defendant is a physician in good standing and that brother physicians are united in his defense.

When medical societies generally shall have

adopted this system introduced by The New York State Medical Association they will doubtless see the same encouraging increase in membership that has followed the diffusion of the knowledge with regard to defense against blackmail here in New York State.

Undoubtedly there are other features of medical society life that will admit of improvements calculated to make the membership of these bodies not only larger, but more united. As at present constituted, proceedings are often too formal, and the social side of organization is not sufficiently cultivated. Commonly to have members of the profession meet on a plane of sociability is to get rid of many of the temptations to friction in practical life and obviate in the easiest possible way by prophylaxis infractions of medical ethics.

While meetings are primarily intended for mutual help from a scientific standpoint and for the rapid, easy diffusion of medical advances, it must not be forgotten that physicians do not cease to be examples of the animal sociale and opportunities for the cultivation of the amenities of life must be afforded.

The close union of interests that could be thus secured, if all the practicing physicians of this country were brought into intimate contact with brother practitioners, would redound not only to the benefit of the profession, but also to that of the public by more effectual regulation of medical abuses. Those sincerely interested in medical advance and in the public welfare owe it to themselves to spare no effort in this direction, with the purpose of securing efficient medical union as the greatest crying need of our time, and in itself the solution of most of the other medical abuses of which we hear so much complaint.—*The Medical News*, November 14, 1903.

EUTHANASIA.

At the annual banquet of The New York State Medical Association on October 21st, one of the speakers was the Rev. Merle St. Clair Wright, of the Lenox Avenue Unitarian Church. In the course of his remarks he said: "I appreciate the practical difficulties in the way of the practical application of the doctrine, but it seems to me that it is not beyond the bounds of possibility. Of course, it would be necessary to have the advice and approval of men of the highest scientific attainment. The city might be divided into districts, and every application should be considered most carefully, not merely by physicians, but by some eminent clergymen selected for the purpose. And, of course, there should be the consent of relatives and the consent, even the request, of the patient himself. But where all these conditions are fulfilled, and where the prolongation of life is simply the prolongation of hopeless agony, it seems to me that it would be proper that such a patient should quietly, decently, modestly, be allowed to end the sufferings. It seems that such a course would be a step forward in civilization and a step further away from barbarism."

Association News.

THE NEW YORK STATE MEDICAL ASSOCIATION.

Twentieth Annual Meeting, Held in New York City, October 19-22, 1903.

First Day--Monday, October 19th.

MEETING OF THE COUNCIL AND FELLOWS.

The meeting was called to order in the New York Academy of Medicine by the President, Dr. Frederick Holme Wiggin, at 1.45 P. M.

After the calling of the roll by the Secretary, the President read his address on the condition and needs of the Association. Published in the November number of the JOURNAL.

Dr. C. A. Wall, of Buffalo, moved that the report be received and that the recommendations be taken up under the head of new business. Seconded by Dr. E. D. Ferguson, Troy, and carried.

The annual report of the Council was read by the Secretary.

ANNUAL REPORT OF THE COUNCIL.

The year which has elapsed since the holding of the Nineteenth Annual Meeting of The New York State Medical Association has been productive of most satisfactory results in the affairs of our organization in divers directions, and I desire to call more particularly your attention to, and go somewhat into detail regarding the advance which has been made in a direction especially brought to the notice of the office of Secretary, namely, the most solid and eminently satisfactory increase, both in the number of members in toto and in the number of affiliated county organizations.

The phenomenal increase in County Associations during the past year, whereby fourteen new counties have established associations in affiliation with, and adopted By-Laws which have been accepted by, the State Association, becoming thus part thereof, demonstrates most irrefutably the success which has attended individual and general effort and the appreciation by the profession at large of the benefits to be derived from membership.

All who have come in contact with the indefatigable work and untiring efforts of our State President and of the President of the Fourth District Branch, Dr. J. W. Morris, realize most forcibly the power which they have exerted in presenting these benefits to the minds of the profession and the labor they have exerted in the routine work of organization.

In the First District Branch we find a total increase in membership of 32, and that during the year three counties have been organized—Herkimer, Jefferson and Lewis.

Herkimer, which is a reorganization of a County Association, the affairs of which had become hopelessly involved, had last year seven (7) members. This year eight (8), an increase of

one member. It may be mentioned in passing that these figures do not show the acquisition of a number of new members which has actually taken place in this county, for naturally during the reorganization a number of old members were dropped and a corresponding number, plus one, of new members added.

The membership of Jefferson County Association numbered last year three (3), against thirteen (13) at present, showing an increase of ten (10).

Lewis County last year had one (1) member; it has now eleven (11), an increase of ten (10).

The Second District Branch shows a falling off of three members during the year. In this Branch, Essex County, the only newly organized representative last year had seven (7) members, now fifteen (15), giving us an increase of eight (8).

The Third District Branch shows an increase in membership of thirty-six (36) and the formation of two (2) new county organizations, namely, Seneca and Tompkins.

Seneca had last year two (2) members; this year nineteen (19), showing an increase of seventeen (17).

Tompkins last year had five (5) members, against a membership at present of twenty-three (23), gaining thereby eighteen (18).

The Fourth District Branch shows a total increase of 151 in its membership and an organization of eight (8) County Associations, namely: Allegany, Cattaraugus, Genesee, Monroe, Niagara, Orleans, Wayne and Wyoming. Three of these, namely, Allegany, Genesee and Wyoming, were, like Herkimer, in the First District Branch, reorganizations of hopelessly involved associations:

Allegany	had a memb'ship in 1902 of 6; 1903, 21—inc. 15
Cattaraugus	“ “ “ “ “ 3; “ 20— “ 17
Genesee	“ “ “ “ “ 4; “ 11— “ 7
Monroe	“ “ “ “ “ 11; “ 14— “ 3
Niagara	“ “ “ “ “ 2; “ 26— “ 24
Orleans	“ “ “ “ “ 5; “ 11— “ 6
Wayne	“ “ “ “ “ 4; “ 13— “ 9
Wyoming	“ “ “ “ “ 5; “ 17— “ 12
Total, 8 counties,	40; 133— 93

In the Fifth District Branch there have been 38 members added and no new organizations formed since our last annual meeting.

Summarizing, the Association has acquired 432 new members during the past year, has had 15 resignations, 23 deaths, 2 removals, and there are 95 delinquents in the matter of dues, showing an actual increase of 297 and making the membership 1,662.

During the latter part of July I received the following communication:

1729 CHESTNUT STREET, Philadelphia,
July 25, 1903.

My Dear Doctor—At the New Orleans meeting of the American Medical Association a committee, of which I am chairman, was appointed to take necessary steps toward raising \$20,000

for a memorial to the late Dr. Walter Reed, U. S. A., in commemoration of his remarkable services both professionally and humanitarian in reference to yellow fever.

In pursuance of this object, will you kindly send to me within the next ten days, if possible, to 823 Beach avenue, Cape May, N. J. (where I am staying for the summer) a list of the secretaries, with their addresses, of each County Medical Society in your State? If there is no secretary, please send me the name of the president.

While doing this, let me say it is of great importance that at the next meeting of your State Society this matter shall be brought to the attention of the Society and suitable measures taken to raise as large a sum as possible.

It is not contemplated that the subscriptions shall be limited to the profession. In fact, as the general public will benefit much more than the profession from Dr. Reed's researches, it is particularly desirable that the general public shall be solicited to subscribe to this worthy effort.

You will find an excellent biographical notice of Dr. Reed and his work in the *Journal of the American Medical Association* for November 29, 1902, page 1402.

Yours very truly,
W. W. KEEN, Chairman.

The figures from the books of the Treasurer, which, in accordance with the By-Laws, I submit to you at this time, are as follows:

INVESTMENTS:	
Real estate mortgage.....	\$3,250
In savings bank.....	458
Total	\$3,708

CONDITION OF FUNDS:	
Receipts	\$14,465.92
Balance	725.55
Expenditures	\$13,740.37

MEETINGS OF THE COUNCIL.

The Council has, since the close of the annual meeting of 1902, held six meetings.

The first meeting of the Council was held on October 23, 1902, ten members being present. Application for non-resident membership of Dr. Joseph A. Link, of Springfield, O., was submitted by the Secretary and was referred to the next subsequent meeting of the Council. Moved, seconded and carried that the matter of the final disposition of the transactions be left entirely in the hands of the Treasurer. The chairmen of the several committees submitted names of desirable members for their committees, which were duly acted upon by the Council. Moved, seconded and carried that a Committee on Finance be appointed, to consist of the President, Secretary and Treasurer. Matter of legal defense and prosecution of illegal practitioners was then introduced. It was moved, seconded and carried that the proposition of the attorney, relative to

medical defense and prosecution of illegal practitioners, be adopted.

At the meeting of the Council, held December 4, 1902, there were present nine members. Dr. Link's application for non-resident membership was again submitted and referred to the Secretary for further investigation. The chairman of the Committee on Publication requested that permission be granted for the printing of the names of the members of the Committee on Publication on the editorial page of the JOURNAL. This request was unanimously granted. Chairman of the Committee on Conference read the following resolution, as presented at the last meeting of the Committee on Conference:

"WHEREAS, Information has reached the Committee on Union since the last Annual Meeting of The New York State Medical Association, that important changes have been made in the Constitution and By-Laws of the American Medical Association, placing the committee in a position of being unable to properly comprehend those changes; therefore be it

"Resolved, That the question be referred to the Council of The New York State Medical Association for such action as it deems fit to take and such instruction relative to the union of The New York State Medical Association and the Medical Society of the State of New York."

After discussing the changes made in the Constitution and By-Laws of the American Medical Association it was moved, seconded and carried that it is the sense of the Council of The New York State Medical Association that the Committee on Conference is limited in its action in conference with like committee from the Medical Society of the State of New York to procure a new charter from the Legislature. Moved, seconded and carried that it is the opinion of the Council of The New York State Medical Association that the Code of Ethics exists as strongly as a rule of order under the present as under the previous By-Laws of the American Medical Association.

At the meeting of the Council, held April 22, 1903, there were present ten members. The application of Dr. Joseph A. Link for non-resident membership was unanimously accepted. Requests from two physicians for legal defense brought before the Council. It was then moved, seconded and carried that both cases under consideration be carried on. The application of the Medical Association of the County of Lewis to be affiliated with The New York State Medical Association and to represent it in the County of Lewis was then read and accepted by the Council. It was then moved, seconded and carried that the Committee on Finance be appointed to act for the Council in revision of By-Laws submitted by the new county organizations and empowered to give approval of the same. A communication, which requested organization of a section on tropical medicine of the American Medical Association, was submitted. Moved, seconded and carried

that this be referred to the delegate of The New York State Medical Association to the House of Delegates of the American Medical Association without recommendation. It was then moved, seconded and carried that The New York State Medical Association, through its Council, request that the House of Delegates of the American Medical Association continue its Committee on Proposed National Bureau of Medicines and Foods and suspend final action for at least one year, as the subject is much too broad for thorough consideration within the time available. A statement was then presented by the Treasurer relative to the matter of investment of the building fund. Moved, seconded and carried that the Council hereby confirms the action of its Treasurer in carrying out the previously established form of the State Association's Constitution in continuing its building fund investment in improved real estate, by renewal of the same mortgage for the next three years with a bond and mortgage company at $4\frac{1}{2}$ per cent. A statement of the finances of the Association from October 1, 1902, to March 31, 1903, was then read by the Treasurer. Moved, seconded and carried that the Treasurer shall submit to an adjourned meeting of the Council, statement of the bills collectable, whether of dues from members, or from advertisements in the *JOURNAL* or *Directory*, or any other sources of revenue; also amount of advertising contracts signed to date, also of the probable financial obligations of the Association for the remainder of the fiscal year. The subject of national incorporation for the American Medical Association was then brought up and it was moved, seconded and carried that The New York State Medical Association request the House of Delegates of the American Medical Association to apply to Congress for a special charter granting a national incorporation to the American Medical Association; and also that all changes made in the Constitution and By-Laws of the American Medical Association be printed in the *Journal of the American Medical Association* within three months after the annual meeting. Moved, seconded and carried that the pamphlet reprint from the April and May numbers of our *JOURNAL* upon National Incorporation for the American Medical Association be sent to each and every officer of the American Medical Association and to each delegate of the House of Delegates at the expense of The New York State Medical Association.

At the meeting of the Council, held May 27th, there were present eleven members. Communication from the chairman of the Committee on Publication, relative to an offer to buy books from the library, was directed by the Council to be transferred to the Chairman of the Committee on the Library. The Treasurer made a report in accordance with order of previous Council meeting on the finances of the Association, whereupon it was moved, seconded and carried that the Finance Committee be empowered to contract

with the Trow Directory Company to print the *Directory* for 1903.

At the meeting of the Council, held October 1, 1903, there were present thirteen members. Resignation of Dr. E. H. Squibb, from office of Treasurer, was read, and correspondence between Dr. Squibb, President and Secretary during the past few months was submitted. Moved, seconded and carried that the resignation of the Treasurer be accepted. It was then moved, seconded and carried that Dr. Wisner R. Townsend be appointed to fill the office of Treasurer, left vacant by the resignation of Dr. Squibb. Moved, seconded and carried that a committee of two be appointed to audit retiring Treasurer's report. Matter of trust fund invested in Dr. Squibb as Treasurer of the Fifth District Branch was then discussed, following which, Dr. Denison moved that the Auditing Committee investigate and ascertain the facts regarding this "Special fund," so-called, and report to the next meeting of the Council. The President then appointed Drs. Townsend and Bierwirth as members of the Auditing Committee.

At the meeting of the Council, held October 19, 1903, ten members were present. Report of the Secretary read and approved. Report of the First District Branch relative to matter of investigation of charges against members read, accepted and ordered published in the next number of the *JOURNAL*.

Communication from Dr. W. W. Keen read and ordered presented to meeting of the Council and Fellows. Report of the Treasurer read and unanimously accepted.

Resolved, That it is the opinion of the Council that local treasurers should add statement of fact and date of election to dues of new members when forwarded to State Treasurer.

Moved, that Finance Committee be empowered to renew rental of premises of Mott Memorial Library.

Reports of Chairmen of Publication Committee and Committee on Public Health read and accepted.

Moved, that attention of Board of Trustees of the American Medical Association be called to the matter of the character of advertisements inserted in the *Journal of the A. M. A.*, with special reference to one occurring in a recent issue which announced an instrument for the procuring of abortion.

Report of Council read and accepted.

Application of Dr. J. H. Wilkins, of Rushville, Yates County, favorably acted upon.

(Signed) GUY DAVENPORT LOMBARD,
Secretary.

On motion of Dr. E. D. Ferguson the report was accepted.

The report of the Treasurer was presented by Dr. W. R. Townsend. Published in the November number of the *JOURNAL*.

On motion of Dr. DeLancey Rochester, Buf-

falo, the report was received and referred to the Auditing Committee.

The President appointed as the Auditing Committee Dr. C. A. Wall, Buffalo, and Dr. David P. Austin, New York.

On motion the thanks of the Association were extended by a unanimous vote to Dr. E. H. Squibb for the manner in which he had conducted the financial department during the time he held office as Treasurer.

Dr. E. Eliot Harris, New York, presented the report of the Committee on Legislation.

REPORT OF THE COMMITTEE ON LEGISLATION.

Mr. President and Gentlemen—Your Committee on Legislation received 110 Medical bills from Albany this year, which is about ninety less than last year, and every bill opposed by the Committee, I might add, as a coincidence, failed to become a law.

Your Committee had one bill introduced in the Legislature this year which was reported favorably from the Senate Committee on cities and finally passed the Senate, but was held up in the Assembly for some mysterious reason. This bill, entitled "An Act to amend the Greater New York Charter, authorizing the Board of Health of the City of New York to appoint a chief medical examiner and medical examiners and prescribing their powers and duties, creating a bureau of medical examiners in the department of health, abolishing the office of Coroner in the city of New York, and providing for the performance of the powers and duties heretofore exercised by the Coroners in such city," was framed by a special committee in which your Committee on Legislation and the New York and Kings County Medical Associations were represented. Dr. Stephen Smith was the chairman of the joint committee, which recorded its conclusions as follows:

After a very full discussion of the various phases of the subject the conference unanimously concluded that it would be in the interests of a sound public policy if the office of Coroner were abolished and the duties conferred upon that official were properly adjusted among other branches of the municipal government. These duties are twofold, viz., 1. Medical, or those relating to the determination of the cause of death in cases where the cause is unknown; and 2. Legal, or those pertaining to the conduct of the proceedings in the investigation of the crime and the detection of the criminal by an inquest. 3. Judicial, or those of the court holding its inquest.

Evidently these duties belong to two entirely different professions and for their proper performance require men of learning and large experience in their respective professions. Whatever may be the merits of individual Coroners it "goes without saying" that no one has yet been elected to that office in this city who brought to the performance of these duties adequate knowledge of both professions to give the best and most reliable results. And it is doubtful if such a person ever will be or even can be elected. The Committee hold that in the very nature of these duties and of the conditions governing the selection and election of Coroners a thoroughly competent person cannot be secured for that office. We believe it is for this reason

chiefly that the office of Coroner has been under condemnation in every civilized country for more than two centuries. It is the reproach of an imperial city like New York, which is so progressive in the department of its sanitary service, to longer tolerate a branch of its civil administration incapable, in the very nature of its duties, of meeting the just demands of medico-legal science. It is the more surprising that we cling to this relic of the past when we have in the organization of our municipal government all the machinery essential to the performance of these duties with that promptness and accuracy which the service requires to insure the highest degree of success.

The first conclusion reached by the conference was that the medical duties, or the investigation of the cause of death, should be transferred to the Health Department, where those functions properly belong. It was held that the very foundation of an intelligent and efficient administration of laws, rules and regulations for the protection and promotion of the public health are accurate vital and mortuary investigations and registration. No health authority can exercise its functions properly which does not thoroughly understand the causes of mortality among the people. This knowledge can only be obtained by exhaustive inquiry into the circumstances and conditions under which every death occurs by persons fully qualified and equipped to employ the latest resources of science in their methods of investigation. It is apparent, therefore, that it is not only a legitimate function of the Board of Health, but it should be its statutory duty to investigate every death in the interest of the public health. And this duty should be the more imperative in cases of deaths from violence or from sudden and unknown causes, for the latter are liable to be due to conditions which are preventable and which should, therefore, be at once taken cognizance of by the Health authority.

The plan of organizing this service which, in the opinion of the Committee, is most feasible may be stated as follows: Empower the Health Department to establish a bureau especially devoted to the verification of deaths from uncertain causes; appoint as its chief officer a physician recognized as an authority in pathological investigations; appoint a sufficient number of medical examiners under the civil-service rules, but having as a special qualification practical familiarity with autopsical investigations; give to this bureau the full use of chemical and biological laboratories. The practical operation of this scheme would be as follows: Every death from unascertained cause reported to the Health Department would be at once referred to this new bureau for verification. The chief officer would immediately despatch a medical examiner to the place where the body lies, who would take possession of the body and all articles and clothing found upon it. He would have power to summon to his aid the police, or bystanders, or other Health officials, or a representative of the District Attorney's office. He would at once begin a systematic study of all conditions and circumstances attending the death, making ample notes, with the aid of a stenographer, of every fact ascertained. If to determine the cause of death autopsy is required, he may proceed to make it, and he has the power to summon to his aid another medical examiner, or bystanders, or the police. If chemical or biological tests are necessary the laboratories of the Department are at his immediate service, the examinations being by experts. Having completed his examination he submits to the chief of the bureau a full and detailed account of his findings. If this officer is satisfied that the death was due to natural causes and that there is no suspicion of crime, the usual certificate of death is made to the Bureau of Vital Statistics and the case is closed, the papers being filed in the bureau. If, however, there is evidence of crime, the chief officer reports all the facts to the District Attorney, with the recommendation that an inquest be held. This closes the first or purely medical part of the proceeding. The intrinsic merit of this method may be thus stated: 1. The investigation into the cause of death is made in a department especially

interested in determining the exact circumstances under which it occurred. 2. The medical examiner is thoroughly qualified for his duties and is under the direction and supervision of an eminent pathologist. 3. In prosecuting the investigation all the resources of the Health and Police Departments and the District Attorney's office are at once available. 4. These conditions secure to the medical inquiry prompt action, precision of details, expert knowledge at every step of the inquiry, abundant laboratory facilities, accurate results and economy in the expenditure of money.

The second conclusion of the conference was that the District Attorney or his representative should conduct the legal proceedings at the inquest in a magistrate's court. With the filing of the findings of the medical examiner in the office of the District Attorney would begin the legal and judicial proceedings in the case. The inquest would be conducted by a representative of the District Attorney before a magistrate and the medical examiner, and those who aided him would appear to give testimony as to the facts discovered in the preliminary investigation. These judicial proceedings would be conducted with proper dignity and in accordance with recognized rules governing the admission of evidence. If crime is revealed and the criminal discovered the farther prosecution of the case will be directed by the District Attorney, who will be better prepared to manage the subsequent details because he may have been familiar with all the preceding stages.

The third conclusion of the conference was that all other duties pertaining to the office of Coroner than those relating to the investigation of the causes of death and the holding of inquests be transferred to the City Chamberlain.

The following bill was drawn up after many conferences with James Taylor Lewis, counsel of the State Association, Senator Elsberg, Dr. Lederle, president of the New York City Board of Health, the presiding justice of the city magistrates, and the District Attorney:

AN ACT

To amend the Greater New York charter, authorizing the Board of Health of the City of New York to appoint a chief medical examiner and medical examiners, and prescribing their powers and duties, creating a bureau of medical examiners in the Department of Health, abolishing the office of Coroner in the City of New York, and providing for the performance of the powers and duties heretofore exercised by the Coroners in such city.

SECTION 1. Sections eleven hundred and seventy-nine, eleven hundred and ninety-four and twelve hundred and three of the Greater New York charter, as re-enacted by chapter four hundred and sixty-six of the laws of nineteen hundred and one, are hereby amended to read as follows:

SEC. 1179. Bureaus.—(*There shall be [two] three bureaus in the department of health.*) The chief officer of one bureau shall be called the "sanitary superintendent," who, at the time of his appointment, shall have been, for at least ten years, a practicing physician, and for three years a resident of the city of New York, and he shall be the chief executive officer of said department. The chief officer of the second bureau shall be called the "registrar of records," and in said bureau shall be recorded, without fees, every birth, marriage and death [, and all inquisitions of coroners,] which shall occur [, or to be taken] within the city of New York. [But in cases of inquests, where the jury shall find that the death was caused by negligence or malicious injury, only a copy of the record need be filed in said bureau.] (*The third bureau shall comprise the chief medical examiner and the medical examiners and the other assistants or employees of such bureau appointed as hereinafter provided, and shall be known as the "bureau of medical examiners of the department of*

health." *The chief medical examiner shall be the chief officer of said bureau.*)

SEC. 1194. Salaries.—(The annual salaries to be paid to persons herein named, and appointed to the several specified positions, shall from and after their entrance upon their duties, be as follows,) and such salaries shall be in full for all services rendered by them to the city in any capacity whatever: To the commissioner of health, seven thousand five hundred dollars; to the sanitary superintendent, five thousand dollars; to the secretary, five thousand dollars; to the assistant sanitary superintendents, each three thousand five hundred dollars; to the registrar of records, four thousand dollars; to the assistant registrars of records, each three thousand dollars; to the chief clerk of the department of health, three thousand dollars; (*to the chief medical examiner, a salary not to exceed six thousand dollars; to each medical examiner a salary not to exceed three thousand and five hundred dollars.*)

SEC. 1203. [Coroners'] *Medical examiners'* returns.—(The department of health may, from time to time, fix and define the time of making, and the form of returns and reports to be made to said department by the) [coroners of the city of New York, in all cases of post mortem inquests, or viewing of dead bodies held by them or any of them; and the said coroners are hereby required to conform to the directions of said department in the premises, and it shall be the duty of every coroner at once, and before holding any inquest, upon being called upon to hold an inquest as aforesaid, or notified thereof, to immediately transmit and cause to be delivered to the secretary of said department of health, written notice of the fact of such call, in which shall be stated every particular then known to said coroner as to said call, the body, the place where it is and the reported cause of death.] (*medical examiners in all cases of examination or autopsies of dead bodies held or made by them or any of them and in all other cases where such medical examiners may be charged with the performance of any duties under this act or otherwise.*) If at any time said department, or the sanitary superintendent, shall deem the protection of the public health to demand, it may, so soon as the [coroner's jury or physician] *medical examiner* may have viewed the dead body, and an autopsy thereof shall have been made, provided the [coroner] *medical examiner* deems the same necessary, order the immediate burial of any dead body, or if he or it deems that the public health demands an immediate removal of said body from the place of death to another place for [inquest] *autopsy* may likewise, at any time, order said removal and shall have power to cause said orders to be obeyed and executed.

SEC. 2. Title two of chapter nineteen of the Greater New York charter, is hereby amended by adding at the end thereof the following new sections:

(SEC. 1242. Office of coroner abolished; appointment of a chief medical examiner and of medical examiners; assistants for "bureau of medical examiners."—On and after September first, nineteen hundred and three, the office of coroner in the city of New York shall be abolished and the terms of office of the coroners of said city and of all officers, clerks, and subordinates appointed by such coroners shall cease and determine on that day. On or before such day the board of health of the city of New York shall appoint a chief medical examiner who shall be a citizen of the United States and a resident of the city of New York and shall be a physician duly licensed to practice medicine in the state of New York and shall be a skilled and practical pathologist; and said board shall also appoint medical examiners for such city as follows: Not to exceed six for the borough of Manhattan; not to exceed four for the borough of Brooklyn; not to exceed two for the borough of Queens; not to exceed two for the borough of the Bronx, and not to exceed two for the borough of Richmond. Such medical examiners shall be citizens of the United States and residents of the city of New York, and shall be physicians learned in pathology, duly licensed to practice medicine in the state of New York.

and who have practiced their profession within the city of New York for a period of at least five years next preceding their appointment. Such medical examiners shall in the first instance be appointed from the coroner's physicians in office when the office of coroner is abolished as provided in this act, and thereafter shall be appointed from among those standing highest upon an eligible list prepared by the civil service commission after a competitive examination held therefor. The board of health may designate one of the medical examiners, in each borough, other than the borough of Manhattan, to be assistant chief medical examiner for that borough. The board of health shall establish and maintain one or more offices in each borough, in connection with the offices of the department of health already established, if that be possible and convenient, for the use of the "bureau of medical examiners." Such offices in the boroughs of Manhattan and Brooklyn shall be kept open on every day in the year, including Sundays and legal holidays, with a clerk in constant attendance at all times of the day and night. In the boroughs of the Bronx, Queens and Richmond, such offices shall be kept open during such hours as the board of health may determine. The board of health may appoint such assistants for the "bureau of medical examiners" as may be necessary for the performance of the work of such bureau. The salaries of such assistants shall be fixed in like manner, as the salaries of other employees of the city of New York. The board of health may adopt rules, not inconsistent with the provisions of this title, prescribing the duties of the chief medical examiner, of the medical examiners and of all the employees of said bureau.)

(SEC. 1243. Certain jurisdiction, powers and duties of coroners to be vested in department of health.—The chief medical examiner and the medical examiners, appointed as provided in the preceding section, shall perform the duties of their office as prescribed by the board of health, in respect to the determination of the cause of sudden or suspicious deaths within the city of New York. The jurisdiction, powers and duties heretofore possessed or exercised by the coroners in the city of New York, in respect to the determination of the cause of sudden or suspicious deaths in said city, shall, on and after September first, nineteen hundred and three, be to the extent specified in this title vested in and imposed upon the department of health of the city of New York, and shall be exercised through said bureau of medical examiners.)

SEC. 1244. Notice of death from violence or sudden death.—Any person who shall be made aware of the death of another from criminal violence, or by a casualty, or suddenly when in apparent good health, or when unattended by a physician, or in prison, or in any suspicious or unusual manner, shall immediately notify the department of health, or a police officer whose duty it shall be to forthwith notify the health department of such death, and no person except those hereinafter specified to make the examination, shall touch, remove or disturb the body or the clothing or other articles upon, or near the body of such deceased person, except by order of the board of health.

SEC. 1245. Duties of medical examiners; autopsy; report.—Upon the receipt of a notice of the death of a person as provided in the preceding section, or whenever directed by the department of health, one of the medical examiners shall proceed at once to the place where the body of such person lies and take charge of the same. Such medical examiner may direct the removal of such body to such place as he may select or designate. He shall view the body and all its surroundings, and make careful and personal inquiry into the cause and manner of death. If, in the opinion of such medical examiner, the cause of death is not apparent or a further examination is necessary, he shall notify the district attorney of the county where such death occurred of that fact, and shall proceed to make an autopsy in the presence of the district attorney or a representative of the district attorney and a police officer, or of any two discreet persons. Such medical examiner shall

make a report in writing, stating in detail and at length all the facts and circumstances connected with the death, tending to show the cause thereof, the condition of the body when found, the result of the autopsy if one be made, and his opinion as to the cause of the death. Such report shall be subscribed and verified by such examiner and shall be filed in the office of the department of health. In any case in which, in the opinion of the medical examiner, the death was caused by criminal violence, and in all cases in which an autopsy has been made, a certified copy of such report shall be delivered to the district attorney of the county where the body was found. The medical examiner shall take into his custody all letters, private memoranda, articles and other property found about and upon the body of such person, or pertaining in any way to his death, and shall carefully seal and preserve them, and shall deliver them to the department of health. Any or all of such articles may be turned over to the district attorney, if requested by him for use in a criminal proceeding to be instituted in respect to such death. No person shall touch, remove or disturb the body of any such person or the clothing or other articles upon or near the body, unless duly authorized by the medical examiner or by the board of health. Any person violating any provision of this or the preceding section is guilty of a misdemeanor.

SEC. 1246. Inquiry by city magistrate.—If there is a suspicion of the commission of a crime in connection with the death of any person so examined, the district attorney of the county where said crime is committed, or any person accused or charged of having any guilty knowledge of a crime in connection with such death, may require the city magistrate of the district wherein said body was discovered, to hold an inquiry into all the facts surrounding the cause of such suspicious death, and such city magistrate may issue subpoenas and otherwise compel the attendance of witnesses before him upon any inquiry held as herein provided.

SEC. 1246a. Ante-mortem statements.—Any person who shall be made aware of the impending death of another from criminal violence, or by a casualty, or in any suspicious or unusual manner shall immediately notify the department of health or a police officer. Upon receiving such notification, the board of health shall immediately notify the district attorney of the county of the facts, and he or his representative shall with a medical examiner attend the person whose death is impending, and, if advisable, the medical examiner may alone or in the presence of the district attorney or his representative reduce to writing, witness and attest a statement of any and all facts surrounding or in any manner pertaining to the physical condition of such person whose death may be impending.

SEC. 1246b. Certain civil duties to be performed by city chamberlain.—All the civil and other functions not herein specifically provided for, which were heretofore exercised by coroners located within the boundaries of the city of New York, are on and after September first, nineteen hundred and three, hereby made a part of the duties of the city chamberlain of said city.

SEC. 1246c. Disposition of property and money found upon body.—Where money or property found on the body of a person, the death of whom was investigated as provided in the preceding sections hereof, has been turned over to the department of health, said department of health shall as soon as practicable deliver the same, except such as may have been required by the district attorney for use in a criminal proceeding to be instituted by him, to the city chamberlain, who shall hold the same subject to the demand of the legal representatives of such person. Unless such money or other property is called for within sixty days from such delivery, the city chamberlain shall deposit such money in the manner provided by the code of civil procedure in case of money paid into court; or in case of other property he shall sell it at public auction upon reasonable public notice, and deposit the proceeds thereof in the same manner. The money so deposited, with interest, shall be paid to the legal representatives of such

person at any time, within six years from the time of the delivery of such money or property to the city chamberlain, upon an order of a justice of the supreme court residing within the city of New York. Nothing in this section contained shall affect the rights, powers and duties of the public administrator or the county of Kings or of New York, in respect to the property and effects of deceased persons as provided by law.

Sec. 2. All the books, papers, records and other property of the coroners in the city of New York, shall, upon the termination of their offices, as provided in this act, be transferred by such coroners to the board of health.

Sec. 3. Sections fifteen hundred and seventy and fifteen hundred and seventy-one of the Greater New York charter are hereby repealed.

Sec. 4. All acts inconsistent or in conflict with the provisions of this act are, to the extent that they are so inconsistent, hereby repealed.

Sec. 5. This act, except in so far as it adds a new section twelve hundred and forty-two to the Greater New York charter, shall take effect September first, nineteen hundred and three. Section twelve hundred and forty-two, as added to and inserted in said Greater New York charter by this act, shall take effect immediately.

The chairman of your committee conducted the presentation of the side in favor of the bill before the Senate Committee on Cities and was aided by James T. Lewis, Dr. Alexander Lambert, Dr. Harry R. Purdy, Dr. W. Travis Gibb and Dr. A. Jacobi. The opposition was conducted by special counsel aided, Ex-coroner Tuthill, Coroner Berry, Coroner Goldenkrantz and others. At the hearing it was stated that the Committee on Legislation of The New York State Medical Association had always maintained before several committees of the Legislature, that the interests of the medical profession and the interests of the general public are identical, and we are ready to apply this principle in the argument favoring State bill No. 283, otherwise known as Senator Elsberg's Coroner's Bill.

The bill had its origin in the work of a special committee which examined the organization and operations of the Coroners office in New York, and also enquired into the methods of verifying the deaths from unknown causes in other States and countries. The conclusion reached was that the present Coroner's system does not, and under the conditions by which the coroners are selected cannot, meet the demands of modern scientific medicine. The Committee recommend that a system should be devised which would entirely divorce the organization and operations of the branch of public service devolved to the duties now imposed upon the Coroner, from political influences of every kind. When the question is asked why is the office of the Coroner in the city of New York the butt of the paragrapher, the subject of ridicule by the press and so little respected by the community at large, the answer seems to me to be in the fact that the Coroner in the city of New York exercises extraordinary authority and fills many offices.

There is no man to be found to-day with such power of mind and versatility of talent, who as Coroner, can sit upon the Bench as a judge deciding the kind of evidence that shall be sub-

mitted to his jury, who possesses the judicial authority to issue warrants for the arrest of those who fail to obey his command to appear before him; who leaves the Bench to answer a summons to go to any place to take the antemortem statement of some poor, injured mortal; who may be called to some hole in the ground to examine a body, and decide the question of the cause of death, incorporating in his decision the latest researches in chemistry, biology, toxicology and pathology; who, under Section 773 of the Code of Criminal Procedure, in cases of sudden death, if he has reasonable ground to suspect a crime, or in all cases of suicide—the Coroners in cities of the first class, only, must summon not less than nine or more than fifteen persons to serve as jurors, and Section 775, of the same code, commands that the jury must be present while the inspection of the body is being made.

The Coroner is higher than the Sheriff and replevins merchandise from him in civil suits.

Greater New York should be relieved of that officer known as the Coroner, whose numerous duties, as provided by the statute laws of the State, must surely, at some time in his official career, make him appear ridiculous.

The Coroner is an expensive relic of bygone ages. He has outlived his usefulness and should be placed with all those extinct species which evolution has shown to be unfit to survive.

By analyzing Senator Elsberg's Coroner's bill we can understand how the several existing departments of our city government can do, with a great saving of the city's money, the work of the Coroner much more satisfactorily than it has been done heretofore. A wise economy and a better official service demand that the office of Coroner in the city of New York should be abolished.

The bill transfers the judicial functions of the Coroner to the present city magistrates, whose duties are not mixed, but are essentially those of judges.

The medical duties associated with the office of Coroner are transferred by the bill to the Department of Health; the work of its laboratories has received honorable mention in the great medical congresses of the world, and its results have stimulated other cities to copy its admirable work.

We feel very safe in delegating the medical duties to the Board of Health as provided in the bill. The legal duties that are necessary for conducting the inquests properly are transferred by the bill to the District Attorney, where they naturally belong.

The civil duties of the Coroner have been transferred to the City Chamberlain, an officer of the city government who is in every way qualified for the responsibility imposed upon him by this bill.

In conclusion, we may add that Massachusetts and many other States have long since reformed their systems of verifying deaths, either by re-

organizing the system or by abolishing the office altogether and substituting modern scientific methods. We believe that it is in the interest of sound public policy that the city of New York, which is so abundantly supplied in its different departments with the means of superseding the work of the Coroners, should be relieved of this antiquated office.

And it now remains for the Legislature, through the help of this Committee, to give to the city of New York the much-needed relief from the unnecessary and costly Coroners, and their useless juries, which add another terror to the thought of sudden death.

After the hearing the bill was reported favorably to the Senate and finally passed by that body.

The New York State Medical Association is responsible for placing the dispensary law upon the statute books. This is an extract from a communication received:

"After graduating from the New York College of Physicians and Surgeons in 1896 I spent a year as interne in each of two large hospitals in New York City. Since I began practicing I have worked continuously in some one of the large dispensaries connected with these hospitals. During all this time there has been growing in me, as in many of my colleagues, a feeling of deep resentment against the authorities of these hospitals because they allow so many well-to-do people to be treated free."

I then wrote to the secretary of the State Board of Charities and received this answer:

"DISPENSARY REFORM.

"STATE BOARD OF CHARITIES,

"ALBANY, N. Y., March 17, 1903.

"E. ELIOT HARRIS, M.D.,

"Chairman Committee on Legislation, the New York State Medical Association, 33 West 93d street, New York City:

"My Dear Dr. Harris—In my opinion the Dispensary Law, Chapter 368 of the Laws of 1898 (the enactment of which you and other officers of the Association worked so hard to secure) and the rules and regulations adopted by the State Board of Charities, pursuant thereto, have been productive of much good.

"The Board, as you doubtless know, employs an inspector, whose sole duty is to inspect the dispensaries and to report in writing to the Board with relation to their observance of the rules. His reports are in turn brought to the attention of the officers of the dispensaries with the request that any violation of the rules be corrected.

"While a few of the dispensaries are not as cordial as they might be in cooperating with the Board in its attempt to bring about a better system of administering medical relief, most of them are really trying to improve conditions in this respect.

"That there has been more discretion exercised in dispensing medical relief in this State is shown by the fact that the dispensaries within the juris-

diction of the Board have reported a continual decrease in patients since the law took effect. In these dispensaries there were almost one hundred thousand less patients treated during the year 1902, as compared with the year 1898, before the Dispensary law was enacted.

"The State Board of Charities means to continue its inspection of the dispensaries with confidence that greater improvement and more discrimination in their work will continue to be shown as time goes on. The Board will also continue to depend upon the State Medical Association for assistance in securing this and other desired reforms.

"Respectfully yours,
 "(Signed), ROBERT W. HEBBERD, Secretary."

Respectfully submitted,

E. ELIOT HARRIS, Chairman.

On motion of Dr. H. R. Purdy, New York, the report was accepted with thanks, and the committee was continued, with the request that it replace the coroner's system with one more in line of modern progress.

The report of the Committee on Public Health was sent by the Chairman, Dr. J. Scott Wood, Brooklyn, and in his absence it was read by the Secretary.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH.

During the year action has been taken by this committee on the following subjects:

1st. A set of resolutions entitled "The Kyger Resolutions for the Abolition of the Newspaper Publication of Personal Medical Advertisements" was transmitted for action to our committee by the Secretary of the Association. These resolutions, which read as follows, were acted upon by the passage of a resolution which is also appended:

In a paper read by Dr. J. W. Kyger, before the Kansas City Academy of Medicine, on "The Decadence of the American Race," it was deemed of sufficient importance to appoint a committee to draft resolutions expressing the feeling of the regular medical profession in regard to the abatement of one of the causes of this condition, and also asking for the cooperation of the profession throughout the United States.

KYGER RESOLUTIONS.

WHEREAS, It can and has been shown, by ample statistics, that the American race is rapidly decreasing in its birth rate, thereby threatening ultimate and complete decadence of the race; and

WHEREAS, Such decadence has become so apparent that it should claim the serious attention of those of influence and power to in any degree lessen this evil; and

WHEREAS, Without a special effort to investigate, it must have been observed by the most indifferent with what flagrant violation of all sense of delicacy the public press gives place to advertisements of nostrums and means intended to

prevent or cut short pregnancy, these advertisements appearing in a column of the paper set apart for such purpose under the name of "Personal Medical Advertisements," and referred to as "Guarantees," "Sure Relief," "Sure Prevention," etc., occupying in some Sunday editions of reputable papers as much as two columns, destined to fall into the hands of all classes; and,

WHEREAS, We recognize the press as a most potent factor in the education of the masses; be it

Resolved, By the Academy of Medicine of Kansas City, Mo., that we respectfully recommend that a censorship over the public press should be exercised to the end of correcting such practice of publishing advertisements as those referred to in our whereases. Be it further

Resolved, That it should be deemed of sufficient moment for the attention of the Post-Office Department of the United States of America restricting or prohibiting the distribution of such papers, periodicals or magazines through the United States mail if they so continue to prostitute their columns with such matter. And be it further

Resolved, That a copy of these resolutions be sent every State Medical Association in the United States, urging their cooperation in this movement by the adoption of these resolutions.

Resolved, That we request the Secretary of every State Medical Association adopting these resolutions to forward two copies, one to the American Medical Association and the other to the Postmaster-General, petitioning for relief from this destructive influence.

Committee { JOHN W. KYGER, M.D.,
H. C. CROWELL, M.D.,
B. H. ZWART, M.D.
January 28, 1903.

Resolved, That we, the Committee on Public Health of The New York State Medical Association, after careful consideration of "The Kyger Resolutions for the Abolition of the Newspaper Publication of Personal Medical Advertisements," do hereby give our unqualified approval and indorsement of said preambles and resolutions.

(Signed)

Committee { HENRY M. SILVER, M.D.,
GERRIT F. BLAUVELT, M.D.,
CHARLES A. WALL, M.D.,
D. C. MORIARTA, M.D.,
FREDERICK HUHNE, M.D.,
J. SCOTT WOOD, Chairman.

2d. A communication received through the President of The New York State Medical Association from Dr. Allport, of Chicago, urging the adoption of resolutions favoring the systematic annual examination of eyes and ears of school children and bringing to our notice the action taken by Illinois regarding this matter.

I append hereto the official request therein embodied and resolutions passed by this committee:

"At the last meeting of the American Medical Association, held in New Orleans, May, 1903, the Section on Eye Diseases, and the American

Medical Association as a whole, adopted the following resolution:

"WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures; therefore be it

Resolved, That it is the sense of the American Medical Association that measures be taken by boards of health, boards of education and school authorities, and, where possible, legislation be secured, looking to the examination of the eyes and ears of all school children, that disease in its incipency may be discovered and corrected."

It will therefore be seen that this movement has been indorsed and recommended by the most representative medical organization in the United States, and the undersigned takes the liberty of calling the attention of your honorable board to the matter, and of urging your honorable board to take such measures toward a systematic and annual examination of the eyes and ears of the school children of your State as may seem wise and expedient, after giving the matter intelligent and thoughtful consideration. The undersigned desires, if possible, to secure an accurate report of the work being accomplished along these lines, and therefore begs for the cooperation of your honorable board, and would request the answering of the questions printed on the enclosed sheet. The undersigned begs to enclose certain communications sent by the Illinois State Board of Health to county superintendents of schools throughout the State, in order to demonstrate what is being accomplished in Illinois along these lines, and thinking that perhaps it might be suggestive to your honorable board. An early reply would be gratefully received.

Respectfully yours,

FRANK ALLPORT.

RESOLUTION PASSED BY THE NEW YORK STATE MEDICAL ASSOCIATION.

WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures; therefore be it

Resolved, That it is the sense of The New York State Medical Association that measures be taken by boards of health, boards of education and school authorities, and that needed legislation be secured, looking to the examination of the eyes and ears of all school children, that disease in its incipency may be discovered and corrected.

(Signed) J. SCOTT WOOD, Chairman.

HENRY MANN SILVER,

CHARLES A. WALL.

Respectfully submitted,

J. SCOTT WOOD,

On motion of Dr. DeLancey Rochester the report was received and its recommendations adopted unanimously.

Dr. C. E. Denison, New York, presented the report of the Committee on Publication.

REPORT OF THE COMMITTEE ON PUBLICATION.

Your Committee on Publication begs leave to report the work done during the past year, in publishing THE NEW YORK STATE JOURNAL OF MEDICINE and the fifth volume of the *Medical Directory of New York, New Jersey and Connecticut*.

The JOURNAL has been sent to the members regularly each month. During the past twelve months there have been published thirty-seven papers read at the nineteenth annual meeting of the State Association, nineteen papers read at the District Branch Associations, and twenty-six papers read at the County Associations.

An effort has been made to secure all the papers read at district and county meetings throughout the State. A larger number has been secured this year, and an early response from the writers would greatly lighten the work of the committee. In addition to the original papers there have been published fifty-three book reviews; in the Association news, matters of interest connected with the Association; the proceedings of the meetings of the District Branch and County Associations have been faithfully and carefully done by the secretaries; we desire to thank them for their promptness and good work. It has been necessary to increase the size of the issues, which has added materially to the expense of the JOURNAL this year.

The *Medical Directory* has been sent to the members a month later than formerly, but this was due to the strikes on the new building of the printer and has greatly hampered us in our work.

Our purpose has been to make the *Medical Directory* the best that can be obtained, and the work can be facilitated by every member notifying the committee of errors and omissions.

The business office has been in the charge of the committee this year. All the work done for the President, Secretary and the various committees has been successfully carried out, as well as sending out bills and collecting amounts due on advertisements. Orders for *Directories* have been received and cash collected about \$1,000. For work paid by the District and County Associations there has been collected over \$100.

There has been collected from advertisements over \$2,000. The net cost of the JOURNAL has been about \$700 to the Association.

(Signed) CHARLES E. DENISON,

October 19, 1903. Chairman.

On motion of Dr. E. D. Ferguson the report was received.

Counselor James Taylor Lewis sent his report, which was read by the Secretary.

REPORT OF THE COUNSEL.

October 15, 1903.

The New York State Medical Association, Its Council, Officers and Members.

Gentlemen—The development of The New York State Medical Association along the new

channel for the past year requires from me perhaps a more extended report of the work done in the legal department.

In addition to the prosecution of illegal practitioners of medicine, there has been inaugurated during the past year the malpractice defense of members of the Association; since this work has been fairly gotten under way two members have been threatened and express a desire for defense if sued, and six other members have been actually defended, and, best of all, the fact of this defense has been brought to the attention of the public, which fact alone in future is bound to become a deterrent against unjust attacks of this kind, and will cause the intending litigant to pause, and his advisor attorney stop and consider whether or not it is best to take a case upon a contingent fee, which promises a fight to the Court of Appeals.

The following is a detailed report of the various actions defended by your counsel under the provision of the by-laws covering such defense, part of which it might not be out of place to recite at this point in my report:

"Article II, Section 7.—The Council shall, upon request and compliance with the conditions hereinafter provided, assume the defense of suits of alleged malpractice brought against members of this Association. The Council shall not undertake the defense of any suit based upon acts prior to the qualification of the accused as a member of the Association," etc.

The following are the cases:

1. Philip Kronenberger vs. Dr. McC., of New York. This action was begun on the 16th day of October, 1902, by the service of a summons upon the defendant, and was followed on November 5th with a complaint unverified. The action was brought by an attorney named Robert Kuhnert, of this city; a counter claim was set up for services of the physician, but the plaintiff has made no further progress with his case and has not put the case on the calendar for trial. The unfortunate part of this case is that at present the complaint cannot be dismissed for want of prosecution, so that the matter will have to stand.

2. An action was brought by Dr. J., of this city, against one Harvey to recover on a bill. The patient had threatened to sue the doctor for malpractice if the doctor sued for his bill. Dr. J. promptly sued and the case was tried, with the result that the doctor got a judgment for his bill, and the charge of malpractice was completely disproved. The defendant set up a counter claim of \$5,000 for malpractice in the action.

3. This was an action brought against a member of the Association, Dr. Von D., but as another attorney was already in the case, and as it was impossible for me to act as attorney of record, I volunteered my services as counsel and appeared in court. The result in this case was most satisfactory.

4. William Naehner, of Buffalo, brought an action against Dr. G., of Buffalo; the summons

was received by the doctor on April 27, 1903; the answer was served on April 30th, by mail. On August 1st a letter was received from the plaintiff's attorney, followed by a call from him, when he expressed a wish to settle for \$200, saying that his client was about to leave the State. The proposition was immediately declined and the attorney was informed that he would not be allowed to discontinue without paying costs. The counsel believes that the case will never be tried.

5. Maurice S. Casey, of New York, brought an action against Dr. S., of this city, who is a member of the Association; the suit was also brought against Dr. G., of this city, who is not a member of the Association, plaintiff claiming that they were both jointly liable for the death of an infant, to the plaintiff's damage. The action was brought by Lawyer Oppenheim, of this city; another attorney represents the non-member. I have served an answer in the case covering the whole ground, and there is no doubt in my mind but that the complaint will be dismissed if the case is ever put on the calendar.

6. Wood, as administrator, vs. Dr. W., of New York. About two years ago an action was brought in Queens County against this physician; the jury disagreed, and after an appeal had been taken in the case, the matter was again brought on for trial before Judge Marean and a jury in Long Island City, on October 8, 1903. Verdict for the defendant.

Your counsel was not the attorney of record in this case and was not in any way connected with it at the first trial, but was called in at the request of the doctor, and assisted as counsel at the trial recently held.

There were other cases reported, and it is believed that the knowledge brought to the proposed plaintiff, that the State Association would furnish defense gratis to the doctor sued, has caused the complainant to desist.

All of which is respectfully submitted,

(Signed) JAMES TAYLOR LEWIS, Counsel.

On motion the report was accepted.

Dr. C. A. Wall reported for the Auditing Committee that the accounts of Dr. E. H. Squibb had been examined by a public accountant, and found correct in each item, and that they had also been audited by the Council. In addition the acting Treasurer had prepared and had printed a report of the present financial condition of the Association.

REPORT OF THE AUDITING COMMITTEE.

Your committee appointed to audit the report of the Treasurer find that the accounts of Dr. E. H. Squibb were examined by a public accountant and found correct in each item, and they have also been audited by a committee appointed by the Council, and we therefore recommend the approval of the report as submitted.

We commend the supplementary report as

placing before us a plain statement of our present condition.

(Signed) CHARLES A. WALL,
D. P. AUSTIN,

Committee.

New York, October 19, 1903.

On motion the report was accepted.

Under the head of new business the recommendations made by the President were taken up.

DR. JOSEPH D. BRYANT, Chairman of the Committee on Incorporation of the American Medical Association, said: "There seems to be a general feeling in favor of incorporation, but there seems to be a question of expediency as to whether the incorporation shall be national or not. I have no doubt that national incorporation in the District of Columbia can be secured, for I have obtained the opinion of a United States Circuit Court Judge to that effect. I should like to ask Dr. Wiggin if he would be willing to have all allusion to place of incorporation and the incorporating power dropped from the resolution."

DR. WIGGIN: "I have given this matter a great deal of personal consideration during the past year, and I believe, not only from the facts presented by Dr. Bryant, but also from a recent opinion given by Judge Grosscup, one of the United States Judges, that it is entirely possible to get a special charter from Congress which will allow of our doing business anywhere in the United States. I know that such a charter can be obtained from the State of New York; also in Delaware, Maryland and elsewhere. My contention is that as long as this can be done by an act of Congress it will add to the dignity and importance of the medical profession to have a charter from the National Government. Just as the State bodies have their charters from the Legislature, so should our national organization hold its power from the United States Government. The present plan of organization of the American Medical Association is founded on that of the United States Government."

DR. BRYANT: "I must then move, as an amendment, that the resolution presented by the President be adopted with the elimination of reference to the place of incorporation and the power of incorporation." Seconded.

DR. ALVIN A. HUBBELL, Buffalo: "I move the adoption of the following resolution:

"WHEREAS, It is the belief of The New York State Medical Association that reincorporation of the American Medical Association under a national charter would elevate the position and increase the dignity of the medical profession of this country, therefore be it

"Resolved, That the American Medical Association be hereby requested to make application through its committee to Congress for a special charter permitting the Association to hold property and to meet anywhere within the territorial limits of the United States; and be it further

"Resolved, That the members of the House of Delegates of the American Medical Association,

representing this Association, are hereby instructed to favor and vote for such national incorporation for the American Medical Association, and the Secretary is hereby instructed to forward copies of these resolutions to the President, the Secretary and the Chairman of the Committee on National Incorporation of the American Medical Association."

Seconded by Dr. C. A. Wall.

Dr. W. H. Thornton, Vice-President, then took the chair.

DR. WIGGIN: "It seems to me perfectly clear that the charter can be obtained from Congress provided there is a sufficiently marked expression of opinion from the medical profession of the country. I do not want a charter from the District of Columbia, but from the Congress of the United States."

DR. BRYANT: "My only object in moving this amendment was to simplify matters. I thought, as chairman of the committee, that it would be wiser if the State which I represent did not express itself so forcibly."

DR. DELANCEY ROCHESTER, Buffalo: "I think it is much wiser for us, as Fellows of The New York State Medical Association, to send our delegates to the American Medical Association with explicit instructions that we believe that the American Medical Association should receive its incorporation from the Congress of the United States. Our national organization is formed just as is the Congress of the United States, and I think the national body should receive its charter from the National Government, if such a thing is possible. I hope the amendment will not be adopted."

The amendment was then put to a vote, and was lost.

The original resolution was then unanimously adopted.

Dr. C. A. Wall moved that a committee of five be appointed by the Chairman to take into consideration the codification of the By-Laws of The New York State Medical Association, and report at the next meeting. Seconded by Dr. D. S. Dougherty, New York, and carried unanimously.

Dr. A. A. Hubbell then moved the adoption of the following resolution:

"WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures, therefore be it

"Resolved, That it is the sense of The New York State Medical Association that measures be taken by boards of health, boards of education and school authorities, and that needed legislation be secured, looking to the examination of the eyes and ears of all school children, that disease of these organs in its incipiency may be discovered and corrected."

Seconded and carried unanimously.

Dr. H. H. Seabrook, New York, then moved the adoption of the following resolution, as an

amendment to the recommendation contained in the President's report:

"Resolved, That the Committee on Legislation be requested to further a law making it a misdemeanor, punishable by fine or imprisonment, for men not graduates in medicine to advertise themselves as eye specialists, or for sellers of glasses to sell correcting lenses when they are not able 'to raise the vision to twenty-thirtieths Snellen.'"

Seconded by Dr. A. A. Hubbell and carried unanimously.

The following were appointed as the Committee on Revision of By-Laws: Drs. J. W. S. Gouley, C. E. Quimby, J. C. Bierwirth, W. H. Thornton and John S. Kirkendall, of Ithaca.

Dr. C. E. Quimby presented the report of the Committee on Nominations as follows:

President, Dr. W. H. Thornton, Buffalo; Vice-President, Dr. Charles S. Payne, Liberty; Secretary, Dr. Guy Davenport Lombard, New York; Treasurer, Dr. Frederick A. Baldwin, New York; Chairman of the Committee on Arrangements, Dr. Samuel A. Brown, New York; Chairman of the Committee on Legislation, Dr. E. Eliot Harris, New York; Chairman of the Committee on Library, Dr. John Joseph Nutt, New York; Chairman of the Committee on Public Health, Dr. Louis C. Ager, Brooklyn; Chairman of the Committee on Publication, Dr. Charles E. Denison, New York; Chairman of the Committee on Nominations, Dr. J. Orley Stranahan, Rome; Delegates to the annual meeting of the American Medical Association, Dr. Joseph W. Grosvenor, Buffalo, and Dr. E. Eliot Harris, New York.

On motion the report was received and unanimously adopted.

The minutes of this meeting were then read and adopted as read.

On motion the meeting adjourned at 3.30 P. M.

Second Day—Tuesday, October 20th.

MORNING SESSION.

The meeting was called to order by the President at 9.45 A. M.

Dr. S. A. Brown delivered the Address of Welcome, after which the scientific program was taken up.

ADDRESS OF WELCOME OF THE CHAIRMAN OF THE COMMITTEE ON ARRANGEMENTS.

Ladies and Gentlemen—It is my privilege and pleasure to welcome you in the name of the Committee on Arrangements and the Fellows of the County of New York to the twentieth annual meeting of The New York State Medical Association. A program has been placed in the hands of each member giving the titles of all papers and the order in which they will be read. The sessions, as usual, will begin promptly at 9.30 o'clock in the mornings and at 2 P. M. in the afternoons, and it is hoped that all members of the Association will appreciate the necessity of beginning the session on time and also of making

a personal effort to be present to hear and discuss not only the papers during the middle of the day, but also those in the early part, for it will be observed that many very valuable papers were of necessity placed in the early part of the session.

We wish to thank the members of our Association and our guests who have consented to be present and to take part in the reading and discussion of the papers. The Secretary of the Committee on Arrangements, Dr. W. R. Stone, will be present to receive the railroad certificates, and it would facilitate matters very much if the certificates were turned in immediately upon arrival, as it is necessary to have one hundred certificates before they can be signed by the trunk line agent. A fee of 25 cents must be deposited with each certificate to cover the expense.

Members will kindly register as early as possible. A luncheon has been arranged for each day at 1 o'clock and all are cordially invited to partake. It will be noted that the Committee have omitted a program for Tuesday evening. It was deemed wise to leave this evening open for social engagements, theaters, etc.

On Wednesday evening the annual dinner will be held at the Hotel Manhattan, and we can now assure from present indications that it will be one of the largest ever held. It will greatly assist the committee if all members who desire to attend the dinner will notify the Secretary or Chairman as early as possible. The dinner committee will endeavor to arrange the seating, if the members will hand to Dr. Leo the names of the diners with whom they wish to be seated. If not specified the committee will leave arrangement as to the seating to members, as at the dinner last year.

SAMUEL A. BROWN,

Chairman Committee on Arrangements, The New York State Medical Association.

Dr. R. Abrahams, New York, read a paper "Sea Bathing."

Dr. V. D. Bozovsky, Dunkirk, read a paper, "Treatment of Compound Fractures."

Dr. F. J. Douglas, Utica, read a paper, "Stab Wounds of the Abdomen."

Dr. George W. Goler, Rochester, read a paper, "The Relation of the Municipal Milk Supply to the Health of Children." It was discussed by Dr. DeLancey Rochester, Buffalo; Dr. James J. Walsh, New York, and Dr. H. O. Marcy, Boston, and the discussion was closed by Dr. Goler.

Dr. Augustin H. Goelet, New York, read a paper, "The Causes of Failure After Operation for Nephroptosis." It was discussed by Dr. E. D. Ferguson, Troy; Dr. Martin B. Tinker, Clifton Springs; Dr. R. H. Gibbons, Scranton, Pa.; Dr. Marcy, and the discussion was closed by Dr. Goelet.

Dr. W. B. Reid presented "A Report of a Case of Strangulated Hernia in an Infant; Reduction by Taxis."

Dr. James P. Tuttle, New York, read a paper, "Results from Operative Treatment of Cancer of

the Rectum," and exhibited several patients. The discussion was participated in by Dr. H. O. Marcy, Dr. E. D. Ferguson and Dr. W. B. Ulrich, Chester, Pa., and the discussion was closed by Dr. Tuttle.

The following delegates from other societies were received and introduced: Dr. E. B. Silvers, Rahway, N. J.; Dr. Clarence E. Skinner, of New Haven, Conn.; Dr. R. H. Gibbons, Scranton, Pa., and Dr. William B. Ulrich, Chester, Pa.

Dr. W. B. Ulrich, President of the Medical Society of the State of Pennsylvania, said: "Mr. President and members of The New York State Medical Association: The Medical Society of the State of Pennsylvania sends greetings to you, and, recognizing the achievements of organization and cooperation in the past, desires to affiliate thoroughly, strenuously and fully, not only with your society, but with every other society in ethical standing, not only in this country, but in the world, in the effort to advance scientifically, socially and ethically the interests of our profession. Organization reaches far beyond individual exertion. This is patent to the mind of everybody connected with the profession. The higher standard of medical education within the past thirty years has been achieved by organization. It is to be hoped that along these lines there will be a strenuous effort at all points to still further our progress and our interests.

"I see by your program that it is full of interesting subjects, and I shall therefore not occupy your time further than to extend to you, from the State of Pennsylvania, a hearty God-blessing and God-wish that you may prosper in the future as you have in the past."

DR. E. B. SILVERS, of New Jersey: "I come from the State of New Jersey, and from the oldest medical society in the United States, bringing to you warm paternal and fraternal greetings. Many times I have had the pleasure of representing that State, not only here, but in other States, but of all the States to which I have gone—I have not been to Pennsylvania—I feel that, of all our progeny, you are a great credit to us. I carry home with me very pleasant memories and my mind liberally stored with medical pabulum. I thank you for your hospitality."

The Chairman, DR. E. D. FERGUSON: "It is always a pleasure to meet the delegates to the meeting from our sister States. We are very glad that Dr. Silvers has been with us so many times, and we trust that this will not terminate the dealership of any of the representatives we have had the pleasure of welcoming this morning."

Adjournment at 12.30 P. M.

Delegates from other State societies who were present at the annual meeting of The New York State Medical Association:

Connecticut—Rush W. Kimball, Norwich; Clarence Edward Skinner, New Haven.

New Jersey—Daniel A. Currie, Englewood; Elihu B. Silvers, Rahway.

Pennsylvania—William H. Dudley, Easton;

Richard B. Gibbons, Scranton; Edgar M. Green, Easton; William B. Ulrich, Chester.

AFTERNOON SESSION.

The meeting was called to order at 2 p. m. by Dr. W. H. Thornton, the Vice-President. The scientific program was resumed.

Dr. E. D. Ferguson, Troy, read a paper, "One of the Dangers in the Surgery of the Biliary Passages."

Dr. Seymour Oppenheimer, New York, read a paper, "Extradural Abscess and Mastoid Disease." It was discussed by Dr. Frank W. Higgins, Cortland, and Dr. Oppenheimer made some closing remarks.

Dr. H. Ernst Schmid, White Plains, read a paper, "School Hygiene and the Great Need of Regular Medical Supervision." It was discussed by Dr. E. B. Silvers, Rahway, N. J., and Dr. James J. Walsh, New York, the discussion being closed by Dr. Schmid.

Dr. Cordelia A. Greene sent a paper, "The Influence of Oxygen, Taken by Full Normal Respiration, When Chemically Pure, as a Means of Sustaining and Increasing Mental, Nervous and Physical Energy." The paper was read by Dr. J. J. Walsh, and was discussed by Dr. DeLancey Rochester, Buffalo, and C. E. Quimby, New York.

Dr. William H. Park, New York, read a paper, "Bacteriology and Pathology of Dysentery in Children." It was discussed by Dr. W. P. Northrup and Dr. Charles G. Kerley, New York, and the discussion was closed by Dr. Park.

Dr. Martin B. Tinker, Clifton Springs, read a paper, "Some Less Usual Causes of Post-Operative Elevations of Temperature." It was discussed by Dr. Elias Lester, Seneca Falls; Dr. H. D. Didama, Syracuse; Dr. William B. Ulrich, Chester, Pa., and Dr. Fritz K. H. Maass, New York.

Adjournment at 5 p. m.

Third Day—Wednesday, October 21st.

The meeting was called to order by the President at 9.45 a. m., and the scientific program was at once taken up.

Dr. Alfred T. Livingston, Jamestown, read a paper, "Ergot in Alcoholism and Morphinism, and the General Class of Drug Habit Cases." It was discussed by Dr. Alexander Lambert and Dr. Frederick Holme Wiggin, New York, and Dr. H. D. Didama, Syracuse, and the discussion was closed by Dr. Livingston.

Dr. V. A. Robertson, Brooklyn, read a paper, "Laboratory Aids to Diagnosis for the General Practitioner." It was discussed by Dr. DeLancey Rochester and Dr. W. H. Thornton, Buffalo, and Dr. Eden V. Delphey, New York. The discussion was closed by Dr. Robertson.

Dr. James Hawley Burtenshaw, New York, read a paper, "Treatment of Puerperal Sepsis," which was discussed by Drs. Joseph B. Cooke and Eden V. Delphey, New York, and Dr. DeLancey Rochester, Buffalo. Dr. Burtenshaw closed the discussion.

Dr. Irving S. Haynes, New York, read a paper, "When and How to Operate for Gall Stones."

Dr. Frederick Holme Wiggin, New York, presented a patient upon whom he had operated five years before for carcinoma of the sigmoid flexure, colon and rectum.

Dr. Chauncey P. Biggs, Ithaca, N. Y., read a paper, "The Typhoid Epidemic in Ithaca, with Special Reference to Causation, Prevention and Treatment."

THE PRESIDENT: "Permit me to introduce to you at this time the President of The Medical Society of the State of New York, Dr. A. T. Bristow, of Brooklyn. I can say that I have had six months' personal acquaintance with Dr. Bristow, and I have found no better friend of the medical profession in the United States, and none who desires more earnestly than he unity of the medical profession of the State of New York."

DR. A. T. BRISTOW: "It is good to be among my friends, and I know that I am among my friends by the greeting which you have given the President of the State Society.

"There are, I see, many of us here who are old enough to go back to twenty-five years ago, the time when we did not know anything about coin, greenbacks being then in vogue. No one seemed to know when we were going back to specie payment. After a time John Sherman came to the front and made the statement that the only way to resume specie payment was to resume, and this was done. We have come to the conclusion that the only way to resume specie payment is to resume. The State Society and the State Association are going to resume their former harmonious relations, and in a very short time we shall not be two societies, but one." (Prolonged applause.)

THE PRESIDENT: "We have with us another very good friend of The New York State Medical Association, and one who has, in times of considerable trouble and difficulty, often stood behind it. I should like to present Dr. George H. Simmons, Secretary of the American Medical Association."

DR. SIMMONS: "Mr. President, Ladies and Gentlemen—Your President came to me a few minutes ago and requested me to come to the platform and be introduced. I replied that if that were the case I would not go. However, he has introduced me anyhow. I wish to say that it gives me great pleasure to be here, for I have met many of you before. Nothing has given me greater inspiration, greater pleasure and greater hope for the future, not only as regards the profession of New York State, but of the whole United States, than the action taken by the two bodies of the representative men of the medical profession from the two organizations in this State. There is nothing which has hindered uniform medical organization and has prevented making the profession of the United States a united body but the little misunderstanding that occurred in this State long ago. Let us rejoice that this little

misunderstanding has been done away with, and that we can shake hands as brothers and can take a hand in the good work of elevating the medical profession in the very best sense of that word." (Applause.)

THE PRESIDENT: "I see another good friend of the medical profession with us, Dr. Philip Marvel, of New Jersey."

DR. MARVEL: "Members of The New York State Medical Association, Ladies and Gentlemen—It would be very much like having the trade dollar in circulation for me to attempt to say anything after the address of the President of the Medical Society of the State of New York, and after the very pleasant words of the Secretary of the American Medical Association. Perhaps I may simply add these words of invitation: In 1900 the American Medical Association met in Atlantic City. I do not know of any better place for the two medical societies of the State of New York to unite and join hands than at Atlantic City at the coming meeting of the American Medical Association next June, and I hope you will all be there."

THE PRESIDENT: "I desire to present the representative of the Ohio Medical Society, Dr. C. L. Bonifield, of Cincinnati, for many years the Secretary of the Section on Gynecology of the American Medical Association."

DR. BONIFIELD: "Mr. President, Ladies and Gentlemen—I am very glad indeed that I am with you to-day. I did not suppose when I left Cincinnati that it would be my good fortune to be present at the love feast which we have just witnessed. It is an epoch in America, and I rejoice that I am present."

THE PRESIDENT: "I desire also to present Dr. Kimball, delegate from the Connecticut Medical Society, and Dr. W. H. Dudley, of Pennsylvania."

DR. DUDLEY: "The physicians of the State of Pennsylvania have watched the progress of the two State societies here, and none will rejoice more over the prospective union than your brothers in Pennsylvania. I have been here on some previous occasions, and I have always enjoyed myself. I count myself particularly fortunate to be here at the time when the way seems paved for the consummation of the long-deferred object of our desires."

Adjournment at 12.45 P. M.

AFTERNOON SESSION.

The meeting was called to order by the President at 1.30 P. M., who then delivered his address, taking for his theme, "The Past and Present Needs of the Medical Profession."

On motion of Dr. DeLancey Rochester the thanks of the Association were extended to the President for his interesting address.

Dr. E. M. Green, of Pennsylvania, was then introduced. He said:

"I am very sure, Mr. President, it is a great pleasure for me to come to your meeting, for, in

the past, I have always enjoyed them exceedingly."

The scientific program was then resumed.

Dr. Charles B. Tefft, Utica, read a paper, "Sewage Disposal as a Means of Purifying the Water Supply of the Cities and Towns of the State."

Dr. David P. Austin, New York, presented a patient from whom he had removed the superior maxilla of the left side for phosphorous necrosis on May 4, 1870. The case was discussed by Drs. C. N. Dowd, J. W. S. Gouley, F. H. Wiggin and J. A. Bodine, of New York, and the discussion was closed by Dr. Austin.

The paper by Dr. R. H. Hutchings, Ogdensburg, entitled "Suggestions for Examination of the Presumably Insane," was, in the absence of its author, read by title. Dr. C. A. Atwood, White Plains, discussed the subject.

Dr. DeLancey Rochester, Buffalo, read a paper, "The Treatment of Pneumonia." It was discussed by Drs. A. Alexander Smith and W. P. Northrup of New York and Dr. Frank D. Reese, Cortland. The discussion was closed by Dr. Rochester.

Dr. Charles Stedman Bull, New York, read a paper, "Arteriosclerosis and Its Bearing on Certain Lesions of the Retina and Optic Nerves."

Dr. Charles L. Bonifield, Cincinnati, O., read a paper, "Dysmenorrhea."

Dr. Richard C. Cabot, Boston, Mass., read a paper, "Properties of the Blood Serum as Illuminated by Ehrlich's Researches."

On motion of Dr. A. T. Livingston, the thanks of the Association were tendered Dr. Cabot for his exceptionally interesting and instructive communication, and the Secretary was instructed to notify Dr. Cabot of this action.

Dr. Frank W. Higgins, Cortland, read a paper, "Minus Cylinders; Those Who Prescribe Them and Those Who Wear Them."

Adjournment at 5.15 P. M.

Fourth Day—Thursday, October 22d.

The meeting was called to order by the President at 10 A. M.

Dr. J. R. Sturtevant, Theresa, read a paper, "Diphtheria in the Country; Its Diagnosis and Management." It was discussed by Dr. James J. Walsh, New York; Dr. J. Orley Stranahan, Rome; Dr. DeLancey Rochester, Buffalo; Dr. William B. Ulrich, Chester, Pa.; Dr. Frank D. Reese, Cortland; Dr. E. D. Ferguson, Troy; Dr. A. C. Way, Perry Center, and Dr. C. B. Tefft, Utica. The discussion was closed by Dr. Sturtevant.

A communication from the Mississippi Valley Medical Association, asking for the indorsement of certain resolutions looking to a change in the method of celebrating the Fourth of July, whereby tetanus infection would be reduced, was read by the Secretary, and on motion of Dr. E. D. Ferguson the communication was received.

Dr. B. Onuf, Sonyea, read a paper, "Some Features of the Epileptic Attack." It was dis-

cussed by Dr. W. A. Macpherson, LeRoy, and Dr. Onuf made some closing remarks.

Dr. Parker Syms, New York, presented "A Report of Twenty-five Prostatectomies." It was discussed by Dr. G. E. Goodfellow, San Francisco; Dr. Henry Roth, New York, and Dr. William M. Bemus, Jamestown. The discussion was closed by Dr. Syms.

The President at this juncture introduced Dr. John H. Musser, of Philadelphia, Pa., President of the American Medical Association. Dr. Musser said:

"It gives me great pleasure indeed to be present with you to-day and take part in your conferences. I wish to urge all of you to look forward to the meeting of the American Medical Association in Atlantic City early next June, and I hope you will all be present. From all accounts we shall have a very large gathering, and the chairmen of the various sections report that the work to be done in the sections is likely to be above the high-water mark of those bodies. The scientific work will, therefore, well repay your coming, and the enormous hotel accommodations and the many amusements and means of recreation at Atlantic City should afford you an abundance of recreation. I hope every member of the American Medical Association will feel that the success of the organization depends upon his individual efforts."

Dr. S. Busby Allen, New York, read a paper, "Knowledge of the Eye That Is of Use to the General Practitioner." The paper was discussed by Dr. Frank W. Higgins, Cortland, and Dr. J. J. Walsh, New York, and the discussion was closed by Dr. Allen.

Dr. James J. Walsh, New York, read a paper, "The Early Diagnosis of Tuberculosis." It was discussed by Dr. DeLancey Rochester, Buffalo, and Dr. S. A. Knopf, New York, and the discussion was closed by Dr. Walsh.

Dr. George Tucker Harrison, New York, read a paper, "Treatment of Septic Affections by the Intravenous Injections of Collargol."

Adjournment at 1 P. M.

AFTERNOON SESSION.

The meeting was called to order by Dr. Frank W. Higgins, at 2 P. M.

Dr. George F. Cott, Buffalo, read a paper, "Peculiar Symptoms Following a Radical Operation on the Ear." The patient was presented.

Dr. John H. Musser, of Philadelphia, Pa., read a paper, "Acute and Chronic Cholecystitis." It was discussed by Drs. Robert T. Morris and Alexander Lambert, of New York, and the discussion was closed by Dr. Musser.

Dr. Edward J. Ill, Newark, N. J., read a paper, "The Etiology and Pathology of Salpingitis."

Dr. Henry C. Coe, New York, read a paper, "The Surgical Treatment of Salpingitis."

Dr. W. Travis Gibb, New York, read a paper, "The Non-Operative Treatment of Salpingitis."

The general discussion was participated in by Dr. W. M. Polk, New York; Dr. C. L. Bonifield, Cincinnati, and Dr. J. Riddle Goffe, New York.

Dr. Thomas M. Rotch, Boston, Mass., read a paper, "Clinical Aspects of Ileocolitis in Children."

Dr. Albert H. Ely, Southampton, read a paper, "Colon Bacillus Infection of the Female Genito-Urinary Tract." Discussion on the two foregoing papers was participated in by Drs. W. H. Park, L. Emmett Holt, J. E. Winters and R. G. Freeman, of New York, and the discussion was closed by Dr. Ely.

On motion of Dr. Alexander Lambert a vote of thanks was given to Drs. Bonifield, Ill, Musser and Rotch, especially to the last-mentioned gentleman, who had come here at some personal inconvenience, arising from a misunderstanding as to his assigned place on the program.

Dr. Wiggin, the retiring President, having invited the officers-elect to the platform, said:

"This Association was born for the purpose of establishing the fact that the majority should rule, not only in the medical profession, but in the United States of America. I hope it will keep this object in view. The gentlemen who formed this Association believed the majority should rule; the gentlemen who stayed in the Medical Society of the State of New York believed the minority should rule. But this matter has now all been settled, and we are at present all agreed that the majority should rule. This is what I have fought for, and there is no longer any occasion for me to hold office. I therefore take pleasure in introducing one of the loveliest and most peaceable of men in the State of New York, my successor, Dr. William H. Thornton, of Buffalo.

DR. THORNTON: "It is a great pleasure to succeed a man of such energy and power for organization as Dr. Wiggin: a man who has given unselfishly for years time, money and unlimited energy to the work of the Association.

"I cannot but shrink from taking this office. The profession of the State of New York has, at the present moment, reached a period of very great importance, not only to our Association, but to the entire State of New York, and, in the words of the Secretary of the American Medical Association, of vast importance to the medical profession throughout the entire country. The stream of progress has been divided, we might say, by an island. For twenty years the streams have flowed in nearly parallel lines, but in a divided course. I am happy to say that the end of the island is in sight, and I know we all feel that when the two streams come together again it will be with renewed energy, and that this will give an immense impetus, which will be for the good of the entire medical profession of the State of New York.

"I have the pleasure of introducing Dr. F. A. Baldwin, our Treasurer for the ensuing year."

On motion the Association adjourned at 5.50 P. M.

COUNTY ASSOCIATION MEETINGS FOR DECEMBER.

Kings County.—Tuesday, December 8th.

Tompkins County.—Tuesday, December 8th.

Orange County.—Wednesday, December 16th.

Cortland County.—Friday, December 18th.

New York County.—Monday, December 21st.

Monroe County.—Tuesday, December 29th.

Kings County Association.—The regular meeting of the Association was held at 315 Washington street, Brooklyn, on Tuesday, November 10th, at 8.30 P. M.

Dr. George G. Hopkins showed a specimen of radium, in conjunction with an instrument for the interstitial treatment of malignant growths—also a negative of coins, made with the radium rays.

Dr. Frank E. West introduced the topic of the evening, "Common Cardiac Therapeutics," with a discussion on Cardiac Stimulants. He was followed by Drs. Mosher, Riggs, Squibb, Sullivan, Lloyd and Hopkins, in a general discussion of the subjects. At the executive session, Dr. John C. Lester was elected to membership.

F. C. RAYNOR, Secretary.

New York County Association.—The stated meeting was held November 16, 1903. Among the newly elected members was Dr. Follen Cabot. When the list of candidates for membership was read the president stated that, as the daily newspapers had given publicity to the fact that the Health Department had brought charges of unprofessional conduct against Dr. Cabot, at that time one of the physicians of the Department, at the request of Dr. Cabot the Committee on Ethics of the Association made an investigation. The report of the Committee on Ethics and Discipline:

NEW YORK, NOV. 6, 1903.

To the President and Executive Committee of The New York County Medical Association.

In the matter of Dr. Follen Cabot, Jr., your Committee on Ethics and Discipline begs to report that they have investigated the charges of unprofessional conduct, based upon the preamble and resolution of censure adopted by the Board of Health under date of May 15, 1903, and find that said charges are unsustained.

(Signed) CHARLES E. QUIMBY, Chairman;
BRYSON DELAVAN,
HENRY A. DODIN.

Dr. Frederick Holme Wiggin showed two appendices, the patients from whom they had been removed having shown some interesting diagnostic symptoms. The first specimen was one of unusually large size, and had been removed from a male 36 years of age, who had been sent to the speaker with a diagnosis of acute indigestion, which probably had been made because, in addition to other symptoms, the patient had suffered from severe pains in the left side of the abdo-

men. The patient gave a history of having had attacks of recurring appendicitis since last July. On examination the body temperature was found to be 104° F., respirations 40 and the pulse-rate 120. The abdomen, on examination, was found to be distended, rigid and tender; the pain, on pressure, being more marked to the left of the median line than over the cecal region. It was decided, notwithstanding this fact, that the patient was undoubtedly suffering from appendicitis. He was prepared for operation, and when the abdomen was opened, it was found that the reason of the pain being on the left side was due to the fact that the appendix lay to the left of the median line, and held there by numerous adhesions. This case seems to show in an unusually marked degree that when we have a patient giving the symptoms of appendicitis that we should operate, notwithstanding the fact that the abdominal pain is not in the usual place.

The second specimen was removed from a girl 23 years old, who came under the speaker's notice with a diagnosis of floating kidney, and who desired to be operated upon for the relief of that condition. Examination revealed the fact that while the right kidney was somewhat displaced, this displacement was not responsible for the pain in the right iliac region, increased by pressure, and the other symptoms from which the patient was suffering. At the time of the operation this view proved to be correct, as decided evidence of peritonitis and an acute inflammatory process of the appendix were found to exist. Microscopical examination of the tissues of the appendix showed the disease to be well advanced. Both patients made a good recovery.

"Milk in Reference to Infant Feeding."—Dr. William H. Park and Dr. L. Emmett Holt were the authors of this paper, which was read by Dr. Park. In it were given the results of the systematic investigation, made during the summer and winter of the past two years, the work having been done under the supervision of Dr. Park, while the results had been analyzed and tabulated by Dr. Holt. The conclusions were concurred in by both authors. The method adopted had been to give each clinical observer about 50 children to watch for a period of about 10 weeks. Bacteriological examinations of the milk used were made at short intervals, and, as a result, 239 varieties of bacteria were isolated, and were divided into 31 classes. It was found that two very important factors in determining the number of bacteria were the degree of cleanliness observed in handling the milk and the temperature at which the milk was kept. The failure to discover definite pathogenic bacteria had made it necessary to rely upon the clinical observations. The children used for this investigation lived in the crowded East Side, and, strange to say, it was found that a very large number of the children in this quarter were breast-fed. The store milk gave bad results in 44 per cent., condensed milk in 40 per cent., good bottled milk in 39 per

cent. Practically the same results were obtained in the winter, but it was worthy of note that infants did well in the winter upon all sorts of food, and that heat and humidity, especially the former, were important factors in the summer. To summarize, the most important factor was intelligent care. The effect of heating milk was determined by placing half of the children, after a certain date, upon the same milk as they had been taking, with the exception that it was raw. The observation extended over three months, and it was found the first summer that 20 out of 27 infants fed on this raw milk developed more or less severe diarrhea in a very short time, and that 75 per cent. of those on Pasteurized milk remained all summer. The next summer, of the 24 infants, 10 lived on the raw milk all summer without bad result, and 16 out of 21 babies on Pasteurized milk did well throughout the summer. It was evident that, even when a pretty good milk was used, there was less sickness among the infants for whom the milk was Pasteurized. After the first year of life, infants were not so easily disturbed by the ordinary bacterial contamination of milk, and children of 3 or 4 years would often do well on milk containing a very large number of bacteria. In the opinion of the authors, the best method of feeding the infants of the tenements was by milk from central distributing stations.

Dr. W. P. Northrup, who opened the discussion, narrated a number of striking cases to show how difficult it was to obtain really intelligent care, even among families in easy circumstances.

Dr. Charles G. Kerley said that, according to his dispensary records, only about 12 per cent. of infants under six months were at the breast. He declared that, as it was impossible to purchase in this city a safe milk for 6 or 8 cents a quart, it followed that such milk was beyond the reach of the tenement-house population. Much could be done in dispensary work by properly instructing the mothers, and this was well shown by the fact that in 912 infants treated in the out-patient service of the Babies' Hospital only a little over 3 per cent. died. In the summer the infants' food should be made weaker and should be heated up to about the boiling point. For those too poor to indulge in the luxury of ice, canned condensed milk became a necessity. This was also useful as a temporary diet in sickness.

Dr. A. Seibert referred to a paper, read by him in 1888, in which he had given the results of a comparative study of the meteorological conditions, and the mortality statistics of the city for the preceding ten years, as bearing on the production of infantile diarrhea. He had pointed out that gastroenteritis was regularly epidemic in this city from June 15th to October 15th, or during the period when the lowest temperature at night did not fall below 60° F. He had found that heat and humidity acted with equal potency on breast-fed and bottle-fed infants, but the difference in the results was to be attributed to the fact that

artificially fed infants took dirty food, swarming with bacteria.

Dr. R. G. Freeman said that the investigation embodied in the paper of the evening corroborated what many physicians had learned from their individual experience—*i. e.*, that infants did about as badly on condensed milk as upon store milk filled with bacteria. There was a growing tendency to go back to the use of raw milk for infants; hence, he was glad that the superiority of heated milk had been so clearly shown. It was remarkable how frequently a good milk was often spoiled by adding to it stale commercial cream. Breast milk usually contained pyogenic bacteria derived from the milk ducts, as well as bacteria introduced from the nipples of the mother.

Dr. Walter M. Seward spoke of the necessity for the physician's giving simple and explicit directions if he would secure the intelligent care and cooperation which had been pointed out as of such great importance in securing good results in infant feeding.

Dr. Park, in closing the discussion, said that the bad effect of hot weather upon infants could not be entirely explained by its action in swelling the bacterial content of the food. It was probable that the lowered resistance of the infant in summer partly accounted for the very different results observed in summer and winter from the use of milk contaminated with bacteria.

OGDEN C. LUDLOW, Secretary.

* * *

Orange County Association.—The regular monthly meeting was held at the Russell House, Middletown, N. Y., November 16, 1903, at 2 P. M. There was a good attendance from various parts of the county.

Dr. W. I. Purdy, president, presided. Dr. M. C. Conner, of Middletown, presented a paper on "Appendicitis." The doctor handled the subject in a masterly way and gave a record of some sixty cases treated during his practice in Middletown, many of which were before operative procedures were introduced. Since resorting to operation in all cases there had been less mortality than formerly. The causes, symptoms, diagnosis and treatment, both medical and surgical, were given in detail.

A general discussion was entered into by those present. Dr. Douglas discussed the purely medical treatment; Dr. Purdy, both the medical and surgical side of the question; Dr. Mary Dunning, of Newburg, the medical treatment; Dr. Redfield, the differential diagnosis, citing some rare instances in the point of diagnosis observed in actual practice; Dr. Preston, the causes of appendicitis, dwelling at length on the chemistry of the intestinal tract. Dr. Merritt, of Pine Bush, the medical treatment. At the conclusion of the remarks, Dr. Conner summed up the various criticisms. A vote of thanks was extended to the doctor for his excellent paper.

Dr. Purdy then stated that a general discussion

of the topic of tuberculosis was to be taken up by some of the members who had volunteered to speak on the various divisions of the subject. Dr. Redfield then read a résumé of the "Pathology of Tuberculosis" with especial attention to pulmonary tuberculosis, in which the macroscopic and microscopic lesions were fully described, and also presented some microscopic specimens, including the tubercle bacillus. Dr. Preston followed with a few remarks on the early symptoms and diagnosis of pulmonary tuberculosis, bringing out many of the distinctive features of the disease in its formative stage. He laid especial stress on making a thorough physical examination of the lungs in early cases.

Dr. W. E. Douglas then read a very valuable paper on the "Treatment of Pulmonary Tuberculosis." The medical remedies were carefully reviewed, as well as the influence of proper climate on the various types of consumption. He also described the special benefits of the pneumatic cabinet for compressed air and the effects of ozone generated by electricity with the static machine, both of which he had personally tried in his office treatment of those cases, with marked improvement in all the symptoms.

At the conclusion of the remarks those present discussed in detail the entire subject, and the thanks of the Association were extended to the gentlemen who had so ably prepared papers on the subject.

CHARLES I. REDFIELD,
Secretary.

* * *

Otsego County Association.—The semi-annual meeting of this Association was held in the Supreme Court Chambers, Oneonta, on November 10th. Ten members were present. In order to make the By-Laws conform with those of the State Association, the date of the annual meeting was changed to the fourth Tuesday in April, and that of the semi-annual meeting to the fourth Tuesday in November. In the scientific session an extract was given from a paper by Dr. Frederick Holme Wiggin, on "Country Medical Life." The treatment of appendicitis was summed up by Dr. Arthur W. Cutler in four words: Rest, clean intestinal tract, starvation and ice. A report of a "Case of Psoas Abscess" was given by Dr. Andrew J. Butler, and a "Case of Strangulated Hernia and Cure" was reported and discussed by Dr. Frank L. Winsor. There was also a report given of the State Association meeting by Dr. Julian C. Smith. The next meeting will be the fourth Tuesday in April.

ARTHUR H. BROWNELL, Secretary.

* * *

Cortland County Association.—The regular meeting of this association was held at the office of Dr. F. S. Jennings, Cortland, on Friday, November 20th. In the scientific session Dr. H. S. Braman read a paper on "Cause and Treatment of Convulsions in Children," which was followed by a general discussion. A request was made that Dr. F. W. Higgins read a paper at the next

meeting on "Choice of Drugs to Be Used in Heart Disease."

HARRY S. BRAMAN, Secretary.

* * *

Ulster County Association.—The regular meeting of this association was held at the Huntington, Monday, November 23d. Among the guests present were the officers and some of the members of the Medical Society of the County of Ulster.

Dr. Henry Van Hoevenberg, president of the County Association, occupied the chair and called the meeting to order at 8 P. M. In a few well-chosen words he welcomed the members of the County Society, and then introduced Dr. Alexander Lambert, of New York, who was most heartily greeted. The principal subject for discussion was "The Use of Ergot in Chronic Alcohol and Morphine Cases." He stated that Anstie taught fifty years ago that alcoholism was a nervous disease. From his own experience he did not consider it entirely so now, for from the physiology of alcohol it is known that it acts on the vaso-constrictis and dilates them, thus changing the distribution of the blood, but making no increase of blood pressure. This is the key to the treatment. The pathology shows serous exudation on the brain, atheromatous degeneration of the aorta, fatty degeneration of heart, liver and kidneys, with more or less proliferation of connective tissue. Beer drinking gave most frequently the fatty degenerations of liver, while spirituous liquors gave the cirrhotic types. He thought the mixed type was most common today.

In the illustrative cases cited by him he stated that if the patient was strong and actively delirious, a shower bath was frequently an excellent remedy to quiet him, but if the patient was not strong it was better to give a hypodermic of apomorphia. In cases of alcoholic women 10 gr. sulphate of zinc, combined with equal amount of sulphate of copper, was very efficacious in stopping their abusive tongues. In all cases he gave as a cathartic \mathfrak{ss} castor oil from one to three times a day until free effect was obtained. In cases "in full drunk" frequently from \mathfrak{ij} to \mathfrak{iii} paraldehyde in \mathfrak{ss} whisky would quiet them and put them asleep; but if they had stopped drinking for the time, this remedy should not be used, as it would start them at it again. Then it was better to use what was sometimes called "snake mixture," composed of chloral, 30 gr.; morphia sulph., $\frac{1}{4}$ gr.; tinct. hyoscyamus, \mathfrak{ss} ; tinct. ginger, \mathfrak{ss} ; tinct. capsicum, \mathfrak{m} ; water q. s. ad \mathfrak{ss} . This may be repeated once in an hour, if necessary. In severe maniacal conditions, apomorphia, strychn. and hyoscyamus will often be needed. In cases of "wet brain" all remedies have been tried, but until ergot came to be used most cases ended fatally. With its use the mortality has been greatly lessened in the Bellevue alcoholic wards. Under its influence patients show much less tremor and delirium. This, in his opinion, was so because the ergot stimulated the coordinating centers of the brain and the unstriated muscle fibers,

thus bringing about an equalization of the circulation. The solution of ergot used was after Dr. Livingston's formula—5j solid ext. ergot, 3m chloroform, 5j sterile water. Inject 30m into the gluteal or deltoid muscle. Repeat once in an hour, if necessary, and after that once in two hours. He also stated that he had used ergot in angina pectoris and pneumonia with good results.

Drs. Gallagher, Loughran, Collier, Nelson, Preston, Vroman, Mambert and Sebring entered into the discussion of the subject, after which Dr. Lambert discussed in general "The Medical Value of Leucocytosis," and Dr. J. H. Lewis discussed it from the surgical standpoint.

Dr. E. H. Loughran proposed a vote of thanks to Dr. Lambert, to which all very heartily responded.

A short business session was held, and Dr. F. A. Hunt, of Naponoch, reelected to membership. Dinner was then served, during which much informal discussion of the hoped-for reorganization of the medical profession took place.

MARY GAGE-DAY, Secretary.

* * *

Westchester County Association.—A regular meeting was held at White Plains, November 19, 1903. Dr. Wm. D. Granger, of Bronxville, N. Y., read an excellent paper on "Dysentery." A general discussion of this *disease* followed the reading of the paper and many valuable ideas were presented.

Dr. Norton J. Sands, of Portchester, N. Y., read a paper on "Prolonged Fasting as a Factor in the Treatment of Acute Diseases, with Special Reference to Affections of the Alimentary Canal." The merits of the paper were highly instructive, and the Association requested that it be published in THE NEW YORK STATE JOURNAL OF MEDICINE.

Several cases were reported and discussed.

The next regular meeting will be the fourth Thursday in January, 1904, at White Plains, at 2 P. M.

I send this as an item of news. Our Association is a live one. T. J. ACKER.

PERSONALS.

Dr. Bernard S. Moore, of Syracuse, has been elected a member of the Committee on Public Health, to take the place of Dr. George A. Leitner, resigned.

* * *

Dr. J. W. S. Gouley is giving an interesting course of lectures on Wednesday evenings, at Bellevue Hospital, on "The Principles of Conduct Adapted to Medical Students and Physicians."

* * *

Dr. Raoul A. Amador, of New York, has been appointed as the first Consul-General in New York from Panama.

* * *

Dr. William J. Tierney married Josephine Mullane on Wednesday, November 18, 1903, at the Holy Trinity Chapel.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

THIRD DISTRICT BRANCH.

Onondaga County.—J. Berton Allen, Syracuse.
Tompkins County.—John M. Townsend, Trumansburg.

FOURTH DISTRICT BRANCH.

Allegheny County.—Edith Stewart, Hume.
Erie County.—George A. Himmelsbach, Buffalo.

FIFTH DISTRICT BRANCH.

Kings County.—John F. FitzGerald, Brooklyn; John C. Lester, Brooklyn.

New York County.—Harold W. Bell, New York; William S. Bryant, New York; James N. Butler, New York; Follen Cabot, New York; Frederick C. Heckel, New York; Francis Huber, New York; John D. McLaren, New York; Seth M. Milliken, Jr., New York; Mary Goddard Potter, New York; Leander H. Shearer, New York; Louis Spingarn, New York; Myles J. Tierney, New York.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Harold W. Bell, New York.
William S. Bryant, New York.
Follen Cabot, New York.
Frederick C. Heckel, New York.
Francis Huber, New York.
John D. McLaren, New York.
Seth M. Milliken, Jr., New York.
Louis Spingarn, New York.
Myles J. Tierney, New York.

OBITUARY.

Dr. Cornelius Cox Wyckoff, a well-known physician of Buffalo, died at his residence in that city on November 7th. The doctor was a graduate of the University of Buffalo, Class of 1848. He was a member of the American and The New York State Medical Associations, the Medical Society of the County of Erie and the Buffalo Academy of Medicine. He was also consulting physician to the Buffalo General Hospital.

MEMORIAL ADOPTED BY THE ERIE COUNTY MEDICAL ASSOCIATION AT A SPECIAL MEETING HELD NOVEMBER 10, 1903.

In the fulness of years, while still in the active performance of the arduous duties of a physician, Dr. Cornelius C. Wyckoff has been called from us.

He was one of the oldest, most active, most charitable and kind-hearted men in the profession. It was always an inspiration to the younger members of the profession to meet him. His years of experience, his wise counsels, his mature judgment and kindly advice were ever at the command of his fellow-practitioners, and were largely sought and appreciated.

During the whole of his long life of active practice he held the esteem, regard and highest respect of his professional brethren and of the citizens of this community.

He was the type of old-fashioned family physician, ever ready to respond to the call of those in need, sympathetic to all their ills and troubles, and was loved and respected by all his patients as their family friend.

Dr. Wyckoff always took an active interest in medical organization. He was one of the founders of The New York State Medical Association, and for many years a member of the American Medical Association, both of which have profited by his contributions and valuable counsels.

The Erie County Medical Association laments the loss of this distinguished member, and tenders to the bereaved family its sincere and heartfelt sympathy.

ALVIN A. HUBBELL,
WILLIAM H. THORNTON,
CHARLES A. WALL,
Committee.

Dr. Charles A. H. de Szigethy died on Tuesday, November 17th, at his residence in Brooklyn. He was a native of Transsylvania. He studied medicine at the Universities of Zurich and Vienna, and came to America in 1865. The doctor was a graduate of the University of Giessen, Germany, 1867. He was a member of the American Medical Association, The New York State Medical Association, Medical Society of the County of Kings and the Brooklyn Pathological Society.

LEGAL NOTES.

Malpractice Defense—Prosecuting Quacks.

Since the last issue another member of the Association has asked for defense for an action brought by Messrs. Lindsley & Mackie, attorneys, of Utica, N. Y., on behalf of Mr. Capron. According to the complaint in the action, the member of the Association was called in to treat a broken ankle, and it is alleged that the ankle was kept in non-use so long it had become stiffened and lame, and required an operation to be performed in one of the city hospitals of Utica. The doctor has made the necessary authorization for defense, and Counsel of the Association is preparing the answer for the doctor. The case will be tried at an early date, as the calendar in Oneida County is kept up to date. The laws with reference to the care necessary for physicians to take have been so many times laid down and so thoroughly digested by the various Justices of the Supreme Court that it is doubtful if the case ever reaches the jury, as the doctor seems to have an absolute defense to the action.

Of much interest to the Association members, especially the physicians on the West Side, are

the two cases held by Magistrate Breen in the 54th Street Court on November 21st. Helen Opp, a midwife, of West 57th street, was arrested on complaint of one of the detectives of the Association for furnishing abortive medicines, as was also William Schmitt, a druggist, at the corner of Tenth avenue and 57th street, who is also a near neighbor of Mrs. Opp. It appeared from the evidence that the two are working together; in fact, Schmitt said to the witness that he had just helped two young girls out of trouble, and that if his pills did not work he could send her to a physician who would do the business.

The case of Lottie Karl got into the newspapers. This was a case where a clairvoyant was furnishing medicines in connection with her "readings" and astrological observations to the weak-minded who came to her and paid her 50 cents or \$1. The Court of Special Sessions fined her \$150 or sixty days in the City Prison. After she had served about twenty days of the sentence the fact was brought to the attention of the Counsel for the Association that she had a little boy without care or home, and at the suggestion of the Court of Special Sessions she was taken out of prison, the child given to her, and she was seen to take a train for her former residence—New Haven.

William Bracklo, of 10 Greenwich street, New York, one of the firm of Bracklo Bros., druggists, was, on November 18th, fined \$100 or serve thirty days in the City Prison for giving abortion medicines.

William Burns, who pleaded guilty before the Court of Special Sessions for the second offense, was fined \$50. The Court felt in that case that his having just lost his wife and child, and the fact that he was a very poor man, should be taken into consideration, and therefore made the fine a very small one for the second offense.

A complaint was entered by an outsider against Nathan Criss, a druggist at the corner of Broome and Goerck streets, and two charges were secured against him, one by the original complainant and one by the Association's detectives. Criss was represented by the newly elected Justice Sanger, of the East Side. The result was a conviction in both cases, and the Court suspended sentence in one case, and fined the defendant \$75 in the other.

The case against Katharine Vogel, a midwife, will be on for trial on Wednesday, November 25th, in the Court of Special Sessions. She is charged with having administered and prescribed medicines which, if followed, would have resulted in the commission of an unlawful abortion.

News Items.

FOR SUPERINTENDENT AND RESIDENT PHYSICIAN IN THE NEW YORK STATE HOSPITAL FOR THE TREATMENT OF INCIPIENT PULMONARY TUBERCULOSIS.

The State Civil Service Commission will hold open competitive examinations for the above-mentioned positions, November 28, 1903. Full particulars and application blank may be obtained by addressing, Chief Examiner, State Civil Service Commission, Albany N. Y.

TETANUS.

At the twenty-ninth annual session of the Mississippi Valley Medical Association, held at Memphis, October 7-9th, the following resolutions were adopted:

In view of the fact that more than 400 deaths from tetanus occurred following the Fourth of July celebration in 1903, as shown by the statistical report elaborated by Dr. S. C. Stanton, of Chicago, and published in the *Journal of the American Medical Association* of August 29, 1903, the great majority of which might have been prevented had proper precautions been taken; therefore,

Be It Resolved, That the conclusions which follow, as offered by Dr. Stanton in a paper presented before the Association, at the above meeting, be endorsed as the sense of the Association, and further

Be It Resolved, That the secretary be instructed to forward a copy of these resolutions and conclusions to the Medical Press, Associated Press and the secretaries of the several State medical societies, with the request that they publish same and take suitable action thereon.

1. Enforcement of existing laws regarding the sale of toy pistols and other dangerous toys.

2. Enactment of laws by the nation, States and municipalities prohibiting the manufacture and sale of toy pistols, blank cartridges, dynamite canes and cannon crackers, etc.

3. Open treatment of all wounds, however insignificant, in which from the nature or environment there is any risk of tetanus.

4. Immediate use of tetanus antitoxin in all cases of Fourth of July wounds, or wounds received in barnyards, gardens or other places where tetanus infection is likely to occur.

5. As a forlorn hope, the injection of tetanus antitoxin after tetanus symptoms have appeared.

MEDICAL DIRECTORY.

In a letter to the Committee on Publication, from a purchaser of the *Directory* for 1903, the statement is made: "We enclose herewith our check for your very useful *Medical Directory*, and we wish to state that we feel your price of \$2.50 for this book, which contains so much labor, is very reasonable."

The Secretary has received programs and announcements of the twenty-third convention of the Colorado State Medical Society, which was held at Denver, October 6th, 7th and 8th; of the eleventh annual meeting of the Idaho State Medical Society, which was held at Boise, on October 8th and 9th, and of the Vermont State Medical Society, whose ninetieth annual meeting was held at Bellows Falls, October 15th and 16th.

JOURNAL PUBLICATIONS.

On motion it was unanimously decided to not publish any papers read at the last meeting of the State Society which had been published in some other periodical prior to their publication in this *Journal*. It was decided that if authors of papers desired to have them printed elsewhere they should communicate with the *Journal*, to the end that simultaneous publication in the two periodicals might be arranged for. Several papers were rejected for this reason.—*California State Journal of Medicine*.

Interesting clinics were held for the New York State Association of Railway Surgeons, on Friday, November 13th, by Dr. Frederick Holme Wiggin, at the City Hospital, and Dr. Joseph A. Blake, at Roosevelt Hospital, operations in general surgery being performed at both clinics.

DOCTORS NOW AGREE.

It is proverbial that doctors disagree, and when the average M.D. forms an opinion he generally sticks to it for a lifetime. Something like five and twenty years ago the question of permitting physicians of the old school to consult with practitioners of the homeopathic and eclectic sects came up at the annual meeting of the Medical Society of the State of New York. Those who favored a liberal interpretation of the ethics won: whereat the doctors who believed that the allopaths should refuse to consult with any doctor of a different school formed a new organization known as The New York State Medical Association.

The fight was carried without abatement through the many years that followed, and taken up to the American Society, which adhered to the old doctrine, and upheld those who stood for a strict and radical interpretation of the ethics. As the times progressed, however, the liberality among physicians became marked, and at the last session of the American Society the view of the New York State Society was adopted. This eradicated the differences that have existed for so many years between the two rival organizations in the State of New York, and recently committees were appointed by each association to arrange for a consolidation.

The medical societies will soon be united, and when the next annual session is held in Albany, in January, 1904, a great gathering will be here, and the former rivals will hold a love feast. It is interesting to Albanians to know that Albany physicians played an important part in the bringing together of the two organizations, and that to their efforts principally the consolidation is due. The Albany doctors stood for liberality in the beginning and had the courage of their convictions throughout. They now have the satisfaction of seeing their views adopted and approved by all the practitioners of the State.—*Albany Argus*.

TRANSACTIONS OF STATE MEDICAL SOCIETIES IN JOURNAL FORM.

Year by year, since the establishment of the *Pennsylvania Medical Journal* in 1897, there has been an increasing number of State medical societies that have recognized the superior advantages of the publication of the transactions in journal form over the old annual bound volume. The order in which the different State societies adopted the new method of disseminating their official transactions was as follows: Illinois, New York, Kansas, California, Michigan and Kentucky. Colorado is in the transition stage, and its society will soon represent the eighth State organization to follow in the footsteps of Pennsylvania.

The advantages of this method of publishing the transactions are now so well known that many other States will doubtless in the near future adopt the same process. An official journal instils a vitality into a medical organization that is impossible under ordinary circumstances. It offers opportunity for the presentation and discussion of living issues, as well as for recording the work at the annual meetings.—K., *Pennsylvania Medical Journal*.

A SUCCESSFUL PHYSICIAN.

The successful physician is usually the man who attends strictly to his own business, and refrains from intruding into the affairs of others; who speaks kindly of his fellow practitioner, whether he deserves it or not; who is studious and observant, and profits by his own and the experience of others; who is full of good cheer, and is competent to give wholesome advice. If all physicians belonged to this school the medical profession would be a mighty power, capable of engineering mighty plans for the good of the people, united and respected, free from unjust criticism, and possessed of more than a "common mind."—*Northwestern Lancet*.

WHAT MAKES A DOCTOR.

The skill of a physician is in part similar to that of any other man of science. Primarily he should have a mind of detail and exact thinking. The method of exclusion, "It cannot be anything else, so it must be typhoid," is the sign of vagueness, and has diminished with the progress of the laboratory spirit. The able diagnostician recognizes each disease not by loose, obvious symptoms, but by a variety of exact details, often discoverable only on analysis, and peculiar to that disease. This exact mind for detail makes the physician on the side of diagnosis. When it comes to acting on his understanding, to removing a condition which he understands, other qualities become requisite.

No profession in our day has made such progress as the medical, counting surgery as part of it; and its unexampled improvement is part of our progress in science, the field of thought in which the nineteenth century was most notable.

In many professions there has been no progress at all, certainly not in law or in the pulpit.—*Collier's*.

PHYSICIAN CAN BE PRESIDENT.

To the Editor of the JOURNAL: NOVEMBER 7, 1903.

My Dear Doctor—I note on page 429 of the JOURNAL in the President's address the following: "A physician can be Prime Minister of France or the Governor of Cuba, but not president of the New York City Board of Health." I call your attention to this paragraph for the purpose of correcting the error.

For many years this statement was true, and then the law specifically stated that the president of the Board of Health could not be a physician. This matter was called to my attention by the Committee on Legislation, and I in turn went before the Commission which had in charge the revision of the Greater New York Charter, and as a result this ban was removed. A physician may now be president of the Board of Health.

Very truly yours, JAMES TAYLOR LEWIS.

List of those present at the meeting of the Council and Fellows of The New York State Medical Association, October 19, 1903:

MEMBERS OF THE COUNCIL.

Dr. Frederick Holme Wiggin, Dr. William Harvey Thornton, Dr. J. Orley Stranahan, Dr. Everard D. Ferguson, Dr. J. W. Morris, Dr. Guy D. Lombard, Dr. Wisner R. Townsend, Dr. Samuel A. Brown, Dr. E. Eliot Harris, Dr. Charles E. Denison, Dr. Charles E. Quimby.

FELLOWS.

Dr. Andrew J. Dick, Dr. Fred J. Douglas, Dr. William E. Swan, Dr. Frank D. Reese, Dr. Julian C. Smith, Dr. Orrin A. Tompkins, Dr. William M. Bemus, Dr. DeLancey Rochester, Dr. Alvin A. Hubbell, Dr. Charles A. Wall, Dr. Bernard Cohen, Dr. James C. Davis, Dr. Edward Munson, Dr. Albert C. Way, Dr. John W. Atwood, Dr. Martin Linderth, Dr. William D. Davis, Dr. Morris C. White, Dr. S. Busby Allen, Dr. David D. Austin, Dr. Charles S. Benedict, Dr. Joseph B. Bissell, Dr. Joseph D. Bryant, Dr. Henry A. Dodin, Dr. Daniel S. Dougherty, Dr. John W. S. Gouley, Dr. Frederick P. Hammond, Dr. Neil J. Hepburn, Dr. J. B. Leo, Dr. William Leszynsky, Dr. Samuel Lewengood, Dr. M. Appleton, Dr. Emil Mayer, Dr. William R. Stone, Dr. John Joseph Nutt, Dr. Harry R. Purdy, Dr. Harry H. Seabrook, Dr. Stephen Smith, Dr. Albert W. Preston, Dr. Worthington S. Russell, Dr. Mary Gage-Day, Dr. Charles G. Kerley.

FELLOWS AND ALTERNATES.

Following is a letter recently received by the former President of the Association, Dr. Frederick Holme Wiggin, together with his reply thereto:

My Dear Doctor Wiggin—Your card received really before you sent it, or you forgot the date. It is too late to notify the Alternate now, nor can I get there in time myself. I never knew I was a Fellow or I might have been on time. Now I cannot leave until Monday evening. I should think it were better to notify each Fellow of his appointment. Yours truly,

REPLY.

Dear Doctor—Your letter has been received. I regret greatly that you were not able to get here sooner, but it is the fault of the secretary of your county association, whose duty it is to notify members of their appointment as Fellows, if you did not receive proper notice of your election as Fellow of your association. The card I sent to you was only to remind you of our annual meeting and to urge you to be present.

Hoping that you will not fail to be present at as many of the sessions of the meeting as possible, I am,

Yours sincerely,

FREDERICK HOLME WIGGIN.

Book Reviews.

THE PRACTICAL APPLICATION OF THE ROENTGEN RAYS IN THERAPEUTICS AND DIAGNOSIS. By William Allen Pusey, A.M., M.D., and Eugene Wilson Caldwell, B.S. W. B. Saunders & Co., 1903.

The work is divided into two parts, Part I, "X-ray Apparatus and Its Use in Diagnosis," by Eugene Wilson Caldwell, B.S., and Part II, "The Therapeutic Application of X-rays," by William Allen Pusey, A.M., M.D. This division is an admirable one, in that it separates the purely technical matter from its therapeutic application and therapeutic effects. The first part is divided into eight chapters, as follows: The Essentials of X-ray Equipment, X-ray Tubes, Induction Coils, Interrupters and their Management, Static machines and their Management, Fluoroscopy, Radiography, Photographic Materials and their Manipulation, the Choice of an X-ray Outfit.

The subject is presented in a very clear and comprehensive way, much more so than in several other works published, and enables the beginner in X-ray work to quickly grasp the fundamental principles. To the worker in X-ray therapeutics it will prove a valuable guide, and will enable him to easily refresh his memory on any doubtful point. The illustrations of tubes, apparatus and diagrams are most excellent, and the colored plates deserve especial mention for their true presentation of the tubes when in operation under varying conditions. The author, very wisely, avoids all doubtful questions, but he presents to the reader in the best possible manner the technical part of the subject.

Part II, "The Therapeutic Application of X-rays," by William Allen Pusey, A.M., M.D. The author reviews the literature of the subject up to date in a fair and impartial manner, does not hesitate to criticize the opinions and observations of others, and presents his own views in a clear and practical manner. The first chapter is devoted to the "Effects of X-ray on Tissues," and considers the gross effects, such as pigmentation, dermatitis and X-ray burns of varying degrees, together with their treatment. The second chapter treats of the "Histological Changes Produced in Tissues by X-Rays," and is of especial interest and value in that it presents the views of the best workers in the field, and gives a very complete picture of the subject. A short chapter on "The Effects of X-rays on Bacteria" follows, in which a résumé of the work of various experimenters is given. The work in this direction is too incomplete for definite conclusions. The next chapter on "The Causes of the Phenomena Observed in Tissues After Exposure to X-rays" is of absorbing interest to the reader, although it is of necessity largely speculative. The views of the best experimenters and observers are given, which open up a wide field for thought. Chapter V treats of "The Technique of X-ray Exposures for Therapeutic Purposes." This is perhaps the most important one in the whole book, because of the difficulty encountered of expressing in adequate terms a good working technique, and because of the widely different opinions of the different workers. The author presents in detail the technique of several, and the reader is at once struck with the wide divergence of opinion in regard to quality of tube, duration of exposure and distance of tube from the part to be treated. The author's technique differs from other workers, mainly in the distance of the tube, and it is difficult to conceive how he can use a tube of his own standard light at the close distance of from five to eight cm. for any number of sittings. We do not wish to doubt the author's statements, but they prove again the difficulty of expressing adequately any technique. The succeeding chapters are devoted to the treatment of X-ray burns, the X-ray treatment of the various skin diseases, of tuberculosis and of malignant disease in all parts of the body, together with reports of a large number of the author's cases in detail. The book is a valuable addition to the literature of X-ray therapeutics and should be in the hands of every worker in this field.

CLINICAL TREATISE ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Dr. Carl von Noorden, Physician-in-Chief to the City Hospital in Frankfort a/M. Authorized American edition, translated under the direction of Boardman Reed, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia, etc. Part II, Nephritis. New York: E. B. Treat & Co., 1903.

These three monographs usher in a series in which the author hopes systematically to cover a field at once of great importance to the general practitioner and to a considerable degree neglected.

While they are written in the mother tongue of the author (German) and published in Berlin, it has been arranged to have the subsequent volumes appear as nearly as possible simultaneously in English, published in New York.

In Dr. von Noorden's preface to the American edition he states that the series is written to give utterance to the personal views of himself and his collaborator, Dr. Carl Dapper, relative to the diseases of metabolism and their treatment.

Were the authors less eminent, this would render the series of little or no value; instead of which, owing to their international reputation, it rather enhances the value thereof.

Part first deals with Obesity, and considers the indications for reduction cures. Being a systematic and rational treatment of a condition too frequently relegated to the casual. It gives evidence of a careful and exhaustive study of obesity, such as only immense clinical facilities, combined with that attention to minutiae of detail, so characteristic of German scientific work in whatsoever line we encounter it.

In part second Professor von Noorden devotes 112 pages to the therapy of Nephritis. His contradictions of many wildly accepted theories are at first glance rather startling, but his reasoning is clear and convincing and the range of his experience unquestioned. We cannot do better than to quote relative to these points from the note by the American editor, Boardman Reed, who then writes as follows: "Professor von Noorden's handling of the subject of nephritis in the following pages is bold, original and somewhat iconoclastic. He rides roughshod over moss-covered tradition. Nothing is sacred to him but indubitably demonstrated truth. He has a way, too, of confirming or refuting alleged truth for himself, taking nothing for granted. This is the proper course in the determination of scientific questions."

The third part, which treats of Colitis, has already been reviewed in the June number of the JOURNAL. Further mention would, therefore, be superfluous.

TEXT-BOOK OF CLINICAL ANATOMY. For Students and Practitioners. By Daniel N. Eisendrath, A.B., M.D., Clinical Professor of Anatomy in the Medical Department of the University of Illinois, College of Physicians and Surgeons; Attending Surgeon of the Cook County Hospital, Chicago, etc. Handsome octavo of 515 pages, beautifully illustrated with 153 illustrations, a number in colors. Philadelphia, New York, London: W. B. Saunders & Co., 1903. Cloth, \$5 net; sheep or half morocco, \$6 net.

In this most admirable book the general practitioner, the surgeon and the specialist in all departments of medicine will find much of value and interest.

It combines the surgical anatomy of a part with clinical data in a way that any one can understand, and should prove useful to the student of medicine preparing for his examinations or just beginning practice, and also to the busy practitioner of many years' standing.

To the student who has thoroughly mastered "Gray" or any standard text-book of anatomy, it presents the Regional or Topographic Anatomy in a manner that will enable him to make the diagnosis of various diseased conditions where a knowledge of anatomy is essential.

To the busy practitioner, whose memory is hazy as to the exact point of exit of a given nerve from the spine, or whether the upper epiphysis of the humerus has united at the tenth year, etc., it will prove invaluable, for by reference to the index or the proper portion of the book, all such and much other data are easily found.

The plan of making drawings from X-ray pictures rather than printing the pictures is a good one, as it shows the lesions much more clearly.

The text is clear and easily understood, the drawings and cuts are most excellent in character and the publishers have supplemented the good work of the author in a most creditable manner. W. R. T.

A TEXT-BOOK OF DISEASES OF WOMEN. By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania; Gynecologist to the Howard, the Orthopedic and the Philadelphia Hospitals, with 655 illustrations, many of them in color. Philadelphia, New York, London: W. B. Saunders & Co., 1903.

The author of the book before us is known as an obstetrician, and in that field has had large experience, has gained distinction and is entitled to speak with authority. His text-book on obstetrics is a standard work. Nothing original was to be expected in a book from his hands on diseases of women, except, perhaps, in the limited field in which obstetrics dominates gynecology, and the reader, therefore, is not disappointed to find that it follows old familiar lines and beaten paths. Nothing is therein contributed to the specialty in the way of new methods of diagnosis, original technic or surgical procedure.

This is far from saying that the work is not a good text-book for students, and that is what it professes to be, although it does not advance the knowledge of the science and art of gynecology in any particular. There may be decided differences of opinion upon many points of detail in the teaching, but, as a whole, the opinions accord with the general consensus of leading gynecologists, the pathology is abreast with the latest teaching and the treatment is conservative. The lessons are impressive and the style fluent and interesting.

The book is a general work on the diseases peculiar to women, and systematically covers the entire subject. The contents embrace twelve chapters or parts, each divided into many subheads and so arranged that each subject leads logically to its successor.

The chapter on Displacements and Diseases of the Uterus discusses the subject in a most interesting way, but contains many statements to which teachers of gynecology will take exception. That sudden violent jolt or jar stands next in frequency to child birth as a cause of retroversion does not square with the experience of most observers. Nor is horseback riding to be discountenanced because of any tendency to produce displacement. The author excludes, and very properly, soft rubber pessaries, which harbor sepsis, but recommends the hinged anteversion (!) pessary of Thomas. In the explanation of the mechanism of a retroversion pessary the instrument is made to stay in place by being hooked over the cervix. It is rather paradoxical that an instrument should be held up by an organ which the instrument itself is designed to support. In the selection of operative procedures for the relief of retroversion, approval is given only to the Alexander operation and abdominal fixation. Fixation is clearly meant in distinction from suspension, for the fixation stitch is passed through the rectus muscles. The treatment advised for the cure of prolapsus and procidentia is no longer considered anything but palliative. The building up of buttresses in the vagina to support a procident uterus has been long antedated.

The illustrations are abundant, well executed, and, as a rule, assist in illuminating the text. If there be any error in this feature of the book it consists in the multiplicity of illustrations, some of them being altogether useless. What is to be learned, the author may justly be asked, from Fig. 14 or Fig. 17? And what

demonstration do Figs. 188 and 189 give that the sphincter muscles of the rectum have been restored? A long, smooth perineum is there to be sure, but the corrugations that indicate the presence of the sphincter muscle of the anus are absolutely wanting. In the attempt at colored plates the author has been especially unfortunate. Every one knows the difficulties of this feature of illustration and sympathizes with the author who attempts it. But why resort to the advertising claptrap of color when the cut is absolutely devoid of truthfulness of color? The colored picture of caruncle is an exception to this criticism. The publisher has done his work well, with the exception of the colored plates. J. R. G.

AN AMERICAN TEXT-BOOK OF SURGERY. For Practitioners and Students. Edited by William W. Keen, M.D., LL.D., F.R.C.S. (Hon.), Professor of the Principles of Surgery and Clinical Surgery, Jefferson Medical College, Philadelphia, and J. William White, M.D., John Rhea Barton, Professor of Surgery, University of Pennsylvania, Philadelphia. Fourth edition, thoroughly revised and greatly enlarged. Handsome octavo of 1,363 pages, with 551 text-illustrations and 39 full-page plates, many in colors. Philadelphia, New York, London: W. B. Saunders & Co., 1903. Cloth, \$7 net; sheep or half morocco, \$8 net.

In this present edition every chapter has been extensively modified, and many of them have been partially, and some entirely, rewritten. Notably among such chapters are those on Surgical Bacteriology, Tumors, the Osseous System, Orthopedic Surgery, the Surgery of the Nerves, the Joints, the Abdomen, etc. The most recent researches of Monks on the Intestines, Crile and Cushing on Shock and Blood Pressure, Matas on Neural Infiltration and Aneurysm, Edebohls on Renal Decortication, etc., have been included. The use of paraffine in nasal deformities, the methods of spinal and local anesthesia, and the newer anesthetics have also been described. And this is but an illustration of the completeness and thoroughness of the entire work.

Besides the extensive revision and amplification of the old matter, there have been added six new chapters of the utmost importance, written by men whose positions and experience especially fit them to speak with authority. These chapters are Military Surgery, Naval Surgery, Tropical Surgery, Examination of the Blood, Immunity, and Surgery of the Pancreas. Though there was a brief chapter on the pancreas in the third edition, in this present edition it has been expanded so greatly that it really is wholly new, the modern surgery of the pancreas having been created since the last edition. A number of the old illustrations have been replaced by better ones, and, in addition, there have been added a number entirely new. In fact, we know of no single volume work that is even its equal in the expounding of the advanced and practical principles of modern surgery.

A DICTIONARY OF MEDICAL SCIENCE. By Robley Dunglison, M.D., LL.D. Twenty-third edition, thoroughly revised, with the pronunciation, accentuation and derivation of the terms. By Thomas L. Stedham, A.M., M.D. Philadelphia and New York: Lea Bros. & Co., 1903.

An old friend in a new dress is Dunglison's Dictionary. The definitions are as full and complete as formerly, and for the first time illustrations have been added, which permits more conciseness of definition and a more complete understanding. The number of new terms in medicine has added greatly to the importance of a work of this character. We have more than synonyms and bald statements; there is a clear explanation of terms and encyclopedic in its definitions. This book has lost nothing in its new form and is of great value to the student and to the large number of practitioners of medicine familiar with it in their college days. It is a dictionary intended for all interested in any of the medical sciences.

A NURSE'S HAND-BOOK OF OBSTETRICS. By Joseph Brown Cook, M.D., Fellow New York Obstetrical Society; Lecturer on Obstetrics, New York Training School, etc.

In the preface the author states that "the trained nurse of to-day devotes not less than two, and usually three, years of her life to the study of her profession, a period of time which, until recently, was regarded as sufficient for the medical student to gain all the knowledge necessary for the acquisition of his diploma as a fully qualified physician and surgeon." In acquiring the art of nursing, but a fractional percentage of the time is devoted to the study of the science of medicine and surgery, while the medical student reverses this order and devotes almost 100 per cent. of the time to scientific study and almost nil to the art of medicine. A good nurse must necessarily be intelligent and with the judicious guidance of wise teachers will glean more medical and surgical information from text-books written for medical students than from books written especially for her use, because she goes to the fountain-head for this knowledge, hence she does not need medical and surgical books written expressly for her.

The book, which is profusely illustrated and written in a clear style, is, however, not a hand-book of obstetrics for nurses alone, but far more a most excellent hand-book for the average intelligent prospective mother. If the nurse could be the mentor of the woman throughout her pregnancy, the many valuable suggestions which the author has thrown out on every page of the book might be acted on with profit, but unfortunately the half hour or so that the expectant mother sees her nurse when she engages her prior to the onset of her labor is devoted to little else besides financial arrangements. This text-book is so clear that any mother of average intelligence can not only understand, but must be benefited by its perusal. The author, by retaining its present title, curtails its legitimate scope. The chapter on infant feeding is especially to be commended for its accuracy of detail.

CUSHNY'S PHARMACOLOGY AND THERAPEUTICS. A Text-Book of Pharmacology and Therapeutics; or, The Action of Drugs in Health and Disease. By Arthur R. Cushny, A.M., M.D., Professor of *Materia Medica and Therapeutics*, University of Michigan. Department of Medicine and Surgery, Ann Arbor, Mich. Third edition, revised and enlarged. In one handsome octavo volume of 750 pages, with 52 engravings. Cloth, \$3.75 net; leather, \$4.75 net. Philadelphia and New York: Lea Bros. & Co., publishers, 1903.

In this third edition the author has found it necessary to change the text owing to the important advances made in pharmacology, the most important being the determination of the food value of alcohol, and in connection with the article on alcohol in the November number of this JOURNAL is very instructive. The work shows the present knowledge of pharmacology and therapeutics in health and disease and deserves the warm welcome it has received.

BACTERIA IN DAILY LIFE. By Mrs. Perry Frankland, Fellow of the Royal Microscopical Society, Honorary Member of the Bedford College, University London, Joint Author of *Micro-Organisms in Water. The Life of Pasteur*. London, New York and Bombay: Longmans, Green & Co, 39 Paternoster Row, 1903.

In this work of 216 pages the well-known English writer, Mrs. Perry Frankland, who, working in co-operation with Mr. Frankland, has added much to our knowledge of micro-organisms and their life history, gives to us a volume which, on the whole, will be read with much interest and profit by both the physician and the layman. It can most certainly be recommended with advantage to our patients as a book which is at once popular, interesting, instructive and scientifically accurate.

The authoress has here gathered together a series of

articles which originally appeared in popular periodicals, at the same time bringing them thoroughly up to date. The series deals with those bacteria which infect the media necessary to the maintenance of life, and in separate articles discusses those which we find most commonly in air, water, milk and ice.

The last chapter of the work deals very briefly with the poisons of rabies, tetanus and snake venom, and adds most interesting statements relative to the poisons which are found in the blood of eels.

Mrs. Frankland has carved out a unique career for herself by thus joining in her husband's life work and has demonstrated a field of work for women which is comparatively new to them. It remains to be seen how well other members of her sex are adapted to this line of work. Her personal success has already been amply demonstrated.

A TEXT-BOOK OF PATHOLOGY. By Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Octavo volume of 933 pages, with 394 text-illustrations, many in colored plates. Philadelphia, New York, London: W. B. Saunders & Co., 1903. Cloth, \$5 net; sheep or half morocco, \$6 net.

The fact that a reliable text-book has gone through four editions within five years of its first appearance is sufficient evidence of its popularity. Meanwhile it is an evidence that works on pathology are no longer written solely for the purposes of the laboratory worker and the student, but are purchased and read by the general practitioner. The book before us is well and pleasantly written and adorned with good and appropriate illustrations. The author does not incline to the belief that there is a contagious element in the production of cancers. He still clings to the old idea that infection in most cases of pulmonary tuberculosis occurs as a result of the inhalation of the bacilli into the bronchial tubes, although Aufrecht's investigations clearly demonstrate the contrary. In general there is little to criticize and much to praise in this volume. A compend of the laboratory technique and formula used in pathological examinations is appended. The student will miss the customary article on post-mortem technique, which might well have been added. The printing and general make-up of the book are excellent.

NOSE AND THROAT WORK FOR THE GENERAL PRACTITIONER. By George L. Richards, M.D., Fellow of American Laryngological, Rhinological and Otological Society; Fellow of American Otological Society; Associate Editor "Annals of Otolaryngology and Rhinology"; Otolaryngologist, Fall River Union Hospital, Fall River, Mass. Published by the International Journal of Surgery Company. \$2.

The author has entered fully into the anatomy, physiology and general symptomatology of the nose and throat, also clearly defining the methods of examination. It is a good working guide for the general practitioner of medicine who is too busy to study more complete treatises.

This book derives especial importance from the fact that the diseases described therein constitute so large a share of the physician's daily routine of practice. It has been the author's aim to teach the practitioner how to diagnose these cases and how treat them successfully and according to modern methods. With this object in view every effort has been made to describe the treatment in such detail as to leave no point obscure, and to simplify the technics as much as possible so as to avoid the necessity of an elaborate and expensive armamentarium. No space is occupied with theory, and the information given is based for the most part upon the author's own extensive clinical experience in diseases of the nose and throat. For the sake of completeness a number of conditions are discussed which properly belong to the specialist, but with these few exceptions the diseases described are such as can be treated by the general practitioner. A noteworthy feature of this work is the large number and excellence of the illustrations.

A SYSTEM OF PHYSIOLOGIC THERAPEUTICS. A practical exposition of the methods, other than drug giving, useful in the prevention of disease and in the treatment of the sick. Edited by Solomon Solis Cohen, A.M., M.D., Senior Assistant Professor of Clinical Medicine in Jefferson Medical College; Physician to the Jefferson Medical College Hospital and to the Philadelphia, Rush and Jewish Hospitals; one time Professor of Medicine and Therapeutics in the Philadelphia Polyclinic, etc. Volume V. Prophylaxis, Personal Hygiene, Civic Hygiene, Care of the Sick. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

The present work includes the important knowledge necessary for an introduction to the science of medicine. The book is divided into parts and sections. The first part, first section, introduces the origin of disease in five chapters; the following section of five chapters, the diffusion of disease. These two sections are concisely written, yet clearly show the importance of close attention and knowledge. The most important sections, the prevention of disease and prophylaxis of special infection, are treated very fully and intelligently. Hygiene and nursing are given in a clear and practical form. The details are necessarily minute and should be known by all physicians.

A TREATISE ON MASSAGE: ITS HISTORY, MODE OF APPLICATION AND EFFECTS, INDICATIONS AND CONTRADICTIONS. By Douglas Graham, M.D., of Boston, Mass., Member of the American Association for the Advancement of Science, American Medical Association, Massachusetts Medical Society, etc. Third edition, revised, enlarged and illustrated. Philadelphia and London: J. B. Lippincott Company, 1902.

It is worth the while for the physician to read this book; the usefulness is rapidly extending into the general branch of medicine, so clearly are the principles of massage set forth as to be readily followed and understood by any one familiar with anatomy and physiology.

BOOKS RECEIVED.

LESSONS ON THE EYE. For the Use of Undergraduate Students. By Frank L. Henderson, Ophthalmic Surgeon to St. Mary's Infirmary and the Christian Orphans' Home; Consulting Oculist to the St. Louis City Hospital, the Wabash Railway and to the Terminal Railway Association; Member of the Missouri State Medical Association; Member of the St. Louis Medical Society, and trustee of the St. Louis Medical Library Association. Third edition. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

ANNUAL REPORT OF THE SUPERVISING SURGEON-GENERAL OF THE MARINE HOSPITAL SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1901. Washington: Government Printing Office.

A MANUAL OF HYGIENE AND SANITATION. By Seneca Egbert, A.M., M.D., Professor of Hygiene and Dean of the Medico-Chirurgical College of Philadelphia; Member of the Academy of Natural Sciences of Philadelphia; Member of the American Medical Association, etc. Third edition, enlarged and thoroughly revised. Illustrated with 86 engravings. Philadelphia and New York: Lea Bros. & Co.

ANATOMY. A Manual for Students and Practitioners. By Henry E. Hale, A.M., M.D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons, Columbia University in the City of New York; Clinical Assistant in Pediatrics, Vanderbilt Clinic, New York. Series edited by V. C. Pedersen, A.M., M.D., Instructor in Surgery and Anesthetist and Instructor in Anesthesia at the New York Polyclinic Medical School and Hospital; Deputy Genito-Urinary Surgeon to the Out-Patient Department of the New York Hospital; Physician in Charge, St. Chrysostom's Dispensary; Anesthetist to the Roosevelt Hospital (First Surgical Division). Illustrated with 71 engravings. Philadelphia and New York: Lea Bros. & Co.

FUNCTIONAL DIAGNOSIS OF KIDNEY DISEASE. With especial reference to renal surgery. Clinical experimental investigations by Dr. Leopold Casper (Privatdocent an der Universität) and Dr. Paul Frederick Richter (Assistant to III Med. Klinik) in Berlin. Translated by Dr. Robert C. Bryan, Adjunct Professor Genito-Urinary Diseases, University Medical College, Richmond, Va., and Dr. Henry L. Sanford, Resident Surgeon, Lakeside Hospital, Cleveland. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1903.

THE MEDICAL NEWS VISITING-LIST, 1904. Philadelphia and New York: Lea Bros. & Co.

PHYSICIAN'S POCKET ACCOUNT BOOK. By J. J. Taylor, M.D. Published by the Medical Council, 4105 Walnut street, Philadelphia, Pa.

COMPEND OF GYNECOLOGY. By William H. Wells, M.D., Chief of the Gynecological Staff of the Mount Sinai Hospital, Philadelphia; Demonstrator of Clinical Obstetrics in the Jefferson Medical College, Philadelphia; Fellow of the College of Physicians and of the Gynecological Section of the same; Late Assistant in the Gynecological Department of the Jefferson Medical College Hospital, etc. Third edition, revised, enlarged, with 145 illustrations. Philadelphia: P. Blakiston's Son & Co., 1912 Walnut street, 1903. Price 80 cents net.

TRANSACTIONS OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. Thirty-sixth annual session, held at Vicksburg, April 16, 17 and 18, 1903, with the roll of members, reports on Medical Topics, Constitution and By-Laws. Next meeting will be held in Jackson, April 20, 1904. Globe Printing Company, Oxford, Miss., 1903.

CLINICAL TREATISES ON THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Prof. Dr. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfurt a./M. Authorized American edition under the direction of Boardman Reed, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia, etc. Part IV, the Acid Auto-intoxications. By Prof. Dr. Carl von Noorden and Dr. Mohr. New York: E. B. Treat & Co., 1903.

INFECTIOUS DISEASES, Their Etiology, Diagnosis and Treatment. By G. H. Rogers, Professor Extraordinary in the Faculty of Medicine of Paris, member of the Biological Society, Physician to the Hospital of Porte D'Aubervilliers. Translated by M. S. Gabriel, M.D. Illustrated with 43 engravings. New York and Philadelphia: Lea Bros. & Co., 1903.

ATLAS OF THE EXTERNAL DISEASES OF THE EYE, including a brief treatise on the Pathology and Treatment. By Prof. Dr. O. Haab, of Zurich. Authorized translation from the German. Second edition. Revised. Edited by G. E. de Schweinitz, A.M., M.D., Professor of Ophthalmology in the University of Pennsylvania; Consulting Ophthalmic Surgeon to the Philadelphia Polyclinic; Ophthalmic Surgeon to the Philadelphia Hospital; Ophthalmologist to the Orthopedic Hospital and Infirmary for Nervous Diseases. With 98 colored lithographic illustrations on 48 plates. Philadelphia, New York and London: W. B. Saunders & Co., 1903.

A TREATISE ON ORTHOPEDIC SURGERY. By Royal Whitman, M.D., Instructor of Orthopedic Surgery in the College of Physicians of Columbia University, New York; Associate Surgeon to the Hospital for Ruptured and Crippled; Orthopedic Surgeon to the Hospital of St. John's Guild; Chief of the Orthopedic Department of the Vanderbilt Clinic; Member of the Royal College of Surgeons, of England; Member and sometime President of the American Orthopedic Association; Corresponding Member of the British Orthopedic Society; Member of the New York Surgical Society, etc. Second edition. Revised and enlarged. Illustrated with 307 engravings. Philadelphia and New York: Lea Bros. & Co., 1903.

Original Articles.

ETIOLOGY AND PATHOLOGY OF TYPHOID FEVER.¹

By G. SCOTT TOWNE, M.D.,
Saratoga Spa, N. Y.

IT may be of interest in this opening paper upon this symposium to-day to mention briefly the chief historical points of this disease, which has so long been a menace to human life and a foe to health boards throughout the world.

Typhoid is doubtless coeval with civilization. In fact, it is easily recognizable in the description of Hippocrates, 460 B. C., and Galen, 170 A. D., and in more modern times, of Thomas Willis, 1659; F. Hoffman, 1699, and others in the seventeenth century and in the next, especially of Gilchrist, 1734; John Huxhams, 1739, and R. Manningham, 1746.

Probably Huxhams' "Slow Nervous Fevers," described in his "Essay on Fevers," was the typhoid of the present day, and his "Putrid Malignant" the rarer typhus of to-day. It was, however, regarded by him rather as a variety of continued fever than as a distinct and separate disease, and it was not until 1813 that Breteneau, of Tours, identified it as a separate condition. But it was the writings and teachings of Louis, the great French physician, which did the most to disseminate a knowledge of the true nature of typhoid fever, and it was he who gave it the name it now bears. Louis' great work was published in 1829, while his pupils came from every quarter. Included among them were three Americans, Gerhard and Pennock, of Philadelphia, and Jackson, of Boston.

After their return to America Gerhard and Pennock had the opportunity of studying the disease in the wards of the Philadelphia Hospital in the spring and summer of 1836 and of contrasting it with typhus fever, of which there was an epidemic then prevalent in Philadelphia. The publications of these two men pointing out the distinctive features of these two diseases in 1837 were followed in 1838 by a paper by the senior Jackson entitled "Report on Typhoid Fever," and another by Enoch Hale on "The Typhoid of New England," which probably had their impulse in the knowledge furnished by the younger Jackson to his father on his return from Paris.²

Thus it came to pass that Elisha Bartlett's work on the diagnosis and treatment of "Typhus and Typhoid Fever," an American text book published in 1842, contained the first separate description of the diseases.

In England it was not until 1849-51 that Sir William Jenner clearly demonstrated their difference, and about the same time definite ideas were arrived at in France.

Since 1850 the two diseases have everywhere been recognized and described as distinct and

separate, except in Germany, where the recognition came a few years later.

So much for the history and now we come to the etiological features of the disease. Previous to the discovery of Eberth in 1880 of the bacillus which bears his name the etiology was regarded as strictly predisposing, and many weird theories were advanced which in the light of our present knowledge seem extremely visionary. Since Eberth's discovery, however, the true etiological conditions have been separated and now are classified as predisposing and exciting causes.

First, in regard to the predisposing causes. Experience fails to establish definite individual causes of typhoid fever, but according to Tyson newcomers are more likely to be attacked than old residents. It certainly often attacks the strong and healthy as fiercely as the feeble and delicate; in fact, there is reason to be believed more readily, as I think the experience of every member of the society present here to-day will verify. While allowance, of course, must be made for the more frequent exposure of the healthy.

Typhoid fever thus caused may be unlimited in its distribution by climate or civilization, but it may be complicated by disease peculiar to certain localities, preeminently malaria.

It is a disease of adolescents and adults under 30, although it may occur at any age. Less common in children, perforation has been found in a child five days old, while not a few cases have been reported in sucklings. In the young the duration of the disease is short and the prognosis is singularly favorable. On the other hand cases have been reported at the extreme ages of 75, 86 and even 90.³

More men than women have typhoid. According to one authority the ratio is four to one, but judging from personal experience in hospital practice with 600 patients I would place the ratio at about two to one. This difference is doubtless due to their more frequent exposure rather than greater susceptibility. The pregnant state seems to protect against typhoid fever. At least it is rare in the pregnant woman. Typhoid fever is undoubtedly more common in the late summer and autumn months than at any other time of the year. Heat has probably to do with the ripening of the cause, but the relation of the moisture to such maturing is not so well settled. It has, however, been observed that hot and dry summers are followed by more cases than hot and moist summers.

It has been shown also that more cases succeed seasons when the ground water is low—that is, when the springs are low and the upper layers of the soil comparatively dry—than when the ground water is high and the soil saturated with moisture to a point nearer to the surface. Under the latter conditions of high ground water the germs are retained "in situ." When the ground water is low, on the other hand, the constant circulation between the air in the loose soil and that above it conveys the germs upward

¹Read at the meeting of the Saratoga County Medical Association, Saratoga Springs, September 22, 1903.

and they pervade the air accordingly.* This, of course, has nothing to do with the causes of special epidemics which may occur at any season, and may quite eclipse the operation of ordinary causes; thus the recent epidemic of typhoid fever at Ithaca, N. Y., began in January and raged with greatest fury during February and March. Other epidemics illustrate the same truth. Libermeister prefers to explain the relation of typhoid to the hot and dry season by the fact that at this season the quantity of solid matter in springs is relatively larger; that the poison, in other words, is more concentrated, and therefore more virulent.

The exciting cause of this disease is the typhoid bacillus. It was discovered by Eberth in 1880 in the intestines of a case of the disease. This observation was promptly confirmed by Klebs, Friedlander and several others, who found it in the intestines, lymphatic system, including mesenteric glands and spleen in the liver and kidneys, the blood and bone marrow, and even bile and urine, as well as the rose-colored spots.

The bacillus is described as a short, rod-like bacterium, whose length is about one-third the diameter of a red blood corpuscle and whose breadth is about one-third its length, though its size and shape vary somewhat with the medium and age of the culture. Its ends are rounded, and sometimes there may be seen near them dark-colored glistening round bodies, at one time believed to be spores, but recently this germ has been classified among those which do not form spores.

The resisting powers of the typhoid bacillus are very great. It thrives at room temperature. The thermal death point is given by Sternberg at 156 degrees Fahrenheit, while cold has no effect upon them, for freezing and thawing several times fails to kill them. Of all the agents except high heat, sunlight seems to be among the most powerful to destroy them.

Breiger announced in 1885 that the pathogenic action of the typhoid bacillus was due to a specific product of the bacillus, a typhotoxin. More recently Pfeiffer concluded that the specific poison of the bacillus is not present in the filtered cultures, but is clearly connected with the protoplasmic bodies of the bacteria themselves. Whether typhoid fever is caused by the direct action of its specific bacilli, or by a typhotoxin produced by them, the bacillus itself most frequently enters the blood through stomach in drinking water or milk, in both of which it has been found during epidemics. It may also be inhaled. It is also quite well settled that the bacilli find their way into food and drink through the careless disposition of alvine discharges from typhoid fever patients.

It is still an unsettled question, however, whether or not the bacilli multiply outside of the body after they have gained access to the water of wells or rivers, but, judging from the large number of persons sometimes infected from such sources, it is not unreasonable to conclude that

such multiplication does take place. Noteworthy instances of this kind are numerous, such, for example, as the epidemic at Ithaca, N. Y., already referred to, and also the epidemic at Plymouth, Pa., in which 1,200 cases developed, with 130 deaths, all the cases coming from a single subject, whose discharges contaminated the water supply.

The fact has been established that the bacilli develop rapidly in milk, which acts as a favorable culture media, and also in the soil. The Chinese as early as 1,000 B. C. discovered that water from springs or wells, which were doubtless contaminated with typhoid bacilli, was less likely to make them ill if it was boiled than if it was not, and this they did for centuries, without knowing any special reasons for doing so. Incidentally, this custom of boiling water was the origin of the tea-drinking habit. The tea leaves furnished a fair substitute for ice, which was then unknown in their torrid climate.

MORBID ANATOMY.

The essential morbid anatomy of typhoid fever includes the changes in the lymphatic structures so constantly associated with the disease. These are more striking in the solitary glands of the ileum and Peyer's patches. The glands are enlarged by the accumulation of outwandering and proliferated leucocytes, which develop to the stage of epitheloid cells, when they become necrotic and disintegrate. The acme of this process prior to disintegration is known as medullary infiltration and is reached from the eighth to tenth day of the disease. The disintegration is molecular or massive. The former is followed by a corresponding absorption, the latter by a massive discharge of the dead cells into the bowels, resulting in the well-known typhoid ulcer.

The borders of an ulcer are usually raised. The floor is commonly the sub-mucosa, or the muscular coat of the bowel, but it may be the peritoneum; and even this is sometimes sphacelated, appearing as an opaque white membrane, which sooner or later breaks, and the bowel is perforated.

More commonly, however, the ulcer heals and the patient recovers, but the normal granular structure of the gut at the seat of the ulcer is not restored.

Autopsy discovers the ulcers in different stages of healing, sometimes all healed except the single fatal spot which has become the seat of the perforation. The large intestine is invaded in probably about one-third of the cases, and the process may terminate here also in perforation.

Similar infiltrations on the lymph nodules and lymph cords of the mesenteric glands and of the spleen may occur, contributing to the enlargement of these organs. In the spleen it is associated with an active hyperemia, which contributes to the further enlargement generally recognizable during life. The organ may reach twice or three times its normal size. There has even been rupture of this organ. Hemorrhagic infarcts have been found in the

spleen in 4 to 7 per cent. of cases coming to autopsy.

As lesions not essential to the disease may be mentioned, cloudy swelling, granular and fatty degeneration of the liver cells, liver abscess with pylophlebitis and acute yellow atrophy. Also cloudy swelling and granular degeneration of the renal cells, more rarely acute nephritis, which may even be hemorrhagic, also miliary abscesses, in which typhoid bacilli may be found. Diphtheric and catarrhal inflammation of the pelvis of the kidney and catarrhal inflammation of the bladder are occasionally present.

Changes in the respiratory organs are often found, such as hypostatic congestion of the lungs, abscesses of the lung and sometimes pleurisy and empyema.

Thrombosis of the veins, especially of the femoral, causing the not very rare symptom of milk leg, occurs; more rarely there is thrombosis in the femoral artery, which may be from embolism.

Notwithstanding the intensity of the nervous symptoms at times meningitis is a rare event.

BIBLIOGRAPHY.

2. Amer. Med. Examiner, 1840.
3. Tyson's Practice of Medicine.
4. Tyson's Practice of Medicine.

COMPLICATIONS AND PROGNOSIS OF TYPHOID FEVER.¹

By GEORGE F. COMSTOCK, M.D.,
Saratoga Springs, N. Y.

TO my mind it is a difficult matter to separate or draw an arbitrary line between the symptoms and complications of typhoid fever, as many of the unusual symptoms are due to mixed infections of typhoid bacilli. Under these conditions you will pardon me if I appear to encroach on what may properly be termed as symptoms.

The most frequent complications will be found in the circulatory system. We are all solicitous from the very first in regard to the heart. The most serious complication we have is myocarditis, which usually begins at the end of the second week or the beginning of the third, when the pulse may become unusually frequent, irregular and intermittent without a corresponding rise of the temperature. The pulse soon becomes weak and running, and symptoms of dilatation set in, which at first involves the left side of the heart, the apex beat becomes weak and at times cannot be made out. Although this condition is very alarming it is not necessarily fatal.

Endocarditis and pericarditis are less serious complications. Little is known in regard to the changes that take place in the arteries, although we often see what is apparently an infectious arteritis, producing a thrombus resulting in gangrene of the lower extremities, which

will remain dry so long as the arteries alone are affected. When the veins become involved, moist gangrene will be set up; however, gangrene is not as liable to follow venous thrombosis as arterial.

We more frequently have a condition known as phlegmasia alba dolens, which may involve the whole leg or only a portion of it. Whether typhoid phlebitis is specific—that is, whether it is caused by the bacillus of Erbeth—is not as yet certain.

Gangrene may attack any portion of the body, according to the arteries or veins that become involved.

Another very serious complication that is liable to occur during the second week or the beginning of the third is intestinal hemorrhage; although it occurs most frequently at this time it may occur late in the disease, even after convalescence has well begun.

Intestinal perforation, peritonitis, persistent diarrhea are other complications of grave importance.

In some epidemics appendicitis is a frequent late complication. Intestinal hemorrhage and perforation may come on at a time when patients are apparently doing perfectly well. They may be awakened from a quiet sleep with a severe pain in the abdomen and all the evidence of a severe shock. Pain is nearly always severe for a short time, at least in a perforation. Not so in hemorrhage, which may occur without any pain or only in a mild degree. This is a very important differential diagnostic symptom. Between these two complications, of course, both hemorrhage and perforation may occur at the same time, and, in a small percentage of cases, do so occur.

In intestinal hemorrhage frequently we do not get any signs of it in the stools or from the rectum for several hours and at times not for days. In such cases the hemorrhage has taken place high up in the intestinal tract, making the differential diagnoses between hemorrhage and perforation more uncertain.

Respiratory organs may become involved, the nose and throat. Bronchitis, pneumonia and pleurisy, neuritis, meningitis, necrosis of bones, and abscesses are all frequent complications.

In many cases the nervous system becomes early affected, the patients becoming more or less wildly delirious, which shows itself in hallucinations or mental depression, making it necessary to constantly watch patients lest they do themselves bodily harm.

The prognosis of typhoid fever depends largely upon the virulence of the typhoid bacillus, the age of the patient, the condition of the general health and the reaction of the individual to the poison, and whether the central nervous system, the heart and vessels are early and markedly affected.

New York City's Milk.—One and a half million quarts of milk are distributed in New York City every morning.

¹Read at the meeting of the Saratoga County Medical Association, Saratoga Springs, September 22, 1903.

MEDICAL TREATMENT OF TYPHOID FEVER.

By JOHN F. HUMPHREY, M.D.,
Saratoga, N. Y.

WRITING upon the treatment of typhoid fever is like taking a composite photograph of several cases of melancholia to get the typical picture and expression of the features of that disease, and so we have taken the combined ideas of all the treatments of the centuries, and especially of the past thirty years, and from that we have formulated our treatment of to-day.

We really have not until within the last ten or twelve years made our treatment sufficiently perfect by our more thorough understanding of the pathology and by our grasping the idea of the more perfect hygiene of our patients to modify our death rate and the contagious character of the disease.

With these fundamental principles impressed upon the profession it became apparent that prophylaxis was quite as important to the public as the drug treatment to the patient.

Prophylaxis.—By prophylaxis or prophylactic treatment we mean the prevention of the occurrence and of the spreading of the disease, and as this is an age of preventive medicine it has become one of the most important features of the treatment of typhoid fever.

It is at present a well-known fact that the prevalence of typhoid fever is directly proportionate to the inefficiency of the water supply and systems of drainage; in fact, it is the sanitary indicator of any city or village.

The physician must keep in mind the fact that each individual case of typhoid fever is a focus for the spreading of the disease; therefore, we must look to every possible measure that will in any way affect the occurrence and the contagious character of this disease.

In assuming the control of a case of typhoid fever the water supply and milk supply and any form of food and drink in which water or milk could possibly be a carrier of typhoid bacilli must be thoroughly examined for the protection of the patient, and most of all that it may be excluded from the menu of the family that they may not become victims of the same disease.

Paramount in the prophylactic treatment is the thorough disinfection of the stools, urine and vomited matter of typhoid patients, and probably the best disinfectant for cheapness, harmlessness and effectiveness is chlorinated lime, four parts in 100 of water; carbolic acid, one part in ten or twelve parts of water; bichloride of mercury, one part in 2,000 of water; also crude sulphate of iron and sulphate of zinc are very frequently used because of their cheapness and efficiency, but are not true disinfectants, only antiseptic in their action.

The following suggestions, made by Drs. Osler and Tyson, will outline the precautions that

should be taken in the treatment of these cases.

1. Inasmuch as the contagion is transmitted by the urine, stools and vomited matter, it is important not only that these should be thoroughly and properly disinfected, but also that all bed linen and garments worn by the patient, whether soiled or otherwise, should, upon being changed, be sterilized by boiling in carbonate of soda solution for one hour.

2. The urine, stools and vomited matter should be disinfected in the following manner: Place in bedpan or bowl a small quantity of carbolic solution (1-20) or chlorinated lime of same strength. Cover the evacuation well with the same solution and mix thoroughly and let stand for one hour before emptying into privy vault or water-closet hopper, rinsing out the emptied vessel thoroughly with same solution and boiling water, repeating the same process for all urine and vomited matter of the patient. Linen may be submerged in the carbolic solution or that of carbonate of soda and boiled for one hour before being washed.

3. After the bowels have been evacuated the buttocks and anus should be thoroughly bathed with carbolic solution 1-60 or bichloride of mercury solution 1-2,000, followed by hot water and soap.

4. Door knobs and parts of doors, rectal thermometers, syringes, tubes and all utensils or anything touched with the soiled hands of attendant should be washed with carbolic solution, since they are a possible source of infection through the particles of fecal matter drying upon them and so passing into the air.

5. Finally the nurse should wash her own hands with soap and water and then rinse them in fresh bichloride solution, as it is either by soiled hands or by bacteria floating from dried feces that nurses and attendants who acquire typhoid fever become infected, so the importance of these injunctions cannot be overestimated.

6. Where tub bathing has been employed it is possible that the water of the bath, which has been used several times, may be a source of infection. The nurse or attendant should therefore wash her hands after tubbing a patient, and watchful care should be exercised not to carry them to her mouth during a bath.

7. After death or upon the discharge of a patient the mattress, which should be well protected by a rubber sheet, ought to be well aired or even renovated. The rubber sheet should be wiped frequently with carbolic solution, rinsed in warm water and dried in open air.

Disinfection of urine and stools should be commenced as soon as the diagnosis is assured and ought to be continued for ten days after the temperature is normal.

9. In localities where a proper drainage system is not in use the stools should either be mixed with sawdust and cremated or buried in a trench four feet deep, far removed from any well or stream, after being covered with chloride of lime.

10. When epidemics are prevalent the drink-

¹Read at the meeting of the Saratoga County Medical Association, Saratoga Springs, September 22, 1903.

ing water and milk used in families should be boiled. Travelers should drink light wines or mineral waters rather than the local water or milk. Care should be exercised to thoroughly cook oysters which have been fattened or freshened in streams contaminated with sewage.

TREATMENT.

General Management.—The sick room for a typhoid patient should be a large, airy, sunshiny room, and the patient ought to be confined to the bed entirely from the outset and continue in the recumbent position until convalescence is well established, *i. e.*, one week or ten days after temperature is normal.

The ideal bed is a three-quarter bed, woven-wire springs, soft hair mattress, covered with one or two blankets and a rubber cloth, placed underneath the sheet. The sheets of the bed and the garments of the patient should be changed daily, or, if not possible, should be aired daily and changed twice weekly.

The nurse should be an intelligent person, if not trained, so that directions may be carried out to the letter, as the nursing is so very important in typhoid fever.

Diet.—The food should be liquid in character, such as milk, soups, broths and gruels of different kinds, which I believe to be as well as a straight milk diet, and much more palatable to the patient, all of which should be well diluted and from ζ iv- ζ viii, each two or three hours, according to the indications.

During the past decade there have been much discussion and many suggestions regarding a more liberal diet in the treatment of this disease. Even as early as 1888, to my knowledge, Dr. Peabody, in the wards of the New York Hospital, pursued a diet according to the desires of his patients, but as a student I thought it all right for a hospital regimen, but could not be followed in private practice, and so no great attention was given the subject.

In the past two or three years Dr. William E. Robertson, of Philadelphia, has given much literature to the profession on this subject, and so, no doubt, has stimulated many or few to give the more liberal diet a trial.

The departure of giving solid food to typhoid patients from the very inception of the disease seems at first a little hazardous, *i. e.*, steak, chops, roast beef, chicken, fish and eggs, with toast, vegetables, desserts, etc., but after a few days your timidity wears off and you become more brave and see your patients go along through the series of days which the fever exists without mishap or with no more difficulty than in the use of the milk or liquid diet.

The advantage of a diet of more solid food is the maintenance of the strength of the patient to combat any possible complication that may arise and the limitation of the convalescent period to a much shorter time than by the use of the liquid diet, and the general good feeling of the patient throughout the entire course of the disease.

in that they are allowed food as soon as they have the desire for it, which relieves the patient's mind and at the same time strengthens the body.

In children and in nervous, excitable patients it is a most decided advantage, in that it relieves their constant pleading for something to eat, making their care and management very much easier than under the old regimen.

The contra-indications in the early days of the disease are an irritable stomach, with vomiting and the inability to get the patient to take food in the state of delirium.

The indications to withhold solid food are hemorrhage of bowels, perforation and a very severe diarrhea.

The movements or stools should be daily examined to ascertain if any foods are not being thoroughly digested, that there may be no irritation in the intestinal tract.

When the stomach is nauseated all food is withdrawn and a trial is made of albumen water, in the proportion of the white of one egg to four to six ounces of water, which may be flavored with orange, whisky or brandy, also wine, whey, kumiss, matzoon, champagne iced, and sherry wine iced—all in small quantities—clam juice or toast water.

If the stomach will not tolerate food at all, then we must withhold all food and drink as long as indicated, and sustain the patient by rectal alimentation.

The nutrient enemas may contain peptonized or malted milk, four ounces, with whisky, strychnia or whatever drugs that are necessary for the existing condition.

In mild cases patients need not be aroused at night for food, but the more severe cases with high temperature, delirium and stupor should be awakened at regular intervals, as in the day.

Alcohol is indicated when weakness becomes marked, with high temperature, failing heart action, and muttering delirium, in quantities of ζ iv- ζ xii in twenty-four hours, if necessary.

Drugs.—The treatment of typhoid fever by drugs have been many and various and the one which we as practitioners are most familiar with in our private work, and by which we have been able to guide our cases through successfully and without complication, but, no doubt, not with as much comfort to our patients as if they had had the tub baths when indicated. As we have not been favored with the facilities for tub bathing we have gotten along with sponging and a few drugs, giving as much water as possible for the conditions, and, withal, a fair degree of success has been attained.

The drug which I believe has forged my success in these cases, and which I have given in every case, almost without exception, has been the mild chloride of Hg., with the greatest satisfaction to myself and comfort to my patients.

I have administered the calomel in doses of gr. v in adults each third night through the entire exhibition of temperature, followed by a saline in

the morning, with a very happy effect, only withholding it in the presence of hemorrhage and perforation.

The physiological action of this drug is antiseptic, primarily and secondarily acting upon the bile ducts, liberating the bile to the intestines, thereby supplementing the former action with a soothing effect upon the ulcerating Peyer's patches: also lessening the fermentation processes in the intestines, and with increased flow of bile and saline the stools are thereby augmented, laden with the bacilli of typhoid, which must inhibit the bacterial intoxication and in the end relieve the patient of many serious symptoms.

The plan followed continuously as I have indicated certainly does produce an effect when you observe the cases to the number of between one and two hundred, and well toward the latter you are impressed with their mildness, with the lack of speedy disappearance of the delirium, tympanites, nausea and diarrhea whenever present.

I do not wish to convey the idea that calomel is an absolute specific for typhoid, but I do wish to impress you with the fact that it has the effect of modifying the intensity of all the symptoms in most of the cases, thereby producing a more mild disease with which to contend and a minimum death rate.

INTESTINAL ANTISEPTICS.

This form of treatment has been tried thoroughly for a number of years without any apparent influence upon the death rate and very little upon the bacilli or their toxins.

The drugs used to this end are salol, bismuth-bata-naphthol, carbolic acid and iodine, turpentine, etc.

SERUM TREATMENT.

Several investigators have presented to the profession serums for which much was claimed, but practical application has demonstrated that they contained no curative value.

They did seem to affect the temperature for a few hours as an antipyretic, but were not efficacious as a cure.

Special symptoms demand treatment as they exist in their more exaggerated form. Delirium is best controlled by the icebag to the head, leeches to temples or back of ears, and sulphonal in gr. v doses, each four hours, has seemed to have produced almost a specific effect.

Hyperpyrexia may be effected by the use of icebags to the head and abdomen, with tubs or cold sponging, and the drug which will assist in all this is thermol in gr. xv-xx, each four hours. This is a safe drug to use straight along; the only disadvantage is that every case under my observation has been extended two or three weeks as compared with other cases, whether by chance or otherwise, I cannot account.

Hemorrhage of the Bowels.—Requires active treatment in the use of icebag over abdomen, per-

fect quiet, food reduced to a minimum or withheld for a few hours, foot of bed elevated, strophia gr. 1-150, morphia gr. $\frac{1}{4}$, if in profound shock, otherwise not any; adrenalin chloride ℥ xv-xx, each two to four hours, will probably control bleeding best of any drug; lead and opium pill are frequently used, as are argentinum nitrate, ergot, etc.

Tympanites is a very distressing symptom, relief being obtained by ℥x spts. turpentine each four to six hours, with turpentine stupes applied to abdomen, rectal irritations of quinine 1-500; also of spts. turpentine, and leaving of rectal tube in situ; sometimes poultices of flaxseed with a hypo of morphia may be necessary for the pain. Acetozone is also of value given through the disease.

Perforation is only relieved by early recognition of the condition, followed by early operation for the repair of same, with a result of 19 per cent. of recoveries by laparotomy.

Insomnia is frequently a symptom of first week, but rarely lasting longer, and yields often to hot milk at retiring or trional, sulphonal, chlorotone 1-3 capsules of gr. iii each, paraldehyde by rectum or chloralamide, etc.

Bed sores occur rarely and less often with more liberal diet, as the patients do not become so emaciated, but careful watching for inflamed points and keeping them bathed and powdered will obviate this discomfort.

Constipation is a condition for which we must be on the constant lookout near the end of a course of typhoid fever and during convalescence, for fear of rectal impaction, which will occur occasionally in spite of our best efforts to prevent its occurrence. Patients should be warned of this possibility when discharged as occurring at any time for six months to come. This condition may be relieved by some anti-constipation pill rather than a saline or comp. liquorice powder. Impaction, if occurring, must be removed by manual efforts and bowel irrigated.

Relapse receives the same treatment as the original disease, except more careful watching of the heart action from having passed through one attack.

Convalescence.—In this interval of sickness and health we always feel an anxiety lest a relapse may occur, but come if it may, we can feel that nothing can prevent it in any way. Our greatest thought is lest the patient sit up too long at a time and overtire himself and in that way prolong the time of getting strong. Careful feeding is important, but with the more liberal diet the ice is broken, so the extreme care of former times is not called for, as they are eating already and much stronger than by liquid diet, thereby prepared to get out of bed and walk the sooner. The patient should remain in bed for one week after temperature is normal and then sitting up gradually and after a few days as is indicated, walking about slowly and for shorter distances until strength is fully gained.

HYDROTHERAPY IN TYPHOID FEVER.¹

By FREDERICK J. RESSEGUIE, M.D.,
Saratoga Springs, N. Y.

I THINK you will all agree that the use of water in the management of typhoid fever is the most important therapeutic agent we have. Indeed, so great is the value of water in treating these cases that I might make bold to say that its abuse would consist mainly in withholding it.

I believe it is now generally agreed among physicians that the best mode of treating typhoid fever is by the cold bath. This was introduced originally by Currie, of London, more than one hundred years ago; but the reintroduction of its use by Brand, of Stettin, is more familiar to us. Indeed, ordinary cases require little or no medicine where the baths can be employed. Unfortunately, it is often impossible to carry out the systematic use of the baths, particularly in private practice, and for various reasons. A few of the most important that come to my mind are: First—Improper or insufficient attendants, it usually requiring three or four in the adult cases and two in children. Second—The lack of proper apparatus, as portable bath-tub, rubber sheetings, etc. Third—The objections of patients or relatives. Fourth—The natural aversion of some people to water. It is mainly for these reasons, no doubt, that bathing is not universally carried out in the management of typhoid cases. However, its efficacy has been proven, and is without question, the mortality in all hands having been materially lessened by its use. Authors, of course, differ in respect to the percentage reduction in mortality, but all are agreed that it is much reduced. Most of you, doubtless, are familiar with the enthusiastic assertion of Brand that "every case of typhoid fever treated regularly from the beginning by cold water will be exempt from complications and will get well." I have never seen this statement confirmed by statistics, and I have reasons to doubt its stability, as reports from all known forms of treatment give a mortality to perforation alone between 3 and 4 per cent. European advocates of the method report the mortality as less than 5 per cent., with no deaths in the cases that come under treatment before the fifth day. American observers, however, report a strikingly uniform average mortality of 7.3 per cent. During five years 408 cases were treated by baths in the Royal Victoria Hospital in Montreal, with a mortality of 4.4 per cent., and Zeimssen reports a great reduction of mortality in Germany.

Some physicians have raised the excuse that there are remedies at our command which are harmless, or nearly so, and if given will reduce the temperature in typhoid quite as much as the baths, and with much less discomfort to the patient. But we must not forget that hyperpyrexia is not the only enemy the cold bath will conquer. Dujardin-Beaumetz, who is an advocate of hydrotherapy, insists that the "effects of the bath

upon the functions of the nervous system are of greater importance than the mere abstraction of heat in favoring recovery and diminishing the liability to complications." And Anders, in his new text-book, tells us that the benefits offered to the patient by this method are so great and varied that it becomes the duty of every physician who treats typhoid fever to be prepared to employ it, and he sums up the beneficial influences of the bath as follows: "They absorb the body heat directly, thus reducing the temperature and overcoming the ill effects of high fever, this action becoming more marked after a day or two of the treatment; (2) they improve the nervous symptoms, also render the mind clear; they diminish mental dulness, stupor, muscular tremors and twitchings and induce sleep; (3) they strengthen the heart, thus obviating the danger of sudden circulatory collapse and the consequences of increasing cardiac weakness (hypostatic congestion of the lungs, venous thrombosis, etc.); (4) they stimulate the respirations, whereby the inspirations are deepened and the tendency to pulmonary complications greatly lessened, especially severe bronchitis, lobular pneumonia, etc.; (5) the renal function is invigorated, and as a result the elimination of typhotoxins by the kidneys is increased (Roque and Weil); (6) on account of the cleanliness of the skin, which they insure, bed sores rarely occur; (7) they may shorten the stay in the hospital or sick room, but not the stay in bed, except, perhaps, in the lighter types."

Brand recommends that the baths be commenced when the temperature in the rectum reaches 102.2 degrees Fahrenheit, and they are unusually continued until the evening temperature remains below 102 degrees Fahrenheit.

The Brand method, which is familiar to most of you, consists, briefly, of the baths at a temperature of 64 to 68 degrees, given every three hours and of fifteen to twenty minutes' duration, day and night, as long as the rectal temperature exceeds 102.2 degrees Fahrenheit. From the sources of information that I have been able to reach I find that the water now mostly used is from 85 degrees cooled down to 80 degrees, or, in the rarer instances, to 75 or 70 degrees. The effect of the bath on the hyperpyrexia is shown when the temperature is taken one-half hour after the conclusion of the bath, when it is found usually two or three degrees lower than before. In the cases with severe infections and accompanying high temperatures the drop may be only one degree, occasionally less, in which case the bath should be prolonged to twenty minutes, and repeated every three or four hours; while in the lighter cases six to eight hours is usually found sufficient. In any event, they should not be repeated oftener than every three hours. Warm baths of much longer duration are highly recommended when cold baths are badly borne or the results are not satisfactory. I shall only mention the contra-indications to the cold bath, without dwelling upon them: (1) Advanced cases of the fever (after the

¹Read at the meeting of the Saratoga County Medical Association, Saratoga Springs, September 22, 1903.

second week has passed), as alarming and sometimes fatal collapse have followed under these circumstances; (2) peritonitis or the occurrence of perforation; (3) intestinal hemorrhage, and (4) extreme cardiac weakness.

In consequence of the prejudice which exists against the cold-bath treatment of typhoid and the lack of ways and means for carrying it out there are several substitutes, and perhaps the one most commonly employed is that of sponging, and I may state from experience that this is highly satisfactory. This method can be employed in private practice, where there is a fairly intelligent nurse at hand, quite as well as in a hospital ward, and it has that to recommend it. The indications for sponging are the same as for the baths, but the water should be about 70 degrees, or about the temperature of the air of the room. The patient is to be stripped, the limbs successively sponged and dried, and then the trunk and abdomen. A single nurse is usually all that is necessary for this, and the patients are but slightly disturbed. Care should be taken to rub the surfaces lightly in drying, as it has been my experience that you will occasionally get a higher temperature rather than a reduction, a result, no doubt, of the friction used. These spongings may be repeated as often as required; alcohol or vinegar is often added to the water to be used and with good effect. This method is routine in the Saratoga Hospital, and its results are all that could be wished for.

The cold pack may also be used, although I believe it is not so popular as sponging. Blankets are put over and under the patient, and a sheet (two are better) is wrung out of water at a temperature of 70 to 80 degrees, and wrapped closely around the patient, after which the blankets are also closely wrapped about him. He remains thus from a half hour to an hour or more, free diaphoresis soon occurring and the fall of temperature enhanced thereby; this can be repeated as often as required. Instead of covering with blankets water of a temperature of 65 to 70 degrees may be frequently sprinkled over the sheet, or, in the obstinate cases, ice may be rubbed over as desired. Ice-water enemata are occasionally used, but not frequently required.

I cannot close without saying a word about the use of pure cold water as a drink in typhoid fever. I know, from my own experience and the experience of my colleagues, that in sufficient quantities (and I mean by sufficient quantities enough to keep the tongue moist, be it quarts or gallons) we have in water a remedy that will carry along your cases with fewer complications, with lower temperature, with little or no delirium, or tympanites, a cleaner tongue, and, in short, with the least possible care or worry, than all the drugs at our command, and a good treatment for this widespread disease could be briefly summarized: Water, externally; water, internally; more water.

THE INFLUENCE OF THE MUNICIPAL MILK SUPPLY UPON THE DEATHS OF YOUNG CHILDREN.¹

By GEORGE W. GOLER, M.D.,
Rochester, N. Y.

PRELIMINARY NOTE.

THIS paper, as its name implies, is an attempt to show the effect of a careful inspection of both the sources and the distribution of the municipal milk supply, and the effect of seven summers' educational work through the establishment of municipal milk stations in charge of trained nurses, upon the death rate in children under 5 years of age for the city of Rochester, N. Y.

In this paper the death rate is not figured upon the basis of population. Neither are the causes of death under 5 years of age given for intestinal diseases alone. Every death that has occurred under 5 years of age from any cause whatsoever has been included in the figures, for it is assumed that milk as food affects the death rate of all young children.

The deaths in children under 1 year of age and those between 1 and 5 years of age for the city of Rochester, N. Y., between 1891 and 1896 were as follows:

Deaths Under 1 Year.	Years.	Deaths Under 5 Years.	Total.
539	1891	240	779
589	1892	374	963
483	1893	279	762
391	1894	241	632
415	1895	170	585
462	1896	192	654
2,879		1,496	4,375

The deaths in children under 1 year of age and those between 1 and 5 years of age for the city between 1897 and 1902 were as follows:

Deaths Under 1 Year.	Years.	Deaths Bet. 1 and 5 Years.	Total.
316	1897	142	458
354	1898	128	482
305	1899	178	483
333	1900	165	498
288	1901	155	443
291	1902	108	399
1,887		876	2,763

In the last period of six years 992 fewer children died under one year, and 620 fewer children died between 1 and 5 years of age. The diminution in mortality for the last period over the first period is 65 per cent. for children under 1 year of age, 58 per cent. for children between 1 and 5 years of age.

In the first period from all causes more than

¹Read at the Twentieth Annual Meeting of The New York State Medical Association, New York City, October 19-22, 1903.

28 per cent. of children died under 5 years of age; in the last period 19.5 per cent. of children died under 5 years of age.

These tables of the deaths in children under 5 years of age for a period of years hardly does credit to the boasted civilization of the end of the nineteenth century. The conditions believed to be responsible for this enormous infantile mortality at the end of the nineteenth century are mainly two. First, there is a general unpreparedness for the duties of parenthood. "What should be done with the baby? How should it be cared for? How fed? When and how weaned? How given water? How given air? How dressed? How bathed? What about its sleep? Should it be let alone? Should it be amused?" And not only how may all these things be done in a general way, but how must each child have its individual wants ministered to during its earliest period of development? These are questions which every mother asks, or ought to ask. Who shall answer them? Usually the old dame answers them. She answers them out of the musty legends handed down to her from the time when a necklace of bears' teeth softened the gums, when the souls of unbaptized infants were contained in the pot-de-chambre, and when bedbugs from their clinical association were valuable to lying-in women. At the dawn of the twentieth century we have schools in which to teach all manner of things but the duty of parenthood. Realizing the necessity for reasonably intelligent answers to some of the questions here propounded, a little pamphlet in four languages, elsewhere alluded to in this paper, has been published in which an attempt is made to answer some of these questions. But however well these questions may be answered in the pamphlet, or by nurse or physician, the mother becomes almost powerless in an attempt to rear her child because of the dirty condition that maintains in the majority of places from which the city's chiefest food—milk—is drawn. The child, if it has an ordinary heritage of health as its birthright, may be reared in stuffy rooms, overdressed, seldom bathed, dandled and tossed, and it may even be overfed to a certain limit, but it can seldom be fed on bad food without falling sick, and, in many cases, dying. As milk is the chief, most necessary and most perfect food for children, so it is quite the dirtiest of all foods. After it becomes dirty, as it usually does from barnyard filth, street dust, etc., it is quite impossible to clean it. Meat, vegetables, cereals, even shell fish may be washed, but no washing, no process of filtration, Pasteurizing or sterilizing can possibly clean milk after it has once been soiled, so as to make it fit food for infants. The various processes referred to may lessen a danger they do not wholly remove, and the infant fed upon dirty milk subjected to a heating process is no longer fed upon milk, but upon the chemical constituents of a fluid that was once milk, containing products derived from bacterial life transformed by heat and unfit for the digestive apparatus of an infant.

For these reasons milk, for infants at least, should be clean at its source. Adult persons may have milk well manured from dirty barnyards and thrive upon it. Such milk Pasteurized may enable the ordinarily well adult to live without serious illness, but for the baby no such Pasteurized or sterilized manured products will do—nothing but clean, whole milk, unchanged by heat and containing not more than 100,000 bacteria per C.C., and preferably not more than 10,000 bacteria per C.C.

In order that at least a majority of the milkmen should supply a city with milk having such a standard of cleanliness stable inspections in the adjoining towns from which a city gets its milk supply must be rigidly carried out; the barns, cattle and milk utensils must be rigidly inspected and cleanly requirements enforced; the dairy of the milk peddler, his cans, wagons, etc., must be subjected to the same precautions, and finally the city milk laboratory must insist upon a bacterial standard of cleanliness in order that the milkman hold his license.

I am aware that the bacterial standard of cleanliness is considered impracticable by some of those engaged in scientific milk work. Observe, if you please, what has been accomplished in the city of Rochester to aid in securing a cleaner and better milk supply through this means. In 1900 a circular was sent to all of the milkmen supplying milk to Rochester, informing them that thereafter 100,000 bacteria per C.C. would be made a standard for cleanliness in Rochester's milk supply. Some newspaper comment was awakened by this circular, and the Milk Producers' Association held that such a standard was foolish and impracticable; nevertheless we have attempted to maintain that standard for nearly four years, with what success the following figures show:

Prior to 1900 the average bacterial counts of 86 samples of milk showed 837,000 bacteria per C.C., excluding 26 per cent. of the samples which contained over 5,000,000 bacteria per C.C.

After the bacterial standard had been made, in 1900, 319 samples averaged 796,000 bacteria per C.C., 15 per cent. contained under 100,000 bacteria per C.C., and 10 per cent. over 5,000,000 bacteria per C.C.

In 1901, 287 samples averaged 275,000 bacteria per C.C., 28 per cent. contained under 100,000 bacteria per C.C., and 9 per cent. over 5,000,000 per C.C.

In 1902, 531 samples averaged 215,000 bacteria per C.C., 34 per cent. contained under 100,000 bacteria per C.C., and 6 per cent. over 5,000,000 bacteria per C.C.

In 1903, to September 1st, 329 samples averaged 209,000 bacteria per C.C., 33 per cent. contained under 100,000 bacteria per C.C., and 4 per cent. over 5,000,000 bacteria per C.C.

Turning to the records of the health office, it is found that a milk inspector was appointed late in 1891, and that prior to 1891 no milk inspection of any kind was made in the city of Rochester.

For lack of facilities the milk inspector, who is a trained chemist, was at first compelled to do the work of analyzing samples of milk in his own house. Between the time of his appointment and the year 1895, because of imperfect facilities, both for the collection and examination of milk, but comparatively few samples of milk were examined. Between 1895 and the present time from 3,500 to 5,000 samples of milk have been taken each year. Stable inspections have been frequently made both in the city and in the country.

The conditions of the municipal milk supply prior to 1897 are believed to have been responsible for the large infantile mortality prior to that time. As has been shown, after 1897 there was better and more frequent milk inspection, both of the farms and the dairies. In the summer of 1897, believing that an improved milk supply for little children would diminish the infantile death rate, the then Health Commission was asked to allow an expenditure of \$400 to provide milk stations where pure milk ready bottled for nurslings might be sold during the months of July and August. In the first week of July in a vacant store in one of the most populous sections of the city a milk station was established for the sale of pure milk for nurslings. The station was placed under the control of a trained nurse, who, with an assistant, prepared the milk by properly diluting it and making it ready for use in sterile nursing bottles corked with sterile rubber corks, after the general plan of Siebert, of New York. This milk was sold at cost price to mothers, who in every instance at first brought their children with them to the milk station. At the station the nurse weighed the baby, and first talked to the mother about the importance of nursing her child; or, if hand-fed, of feeding according to weight, and instructed her as to the general care of the child in the absence of any specific directions from a physician. At the stations pillows and beds of excelsior covered with cheesecloth, and toothbrushes were sold at cost. Little booklets embodying the salient features of infant care and feeding were printed in English, German, Italian and Hebrew and distributed free of cost.

Such was the success of the work in the first season that four weeks later another station was established in another section of the city. Both stations were run at their greatest capacity until the first of September, when they were closed. In July, 1897, but fifty children died under 5 years of age, and but fifty-seven in the month of August. For six years prior to this time the deaths in children under 5 years of age had averaged 112 for July and ninety-nine for August. At the close of the year it was found that 200 fewer children had died in 1897 than in 1896. There was a total of 452 deaths in children under 5 years of age for the year 1897. This was 125 fewer deaths in children under 5 years of age than any year of which the Health Department had record.

This experiment in 1897 was given widespread

publicity in the local press, more attention was paid to the condition of the milk supply by the people, and more to that part of the milk supply going to little children. Of the decreased mortality, the critics said, it was an accident, that the milk had nothing to do with the decrease in infantile mortality, and that the diminution in infantile mortality could not be maintained.

It is now six full years since the summer milk stations were first established. In 1898 they were increased to four in number—two in vacant stores, one in a schoolhouse, one in a police station—each controlled by a trained nurse. A central station at which the milk is prepared is organized each season on a farm outside the city, where a trained nurse and assistants have full control of the cows, utensils, bottles, etc., and where all of the milk work is carried on in a portable milk laboratory. Everything coming in contact with the milk is thoroughly sterilized in steam sterilizers. The milk itself is not subjected to any Pasteurizing or sterilizing process. Sterilizing and Pasteurizing are only an open invitation to the milkman to be careless in the production and handling of milk.

At the milk station on the farm the milk is taken from clean, well-fed, tested cattle, into sterile cans, which are carried to the barn in sterile cheesecloth bags. Just before milking the cows' udders are washed. A sterile cheesecloth fly cover is placed over the cow, the first portion of the milk being rejected. So soon as the cans are filled they are immediately covered by a layer of cheesecloth held in position by a rubber band. The cans of milk thus covered are immediately taken from the barn into the laboratory, about two hundred yards away, where the milk is properly diluted, sweetened, and turned off into sterile nursing bottles of various sizes of the Siebert type. The bottles are corked with sterile rubber corks, placed in racks, covered with cracked ice and immediately transferred to the city for use. Of the cleanliness of milk prepared in this way forty-three daily samples were found to average not more than 14,000 bacteria per C.C., while city milk for the same period approximated 235,000 bacteria per C.C.

From the milk farm an average of more than 600 bottles of milk were sent to the four city milk stations and by the nurses distributed to more than one hundred families.

This work has now been carried on for six successive years. During these years the mortality of infants under 5 years of age in Rochester has fallen from 28 per cent. of the total mortality from all causes to in the last six years 19.8 per cent. of the total mortality for all causes. From 1897 to 1902 there were 1,612 fewer deaths in children under 5 years of age than in the period from 1892 to 1896. How well we compare with the mortality in children under 5 years of age in nine cities in the State of New York with a population above 35,000 is shown by the following table:

PERCENTAGE OF DEATHS UNDER 5
YEARS TO TOTAL DEATHS.

	1897.	1898.	1899.	1900.	1901.	1902.	Average.
New York..	39.5	39.0	36.1	36.1	34.9	36.7	37.0
Brooklyn ..	38.2	37.2	36.8	36.9	34.2	33.6	36.1
Long I. C..	36.0	36.2	35.6	33.9	31.0	35.3	34.7
Albany	24.3	24.9	25.7	21.9	16.9	15.5	21.5
Yonkers ...	42.9	34.4	37.6	37.6	32.8	39.3	37.4
Troy	20.5	24.6	24.1	24.0	20.3	22.9	22.7
Utica	27.2	26.1	19.5	27.4	21.5	21.6	23.9
Syracuse ..	28.0	23.1	21.6	21.9	21.9	22.0	23.1
Buffalo	35.7	34.2	31.1	32.9	30.7	29.5	32.3
Rochester ..	19.8	21.2	19.5	22.1	18.7	17.7	19.8

The average cost of distributing the milk, and what is far better and more important, spreading abroad some knowledge of the care and feeding of infants, has averaged less than \$900 per year.

This is an example of what may be done to prevent infants from dying needless deaths from dirty milk. The success of this plan is not dependent so much upon the amount of milk sold at the milk stations as it is upon the educational factor in the work, upon the knowledge imparted to the mothers by the nurses at the stations and by the work of the press. The success of this plan, too, has largely depended upon the system of milk inspection. Last year more than 4,000 samples of milk were taken from the 300 retail dealers supplying the city. Stable inspections were carried on in all of the surrounding towns supplying the city with milk.

While the educational part of the plan in the milk stations is the part most worthy of attention it is the correlation of stable and dairy inspection and the maintenance of a bacterial standard of cleanliness for our municipal milk supply that has enabled us to report these results.

DISCUSSION.

Dr. DeLancey Rochester, Buffalo, said he wished to congratulate the author on his paper. A similar plan had been tried in Buffalo, but had been found impracticable. Some physicians had then attempted to inaugurate the plan of certifying to the purity of the milk from a particular dairy. This was done for a certain length of time, but it was found impossible to compel the dairyman to live up to the requirements. For the first eighteen months he kept to his agreement pretty well because of frequent and unexpected visits of inspection, but after that, these visits becoming a little more irregular and infrequent, there was a remarkable increase in the impurity of the milk. After that it was impossible to get him to go back to the original standard. The speaker said he desired to emphasize what the reader of the paper had said about sterilization and Pasteurization of milk by dairymen or deliverers—*i. e.*, that it was also a sop to those who desired to supply dirty milk. It had been shown that even dead bacteria were not desirable in milk, and it was well known that sterilized and Pasteurized milk were more difficult of digestion.

Dr. James J. Walsh, New York, said that this subject was extremely important. What had been accomplished in a city of medium size was par-

ticularly instructive, for it was just from cities of the middle class that we had received some of our best lessons in sanitation. The work could be done in such cities more easily because it was not necessary to move a large and intricate political machinery. It was said that there will be 15,000 fewer little graves in the city of Chicago this year than there would have been had it not been for the improvement in sanitation that has taken place since 1895. This gives some idea of how much can be accomplished by sanitary effort.

Dr. H. O. Marcy, Boston, said that sometimes surgeons thought they accomplished a great deal when they saved a few lives by prompt surgical interference, but the last speaker had shown another way of saving lives, and on a large scale. At one time a committee in Boston, of which he had been a member, had endeavored to reduce the infantile mortality in that city. The first year of their supervision deaths from cholera infantum were less than during the preceding year by about 20 per cent. Their efforts began with the producer and extended to the consumer, but the work was found to be so difficult and the duties so manifold that all of the commission were glad to resign at the end of the year. However, the good work has been kept up. In the particular year referred to the greatest danger was found to be what was known as "one cow's milk." It was found that the mixed milk coming in from the trains was taken to a stable, which was anything but clean, and was put into special bottles and sold as special milk for infants. With the idea of keeping out dirt and bacteria I devised rubber shields for the teats with tubes carried through the cover to the pail, which otherwise fitted tightly and an effort was made to introduce them. Theoretically they were all right, but in practice it was so difficult to have them used that they were abandoned. Another method was to take cheesecloth, cut four holes in it for the nipples and fasten over the back of the cow, and so protect the milk receptacle. This method has now been in operation about six years. The milk is first taken from a strain of good thoroughbred cattle. The milk is brought quickly to the receiving station, where it is refrigerated until about the consistency of sherbet. It is then put into a centrifugal machine, whereby most of the water is driven out quickly. The milk in this concentrated form does not undergo change anything like as quickly as does ordinary milk. Such milk is kept sweet for about two weeks. There is no reason why, by this process, Wisconsin should not supply New York City with milk of good quality. Milk in eight-quart cans can be sent to Bermuda and has come back to Boston perfectly sweet. The possibilities of this system are great, and can be appreciated by all who have considered this question. A better milk can be supplied at half cost because it is not necessary to deliver the milk at such short intervals. Dr. Marcy looks forward to seeing this system revolutionize the distribution of milk.

Dr. Rochester asked whether this process did not simply throw down the casein and fat, and if it did not throw out in the water the salts and the sugar of milk in solution.

Dr. Marcy replied that practically this was not the case. The first process was the separation of the milk fats. The only reason the milk cannot be made an absolute solid is because of its viscosity. The product is a pure milk with very little loss of albumins or salines. The experiment had been tried of macerating thirty pounds of meat in water until the water was of the color of dark wine, and then refrigerating this fluid. It was found that 80 per cent. of the water was taken away. This water was in the form of thick ice, and was absolutely free from color. Some of this ice was placed in a sterile bottle and examined in the laboratory. It was found to contain a very few blood cells and a very slight trace of albumin.

Dr. Goler said that the milk provided in Rochester had been kept at the room temperature for from five to eight days, and had been found at the end of that time perfectly sweet.

THE CAUSES OF FAILURE FOLLOWING OPERATION FOR NEPHROPTOSIS.¹

By AUGUSTIN H. GOELET, M.D.,
New York City.

IN estimating the causes of failure following attempts to overcome nephroptosis the objects to be attained that would entitle the operation to be regarded as successful must first be taken into consideration. They are as follows:

1. Fixation of the kidney in its normal position.

2. Complete separation of the colon and duodenum from the kidney to obviate subsequent dragging upon the kidney by the colon when it becomes distended.

3. Avoidance of injury or mutilation of the kidney.

4. Avoidance of injury to the structures penetrated in gaining access to the kidney and a disfiguring scar.

5. Cure of the symptoms and conditions coincident to the prolapse.

Causes of failure following operation for this condition may be grouped under three heads, viz.:

First—Those which obtain before operation, including preparation.

Second—Those due to faulty technique.

Third—Those arising from post-operative management of the patient.

THOSE WHICH OBTAIN BEFORE OPERATION.

1. Delay in operating until the health of the patient and the digestive apparatus are seriously impaired and perhaps incurable.

2. Delay in operating until the kidney has become seriously disabled or an incurable nephritis has developed. Hydronephrosis, pyoneph-

rosis and atrophy of the kidney may result from long-neglected prolapse of this organ. Fixation of the kidney in an abnormal position, the result of perinephritis, I have observed frequently.

3. Unusual and irreparable ptosis of the abdominal organs as a complication of the nephroptosis. In such cases, however, since the kidney is many times the most important element of the enteroptosis, fixation of that organ and support of the others by belt makes the patient comparatively comfortable.

4. Failure to prepare the patient properly for the operation, and thus obviate severe retching and vomiting following anesthesia, which may loosen the kidney from its fresh attachment.

FAILURES DUE TO FAULTY TECHNIQUE.

5. Failure to detach completely the fatty capsule from the kidney—that on the posterior surface to permit the kidney to come into contact with the structures to which it must become adherent, and that on the anterior surface, so as to separate the attachment of the colon and duodenum from the right kidney, and the colon and small intestine from the left kidney. Unless this detachment of the colon from the kidney is complete it will still drag on the kidney when it becomes distended, and if it does not pull the kidney from its attachment again will give rise to very annoying pain and other symptoms.

6. Improper insertion of the sustaining sutures, whereby they either tear out completely or cut through the fibrous capsule, permitting mobility of the kidney and preventing its attachment.

7. Failure to immobilize the kidney until it can become permanently attached either by improper tying of the sutures, or the use of suture material that stretches when it becomes softened after being buried in the deep tissues of the back or absorbs too quickly, or by fastening the retention sutures to the soft structures only which yield to the constriction of the suture, allowing the suture loop to loosen.

I believe that silkworm gut as a sustaining suture fulfils the requirements if it is brought out upon the external surface of the back and tied as I have described.²

8. The use of silk sutures, which may subsequently give trouble in the kidney or cause a fistula.

9. Penetration of the structure of the kidney by the suture, which may cause suppuration or subsequent atrophy of the kidney. Several such cases have been reported to me.

10. Attachment of the kidney too low down in an abnormal position, where it will be constricted and irritated by the clothing at the waist or by the corsets. If the kidney is fixed lower down than normal the condition of the patient is far worse than before the operation, because the pressure of the corset or clothing cannot displace it, and

²Nephropexy for Prolapse of the Kidney, *International Medical Magazine*, March, 1902. Technique of Fixation of the Kidney, *American Medicine*, December 28, 1902. Fixation of the Prolapsed Kidney, *Journal of American Medical Association*, November 7, 1903, etc.

¹Read at the Twentieth Annual Meeting of The New York State Medical Association, New York City, October 19-22, 1903.

there is not proper drainage for the excreted urine, which must travel up around the bend in the ureter before it can reach the bladder. It is not so much the mobility of the kidney, but its abnormal position that causes trouble in this condition.

11. Too early removal of the sustaining sutures or their too early absorption when absorbable material is used. In one instance which came under my observation the surgeon removed the sustaining sutures on the third or fourth day and did not obtain a satisfactory result because he did not get complete immobility of the organ.

We do not know positively how long it is necessary to retain the sutures, but I believe it is best not to remove them until the patient is ready to get up, provided they are not causing any trouble, and I therefore do not remove them until the twentieth day.

12. Delay in removing the gauze drain too long after operation, which would permit accumulation of the discharge back of the gauze and its insinuation between the kidney and the structures to which it should adhere. I believe it should not be retained longer than forty-eight hours.

FAILURES DUE TO POST-OPERATIVE INFLUENCES.

13. Excessive vomiting or coughing shortly after operation, following anesthesia, may loosen the kidney from its fresh attachment.

14. Permitting the patient to turn on the opposite side too soon after operation may cause detachment.

In one patient upon whom I was obliged to repeat the operation done by another surgeon this occurred as late as the twelfth day after operation.

15. Permitting the patient to assume the erect position too soon after operation. Some surgeons favor the patient getting up in two weeks. I cannot feel it is safe to get them up earlier than three weeks.

16. Neglect to adjust proper support for lax abdominal walls after operation when the patient gets out of bed. In all cases I believe it is safer to have them wear an abdominal belt for a time after operation. It certainly gives the patient a feeling of greater security and may be recommended as a precautionary measure.

17. Too early resumption of the corsets or their improper adjustment. If these patients can be made to wear a properly fitted corset I believe the belt may be dispensed with after operation.

18. Permitting too soon such exertions as would put unusual strain on the freshly attached kidney. The patient should be permitted to regain her strength before she resumes her accustomed duties.

19. Neglect to correct after operation derangement of the digestive apparatus and other conditions caused by the prolapse.

My experience with failures is limited to the cases of other surgeons that have come under my observation. My own record is 171 consecutive nephropexies on 134 patients without a failure to secure satisfactory fixation, which leads me to

feel satisfied with the technique that I have adopted.*

The failures of earlier operators are to be accounted for by lack of experience which had yet to be gained, and should not militate against the operation, which, as has been shown, can be made successful. There are enough reasons for failure as outlined above to carry the conviction that this is an operation requiring more than ordinary care, both in its execution and subsequent management.

I would add in conclusion that a proper appreciation of the indications for operation is essential. This includes recognition of the injury which may result to the kidney from interference with its circulation and draining off of the excreted urine due to the prolapse.

DISCUSSION.

Dr. E. D. Ferguson, Troy, asked if the sutures were placed in such a way as to remove kidney structure; also if the author depended largely upon gauze for support.

Dr. Goelet replied that the sutures were passed under the fibrous capsule. The gauze drain was used only as an auxiliary support.

Dr. Ferguson said that it went without saying that all plastic operations of this kind should result in as speedy a union as possible in order to secure the kind of union which would bear the test of time. When inflammatory conditions existed and reconstructive material was formed in the presence of septic conditions the resulting union could not be depended upon so much as where it formed in the absence of inflammatory conditions. His own feeling was that in anchorage of the kidney the tissues should be brought in contact, which would give as firm and reliable a hold as it was possible to secure, and that in order to do this one should either excise or roll back the fatty capsule completely, and then bring the kidney in contact with tissues which offered every advantage for securing firm and lasting union. The level at which the kidney should be anchored was one of the points that each surgeon must settle in accordance with his individual judgment. The old method of passing the suture through the kidney never appealed to him because of the friability of this organ. With regard to the peeling back of the capsule of the kidney or the passing of the sutures through the capsule, he thought it was best to decorticate the kidney quite thoroughly. Practically in handling the kidney in these operations he had found that the tearing of the suture out of the mere bit of capsule which held it was much more liable to occur during the manipulation necessary to the application of these sutures than where the capsule was well rolled back. By su-

*Since writing the above I have discovered one failure in one of my cases. Both kidneys were fixed in June last. The patient was in a most unfavorable condition at the time of operation. The cause of failure was excessive retching and vomiting, following anesthesia for an abdominal operation for pelvic tumor done ten days after the operation on the kidneys. The right kidney has remained firmly attached, but the left is loose again. I shall repeat the operation.

tures placed in a row, after decortication of the kidney from pole to pole, the remaining portion of the fatty capsule could be carried back and so expose a fresh surface in which union could take place. If the kidney were properly placed the union would not be so rigid as to cause discomfort, which was apt to follow from improper placing and too rigid fixation of the organ. The union obtained probably did not result in any special change in the circulation of the kidney, as some had thought. Personally, he did not resort to drainage of the wound, and he made use of absorbable sutures entirely.

Dr. Martin B. Tinker, Clifton Springs, thought that the reason there were so many failures after nephropexy was that the symptoms were not simply dependent upon displacement of the kidney, but upon a general enteroptosis. It made no difference how securely the kidney was fixed if the general enteroptosis were overlooked. The speaker said that he was located in an institution where there were many chronic patients. In the past few months he had seen a number of cases operated upon by most excellent surgeons, and yet the patients had returned complaining of all the original symptoms, and the cause of the failure was found to be as already stated.

Dr. R. H. Gibbons, Scranton, Pa., said that he believed that most cases of loose kidney caused symptoms largely because of the interference, by reflex disturbance, with the functions of the small intestine through irritation of the large intestine, thus causing the elimination of excessive indican in the urine. The fixation of the kidney removed this intestinal irritation. Edebohls had apparently proved that Bright's disease could be cured by the fixation of a movable kidney. This was an additional reason for operating upon the displaced and movable kidney. He believed that Beyea's operation, as originally planned, was often necessary in connection with the fixation of the kidney. In Edebohls' operation the colon was stripped from the kidney, if decapsulation were done, and it certainly should be done.

Dr. H. O. Marcy, Boston, congratulated the reader of the paper on his admirable results. He said that for a long time he had himself felt that in operating upon aseptic cases the abdomen should be closed without drainage, and certainly the technique outlined in the paper was most excellent.

Dr. Goelet, in closing the discussion, said that he employed the gauze as an auxiliary support, and also for the purpose of drainage. There was a good deal of serous oozing after the operation and he thought it was desirable to get rid of this; however, he must admit that in some cases he had dispensed with the gauze drain and the result had been just as good. He was careful to leave a part of the fatty capsule beneath, which was tucked in for the kidney to rest upon. He always did this most carefully in cases in which a gauze drain was not used. He had laid particular stress upon the complete detachment of the

colon from the kidney because one often thought that this had been done, when, in reality, it had not. This mistake was more apt to occur if the kidney were delivered on the external surface of the back. If sutures were introduced into the kidney according to his method, and then according to various others, it would be found that by other methods the capsule would not hold the suture. In stripping the capsule back the kidney could not be brought into position and must be fixed lower than normal. He was of the opinion that the union secured between the raw kidney surface and the structures to which it was attached was not anything like that obtained by the use of the intact capsule. The kidney structure was friable, and a strain was apt to pull away some of the kidney tissue. He had been induced to depend upon the attachment secured by the intact capsule by finding it so often adherent within the fatty capsule. He wished to lay great stress upon the unreliability of absorbable sutures, even of chromicized catgut, when buried in soft tissues. According to his experience, it was exceptional to find general enteroptosis associated with nephropexy. In at least 75 per cent. of cases in which the prolapse of the kidney had extended to the third degree there was already a pyelonephritis or an interstitial nephritis.

THE TREATMENT OF COMPOUND FRACTURES.¹

By VACIL D. BOZOVSKY, M.D.,
Dunkirk, N. Y.

THERE has been so much said and written about the modern treatment of fractures, compound fractures in particular, that I realize I have nothing new to offer. But I feel that a discussion on this subject might be instructive, even though we lack the skill of experts. The treatment of fractures is an art in itself, and an art that brings opportunities to surgeons and physicians who may not be laparotomists.

Nor do I intend to go into the classic writings and dig up some forgotten hints and points that we should not remember and still less practice. But it has occurred to me that in our anxiety to assert our skill in the aseptic and antiseptic treatment of wounds, we are apt to carry it to such a degree that we would undertake to save limbs that would be better lost after function is destroyed. In this age of science and precision we are called upon to decide whether a compound comminuted fracture of a bone or joint is to be treated too conservatively and impair a patient's health and vitality, and even endanger his life in order to save a useless limb, or make a nice, clean amputation, get the patient about in two to four weeks, then hear that you have done what you should not have done and be cheated out of your fee besides, or even threatened with a malpractice suit.

¹Read at the Twentieth Annual Meeting of The New York State Medical Association, New York City, October 19-22, 1903.

That the most skilled surgeons are puzzled at times as to what to do is neither denied nor considered a disgrace. But that we do not often enough learn from each other's experience is also an undisputed fact.

This particular branch of surgery requires a vast amount of experience and observation to be able to decide in each given case what is best to do. The injury to soft parts requires the most important consideration in one case; the comminuted bones in another; the age and constitution in another; the nature of probable infection in another; the probable length of time of keeping the patients in bed in many. It is impossible to rely on any rules until we have perfect scientific principles governing all conditions that can be applied to all given cases. I cannot go into details, but the bad results in my cases have been as follows:

Case No. 1—Non-union, due to comminuted fracture with a large wound, torn periosteum, long confinement in bed and bad recuperative powers. Even secondary wiring with perfect immobilization has failed to produce union after eight months' treatment, six months of which the patient has spent outdoors with ambulatory splint. This was a fracture of the tibia and fibula; tibia was wired, the fibula was not; the tibia failed to unite, nor was there any callus; the fibula united. The tibia, being of greatest density of all bones except the skull, may have something to do with it, but the probable cause was the torn periosteum at the time of the accident. This man had negative family history, habits good, weight 130 pounds, height 5 feet 8 inches, age 32. Since this was written I have received a letter from the surgeon who has treated him with the ambulatory splint at his home, informing me that there is a firm fibrous union, the patient is on his feet with the help of a brace, and there is no pain at the seat of the fracture, and that the ultimate result will be a good bony union.

The second case was a man 22 years old, height 5 feet 7 inches, weight 160 pounds, family history negative, habits good, patient perfectly healthy. Kicked in the leg by a horse, sustained a compound comminuted fracture of both bones. The periosteum of the proximal fragment of the tibia was so injured that necrosis took place of that fragment and three months later amputation had to be done, with prompt healing of the stump. The wound in this case was small and no septic condition developed except the sloughing of the periosteum. These two cases have been troublesome; that is, two out of seventeen cases of compound fractures I have treated in nine years, two of which were of the elbow joint, one of the femur, one of the lower maxilla, one of the bones of the foot and the rest of the leg.

After passing the question of decision when and what to do, we have two other important questions: First—How to reduce and maintain the fragments in apposition when a large and troublesome wound is interfering. Second—What

shall be the means and manner in which the fixation dressing shall give the best results? On going over the ground, then, I only intend to allude in a concise manner to some of the important points that are still in the experimental class, and will omit entirely the mention of certain recognized and fixed principles, such as antiseptic precautions and dressings, extension in the treatment of the femur, fixation of proximal joints, etc. A surgeon of experience and excellent judgment says: "The treatment of the wound is of far greater consequence than that of the fracture itself, more especially during the first two weeks." Now, that rule will cover a great many cases, but in my own practice I have had little trouble in dealing with the wound, but considerable with the fracture. The small wound of a fracture, even if the bone protrudes, should not be explored, for in these cases the opening is aseptic under the skin. Exception: Where the wound is made by some implement in an infected locality the wound should be even enlarged, irrigated and drained. The same is true of joint resection, especially in bullet wounds. During the Greco-Turkish war the Greek doctors let bullet fractures of joints alone, and they had over 60 per cent. of restored function, while the Turkish doctors interfered with the knife quite often and had 45 per cent. of infection and 60 per cent. of loss of function. A rise of temperature after first twenty-four hours means infection, but in children the rise of temperature will occur from other causes; while in old and feeble persons there might be infection, and yet the elevation of temperature insignificant. The appearance of the tongue is a better guide in septic conditions than the pulse and temperature. Dry, brown tongue means infection, while moist, coated tongue indicates mild ferment intoxication. In small wounds dry dressings with some mild antiseptic powder as a rule will induce prompt healing without suppuration. Again, if moist dressings are to be used in fresh wounds 5 per cent. solution of carbolic acid for adults and 2 per cent. for children on sterilized gauze is better, while in old wounds 1 to 4,000 bichloride solution is more effective. Thiersh's solution is admirable if the wound has to be irrigated continually, especially in children. On the other hand, 6 grams of ichthyol to 500 grams of boiled water is equally antiseptic and more sedative.

DIRECT FIXATION.

In regard to maintaining the fragments in apposition when once reduced there are so many methods and materials used that one would be at a loss whose advice to follow, but the whole thing can be put in a few words. For suturing the silver wire has proved the most reliable, and now, since we know it need not be disturbed, if the work has been done by clean hands, after the wound has healed, it is the best until we know of something better. If you cannot wire the fragments, tie them together with catgut or silkworm gut. Large fragments without periosteum will not unite, but small chips will, even when taken

out, disinfected and replaced. The experiments of Jakimowitch have proved that they will unite even if the fragments have been reversed in position and order. Von Burgman has also shown us that the transplantation of bone can be relied upon as one of the means of filling up gaps between fragments. If considerable of the periosteum is torn off, soft connective tissue and muscle should be used to cover up the bone, but do not rely on the skin. I had considerable amount of trouble in one of my cases, where a fragment of the comminuted tibia could not be covered with anything but skin, after the periosteum was torn, and that part of the fragment had to be excised later. Substituting decalcified bone for lost bone has not proved to be of any great value, as was once expected. In many cases where the wound is large there is a temptation to do suturing or pegging to hold the fragments firm, but considering the time it takes to do it, possibly the prolonged anesthesia and perhaps other hidden causes so affect the patient that it is practically a settled fact by the best surgeons at present that whenever possible the old way is the better as yet, *i. e.*, put the fragments together and attend to the wound and depend upon the fixation dressing for holding the many fragments together. When it has to be done the method used by Wille, of Denmark, of drilling through the whole thickness of the bone has given the best results. His drill has an eye near the point to carry the wire. The wire is tightened by a short twist turned to the bone and covered with periosteum.

In oblique fractures, especially with strong muscular contraction, grooving the fragments on the outside in right angle to the line of fracture and placing the wire in the groove well tightened will hold the fragments better than suturing. The ivory cylinders used by Bircher, Volkman and Heine have been satisfactory in their hands, but many of the cases reported have been accompanied by suppuration. Socin has used them with better results, so much so that he has used them in subcutaneous fractures. Senn has used perforated hollow cylinders, which he likes very much. He has also tried with success the bone ferrules made of corresponding bone of the ox, and only 1-16 inch in thickness and $\frac{1}{2}$ to $1\frac{1}{2}$ inches wide. If these bone rings used by Senn could be readily obtained and kept sterile they would be the most practical means of direct fixation and would make the treatment of compound fractures less hazardous. Another factor that could be considered as one of the most recent accessories to the treatment of fractures is the Roentgen rays. The skiagraph would point to us in the same day of the accident whether the enlargement of the wound is necessary to make the reduction perfect, and whether direct fixation is needed.

THE FIXATION DRESSING.

It is not sufficient that the fragments be properly reduced and so retained by direct fixation, but this condition must be maintained by proper immobilization of bone and soft parts as well. It is notice-

able that the simplest fixation dressing is being universally adopted as the best suited and the least expensive. We can with this dressing have any reasonable amount of modification to suit the conditions and it can be applied from the very start without any fear of any harm if the circulation of the limb is watched; if it is needed to have it in sections, that can be done a great deal easier than with manufactured splints.

The ambulatory splints can be used with advantage in proper cases, but too early and indiscriminate application of same would be harmful.

REPORT OF A CASE OF STRANGULATED HERNIA IN AN INFANT; REDUCTION BY TAXIS.¹

DR. W. B. REID, of Rome, reported the following case: The mother of the infant upon whom he reported a year ago having done an operation for strangulated hernia gave birth recently to another child, and this infant, when seen by Dr. Reid, also had a strangulated hernia. The child was taken to the hospital, and, under an anesthetic, an attempt was made to reduce the strangulation by the method which he had described in a previous report. In this instance he was fortunately successful. The method consists in taking the child in both hands, grasping it over the shoulders, with each thumb under the same, the palms supporting the back, and allowing the head to lie very low; practically, the child is stood upon its head. The operator then grasps the leg at the side of the strangulation, and flexes the limb. In the case just reported the strangulation was so firm that he had almost given up, but at the last moment success crowned his efforts. A sterile pad was applied with pressure so as to prevent a recurrence of the strangulation.

SPINALGIA AS AN EARLY SYMPTOM OF TUBERCULOUS INFECTION.

J. Petruschky is of the opinion that tuberculosis of the bronchial glands always precedes pulmonary tuberculosis. He quotes several very striking instances of advanced glandular disease, associated with pulmonary lesions, so slight as to be without symptoms, and advances a theory to show how the tubercle bacilli reach the glands primarily. As a very early symptom of bronchial gland tuberculosis he mentions spinalgia, "tenderness of definite vertebral spines to pressure." The following symptom-complex is usually present: 1. Several spinous processes are tender to touch, while the others are not at all; this tenderness increases with repetition of pressure. 2. The painful spines are usually somewhat depressed. 3. The processes are usually broader, softer and more elastic. 4. They are usually included between the second and seventh dorsal vertebra. The tuberculin reaction is necessary to settle the diagnosis beyond a doubt. In 79 cases of spinalgia the tuberculin reaction was positive in 77 cases, and only 14 of these had tubercle bacilli in the sputum. In advanced cases the symptom is rarely present. It must not, however, be considered a pathognomonic sign, but only a link in the chain of symptoms.

¹Reported at the Twentieth Annual Meeting of The New York State Medical Association, New York City, October 19-22, 1903.

INDEX TO VOLUME 3.

CONTRIBUTORS.		
Abrahams, Robert	33	
Acker, Thomas J	445	
Allen, Charles Warrenne	280, 281	
Bassett, John N	389	
Bayley, Norman B	87	
Berkeley, W. N	269	
Besemer, Howard B	296	
Biggs, Chauncey P	267	
Blauvelt, Gerrit F	180	
Blumer, George	15	
Bozovsky, V. D	499	
Brooks, M. J	61	
Burtenshaw, James Hawley	357	
Carter, H. W	242	
Cooke, J. B	198	
Comstock, George F	488	
Crosby, J. Howard	176	
Crothers, Thomas D	364	
Delphey, Eden V	282, 287	
Douglas, W. E	353	
Dunham, Theodore	93	
Ferguson, E. D	264	
Gage-Day, Mary	193	
Gallant, A. Ernest	232	
Gibson, C. L	318	
Gillette, H. F	351	
Golet, Augustin H	291, 497	
Goffe, J. Riddle	48	
Goler, George W	496	
Gordinier, Hermon C	325, 391	
Gottheil, William S	33	
Gouley, J. W. S	51	
Greeley, Jane L	332	
Green, Charles O	234	
Greene, Cordelia A	443	
Gregor, Gilbert D	406	
Grosvenor, J. W	95, 139	
Hammond, Frederick P	190	
Harvie, J. B	236	
Hastings, Thomas W	18	
Hotchkiss, Lucius W	56	
Humphrey, John F	489	
Hutchison, J. C	450	
Ingalls, J. W	188	
Jack, Harvey P	446	
Jones, Allen A	395	
Kenyon, Frank	348	
Kinnicutt, Francis P	320	
Kirkendall, J. S	350	
Klein, W. T	275	
Kline, C. D	175	
Lambert, Alexander	7, 184, 436	
Lambert, Edward	144	
Lee, E. W	327	
Leitner, George A	59, 177	
Lewis, F. Park	397	
Livingston, Alfred T	182	
McGoldrick, Thomas A	389	
Macpherson, William A	401	
Meyer, William J	448	
Neary, Philip M	347	
Ogden, J. Bergen	141	
Phelps, W. C	403	
Polak, J. O	186	
Purdy, Harry R	89	
Reid, William B	239, 501	
Resseguie, F. J	492	
Seymour, W. W	355	
Shipman, Frank W	316	
Sturtevant, Jeremiah R	229	
Syms, Parker	54	
Thayer, William S	21	
Thompson, W. Gilman	28	
Toms, S. W. S	82, 177	
Towne, G. Scott	486	
Tucker, Alfred B	231	
Van Buskirk, Michael B	319	
Weeks, Henry Clay	272	
Wiggin, Frederick Holme	428, 432	
Woodward, Julius H	324	

SUBJECTS.		
A		
Abbe, Robert	308	
Abortion, Moral Aspect of	381	
Address, Change of	159	
Advertising	305	
Aged Physician in Want	259	
Albany Hospital for Contagious Diseases	342	
Alcohol, Physiologic and Therapeutic Actions of	436	
Amador, Raoul A	478	
American Medical Association:		
Committee on Arrangements	5	
Constitution and By-Laws	34	
List of Members	221, 256, 308, 478	
Meeting of the	45, 132, 251	
Membership in the	78, 79, 103, 158	
National Charter of the	120	
National Incorporation for the	104, 153	
Program of the	160	
Proposed Special Charter for the	156	
Special to New Orleans	212	
American Social Science Association, Charter for the	156	
Therapeutic Society	222	
Anesthesia, Local	410	
Antitoxin Frauds	248	
Antivivisection	4	
Appendicitis, Some Reflections Relative to the Time and Method of Operating, by E. D. Ferguson	264	
Arnold, Glover C	308	
Arrangements, Address of Welcome of the Chairman	470	
Arrowsmith, Hubert	257	
Aseptic Labor, Essentials for, by A. E. Gallant	232	
Association Defense	168	
Dinner	457	
Dues	78, 128	
Meeting, State	459	
Association Meetings, County:		
Albany	161	
Allegany	161, 307	
Broome	79, 161, 419	
Cattaraugus	218, 419	
Chautauqua	75, 254, 420	
Columbia	161	
Cortland	45, 477	
Erie	5, 254	
Genesee	123	
Jefferson	307	
Kings	5, 45, 79, 123, 218, 255, 420, 475	
Lewis	161	
Monroe	123	
New York	6, 45, 80, 123, 161, 218, 255, 420, 475	
Niagara	307	
Orange	6, 75, 125, 163, 219, 255, 421, 476	
Orleans	219	
Otsego	219, 477	
Rensselaer	125	
Rockland	45, 163, 307, 421	
Saratoga	163, 379	
Seneca	307	
Steuben	164, 422	
Sullivan	220	
Tompkins	164	
Ulster	61, 220, 256, 339, 477	
Wayne	164, 379	
Westchester	164, 478	
Wyoming	46, 164	
Auditing Committee, Report of the	469	
Automobile Accident	380	
Ordinance	3	

B

Babies, Directory of 250
 Barbers' Shops, New Rules of 342
 Barrows, C. C. 257
 Becker, Alfred A. 75
 Beef, Diseased from the Country 167
 Bellevue, Alumni Dinner 105
 Benedict, Alfred J. 423
 Beth Israel Hospital Fair 4
 Bichloride of Mercury Douche, Poisoning by 298
 Biggam, William H. 222
 Biggs, Chauncey P. 126
 Biggs, Hermann N. 222
 Billings, Frank 42
 Letter on Membership in the American Medical Association, and the New York Profession. 101
 Biochemisches Centrablatt 132
 Bishop, Louis F. 257, 340
 Blake, Joseph A. 257
 Blumer, George 380
 Boards of Health, Powers of 309
 Book Reviews:
 Anatomy, Clinical, by D. N. Eisenbarth. 482
 Bacteria in Daily Life, by P. Frankland. 484
 Bacteriological Technique, by J. W. H. Eyre. . 39
 Bronchi, Lungs and Pleura, by Prof. F. A. Hoffman 67
 Cellular Toxins or the Chemical Factors in the Causation of Disease, by V. C. Vaughan. . 41
 Causes of Death, Manual of, 227
 Children, Diseases of, by M. P. Hatfield. 263
 Development and Evolution, Including Psychophysical Evolution, by J. M. Baldwin. 67
 Dictionary of Medical Science, by R. Dunglison 483
 Eye, Disease of the, by G. E. DeSchweinitz. . 412
 Manual of the Diseases of the, by C. H. May 387
 Genito-Urinary Organs, Surgical Diseases of the, by E. L. Keyes. 346
 Gynecology, a Text-Book for Students and a Guide for Practitioners, by W. R. Pryor. . 346
 Heart and Arterial System, Diseases of the, by R. H. Babcock. 315
 Hernia, Abdominal, Atlas and Epitome of, by Privatdocent George Sultan 112
 Histology, Human and Microscopical Anatomy, by Johannes Sobotta. 137
 International Clinics 227, 334
 Iowa State Medical Society, Transactions. 42
 Legal Medicine and Toxicology, Edited by F. Peterson 345
 Medicine and Surgery, American Year Book of 228, 315
 Mouth, Pharynx and Nose, Diseases of the, L. Grunwald 137
 New Hampshire State Medical Society. 42
 Nose and Throat, George L. Richards. 484
 Obstetrics, Text-Book of, R. C. Norris. 40
 Text-Book of, J. C. Webster. 425
 Text-Book for the Use of Students and Practitioners, J. W. Williams. 137
 Nurses' Handbook of, J. B. Cooke. 484
 Ophthalmology, C. A. Veasey. 387
 Pancreas, Diseases of the, E. L. Opie. 314
 and Their Surgical Treatment, A. W. Mayo Robson 41
 Pathology and Therapy of Metabolism and Nutrition, Clinical Treatise on, C. von Noorden 228, 482
 Text-Book of, A. Stengel. 484
 Pharmacology and Therapeutics, A. R. Cushny. 484
 Practical Hygiene for Students, Physicians and Medical Officers, a Manual of 174
 Practice of Medicine, How to Succeed in the, J. McD. Mathews 40
 Practical Medicine, Nothnagel's Encyclopedia on, by Alfred Stengel. 346
 Text-Book on. W. Gilman Thompson. 314

Practical Medicine, Text-Book of the Science and Art of, by H. J. Garrigues. 67
 Roentgen Ray, the Practical Application of, by W. A. Busey 482
 Surgery, American, by W. W. Keen. 483
 Surgery of the Head, Surgical Emergencies, by Bayard Holmes 345
 Operative, Atlas and Epitome of, by Otto Zuckerkandl 41
 Therapeutics, a System of, S. S. Cohen. 485
 Thesaurus of Words and Phrases, by W. M. Barton 387
 Traumatic Fractures and Dislocations, Atlas and Epitome of, by Prof. H. Helferich. 40
 Tuberculosis, by N. W. Bridge. 424
 Women, Diseases of, by B. C. Hirst. 483
 Boycott in Waterbury. 258
 Brain Tumor, Abscess Diagnosed as, by H. C. Gordinier 325
 Bronchial Tube, Foreign Bodies in a, Recovery, T. A. McGoldrick 389
 Brown, S. A. 257
 Buffalo Marine Hospital 342
 Burtenshaw, James Hawley 126
 By-Laws, Revised 4
 American Medical Association 34
 New York State Medical Association. 71

C

Calf Path 305
 California in Line 43
 Cancer, Mortality 409
 of the Tongue 370
 Result of Fifty Cases Treated with Roentgen Rays, by C. W. Allen. 280
 Value of Radiography in Cutaneous, and Diseases of the Skin, by C. W. Allen. 281
 Careful Inquiry 241
 Cargile Membrane in the Nose, Use of, in Order to Prevent Adhesions 200
 Carlisle, Robert J. 221
 Carmalt, C. C. 3
 Chloral Hydrate, a Large Dose of, by T. J. Acker. 445
 Christian, Frank L. 166
 Colds, Symptomatology of, by G. F. Cott. 147
 Treatment of, by A. A. Smith. 147
 Coley, W. B. 257
 Colitis, Acute, Treatment of. 46
 Surgical Treatment of, by C. L. Gibson. 318
 Commercial Houses, Impropriety of Accepting Gifts from 203
 Commissions 247
 for Business 457
 Committees, Standing 117
 Communication, Anonymous 1
 Conference Club 126
 Consumption, Facts, Fallacies and Fancies in the Treatment of, by M. J. Brooks. 61
 Convalescents, Hospital of 309
 Cooke's Signs of Pregnancy 228
 Coroners 107
 Bill 129
 Bill Abolishing the Office of. 130
 Office 150
 Counsel, Report of the 468
 Council, to the 375
 and Fellows, List of 481
 and Fellows, Meeting of the. 377
 Annual Address of the President to the. 432
 1903-1904 419
 Twentieth Annual Report of the. 459
 County Association Meetings:
 for March 79
 for April 122
 for May 161
 for June 218
 for October 379
 for November 419
 for December 475

County Association, Difficulties of Organizing.....	173
Associations Organize	159
Organization	203
Organization in Nebraska	248
Difficulties in Organizing a, Overcome.....	205
Societies and Public Questions	159
What One Is Doing.....	110
Work	248
Cretinism, Sporadic, with Report of Three Cases, by H. C. Gordinier	391

D

Daily Work, Business Phase of	249
Danziger, E.....	257
Delinquents	205
Dench, E. B.....	257
Denison, Ellery	308
Diabetes, Clinical History and Treatment of, by C. O. Green	234
Directory, The	44, 375
for 1903	373
Increased Demand for the	168
Medical	338, 480
Dispensary Reform	133
District Branch News:	
First District.....	121, 160, 217
Second District	122, 252
Third District	217, 252
Fourth District	252
Fifth District	122, 161, 217
Doctor Sues for \$10,000 Fee.....	168
Doctors Should Be Cheerful and Optimistic.....	189
Now Agree	480
Downs, W. A.	257
Drug Samples	309
Substitution, and The New York College of Pharmacy	262
Trade, Frauds in the.....	263
Dry Labor, Management of.....	44
Dues, Association	340, 384
Collection of	258
Payment of	168, 304
Duty, an Urgent	158
of the Hour	117
Dysentery, Observations on an Epidemic of, by F. W. Shipman	316

E

Einhorn, Max	222
Erdmann, J. F.....	257
Ergot in Pneumonia, by A. T. Livingston.....	182
Therapeutic Possibilities of	225
Esophagus, Stricture of the, New Devices for the Treatment of, by Theodore Dunham.....	93
Ethics, Medical	203
Medical in Canada	385
Medical Upheld	146
Need of a Code of.....	43
Principles of Medical	214
Report of the Committee on Medical.....	213
Side Light on	68
Euthanasia	458
Examinations, New York State Medical.....	129

F

Faith Healers, the Law of.....	453
Family Physician, by Chauncey P. Biggs.....	267
and the Children	42
Fellows, to the	375
and Alternates	481
First District Branch, Report of the Executive Com- mittee	419
Fitzhugh, P. H.....	257
Food, Pure	342
Formalin, Experiments with	111
Fractures, the Treatment of Compound, V. D. Bozovsky	499

G

Gage-Day, Mary	257
Gall-Stone Surgery, Present Position, by W. W. Seymour	355
Gastric Symptoms, Spurious, by Allen A. Jones..	395
Gaylord, H. R.....	222
Gouley, J. W. S.....	478
Gross, Samuel D., Prize.....	169
Gwyer, F. W.....	257
Gynecology, Treatment in, from a Medical Stand- point, by Mary Gage-Day.....	193

H

Hancock, James C.....	222
Hayd, H. E.....	166
Hayes, W. van V.....	423
Health Bill, Local Boards of	136
Department	383
Rules from an Old Bible.....	34
Heating and Fresh Air	306
Heller, J. M.....	166
Hemophilia, Some Remarks on, by J. C. Hutchison.	450
Hemorrhage, Management of	368
Subconjunctival, a Sign of Chronic Renal Disease	413
Heredity, with a Study of the Statistics of the New York Hospitals	300
Hernia, by G. D. Gregor	406
by S. W. S. Toms	82
Strangulated in Children Under 1 Year of Age, by W. B. Reid.....	239, 501
Herrick, F. P.....	340
Herter, Christian A.....	221
Hospital, Albany for Convalescents	342
Charity Abused	132
for Convalescents	309
for Insane	193
Incorporation	169
Manhattan Maternity	342
May a, Steal?.....	382
New Eye and Ear	4
Upper East Side	342
Woman's	342
Hygiene and Demography, Eleventh International Congress of	109

I

Idiopathic Atrophy of the Skin, Report and Presentation of a Case, by W. S. Gottheil..	33
Ileus, Acute	4
Immunity, the Present Ideas of, by Alexander Lambert	7
Imperatori, Charles	126
Index Medicus	75
Infancy, Hints Upon the Hygiene and Dietetics, by H. F. Gillette	351
Infant Mortality	208
Infants, Summer Complaint	298
International Medical Congress	169, 209
Intestinal Obstruction, by J. B. Harvie.....	236
by W. C. Phelps	403

J

Journal, Monthly, Versus Yearly Volume of Transactions	244
Publications	480
Journalism, Medical	205
Journals, Binding of	34
Medical	44

K

Kerley, Charles G.....	221
Kidney, Surgical Diseases of the, from the Stand- point of a Country Physician, by G. A. Leitner	59
Kinnicutt, F. P.....	257
Knapp, A. H.....	166
Know Thyself	4

L

Lambert, Alexander	221
Legal Department	222
What Is Going on in the	258
Legal Notes	127, 341, 380, 418
Malpractice Defense	479
With Reference to Claims Against Decedent Estates	166
Legislation, a Need of	3
Committee on	174
Report of the Committee on	462
Leszynsky, William M.	42
Lewis, F. Park	308
Library of The New York State Medical Association	137
Linderoth, Martin	222
Local Conditions of Interest	209
Lombard, Guy D.	257
Lorenz, Professor	2

M

McBurney, Charles	257
McCormack, J. W.	380
Maddock, G. F.	257
Magazine Declines Curative Advertisements	206
Maloney, J. J.	3
Malaria, to Prevent	4
Laboratory and Life Cycle of the Parasite of, by W. T. Klein	275
Malpractice Suits, Associated Defense of	115
Defense of	418
Suits of Alleged	208, 314, 341
To Limit	168
Malpracticers, Difficulties in Apprehending	303
Manhattan Maternity Hospital	342
State Hospital, Consulting Physician to	234
Massachusetts Medical Society, Delegates to the	222
Mead, Harry	257
Medical Association, Reasons for Joining the	77
Medical Bribery	203
Certificate	342
Charities	381
Colleges Forward Step	247
Daily	338
Discoveries by Practicing Physicians	338
Etiquette	250
Law, a New	136
Mountebank	453
Profession, Appeal to the	309
Profession, Past and Present Needs, by F. H. Wiggin	428
Needs	458
Services Rendered the State, Compensation for	224
Society, Educational Value of the	310
Society Habit	305
Union in New York State	247
Medicines of Unknown Compositions, Objections to Prescribing	226
Melancholia Agitans, a Case of, by W. E. Douglas	353
Members, Additional Lists of	66, 81, 125, 165, 221, 256, 308, 340, 379, 422
List of, American Medical Association	221, 256
Members in Arrears	168
in Transit to New Orleans	160
Privileges of	384
To Our	153
Membership, Large Increase in	153
Merrigan, Thomas D.	340
Milk Supply, Municipal, by G. W. Goler	496
Moore, Bernard S.	478
Moore, V. A.	257
Moriarty, D. C.	423
Mosquito, Concurrence of the Anopheles and Malaria, by H. C. Weeks	272
Morphology of Anopheles, Habits, Modes of Destruction, by W. N. Berkeley	269
Mulkulicz, Prof. J.	166
Murray, Francis W.	166

N

Nagel, J. T.	257, 340
National Bureau of Medicines and Foods	169, 260
*Conservatory of Music of America, Charter of, Incorporation	78, 104, 153, 204
Navy in Need of Young Surgeons	187
Nephrotosis, Operation for, by A. H. Goelet	497
Nephropexy, a Study of the Indications for, by A. H. Goelet	291
New Era, by J. R. Sturtevant	229
New Eye and Ear Hospital	4
New Jersey, Medical Practice for	258
Medical Society of	308
New Orleans, Special Train to	160
Newspaper Advertisements	248
Newspapers Censured	207
New Year Greeting	110
New York Board of Health, Annual Report of	173
New York State Medical Association, Annual Dinner	339, 417
Annual Meeting	373, 377, 417
Council, 1903-1904	419
Manifold Advantages of Membership	303, 373
Meeting of	307
Program of	339, 373
Reasons for Joining	337
Nitrous Acid in General Surgery, Advantages of, by H. W. Carter	242
Nurses, New Law for Registration	223
Nutt, J. J.	257

O

Obstetrics, Roentgen Rays in, by J. S. Cooke	198
Obituaries:	
Beers, George	126
Byrne, John	65
Chamberlain, Dwight S.	221
Chaveau, Jean F.	423
Cheesman, Hobart	221
Demby, Alexander	4
Franklin, David	422
Fritz, William C.	165
Gallagher, William C.	66
Gillespie, John, Jr.	308
Hills, J. Ernestine	308
Howard, Daniel B.	379
Kraus, Jacob M.	66
Love, Isaac Newton	298
Newman, Robert	379
Piper, Charles W.	340
Pray, Susan R.	65
Rochester, Thomas M.	308
Szigethy, Charles A. H. de	479
Thomas, T. Gaillard	125
Whitwell, William	165
Woolworth, Eugene	126
Wyckoff, Cornelius C.	478
Ocular Incoordination and Cerebral Reflexes, by F. P. Lewis	397
Onuf, B.	222
Overcrowded Street Cars, Serious Results from	207
Oxyluria, the Significance of, by J. Bergen Ogden	141
Oxygen, Experience in the Medical Use of, by C. A. Greene	443

P

Patent Medicine Testimonials	224
Pelvic Floor, Lacerations of the, Principles Involved in the Repair of, by James Hawley Burtenshaw	357
Pennsylvania Medical Society, Delegates to the	374
Perineal Operations, New Method of Denuding and Introducing Sutures in, by A. B. Tucker	231
Personality vs. Organization	200
Pharmacology in Our Medical Colleges	134

Physician, an Unlicensed 3
 as a Business Man 1
 Can Be President 481
 Investments for 413
 The Ideal, Our Needs, by J. W. Grosvenor. . . 139
 Physician's Personal Side, by M. B. Van Buskirk. . 319
 Profession, Rights and Duties of. 382
 Wives' Club 309
 Pneumonia, Complications of with Surgical Operations, by G. A. Leitner..... 177
 Complications of, by S. W. S. Toms..... 177
 Diagnosis in, by J. H. Crosby..... 176
 Discussion on, by A. Lambert..... 184
 Ergot in, by A. T. Livingston..... 182
 Etiology of, by C. D. Kline..... 175
 Treatment of, by G. F. Blauvelt..... 180
 Treatment of, by J. W. Grosvenor..... 95
 Post-Graduate Instruction 337
 Practicers' Qualifications 343
 Pregnancy, Albuminuric Retinitis of, by J. W. Ingalls 188
 Kidney of, by J. O. Polak..... 186
 Press, Our Conscientious 136
 Profession, for Union of 424
 Proprietary Remedies 77
 by N. B. Bayley..... 87
 Prescribing with Copyrighted Names..... 205
 Unscientific and Careless Prescribing and, by Harry R. Purdy 89
 What Are, Patent Medicines and Nostrums?.. 116
 Public Health Law, Amendments to the..... 100
 Report of the Committee on..... 466
 Publication, Report of Committee on..... 467
 Publications, Simultaneous 2
 Puerperal Eclampsia, by F. P. Hammond..... 190
 Insanity, Note on the Treatment of in Asylums 299

Q

Quacks, Attacks, Advertising 424
 Prosecution of 167
 Quackery 305
 Quackery's New Enemy 167
 Quinlan, F. J. 257

R

Rabies 158
 Raynor, F. C..... 75
 Reason Why a Member of The New York State Medical Association Does Not Apply for Membership in the American Medical Association 207
 Reduction of Fares 339
 Reilly, Thomas F..... 221, 340
 Renal Tuberculosis, Diagnostic Points of..... 383
 Robinson, W. J. 221
 Roentgen Ray, Its Mechanics, Physics, Physiology and Pathology, by Eden V. Delphey..... 282
 in Gynecology, by Eden V. Delphey..... 287

S

St. Peter's Hospital 342
 Senile Cataract, the Course and Management of Incipient, by J. H. Woodward..... 324
 Senn, Nicholas 222
 Septicemia and Death Following X-ray Burns, by H. B. Besemer 296
 Services, Acknowledgment of 208
 Skin Grafting, Substitution for 412
 Smallpox, by W. A. Macpherson..... 401
 in Old Clothes 181
 Patients, Boards of Health Duties to Furnish Care to 342
 Squibb, E. H. 380
 State Association 375
 Dinner 417
 Medical Association Immediately Acts 119

Stockton, C. G..... 221
 Street Cars, Overcrowding of 2
 Surgeons in Emergency 299
 Surgery, Standard Technics in Operative, by E. W. Lee 327
 Syphilis as a Contagious and Infectious Disease, by W. J. Meyer 448

T

Terriberry, W. S..... 257
 Tetanus 480
 Therapeutics of Conversation, by J. L. Greeley. . . 332
 Measures, Another Death from Unprofessional Administration of 223
 Thornton, William H..... 126
 Tierney, J. J..... 380
 Tierney, W. J..... 478
 Toxic Insanities, Unrecognized, by T. D. Crothers. 364
 Transactions..... 3, 129, 169, 223, 259, 381
 of State Medical Societies in Journal Form.. 481
 Treadwell, G. H..... 257
 Treasurer's Report 426
 Truth 249
 Tuttle, Dr. and Mrs. J. P..... 221
 Typhoid Fever, by P. M. Neary..... 347
 Arteritis and Arterial Thrombosis in, by W. S. Thayer 21
 Complications and Prognosis of, by G. F. Comstock 488
 Etiology and Pathology of, by G. S. Towne... 486
 Hydrotherapy in, by F. J. Resseguie..... 492
 in Ithaca..... 118
 Medical Treatment of, by J. F. Humphrey... 489
 Modern Treatment of, by W. Gilman Thompson 28
 One Hundred Days of, by Frank Kenyon.... 348
 Otitis Media Purulenta, Followed by Mastoiditis as a Sequela of, by J. S. Kirkendall..... 350
 Serum Reaction in, by T. W. Hastings..... 18
 Some Aspects of the Pathology and Bacteriology of, by G. W. Blumer..... 15
 Some Peculiarities of the Pulse of, by J. N. Bassett 389

U

Urethral Stricture: Remarks Introductory to a Discussion on Its Modern Treatment, by J. W. S. Gouley 51
 Urethrotomy, External Perineal, by Parker Syms.. 54
 Internal, by L. W. Hotchkiss..... 56
 Urine, Importance of Hyaline Casts in the..... 60
 Prognostic Significance of Albumin in the, by E. W. Lambert 144
 Uterus, Perforation of the 7
 Present Status of the Treatment of Retro-Displacement of the, by H. P. Jack..... 446
 What Advice Should Be Given to a Woman Suffering from Fibroid Tumor of the, by J. Riddle Goffe 48

V

Vaccination in the Schools 169
 Variola and Various Dermatoses, Finsen's Phototherapy in, by F. P. Kinnicutt..... 320
 Vomiting, Treatment of Obstinate 412

W

Warning, a 3
 Waterman, James Sears 3
 Weir, Robert F..... 221
 White, W. A..... 380
 Wiggins, F. H..... 222

X

X-Ray for Malignant Disease..... 47

Officers of The New York State Medical Association—Continued.

First or Northern District Branch.

President—J. Orley Stranahan, Rome.
Vice-President—John R. Bassett, Canton.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.

HERKIMER COUNTY MEDICAL ASSOCIATION.

President—Charles H. Glidden.
Vice-President—Seymour S. Richards.
Secretary—Edgar H. Douglas.
Committee on Publication—Edgar H. Douglas, Seymour S. Richards, Maynard G. Burgess.
Committee on Public Health—Charles H. Glidden, John L. Crofts, William P. Earl.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Byron C. Cheeseman.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles E. Douglass, Lowville.

ONEIDA COUNTY MEDICAL ASSOCIATION.

Vice-President—James W. Douglass.
Secretary—J. Orley Stranahan.
Treasurer—John Groman.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Vice-President—Robert Selden, Catskill.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge.
Vice-President—Clement F. Theisen.
Secretary and Treasurer—Merlin J. Zeh.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—T. Floyd Woodworth.
Vice-President—H. Lyle Smith.
Secretary and Treasurer—Henry Warner Johnson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Lyman G. Barton.
Vice-President—Velona A. Marshall.
Secretary and Treasurer—Warren E. Pattison.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen.
Vice-President—Matthew B. Hutton.
Secretary and Treasurer—Frederick A. Smith.

Third or Central District Branch.

President—Frank W. Higgins, Cortland.
Vice-President—Franklin J. Kaufmann, Syracuse.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham.
Vice-President—William A. White.
Secretary—Clark W. Greene.
Treasurer—William H. Knapp.
Committee on Legislation—John M. Farrington, John H. Martin, Benjamin W. Stearns.
Committee on Public Health—John H. Martin, William Henry Knapp, Lester H. Quackenbush.
Committee on Medical Charities—John G. Orton, Clark W. Greene, Frank P. Hough.
Committee on Ethics and Discipline—John G. Orton, William A. White, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—S. J. Sornberger.
Vice-President—Frank S. Jennings.
Secretary—H. S. Braman.
Treasurer—Emory A. Didama.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Amos Sheldon Edwards.
Vice-President—Thomas B. Dwyer.
Secretary—Charles B. Gay.
Treasurer—Alexander J. Campbell.

Fourth or Western District Branch.

President—J. William Morris, Jamestown.
Vice-President—Bernard Cohen, 497 Niagara street, Buffalo.
Secretary—William Irving Thornton, 152 Jersey street, Buffalo.
Treasurer—Henry A. Eastman, Jamestown.

ALLEGANY COUNTY MEDICAL ASSOCIATION.

President—George H. Witter.
Vice-President—William O. Congdon.
Secretary and Treasurer—Horace L. Hulett.

CATARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent.
First Vice-President—Myron C. Hawley.
Second Vice-President—Charles P. Knowles.
Secretary and Treasurer—Carl Tompkins.

Committee on Legislation—E. D. Ferguson, chairman; William Finder, Jr., William L. Allen.
Committee on Public Health—J. B. Harvie, chairman; D. W. Houston, W. L. Hogeboom.
Committee on Ethics and Discipline—J. P. Marsh, chairman; H. C. Gordinier, George L. Meredith.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Miles E. Varney.
Vice-President—A. W. Johnson.
Secretary—James T. Sweetman, Jr.
Treasurer—William E. Swan.
Executive Committee—G. T. Church (2 years), Francis W. St. John (3 years), F. J. Sherman (3 years).

WARREN COUNTY MEDICAL ASSOCIATION.

President—David J. Fitzgerald.
Vice-President—Dudley M. Hall.
Secretary and Treasurer—Frederick G. Fielding.

Committee on Legislation—Henry D. Didama, Charles Walsh, S. F. Snow.
Committee on Public Health and Medical Charities—George A. Edwards, Florince O. Donohue, Adelbert D. Head.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith.
Vice-President—Sylvester G. Pomeroy.
Secretary—Arthur H. Brownell.
Treasurer—Frank L. Winsor.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Swift.
Committee on Public Health—Arthur H. Brownell, Milton C. Wright, George E. Schoolcraft.
Committee on Ethics and Discipline—Frank L. Winsor, Marshall Latcher, Arthur W. Cutler.

SENECA COUNTY MEDICAL ASSOCIATION.

President—William Austin Macy.
Vice-President—George O. Bellows.
Secretary—J. Spencer Purdy.
Treasurer—Carroll B. Bacon.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—John S. Kirkendall.
Vice-President—William C. Douglass.
Secretary and Treasurer—Marcus A. Dumond.
Executive Committee—Arthur White, C. P. Biggs, H. B. Besemer.

CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.

President—Orrin C. Shaw.
First Vice-President—Era M. Schofield.
Second Vice-President—Vacil D. Bozovsky.
Secretary and Treasurer—Henry A. Eastman.
Committee on Legislation—Laban Hazeltine, George F. Smith, Herbert W. Davis.
Committee on Public Health and Medical Charities—Elton S. Rich, Chauncey A. Rood, A. Austin Becker.
Committee on Ethics and Discipline—Alfred T. Livingston, Vacil D. Bozovsky, H. Francis Hunt.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Allen A. Jones.
Vice-President—Carlton C. Frederick.
Secretary—Jacob S. Otto.
Treasurer—William I. Thornton.
Committee on Ethics Discipline and Membership—Charles G. Stockton, chairman; Grover W. Wende, Arthur G. Bennett.
Committee on Legislation—Herman E. Hayd, chairman; F. Park Lewis and Marshall Clinton.
Committee on Public Health and Medical Charities—Julius Ullman, chairman; De Lancey Rochester and Albert E. Woehnert.

GENESEE COUNTY MEDICAL ASSOCIATION.

President—Albert P. Jackson.
Vice-President—Henry E. Ganiard.
Secretary and Treasurer—C. Louise Westlake.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare.
Vice-President—Edward Mott Moore.
Secretary and Treasurer—James Clement Davis.
Committee on Legislation—Bleeker L. Hovey, Richard M. Moore, George W. Goler.
Committee on Public Health—E. Mott Moore, Daniel F. Curtis, S. Case Jones.
Committee on Ethics and Discipline—S. Case Jones, Peter Stockschlaeder, James C. Davis.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer.
Vice-President—William Q. Huggins.
Secretary—Alva Le Roy Chapin.

Treasurer—Frank Guillemont.
Executive Committee—F. J. Baker, E. E. Campbell.

ORLEANS COUNTY MEDICAL ASSOCIATION.

President—Edward Munson.
First Vice-President—John H. Taylor.
Second Vice-President—Charles E. Fairman.
Secretary and Treasurer—Howard A. Maynard.

STEUBEN COUNTY MEDICAL ASSOCIATION.

President—Charles O. Green.
Vice-President—Frank H. Koyle.
Secretary and Treasurer—Charles R. Phillips.
Committee on Legislation—Bertis R. Wakeman, Charles M. Brasted, William E. Palmer.
Committee on Public Health—John D. Mitchell, William E. Hathaway, Harvey P. Jack.
Committee on Ethics and Discipline—John G. Kelly, Clair S. Parkhill, C. O. Jackson.

WAYNE COUNTY ASSOCIATION.

President—James W. Putnam, Lyons.
Vice-President—M. Alice Brownell, Newark.
Secretary—George S. Allen, Clyde.
Treasurer—Darwin Colvin, Clyde.

WYOMING COUNTY MEDICAL ASSOCIATION.

President—Philip S. Goodwin.
Vice-President—Lyman C. Broughton.
Secretary and Treasurer—L. Hayden Humphrey.
Committee on Public and Medical Charities—George H. Peddle, Dorothea Payne, Clarence R. Seeley, Cordelia Greene, Mary Slade, Cora B. Cornell.

Fifth or Southern District Branch.

President—Julius C. Bierwirth, 253 Henry street, Brooklyn.
Vice-President—Milton C. Conner, Middletown.
Secretary—Ernest Valentine Hubbard, 138 West 74th street, New York City.
Treasurer—Henry A. Dodin, 1194 Washington avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy.
Vice-President—Edwin Barnes.
Secretary—John W. Atwood.
Treasurer—Louis Curtis Wood.

KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.

Meets at 315 Washington street, Brooklyn, at 8.30 P. M., on the second Tuesday of each month, except July, August and September.

President—George H. Treadwell, 64 South Portland avenue, Brooklyn.

Vice-President—Arthur C. Brush, 29 South Portland avenue, Brooklyn.

Recording Secretary—Frank C. Raynor, 54 Livingston street, Brooklyn.

Corresponding Secretary—George F. Maddock, 80 McDonough street, Brooklyn.

Treasurer—Edward H. Squibb, P. O. Box 760, Brooklyn.

Executive Committee—James Cole Hancock, Hubert Arrowsmith, John O. Polak, L. Grant Baldwin.

Committee on Public Health and Medical Charities—Louis C. Ager, chairman, Silliman place and Third avenue, Brooklyn; Chas. B. Bacon, Thos. A. McGoldrick, William H. Shepard, Morris G. White.

Committee on Ethics and Discipline—John D. Sullivan, chairman, 74 McDonough street, Brooklyn; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.

Committee on Legislation—Charles P. Gildersleeve, chairman, 18 Schermerhorn street, Brooklyn; James H. McCabe, Charles D. Napier, Nelson L. North, Jr., William H. Steers.

THE NEW YORK COUNTY MEDICAL ASSOCIATION.

Boroughs of Manhattan and Bronx.

Meets at the Academy of Medicine, 17 West 43d street, at 8 P. M., on third Monday of each month except July, August and September.

President—Alexander Lambert, 125 East 36th street, New York.
First Vice-President—Francis J. Quinlan, 33 West 38th street, New York.

Second Vice-President—S. Busby Allen, 53 East 86th street, New York.

Secretary—Ogden C. Ludlow, 234 West 135th street, New York.

Corresponding Secretary—John Joseph Nutt, 2020 Broadway, New York.

Treasurer—Charles Ellery Denison, 68 West 71st street.

Executive Committee—Charles S. Benedict (1 year), Parker Syms (2 years), Frederick P. Hammond (3 years).

Committee on Public Health and Medical Charities—Edward L. Keyes, Jr., chairman, 109 East 34th street, New York; John F. Erdmann, Charles G. Kerley, Joseph D. Nagel, Robert J. Carlisle.

Committee on Ethics and Discipline—Charles E. Quimby, chairman, 44 West 38th street, New York; William G. Le Boutillier, Frederick M. Townsend, D. Bryson Delevan, Henry A. Dodin.

Committee on Legislation—W. Travis Gibb, chairman, 55 West 38th street, New York; Frank S. Fielder, Robert N. Disbrow, Harry H. Seabrook, William H. Luckett.

ORANGE COUNTY MEDICAL ASSOCIATION.

President—Willis I. Purdy.
Vice-President—William E. Douglas.
Secretary and Treasurer—Charles I. Redfield.
Committee on Legislation—Charles E. Townsend, chairman; William E. Douglas, Frank D. Myers.
Committee on Public Health—Worthington S. Russell, chairman; Lawrence G. Distler, Joseph B. Hulett.
Committee on Medical Charities—Willis I. Purdy, chairman; Albert W. Preston, Edgar A. Nugent.
Committee on By-Laws—William E. Douglas, chairman; Charles E. Townsend, Frank W. Dennis.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

President—Daniel Burr Van Wagenen.
Vice-President—George A. Leitner.
Secretary and Treasurer—Norman B. Bayley.
Committee on Public Health and Medical Charities—George A. Leitner, Piermont; Daniel B. Van Wagenen, Suffern.
Committee on Legislation—Edward H. Maynard, Nyack; Robert R. Felter, Pearl River.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

President—J. L. C. Whitcomb.
First Vice-President—Sherman D. Maynard.
Second Vice-President—Oscar N. Meyer.
Secretary—Howard P. Deady.
Committee on Legislation—John L. C. Whitcomb, George R. Bull, Richard A. DeKay.
Committee on Public Health and Medical Charities—A. B. Sullivan, chairman; Sherman D. Maynard.
Committee on Ethics and Discipline—Harriet M. Poindexter.

ULSTER COUNTY MEDICAL ASSOCIATION.

President—Henry Van Hoenberg.
Vice-President—George S. LaMoree.
Secretary—Mary Gage-Day.
Treasurer—Alice Divine.
Committee on Legislation—Frederick Huhne, Frederick A. Hunt, Elijah Osterhout.
Committee on Public Health—James L. Preston, Benjamin Neal, Albert Reed.
Committee on Ethics—Frederick Huhne, Alexander Stilwell and Arthur Judson Benedict.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

President—Thomas J. Acker.
Vice-President—William D. Granger.
Secretary and Treasurer—Donald T. McPhail.
Executive Committee—Thomas J. Acker, chairman *ex-officio*; Benjamin Jerome Sands, William J. Meyer.
Committee on Legislation—H. Ernst Schmid, chairman; William L. Wells, Edward F. Brush.
Committee on Public Health and Medical Charities—William D. Granger, chairman; H. Eugene Smith, William J. Meyer.
Committee on Ethics and Discipline—N. J. Sands, chairman; Peter A. Callan, Henry T. Kelly.

