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THE New York State Journal of Medicine.

The Official Organ of The New



York State Medical Association.

VOL. 5. No. 1.

NEW YORK, JANUARY, 1905.

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EDITORIAL COMMUNICATIONS.

Articles for publication under Editorial Communications must be accompanied by the name of the author. No name will be used in the publication unless requested by the writer. All such articles can be sent to Dr. C. E. Denison, 68 West 71st street, New York City.

A COMMUNICATION FROM THE PRESIDENT.

To the County Associations and District Branches:

Greeting—At the beginning of the new year it seems proper that we, as a medical organization, should consider how we can best employ our opportunities to benefit our individual members and accomplish the objects for which our organization stands.

The year is opening most auspiciously. Every County Association can take inspiration from the November meeting of Ulster and of New York Counties. The meeting of the Ulster County Association at Kingston, November 21st, was reported as one of the most interesting and most largely attended in its history. All the profession of the county, members and non-members, were invited, with the result that the membership roll was largely increased before the meeting adjourned. The November meeting of the New York County Association was phenomenal in its attendance, the audience overflowing into the adjoining reception and refreshment rooms. The list of new members here also showed that Association membership has advantages which are appreciated by the practicing physician.

The annual meetings of the County Associations will be held during the first four months of the year. It is important that these annual meetings convene at the time prescribed by the by-laws, and in accordance with strict parliamentary and constitutional provisions, so that the proceedings may at all times be free from any and all technical objections.

There is wise purpose in these provisions of

the constitution and by-laws. It was the intent of the originators of these articles that the annual meeting of the County Association should come first, in order that the officers and delegates elected might know the needs of the county units, and so be prepared to present them at the annual District Branch meetings, which follow in May and June. These meetings in turn lead up to the annual meeting of the State Association, where all matters are discussed and decided. All the County Associations are therefore requested to follow the prescribed regulations of the constitution and by-laws in the transaction of business, and especially in reference to the date of the annual meeting.

At the approaching annual meeting, Fellows will be elected to the number of one for every ten members to represent their respective counties in the annual meeting of the Council and Fellows, to be held on the third Monday in October, 1905. It is important that the Fellows chosen shall be men who will attend the annual meeting, and will represent the sentiments of their respective County Associations. The experience of the County Associations having the largest attendance has shown that this is best accomplished by arranging an attractive program of scientific papers and discussions. Make the meetings at all times, and especially the annual meeting, so attractive that the men of the county cannot afford to stay away. One or two men may be invited from a neighboring county or city, men who can speak with authority on their special subject. Arrange with members of your own Association to open the discussions, and the result will be all that could be desired. Such a program requires time and thought on the part of the officers, and cooperation of the members.

Three years ago a club was organized within the Association, known as the Conference Club. The object being to consider, from time to

time, the interests of the Association, and how they can be best subserved. Membership in the club is accorded to all the elective officers of the State, District Branch and County Associations and members of all standing committees. The club meets three times during the year. This organization has been of great service in keeping the constituent branches in touch with each other, cultivating mutual confidence and esteem, and knitting together State, Branch and County Associations into one organic whole. The dates of the next two meetings have been determined and are announced in another column of this JOURNAL.

Nothing contributes more to the esprit de corps of our members than attendance upon these meetings of the Conference Club, and we earnestly hope that all who are eligible will make a special effort to attend the coming meetings.

(Signed) J. RIDDLE GOFFE, President.

THE CONFERENCE CLUB OF THE NEW YORK STATE MEDICAL ASSOCIATION.

This club was organized in 1901, when, pursuant to an invitation sent out by Dr. E. Eliot Harris, there assembled in the private dining-room of the Yale Club, on the evening of December 20, 1901, the following gentlemen, all members of the State Association:

Drs. J. W. S. Gouley, F. H. Wiggin, E. E. Harris, A. A. Hubbell, E. M. Alger, E. L. Cox, C. E. Denison, A. Lambert, G. T. Harrison, E. D. Ferguson, J. C. Bierwirth, C. E. Quimby, F. P. Hammond, P. Syms, E. Mayer, H. Arrow-smith, F. W. Loughran, R. Kalish, M. L. Maduro (deceased), J. J. Nutt, J. R. Goffe, J. A. Wyeth and Mr. J. T. Lewis.

After an excellent dinner, Dr. Harris stated the object of the meeting to be the organization of a club whose purposes and aims were to advance the best interests of the Association, and promote a friendly feeling between the officers, and those serving on committees. It was thought desirable to hold a series of dinners, after which subjects might be discussed that were of special interest to the profession apart from the strictly scientific subjects, which properly belonged to medical meetings. It was felt that if the men knew each other better that matters of interest could be more freely discussed at such meetings than at the business meetings either of committees or of the associations.

Through the courtesy of Dr. Lambert it was made possible to have future meetings at the Yale Club, where the dinner provided would be far better for the same money than could be secured at restaurants, and where the necessary privacy for full and free discussion might be had.

No formal constitution and by-laws were adopted, the idea being that the meetings should be as informal as possible. The founders made but two requirements, one that all officers and members of committees of the State, District Branch, or County Associations, resident in

Greater New York, should be eligible to membership by the payment of annual dues, all other members by the payment for the dinners which they attended. The other provision was, that the management of the club should be intrusted to the officers and Executive Committee, consisting of the chairman of the six standing committees of the State Association.

At a later meeting Dr. Wiggin proposed, and it was carried, that membership at any time in the club makes the member eligible for continuous membership by payment of dues. This was to keep up the interest of those who had been at one time officers or members of the committees, and also that other members might benefit by their experience.

The first president was Dr. E. Eliot Harris, and the secretary, J. Riddle Goffe. They both served until March 18, 1903, when Dr. Emil Mayer was made president, and Dr. J. J. Nutt, secretary and treasurer. Since its organization, the club has held a number of delightful dinners, and many subjects of interest have been discussed.

At the meeting held December 14, 1904, Dr. Wisner R. Townsend was elected president, and Dr. J. J. Nutt, secretary and treasurer.

It was resolved that two dinners be held in 1905, on Saturday, February 25th, at the Yale Club, 30 West 44th street, New York City, at 7.15 p. m., and on Saturday, April 29th, at the same place and hour. The dues were fixed at \$5 for the ensuing year for resident members or for non-resident members \$2.50 for each dinner, and all those desirous of joining were requested to communicate with Dr. J. J. Nutt, secretary and treasurer, 2020 Broadway, New York City. It is hoped that every member of the Association who is entitled to membership will join, as he can thus show his interest in the organization, and he will not only enjoy a good dinner, but will have the pleasure of becoming better acquainted with those who have been placed in control of the State, District Branch and County organizations for the ensuing year. Many topics of interest will be presented for discussion, and it has been the experience of those who are members, that these informal talks have not only been entertaining, but of great value. The proceedings are not published, so no one need feel any hesitancy in freely expressing his views.

Due notice will be given by the secretary in advance of the meeting to all members, but should, by any chance, a member fail to receive his notice, it is hoped that all will feel that they are expected to be present on February 25 and April 29, 1905.

ISLAND HOSPITAL FOR CONTAGIOUS DISEASES.

The Government plans to raise an island in the upper bay near Ellis Island and build a hospital for the reception of contagious diseases. Dr. Thomas Darlington, president of the Board of Health, is in hearty accord with the scheme and

says there is not a particle of danger from it to the health of the people of New York or those nearby in New Jersey. The wind would carry no infectious taint and no taint of the kind would get into the water.

"Under modern conditions hospitals where cases of contagious diseases are cared for are not centers of dissemination of those diseases. What happened at the time of the Slocum disaster was sufficient demonstration of that fact. Survivors of that disaster were actually clothed in the disinfected and scalded garments that had been worn by persons suffering from contagious diseases. We carefully kept track of every instance of that kind and in not a single case was disease contracted. Nor did anybody contract disease from the hospital nurses, who were all about in the crowd ministering to the survivors. People lay on the grass all about the hospital. There was not a case of anybody contracting disease.

"With the hospital the Government proposes to build there might be means of reducing the number of persons with contagious diseases who, under present conditions, get to the city. At all events such a hospital would avoid danger to the patients from transporting them, and I believe would tend to diminish the danger of their diseases being spread. I hope the hospital will be built as speedily as possible."

PURE MILK.

The Health Board of New York, under the presidency of Dr. Thomas Darlington, is making vigorous war on the sellers of impure milk. No milk can be sold in the city without the permission of the Health Department, and the source of the milk supply being known, it is essential to know the character of the dairies. Special agents were sent to Blooming Grove, Orange County, and they visited the dairy owned and operated by the Metropolitan Milk and Cream Company. They found the floor of brick and stone dilapidated, puddles of dirty water in places, and the drainage broken or stopped up. The ground about the creamery was saturated with filth and had an offensive odor. There was dirty water in the milk-room tanks, the water for washing the cans was taken from a spring in the center of the buildings, and a horse was stabled in one of the rooms of the dairy. Cans marked buttermilk were examined and found to contain skimmed milk and water. Several bottles containing a preserving fluid were, on analysis, found to contain formaldehyde. The Department of Health revoked the license of the Metropolitan Company. In connection with securing pure milk in the large cities of the State Dr. Darlington has held several conferences with Dr. W. C. Greene, of Buffalo, to extend the system of examination and control of the dairies supplying milk to the dealers in the large cities. It is expected to carry forward the work among the cities of the second class and thus practically cover all the milk supply in this State.

THE OPERATIVE TREATMENT OF FRACTURES OF THE PATELLA.

It is beyond question that the operative treatment of recent fractures of the patella yields more satisfactory results than the non-operative treatment. In spite of the known dangers of an operation, the tendency at present is to operate more frequently. This is mainly due to improvement in the mode of procedure. It seems needless to state that not all fractures of the patella need be operated upon to obtain satisfactory results and that there are contraindications which need to be taken into account. It is in the class caused by indirect violence and known as "tear" fractures and in "combination" fractures or those caused by a combination of direct and indirect violence that operative treatment is very strongly indicated.

In these fractures there is a decided separation of the fragments with interposition of the torn periosteum and considerable laceration of the capsule on either side of the bone. Great stress is laid upon the importance of the torn capsule, and Joseph A. Blake (*Journal of the American Medical Association*, October 1, 1904), in a recent article states that "the indications for operation consist, then, not in the extent of injury to the patella itself, but to the lateral extensions of the insertion of the quadriceps extensor muscle." He refers to them as the lateral patella ligaments and considers their function so important that he is led to state "that when these structures are torn as in 'tear' fractures, no operation based on the suture of the patella alone is correct. The lateral patella ligaments should be sutured as well." He relies mainly on the sutures of these ligaments and uses only enough fine catgut sutures to unite the torn periosteum of the patella. The injury is exposed through a curved transverse incision and all manipulations are performed with instruments. The torn ligaments are united by two chromic catgut or kangaroo tendon sutures; the sutures are introduced on either side and as close to the fragments as possible and tied only after both are in place. A few additional sutures are used to close the extensions of the tear.

The advantages justly claimed for this method are its "simplicity and ease, the avoidance of prolonged manipulation and traumatism, which is unavoidable when the fragments are bored for sutures; the exertion of the lines of the restraining force in the most efficient direction, the absolute coaptation, use of absorbable sutures and its rapidity."

Blake does not wait for the effusion to subside, but operates as soon as is convenient after the injury. He used this method for the last three years and during this time sutured twenty-three fractures of the patella, all healing by first intention and resulting in bony union and satisfactory function in all cases which he could trace. Surgeons are somewhat at variance in regard to the times which they allow to elapse between the time of injury and the operation. E. Eliot

(*Medical News*, January 11, 1904), in a report upon thirteen cases of uncomplicated fractures of the patella, advises delay until the extravasation in the joint subsides, and waits up to the tenth day before he operates. He also found marked laceration of the capsule on both sides of the patella, and lays great stress upon the exact suture of the torn capsule. J. A. Hutchinson (*Annals of Surgery*, October, 1904), reports six operative cases and reviews the subject from the time of Lister's first operation. His views are in accord with most of the recent writers. He postpones the operation for seven to ten days after the injury and operates through a curved transverse incision with the convexity downward, not unlike the incision employed by Eliot. Stress is laid upon careful suture of the lateral expansion of the tear, early massage and passive motion. He points out the importance of a quick operation, the use of rubber gloves, continuous irrigation with salt solution and all manipulation carried out with instruments. The operation proposed and practiced by Blake is a great improvement upon the older methods and has many points to recommend it; not the least of these are the avoidance of boring the bone and the use of absorbable sutures. Not being necessary to pass sutures through the bone shortens the time necessary for operating and diminishes the necessary manipulations to a minimum, thus diminishing the dangers of infection very materially. Though the operation for recent fractures of the patella is not difficult, it should never be performed unless the strictest asepsis is possible. Hutchinson quotes Lord Lister, who, before commencing his first operation, made the following statement: "No man was justified in performing this operation unless he could say with a clear conscience that he considered himself morally certain to avoid the entrance of any septic mischief into the wound." This quotation should be considered by all who contemplate the performance of an operation for fracture of the patella.

SANATORIA FOR CONSUMPTIVES.

NEW YORK, November 16, 1904.

Editor NEW YORK STATE JOURNAL OF MEDICINE,
64 Madison Avenue, City.

DEAR SIR—You were good enough to honor me by asking for a few words of comment on the admirable inaugural address of our new and very distinguished president, Dr. Francis J. Quinlan. If I should dwell on and comment all the various and useful subjects dealt with in that admirable address, the comment would be as long as the original communication, and this, I know, you would not wish. You will find it natural then if I pick out for comment the subject in Dr. Quinlan's address which is nearest my heart, namely, the provision of sanatorium facilities for the consumptive poor in our great metropolis.

Here is what the distinguished new President of the largest medical association of New York has to say on this subject: "Let the physician urge that proper places be provided for those suffering both with acute and chronic diseases. Look at that beautiful island lying east of this great city, a refuge placed by the hand of God, where all the healing powers of Nature—air, light, sun—have their fullest sway, and where health, if it

could ever return, would be brought back to the suffering. Situated as it is between the ocean and Long Island Sound, what a haven of refuge it would be to the despairing sick. But no, it is made a luxurious resort for criminals, and the poor tuberculous sufferer who might be restored to health is exiled from all he loves and holds most dear, is pointed at as the leper of old and is really transformed into a useless burden on society. The tuberculous patient has his rights as well as the public."

We have already on Blackwell's Island the Phtthis Infirmity, and on North Brothers Island the Riverside Sanatorium, and in spite of the fact that only cases in the advanced stages of tuberculosis reach these institutions, really wonderful results are obtained by the simple hygienic and dietetic treatment and the excellent climatic advantages these islands offer. I would not wish to have the criminals transferred to any unhygienic locality where disease would likely be added to their punishment or confinement. But I agree with the distinguished president when he says that the honest citizen when sick and suffering should be given the preference of a salubrious locality. What seems to me of equally great importance is that we should have our sanatoria for consumptives as near the city as possible so that nostalgia is not added to the suffering of the poor consumptive. Since he has had to leave his home let us give him at least opportunity to see his loved ones from time to time without too much loss of time and expense to them. It matters less to the unfortunate criminal whether he is removed a few hours more or less from New York. Ever since the Goodsell-Bedell law was signed by Governor Odell the finding of a suitable locality for a sanatorium has been made well-nigh impossible. Let us hope that the suggestions of Dr. Quinlan will be listened to and our beautiful islands be utilized for the treatment of our consumptive poor. Very sincerely yours,
S. A. KNOPP.

At the fourth annual conference of the New York State Sanitary Officers, held in Albany, December 15 and 16, 1904, a resolution was unanimously passed in favor of repealing the Goodsell-Bedell law.

WRITE.

One should write what he sees, or thinks he sees, and not feel that he must limit his writing to mere compilation, though, of course, references to the opinions held by other writers are not objectionable. Whenever anything impresses one as out of the ordinary, that is the thing to study and report. By doing so he will broaden his own mind and possibly assist others to understand similar conditions. Do not be afraid to report facts because they are not in keeping with the so-called "authorities." Mistakes in medicine, as in every other department of life, are handed down from generation to generation until some strong spirit observes the error and dares to combat it.

Writing makes a careful man and the careful man is the safest and best doctor. Writing for one's journal and society gives one a personal interest as nothing else can. Therefore, by all means write and, of course, write the best you can.—*Kentucky Med. Jour.*

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR JANUARY.

- Rensselaer County, Tuesday, January 3d.
(Annual.)
Allegany County, Tuesday, January 10th.
(Annual.)
Kings County, Tuesday, January 10th.
Niagara County, Tuesday, January 10th.
(Annual.)
Wyoming County, Tuesday, January 10th.
(Annual.)
Warren County, Wednesday, January 11th.
(Annual.)
New York County, Monday, January 16th.
Chautauqua County, Tuesday, January 17th.
(Annual.)
Orange County, Wednesday, January 18th.
(Annual.)
Rockland County, Wednesday, January 18th.
(Annual.)
Cortland County, Friday, January 20th.
(Annual.)
Westchester County, Thursday, January 26th.
Columbia County, Tuesday, January 31st.
(Annual.)
Lewis County, Tuesday, January 31st.
(Annual.)
Monroe County, Tuesday, January 31st.

COUNCIL MEETING.

The next meeting of the Council of The New York State Medical Association will take place January 5, 1905. All communications should be addressed to the Business Office, 64 Madison avenue, New York City.

Dutchess County Association.—The regular meeting of this Association was held at Vassar Brothers' Hospital, October 26, 1904. The meeting was called to order by the president, Dr. LeRoy, at 2.15, Dr. Bayley acting secretary, and Drs. Van Etten and Wood present. Dr. von Tiling read a paper on the Widal reaction, as modified by Flicker, showing results, and explaining the simplicity of the procedure, and its convenience for the busy practitioner. Dr. Bayley presented a healthy appendix which he had removed this morning under protest, at the urgent request of its owner; also a large fibroid uterus with tubes and ovaries, which he had removed this morning, which was interesting from a secondary growth of large size attached to it by a very small pedicle.

Dr. LeRoy presented a memorial notice of the

late Dr. Barnes, which was read and ordered spread on the minutes. Dr. LeRoy gave a short history of a case of spinal apoplexy which he thought to be a rare condition. Dr. Van Etten gave a history of a case in which two leading physicians diagnosed cancer of stomach, in which the subsequent history proved to be incorrect. Dr. Wood gave a history of a case of twisted gall-bladder, which had puzzled several surgeons. He also reported a case of rapid return of malignant disease of the removal of ovary for cancer, and also reported case of dilatation of the heart greatly improved by the treatment at Nauheim. On motion, adjourned.

(Signed) GUY C. BAYLEY,
Secretary, Pro Tem.

* * *

Eric County Association.—The meeting of this Association was held December 12, 1904, at 8.30 P. M., in the University Club, Buffalo, N. Y.

Dr. Roswell Park read a paper on "The History of Surgery in America."

Dr. Vertner Kenerson reported nine cases, illustrating six different points in diagnosis and treatment (to be published later.)

The meeting adjourned at 10.30.

(Signed) DAVID E. WHEELER,
Secretary.

* * *

New York County Association.—The State meeting of the New York County Medical Association was held at the Academy of Medicine, New York City, December 19, 1904.

Meeting called to order at 8.30 P. M., by the president, Dr. Francis J. Quinlan. In the absence of the secretary, Dr. W. R. Stone, the reading of the minutes of the last meeting were omitted, Dr. J. J. Nutt, corresponding secretary, acting as secretary. Minutes of Executive Committee were read and approved. The following candidates were elected: Drs. Brooks H. Wells, Jerome M. Waterman, Percy H. Williams and William P. Healy.

A memorial to Dr. William R. Pryor was given by Dr. C. J. MacGuire.

The Treatment of Leukæmia and Pseudo-leukæmia by the X-rays, with Illustrative Cases, was read by Dr. Arthur Holding, who is in charge of the laboratory in connection with Cornell University Medical College.

Dr. Holden thought that there were two facts which explain the action of the X-rays in these diseases. First, in lower animals the greatest changes from exposure to X-rays have taken place in the lymph nodes and glands; second, many cases of tubercular adenites have been reported as cured by X-rays by thoroughly trustworthy men.

After a short review of the literature of cases of leukæmia and pseudo-leukæmia, and some statistics upon cases reported, he presented two cases, one of spleno-myllog leukæmia and the other of pseudo-leukæmia, showing improvement on X-ray therapy.

Dr. Mortimer Warren gave a report on the blood units in Dr. Holden's cases. Dr. E. B. Finch opened the discussion. For the last eighteen months he had been struggling with a case of Hodgkins' disease. He has been making reports of this case in the *Medical Record*. After seemingly fully cured, this patient has returned on account of the reappearance of tumors. X-rays have always been reapplied and apparently successfully. Exposures are made of ten minutes duration at a distance of ten inches, and 147 were made in one series.

Dr. Finch's experience in the treatment of leukæmia had not been very satisfactory.

Pertinacity he considered of the utmost importance in the X-ray treatment of those diseases.

Dr. Finley R. Cook said he had no experience with the X-ray in leukæmia, but had used this treatment very successfully in tubercular glands. He had also cured a case of exophthalmic goitre.

The one case of Hodgkins' disease which he had treated had not turned out very successfully.

Dr. C. W. Allen thought it very much to be deplored that there existed so much fear as to the X-rays. Undoubtedly their therapeutic value in these diseases were much underestimated.

Dr. Hermann Grad thought Dr. Holding's results remarkable. The differences were very great between Hodgkins' disease and leukæmia. In the former it was not so difficult to understand how X-ray therapy might be of great use. In leukæmia, however, he thought we should have a care not to become too enthusiastic.

A paper entitled *The Abuse of Water Drinking* was read by Morris Manges, M.D. He said that the normal amount was $1\frac{1}{2}$ to 2 liters a day. Only 10 per cent. is absorbed by the stomach. Excretion into the stomach may also take place. The more liquid taken into the body means so much more work for the heart. All the water must be expelled by the heart. Increased drinking of water does not cause increase in the breaking down of albumen. Metabolism is increased, but at the expense of fats and carbohydrates. Diuresis does not depend upon the amount of water so much as upon heart pressure.

As to the common opinion of water at meals and obesity, more food can be taken at meals if large quantities of water are taken.

The most striking abuse is seen in chronic nephritis. In heart disease the abuse is seen especially at the spas.

Dr. Manges found the temperature of soda-water as obtained at the counter to be 40 degrees, and the ice-cream to be 32 degrees. This soda-water habit is much worse than eating a plate of ice-cream, as the latter was taken slowly.

Dr. Simon Baruch opened the discussion. The greatest abuse is due to the inexact way prescribing water. The internal and external uses of water are much alike.

A few ounces of ice-water are stimulating to

the gastric mucous membrane. He uses it as a diuretic, in small quantities, not more frequently than every two hours.

Dr. Alfred Meyer thought that this matter as well as all therapeutic measures needed, more than anything, to be considered with a due consideration for the personal idiosyncrasies of the patient. He believed that there was more excess in egg eating in tuberculosis than excess in water drinking in these cardiac, nephritic and gastric diseases.

Dr. Beverly Robinson held to the opinion that water was most valuable in febrile conditions. He does not think the danger to the heart is usually present.

He referred to the report of typhoid cases treated in Paris by the use of water internally, with results comparing most favorably with the reports from Germany, where the Brand method was used.

Dr. Charles Cook Ransom believed there was no better stimulant to metabolism than water correctly prescribed.

Dr. Charles B. Fitzpatrick had seen a number of cases where large quantities of water had been of the greatest use. He did not believe the drinking of water abused to any great extent in this city. Water is of the greatest value where a toxæmia exists.

Meeting adjourned at 11 P. M.

J. J. NUTT, Acting Secretary.

* * *

Orange County Association.—The regular meeting of this Association was held at the Russell House, Middletown, N. Y., on Wednesday, December 21, 1904, at 2 P. M. There was a good attendance, twelve members being present.

Dr. E. D. Woodhull, vice-president, opened the scientific session in the absence of Dr. W. E. Douglas, president, who arrived later, and took charge of the meeting. Dr. C. W. Many, of Florida, reported the case of a child 8 months old, who swallowed an open safety pin which was retained in the intestinal tract for the remarkable period of eight months before being discharged.

Dr. Redfield reported some peculiar cases, as follows: A case of hypospadias, a case of supernumerary breast in a nursing mother, a case of menstruation in a 5-days-old infant, a case of three abortions in nine months in a syphilitic mother who refused anti-syphilitic treatment, a case of appendicitis in which the diagnosis was in doubt with reference to urethral calculus, and a case of chicken-pox with a temperature of 106 degrees F. on the second day of the eruption followed by complete recovery.

Dr. Fancher then read a paper on "Some Personal Experiences in the Treatment of Gonorrhœa." This paper was thoroughly discussed by all present. Dr. Fancher was given a hearty

vote of thanks for his admirable and instructive paper.

At the business session, after the reading and approval of the minutes of the previous meeting, the following resolution was discussed and finally laid over until the annual meeting in January:

"That an amendment to the by-laws be made whereby the meetings of this Association shall be held bi-monthly instead of monthly as heretofore, and at such places in the county other than at Middletown, as has been the custom since the organization of this Association."

Dr. Distler made the following resolution, seconded by Dr. Dennis:

"That an amendment to the by-laws be made whereby there shall be elected at the annual meeting three vice-presidents instead of one as heretofore, these vice-presidents to be from different parts of the county, and to aid the president in arranging a scientific meeting in the section of the county where the meetings shall be held." Unanimously carried, but ordered to lay over until the next meeting.

Dr. Redfield called attention to the meeting of the Fifth District Branch to be held at Newburg on the first Tuesday in February.

A request from the chairman of the Publication Committee of the State Association for papers read at the County Association meetings was read by the secretary, also a request for some one to abstract from journals and write editorials for the *STATE JOURNAL OF MEDICINE* was brought up.

Dr. Redfield called attention to the fact that a surgical fee bill was under consideration, and that members from different parts of the county were to furnish the secretary with copies of the fees prevailing in those places, but as yet no one had responded.

The secretary called attention to the fact that the annual meeting occurred in January, and thought that a nominating committee ought to be appointed. On motion, the president was authorized to appoint such a committee, the names to be known only to him.

Dr. Redfield reported that the condition of Dr. J. B. Hulett, of Middletown, who had been ill since an injury in a railroad accident in November, had so far improved as to permit him to be out again.

The secretary then presented his resignation, to take effect at the annual meeting in January, stating as reasons for such action that his extra duties as secretary of the State Association, together with private professional work, would compel him to relinquish the office. His resignation was received and placed on file.

There being no further business before the Association, adjournment was made until Wednesday, January 18, 1905.

(Signed) CHARLES I. REDFIELD,
Secretary.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Calvin Thayer Adams, New York City.
Charles P. Beaman, Ithaca, N. Y.
Howard Burhans Besemer, Ithaca, N. Y.
Bennett S. Beach, New York City.
Chester Emerson Campbell, Niagara Falls, N. Y.
Charles Eugene Douglass, Lowville, N. Y.
William T. Getman, Buffalo, N. Y.
John C. S. Lappeus, Binghamton, N. Y.
Edwards Jarad Loughlen, Andover, N. Y.
Herbert E. Phelps, Carthage, N. Y.
Donald Lawrence Ross, Sonyea, N. Y.
William G. Sprague, Barker, N. Y.
Antonio Stella, New York City.
Frank B. Storer, Holley, N. Y.
John Edward Sutton, Albion, N. Y.
John S. Tanner, New York City.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIFTH DISTRICT BRANCH.

New York County, Warren B. Chapin, New York; William P. Healy, New York; Hubbard Winslow Mitchell, New York; J. Hilton Waterman, New York; Percy Herbert Williams, New York; Brooks H. Wells, New York; Gessel Wolf, New York.

Orange County, Andrew Curtin Santee, Scotchtown.

LEGAL NOTES.

There seems to be renewed activity in the direction of litigation wherein malpractice is charged, for three cases are noticed for trial, two in Utica and one in Niagara County at Lockport, for Monday, January 2d. It is expected that one of the cases will probably be disposed of, another will be put over until March to be tried at Rome, and in the third the complaint probably will be dismissed.

The last action against one of the members of the Association is brought by a woman against Dr. G., of this city, for an alleged improper setting of the shoulder; the woman was subsequently taken to the German Hospital and there attended by physicians in that institution. The actions seem bound to involve the acts of several different physicians and surgeons. The answer in this case was served on November 26th.

So far during the month of December there has been no action brought, all of which demonstrates the power which this malpractice defense is having in stemming this tide of malpractice suits.

During the month of November the severest penalty for a first offense was imposed upon a midwife, Anna Dintenfass, of West 23d street, who was registered in the Board of Health under the name of Weill and also under the name of Weiss, where a plea of guilty was interposed. The sentence was thirty days in the City Prison in addition to a \$150 fine. Usually these fines

for a first offense, where the plea is guilty, are \$50 or \$70. In this particular case, after the woman had served her term in the City Prison application was made to the Court for a remission of the fine on December 14th, which was opposed by counsel, but upon the promise of the husband of the woman and the woman herself to leave the State, the Court thought that the Association should be glad to get rid of the defendant finally and remitted the fine, and the husband and wife have actually both left the State.

Another case is one where a fine of \$100 or sixty days in the Penitentiary was imposed upon a palmist by the name of Atwood; the defendant took the alternative and served her sixty days in the Penitentiary.

On December 19th two cases were disposed of, one against Chira, a palmist, who was acquitted, and the other against Marcella Bryan, also a palmist, who received the severest sentence in the history of punishment of illegal practice of medicine, six months in the Penitentiary and a \$50 fine.

The severity of these sentences by the Court is bound to have the desired effect of checking this illegal practice.

WAR ON HOODOO DOCTORS.

The arrest of an east-side "wizard" at the instance of the State Medical Association is an act for the protection of the gullible public against the wiles of occult imposture of which there should be more in a city where the charlatan and the fakir of this order flourish and reap a golden harvest.

This particular professor of the black art practised in a region where belief in sorcery is a race inheritance. He dealt in charms to avert the baleful effects of the "evil eye" and charged roundly for them. One customer had paid \$70 for incantations and magic medicine. At such credulity on the east side the west side will smile. But in doing so let it ask of itself how many patrons it supplies the palmist, the fortune-teller and the necromancer located in a more fashionable quarter, and how implicitly it puts confidence in the shuffling of a pack of cards to forecast the complexion of the husband-to-be or to determine at what date a fortune will be inherited from the dark man.

In Boston this fraternity has been sharply dealt with. New York has unwisely treated their deceptions with greater tolerance. The announcement by the counsel for the State Medical Association of a crusade against hoodoo doctors generally is good news.—*The World, Tuesday Evening, December 6, 1904.*

OBITUARY.

Dr. Clarence Sumner Elebash died at his home in New York City on Tuesday, December 20, 1904. Dr. Elebash was a graduate of the New York University, Class of 1891. He was a member of the American Medical Association, The New York State Medical Association and the New York Academy of Medicine.

MEMOIR OF DR. EDWIN BARNES.

BY IRVING DEYO LEROY, M.D.

Dr. Edwin Barnes died at his home at Pleasant Plains, N. Y., January 22, 1904. He was born in Troy, N. Y., July 28, 1844.

He was the son of Stephen S. Barnes and Huldah Britton Hall. His preliminary education was obtained in the district schools at Hyde Park, N. Y., and also at a private school taught by Rev. Sherman Hoyt.

He began his medical studies with an uncle, Camillus Hall, M.D., at Burlington, O., where he remained a year and a half. He then entered the Albany Medical College, but in 1864, before his course was completed, he joined the army as a cadet on the medical staff. He served in the Department of the Cumberland, of West Virginia and of the East, until mustered out, February 3, 1866. In the meantime, his degree of M.D. had been conferred upon him by the Albany Medical College, December 28, 1865, while he was on duty at the Ira Harris Central Hospital. Ten days after his return home, he began the practice of his profession at Pleasant Plains, N. Y., where he has since resided. On November 13, 1866, Dr. Barnes married Miss Matilda, daughter of Truman Armstrong, who with a son and daughter, survives him.

He was a member of the Dutchess County Medical Association, an original Fellow of The New York State Medical Association, and a member of the American Medical Association, attending the meetings frequently and always taking a lively interest in their welfare.

His funeral, which took place from the Presbyterian Church at Pleasant Plains, N. Y., was largely attended by members of the medical profession and representative citizens.

One of his conspicuous characteristics was his sympathy and tenderness in the sick room, personally administering to the wants of his patients.

There are few physicians who possess more completely the confidence of their patients than he did, few will be more widely missed or so sincerely mourned. Deeply must all regret that one so capable by culture and long experience of doing good to his fellow-men should be taken away in the full development and fruition of a successful career. We can only explain such mysteries by a reference to that Higher Power who controls every incident of the universe. Requiescat in pace.

MEMORIAL—WILLIAM R. PRYOR, M.D.

BY C. J. MACGUIRE, M.D.

Mr. President and members of the County Medical Association of New York: The invitation extended to me to address you this evening, commemorating the life of our deceased friend and fellow-member, William Rice Pryor, I accepted with great hesitation and I might say reluctance; not that the subject did not appeal to all that is best in me, love of friend (and with my race that stands for a great deal), admiration of genius, and Dr. Pryor possessed it in a high degree, application of genius with acquired knowledge to the solution of unsolved problems in his chosen career, and he was original and independently solved problems—yet I accepted reluctantly because I felt that though closely and affectionately associated with him I cannot do justice to the subject.

Pryor was a lovable and sweet character to those who knew him best. Introduced to the world at a most momentous and stormy period of the history of this country, just before the war of secession, it often seemed to me that he absorbed then, while yet unborn, that strong, uncompromising, defiant expression of what he believed was right or wrong, that we all recognize in the fiery and heated debates of that period.

Dr. Pryor was born in Richmond, Va. His father, Hon. Roger Pryor, for many decades has been one of our most esteemed and distinguished citizens. Indeed, I might say that few men in our country have had such a long, eminent and spotless career. Minister to Greece in 1855, Congressman from Virginia in 1857 to the unfortunate secession of that State, a general in the Confederate army, sacrificing his all for what he then believed to be right; passing through the frightful war with his family suffering privations now hardly credible, a prisoner in New York, yet like the phoenix, rising from its ashes, we find him working his way through the legal ranks in New York to be one of the leaders of the bar and obtaining the ultima thule of legal ambition—a seat on the Supreme Court Bench.

Paternity may be an accident. Maternity is a certainty. William Rice Pryor had great reason to be proud of the maternal side of his house, and he always was. Many times he told me of all he owed to his mother; the sacrifices she made, the privations she endured to make opportunities for him, the constant and ever dinnng into his boyish brain the ambition for high ideals, the love of truth, of bravery and honor.

After careful training at home and at preparatory schools in Virginia, young Pryor entered Princeton University, where he was distinguished, not alone in letters, but in athletics, and the same love of field sports remained with him to the end. I am informed, during his medical student career, he enjoyed the reputation of being a conscientious worker, holding a fair average position in his classes. He graduated from the College of Physicians and Surgeons in 1881 and from Bellevue in 1882. For four years he did

general practice preparing himself untiringly for the special branch of medicine to which he devoted his life. In 1886 he was appointed clinical assistant to the Chair of Gynecology in the Polyclinic, and, filling all the intermediate positions, he was in 1895 made full Professor of Gynecology.

During this time and until his appointment in 1893 to the staff of Charity Hospital, my acquaintance with him was slight. I well remember the first meeting of the Board at which he was present. Then the conditions in Charity Hospital, now the City Hospital, were not what they are to-day. At each monthly meeting resolutions were passed and sent to the Commissioners informing them of defects in management, of poor and insufficient equipment, of the impossibility of giving to the city's wards the advantages of aseptic surgery, or properly nourishing them, owing to the inferior character and meagerness of the food supplied. As a rule, these resolutions were received in a perfunctory manner and placed on file. At times they were told that the Commissioners did not see that the necessities pointed out existed, or that the appropriation did not permit the expenditure the improvements called for. I must say that the Board rather tamely submitted to snub and reproof. This Board, consisting of men more or less distinguished in their profession, giving their time and scientific knowledge gratuitously to the care of the city's sick poor, men of independence and courage outside of the Board meeting, from month to month, saw their recommendations ignored or they were tersely told they were making demands unnecessary and absurd. This treatment, I blush to recount, was submissively submitted to with an occasional mild protest. Not so with the latest addition to our number. Though custom and tradition assigned a modest part in the discussions to the junior member, the abuses were so flagrant and the neglect of the Commissioners so manifest that Dr. Pryor could not sit still, but arose and fiercely and fearlessly denounced the system and appealed to his colleagues to stand together and exact what the city was paying for, the best possible treatment for the sick poor. Though some criticized and advised against any friction with the all-powerful Commissioners, that nothing would be gained by antagonizing them, I and others agreed with Dr. Pryor and the friendship that was formed that day between him and me increased and lasted to the end.

Dr. Pryor, during his connection with the City Hospital, was an indefatigable worker. In the care of his patients before and after operation he exhibited a zeal and a sacrifice of personal comfort that were peculiarly his own. Most of you, gentlemen, are familiar with the cold, bleak winds of a winter's night on the East River between Blackwell's Island and 52d street. The run over on a launch was not comfortable. But many a night, with river full of ice and snow and sleet pelting straight in his face, Dr. Pryor

crossed in a rowboat to see the poor waif he had operated on in the daytime and carry with him some delicacy the hospital diet-sheet did not afford—physician and samaritan.

During this time was laid the foundation whence sprung his success as a teacher, operator and writer. As a teacher, he was lucid, direct, enjoying great facility of expression, with a happy knack of conveying his knowledge without being prosy or verbose. Though ordinarily of a quick, nervous temperament, impatient and exacting from his assistants and nurses, before operation, yet once the operation commenced, no steadier hand, no cooler, clearer head, no accident flurrying him, full of expedient he was equal to every emergency.

His colleagues of the Polyclinic in their resolutions state he deserves the highest recognition for his enthusiastic advocacy of the vaginal route in the surgical treatment of pathological conditions of the pelvic organs of women and for the very great skill and originality of his technique in this work—in fact, that he did more than any other to exploit and make popular the vaginal method in this country. His gynecology, published in 1903, describes fully his favorite operations and is strongly marked with his individuality. It was written when his health was already being sapped by overwork, when the day was too short for his labors. I will not now enumerate the many original operations that stand unquestioned to the credit of Dr. Pryor, his practically bloodless hysterectomy, the treatment of puerperal sepsis, a new and rapid method of dealing with intra-ligamentous fibro-myomata—and here permit me to do honor to one who in Pryor's lifetime had the manliness and sense of justice to give him credit for priority in the technique of this operation—Dr. Howard Keilly, of Baltimore. One word more to prove the scientific excellence of the man, a record of one-third of 1 per cent. in vaginal hysterectomy in pus cases. Mr. President and Gentlemen, this part of his career I leave where it will receive the recognition it deserves, I leave it to medical history.

If I were asked what was Pryor's chief characteristic of medical excellence, I should say a tireless worker, an original thinker, logically working out his own conclusions, honestly believing in them, defending them against all comers, like the knights of old or the cavalier stock from whom he boasted his descent. Pryor did his own thinking, evolving his own conclusions, unanswerable if his premises were correct, ever fearless in expressing them. Every point connected with his chosen work commanded from the outset his earnest, concentrated attention. He devoured and digested every work published touching on his own specialty. In this he was exceptional, in my experience extraordinary. Once at dinner he, in his abrupt manner, said to me: "MacGuire, such a man has published a brochure on such an operation in gynecology, and though it amounts to nothing I am ashamed I

have not read it—there may be something in it and, honestly, I should have read it."

His mind once made up as to his diagnosis and treatment then all his thought, all his energy were given to embodying that decision in action, absolutely free and untrammelled by doubt or misgiving. To those who differed from him and saw only obstinacy in the strenuousness with which he upheld his opinions and sought to enforce them, he may have seemed intolerant, aggressive and prejudiced, but those who more intimately knew him, who were closely allied with him and who had opportunities to learn on how much careful thought and observation and research these opinions were based, could not fail to appreciate the pains he took to be right, his breadth of view and original thought.

I approach now what was to me a trying epoch and the final one in his career, his sickness and carrying away. I will deal lightly with it, though I feel deeply. In the late spring, the symptoms of the fell disease that proved fatal to him manifested themselves and with some hopeful periods intervening continued to the end. Details are harrowing; enough to tell you that Dr. Pryor, while wrestling with what he knew himself to be a hopeless issue, displayed a courage, fortitude and resignation that would cast a halo on a martyr. Early in June he showed a marked improvement that inspired us with hope and he yearned for the country, for the mountains, the lakes and the wilderness of Nature he so dearly loved. Believing that health and vigor would be restored he insisted on going to his hunting club in the mountains of Pennsylvania—Bloominggrove Club—where he was so beloved, the most popular, keen and successful sportsman of the association. Alas, he was fated to be disappointed. His first letters to me breathed hope, but soon he wrote, "Dear C. J., I am going down hill, I am growing worse. I wish I could see you, but I am afraid of the journey. I am doing everything to get well, following instructions closely, but, old man, I am afraid we are licked in this fight." The same spirit, the same grit he always showed. I went to Bloominggrove and found his condition desperate. I frankly went over his case with him, showing the hopelessness of treatment where he was, the danger of transporting him to the city, pointing out the advantages he would enjoy when there. He said: "If you think I can stand the journey, I am satisfied, but I would like to go to St. Vincent's Hospital and have Room 33; my favorite room." Appreciation for every little attention, a chivalrous politeness to the good sisters who nursed him, the fondest expression of affection and solicitude for his dear wife and children marked the last moments of my friend.

"A fiery soul, which, working out its way,

Fretted the pygmy body to decay.

And o'er informed the tenement of clay,

A daring pilot in extremity;

Pleased with the danger, when the waves went high,

He sought the storm."

News Items.

The Pan-American Congress will be an excellent opportunity for a mid-winter vacation with scientific advantages.

Never before in its history has the New York County Medical Association been as strong and healthy as it is to-day.

Reports from several counties show an unprecedented activity in the enrolment of new members.

Ask your secretary for a few application blanks and send them to your friends. It is a great favor to them and of little trouble to you.

Potential enthusiasm is of no value as such—make it kinetic.

Chairmen of committees are incompetent as long as they wait for work to come to them. They should look for work to do.

No duty is too insignificant for the man who is capable of large affairs.

Dr. E. A. Sharp, of Katonah, member of the Westchester County Medical Association, read a paper entitled "Private Colonies for Epileptics" at the meeting of the National Association for the Study of Epileptics and the Care and Treatment of Epileptics, which was held in Boston, November 22d.

Dr. Francis P. Kinnicutt, member of the New York County Medical Association, has returned to town from Morristown, N. J.

Dr. Francis J. Quinlan having resigned from the Committee on Publication, Dr. William R. Stone has been appointed to succeed him.

Dr. William L. Russell, of Poughkeepsie, member of the Dutchess County Medical Association, discussed the importance of recognition and appropriate care of distinct phases of mental defects before the New York State Conference of Charities and Corrections, which recently met at Syracuse.

OPPOSE OPTOMETRY BILL.

Resolutions passed in opposition to the Optometry Bill by the Medical Society of the County of Orange, at a special meeting held in Thrall Hospital, Middletown, on Tuesday, December 20, 1904.

WHEREAS, The President of the New York State Optical Society has announced that the bill to define and regulate the practice of optometry, which failed to pass at the last session of the Legislature, will be brought up again for consideration; and,

WHEREAS, The claim is falsely made that 75 per cent. of the general medical practitioners favor this measure; and,

WHEREAS, We believe from the publications of the opticians who favor this bill that they not only desire to, but are now actually engaged in the practice of a branch of medicine in violation of the present medical law; be it

Resolved, That the Medical Society of the County of Orange, in meeting assembled, protests against the enactment of such a bill as contrary to the best interests of the people of State of New York.

Resolved, That a copy of this protest be forwarded to each Senator and Assemblyman representing this county.

Resolved, That a committee of three be appointed to take such action as may seem best fitted to accomplish the defeat of this and similar measures.

(Signed) C. I. REDFIELD, President.
M. A. STIVERS, Secretary.

SOCIETY NOTES.

BUFFALO ACADEMY OF MEDICINE.—At a meeting held December 20, 1904, Dr. C. A. Bentz read a paper on "A Case of Tuberculosis in the Domestic Turkey." Dr. N. G. Russell on "Lympho-Sarcoma of the Intestines and Kidneys from Cases of Nephritis," considered in connection with urine examinations.

NEW YORK CELTIC MEDICAL SOCIETY.—At a meeting held December 22, 1904, Dr. C. J. McGrath read a paper on "Gastric Ulcer and Its Surgical Treatment."

BROOKLYN SOCIETY FOR NEUROLOGY.—At a meeting held December 29, 1904, Dr. Joseph Frankel read a paper on "Contributions to the Symptomatology of the Posterior Fossa." Dr. Robert Kingman on "Mirror Writing."

MEDICAL UNION.—At a meeting held December 28, 1904, Dr. A. E. Woelmert read a paper on "Urinary Examinations."

CORNING MEDICAL ASSOCIATION.—At a meeting to be held January 5, 1905, Dr. Frank H. Starr will read a paper on "Recent Advances in Orthopedic Surgery."

METROPOLITAN MEDICAL SOCIETY.—At a meeting held December 27, 1904, Dr. H. Lilienthal read a paper on "Some Recent Advances in Surgery," and Dr. A. Wiener on "Some Observations on the More Conservative Treatment of Protracted Cases of Acute Otitis Media Purulenta, with its complications."

Book Reviews.

THE PRINCIPLES OF HYGIENE. A Practical Manual for Students, Physicians, and Health Officers. By D. H. Bergey, A.M., M.D., Assistant Professor of Bacteriology, University of Pennsylvania. Illustrated. Second edition, thoroughly revised and enlarged. Philadelphia, New York and London: W. B. Saunders & Co., 1904.

The entire range of subjects comprising the comprehensive field of hygiene, causes of disease, the study of air, ventilation, heating, water supply, and disposal of sewage is based on the most recent discoveries, and represents the practical advances made in the science up to date. The subjects of food, dieting, exercise and clothing are practically discussed. The chapters on infection and immunity have been rewritten and the discussion of the subject is from the present-day standpoint.

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., 1012 Walnut street, 1903. Price, 80 cents net.

The third edition in the revision has added a sec-

tion on general therapeutics of gynecology and several new operations have been described.

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.

In this seventh edition all changes of nomenclature and description have been carefully followed. Many plates have been added and old ones replaced by new. The author has endeavored to make this volume deserving of first rank among its kind.

SAUNDERS' QUESTION-COMPENDS. Essentials of Nervous Diseases and Insanity, their Symptoms and Treatment, by John C. Shaw, M.D., late Clinical Professor of Diseases of the Mind and Nervous System, Long Island College Hospital Medical School. Fourth edition. Thoroughly revised, by Smith Ely Jelliffe, M.D., Ph.D., Clinical Assistant, Columbia University, Department of Neurology; Visiting Neurologist, City Hospital, New York. Illustrated. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

Dr. Smith Ely Jelliffe, in making the revision for this new fourth edition, has found it necessary to recast the work entirely, bringing the order of arrangement in accord with the present knowledge of these important subjects. Quite a commendable change in arrangement is the grouping of subjects in such a way as to bring out the natural relations of affiliated nervous disorders.

THE ESSENTIALS OF CHEMICAL PHYSIOLOGY, FOR USE OF STUDENTS. By W. D. Halliburton, M.D., F.R.S., Fellow of the Royal College of Physicians; Professor of Physiology in Kings College, London; Author of Text-Book of Chemical Physiology and Pathology. Fifth edition. London, New York and Bombay: Longmans, Green & Co., 1904.

This edition has been carefully and thoroughly revised, and several changes made in the arrangement of exercises. The elements contained in physiological compounds have been introduced in the elementary course. Within the moderate limits of this work the author has kept abreast with the advances in science. The book is valuable to the student, showing how work can be accomplished in a practical way.

SAUNDERS' QUESTION-COMPENDS. Essentials of Anatomy, including the Anatomy of the Viscera, arranged in the form of Questions and Answers, prepared especially for Students of Medicine, by Charles B. Nancrede, M.D., Professor of Surgery and of Clinical Surgery in the University of Michigan; Emeritus Professor of General and Orthopedic Surgery, Philadelphia Polyclinic; Senior Vice-President of the American Surgical Association; Corresponding Member of the Royal Academy of Medicine, Rome, Italy; Member of the American Academy of Medicine, etc. Seventh edition, thoroughly revised. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

In this revision the entire book has been carefully gone over and the section on the Nervous System completely rewritten. The illustrations throughout the text are excellent, showing the anatomy of various parts with unusual clearness.

SAUNDERS' QUESTION-COMPENDS. Essentials of Bacteriology. Being a Concise and Systematic Introduction to the Study of Micro-Organisms, by M. V. Ball, M.D., formerly Resident Physician, German Hospital, Philadelphia; formerly Bacteriologist to

St. Agnes' Hospital. Fifth edition, thoroughly revised by Carl M. Vogel, M.D., Assistant in Pathology, College of Physicians and Surgeons, Columbia University, New York City. With 96 illustrations, some in colors and 6 plates. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

The rapid progress in Bacteriology has involved many radical changes in the science, necessitating a thorough revision in this edition. We note the recent advances in the subjects of Immunity, Tuberculosis, Yellow Fever, Dysentery, Bubonic Plague and other infectious diseases.

SAUNDERS' QUESTION-COMPENDS. Essentials of Medical Chemistry, Organic and Inorganic, containing also Questions of Medical Physics, Chemical Philosophy, Analytical Processes, Toxicology, etc., Prepared especially for Students of Medicine, by Lawrence Wolff, M.D., formerly Demonstrator of Chemistry, Jefferson Medical College; Physician to the German Hospital of Philadelphia; Member of the German Chemical Society, of the Philadelphia College of Pharmacy, etc. Sixth edition, thoroughly revised by A. Ferec Witmer, Ph.G., formerly Assistant Demonstrator of Physiology, University of Pennsylvania; Neurologist to the Out-Patient Department of the Hospital for Ruptured and Crippled, New York City. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

We need but mention the fact that this little work has reached its sixth edition. The recent important discoveries in physics and inorganic chemistry have rendered it necessary to make extensive additions almost to every part of the work. The subject of organic chemistry, especially organotherapy and the substituted ammonias, has also been revised and much new matter added.

SAUNDERS' QUESTION-COMPENDS. Essentials of Materia Medica, Therapeutics and Prescription Writing, arranged in the form of Questions and Answers, prepared especially for Students of Medicine, by Henry Morris, M.D., Fellow of the College of Physicians of Philadelphia; Associate Member of the Association of Military Surgeons of the United States; Member of the American Medical Association, etc. Sixth edition, thoroughly revised, by W. A. Bastedo, Ph.G., M.D., Tutor in Materia Medica and Pharmacology at Columbia University (College of Physicians and Surgeons), New York; Assistant Attending Physician in the Roosevelt Hospital Dispensary and to the Vanderbilt Clinic. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

Much of the text has been in great part rewritten. There have been introduced articles on adrenalin, stypcticin and on the iodine and silver synthetics.

TEXT-BOOK OF CLINICAL DIAGNOSIS. By Laboratory Methods. For the use of Students, Practitioners, and Laboratory Workers. By L. Napoleon Boston, A.M., M.D., Associate in Medicine and Directory of the Clinical Laboratories of the Medico-Chirurgical College, Philadelphia; formerly Bacteriologist at the Philadelphia Hospital and at the Ayer Clinical Laboratory of the Pennsylvania Hospital. Octavo volume of 547 pages, with 320 illustrations, many of them in colors. Philadelphia, New York, London: W. B. Saunders & Co., 1904. Cloth, \$4.00 net; sheep or half morocco, \$5.00 net.

Dr. Boston presents a practical manual of those clinical laboratory methods which furnish a guide to correct diagnosis, giving only such methods, however, that can be carried out by the busy practitioner in his office as well as by the student in the laboratory. He has given special attention to outlining in progressive steps the various procedures in clinical technic, such steps being illustrated whenever possible. All the more recent methods for the examination and staining of blood are described and illustrated by original drawings, and the subject of Serum-Diagnosis is very carefully considered. The newer methods for the estimation of Sugar, Bence-Jones' Albumin, Uric Acid, and Purin have received

thoughtful consideration. The subjects of Animal Parasites, Diseases of the Skin, Transudates and Exudates, and Secretions of the Eye and Ear have received an unusual amount of space. Attention has also been paid to Inoscopy and Cyto-diagnosis. Indeed the book contains much useful material throughout, and being the latest work on Clinical Diagnosis, includes the most recent advances along that line.

EXAMINATION OF THE URINE. By G. A. de Santos Saxe, M.D., Pathologist to the Columbus Hospital, New York City. 12mo volume of 391 pages, fully illustrated, including 8 colored plates. Philadelphia, New York, London: W. B. Saunders & Co., 1904. Flexible leather, \$1.50 net.

Dr. Saxe has presented a work on examination of the urine unusually complete, absolutely up to date, concise, yet explicit in all its parts; and it will be found to meet fully the requirements of the student and practitioner without burdening him with unnecessary analytic procedures. Special attention has been paid to the interpretation of findings as applied to clinical diagnosis, and the student is told what each chemical element and each microscopic structure means when found in the urine. Cryoscopy and other means of functional diagnosis have been given their proper places. The work will be useful because it is practical.

PATHOLOGICAL TECHNIQUE. A Practical Manual for Workers in Pathological History and Bacteriology, including Directions for the Performance of Autopsies and for Clinical Diagnosis by Laboratory Methods. By Frank Burr Mallory, A.M., M.D., Associate Professor of Pathology, Harvard University Medical School; First Assistant Visiting Pathologist to the Boston City Hospital; Pathologist to the Children's Hospital, and James Homer Wright, A.M., M.D., Director of the Clinico-Pathological Laboratory of the Massachusetts General Hospital; Instructor in Pathology, Harvard University Medical School. Third edition, revised and enlarged, with 156 illustrations. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

The third edition of this work keeps pace with the great advances made in pathology, and it retains its value as a laboratory and post-mortem guide. Many additions have been made as the methods for the isolation of typhoid bacilli from the feces, Wright's blood stain, and directions for its application to blood films and malarial parasites. Some new photographs by Mr. L. S. Brown on the malarial parasites are particularly interesting.

BOOKS RECEIVED.

A LABORATORY MANUAL OF HUMAN ANATOMY. By Lewellys F. Barker, M.B., Tor., Professor and head of the Department of Anatomy in the University of Chicago and Rush Medical College. Assisted by Dean De Witt Lewis, A.B., M.D., and Daniel Graisberry Revell, A.B., M.B., Instructors in Anatomy in the University of Chicago. Illustrated. Philadelphia and London: J. B. Lippincott Company, 1904. Price, \$5.

TRANSACTIONS OF THE MEDICAL ASSOCIATION OF GEORGIA, FIFTY-FIFTH ANNUAL SESSION, 1904. Published by the Association, 1904.

TRANSACTIONS OF THE MAINE MEDICAL ASSOCIATION, 1904. Vol. XV, Part 1.

TRANSACTIONS OF THE ARKANSAS MEDICAL SOCIETY, Twenty-ninth Annual Session, held at Texarkana, Ark., May 3, 4 and 5, 1904. Press of Arkansas Democrat Company, Little Rock.

GENERAL CATALOGUE OF MEDICAL BOOKS. P. Blakiston's Sons & Co., Philadelphia.

A TEXT-BOOK OF PRACTICAL THERAPEUTICS, with especial reference to the Application of Remedial Measures to Disease and Their Employment upon a Rational Basis. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson

Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one-time Clinical Professor of Diseases of Children in the University of Pennsylvania; Laureate of the Royal Academy of Medicine in Belgium, of the Medical Society of London; author of "A Text-Book of Practical Diagnosis," etc. Tenth edition, enlarged, thoroughly revised and largely rewritten, illustrated with 113 engravings and 4 colored plates. Philadelphia and New York: Lea Bros. & Co., 1904.

LIBRARY OF CONGRESS. A. L. A. CATALOG, 8,000 volumes for a Popular Library, with Notes prepared by the New York State Library and the Library of Congress under the auspices of the American Library Association Publishing Board. Editor, Melvil Dewey, Director New York State Library and Library School; Associate Editors, May Seymour, Education Librarian, New York State Library; Mrs. H. L. Elmendorf, Special Bibliographer, Buffalo Public Library. Part 1, Classed; Part 2, Dictionary. Washington Government Printing Office, October, 1904.

STRABISMUS, OR SQUINT. Latent and Fixed. A supplement to *The Errors of Refraction.* By Francis Valk, M.D., Professor of Diseases of the Eye, New York Post-Graduate School and Hospital; Consulting Ophthalmologist, Thrall Hospital, and formerly Assistant Surgeon, Manhattan Eye and Ear Hospital; Visiting Ophthalmologist Randall's Island Hospitals and Ophthalmologist to the New York Dispensary; Fellow of the New York Academy of Medicine and of the State and County Medical Society; Member of the Greater New York Medical Society and the Society of Medical Jurisprudence, etc. G. P. Putnam's Sons, New York and London: The Knickerbocker Press, 1904.

A MANUAL OF PERSONAL HYGIENE, PROPER LIVING UPON A PHYSIOLOGIC BASIS. By American authors. Edited by Walter L. Pyle, A.M., M.D., Assistant Surgeon to the Willis Eye Hospital, Philadelphia; Secretary of the Section on Ophthalmology, American Medical Association; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia, etc. Contributors, D. H. Bergey, M.D., J. W. Courtney, M.D., George Howard Fox, M.D., E. Fletcher Ingals, M.D., Walter L. Pyle, M.D., B. Alexander Randall, M.D., G. N. Stewart, M.D. (Edin.), Charles G. Stockton, M.D. Second edition, revised and enlarged. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

DIET IN HEALTH AND DISEASE. By Julius Friedenwald, M.D., Clinical Professor of Diseases of the Stomach in the College of Physicians and Surgeons, Baltimore, and John Ruhrah, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. "These few rules of diet he that keeps, shall surely find great ease and speedy remedy by it."—Burton. Philadelphia, New York, London: W. B. Saunders & Co., 1905.

DISEASES OF THE LIVER, GALL-BLADDER AND BILE-DUCTS. By H. D. Rolleston, M.A., M.D., (Contab.) F.R.C.P., Physician to St. George's Hospital, London; formerly Examiner in Medicine in the University of Durham and Fellow of St. John's College, Cambridge, England. Fully illustrated. Philadelphia, New York, London: W. B. Saunders & Co., 1905.

ATLAS AND EPITOME OF GENERAL PATHOLOGIC HISTOLOGY. By Docent Dr. Hermann Dürck, of the Pathologic Institute, Munich. Authorized translation from the German. Edited by Ludvig Hektoen, M.D., Professor of Pathology in Rush Medical College, Chicago. With 176 colored illustrations on 80 lithographic plates and 36 figures in black and colors. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

GALL-STONES AND THEIR SURGICAL TREATMENT. By B. G. A. Moynihan, M.S. (London), F.R.C.S., Leeds. Fully illustrated. Philadelphia, New York, London: W. B. Saunders & Co., 1905.

Original Articles.

AN ATYPICAL CASE OF APPENDICITIS.¹

Presenting Some Unusual Features Found at the Operation.

BY W. B. REID, M.D.,
Rome, N. Y.

THE fact that such prominent surgeons as Deaver, Fowler, Mynter and Ochsner, who have written special text-books on the subject of appendicitis, have not mentioned the possibility of the complication which we encountered in the case about to be reported, and that no similar case is recorded in the literature stamps it of sufficient rarity to warrant placing a single case on record.

Dr. Howard A. Kelley, in his text-book on "Operative Gynecology," describes a condition under the name of *Physometra*, using it to designate a collection of gas in the uterus, associated with sepsis. The cause of the tympany in Kelley's case was the *bacillus ærogenes capsulatus*. The cause of the condition which we encountered was found to be due to bacteria, which will be described later.

AMENESIA.

The family history was negative.

PERSONAL HISTORY.

On February 20, 1904, I saw Mrs. E. W., with her family physician, and obtained the following history: Age, 49; married at the age of 28; one child.

PREVIOUS HISTORY.

Her general health had always been good, with the exception of a chronic indigestion, associated with mild attacks of pain in the abdomen. She had also suffered from shortness of breath on climbing stairs or making quick exertions. After standing and working hard, she had also noticed some swelling of the feet and ankles.

THE PRESENT SICKNESS.

On February 17th, while riding with her husband, she was thrown from a sleigh, striking on the right side and shoulder. The same night, a severe pain gradually developed in the left hypochondrium. This lasted all night, and toward morning settled to the right lumbar and right iliac regions. The pain remained of a dull, aching character during the next day, but the abdomen gradually became more sore and tender to the touch. On February 19, 1904, the family physician was sent for, and obtained the history as given above. He found the abdomen somewhat distended, markedly sore over McBurney's point, but no rigidity. The respirations were 20; pulse, 90, and temperature, 100.

PHYSICAL EXAMINATION.

General appearance very stout and fleshy. Color somewhat sallow. Height, 5 feet 4 inches. Weight, 175-180 pounds. The heart showed evidences of fatty degeneration, but no murmur was heard. Examination of the chest showed the lungs in a normal condition. Examination of the

abdomen revealed a large umbilical hernia, associated with a general tympanitis. There was a marked tenderness over McBurney's point, associated with board-like rigidity. The pulse was 110; temperature, 101; respiration, 24.

EXAMINATION OF THE URINE.

Total quantity not obtained. Color, yellow. Cloudy precipitate. Specific gravity, 1028. Heller's test showed a ring of albumen. Trommer's test showed a decided trace of sugar.

MICROSCOPICAL EXAMINATION OF URINE.

A drop of precipitate, thrown down by the centrifuge, showed a few pus cells and a large number of granular and hyaline casts. The diagnosis of traumatic appendicitis was made.

Owing to the bad condition of the heart and kidneys, it was thought best to defer the operation for a few days. I advised that the bowels be moved immediately by a high enema, that the starvation treatment of Ochsner be followed, and that the case be kept under the closest observation.

On March 11, 1904, I saw the case again and found the condition somewhat worse. The temperature had varied during intervals from 100 to 103; the pulse from 90 to 114 per minute. The patient was then removed from the country to the hospital, a distance of seven miles.

On admission, the record shows a temperature of 102; pulse, 114, and respirations, 24. The heart was in bad condition, being very irregular, intermittent, and the pulse of very poor volume.

Examination of the abdomen at this time showed a general tenderness, more localized in the right side. A tumor in the same region, the size of a small apple, could easily be palpated and distinctly outlined. The previous diagnosis was confirmed and the evidences of abscess formation very suggestive. The amount of urine passed during the previous ten days had averaged about 12 ounces.

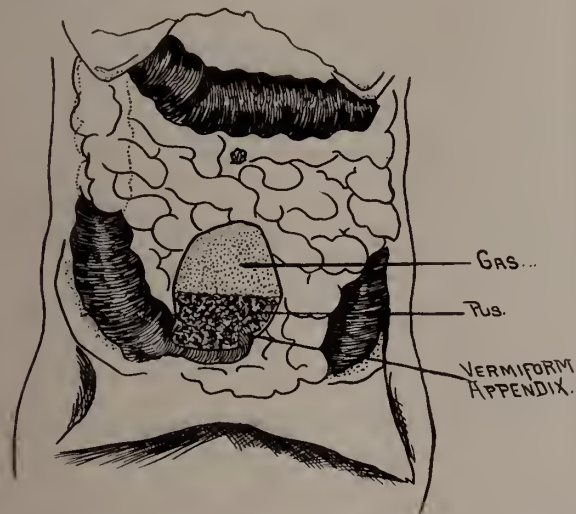
Owing to the bad general condition and the state of the heart and kidneys, we determined to keep the case under observation, and by treatment try to improve the work of these organs. The patient was then placed on a strict liquid diet and given three pints of distilled water daily. The bowels were unloaded by small doses of calomel, followed by a saline. From the date of admission—March 11, 1904, to March 31, 1904—the patient ran an irregular temperature, varying from 100 to 103 degrees. The pulse was irregular, intermittent and of poor volume, varying from 90 to 120 beats per minute. She continued to pass large quantities of albumen and sugar. The average amount of urine passed was 15 ounces per day. Nausea was a continuous and distressing symptom, but no vomiting occurred. Pain was not complained of at any time, but the soreness and tenderness in the right side gradually grew worse. The tumor in the appendicular region increased to the size of a small cocoon. As it seemed impossible to improve

¹Read at the Twenty-first Annual Meeting of The New York State Medical Association, New York, October 17-19, 1904.

her general condition, we determined to operate without further delay.

OPERATION.

Owing to the degeneration of the heart muscle, general anæsthesia with ether or chloroform was considered too hazardous, so I determined to try local anæsthesia. Ethyl chloride was used to anæsthetize the punctures, when the hypodermics were given and the skin incision made. A 2 per cent. solution of nirvanin was used hypodermically, for deep anæsthesia. The total quantity used in the work was two grains. The operation was carried out without causing the patient any pain or suffering. An incision, two inches in length, was made over the most prominent part of the tumor. The skin was incised, and I then proceeded carefully through the muscles and came to the upper wall of a large abscess. This was opened, and, to my great surprise, a rush of foul-smelling gas came through the small incision which had been made. The sound was exactly like that of a pin-hole prick in an over-distended intestine, filled with gas. In fact, that is what we all thought had happened, that a coil



of intestine had become adherent to the superficial wall of the abscess, and had been accidentally incised. As the abscess cavity partially emptied itself of gas, pus, filled with gas bubbles, began to pour forth.

Remembering the facility with which certain bacteria form gas, the suspicion of what had taken place came to my mind. Closer examination through an enlarged opening showed a pus cavity, and sticking up, firmly adherent to the bottom, the end of a gangrenous appendix was found. The cavity was mopped free of pus and packed with gauze. No effort was made to remove the appendix.

BACTERIOLOGICAL EXAMINATION OF PUS.

The Koch gelatin plate isolation cultures, after being in the oven at a temperature of 90 degrees, showed an abundant development of small white colonies. Some of these were of a creamy white with a tendency toward a brownish. They refracted the light sharply when held near the window. The colonies showed a variation in

shape, according to age, the younger tending toward a round, while the older were very irregular. The potato cultures were much more irregular in shape and of a darker color, even showing a tendency in the older colonies of a yellowish-brown or dirt color. The gelatin stick cultures showed an abundant growth, along the line of puncture, grayish-white in the early growth, but tending toward the yellow as the culture aged. A few gas bubbles developed in some of the culture media. The addition of a slight amount of milk sugar to each tube of gelatin, and then followed by a stick culture, showed practically the same macroscopic appearance, but with this distinction, that there was an abundant development of gas bubbles.

MICROSCOPICAL EXAMINATION OF SOME OF THE CULTURES.

A. The hanging drops of all the specimens, both gelatin plate, stick and potato, showed no mobility. B. All the specimens examined took both the fuchsine and methylene blue readily and rapidly parted with the colors by Gram's method. C. The microscope showed a wide variation in the morphological appearance of the different specimens. All showed the same rod appearance with rounded ends. Many colonies were typical of the bacillus coli communis; the average size in most of the specimens ranged from 1 to 3 micromillimeters in length and from 0.2 to 0.7 micromillimeters in breadth. Many specimens showed a large number of bacilli of a much smaller size, and with much more of the appearance of a micrococcus. The general appearance of these small bacilli was about the same, being short rods with rounded ends, the size varying somewhat, but, in the mean, ranging from $\frac{1}{2}$ to 2 micromillimeters in length and from 0.1 to 0.5 micromillimeters in breadth. These smaller bacilli drew my attention to their close resemblance to the bacillus lactis ærogenes described by Sternberg. This suspicion I believed not to have been well founded. My second thought on the question, however, is not at all dogmatic, and I hope my final decision will be materially assisted by the discussion, which you men with a more varied and wider experience in bacteriology may have to offer.

We all know the reputation of the colon bacillus to such a marked variation, both in morphological appearance and biological characteristics.

Sternberg, in speaking of the bacillus coli communis, says: "Numerous varieties have been cultivated by different bacteriologists, which vary in pathogenic power, and to some extent in their growth in various culture media; but the differences described are not sufficiently characteristic or constant to justify us in considering them as distinct species."

Under certain circumstances some of the rods in pure cultures have been observed by Escherich to present spherical, unstained portions at one or both extremities, which closely resemble spores, but which he was not able to stain by the methods usually employed for staining spores,

and which he is inclined to regard as "involution forms."

REMARKS.

1. The case, to my mind, was a case of appendicitis of long standing, as shown by the history of pains in the side and digestive disturbance.

2. The history of traumatism was purely a coincidence.

3. The acute attack was caused by an infection of the bacillus coli communis and followed by abscess formation.

4. The acute nephritis was caused by an infectious toxæmia, as a postoperative examination proved the urine to be free from albumen and casts.

5. The associated diabetic condition, which an examination of the urine on September 28, 1904, showed to still have continued, furnished a sufficient amount of sugar in the culture media, contained in the abscess cavity for the production of gas formation.

In closing, allow me to emphasize the point upon which I hope any remarks of those discussing the report may touch: Did we in this case have a double infection of the bacillus coli communis and the bacillus lactis ærogenes, or was the infection a single one of the colon bacillus, which, under the peculiar condition of the diabetic culture media, produced one of the "involution forms," which resulted in gas formation?

INVOLUTION MELANCHOLIA.¹

BY THOMAS J. CURRIE, M.D.,
Willard, N. Y.

THIS term, as employed in the clinical study of insanity, corresponds practically to the older division of climacteric insanity, except that formerly the tendency was to include cases of maniacal outbreak, with a class of cases developing as a result of the changes accompanying or following the climacteric.

The term *melancholia*, employed in its broadest sense, applies to any state of depression occurring with primary dementia, general paralysis of the insane, hysterical insanity, the period of depression which obtains as a phase of alternating or circular insanity, etc.

The term *melancholia of involution* as understood from the present standpoint, can be applied to two groups of cases, which are characterized by the development of depression, with ideas of fear, delusions of self-accusation, of persecution, and ideas of a hypochondriacal nature, with moderate clouding of consciousness, and disturbance of the train of thought, leading, in the greater number of cases, after a prolonged course, to moderate mental enfeeblement.

Among women, the importance of the mental and nervous changes at the time of the climacteric, are apt to be underestimated. As unstable brains are likely, in certain instances, to be deranged in their mental operations by the slow development of puberty and adolescence, they are accordingly liable to suffer as those most impor-

tant powers of the organism diminish and disappear at the climacteric.

At the climacteric or involution period, there is unquestionably a mental change of peculiarly marked significance in both sexes. There may be a period of increased activity in sexual tendencies, followed by an invariable decrease of these tendencies, and ultimate diminution and extinction of the natural sexual activity and power.

There are changes of form, especially in women. The expression of the face changes, the ovaries become atrophied, and the spleen and lymphatic glands become less active. The ordinary sensory nervous sensations, that are connected with the climacteric in women, such as vertigo, vaso-motor disturbances, flashes of light, uneasy organic sensations, headache, etc., usually occur before the menopause, rather than accompany it.

The time when the reproductive activities cease is usually reckoned as a period when there is special liability to mental breakdown, and climacteric mental disturbances in women, therefore, have a place in nearly all our etiologic classifications of mental diseases. The change has, however, more of the characteristics of a physiologic crisis than the development of puberty and adolescence, and should, therefore, be less likely to be attended by the development of so serious a derangement as insanity.

Individuals having a perfectly normal development, ought not to show any disturbance at this period, but such as possess perfectly normal development and function, are rare, and consequently it occurs very frequently, in the readjustment of the physical functions, that there will be a disturbance of the mental operations, that in extreme cases, or in those already predisposed, extends to actual mental disease.

Probably it would be difficult here, as in the cases of insanity of adolescence, to point out a definite series of symptoms characteristic of the mental derangement, that are so constant and recognizable as to constitute a well-defined species; but we can show a reasonable series of symptoms.

This form of melancholia, developing in the male, does not occur so frequently, relatively, as in women. It rarely develops before 50, usually occurs between 45 and 65. This period of life is supposed to occur, popularly, at the age of 63, just as in the female, the corresponding age is 45, as an average date. There is lessening of activity, spontaneity and courage, aggressiveness and poetic sentiment. There is less keenness of feeling in diverse directions; less delight in former acquaintances; sleep is apt to be less sound, and hours of sleep are shortened. Where the morbid tendencies are prolonged, and deep in impress, symptoms of a character similar to those obtaining in the regular involution cases develop.

ETIOLOGY.

The consensus of opinion among recent writers is that the disease should be regarded as one of

¹Read at the Semi-Annual Meeting of the Seneca County Medical Association, Cayuga Lake, September 8, 1904.

the evidences of approaching senility. The greater number of cases occur between the ages of 40 and 60. It seldom occurs under 40, or over 60. Sixty-five per cent. of the cases occur in women, when it may develop several years after the occurrence of the menopause; in men the onset is later.

Defective heredity can be ascribed as a predisposing cause in a little over half of the cases. Outside causes, such as the loss of friends, mental shock and worry, prostration accompanying or following acute or chronic diseases, surgical operations, exhausting physical labors, all can be located as definite exciting causes.

The only anatomical changes thus far located are those of arterio-sclerosis. The fibro-capillary changes are usually not very marked, being merely the beginning of that process. Direct observation of a considerable number of cases in Willard, reveals evidences of beginning or moderately advanced atheroma, in about half of the whole number of cases.

SYMPTOMS.

The first group of cases may be said to contain the greater number, representing those developing less severe indications of mental disturbances. The premonitory indications are often present for many months. The most common and persistent are headaches, often accompanied by soreness of the scalp at vertex, and heat or boring sensations in that locality. Vertigo, occurring as a regular symptom, when the patient is up and about during the day, or when reclining, or sometimes at night. Loss of appetite, anemia, general debility, constipation, cardiac palpation, and increasing difficulty in accomplishing work, are among the prominent symptoms.

The onset of the actual attack is apt to be gradual, sometimes extending through months, or even years. The patient, who has shown all, or part of the prodromal symptoms enumerated above, may become sad, dejected, and apprehensive, and unable to any longer find enjoyment or interest in her usual occupation, or home surroundings. This condition may be followed by the development of ideas of doubt, fear, indecision and self-accusation. The patients cannot reason correctly, and give little attention to consolation or advice of friends. Sensations of illness develop: they complain of absentmindedness, confusion, of being dumb and helpless, and find it difficult to do anything. During this period the patient may have occasional days when the apprehension, depression and anxiety disappear.

Hypochondriacal ideas assume considerable prominence in many cases. They are afflicted with various physical diseases, the nerves and brain are decayed on account of sexual abuse; they have no appetite, food tastes badly, contains poisonous substances, does not nourish, causes great suffering. Often these cases plead that they be allowed to exist without food. Others may express ideas of having consumption and various other diseases. Ideas of bodily changes

often develop in these patients, as an exaggeration of the marked hypochondriacal trend. One may protest volubly and repeatedly that the throat and esophagus are closed up, that the stomach and intestines, or, in fact, all the abdominal organs are diseased, atrophied, or destroyed. Some claim that food, even when liquid and given in small quantities, causes great distress, and wail about sensations of distention, extreme pain, and sensation as though the stomach, intestines or other organs are bursting.

Constipation is another theme upon which the patient harps, persisting that nothing has passed the bowels in weeks or months, that remedies cause indescribable suffering, that the rectum has been closed for weeks, etc.

Sooner or later, delusions of self-accusation develop as a prominent feature of the picture. The patient becomes retrospective and introspective, reverting to comparatively insignificant errors, and magnifying them into serious misdeeds or positive crimes. One has corrected her child too severely, and now perceived that she had committed a great wrong. Another had neglected her son when he was ill, and now believed that she would never be forgiven. Still another had turned her children out into the inclement weather, and was constantly harassed by the idea that they were starving and freezing.

Sometimes sexual indiscretions, either real or imaginary, are magnified into crimes of appalling importance, which condemn the victim irrevocably to everlasting torment. Some become so thoroughly imbued with the hopelessness of their condition that they invent crimes in their imaginations, in order that severer punishment may be secured, as a relief for their guilty consciences.

Religious concepts and delusions occur with many cases, either as a regular attitude, or as an occasional interruption. They have committed the unpardonable sin, cannot pray, cannot do anything right. God does not hear, or answer prayer. The Lord is punishing them through the miseries of others.

Orientation may remain clear, but is apt to be clouded and uncertain for location and dates, in some cases. On account of the strenuous desire to be free, and the knowledge that they are detained, patients in hospitals frequently develop the idea of imprisonment, or punishment on account of imaginary crimes. Usually, however, they have very fair comprehension of surroundings and circumstances, and consciousness is reasonably clear.

There is usually a degree of insight into the actual condition, the patients realizing that there is something wrong with their brains, but are unable to recognize the symptoms present, as evidence of disease.

The power of thinking is often impaired, quite coherent, and may be relevant to the subject, but the speech production and ideas are apt to be centered around the delusions. There is often a

tendency to repeat phrases connected with dominant ideas, such as "Let me go away. Oh! let me get out in the yard. Let me return to my children!"

Most of the cases show agitation, many distress and incapacity for employment. Some may be inactive, indolent, showing a certain amount of constraint in movements. The countenance is usually expressive of sadness; sometimes indication of suffering. The voice is apt to be high-pitched, strained and monotonous, especially in the agitated cases.

The inclination to suicide is especially prominent in these cases. There may be suicidal impulses without any previous warning, but usually the tendency to suicide is a matter of deliberation and opportunity, and, unfortunately, too many cases terminate by self-destruction, especially among those who are cared for at home during such attacks. This aspect of the matter has been brought forcibly to my notice within the past few days, in the case of a woman who was under treatment in the hospital. She had made four distinct suicidal attempts prior to her admission to the hospital, where she was committed and remained several months. At the urgent and repeated solicitation of her relatives she was discharged to their care about six weeks ago, after very careful arrangements for her care and safety had been agreed to by her relatives, as she was feeble and hopeless, and greatly distressed because of homesickness. Despite precautions which we presume were taken by her people, she managed to commit suicide a few days ago.

Hallucinations of sight and hearing often accompany this condition, but they are usually transitory and indefinite, not exerting any controlling influence.

The more severe form of the disease, includes a larger number of the cases usually seen in a hospital for the insane, and is distinguished by greater prominence of the hallucinations of sight and hearing, delusions of fear, often of a silly character, greater clouding of the intellect, particularly of consciousness, and severe agitation.

The premonitory and early symptoms are usually similar to those of the first group, and, as a matter of fact, some cases, after passing through a phase with symptoms corresponding to those already described, pass on to a condition of more severe disturbance, representing this second group. At the onset, the characteristic case develops more rapidly, especially if the exciting causes be prominent. The comparatively slight melancholia of the initial stage quickly passes into an extreme despondency. The patients develop ideas of extreme wickedness, have committed horrible crimes and desecrations; they plead to be put to death or tortured in the most atrocious and unnatural ways. Every speech or action of those about the patient is interpreted to have an unfriendly, sinister or diabolical motive. Inanimate objects noticed by the patient assume

mysterious importance and meaning, as the observation that a spoon is there for the purpose of giving poison. The hypochondriacal delusions grow extravagant and absurd. The brain is a mass of molten lead, a cake of ice; the blood has all dried up, or become congealed; the lungs have decayed; the body is putrefying; worms infest the flesh, etc. Aural and visual hallucinations are active and vivid. The devil often torments them with visions of fire, of frightful murders, of future punishment awaiting the sufferer. Hallucinations of taste and smell often give rise to delusions of filthy and vile substances in the food. Hallucinations of general sensation are sometimes vivid and terrifying. For instance, one patient insists that a demon is located in the left side of her abdomen. He communicates with her by tapping, the signals being arranged something like the telegraphic code, and her actions are controlled in this way, by this malign spirit, who punishes her by distressing pains and tortures when she hesitates to act according to his bidding.

Sometimes what is termed the "delire de negation" obtains in these cases, when the patients claim that an end has come to everything, that nothing any longer exists, that they are floating in space and the world has disappeared.

These patients are usually confused, show considerable disorientation for time, place and persons, and are prone to repetition of phrases. Frequently, however, as in cases of delirium, the attention of the patient can be secured, and fairly coherent and sensible answers to questions can be obtained, on subjects not connected with delusions. They show marked, and sometimes extreme agitation, beating themselves, wringing their hands in agony, picking at the flesh, and pulling the hair. Impulses to suicide and attempts at self-mutilation are frequent and persistent, and these cases usually require very careful watching on the part of the nurses, to prevent the execution of suicidal designs and impulses.

As already stated, the emotional attitude is always one of depression, which is based upon fear of something that has occurred, or is about to happen, and consequent anxiety and distress, causing agitation and distraction.

PHYSICAL SYMPTOMS.

On account of the agitation, anxiety, distress and distraction, the result of delusions, of fear and apprehension of punishment, the appetite is poor, digestion is disordered, the tongue coated, with fetor of breath often, and constipation obtains. Consequently, the patients become emaciated and reduced physically, usually in proportion to the severity of the mental disturbance. Many cases refuse food obstinately on account of delusions. Obstinate insomnia usually obtains, and some of the patients are harassed by distressing dreams. Cyanosis and coldness of the extremities are often present, and sometimes edema, due to cardiac dilatation, or impaired circulation, due to atheroma of the blood vessels, is noticed.

The course of the disease is usually prolonged. The attack usually develops gradually, continues several months at an almost uniform condition, and the improvement and convalescence in recoverable cases usually slow. Remissions of short duration may occur, and exacerbations frequently occur as the result of special irritations, as the visits of friends, annoyance or fatigue. Curable cases rarely recover within a year, and the duration is usually two years or more.

PROGNOSIS.

A reference to the opinions expressed by various authors, as well as consideration of cases in my own experience, shows this to be an unfavorable form of mental disease, so far as prospects of recovery are concerned. Only about one-third of the cases recover. In the others moderate dementia occurs after a few years. A certain number become quiet, fairly comfortable and sufficiently well to get along in the care of relatives, but even in such cases the danger of suicide is sometimes present.

The prognosis is usually more favorable in those cases, occurring early in the involution period. Many of the cases become emaciated, exhausted, and die of acute physical diseases. They seem particularly liable to attack by tuberculosis. A few who become quiet and improve develop a paranoic condition, without insight or comprehension. They develop ideas of wealth, of being favored of God, of having power to heal disease, and develop a childish attitude generally.

TREATMENT.

Comparatively mild cases may be treated at home, satisfactorily. Indeed, many of the cases who develop symptoms of melancholia of mild type, are cared for in their homes, or at least outside of a hospital for the insane, under the direction of the family physician.

The most important feature of the treatment in the beginning is to place the patient in bed, amid quiet surroundings, away from persons, as well as objects who cause irritation. This class of cases do not react well to long journeys, sight-seeing, or other distractions. Attention to correction of errors of digestion, a varied and abundant diet, tonics when indicated, and suitable remedies to relieve insomnia, are the principal indications.

Even with mild cases the danger of suicide must be guarded against.

More severe cases, with marked anxiety, depression, agitation, and pronounced suicidal tendencies, can be more safely treated in a hospital.

The "rest cure" gives the most satisfactory results in many cases, although some are so agitated and resistant that it is very difficult to keep them in bed. On account of the severe mental restlessness, these patients usually become, sooner or later, much emaciated, show marked edema and lowering of physical function generally. Consequently, the most nutritious diet is re-

quired. This must be varied to meet individual indications, but forced feeding with milk and eggs, and other concentrated foods, usually gives the best results in keeping up the nutrition and strength of the patient.

A considerable proportion of these cases, who refuse food on account of various delusions, or who cannot be induced to take sufficient food, require artificial feeding, sometimes for months, or even years, continuously. These cases are usually of such a severe character that they become chronic. Judicious combinations of various tonic remedies, especially nuxvomica, strychnia, quinine, hypophosphites and iron preparations are all useful. Remedies which aid in digestion and predigested foods are often of service.

Perhaps the most troublesome and distressing condition met with in these cases, is the persistent insomnia. For the relief of this trouble in milder cases hot drinks, of milk, tea, etc., or the hypnotics, such as trional, sulfonal, or paraldehyde, may be efficient, but in more severe cases more active measures will be necessary. For these cases full warm baths or prolonged hot baths, or wet packs, act very well in many cases. The hydro-therapeutic methods of inducing sleep have largely superseded the giving of narcotic sedatives in the wards of hospitals where advanced methods of treatment are applied.

In cases where the insomnia and agitation are very obstinate, more powerful hypnotics, such as chloral-hydrate, chloralamid in combination with the bromides, may be required temporarily. Alcohol frequently acts well as a hypnotic, especially in patients who have been agitated for some time, and are becoming exhausted. It may be given as whisky, wine or beer, in the amount required, in the individual case, to act as a narcotic and hypnotic. Sometimes two or three ounces of spiritus frumenti, with thirty or forty grains of sodii. brom., in sufficient water, will act favorably as a hypnotic in a patient who is extremely frenzied and distracted, when sleep cannot be obtained from any other means, except large doses of chloral-hydrate, or hyoscine-hydrobromate.

In some cases the agitation, psychic distress and frenzied condition can be relieved by increasing doses of opium or morphia. Occasionally this remedy will have a beneficial effect in controlling and relieving a severe outbreak. The mental stress and pain is usually considerably relieved by the morphia. When this remedy is exhibited, it is especially necessary to control the tendency to obstinate constipation, by giving appropriate remedies.

Additional means of treatment are massage, which is especially applicable when patients are kept in bed, to supply the lack of regular exercise. Tonic baths are also beneficial, to improve capillary circulation, relieve vaso-motor disturbances, and thus improve nutrition. Sometimes patients suffering from this malady will improve

faster when given a moderate amount of exercise and diversion out of doors.

The influence of surroundings, and of the nurses who come in contact with the patient, also counts in this, as in other forms of insanity. Persuasion, substitution of thought, where any response can be obtained, gentleness, friendliness and encouragement are often of service in relieving the anxiety and distress, and in diverting the attention of the patient from delusions.

Visits from relatives are often injurious, during the severer part of the disease, and may cause a serious relapse, even after improvement has been effected.

Those who have shown suicidal tendencies should be kept under careful observation both day and night, until convalescence is established.

It is particularly advisable, with this class of patients, that they remain under observation and treatment, until recovery has been established, on account of the liability of latent suicidal inclinations to become prominent when the patient has been relieved from oversight.

The most satisfactory evidence of recovery, is the regaining of insight and the return of good physical health.

DISEASES OF THE RESPIRATORY TRACT.

First, that a person suffering with obstructive intranasal disease—chronic nasopharyngeal catarrh—is not laboring under a mere inconvenience, but has a malady that involves very serious danger, a danger that increases as years advance, and that, uncured, is a constant menace to the integrity of the lower respiratory tract.

Second, the neuroses dependent upon nasal obstruction are often as serious in their symptomatology, as they are distressing to the patient. They affect not only the respiratory tract, but the heart and other organs, often masking the real disease to an extent that may embarrass the examiner in making a differential diagnosis.

Third, that chronic catarrhal bronchitis is a disease of potential importance, slow in its progress, often depending upon nasal obstruction as a primary factor of cause, and is of most serious import in the aged.

Fourth, that asthma is, for the most part, a reflex manifestation of nasopharyngeal disease, generally obstructive in character; that it is seldom idiopathic, but its paroxysms are similar whether it be true or false, whether it be reflex or bronchial; and that its chief importance is as a symptom of disease located elsewhere, spasm of the bronchial tubes being a distressing expression of the lesion.

Fifth, that those diseases of the respiratory tract to which the veteran soldier is peculiarly liable, are often expressions of the rheumatic or gouty diathesis, and that these dyscrasæ are often underlying factors to be reckoned with in reference to origin as logical sequences of pathology.

As a final thought, permit me to suggest that it does not require much mental elasticity or any

distortion of facts, to affirm that a Civil War veteran suffering from chronic catarrhal disease of the respiratory tract, is as much entitled to rating and pension as though he were shot in battle. Such a man who, in childhood, received a slight injury to the nose, causing deformity of the septum, and in young manhood through exposure in the military service, contracted intranasal disease which later, after the development of rheumatism, appears as chronic rhinitis, bronchial catarrh, or pseudoasthma, is entitled to serious and considerate treatment at the hands of the Government.—*Pensioner, October.*

DEVIATIONS OF THE NASAL SEPTUM.

In a review of 100 operations for the correction of deviated septa, by Dr. Joseph S. Gibb, published in the *Journal of the American Medical Association*, October 29, 1904, he offers some very practical remarks on septal operations:

Operations for the correction of deviated septa are undertaken for the purpose of restoring lost or diminished function to the nasal chamber. The disturbance of function is made manifest to the patient by difficulty or impossibility of nasal respiration, necessitating mouth breathing, with all the ills this latter condition entails. Among the lesser, though by no means unimportant, effect of deviated septa there may be interference with excretory ducts, *e. g.*, the nasal duct and the orifices of the accessory sinuses, and pressure neuroses. Any one of these conditions justifies an attempt to relieve by correction of the deviated septum. On the other hand, the correction of a deviated septum in a case in which there are no disturbing symptoms, is open to criticism.

Septal deviations, except in recent cases, are rarely sharply defined; we find associated with the septal irregularity thickening of the tissues—cartilaginous, in those cases in which the cartilage alone is involved; bony, in those in which the bone is also deflected, so that we have in each case a septum pushed out of line, plus a redundancy of tissue composed of either cartilage or bone, depending on the portion of the septum involved. This redundancy of tissue is not confined to the nasal chamber toward which the septum is deflected—not infrequently the concavity is found filled with these thickened masses.

These, then, are the difficulties to be overcome in the operation for the correction of the trouble, and that operation will be most successful which overcomes these difficulties. It is of more importance to carefully study a case on these lines than to enter into an elaborate description of the character of a deviation as to its position in the nasal chamber. It matters little whether a deflection is along the horizontal or vertical axis or is sigmoid in its shape so long as we have a proper appreciation of the amount of deviation, and the concurrent thickening. Each case should be studied in itself and both nasal chambers should be thoroughly investigated, the extent of

the deviation noted, and the amount of thickened tissue comprised within the deviated area carefully estimated.

It is apparent from the complicated nature of the difficulties to be overcome, that no one operation will meet every indication in the correction of a deviated septum. With a careful study of each case, we are in a position to decide which operation or combination of operative procedures will meet the indications in the case before us.

The more simple the operation, the less damage done to the nasal tissues, the better the result, and the less discomfort to the patient. If our study leads us to the belief that by paring off here and there, we may obtain sufficient room to restore the function of the nasal chamber, and to take off pressure on sensitive areas, there seems no good reason to do the more formidable, lengthy and painful operation, or to be more explicit.

If in a given case the removal of an exostosis or echondrosis gives sufficient space in the nasal chamber to ensure good respiration, and take off pressure, the accurate replacement of a septum to a straight line becomes an unnecessary, not to say painful, refinement.

The early methods employed for the correction of deviated septa had for their object the one idea of making the septum movable at its base, thus enabling the operator to push it over to the position he desired.

THE LONDON HOSPITAL AND HOSPITAL ABUSE.

The abuse of hospitals is one of the standing grievances of the general practitioner. That this discontent rests on a solid foundation can hardly be doubted by any candid onlooker acquainted with the facts of the case. The enormous attendance of out and in patients furnishes in itself sufficient internal evidence of the indiscriminate relief obtained at the great general hospitals throughout the kingdom. In spite of generations of complaint on the part of the medical profession the evil is growing by leaps and bounds, and has of late years been increased by the adoption of the pay system by various great general hospitals. Needless to say, the system of part payment is likely to multiply abuses by offering a salve to the conscience of well-to-do folk who might otherwise possibly entertain some lingering scruples as to the moral justification of their acceptance of alms intended for the sick poor. It is of some interest to ask why so little has been done to meet the demands of the general practitioner as regards the loss he sustains through the laxity of the hospital authorities in excluding well-to-do persons from the benefits of which they are the stewards. The causes are complex. First of all the medical charities and the medical profession do not work together. The hospitals are engaged in an internecine conflict and in efforts at self-aggrandisement. Many private and non-medical interests are wrapped up in these institutions, together representing an enormous annual expenditure of money. It is not too much to say that the aim—natural if not excusable—

of all such persons is to swell the funds of the individual hospitals and secure the maximum number of patients, regardless of the medical practitioners outside. It is a serious matter that this attitude is positively supported by the honorary medical staffs, who are induced to give their gratuitous services to many in and out patients perfectly well able to pay the moderate fees of the general practitioner. Much more might be written upon the subject, but the tale is somewhat trite, and its chief points have been familiar to generations of medical men. The great self-evident want is that of organization in all ranks of the profession for the purpose of common support and defence. The East End (London) Medical Association—a strong, local combination—has shown what can be done by firm and united action. For many years the administration of charity at the London Hospital has been called in question. The answer of the authorities has always been to ask for proof of abuse and to deny the existence of the same in general terms. The Society mentioned has furnished a number of cases of abuse of the London Hospital by well-to-do persons. The authorities of the hospital have acknowledged the existence of such abuse and have appointed an almoner to sift cases. The further suggestion, however, that medical men should come to the hospital to identify patients appears to be about as ridiculous and unpractical at it would be possible to expect even from a hospital committee. It is likely that from the circumstances of the case abuse at the London Hospital, situated as it is in the midst of a poor population, is less than at most of the great general hospitals of the Metropolis. Now that the ice has been broken and the first step toward justice and conciliation taken by the hospital authorities, it is to be hoped that in combination with the East End Medical Association they will readjust the relations of the London Hospital with neighboring practitioners. It is to be hoped, also, that the Association will be enabled to banish a system of patients' payments recently adopted at that hospital—a fact which, in our opinion, constitutes a serious blot upon a great charity. Since the publication of the London Hospital disclosures certain interviews, apparently authentic, have appeared in the daily newspapers. They purport to come from stewards and secretaries of other great London hospitals. For the most part they deny the existence of hospital abuse; one of those interviewed contrives to give a good advertisement of the pay wards in his own hospital; all ignore the general practitioner in contemptuous fashion. That is the kind of attitude to which medical reformers have become accustomed. It is only by extending organized attack all along the line that the general practitioner can ever hope to come into possession of his birthright, of which he is at present more or less deprived by hospital competition. The East End Medical Association should be the model and example of local societies throughout the United Kingdom.—*The Medical Press*.

*CONSTITUTION AND BY-LAWS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

CHARTER.

(Granted April 14, 1900.)

An Act to charter "The New York State Medical Association" for the purpose of the cultivation and advancement of the science of medicine, the promotion of public health, and the establishment of a death-benefit fund for the dependents of its members.

(Chapter 452 of the Laws of 1900.)

The People of the State of New York, represented in Senate and Assembly do enact as follows:

Organization.—Section 1. There shall be established by the physicians and surgeons named in Section 6 of this Act an organization styled "The New York State Medical Association," in one corporate body, for the purpose of the cultivation and advancement of the science of medicine, the promotion of public health, the establishment of a death-benefit fund for the dependents of its members, the maintenance of the honor and character of the medical profession and the establishment and furtherance of cordial professional relations and fellowship between the medical profession of the State of New York and the medical profession of other States of the United States and of foreign countries, through the medical associations and societies of such States and countries.

Legal Rights.—Sec. 2. "The New York State Medical Association" may and shall have perpetual succession, shall be capable of suing and being sued, of pleading and being impleaded, answering and being answered unto, defending and being defended, in all courts and in all causes whatsoever, and shall and may have a common seal which may be altered or renewed at the pleasure of the said Association.

Sec. 3. "The New York State Medical Association" may purchase, receive, hold and convey personal or real property and receive bequests and devices of personal or real property by will for an amount not exceeding one hundred thousand dollars.

Death-Benefit Fund.—Sec. 4. "The New York State Medical Association," reconstituted by virtue of this Act, may, in its discretion, establish for its members a death-benefit fund, and may include in its by-laws an article governing the establishment and distribution of the said death-benefit fund, and may form branches and subordinate county associations in the State of New York.

Governing Body.—Sec. 5. The superintendence and management of "The New York State Medical Association," reconstituted by virtue of this Act, shall be vested in a body known and styled the Council and Fellows of "The New York State Medical Association," which body shall have power to make and prescribe by-laws that shall govern its officers, Council, Fellows and

members; to establish the conditions of admission, dismissal, and expulsion of its members; to determine the amount of the annual dues and also to impose assessments from time to time on its members; to collect such dues and assessments by suit or otherwise; and to receive, hold, invest, or otherwise dispose of all moneys or other properties belonging to the said "The New York State Medical Association," and in general to make such by-laws, rules, and regulations for the proper government of the Association and of its branches and subordinate county associations as are not repugnant to the laws of the United States or of the State of New York.

Charter Members.—Sec. 6. The charter members of "The New York State Medical Association," reconstituted by virtue of this Act, shall be the following-named physicians and surgeons residing in the State of New York: D. Ayres, J. C. Bierwirth, L. J. Brooks, J. D. Bryant, H. D. Didama, C. E. Denison, E. D. Ferguson, J. M. Farrington, C. E. Fritts, C. H. Glidden, G. W. Goler, J. W. S. Gouley, E. E. Harris, N. H. Henry, J. G. Hunt, F. W. Higgins, W. E. Johnson, E. M. Lyon, E. M. Moore, D. C. Moriarta, M. C. O'Brien, DeLancey Rochester, B. T. Smelzer, E. H. Squibb, W. H. Thornton, M. W. Townsend, T. A. Wales, F. H. Wiggin, and their associates, consisting of all members in good standing in "The New York State Medical Association" founded in eighteen hundred and eighty-four, and reconstituted by virtue of this Act.

Primary Organization.—Sec. 7. The Council of "The New York State Medical Association" founded in eighteen hundred and eighty-four shall select the officers, Council, Committees, and Fellows of "The New York State Medical Association," reconstituted by virtue of this Act, from its charter members, who shall serve until the close of the annual meeting to be held in the Borough of Manhattan, in the City of and County of New York, in the month of October, nineteen hundred. All subsequent annual meetings shall be held in the City of New York.

Qualifications of Members.—Sec. 8. No physician or surgeon shall be qualified as a member of "The New York State Medical Association" until he shall have signed its by-laws and paid his first annual dues.

Assessments and Dues.—Sec. 9. The several District Branch and subordinate County Associations shall pay to the Treasurer of "The New York State Medical Association" all such dues and assessments as from time to time shall be laid by the Council and Fellows of "The New York State Medical Association."

Sec. 10. This act shall take effect immediately.

BY-LAWS.

(As amended October, 1902.)

ARTICLE I.—ORGANIZATION.

Composition.—Section 1. The New York State Medical Association shall be composed of

*Adopted at the twenty-first annual meeting, October 18, 1904.

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 their 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-officiis, 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 Publications, 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 minutes.
3. Communications from the Secretary.
4. Communications from the Treasurer.
5. Communications from the Chairman of Standing Committees.
6. Unfinished Business.
7. New Business.
8. Adjournment.

Vacancies in Elective Office. 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 Counsel 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 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 re-

ceive 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 their committee to inform itself of all proposed legislation in the Legislature of the State bearing on medical subjects, and to organize and to carry into effect, subject to the approval of the Council, such plans intended to influence legislative 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 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 or Southern District shall embrace the counties of Dutchess, Kings,

Nassau, New York, Orange, Putnam, Queens, Richmond, 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 county 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 stated visitations to such County Associations during the year, shall make himself familiar with the character and quantity 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.

Committees 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 Associa-

tion 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 Associations contemplated in the charter for their respective counties.

Formation.—Sec. 2. When the members of any District 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 election 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, and 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 corre-

sponding members shall be privileged only to take part in the scientific meetings, programs 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.

Application 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 when 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 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 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 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 privilege 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 Associations.—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.

Suspension of By-Laws—Sec. 2. Section 4 of Article III, and Section 3 of Article VI, of these By-Laws may be suspended by unanimous consent at any meeting of the Council and Fellows during such session only.

CHANGES OF ADDRESS.

NEW YORK CITY.

Boroughs of Manhattan and Bronx.

Dr. Joseph H. Abraham, removed to 616 Madison avenue, New York City.

Dr. Warren Stone Bickham, removed to 10 East 58th street, New York City.

Dr. Andrew J. Bilhoefer, removed to 108 West 119th street, New York City.

Dr. Frank A. Bryant, removed to 62 West 42d street, New York City.

Dr. Patrick Henry Fitzhugh, removed to 128 East 34th street, New York City.

Dr. John Randolph Graham, removed to 324 West 21st street, New York City.

Dr. Thomas Wood Hastings, removed to 43 East 58th street, New York City.

Dr. George Tremont Hunter, removed to 348 Madison avenue, New York City.

Dr. Solomon Horace Kempner, removed to 252 West 130th street, New York City.

Dr. Franklin Dana Lawson, removed to 7 West 42d street, New York City.

Dr. A. E. Macdonald, removed to 431 Riverside avenue, New York City, from Ward's Island.

Dr. Louis P. J. de Plasse, removed to 126 Lexington avenue, New York City.

Dr. Oran A. Province, removed to 66 West 46th street, New York City, from Blackwell's Island.

Dr. Sebastian Saladino, removed to 380 Broome street, New York City.

Dr. Preston Satterwhite, removed to 4 East 41st street, New York City.

Dr. G. A. De Santos Saxe, removed to 214 West 44th street, New York City.

Dr. Otto H. Schultze, removed to 44 West 44th street, New York City.

Dr. Thomas Allison Smith, removed to 57 West 75th street, New York City.

Dr. Thomas Madison Taylor, removed to Hotel Ansonia, Broadway and 73d street, New York City.

Dr. Paul E. Tiemann, removed to 41 West 71st street, New York City.

Dr. Terry M. Townsend, removed to 171 West 71st street, New York City.

Dr. Ferdinand C. Valentine, removed to 171 West 71st street, New York City.

Dr. Henry Wahn, removed to 638 Eagle avenue, New York City.

Dr. Z. Swift Webb, removed to 57 West 93d street, New York City.

Dr. Joseph Weinstein, removed to 40 West 115th street, New York City.

BOROUGH OF BROOKLYN.

Dr. Joseph Merzbach, removed to 198 Eighth avenue, Brooklyn.

Dr. Arthur R. Paine, removed to 379 Washington avenue, Brooklyn.

NEW YORK STATE.

Dr. Alva LeRoy Chapin, removed to corner Third and Niagara streets, Niagara Falls.

Dr. Mary Clayton, removed to Craig Colony, Sonyea, from Ogdensburg.

Dr. Louis R. Eichberg, removed to 30 Hamilton avenue, Yonkers, from New York City.

Dr. Jacob Outwater Polhemus, removed to Hotel Endicott, New York City, from Nyack.

Dr. Walter K. Quackenbush, removed to Albion, from Utica.

Dr. Worthington Seaton Russell, removed to North Tarrytown, from Highland Mills.

Dr. Samuel J. Sornberger, removed to 16 Church street, Cortland.

Dr. Eli H. Vail, to Churchville, from Barre Center.

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, Little Falls.
Vice-President—Seymour S. Richards, Frankfort.
Secretary—Edgar H. Douglas, Little Falls.
Committee on Publication—Edgar H. Douglas, William P. Earl, John L. Crofts.
Committee on Public Health—William D. Garlock, A. B. Santry, Charles H. Glidden.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—F. E. Lettice, Watertown.
Vice-President—Andrew J. Dick, Watertown.
Secretary—W. D. Pinsonault, Watertown.
Treasurer—Charles Campbell Kimball, Watertown.
Committee on Legislation—B. C. Cheeseman, F. R. Calkins.
Committee on Ethics, Discipline and Members—E. C. Minor, C. E. Pierce.

Second or Eastern District Branch.

President—Everard D. Ferguson, 1 Union pl., Troy.
Secretary and Treasurer—William L. Hogeboom, 2179 Fifth avenue, Troy.

ALBANY COUNTY MEDICAL ASSOCIATION.

President—William E. Lothridge, Verdoy.
Vice-President—Clement F. Theisen, Albany.
Secretary and Treasurer—Merlin J. Zeh, Watervliet.

COLUMBIA COUNTY MEDICAL ASSOCIATION.

President—Otis Howard Bradley, Hudson.
Secretary and Treasurer—Henry Warner Johnson, Hudson.

ESSEX COUNTY MEDICAL ASSOCIATION.

President—Velsona A. Marshall, Moriah.
Vice-President—Warren E. Pattison, Westport.
Secretary-Treasurer—Albert A. Wheelock, Elizabethtown.

RENSSELAER COUNTY MEDICAL ASSOCIATION.

President—Charles S. Allen, Rensselaer.
Vice-President—Matthew B. Hutton, Valley Falls.
Secretary and Treasurer—Frederick A. Smith, Troy.
Committee on Legislation—E. D. Ferguson, Chairman; William Finder, Jr., William L. Allen.

Third or Central District Branch.

President—Franklin J. Kaufmann, Syracuse.
Vice-President—Sherman Voorhees, Elmira.
Secretary—Clark W. Greene, Binghamton.
Treasurer—Frank Kenyon, Scipio.

BROOME COUNTY MEDICAL ASSOCIATION.

President—LeRoy D. Farnham, Binghamton.
Vice-President—John H. Martin, Binghamton.
Secretary—Clark W. Greene, Binghamton.
Treasurer—William H. Knapp, Binghamton.
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, F. Allen, John M. Farrington.

CORTLAND COUNTY MEDICAL ASSOCIATION.

President—Charles Depew Ver Nooy, Cortland.
Vice-President—Frank S. Jennings, Cortland.
Secretary—H. S. Braman, Homer.
Treasurer—Emory A. Didama, Cortland.

ONONDAGA COUNTY MEDICAL ASSOCIATION.

President—Franklin J. Kaufmann, Syracuse.
Vice-President—George A. Edwards, Syracuse.
Secretary—Charles B. Gay, Syracuse.
Treasurer—Alexander J. Campbell, Syracuse.
Committee on Legislation—A. D. Head.
Committee on Public Health—A. J. Campbell, C. B. Gay, F. O. Donohue.

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, Wellsville.
Vice-President—William Orson Congdon, Cuba.
Secretary and Treasurer—Horace L. Hulett, Allentown.

CATTARAUGUS COUNTY MEDICAL ASSOCIATION.

President—William H. Vincent, Hinsdale.
First Vice-President—Myron C. Hawley, East Randolph.
Second Vice-President—Charles P. Knowles, Olean.
Secretary and Treasurer—Carl S. Tompkins, Randolph.

LEWIS COUNTY ASSOCIATION.

President—Alexander H. Crosby, Lowville.
Vice-President—George H. Littlefield, Glenfield.
Secretary—Le Roy W. King, Lowville.
Treasurer—Charles R. Douglass, Lowville.
Committee on Legislation—I. D. Spencer, D. J. Culver, Le Roy W. King.
Committee on Public Health—F. M. Ringrose, M. S. Hadsall.
Committee on Membership—Le Roy W. King, I. D. Spencer, G. H. Littlefield.

ONEIDA COUNTY MEDICAL ASSOCIATION.

President—Charles B. Tefft, Utica.
Vice-President—Charles R. Mahady, Rome.
Secretary—J. Orley Stranahan, Rome.

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.

SARATOGA COUNTY MEDICAL ASSOCIATION.

President—Francis W. St. John, Charlton.
Vice-President—John Cotton, Burnt Hills.
Secretary—James T. Sweetman, Jr., Ballston Spa.
Treasurer—Dudley R. Kathan, Corinth.
Executive Committee—Frank Garbutt, Francis W. St. John, F. J. Sherman.
Committee on Membership, Ethics and Discipline—F. J. Sherman, Adelbert Hewitt, Edgar Zeh.

WARREN COUNTY MEDICAL ASSOCIATION.

President—Dudley M. Hall, Glens Falls.
Vice-President—William J. Hunt, Glens Falls.
Secretary and Treasurer—Frederick G. Fielding, Glens Falls.

Committee on Ethics and Discipline—B. S. Moore, A. S. Edwards, H. FitzG. Clark.
Committee on Credentials—F. J. Kaufmann, H. FitzG. Clark, F. O. Donohue.

OTSEGO COUNTY MEDICAL ASSOCIATION.

President—Julian C. Smith, Oneonta.
Vice-President—Sylvester G. Pomeroy, West Oneonta.
Secretary—Arthur H. Brownell, Oneonta.
Treasurer—Frank L. Winsor, Laurens.
Committee on Legislation—Andrew J. Butler, Marshall Latcher, Joshua J. Sweet.
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—George O. Bellows, Waterloo.
Secretary—J. Spencer Purdy, Seneca Falls.
Treasurer—Carroll B. Bacon, Waterloo.

TOMPKINS COUNTY MEDICAL ASSOCIATION.

President—William C. Douglass, Ithaca.
Vice-President—E. R. Osterhout, Trumansburg.
Secretary and Treasurer—Howard B. Besemer, Ithaca.
Executive Committee—Arthur White, C. P. Bigg, M. A. Dumond.

CHAUTAQUA COUNTY MEDICAL ASSOCIATION.

President—Era M. Scofield, Jamestown.
First Vice-President—Vacil D. Bozovsky, Dunkirk.
Second Vice-President—Benjamin S. Swetland, Brocton.
Secretary and Treasurer—Henry A. Eastman, Jamestown.
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—W. N. Bemus, J. W. Morris, E. A. Scofield.

ERIE COUNTY MEDICAL ASSOCIATION.

President—Carlton C. Frederick, Buffalo.
Vice-President—Arthur G. Bennett, Buffalo.
Secretary—David E. Wheeler, Buffalo.
Treasurer—Adolph H. Urban, Buffalo.
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, Oakfield.
Vice-President—William A. Macpherson, Le Roy.
Secretary and Treasurer—C. Louise Westlake, Le Roy.
Committee on Legislation—A. F. Miller, B. F. Showerman, W. D. Johnson.
Committee on Ethics and Discipline—B. F. Neal, W. A. Macpherson.

Committee on Public Health—C. D. Graney, F. L. Stone.

MONROE COUNTY MEDICAL ASSOCIATION.

President—Thomas Augustine O'Hare, Rochester.
Vice-President—Edward Mott Moore, Rochester.
Secretary and Treasurer—James Clement Davis, Rochester.
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.

NIAGARA COUNTY MEDICAL ASSOCIATION.

President—Charles N. Palmer, Lockport.
Vice-President—William Q. Huggins, Sanborn.
Secretary—Alva Le Roy Chapin, Niagara Falls.
Treasurer—Frank Guillemont, Niagara Falls.
Executive Committee—F. J. Baker, A. N. Moore, B. F. Dennis.
Committee on Legislation—C. E. Campbell, A. N. Moore, W. Q. Huggins.
Committee on Ethics—Membership and Discipline, W. R. Campbell, C. L. Preisch, H. H. Mayne.

Fifth or Southern District Branch.

President—Henry Van Hovenberg, 195 Wall Street, Kingston.
Secretary—Charles Demarest Kline, 39 North Broadway, Nyack.
Treasurer—Henry A. Dodin, 1194 Washington Avenue, New York.

DUTCHESS COUNTY MEDICAL ASSOCIATION.

President—Irving D. LeRoy, Pleasant Valley.
Vice-President—Guy Carleton Bayley, Poughkeepsie.
Secretary—John W. Atwood, Fishkill-on-Hudson.
Treasurer—Louis Curtis Wood, Poughkeepsie.

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.
Vice-President—Arthur C. Brush, 29 South Portland Avenue.
Recording Secretary—Frank C. Raynor, 54 Livingston Street.
Corresponding Secretary—George F. Maddock, 80 McDonough Street.

Treasurer—Edward H. Squibb, P. O. Box 760.
Executive Committee—James Cole Hancock, Hubert Arrowsmith, L. Grant Baldwin.

Committee on Public Health and Medical Charities—Louis C. Ager, Chairman, Silliman Place and Third Avenue; Charles B. Bacon, Thomas A. McGoldrick, William H. Shepard.
Committee on Ethics and Discipline—John D. Sullivan, Chairman, 74 McDonough Street; William H. Biggam, William B. Brinsmade, Homer E. Fraser, James W. Ingalls.
Committee on Legislation—Charles P. Gildersleeve, Chairman, 18 Schermerhorn Street; 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.

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The New York State Journal of Medicine.

Published Monthly by The New



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EDITORIAL COMMUNICATIONS.

Articles for publication under Editorial Communications must be accompanied by the name of the author. No name will be used in the publication unless requested by the writer. All such articles can be sent to Dr. C. E. Denison, 68 West 71st street, New York City.

NATIONAL INCORPORATION.

A BILL

To Incorporate the American Medical Association.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That Robert M. O'Reilly, doctor of medicine, Washington, District of Columbia; Presley M. Rixey, doctor of medicine, Washington, District of Columbia; Walter Wyman, doctor of medicine, Washington, District of Columbia; E. H. Gregory, doctor of medicine, Saint Louis, Missouri; Henry O. Marcy, doctor of medicine, Boston, Massachusetts; Nicholas Senn, doctor of medicine, Chicago, Illinois; George M. Sternberg, doctor of medicine, Washington, District of Columbia; J. M. Matthews, doctor of medicine, Louisville, Kentucky; W. W. Keen, doctor of medicine, Philadelphia, Pennsylvania; C. A. L. Reed, doctor of medicine, Cincinnati, Ohio; J. A. Wyeth, doctor of medicine, New York, New York; Frank Billings, doctor of medicine, Chicago, Illinois; J. H. Musser, doctor of medicine, Philadelphia, Pennsylvania; T. J. Happel, doctor of medicine, Trenton, Tennessee; Miles F. Porter, doctor of medicine, Fort Wayne, Indiana; E. E. Montgomery, doctor of medicine, Philadelphia, Pennsylvania; W. W. Grant, doctor of medicine, Denver, Colorado; H. L. E. Johnson, doctor of medicine, Washington, District of Columbia; A. L. Wright, doctor of medicine, Carroll, Iowa; William H. Welch, doctor of medicine, Baltimore, Maryland; M. L. Harris, doctor of medicine, Chicago, Illinois; Philip Marvel, doctor of medicine, Atlantic City, New Jersey, and Lewis S. McMurtry, doctor of medicine, Louisville, Kentucky, and their suc-

cessors, and those who may be associated with them, are hereby made and constituted a body politic and corporate by the name American Medical Association, with perpetual succession and power to take, for the purposes of its incorporation, by devise, bequest, grant, gift, purchase, or otherwise, and hold or convey, both real and personal property and transact business anywhere within the United States.

Sec. 2. That the object and purpose of such corporation shall be to promote the science and art of medicine and the public health throughout the United States.

Sec. 3. That such corporation shall have power to make by-laws, rules, and regulations, and choose officers for its government and the attainment of its purposes.

A COMMUNICATION FROM THE CHAIRMAN OF THE COMMITTEE ON INCORPORATION OF THE A. M. A.

32 West 48th Street.

NEW YORK, Jan. 19, 1905.

Dear Doctor—The bill providing for national incorporation of the A. M. A. [H. R. 17,335] is now in the Judiciary Committee of the House, and will soon come up for final action.

Thirty-four States, the District of Columbia, and the Indian Territory have already requested that the bill receive favorable consideration, and additional appeals of a similar nature are consequently coming to hand.

The phraseology of the bill is substantially the same as that of the one already forwarded to you. However, later it may be deemed wise to make minor constructive changes in the wording to obviate technical objections that may arise. In no event, however, will the expressions relating to the powers conferred by incorporation be modified by the Committee of the A. M. A.

You will please at once, and also from time to time, telegraph and write, and otherwise appeal to the representatives of your State in the House and Senate, to the members of the Judiciary

Committee of the House and Senate, and to all interested and influential persons, urging their prompt and vigorous support of the measure to the end that enactment of the bill shall take place during the present term of Congress, *i. e.*, before March 1, 1905.

Prompt and repeated action is essential to fix and hold the attention of the law-makers and stimulate their action at this time.

Yours very sincerely,

JOSEPH D. BRYANT, Chairman.

32 West 48th Street.

NEW YORK, Jan. 23, 1905.

Dear Dr. Simmons—In accordance with your gracious request, I beg to forward a brief letter for publication relating to national incorporation of the A. M. A. by a special act of Congress.

As you well know, the membership of the A. M. A., now already quite large, is rapidly increasing, because of a keen appreciation of the policy of its thoroughgoing organization, stimulated by patriotic desire on the part of the members of the medical profession to assume the responsibilities that properly belong, as good citizens, to their lot in the conduct of human affairs.

The contributing to the sanitary welfare of the country, by means of careful and scientific surveillance and by directing influences in all public matters relating to the domains of medical thought and activity, is the plain duty of medical men, whose compliance therewith, each citizen should demand and no physician should refuse.

The mutual recognition on the part of all concerned of the great gain that would follow hearty reciprocal action in all such matters, will enhance immeasurably business stability and professional station. It should be quite well understood by all thoughtful citizens that the people of our country and its dependencies are now subject to nearly every disease that inflicts mankind. It is of course plain to medical minds that the causes of the inception and of the spread of disease are dissimilar in every essential respect from the causes of all other results of human intercourse; and that disease is more destructive of human aims and ambitions than are earthquakes and wars. The causes of disease are frequently unfathomable, the spread is most insidious and often of speculative limit. Disease exists everywhere in our land, moving from place to place, and exacting human offerings from all classes, regardless of geographic limit, and often in spite of all local efforts of restraint. Therefore, it seems to the members of our profession, that the domain and the opportunities of the forces opposing disease should be at the least co-equal in all respects to those of the tireless foe, so that the struggle may be unhindered by geographic lines and a corresponding multiplicity of confusing advice and effort, as is now too often the case.

National incorporation will increase the dignity and power of the National organization in its

labors for the public weal, and for professional attainment. It will facilitate and properly direct the transaction of its corporate business, and give to the organization increased status in human affairs—a status commensurate with the unlimited time and unstinted effort gladly given for the relief of human suffering and the betterment of public affairs by a large body of professional men, each of whom cheerfully bows in humble obedience to the laws of the country, and willingly imperils his life in serving the country's interests, in opposing alike the foes of health and good order, and of national perpetuity.

The great desire on the part of the officers and members of the A. M. A. for such incorporation is emphatically indicated by the unanimous passage by the House of Delegates of the Association at the meeting held June, 1904, of the following resolution:

“Resolved, That the officers and members of the House of Delegates of the American Medical Association now in session at Atlantic City, do hereby pledge their loyal support and earnest effort in aid of securing national incorporation of the American Medical Association by a special act of Congress.”

This earnest and unreserved desire was further signalized at that time by the House of Delegates in a petition signed by the officers of the A. M. A. and by the members of the House of Delegates representing the A. M. A. of all parts of the country addressed to the “Gentlemen of the Judiciary Committee of the Senate and House of Representatives of the United States of America” requesting the speedy enactment of a bill providing for national incorporation of the A. M. A.

Since then similar petitions have been forwarded to the Committee on National Incorporation from thirty-four States, and the District of Columbia, and a Territory of the U. S. A., expressive of the desire for national incorporation.

Similar expressions from like sources are coming almost daily to the Committee on Incorporation. When one considers the extent of the field of operation, the comparative shortness of the available time, together with the hindrance to efforts in this direction because of the onerous and ever present demands on the physician, it seems to the committee that the desire for national incorporation of the A. M. A. is without gainsay.

Yours very sincerely,

JOSEPH D. BRYANT,
Chairman of the Committee.

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COMMITTEE ON LEGISLATION.

E. Eliot Harris, Chairman.

In accordance with the resolution passed at the last annual meeting, the Committee on Legislation is empowered to continue the work of securing the enactment of a law which will abolish the office of Coroner of the city of New York. The Committee asks for the cooperation of the medical profession to assist in placing the following bill upon the statute books of 1905:

AN ACT

Introduced by Senator Elsberg, to amend the Greater New York charter, providing for the appointment by the Board of Health of the city of New York, of 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 upon the expiration of the terms of office of the Coroners now in office in said city, and providing for the performance of the powers and duties exercised by the coroners in such city.

Section 1242. Office of Coroner abolished.—Upon the termination of the terms of office of the Coroners now in office with the city of New York by the expiration of such terms of office, the office of Coroner in the various boroughs in the city of New York shall be abolished, and the terms of office of all officers, clerks, and subordinates appointed by such Coroners, except the incumbents of clerical positions in said Coroner's office who are on the classified competitive civil

service list, shall cease and determine with the expiration of the terms for which such Coroners were elected.

Sec. 1243. Appointment of a chief medical examiner and of medical examiners by Board of Health; assistants for bureau of medical examiners.—On or before January first, nineteen hundred and six, the Board of Health of the city of New York shall appoint, after a special civil service examination to be held therefor, 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 bacteriologist and pathologist, and who shall have practiced his profession in the State of New York at least five years; 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 three 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 at the time such appointment shall be made and thereafter shall be appointed from among those standing highest upon an eligible list prepared by the civil service commission after a competitive examination especially held for such office. 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.

WANT TO KEEP THE CORONERS.

Brooklyn Republicans Oppose Elsberg's Bill.

The Kings County Republican Executive Committee met at the Joralemon street headquarters, Brooklyn, yesterday afternoon. Ex-Lieut.-Gov. Timothy L. Woodruff was present and had a long discussion with the members regarding legislation and the distribution of patronage. The result of the conference was that the Republican Senators and Assemblymen from Kings County are to be requested to do all in their power to defeat Senator Elsberg's Medical Inspectors bill.

This bill if passed will wipe out the present Coroner's offices and will substitute instead medical inspectors. The Kings County Republicans believe the bill is not popular, and besides that they believe next fall they will be able to elect two Republican Coroners in Brooklyn.—New York Sun.

AN ACT

To amend the public health law and the acts amendatory thereof, in relation to pharmacy. Introduced by Mr. McKeown, in the Assembly—read once and referred to the Committee on Public Health.

AN ACT

To amend the tax law, in relation to the exemption of the property of certain pharmaceutical societies situated in cities of the first class. Introduced by Mr. Cotton, in the Assembly—read once and referred to the Committee on Taxation and Retrenchment.

AN ACT

To amend section twenty-seven hundred and twenty-nine of the code of civil procedure relative to the payment by executors and administrators of funeral expenses of, and charges for nursing, medical and surgical treatment and medicines, rendered and furnished a decedent. Introduced by Mr. Newton, in the Assembly—read once and referred to the Committee on Codes.

AN ACT

To establish a State veterinary college for the eastern portion of the State, at New York University of the city of New York and to provide for the administration thereof. Introduced by Mr. Hartman—read once and referred to the Committee on Ways and Means.

AN ACT

To enable the Medical College Laboratory of the city of New York to convey and transfer its real and personal property. Introduced by Senator Elsberg—read twice and ordered printed, and when printed to be committed to the Committee on Judiciary.

AN ACT

In relation to the sale of proprietary medicines. Introduced by Mr. Platt—read once and referred to the committee on Public Health.

Section 1. No drug, medicine or mixture of drugs, herbs or medicines, commonly known as patent or proprietary medicine, shall be sold, offered or exposed for sale in this state, unless an analysis or formula specifying the ingredients thereof and the quantity of such ingredients is plainly printed upon the label of the bottle or package containing such medicine, and also upon the outside wrapper of the packages containing the same.

Sec. 2. Every person who shall print upon the label of any bottle or package, or upon the outside wrapper thereof a false analysis or formula showing the ingredients or quantity of ingredients of any patent or proprietary medicine, as required by this act, or who shall sell, offer or expose for sale any such patent or proprietary medicine, without such analysis or formula, showing the ingredients and the quantity thereof in any patent or proprietary medicine, as required by this act, shall be guilty of a misdemeanor, pun-

ishable by imprisonment for not less than one month nor more than six months, or by a fine of not less than fifty nor more than five hundred dollars, or by both such fine and imprisonment.

AN ACT

To provide for the treatment of persons, residents of the city of New York, male and female, in the city of New York, who are habitually intoxicated or who are found guilty of intoxication or who become incompetent or dangerous from the use of alcoholic stimulants, opiates, narcotics or drugs of any description. Introduced by Mr. McManus—read once and referred to the committee on Affairs of Cities.

Section 1. There shall be provided by the city of New York a suitable hospital building, with all the necessary accommodations, a staff of competent physicians and surgeons, attendants, and necessary equipment, to treat persons, male and female, who are habitually intoxicated, or who are found guilty of intoxication, incompetent or dangerous from the use and effect of alcoholic stimulants, opium, chloral, cocaine, or other narcotics or stimulating drugs.

Sec. 2. The mayor of the city of New York shall appoint three competent physicians and surgeons, skilled in the treatment of the disease brought on by the inordinate use of alcoholic stimulants and other stimulating drugs. One of said physicians so appointed is designated as physician in chief, who shall have full charge of said hospital and receive an annual salary of six thousand dollars; the two other physicians so appointed shall each be designated as assistant physicians shall each receive an annual salary of five thousand dollars, which shall be paid to them in monthly instalments by the city of New York as hereinafter provided.

Sec. 3. The hospital building provided for in this act shall be constructed and arranged so that the sexes shall be separate and apart from each other.

Sec. 4. Suitable and competent attendants, aids, nurses and assistants required in the administration of the business and conduct of the affairs of said hospital shall be appointed from time to time as shall be necessary, by the said three physicians with the approval of the mayor.

Sec. 5. The board of estimate and apportionment in the city of New York shall take and set aside from the excise moneys received by them or under their control in the city of New York and in the counties of the city of New York, a sum of money adequate to secure a proper site and erect thereon a building, furnish and equip the same in the most approved and scientific manner; and when the same shall have been made ready for occupancy, the said board of estimate and apportionment shall also take and set aside from the aforesaid excise moneys so received as aforesaid, each and every year, such sum as is necessary to pay the salaries of the said physicians and employees so to be appointed, and also

for the payment for all the supplies required, repairs of said hospital building and grounds, medicines, apparatus and the necessary improvements on said building and grounds that may be required from time to time.

Sec. 6. Commitment to said hospital may be made by any city magistrate in the city of New York, or by a justice of the supreme court in said cities for a period of time not to exceed one year. Such commitment shall be made on the sworn application in writing before said magistrate or justice, either by the father, mother, husband, wife, brother or sister, next friend or child of such person to be committed, or the guardian of such child or by said city magistrate, where a person has been found guilty of public intoxication, and said magistrate is satisfied that it would be for the welfare of such person. The magistrate or justice shall make a written or printed commitment of said person so charged as aforesaid to said hospital, for a period not to exceed one year. The superintendent, the physician or person in charge of said hospital shall receive the person committed by said city magistrate or justice and render to such person or persons all the necessary care, treatment and medical attendance required.

FOODS AND DRUGS.

AN ACT

For preventing the adulteration or misbranding of foods or drugs, and for regulating traffic therein, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

DEFINITIONS.

SECTION 5. That the term "drug," as used in this Act, shall include all medicines and preparations recognized in the United States Pharmacopœia for internal or external use. The term "food," as used herein, shall include all articles used for food, drink, confectionery, or condiment by man or domestic animals, whether simple, mixed, or compound. The term "misbranded," as used herein, shall apply to all drugs, or articles of food, or articles which enter into the composition of food, the package or label of which shall bear any statement regarding the ingredients or substances contained in such article, which statement shall be false or misleading in any particular, and to any food or drug product which is falsely branded as to the State, Territory, or country in which it is manufactured or produced.

ADULTERATIONS.

SEC. 6. That for the purposes of this Act an article shall be deemed to be adulterated—

In case of drugs:

First. If, when a drug is sold under or by a name recognized in the United States Pharmaco-

pœia, it differs from the standard of strength, quality, or purity, as determined by the test laid down in the United States Pharmacopœia official at the time of the investigation.

Second. If its strength or purity fall below the professed standard under which it is sold.

Third. If it be an imitation of or offered for sale under the name of another article.

In the case of confectionery:

If it contain terra alba, barytes, talc, chrome yellow, or other mineral substances or poisonous colors or flavors, or other ingredients deleterious or detrimental to health.

In the case of food:

First. If any substance or substances has or have been mixed and packed with it so as to reduce or lower so as to thereby injuriously affect its quality or strength.

Second. If any substance or substances has or have been substituted wholly or in part for the article.

Third. If any valuable constituent of the article has been wholly or in part abstracted.

Fourth. If it be an imitation of or offered for sale under the distinctive name of another article.

Fifth. If it be mixed, colored, powdered, or stained in a manner whereby damage or inferiority is concealed.

Sixth. If it contain any added poisonous ingredient which may render such article injurious to health.

Seventh. If it be labeled or branded so as to deceive or mislead the purchaser, or purport to be a foreign product when not so.

Eighth. If it consists in whole or in part of a filthy, decomposed, or putrid animal or vegetable substance, or any portion of an animal unfit for food, whether manufactured or not, or if it is the product of a diseased animal, or one that has died otherwise than by slaughter: *Provided*, That an article of food which does not contain any added poisonous or deleterious ingredients shall not be deemed to be adulterated in the following cases:

In the course of his remarks on quackery, Dr. McCormack said: "The support of the church press constitutes the backbone of quackery in this country." While we do not concede this to be the case with reference to the itinerant quack, it does hold good in the cast of most advertised medicines. The authoritative statement has come to us that many of the ministers whose names and pictures are scattered broadcast in laudation of alcohol-containing medicines, are subsidized in cash or kind for their testimonials. Many barrels of bad whiskey are foisted upon the public, under the tonic label, by the recommendation of clergymen, who, from their ignorance of the immediate inspiring effect of alcoholics, attribute the phenomenon to tonic rather than stimulating qualities.—*Wisconsin Med. Journal*.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

DISTRICT BRANCH MEETING.

Fifth District Branch, special meeting Thursday, February 2d, at Newburgh, at 2 P. M.

COUNTY ASSOCIATION MEETINGS FOR FEBRUARY.

Orange County, Wednesday, February 8th.
Tompkins County, Tuesday, February 14th.
Cortland County, Friday, February 17th.
New York County, Monday, February 20th.
Onondaga County, Monday, February 20th.
(Annual.)
Ulster County, Monday, February 20th.
(Annual.)
Lewis County, Tuesday, February 28th.
Monroe County, Tuesday, February 28th.
(Annual.)

FIFTH DISTRICT BRANCH ASSOCIATION.

Special Meeting Held at the Palatine Hotel, Newburgh, N. Y., Thursday, Feb. 2, 1905, at 2 P. M.

West Shore train leaves New York, 42d street, 11.35 A. M.

New York Central train leaves New York, Grand Central, 11.15 A. M.

West Shore train leaves Newburgh, 5.32 P. M.

New York Central train leaves Fishkill Landing, 5.11 P. M.

ORDER OF BUSINESS.

Collation at 1 P. M.

Calling the meeting to order.

SCIENTIFIC SESSION.

1. "Inertia Uteri," Joseph Brown Cooke, M.D. Discussion opened by George P. Shears, M.D.

2. "How Should We Handle Chronic Deformities from the Commonest of all Major Fractures (Colles)," Robert H. M. Dawbarn, M.D. Discussion opened by John A. Bodine, M.D.

3. "Some Considerations in the Treatment of Various Cardiac Conditions," Alexander Lambert, M.D. Discussion opened by Samuel W. S. Toms, M.D.

MEETING OF THE COUNCIL OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Held at the Business Office, 64¹/₂ Madison Avenue, New York, on Thursday, Jan. 5, 1905, at 3.30 P. M.

President Dr. J. Riddle Goffe presided. The following members of the Council answered to roll call:

Drs. Goffe, A. A. Jones, Redfield, Baldwin,

Loughran, Denison, Harris, Ager, Lambert, Van Hoesenberg and Townsend.

The minutes of the meeting of the Council held October 19, 1904, were read by the secretary and approved as read.

The secretary read the following communications:

Letter from Dr. D. M. Hall, of Memphis, Tenn., requesting the withdrawal of his name for non-resident membership. Letter from Dr. George Ames, of Kalamazoo, Mich., relating to non-resident membership.

The treasurer, Dr. F. A. Baldwin, reported a balance in the treasury of the Association January 5, 1905, of \$1,216.06, part of which represented dues collected for 1905.

Dr. Loughran, chairman, Committee on Arrangements, reported progress, but wished to get an expression of the views of the members as to which class of scientific programs would best advance the interest of those who attend, *i. e.*, isolated papers or a symposium on a given topic. It was decided after some discussion by Drs. Lambert, Jones, Denison and others, that a symposium on some subject was preferable, and that it was wise to get an authority on a given subject to present the papers.

Dr. Harris, in discussing the question of the advertisements in THE NEW YORK STATE JOURNAL OF MEDICINE, stated that he had sent the following letter to the Committee on Publication of the several States publishing medical journals, and all the answers were favorable except Wisconsin.

Dear Sirs—The Committee on Publication of The New York State Medical Association has referred to me the answers received from the advertisers in THE NEW YORK STATE JOURNAL OF MEDICINE, with power to adjust the questions contained in them. We demand authority to publish the quantity of the active ingredients of all the internal and external medicines, and the elimination of so-called extravagant statements from the copy submitted by the advertiser.

I am herewith sending you a copy of the answers received from our advertisers, in the hope that the several State societies publishing medical journals will be able to agree upon a definite criterion for the admission and rejection of advertisements from its pages.

There are now published in the United States, by State societies, twelve medical journals, as follows:

California State Journal of Medicine, Colorado Medicine, Journal of the Kansas State Medical Society, Journal of the Medical Society of New Jersey, Journal of the Michigan State Medical Society, Journal of the Mississippi State Medical Society, Journal of the Missouri State Medical Society, Kentucky State Medical Journal, THE NEW YORK STATE JOURNAL OF MEDICINE, Pennsylvania Medical Journal, Wisconsin Medical Journal, and the Washington Medical Annals.

You can readily understand that our committee would be able to do better in a conference with the exploiters of certain proprietary mixtures, if it is backed by all the societies publishing medical journals; therefore, first, do you agree to publish no advertisement of an internal or an external remedy unless the quantity of its active ingredients be published?

Second, do you agree to edit the copy submitted, and eliminate all so-called extravagant statements from it?

Third, do you agree that the journals should introduce to its members through its advertising pages only those firms whose reputation for commercial integrity is such that their preparations will prove to be what they are represented to be?

Fourth, do you agree to keep alive in your journal the question of ethical advertisements, so that the medical profession shall some day demand sworn statements of the quantity of the active ingredients of all internal and external medicines, advertised in medical journals?

The above is merely suggestive, in the hope that by cooperation an organized and a united effort may be made to separate legitimate commercial interests in drugs and medicines from the illegitimate commercial interests of the nostrum vendors; the medical profession directing its influence toward the first and against the second. Even from an imperfect beginning, something better and higher may be evolved.

Your immediate answer is much desired by
Yours very truly,

E. ELIOT HARRIS.

Dr. Lambert, chairman of Library Committee, reported that he had carefully reviewed the volumes now in the library and did not think that the plan of a circulating library was feasible as the cost of the work would be too great in comparison with the value of the books.

Under the head of unfinished business the Council took up the letter of Mr. Lewis, counsel for the Association, in which he requested a new contract for the eleven months from February 1, 1905, to December 31, 1905. After discussion of the matter by Drs. Jones, Harris, Ager, Loughran and others, Dr. Lambert offered the following resolution:

"That the matter of a new contract with the counsel, Mr. James Taylor Lewis, be referred to the Finance Committee, with power." Seconded by Dr. Harris; carried.

Moved by Dr. Ager, seconded by Dr. Lambert:

"That the counsel for the Association be required to give the names of complainant and defendant of the suits for malpractice during each year, and the disposition of said cases." Carried.

The following communication was read:

Jan. 4, 1905,

Guy D. Lombard, Secretary New York State Medical Association:

Dear Sir—At a meeting of the Rensselaer

County Medical Association, held January 3, 1905, the following was adopted:

Resolved, That in view of the fact that assurance has been given that the ethical principles will be so placed before the profession of the State that we may expect proper consideration of the subject, the Rensselaer County Medical Association withdraws its objection to the amalgamation of the two State medical organizations.

Yours truly,
(Signed) F. A. SMITH, M.D.,
Secretary.

Dr. Harris moved that the letter from Rensselaer County Medical Association regarding the withdrawal of objections to the amalgamation of the two State organizations be received and placed on file. Seconded by Dr. Denison. Carried.

The resignation of Dr. Morris G. White as a member of the Committee on Arrangements was accepted. Dr. Loughran proposed the name of Dr. S. J. Kopetzky in place of Dr. White. Seconded by Dr. Ager. Carried.

Dr. Denison reported the resignation of Dr. Francis J. Quinlan from the Committee on Publication and proposed the name of Dr. William R. Stone in his place. Unanimously carried.

The letter from Franklin County Medical Society regarding the prevention of tuberculosis was referred to the Committee on Public Health.

SARANAC LAKE, N. Y., Dec. 10, 1904.

Dr. Charles I. Redfield, Secretary State Medical Association, Middletown, N. Y.:

Dear Sir—At a special meeting of the Medical Society of Franklin County, N. Y., held at Saranac Lake, December 8, 1904, the following resolutions were unanimously adopted:

Resolved, That this Society respectfully requests that the State Commissioner of Education urgently consider the advisability of public-school instruction in the necessary hygiene for the prevention of tuberculosis; and it was further

Resolved, That a copy of the above resolution be sent to the New York State Commissioner of Education, to the New York State Commissioner of Health, to the New York State Medical Society, to the New York State Medical Association and to the National Association for the Prevention of Tuberculosis.

(Signed) GEO. M. ABBOTT, Secretary.

Dr. Ager moved that the Finance Committee be required to furnish a statement of the finances of the Association to the Council at the end of the year. Seconded and carried.

Moved by Dr. Loughran, seconded by Dr. Ager, "That two new members of the Finance Committee be appointed by the President." Carried.

The President appointed as such new members, Drs. Lambert and Townsend.

Under the head of new business, the secretary stated that several counties in the State were not in conformity with the by-laws in respect to the time of the holding of their annual meetings and

that he had already written one county regarding the matter, but had as yet received no answer. The secretary was instructed by the Council to communicate with any county not in conformity with the by-laws and call attention to the discrepancy.

(Signed) CHARLES I. REDFIELD, Secretary.

Broome County Association.—The quarterly meeting of this Association was held at the office of Dr. John G. Orton, Binghamton, Tuesday, January 10th, at 10.30 A. M. The president, Dr. Farnham, called the meeting to order. The secretary read the minutes of the previous meeting. The meeting was well attended, twelve members being present.

In the scientific session Dr. J. C. Lappeus read a paper on "The Treatment of Pneumonia," which was discussed by nearly every member present. Dr. L. A. Walker read a paper on "Urinary Calculi."

CLARK W. GREENE, Secretary.

* * *

Chautauqua County Association.—The annual meeting of this Association was held at the Humphrey House, Jamestown, on Tuesday, January 17th. There was the largest attendance in the history of the organization, there being thirty present. The following officers were elected for the ensuing year: President, Vacil D. Bozovsky, Dunkirk; first vice-president, Benjamin S. Swetland, Brocton; second vice-president, Morris N. Bemus, Jamestown; secretary and treasurer, Henry A. Eastman, Jamestown; Fellows, William M. Bemus, George F. Smith, John A. Weidman; Alternates, Walter Stuart, C. S. Cleland, Thomas D. Strong; member of the Nominating Committee of the Fourth District Branch, Era M. Scofield; Alternate, Earl A. Scofield; member of the Executive Committee, H. F. Hunt.

Dr. Charles G. Fisher, Stockton, was elected to membership.

In the scientific session, papers were read by Drs. E. M. Scofield, J. H. Kellogg, H. F. Hunt, B. S. Swetland, M. N. Bemus, which were discussed by the members present.

The next meeting will be held at Dunkirk, the last Tuesday in May.

HENRY A. EASTMAN, Secretary.

* * *

Columbia County Association.—The annual meeting was held at the office of Dr. Henry W. Johnson, Hudson, on Tuesday, January 17th. There were present Drs. Bradley, Wilson, Woodworth, Johnson, Rossman, Bruce and Walker.

The following officers were elected for the ensuing year: President, Otis Howard Bradley, Hudson; vice-president, Eloise Walker, Hudson; secretary and treasurer, Hortense V. Bruce, Hudson; Fellow, T. Floyd Woodworth; Alternate, Henry W. Johnson.

In the business session the minutes of the pre-

vious meeting were read and approved. The report of the treasurer was read and accepted.

On motion, duly carried, a committee was appointed by the president to draft suitable resolutions on the death of Dr. Crawford E. Fritts, president of the Association in 1904. A motion to approve of the efforts of The New York State Medical Association toward unification with the Medical Society of the State of New York was carried.

HORTENSE V. BRUCE, Secretary.

* * *

Kings County Association.—At an executive meeting of this Association, held at the house of the President on Tuesday, January 10th, amendments to the By-Laws were drawn up. It was formally voted to hold three meetings during the coming year, in April, October and January.

LOUIS CURTIS AGER, Secretary.

* * *

New York County Association.—The stated meeting for the month of January was held at the Academy of Medicine, 17 West 43d street, on Monday evening the 16th.

Meeting was called to order at 8.35 P. M. Dr. Francis J. Quinlan, president, in the chair.

The following is a list of the candidates who were elected to membership in the Association:

A. M. Fernandez-Ybarra, M.D., 302 Second avenue.

Walter C. Gilday, M.D., 32 West 36th street.

Frederic Grosvenor Goodridge, M.D., 332 Lexington avenue.

Johannes Walter Wilhelm Hoving, M.D., 726 East 138th street.

James Lee, M.D., 235 East 124th street.

Oran A. Province, M.D., 66 West 46th street.

F. Conger Smith, M.D., 362 West 57th street.

George La Breche Smith, M.D., 318 West 91st street.

Joseph C. Taylor, M.D., 32 West 36th street.

The scientific session began at 8.50 with the reading of the first paper by Walter Wyman, M.D., Surgeon-General of the Public Health and Marine Hospital Service of the United States, under the title, The Health of the Nation.

The second paper of the evening was upon the Health of the State, read by Daniel Lewis, M.D., Commissioner of Health, State of New York.

The third paper of the evening, entitled The Health of the City, was read by Dr. Thomas Darlington, Commissioner of Health, City of New York.

The final paper of the evening was read by Dr. Chas. E. Denison, in the absence of the author, Dr. Alvah H. Doty, health officer, Port of New York.

The title of the paper is the Health of the Port of New York. These papers will appear in State Journal in the next issue.

On motion, duly seconded, the meeting adjourned at 10.45 P. M.

WM. RIDGELY STONE, Secretary.

Niagara County Association.—The annual meeting of this Association was held at Lockport on Tuesday, January 10th.

The meeting was called to order by the president, Dr. C. N. Palmer, who gave a short address on the success and progress of the Association during the past year, at the conclusion of which, he introduced the speaker of the day, Hon. Tracy C. Becker, of Buffalo, his subject being Legal Aspect of Railway Shock. The paper was a most excellent one, as the speaker has devoted much time and attention to the study of this subject. The discussion which followed was both interesting and instructive, being opened by Judge Hickey, of Lockport, and continued by members of the legal and medical profession. At the conclusion of the discussion a vote of thanks was tendered Hon. Tracy C. Becker. Following which, came the annual business meeting and election of officers for the ensuing year.

President, Frank Guillemont, Niagara Falls; vice-president, A. N. Moore, Lockport; secretary, Will H. Potter, Niagara Falls; treasurer, C. L. Priesch, Lockport; Fellows, A. N. Moore, Frank Guillemont, F. J. Baker; Alternates, C. N. Palmer, W. Q. Huggins, A. L. Chapin; member of Nominating Committee, Fourth District Branch, W. Q. Huggins; Alternate, F. J. Baker.

A. L. Chapin was elected member of Executive Committee for three years.

The Association accepted an invitation of the Niagara County Medical Society to meet with them the first Tuesday in April. Arrangements for the meeting was left with Executive Committee.

WILL H. POTTER, Secretary.

* * *

Orange County Association.—The annual meeting of this Association was held at the Russell House, Middletown, on Wednesday, January 18th. There was an attendance of twelve. The following officers were elected for the coming year: President, Edward D. Woodhull, Monroe; first vice-president, Frank W. Dennis, Unionville; second vice-president, John T. Howell, Newburgh; secretary and treasurer, Lawrence G. Distler, Westtown; Fellows, H. E. Wise, J. B. Hulett, F. D. Myers; Alternates, E. C. Rushmore, E. B. Lambert, A. E. Adams; member Nominating Committee Fifth District Branch, Charles E. Townsend. The president appointed the chairmen of Standing Committees as follows: Committee on Public Health, Dr. W. J. Carr, Newburgh; Committee on Legislation, Dr. W. S. Gleason, Newburgh; Committee on Medical Charities, Dr. C. W. Dennis, Goshen; Committee on By-Laws, Dr. W. E. Douglas, Middletown.

At the business session an amendment to the by-laws was made changing the date of the regular meeting from the third Wednesday in the month to the second Wednesday. The meetings to be held monthly as usual. It was discussed and the sense of the meeting was in favor of having the meetings held in various parts of the county.

A letter from Dr. E. B. Lambert was read in which attention was called to an article published in the December number of the *State Journal of Medicine* regarding contract practice among physicians and asking if any action had been taken in the matter by the Orange County Medical Association. Some discussion was entered into and a resolution passed as follows:

"That a committee be appointed by the President to discuss and determine the feasibility of ratifying the resolution adopted by the Fulton County Medical Society in regard to contract practice."

The following committee was appointed by the President: Dr. F. W. Dennis, chairman; Dr. W. E. Douglas, Dr. A. W. Preston and Dr. E. B. Lambert.

Dr. Woodhull called attention to the meeting of the Fifth District Branch at Newburgh on Thursday, February 2, 1905, and urged as many as possible to attend.

Date of next meeting, Wednesday, February 8, 1905.

LAWRENCE G. DISTLER, Secretary.

* * *

Rockland County Association.—The annual meeting of this Association was held at the Hotel St. George, Nyack, on Wednesday, January 18th. Seven members were present. The following officers were elected for the ensuing years: President, George A. Leitner, Piermont; vice-president, Edward H. Maynard, Nyack; secretary and treasurer, J. Howard Crosby, Haverstraw; Fellow, Charles Demarest Kline, Nyack; Alternate, James Alva Dingman, Spring Valley. The following committees were appointed: Committee on Public Health, S. W. S. Toms and N. B. Bayley; Committee on Legislation, R. R. Felter and S. S. Carter; Committee on Membership, G. F. Blauvelt and W. R. Sitler. Dr. J. C. Dingman, of Spring Valley, was elected to membership. The resignation was accepted on Dr. J. A. Dingman, of Spring Valley, because of ill health.

At the business session the following resolution was passed:

WHEREAS, It has come to the knowledge of the physicians of this county that the Board of Supervisors have passed a resolution to the effect that in the future ten (\$10) dollars shall be the fee allowed for an autopsy; and,

WHEREAS, The Board of Supervisors have presumed to dictate a charge for services, the value of which they have no conception, therefore be it

Resolved, That in the future the physicians of the Rockland County Medical Association refuse to perform an autopsy unless the fee be commensurate with the services rendered, and that such fee shall be twenty-five (\$25) dollars for a complete autopsy.

Date of next meeting, Haverstraw, N. Y., April 19, 1905.

J. HOWARD CROSBY, Secretary.

Wyoming County Association.—The annual meeting of this Association was held at the Watkins House, Warsaw, on Tuesday, January 10th. Twelve members were present.

The following officers were elected for the ensuing year: President, Zera J. Lusk, Warsaw; vice-president, George S. Skiff, Gainesville; secretary and treasurer, Lester Hayden Humphrey, Spring Valley; Fellows, Philip S. Goodwin and George S. Skiff; Alternates, Zina G. Truesdell and L. E. Stage; Member of the Nominating Committee of the Fourth District Branch, Henry P. Sharp; Alternate, L. G. Broughton; member of the Executive Committee, Mary T. Greene (3 years). In the business session, the president appointed the following committees: Committee on Membership, Ethics and Discipline, M. Jean Wilson, Lester Hayden Humphrey and Philip S. Goodwin; Committee on Public Health, L. E. Stage, George H. Peddle and Mary Slade; Committee on Legislation, Zera Z. Lusk, Zina G. Truesdell and George M. Palmer.

In the scientific session, an interesting paper was read by Dr. Mary Slade, on "Recreation."

The next meeting will be held on Tuesday, April 11th.

LESTER HAYDEN HUMPHREY, Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Oneida County, William B. Reid, Rome.

SECOND DISTRICT BRANCH.

Clinton County, Julius B. Ransom, Dannemora.

THIRD DISTRICT BRANCH.

Onondaga County, Henry Darwin Didama, Syracuse.

FOURTH DISTRICT BRANCH.

Chautauqua County, Chas. G. Fisher, Stockton.
Livingston County, William P. Spratling, Sonyea.

FIFTH DISTRICT BRANCH.

New York County, Agustin M. Fernandez-Ybarra, New York; Walter C. Gilday, New York; Frederic Grosvenor Goodridge, New York; Thomas J. Hillis, New York; Johannes Walter Wilhelm Hoving, New York; James Lee, New York; Justin de Lisle, New York; Augustus A. Molony, New York; Oran Arnold Province, New York; F. Conger Smith, New York; George La Breche Smith, New York; Joseph C. Taylor, New York.

Rockland County, J. C. Dingman, Spring Valley, N. Y.

Westchester County, Richard B. Coutant, Tarrytown.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Barrick, Calvin W., Buffalo, N. Y.
Bates, William H., Brooklyn, N. Y.
Benedict, Alfred C., New York City.
Fleming, Martin J., New York City.

Gallagher, E. J., Kingston, N. Y.
Gilley, William C., New York City.
Goodrich, Charles H., Brooklyn, N. Y.
Hasbrouck, Cornelius V., Rosendale, N. Y.
Holding, A. E., New York City.
Howell, John T., Newburgh, N. Y.
Joyce, Robert A., New York City.
Keator, Harvey C., Rosendale, N. Y.
Mandlebaum, Frederick S., New York City.
Peck, Morton Roberts, New York City.
Radin, Herman Theodore, New York City.
Rostenberg, Adolph, New York City.
Sheffield, Herman B., New York City.
Van Loan, James C. P., New York City.
Wright, Milton Chauncey, Mount Vision, N. Y.

OBITUARY.

Dr. Charles W. Keifer died at his home, Mechanicsville, N. Y., on December 8, 1904. He was a graduate of the College of Physicians and Surgeons, Baltimore, Class of 1877, and a member of The New York State Medical Association.

* * *

Dr. Churchill Carmalt died at his home in New York City, of pneumonia, on Sunday, January 8th. Dr. Carmalt was a graduate of the College of Physicians and Surgeons, New York, Class of 1891. He was a member of the American and The New York State Medical Associations, Association of American Anatomists and the New York Academy of Medicine. He was Assistant Surgeon to the Woman's Hospital.

* * *

Dr. Louis P. J. de Plasse died in New York City on Monday, January 23d. Dr. de Plasse was a graduate of Louvain, Belgium, 1866. He was a member of the American Medical Association, The New York State Medical Association and the Medical Society of the County of New York.

LEGAL NOTES.

During the past month the State Association has had the novel experience of having been sued for salary by a previous employee during the period of time when the State Association was prosecuting illegal practitioners of medicine in the State, before Mr. Justice Roesch in the First Municipal Court of the City of New York. The case was tried on January 23d and the justice has just handed down a decision in favor of the Association and against the claim of Thomas E. Conway.

During the month of January no action has been brought against any member of the Association for alleged malpractice, and the cases of Smith vs. Cavana and Capron vs. Douglass have not as yet been tried. The latter case will perhaps be reached at the Utica term during February, but there seems little chance of any verdict being secured against the doctor; indeed, in this particular case the most extraordinary care was taken by the doctor and he went to a great deal

of expense and trouble which he was not called upon to exercise, in the interest of the claimant.

The work of the County Association in the prosecution of illegal practitioners of medicine is being continued, and during the past month there has been arrested Evelyn Francis, a colored woman of Sixth avenue, charged with the illegal practice of medicine, who has been practicing among the negro population along the lower West Side and has made a great deal of money. She has united her spiritualism and clairvoyancy with the practice of medicine, and has imposed upon the colored population of that particular section of the city.

Mildred Miller, a midwife and advertiser in one of the daily papers in the city of New York, was arrested on January 11th, and the warrant executed. The hearing was adjourned in the Yorkville Court and was returnable on Wednesday, the 25th, at which time the attorney for the defendant asked for another adjournment which was granted and is now returnable on February 1st in the Morrisania Court, 158th street and Third avenue.

The case of Evelyn Cole has been set down for trial for Thursday, January 26th.

Mary Hogan, of West 35th street, was arrested on January 6th, held for trial, and on January 19th pleaded guilty in the Court of Special Sessions, having been confined all this time without bail. In view of the fact that the defendant pleaded guilty the Court felt that inasmuch as she had not given any abortive remedies, that she had been sufficiently punished for a first offense, and sentence was suspended.

SOCIETY NOTES.

Aesculapian Club, Buffalo.—At a meeting held January 19th, Dr. G. R. Trowbridge read a paper on "The Insanity of Pubescence."

Associated Physicians of Long Island.—At a meeting held on January 28th, the following papers were read: "Observations on the Diagnosis of Carcinoma of the Stomach," Dr. H. G. Webster; "Some Studies in the Pathology of the Kidney," Dr. J. M. Van Cott; "Pneumococcus Infection," Dr. W. N. Belcher; "A Clinical Study of Abscess of the Lung," Dr. W. H. Rankin; "Congenital Dislocation of the Hip; Results of Treatment," Dr. C. D. Napier.

Binghamton Academy of Medicine.—At a meeting held January 24th, Dr. C. L. Stiles read a paper on "Immunity"; Dr. J. F. Pratt, on "Some Considerations of Diseases of the Nose and Throat"; Dr. F. W. Sears, on "A Method of Closing the Appendiceal Stump"; Dr. B. W. Stearns, on "A Marked Cut in the Incomes of the Physicians of Binghamton."

Brooklyn Gynecological Society.—At a meeting held January 6th, Dr. A. A. Hussey read a paper entitled "Remarks on the Etiology of Eclampsia."

Brooklyn Pathological Society.—At a meeting held on January 12th, Dr. A. T. Bristow read a paper, "Remarks on Stone in the Bladder; Report of an Anomalous Case"; Dr. T. H. Dexter, on "Pathology of Vesical Calculus"; Dr. A. H. Bogart, "Sarcomatous Degeneration in Uterine Afibroid; Specimen and History"; Dr. Charles Terry, on "Abominal Hemorrhage of Unrecognized Origin; Report of a Case"; Dr. H. G. Webster, "Sarcoma of the Ovary; History and Slide."

Buffalo Academy of Medicine.—At meetings held on January 3d, 10th and 19th, Dr. John Rodgers read a paper on "The Treatment of Chronic Laryngeal Stenosis"; Dr. David E. Wheeler, on "The Treatment of Chancro

and Chancroid"; Mr. Joseph Lewis, on "Protozoa in the Blood of Frogs"; Dr. DeLancey Rochester, on "The Value of Certain Procedures in the Treatment of Pneumonia"; Dr. Grover W. Wende, on "Some Remarks on the Action of the Roentgen Ray." There was also a preliminary report given on an experimental research concerning the nature of immunity in cancer, by Drs. H. R. Gaylord, G. H. A. Clowes and Mr. F. W. Baeslock.

Elmira Academy of Medicine.—At a meeting held on January 4th, Dr. Joseph Price, of Philadelphia, read a paper on "Plastic Surgery"; Dr. W. B. Jones, of Rochester, on "Perineal Prostatectomy."

Harlem Medical Association.—At a meeting held on January 4th, Dr. C. G. Kerley read a paper on "Treatment of Broncho and Lobar Pneumonia in Children"; Dr. A. Wadsworth, on "Remarks on the Bacteriology of Pneumonia"; Dr. Henry W. Berg, on "Paper on Complicating Pneumonia"; Dr. Richard Van Santvoord, on "The Treatment of Lobar Pneumonia in Adults."

Harvard Medical Society.—At a meeting held on January 28th, Dr. J. W. Brannan read a paper on "The Sea Air Treatment of Tuberculosis of the Bones and Glands in Children."

Jenkins Medical Association, Mount Vernon.—At a meeting held on January 12th, Dr. A. A. Strasser, of Arlington, N. J., read a paper on "Onanism in Children."

Medical Association of Greater New York.—At a meeting held on January 9th, Dr. Arthur C. Brush read a paper on "Professional Responsibility in the Diagnosis and Care of the Insane"; Dr. Frederick Peterson, on "What the State of New York Is Doing for the Insane and for the Advance of the Science of Medicine."

Medical Association of Troy and Vicinity.—At a meeting held on January 3d, Dr. Willard H. Sweet reported a case of extra-uterine pregnancy, and of appendicitis with bilateral lumbar abscesses. Dr. R. H. Irish reported a case of uræmia occurring as a complication in a typical case of exophthalmic goiter. Dr. J. D. Van Wirt read a paper on "Abortive Treatment in Disease."

Newburgh Bay Medical Society.—At a meeting held on January 10th, papers were read by J. D. Brownell, on "Acute Pleurisy"; Dr. W. Hollinger, on "Pleurisy with Effusion"; Dr. H. C. Geyer, on "Empyema."

New York Surgical Society.—At a meeting held on January 11th, Dr. Dawbarn read a paper on the "Surgeon's Enemy, the Skin."

Rochester Pathological Society.—At a meeting held on January 12th, Dr. E. Wood Ruggles read a paper on "Scratching as a Factor in Etiology, Symptomatology and Treatment of Skin Diseases," and at a meeting held January 26th, Dr. Wallace J. Harriman read a paper on "Melancholia."

Saratoga Springs Medical Society.—At a meeting held on January 6th, in the Symposium on Cerebro Spinal Meningitis, Dr. Thompson read a paper on its "Etiology and Pathology"; Dr. Fish, on "Symptoms and Diagnosis," and Dr. Sanford, on "Treatment," and at the meeting held January 20th, in the Symposium on Gall Stones, Dr. Castree read a paper on "Etiology"; Dr. Downs, on "Symptoms," and Dr. Varney, on "Treatment."

Society of the Alumni of the City Hospital.—At a meeting held on January 11th, Dr. Adolph Rupp read a paper on "Appendicitis and Abscess of Liver"; Dr. E. M. Still, on "Sporadic Cretinism."

Utica Medical Club.—At a meeting held on January 19th, Dr. Andrew Sloan read a paper on "Tetanus."

Women's Medical Association of New York City.—At a meeting held on January 18th, Dr. Margaret A. Cleaves read a paper on "Radiant Energy in the Treatment of Tuberculosis"; Dr. Stella S. Bradford, on "Clinical and Therapeutic Problems Suggested by the Gouverneur Tuberculosis Dispensary"; Dr. S. Josephine Baker, on "Methods and Results of Municipal Control of Tuberculosis in New York."

COMPLETE REMOVAL OF THE SHAFT OF THE TIBIA FOR OSTEOMYELITIS, WITH RESTORATION OF THE BONE.

George Ben Johnston reports six cases of removal of the entire shaft of the tibia or fibula. The results of operative treatment were very satisfactory, restoring otherwise hopelessly damaged limbs to usefulness. Attention is called to the importance of early diagnosis and prompt surgical aid. The histories are illustrated with several very good photographs and skiagraphs.

In conclusion, he emphasizes the following facts:

1. All my cases were in males.
 2. In every instance they were in growing children.
 3. The trouble was always traceable to a trivial injury.
 4. Exposed bones were involved; the tibia in five instances, the fibula in one.
 5. There was remarkable variation in the degree of virulence of infection.
 6. The extent of destruction was dependent upon the character of the infection.
 7. There were profound constitutional symptoms where the infection was virulent.
 8. The condition was often mistaken for "growing pains," rheumatism, or erysipelas.
 9. Regeneration in my cases was entirely of periosteal origin, and was rapid and complete.
 10. Deformity resulted only in such cases as had suffered destruction of the epiphyseal line.
 11. There is no deformity where a disk of bone is left between the shaft and the epiphysis.
 12. Invariably the companion bone takes on compensatory hypertrophy.
 13. Time to operate:
 - (a) In acute cases (imperative) immediately.
 - (b) In subacute or chronic cases (elective) when new bone tissue has begun to appear.
 14. Operation:
 - (a) Free incision and complete removal of all diseased bone.
 - (b) Spare all periosteum possible.
 - (c) Avoid curet, or use cautiously.
 - (d) Purify the wound by the strictest antiseptic methods.
- After treatment:
- (a) Maintain aseptic conditions.
 - (b) Avoid too frequent and rough dressings.
 - (c) Treat as a fracture, by immobilisation in a fracture-box.
 - (d) Carefully shape the parts, as bone tissue develops, by bandages or adhesive straps.
 - (e) Protect the young bone by means of plaster-of-Paris.
 - (f) Abstain from use of the limb until the new bone is capable of sustaining the weight of the body.
 - (g) Look after general health.—*Buffalo Medical Journal*, January, 1905.

Book Reviews.

GALLSTONES AND THEIR SURGICAL TREATMENT. By G. A. Moynihan, M.S. (Lond.), F. R. C. S., Senior Assistant Surgeon to Leeds General Infirmary, England. Octavo volume of 368 pages, illustrated with text cuts, some in colors, and nine colored insert plates. Philadelphia, New York, London: W. B. Saunders & Co., 1904. Cloth, \$4 net.

The essentially striking features as one reads this book are the clear, convincing, terse style of the author; the condensation into moderate compass of a wealth of detail bearing upon all phases of gallstone disease; and most valuable of all the introduction of clinical histories which explain, illustrate and complete the statements contained in the text, experiments and histories of individual cases. The work is thus of the greatest practical use to the family physician in enabling him to form an early diagnosis and to the operating surgeon in acquainting him with the possible conditions, complications and operative measures for their relief.

The book is convenient size, practical and authoritative, finely gotten up and beautifully illustrated, and provided with a *complete index*.

The book is thus of great *practical* value to the family physician in helping him to an early diagnosis and to the operating surgeon in acquainting him with all possible conditions and complications, and operative measures for their relief.

The text is fully illustrated by many fine half-tone and colored plates, and rendered accessible by a *complete index*.

Therefore, as an example of book-making, in size, finish and illustrations, and as a source of help, information and practical suggestion for busy men, the work is extremely satisfactory, and can be heartily recommended.

BOOKS RECEIVED.

ANNUAL REPORT OF THE SURGEON-GENERAL OF THE PUBLIC HEALTH AND MARINE-HOSPITAL SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1904. Washington: Government Printing Office, 1904.

TWENTIETH ANNUAL REPORT OF THE BUREAU OF ANIMAL INDUSTRY FOR THE YEAR 1903. Washington: Government Printing Office, 1904.

A COMPEND OF THE DISEASES OF THE EYE AND REFRACTION, INCLUDING TREATMENT AND SURGERY. By George M. Gould, A.M., M.D., Editor *American Medicine*; formerly Ophthalmologist to the Philadelphia Hospital, etc.; and Walter L. Pyle, A.M., M.D., Assistant Surgeon to Willis Eye Hospital, Philadelphia; Associate Member of the American Ophthalmological Society, etc. Third edition, revised and corrected; 109 illustrations, several of which are in colors. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1904.

REPORT OF THE LIBRARIAN OF CONGRESS, FOR THE FISCAL YEAR ENDING JUNE 30, 1904. Washington: Government Printing Office, 1904.

HARE'S PRACTICE OF MEDICINE. A Text-Book of the Practice of Medicine. For students and practitioners. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and *Materia Medica* in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; Laureate of the Royal Academy of Medicine in Belgium; of the Medical Society of London. Author of "A Text-Book of Practical Therapeutics," "A Text-Book of Practical Diagnosis," etc. In one very handsome volume of about 1,000 pages, with about 100 engravings and six full-page plates in colors and monochrome.

Original Articles.

A REPORT OF SOME CASES.¹

BY VERTNER KENERSON, A.M., M.D.,
Buffalo, N. Y.

Mr. President and Members of the Erie County Medical Association:

UNLESS a man has an unusually vivid imagination, or has peculiar advantages, it is hardly possible for a man pursuing his usual course of practice to have either a monstrosity, "unusual feature" or new method of treatment always on hand to present at short notice to any society gathering.

Recognizing, nevertheless, that in the search for the interesting and unusual, that all commonplace reports lose interest, I make bold to apologize in advance for presenting at this time a report of some cases, that are in every way *usual* save in perhaps a small detail.

May I call your attention, briefly, to the points in each case that I propose to report?

First, I report a case of pernicious anemia, essential, and ending fatally where there were two other deaths in the same family within three years, one of whom I had seen, but who died while I was away in the contract service of the United States Army, and was cared for during her last illness by Dr. Taylor, but who undoubtedly had pernicious anemia; the other died in another State, but from the description given by the attending physician and her relatives, her illness closely resembled pernicious anemia and probably was a third case.

The point for discussion is, there seems to be in this case an inherited or family tendency, two sisters and a mother having died of pernicious anemia.

The point of interest in the *second* case is that in amputations for "senile gangrene," the arteries of the lower extremity may be compressed by an assistant, using but little force, and the surgeon need not apply a tourniquet and thus do damage to an already very brittle artery, even though the amputation be necessarily carried to the upper third of the upper leg.

Third, that in operations for the removal of a suppurative kidney (probably tubercular) the abdominal symptoms may be so marked as to lead one to think that there is some involvement of the colon, the nodes of the "pus kidney" being easily discernible through the anterior body wall. That all kidney cases had best be completed in two operations, one to drain the suppurating kidney mass and one to remove the remnant after the suppuration has somewhat subsided.

Fourth, that carcinoma of the pylorus when seen by competent medical observers, can be referred to the surgeon with a fairly accurate degree of certainty, so that the operation can

be undertaken "before any mass can be discovered" by abdominal palpation, and if that is done the mass can be found, delivered, and comparatively easily removed.

Fifth, that in operations on the parotid gland for carcinoma the conditions are made very much easier if the common carotid (not the external carotid) is tied before the operation, and that no ill effects occurred in this case, that under the present operative circumstances the tying was very easy.

Sixth, that in operations for the removal of the parotid the facial nerve has, if the tumor be of any magnitude, already become involved and usually shows some degree of facial paralysis, and that after the operation it may fully be expected that the side of the face on which the operation has been performed will be paralyzed.

I.

In 1899 I met the first case of pernicious anemia in the person of a woman about 55 years old, said to have lost some considerable in weight the two years before, to be suffering from some throat paralysis and to be in general failing health, having been in the hands of several practitioners without any improvement. She weighed 105 pounds, was poorly nourished and her skin was of a lemon hued white, with some tendency to edema under the lids. Her chief complaint was that she suffered greatly with eructations of gas after each meal. There were no growths to be found either in her neck where she said she had occasional pain, usually after having tried to swallow something that was not properly masticated, and there was undoubtedly some partial palsy of the muscles of deglutition, and no tumor of the abdomen could be palpated.

No blood count was made in her case and she remained under my care on arsenic iron, marrow and other foods of similar nature until I left town, when she came under the care of Dr. Taylor.

She died before I returned and without any good and sufficient reason being discovered except her anemia, her strength gradually failing.

The second case was a daughter of the above-named woman, 31 years old, and who also came under my care in 1898, and had from that time until her death some ailment all the time, but of indefinite character. She was the picture of health, weighed about 220 pounds, had fairly good color but had a distinct nervous tendency. Her general complaints were restlessness at night, distress after eating, lassitude, constipation, painful menstruation, and inability to walk any distance without great prostration.

This was attributed to her weight and various attempts were made to reduce her weight by banting, foods, thyroids, medicaments, etc., but all were of no avail because she became so depleted when any heroic remedies were given.

She had frequent attacks of slight sicknesses that compelled her to remain indoors for short periods of time, and frequently complained of

¹Read before the Erie County Medical Association, December 12, 1904.

slight irritating eruptions on her body that left a scaly and rough skin. She was under my care from 1897 up to the time of her death in 1903, with the exception of the time I was away in army service and for one short period immediately after she was married in 1902.

After her marriage she immediately began to complain of greater attacks of lassitude and general weakness, although all the time she remained in good flesh, and finally some slight fistula in ano developed and she consulted Dr. Fredericks, who advised her to see me at once, she having been under my care for some time.

She did consult me, and at this time the diagnosis was very clear, from her general symptoms and her color. I had not seen her from the 7th of June, 1902, up to the time I was called on May 5, 1903, and at that time she had lost flesh and weighed about 185 pounds, as against her former weight of 225 pounds, was short of breath all the time and had to be kept very quiet or she was distressed for breath to such an extent that it was painful to see her. The heart sounds, while indistinct, were normal in tone, and her pulse ran from 78 to 104, but was of very poor quality. She was tried on various forms of iron arsenic, bone, marrow, raw beef, and all of the various foods and remedies did not change the course of the disease at all and she died July 2, 1903.

Three blood counts were made and at no time did the count show 20 per cent. of the normal count of red blood corpuscles.

The third case in the same family with the same clinical history was an older sister of the last patient who died within one year of the time the sister died, and two years after the mother. This case I never saw but once, and then she had the same lemon-colored transparent skin and was feeble, and no form of iron or food seemed to have any effect on her case.

The salient points to the demonstration of correct diagnosis, namely, the blood count, is present in only one of the three cases, but the clinical history is the same in each case, and the fact that three cases have occurred in one family I do not find in the literature.

II.

On November 24, 1904, I operated upon Patrick O'Connor, a man about sixty years old, who was admitted to the hospital suffering from a "sore toe" which had been giving him a great deal of pain for some weeks, and on examination was found to be gangrenous. The man's general condition was not very good and he had been encouraged to wait for several weeks hoping that the local condition and his general health might be improved. The operation was, however, decided upon at this time and at the time of the operation was performed first at the tuberosity below the knee, and there was no tourniquet used, one of the resident surgeons simply compressed the artery at the popliteal space until the leg was severed and the artery

clamped. There was little or no bleeding, and it was found that the arterial supply was not sufficient at that point to supply the leg and a second amputation was performed at a point three inches from the body. At this point also it was not necessary to apply any tourniquet, but the resident simply compressed the femoral at the femoral opening and there was very little except venous hemorrhage, and the artery was found to be of sufficient lumen to warrant the belief that prompt healing would take place.

III.

On the same day there was referred to me a case of a tubercular kidney, but with such marked abdominal tenderness that it seemed not at all unlikely that there was some involvement of the intestines, and so I deemed it wise to make a small exploratory incision in the abdomen on the right side to determine whether the growth might not be a carcinoma of the head of the cecum. After the man had been given the anesthetic the rigidity of the abdomen disappeared and it was found that under the abdominal parieties there could be plainly palpated several nodular masses that appeared not unlike the feel of a nodular growth in the abdomen, say carcinoma of the head of the cecum, and so close to the anterior wall of the abdomen that they surely seemed to be in the abdomen proper. A small incision into the abdomen showed them to be retroperitoneal and the man was at once closed up and the preparations completed to cut down upon the kidney and to remove it if sarcomatous and not yet broken down and to drain it fully if it proved to be softened and filled with pus.

This latter proved to be the case, and the kidney once opened discharged the usual nauseating tubercular uriniferous smelling pus and perhaps ten ounces of pus were discharged.

The wound was then simply packed thoroughly with iodoform gauze and the man returned to bed, and as soon as the kidney has fully drained and the whole contracted down a second operation will be performed and the kidney removed. It is found that the primary removal of the infected kidney has resulted in a high mortality, whereas drainage and later removal is not nearly as dangerous to life.

IV.

Two days after the above operation I also operated at the same hospital for the removal of the pylorus of the stomach in a man about sixty-five years old, an Italian, who gave a history of having swallowed some strong acid some months before, and of having lost consistently about thirty pounds of flesh in the last four months, and an examination of the stomach contents showing that the man "chemically" had a carcinoma of the stomach. Further than that he had at all times a dilated stomach, the greater curvature showing three fingers' breadth below the umbilicus. After the stomach was emptied by means of the stomach tube the curvature would return to the usual two inches

above the umbilicus. The man did not vomit his food, but was in almost constant pain. It seemed to me clear that although there could be no tumor felt under the right costal border that this was undoubtedly a carcinoma of the pylorus and performed an exploratory laparotomy, but with the patient's instructions to remove the growth if found and at the same operation.

The incision was made at the right of the rectus and the specimen was very favorable for this particular operation, as the patient before he began to lose flesh had a well-arched thorax, and the space between the liver and the stomach was roomy and the pylorus was easily available. The omentum was found somewhat dusky in appearance and with hardly a particle of fat in the meshes.

The omentum which has to be counted with in operations upon the stomach to which the greater omentum has its attachment, is composed of the anterior and posterior peritoneal coverings of that organ blended at the lower dependent part, namely, on the greater curvature, and then the two layers blending fall practically the whole length of the abdominal cavity and then turn on themselves coming back almost to the lower or greater curvature of the stomach and being attached to the transverse colon. It is to be noticed that this "apron" hanging on the lower curvature does not hang on the lower side of what is the extension of the stomach, namely, the ascending or horizontal portion of the duodenum, which is free from omental and almost free from mesenteric attachment.

The first part of the duodenum is for about two inches surrounded by peritoneal covering, but the next two or three inches are fastened to the posterior wall of the peritoneal cavity by a fold of the covering of the posterior wall. This fold is not flexible, and when a resection of the pylorus is under the hand it is necessary to so plan that no more of the duodenum will be needed than those first two inches, as no more can be pulled up from the back. The parts of the small intestine that are furnished with a mesenteric attachment give great freedom in the normal movements of the intestines, and if in operating we need to move the small intestines about there is great freedom allowed, with the exception of the duodenum which is practically fast.

One important fact should be borne in mind, and that is that the lymphatics of the duodenum and of the stomach seek entirely different channels and that the extent of the involvement of the pylorus ends when that gate is passed, so that we may cut close to the pylorus in doing a pylorotomy and that without fear of bad results.

The omentum, so far as it covers the part of the stomach to be excised, must be tied off and the peritoneal covering of the duodenum, so far as it prevents encircling the gut, must also be tied off.

In this particular case, the one referred to me by Dr. Russell, there was a distinct nodular growth at the pylorus that closed the opening practically, and yet the entire tumor could be delivered and there were no adhesions either to the common duct, the bladder, or to the head of the pancreas.

This case was treated by the method known as Bilroth's operation, cutting wide of the growth from the stomach side and cutting reasonably close on the duodenum side. This was a particularly favorable case on which to operate because of the ease with which the mass could be delivered, through the roomy peritoneal vault and arched thorax.

The increase in the size of the stomach wound was lessened by a double row of Lembert sutures, the remainder of the opening was closed by the cut end of the duodenum, a double row of sutures closing the seam tight. A small piece of packing was left, reaching down to the closure, and the wound dressed.

The further report of the case is not satisfactory, for the man remained quiet and comfortable, did not vomit, and was nourished for ninety-six hours by rectum, when for reasons unknown to me he had an intractable but short attack of vomiting and undoubtedly loosened the closure and died twenty-four hours later. The point in the case is not the recovery of a successful case, but to commend the early diagnosis by Dr. Russell making the case when thus received early an easy one to operate upon and one that bid fair to recover. (In private discussion of this case afterwards Dr. Roswell Park stated to me that he considered reliance on the absence of hydrochloric acid in stomach contents as not a safe thing to wait for, as he had on that day operated on a woman who had absence of free hydrochloric acid and in whom, for that matter, he could feel a "mass," and was practically sure the case was one of carcinoma, and yet when the operation was performed he found impacted gall stones. He considers, and I certainly agree with him, that "exploratory incision" is the only safe rule even in obstinate dyspepsia, whether the chemical points to carcinoma or not. As the late cases are always hopeless, early inspection must be the rule.)

V.

On Wednesday, November 23, 1904, also, I had occasion to operate at the Erie County Hospital on a man who gave his age as fifty-seven years, his occupation as a canaller, who denied specific history, but who had been in the Erie County Hospital fifteen months before, and who was then suffering from an epithelioma of the left temporal region. He was operated upon at that time by my colleague, and the epithelioma removed, but no glands were removed.

He went away and returned to his regular vocation, and worked during this last summer, and found that his face on the left side over the

region of the parotid gland was swelling and finally became a large mass on the left side of the face and was extremely painful. He was at first told by some of his friends that the growing tumor came from a rotten tooth, and inasmuch as all of his teeth were very rotten, he was easily led to believe the statement, and when he was told to poultice the tumor he did so persistently.

Under this treatment the tumor grew faster than ever and became dark blue in color, fluctuated under deep pressure, a facial paralysis developed slowly and finally his left cheek became freed from lines of expression, and when he attempted to whistle he drew his mouth toward the right and he was unable to close his left eye completely. There was no irritation of the conjunctiva and the tears passed away in the usual channel, but the tumor had on admission to the hospital assumed large proportions, and he was not able to masticate food on the left side of the jaw.

He could, however, swallow liquids, and except for the pain in his face could undertake ordinary manual labor.

I explained to him that the tumor had progressed so far that the nerves of the left side of the face had become involved and that he could not expect to have the tumor removed without having the whole side of the face paralyzed, and that, of course, a large scar would result. Understanding these conditions fully, he desired to have the operation performed and it was done on the date mentioned above, and the house staff assisted me.

The branches of the common carotid that are of major importance in considering operations upon the neck are the external carotid and the internal carotid, each of which have several branches that supply the inside and the outside of the bones of the head and the muscles that are attached. The external carotid supplies the temporal that passes through the substance of the parotid gland, and it was evident that any blood vessel passing through such a distorted and swollen gland as presented that day, would be found so much distorted that it would have bled at practically every manipulation made with the knife. Furthermore, as the tumor had developed there had appeared a large gland in the left side of the man's neck, and, as it was necessary to remove that as well, I decided to remove the gland and tie the common carotid in the triangle of election through the same opening which I did tying the common carotid with twenty-day chromocised catgut in two places about one-half an inch apart without cutting the artery.

The wound in the neck was immediately closed with catgut sutures and covered with a piece of dressing, and the removal of the tumor on the side of the face was begun. An incision commencing at the apex, or rather above the apex of the tumor, and carried well around all

the involved tissue and well back of the angle of the jaw to the external auditory meatus, and well below the angle of the jaw down to a point one inch below the horizontal ramus, and then the tumor was cut away down to the fibrous covering of the temporal bone and the zygomatic process, and then dissecting the tissue away down to the last vestige of the apparent tumor and scraping of the last remnant so far as it could be secured from behind the angle of the jaw, then the skin edges were as closely approximated with silk-worm gut sutures and the wound was dressed with powder and allowed to granulate, and then on December 8, skin grafting was performed and the balance of the wound was covered with skin from the man's leg. Before the operation there was inability to fully close the left eye, and after the operation the man could not close the eye at all, but that was to have been expected, and the man was amply repaid for the inconvenience resulting on account of the comfort he now enjoys as compared to the fearfully painful time he suffered before the operation.

In operations upon the parotid gland it is particularly difficult to satisfy oneself that the last remnant of the parotid from behind the angle of the jaw has been removed and so to assure the patient that there will be no return, but it is much more easy to operate upon the parotid or upon any part of the side of the gland or face if the carotid has been tied in the first place. Operations on carcinomatous tissue where the original supply of blood was of ample quantity, when that tissue is changed and the tissue becomes engorged and swollen, and all the immediate blood supply distorted, then every time one attempts to hurry the matter at all, the flow of blood makes the field difficult in which to work with safety and accuracy, and when the gravity of the tumor or of the operative procedure is of such magnitude that one feels justified in going deep, and tying the common carotid, then the operation is comparatively dry, and can be prosecuted with vigor and satisfaction as the hemorrhage is very little more than venous. The man suffered no inconvenience in the way of brain symptoms and has been up and around the wards since the fourth day after the operation.

May I review the points spoken of in the first part of the paper?

First—One certain and two suspected cases of pernicious anemia in one family.

Second—No tourniquet need be used in senile gangrene, the hemorrhage is easily controlled by light pressure.

Third—Abdominal symptoms may be so marked that an apparently nodular tumor may seem to be in the abdomen and yet prove to be a tubercular kidney.

Fourth—Carcinoma can be diagnosed by chemical analysis of stomach contents, when at

the pylorus; before the tumor can be felt, making the operation easy.

Fifth—Tie the common carotid before operating on the parotid.

Sixth—Expect facial palsy.

MUNICIPAL SEWAGE.¹

BY DOUGLAS C. MORIARTA, M.D.,
Saratoga Springs, N. Y.

Mr. Chairman and Gentlemen of the Conference:

IT is not my purpose in treating this subject at this time, to take up the scientific side of the problem; nor to consider the rights of riparian owners, or what constitutes a pollution of the waters of the State, or the liability to personal infection therefrom, but rather to consider it from the practical side as we have at Saratoga, and I hope I may be able to show you that some changes in the present methods of our State Health Commission would be of value to a municipality, and so indirectly to the State, when they are forced to consider such a problem. Recent enactments of our Legislature clearly demonstrate that in the near future the Health Commissioner of the State will have remedied the pollution of our waterways, by the enforcement of our sanitary laws, and this of necessity means that sewage disposal plants must be constructed. At Saratoga, we were permanently enjoined from using the streams of the State as a terminal for our sewage and were given one year by the courts in which to build a sewage disposal plant and remove our sewage from Kayaderosseras Creek. Special legislation gave the power for a sewer commission and provided the necessary funds.

The commission was appointed with power and funds to install a sewage disposal plant, a time limit of one year being the only condition. This commission organized at once and endeavored to learn where the successful sewage disposal plants were located, and their character; also, if as a whole or in part, any of them were adaptable to our purpose. The commission interviewed several men, who were eminent as sanitary engineers; and it was apparent, after being advised by these learned gentlemen, that the sewage disposal problem was not only in its infancy, but decidedly unsettled. To dispose of the sludge seems to be the difficult part of the problem.

We learned that New York State had done nothing in the way of sewage disposal, except to enact legislation intended to prevent the pollution of its streams. Other States have done but little more, with the exception of Massachusetts, which is practically the pioneer in this study. She had a State experimental station, and more sewage disposal plants in operation than any other State in the Union. Our commissioners visited Boston and met the officers of the Massachusetts State Board of Health, the

president of which was most courteous and gave us the freedom of their experimental station at Lawrence, arranged for us to meet several sanitary engineers, who were prominent in this work in their State, and to visit the several intermittent filtration plants which were in operation.

The experimental station at Lawrence, while small has been established for a number of years, and is under the observation of the State chemist, who plans all the experiments and determines their value. The conclusion from these studies is that the septic tank is uncertain in its action and that intermittent filtration will be the scheme of the future. The latter was the view of all those whom we met who were familiar with the construction or maintenance of these various intermittent filtration beds.

We also visited New York and saw there some chemical precipitation plants in operation, and observed the construction and details of maintenance. We found the original cost of construction of these plants very large and their cost of maintenance prohibitive for our village, due to the fact that the sludge had to be handled, when wet, whether burned or composted.

After a year's observation, we reached the following conclusions concerning the solution of our problem:

1. That our sewage was out of all proportion to the population of our village, due to seepage, surface, storm and waste tap waters, being in amount about 400 gallons per capita per diem instead of 40 gallons per capita per diem.
2. Our sewage must be reduced to a normal quantity.
3. That we would not consider broad irrigation.
4. That contact beds were yet in the experimental stage.
5. That chemical precipitation was an unsatisfactory and extravagant method.
6. That there were several intermittent filtration plants in Massachusetts being successfully operated.
7. That the disposition of the sludge was the one feature that the sanitary engineers had been trying to solve and so far had been unsuccessful.

At this time we were obliged to decide upon some method of sewage disposal for our village, and so, basing our conclusions on our practical observation, and such theoretical knowledge as was available, we decided to accept that of intermittent filtration and employ Mr. F. A. Barbour, a sanitary engineer, of Boston, to come to Saratoga and ascertain if the local conditions were adapted to the intermittent filtration proposition, and if possible, find an area of land that would answer our purpose. Mr. Barbour's report was particularly favorable. We then directed a second report embodying plans and specifications, which if acceptable to us, would be submitted to the State Commission of Health for its approval.

The second report made necessary the meter-

¹Read at the Fourth Annual Conference of Sanitary Officers of the State of New York, Albany, N. Y., December 16, 1904.

ing of our water supply, the construction of many miles of water carriers, a mile or more of trunk sewer, a pumping station and twenty-one filter beds; it also advised the construction of three retaining tanks and an aerator.



1. Bird's-eye view of sewer beds, showing surface of some of the beds furrowed as they are during the winter months.

An intermittent filtration plant consists of a number of beds, each bed having an area of about an acre, under the surface of which tiles are arranged to collect the effluent and conduct it to a common center. The beds are bounded by an embankment, in which the pipes and gates are located to control the distribution of the sewage. The surface of the beds is level, in summer, unless crops are grown; for winter it is plowed in furrows, and where ice forms it is permanent and the sewage flows under the ice in these channels. The sewage is allowed to flow on the beds in definite quantities and at fixed intervals. The quantity of sewage for each bed is governed by the area of the bed, the character of the soil and the interval between the doses, and by the condition of the surface and activity of the bed; the object of the interval is to allow oxygen to gain access to the soil, which is essential if the best result is to be obtained in caring for the sludge, which is deposited on the surface of the beds or in the first inch of the soil, which is laden with scavenger bacteria. The organic compounds present constitute the insoluble portion of the sewage, and are mostly nitrogenous in character. The chemical changes which occur are principally those of oxidation and nitrification—ammonia compounds, nitrites and nitrates of the alkaline bases are the principal compounds formed. While we have studied the sewage and effluent and estimated the chemical changes weekly, since the inception of our plant, as stated, I do not propose taking this study up at this time. The surface of the beds where there are no retaining tanks has to be

groomed one or more times a week and the crust, or deposit, removed, otherwise the bed would become slow or clogged. I am informed that over 3,600 tons of this material have been removed from the surface of the beds at the Brockton plant during the past year. The quantity of sewage at Brockton is about the same as at Saratoga, but is a much heavier sewage. Below the surface of the beds, anaerobic bacteria thrive; these bacteria act particularly on the fats which are contained in the sewage and which are most difficult to dispose of. Thus two classes of bacteria which are present in filtration beds have to do with the results of the problem, though the results must depend upon the period of contact of the sewage with the bacteria, which in filter beds is brief, as the sewage soon leeches away.

That this, Nature's method, might be increased to its greatest usefulness and so dispose of the sludge, was the ambition of our engineer, and he accordingly suggested to us the adoption of the retaining tanks and aerator, that the full bacterial action might be possible. The anaerobic bacteria will act on the sediment at the bottom of the tanks, while the aerobic bacteria will be most active in the scum on the surface of the sewage.

The sewage passes out of the tanks to an aerator, where it flows in a thin sheet over rough surface of metal, not unlike an open umbrella in appearance, which breaks it up, allowing the sewage to more readily take oxygen from the atmosphere, to give activity to the aerobic bacteria while the sewage is passing through the filter beds. By actual tests we know that the sewage takes up 90 per cent. of oxygen while passing over our aerator.

As you know, the activity of all bacteria depends upon the temperature of the medium in which it exists. This was forcibly illustrated last winter—as the temperature of the sewage became lower, the sludge in our tanks increased. In the spring as the temperature of the sewage became higher there was an increased bacterial activity and the accumulated sludge of the winter months commenced to disappear, illustrating most forcibly the necessity of keeping all surface and storm waters from the sewers, as these would materially lower the temperature of normal sewage.

The activity of the bacteria is also modified by antiseptics which are present in the sewage from municipalities where manufactories are present, if they use chemicals which are discharged into the sewer.

After two years of continuous observation and study the commission accepted Mr. Barbour's final report. It was approved by the State Commissioner of Health and we were ready to commence our practical work. We first reduced the

quantity of sewage which was due to our original system being a mixed one, *i. e.*, carrying sewage, seepage, surface and storm waters, and a very large quantity of waste water from our taps; the latter was due to defects in plumbing, and also to its use to protect plumbing in cold weather. In almost every home there was one or more taps that were allowed to run so that the water would circulate and not freeze; the poorer the construction of the house, the more freely water would be allowed to run. This complication was overcome by metering the entire water supply of our village, and charging a fixed rate for each 1,000 gallons of water consumed. The construction of many miles of water carriers, the converting of certain parts of our smaller sewers, where the seepage was great, as well as a mile or more of our trunk sewer, into water carriers, did the rest. The abandoning of our old trunk sewer necessitated the construction of a new one, of a mile or more, which carries the sewage to our pumping station by gravity. Here we established three centrifugal pumps, run by electricity, working automatically and independently or together as required to raise the sewage nineteen feet, through a mile and one-half of pipe into the retaining tanks at the filter beds, here it remains until the bacterial action is accomplished. We have four of these tanks, each having the capacity of 500,000 gallons. We use one or all of these tanks as required to allow the sewage to undergo bacterial action. The exact time it should remain in the tanks is a matter of continuous observation, as conditions of sewage and temperature must always be considered. From these tanks the sewage flows over the aerator, then into a tank called the dosing tank, which holds 50,000 gallons, the quantity usually emptied on one bed at a time. This tank has an automatic apparatus which will distribute the sewage on any one of four beds in rotation that may be selected by the caretaker.

We have in all 21 beds, 19 of which are intended for the usual sewage as it leaves the tanks, while two are arranged for sludge beds, when we shall have occasion to empty the retaining tanks. As yet these beds have not been used. By measurements made twice weekly the deposit in the bottom of the tanks and the amount of scum on top of the tanks is the same in amount as a year ago. (I am speaking of the period from November 1, 1903, to November 1, 1904, when the tanks had only been used five months.) Because of the bacterial action in the tanks there has not been the slightest nuisance from the beds or aerator. As a matter of fact, these sewage beds are an added attraction to our village, and many of our guests visit them and find them not only free from annoyance, but speak of them as picturesque. At the Brockton (Mass.) plant they

do not have retaining tanks, and they have had to remove 3,000 tons of compost from the surface of their beds during the past year, while we have not removed any during the whole experience of a year and a half. This fact with the automatic pumping station and dosing tank reduces our maintenance to an unprecedentedly small figure, our maintenance costing about \$3,000 per year for 1,500,000 gallons per diem.

I will ask your indulgence while I itemize our maintenance for the past year from November 1, 1903, to November 1, 1904, as the maintenance of our plant is of very great moment to those contemplating the establishing of a sewage disposal plant.

One man at pumping station (half time) . . .	\$300
Electrical power of one year	750
One man in charge of filter bed	660
Feeding and incidental expense of one horse	200
Extra labor at beds	1,500
	\$3,410

This includes preparation of beds for winter, leveling and extra care in the spring and the removal of the snow from the sewage runways in each bed. Another year I believe the cost of extra labor will be reduced to \$1,000, and now that our pumps are adjusted our bills for power will be as they have been for the last three months—about \$50 per month, making a saving in the year's power at the pumps of \$250. So I believe the system can be maintained for materially less than \$3,000 annually.

In closing I trust the review of the experience



2. Bird's-eye view of the beds, showing the run-way in which the sewage flows to reach the surface of the beds.

of the commission compelled to install a sewage disposal plant at Saratoga warrants making the following conclusions:

First. That the sewage disposal plan at Saratoga is an ideal one for sewage not contami-

nated with germicides; the beds did perfect work last winter with a temperature that would average zero and for days was from 20 to 30 degrees below that point; there is no local nuisance of any kind at or near the beds. The maintenance is low and the effluent potable, the latter meeting the State's requirements.



3. The aerator as it appears in the winter time.

Second. That the State Department of Health should be in a position to advise a municipality, it is compelling to establish a sewage disposal plant, concerning the proper course to pursue. In other words, the State Department of Health should not only be competent to, but it should be the duty of the department to determine the best and most practical method for the village to adopt, thus obviating the anxiety, delay, uncertainty and expense that our commission had to experience for two years while determining the most practical method of sewage disposal for our village. The whole undertaking necessary to divert our sewage necessitated an expenditure of \$200,000, with no assurance of the plant being of service to the village, other than our own conclusions. This is too much to ask of citizens unfamiliar with the technical knowledge involved.

Third. The State Department of Health should provide means either by establishing a small sewage plant, where all the essential features, both theoretical and practical, could be determined, or else make a temporary experimental station at any of the sewage disposal plants in the State, moving from one to another when all the features of a particular plant are acquired. This would naturally stimulate the head of the department to gain a knowledge concerning all sewage disposal plants in the United States and Europe. The knowledge accumulated in this way with a chemical and practical examination of the sewage from any municipality and an examination of the local soil should enable the State to determine and inform

the city or village that which is best and most practical at a very small cost.

The local engineer could then prepare plans and specifications for such construction as was required. This would save thousands of dollars to the city or village, and, to my mind, insure the installation of sewage disposal plants of a very high efficiency.

Fourth. I would emphasize the above statements and the urgent need of a State sanitary department to take up the study of sewage disposal by reading the discussion of Professor Landreth's paper presented to us in 1901. At this time our Commissioner of Health, Dr. Lewis, said: "Are there any gentlemen present who wish to discuss this paper? You know dinner doesn't come until 8 o'clock to-night. If there is to be no discussion, and I can understand why you do not wish to discuss this paper—it is because you don't know how to discuss it. That is the way I feel about this question of sewage disposal. I have spent considerable time in studying the question. I went with a number of others to England a few years ago with the express purpose of studying their plants and found that the same uncertainty exists there as here as to what is the best and most feasible method of disposing of sewage."

EARLY DIAGNOSIS AND TREATMENT OF PULMONARY TUBERCULOSIS.¹

BY JAMES J. WALSH, M.D., Ph.D.

THERE is no doubt left now in the minds of medical men that tuberculosis, even in the form of tubercular consumption, can be cured if taken in time and properly treated. Long ago Dr. Holmes said that he could cure anything if it only came to him in time. He added, however, that most of the diseases that came under his care to be successfully treated should have come in the persons of the grandparents, or perhaps the great-grandparents of his present patients. Without harking back as far as this, consumption is absolutely curable. Over 70 per cent. of the bodies of patients who have not died from tuberculosis that come to autopsy at the Vienna general hospital present healed tuberculous lesions. Not only are there pleuritic adhesions, but there are puckeringings at the apices and occasionally even calcified nodules to show the former existence of a tuberculous process. No better proof of the general curability of the disease could be afforded. The Germans have a saying, "Wir sind Alle am Ende ein bischen tuberkulös," "we are all of us after all a little tuberculous," which represents the actual truth as to the distribution of tuberculosis

¹Read before The New York State Medical Association at the Twentieth Annual Meeting, New York, October 19-22, 1903.

much better than any supposed relative infrequency of the disease. It is indeed the exceptional human being who has not some tubercle bacilli stored away some place in his system.

The detection of tuberculosis in an early stage is the important preliminary for successful treatment. If we diagnose tuberculosis only when we have the physical signs of a tuberculous lesion in the lung then the disease is advanced too far to hope for complete cure. Oestreich, of Berlin, Professor Virchow's assistant in pathology, showed by a series of demonstrations on the cadaver that for a tuberculous lesion to be detected by percussion it must be at least the size of a large tame cherry. Even when of this size it must not be far from the surface and requires very careful percussion to reveal its presence.

Disturbance of the respiratory rhythm and of the ordinary breath sounds only occurs when the tuberculous lesion is of considerable size, or is situated very close to the surface. The presence of bronchial breathing, for instance, means a good deal of thickening around a bronchus and the consolidation of a number of alveoli. Something can be learned with regard to the existence of pleuritic adhesions by noting the height and depth to which the lungs ascend and descend in their movements. Limitation of such movements may lead us to suspect the presence of pleuritic adhesions and consequently of the existence of a tuberculous process when no other physical signs are present. As a rule, however, physical signs are not sufficient to reveal the presence of incipient tuberculosis.

Too often the physical examination of the chest for incipient tuberculosis is limited to the apices of the lungs. In something over 10 per cent. of all tuberculous cases the pulmonary tuberculosis starts in the lower lobes of the lung, and an examination of these should never be neglected.

At the Institute for Infectious Diseases in Berlin attention is called particularly to the comparative frequency with which the tuberculous process begins in the lower part of the upper lobe of the lung. For the detection of this process the physical signs must be looked for particularly along the third interspace on the right and usually a little bit lower than this on the left.

Before any physical signs are manifest in the lungs certain disturbances of the general health have usually taken place. The most common of these is a disturbance of the pulse frequency. In a suspicious case, if the pulse runs persistently above ninety, and no good reason can be found for this increase in rate, there is reason to think that the patient may be beginning a tuberculosis and proper precautions should be taken not to allow the disease to progress.

The next most important very early general symptom of tuberculosis is the disturbance of the temperature. In the ordinary healthy indi-

vidual there is a regular daily cycle of temperature, whose minimum and maximum are distant from each other about 1.6 degrees. If a patient has more variation than this between the daily maximum and minimum temperatures some pathological condition is at work. It may be only a disturbance of digestion. But it often and nearly always in suspicious cases is due to the development of a tuberculous process, or the relighting up of an old tuberculosis focus. I have not stated what the normal maximum temperature is, though text-books give it very freely because it differs for different individuals. The daily variation of the temperature found by following it carefully every three hours for at least a week is the only way to tell anything about a patient's temperature.

Certain other methods of detecting incipient tuberculosis have been suggested. The use of the Roentgen rays is perhaps the most important of these. There is no doubt that in certain diffuse processes at the apex of the lung the shadow in the radiogram presents evidence of apical consolidation before it can be detected by the ordinary physical signs.

Another method that has attracted some attention is Litten's diaphragm phenomena. If a patient who is not too fat or too muscular (hence tuberculous patients are usually fit subjects) be stripped to the waist and set with the feet toward a good light, all cross-lights being excluded from the room, a linear shadow will be seen to wander down the lower part of his thorax as he inspires and up as he expires. This is due to the peeling of the diaphragm from the internal thoracic wall as it descends. When even slight tuberculous lesions exist, the diaphragm on the affected side makes much more limited excursions than on the well side. This sign is of some value in detecting early tuberculosis, but it requires conditions of light often hard to obtain in a doctor's office and the exposure of the patient is unpleasant.

It must not be forgotten that the Vienna school pointed out many years ago that the excursion of the lower border of pulmonary resonance indicated the extent of the movement of the diaphragm. When this is less than two inches to two inches and a half or is less on one side than the other some pathological condition exists where the limitation is found. This should arouse suspicion as to the presence usually of pleuritic adhesions, but sometimes of a tuberculous process in the apex. The limitation of the movement of the diaphragm on the affected side is also noticed in very early stages of tuberculosis, during examinations by the Roentgen rays. The lessening of the range of movement is Nature's attempt to set the affected lung at rest and so give it proper opportunity to get better. Of late years we have come to realize very completely that absolute rest is the indication for tuberculous joints. Murphy's injections of nitrogen then would seem to have

been a more or less successful imitation of Nature's conservative method of dealing with pulmonary tuberculosis.

Certain other methods of detecting incipient tuberculosis may be mentioned. The detection of bacilli in the sputum is a certain diagnostic sign. A negative examination for bacilli, however, means absolutely nothing. The bacilli do not find their way into the sputum until softening has occurred in the tuberculous area. Long before this the irritating presence of the tubercle bacilli and the inflammatory reaction of the tissues may have caused some non-specific apical bronchitis, which gives rise to cough and even expectoration.

The question of the use of Koch's second serum for the early detection of tuberculosis is still open. So good an observer as Trudeau claims that it is of assistance to him. He is too careful in his treatment of tuberculous patients and knows them too well for us to think that he can be mistaken in the matter. He is too conservative to do anything that could possibly be harmful, yet he has found the use of the tuberculin test valuable and has employed it in a large number of cases. In the infectious disease department of the Charite Hospital in Berlin it is regularly employed by Professor Brieger, Koch's old assistant, and is considered of a great deal of service.

Widal's method exploited at the thirteenth International Medical Congress at Paris of recognizing pleuritic effusions by the cells found in them has attracted some attention. It was hoped that it would prove helpful for the diagnosis of tuberculous pleurisy, but I fear there is not as much in it as its inventor claims. Other observers have failed to obtain the inventor's successful results in its use.

The existence of a family tendency to tuberculosis constitutes, of course, a very important bit of confirmative evidence when the question of pulmonary tuberculosis must be decided. How much is really due to inherited predisposition and how much to the contagion of association remains an unsettled question. There is no doubt now in the minds of younger men at least that contagion is the more important element of the two, though heredity has something to do with it. The position of insurance companies in this matter has changed very decidedly of late years. One prominent New York company, after a careful review of its cases for many years, came to the conclusion that it was more inadvisable to accept a risk on the life of a man twenty pounds under the average weight than on a man who had a family history of tuberculosis on both sides of the family. There is no doubt that running down in weight and being under weight wonderfully predisposes an individual to the contagion of tuberculosis.

Personally I have a theory in the matter. You may take it for what it seems worth. An analysis of the bodies of tubercle bacilli made by

Behring at Marburg shows that they are composed of about 60 per cent. of a material resembling fat. It is only when they are able easily to secure this material for their nutrition that they grow in the human body. Fat is free in the circulation of people who are running down in weight. That is to say, their absorbents are taking fatty material from the deposits in the body and are carrying it where it can be disposed of for heat-producing purposes and other metabolic objects. It is then thin people and those that are running down in weight that must be early suspected of having tuberculosis.

There is, of course, another element in the matter. We are all a little tuberculous, as I have said. That is, we all have tubercle bacilli some place in our systems, though usually they are thoroughly walled off by Nature's protective efforts. At times when the system is losing in weight the connective tissue which surrounds such tubercle bacilli enters into a stage of softening and some of the material may be taken up in the course of metabolism. Tubercle bacilli probably can remain alive in the human system so completely inactive and unproductive for many years. If the connective tissue wall that surrounds them becomes softened, however, they find their way into surrounding tissues and thus an active tuberculous process is set up.

When an American physician wants an authoritative maxim on some point in practical medicine the best place to look for it is in Professor Osler's writings. A recent statement of his on the subject of the treatment of pulmonary tuberculosis sums up completely practically all that I have to say: "Arrest or cure of pulmonary tuberculosis is a question entirely of nutrition and the essential factor is to improve the resisting forces of the body, so that the bacilli cannot make further progress, but are hemmed in and either effectually prevented from breaking through the intrenchments, or, in rare cases, are forced to capitulate." The essence of the treatment of any tubercular process is the improvement of the patient's nutrition. No specific drugs exist. There are remedies which soften and ameliorate the cough, there are others which act as tonic stimulants, there are those which lessen symptoms temporarily, but often insidiously do harm. As a general rule the less drugs put into the stomach the better. On the patient's stomach and its function eventually depends the patient's fate.

We are all practically agreed that feeding is the thing for the consumptive. Yet how few of us make it a point to know just what he eats, the quantity and quality and to recommend how much more he shall eat. The success of the open-air treatment of consumption in the large sanitariums in Europe depends on two things: outdoor air and abundant food. The amount that patients are asked to take at Nordrach seems appalling when they first come. They are asked at once to double the amount that they

have been accustomed to take. They make all sorts of objections. They are given stomachics, and are sent out into the open air and are told they simply must take the amount of food dictated to them. If a fit of coughing comes on in the midst of dinner and they throw off their meals, they are asked to begin at the beginning and eat it all over again. One might say this method of treatment will succeed with Germans, but with no one else. The loudest praisers of the Nordrach system at the present moment are Englishmen, who have "been and gone and done" it for themselves. This must encourage doubters.

Every detail of diet should be dictated to a tuberculous patient. He should have three eggs or a couple of good-sized chops in the morning, with some baked potato and some cereal food, but not that abomination of desolation, fried potatoes, and, above all, not cold fried potatoes. Between 10 and 11 o'clock he should have a cup of milk—a full half pint, at least—with an egg beaten up in it and a small amount of whisky when he is beginning the new régime in order to overcome a certain qualmsiness. If he is liable to diarrhœa, brandy should replace the whisky. The use of alcohol should be discontinued as soon as he begins to gain in weight. At lunch, between 1 and 2, he should have a good piece of steak and a roll and some one of the cereal puddings, not pie nor any pastry. As a rule, there must be no frittering away of his precious digestive power—the only thing that stands between him and the grave—on articles of food that are difficult of digestion and do not contain overmuch nourishment. About 4 in the afternoon he should have milk with an egg, or at the beginning of the treatment a weak milk punch. In the evening he should have a full dinner. Before going to bed there should be another cup of milk, this time without any alcohol unless he is restless, and this helps him to sleep. Nutmeg often takes away the foddy taste of the milk and is a slightly stimulant sedative—something that we do not always remember.

If there is fever in the afternoon, then the principal meal should be taken at midday. During the evening febrile course the appetite is lessened. Where there is fever the amount of whisky allowed may be increased. Alcohol is not a febrifuge, but it replaces better than any other food the tissue waste of febrile metabolism, and it is, as we all know, a food and not an intoxicant for fever patients. If a patient can take this amount of food he will gain in weight, and as soon as he has gained ten pounds the danger from tuberculosis is over for the present.

After the diet comes fresh air. There is entirely too much prejudice with regard to the effect of cold air as a producer of colds. Nansen at the North Pole for a year and a half never had a cold, nor did any of his men. He had been but a week in civilization before himself and three of

his men were down with grippy colds. Until 300 years ago all the civilized world lived with windows wide open winter and summer. At the present moment the sanitariums that are successful in the treatment of tuberculosis keep the temperature of their rooms well down below fifty. At Nordrach the windows are left wide open all day. At Saranac cases of tuberculosis improve during the winter time, living in a tent, temperature often below zero. Tuberculous patients will not take cold if exposed to the outer air in their rooms. They should be warmly clad, but there is no fear of their taking cold, and especially not if they have a fever. Where baths cannot be obtained in typhoid fever the temperature is often reduced by conservative clinicians by keeping the windows open in cold weather for some time, the patient being lightly covered in the meantime. The rooms in which tuberculous patients sleep must be left open all day, and at least one window should be left open at night even in the coldest weather.

With regard to exercise tuberculous patients need very little. They must never exercise when their temperature is above $99\frac{1}{2}$ degrees. When out in the air and the sunlight, which they must have for many hours every day, they should move very gently, if at all, though they may ride. There must be no bicycling.

With regard to the treatment of cough—this is the symptom to which all the supposed specific remedies for tuberculosis have been directed. Creosote, for instance, has all of its vogue, not because of its antiseptic qualities, but because it is a good expectorant. Creosote is undoubtedly the best drug to loosen a hard cough, and it can be borne in small quantities better and longer than any other drug ordinarily used for this purpose. After careful observation some of the best clinicians in Europe deny it all specific virtue. It is practically a mistake ever to give it in doses of more than fifteen minims a day, distributed as you will. It is better to keep the dose under ten minims a day. It should not be given at all if it disturbs the appetite or seems to interfere with digestion.

The cough of tuberculous patients must not be treated in general. Each individual presents special features of this symptom. Some cough most in the early part of the night, just after going to bed. This disturbs their rest for some time. For such patients there are a number of practical suggestions: First, they must sleep in a woolen night dress. The skin reflex awakens cough. Second, they must not get into a bed where the sheets are cold, and especially not in between damp sheets. If they cannot stand sleeping between thin woolen blankets the sheets should be warmed carefully before the fire. Tuberculous patients often have cold hands and feet. These must be thoroughly warmed before going to bed. If these precautions do not ameliorate the cough, then the use of a steam atomizer, in which some turpentine, or some oil

of cloves or some formalin is added to the water should be used. For poor patients a cup of hot water with a pinch of salt and a pinch of bicarbonate of soda, on the surface of which ten drops of turpentine are placed, and the steam breathed in for five minutes through a paper cone will often serve to relieve the cough at the beginning of the night. If, notwithstanding these precautions, the cough continues, one of the opiates should be employed, preferably codein or heroin. This last drug in twelfths of a grain doses produces very little disturbance of the stomach or bowels and often prevents racking cough. To use any of the opiates for the limitation of the cough during the day is usually a serious error. Secretion is retained that Nature meant to throw off. Only when there is danger of hemorrhage, or when patients are very much racked by the cough or when they are losing many meals because of the cough producing vomit should opiates be employed during the day.

Many tuberculous patients could control their cough much better than they do if they made an effort. At one of the large German sanitariums over three hundred tuberculous patients eat together in a common refectory. One would expect a chorus of coughing all during the meal. But the rule is there must be no coughing at meal time.

Patients insist that they cannot control their cough. For the first week they are humored somewhat. Then if they have not already come to taking meals in common of themselves they are told that the rule of the institution is to take meals with the others. They learn to control their cough, and not a single cough is heard during meal times.

For cough in the morning the use of steam inhalations, always alkaline and medicated, if desired, forms the very best method of preventing the spasms of cough which so often bother consumptives' early morning hours. As the result of having swallowed sputum during the night many consumptive stomachs are in a very undesirable state for the reception of food. If food is taken they often throw it off. Such patients should be advised to take half an hour before their meal, a small cup—a demi-tasse—not a large cup of water, as hot as they can stand, in which is dissolved a pinch of salt, just enough to make the water taste like bouillon, and a pinch of bicarbonate of soda. At first this will be thrown off after ten or fifteen minutes, but will bring with it an amount of offensive mucus. After a week or so usually the vomiting will not occur, but the material is carried on to the intestines. This may seem undesirable because of the presence of bacilli, but there is very little danger. The bacilli are imbedded in the mucus, the mucus is indigestible, and besides this bacilli that are free are themselves digested in a healthy intestine. It is surprising how much difference it makes in the appetite for the morning meal to

have patients take this small cup of alkaline salt water.

There are certain dangers of which tuberculous patients should be warned. One of these is ischio-rectal abscess. A patient suffering from fever and eating liberally of milk and eggs is liable to become constipated. If constipation occurs, forcing at stool is almost sure to lead to injury of the tissues in the ischio-rectal space. If there is accumulation of feces in the rectum a number of tubercle bacilli are always present there. It is no wonder that ischio-rectal abscesses and consequent fistulæ are frequent in tuberculous patients. Such patients should be warned, then, never to strain a stool. If a passage is hard they should soften it by the use of salt solution, or plain water to which a little turpentine has been added, and should wait for fifteen minutes after the clyster before going to stool again.

To avoid constipation tuberculous patients should eat plentifully of the two forms of food which are especially conducive to peristaltic movements. These are the sugars and fats. The sugar should be taken plentifully in the shape of simple puddings and cake that is not very rich. The fat may be taken in the form of cod liver oil, but cream is just as good, just as effective and ever so much more tasteful. Every tuberculous patient should be directed to take about one-half pint of cream (in New York City 10 cents worth) every day.

THE VALUE OF TRANSILLUMINATION OF THE STOMACH AS AN AID TO DIAGNOSIS.¹

A New Method with Fluorescent Media, a Modified Gastrodiaphane.

BY ROBERT COLEMAN KEMP, M.D.,
New York.

Mr. President and Gentlemen:

I HAVE selected for the title of my paper this afternoon, before your distinguished society, "The Value of Transillumination of the Stomach as an Aid to Diagnosis," a subject which unfortunately receives but slight attention in the text-books on Diseases of the Stomach, and of which but rare mention is made in our works on the practice of medicine, or in our medical journals. Gastrodiaphany has, however, undoubtedly proved to be of great scientific value as an aid to diagnosis. It has been employed extensively both in our own country and by foreign investigators and you will doubtless be interested to learn that the researches into this method, both on the living subject and on the cadaver, would more than fill a large volume.

In the year 1845, Casenave first applied the method of transillumination to living tissues. In 1867 Milliot succeeded in transilluminating the stomachs of animals and experimented with the stomachs of cadavers. He employed a small

¹Read before The New York State Medical Association, at the Twenty-first Annual Meeting, New York, October 17-20, 1904.

glass tube in which two thin platinum wires were connected with the electrodes of a Middledorpf's apparatus. The credit, however, is due to an American physician, Dr. Max Einhorn, of New York, of being the first to demonstrate successfully transillumination of the stomach on the living subject and the practical value of gastrodia-phany.

His instrument which he denominates a gastrodia-phane, consists in effect of a soft rubber stomach tube, at one end of which is fastened an Edison lamp. Conducting wires run through the tube to the battery, and there is a current-interrupter at some distance from the tube. The lamp is enclosed in a glass bulb—to act as a reflector and prevent the action of the heat on the stomach. He has the patient drink one or two glasses of water—so as not to distend the stomach—inserts the light and examines the patient in a dark room either in the sitting or recumbent position.

Heryng and Reichman employ a modified tube with a water cooler about the lamp. They first pass the stomach tube and pour in from a pint to two quarts of water, examining in the erect position.

Kuttner and Jacobson, under Ewald's direction, performed a great number of experiments. They first used a gastrodia-phane with an inflow and outflow tube and later a single tube, with an inflow above the lamp, introducing the water through this after the light has entered the stomach. These experimenters, together with Meltzing, are the chief foreign investigators into gastrodia-phany. M. Manges, Stockton and many others have employed the method.

Among various gastrodiaphanes are those of Hemmeter, Lincoln, Solis-Cohen, Koplik and Lockwood. To Lockwood we must credit a decided advance in the type of instrument. Many of them are bulky, as large or larger than a stomach tube, difficult to manipulate and often caused vomiting, especially in patients unaccustomed to the passage of a tube and upon whom it was employed for the first time. I can speak from experience, having experimented with the various types. On careful investigation of the literature, I believe we must credit to Lockwood the use of the fine wire-wound cable (rubber insulated) and the small light, no larger than a five-grain capsule. I show you the Einhorn and Lockwood instruments which represent the two types. It would seem best to me that at this point I should describe to you as briefly as possible the most recent methods in transillumination of the stomach, before treating of the value in diagnosis.

My paper is the result of a series of observations made for the past eighteen months during the course of my service in gastrointestinal diseases at the Manhattan State Hospital, West, Ward's Island. It also includes cases from the Manhattan State Hospital, East, which institution I am visiting for Dr. Wm. H. Thomson.

These two hospitals have as inmates over four thousand patients, male and female, and furnish

a fruitful field for investigation into the gastro-intestinal tract. I have also secured valuable material from my service in diseases of the stomach at St. Bartholomew's Clinic, the West Side German Dispensary and in my private practice. In the course of a series of experiments with transillumination of the stomach I found that the employment of a liquid fluorescent medium such as quinine bisulphate gave better results than plain water. In these cases the patient drinks the fluorescent medium, is conducted into the dark room and the electric light bulb is inserted into the stomach in the usual way.

You will find a description of the method in the following journals:

Postgraduate, February, 1904.

New York Medical Journal and Philadelphia Medical Journal, Consolidated, February 13, 1904, entitled "Fluorescin in Transillumination of the Stomach."

Medical News, April 30, 1904, "A New Method for Transillumination of the Stomach by Means of Fluorescent Media," etc.

Medical News, August 6, 1904, "Observations on Dilatation of the Stomach and on Gastrop-tosis."

American Medicine, Dr. Solis-Cohen, of Philadelphia.

Medical Record, Dr. H. Lincoln, of Brooklyn.

There are three fluorescent media so far found to be of value: (1) Bisulphate of quinine, grs. x, in a pint of water. The addition of m V of acid phosphor. dil. or acid sulphur. dil. intensifies its action. The reaction of the quinine solution is acid and the fluorescence is a very pale violet. Increased acidity intensifies its action and fluorescence disappears if the solution is rendered alkaline. (2) Esculin; this is derived from the *Æsculus hippocastanum* (horse-chestnut) indigenous to Europe. Fifteen-grain doses have been given in malaria. One can employ small doses, gr. $\frac{1}{8}$ to gr. $\frac{1}{4}$, in a pint of alkaline solution, which gives a blue fluorescence. This preparation is difficult to secure. (3) Fluorescēin (Merck & Co.), phthalic anhydride (5 parts), a naphthalin product and resorcin (7 parts) heated to 200 degrees C. It is a reddish powder, faintly soluble in water, with a neutral reaction and practically gives thus no fluorescence; soluble in alcohol and in alkaline media, giving a green fluorescence like *liquid opal*. It has been employed to detect ulcers of the cornea. It is extremely cheap. No further literature was obtainable. I therefore injected one to two grains of fluorescēin into dogs and rabbits in alkaline and alcoholic solutions, with no resulting effects either physiological or local. Assisted by Mr. Ferry, chemist of St. Bartholomew's Clinic, I further investigated its properties. He suggested to me the addition of glycerin to intensify fluorescence and we found that the hydrochloric acid of the stomach must first be neutralized. The patient should first be given a glass of water (eight ounces) in which fifteen grains of bicarbonate of soda have been

dissolved. A second glass of water (eight ounces) is then administered in which are dissolved the same amount of sodium bicarbonate, one dram of glycerin and gr. $\frac{1}{8}$ to gr. $\frac{1}{4}$ of fluorescēin. One or two ounces of lime-water may be substituted for the soda bicarbonate. In very fat subjects, or in those with thick muscular abdominal walls, or where much dilatation is suspected it is well to increase the quantity to 3 or 4 glasses. As we increase the fluorescēin in strength, curiously enough fluorescence diminishes and colorization begins. By means of fluorescent media, I have found it possible to transilluminate the stomachs of fat, or muscular subjects, that were formerly unsatisfactory, and to examine for tumors and the location of the stomach with far greater accuracy. I believe I can fairly state that the brilliancy of the transillumination is increased several times.

I pass around for your inspection bottles of these fluorescent media and in addition some fluorescēin and esculin powder.

As a matter of interest, I may state that after a series of examinations of the urine of patients who had taken fluorescēin internally, that no deleterious results occur, no albumen; no sugar, no casts are produced. Though fluorescēin acts in an alkaline medium and free acid destroys fluorescence, yet on catheterization of patients, slightly greenish fluorescent urine is obtained one hour after the internal administration of fluorescēin and this condition persists for about four hours. The acidity of the urine is not due, however, to the presence of free acid. Dr. Ferd. Valentine has also demonstrated that the addition of our fluorescēin solution to either acid, or alkaline urine, colors it and causes it to fluoresce. In fluorescēin solutions, therefore, we have an additional means of testing the permeability of the kidneys.

The Technique of Transillumination of the Stomach is as follows:

1. The patient's stomach should be empty.
2. A dark room gives the only satisfactory results. It can be readily improvised by pinning blankets across the windows. The gastrodiaphane is introduced by candle light, or gas light, the current turned on and the room darkened.

3. It is convenient to introduce the instrument with the patient sitting opposite you in a chair, but the examination should be made with the patient in the *standing position*.

In this last I agree with Meltzing, who states that in the dorsal position only a portion of the stomach is in contact with the abdominal wall. The position of its contents, for example, when water is administered for the purpose of locating the stomach is not as favorable for percussion, as when in the standing position. As a demonstration of the fact, I have administered a pint of fluorescēin solution with the patient lying on the back, inserted the light and endeavored to transilluminate the stomach, with no satisfactory result. As the shoulders are gradually elevated,

the outline of the stomach becomes more visible until finally excellent results are secured in the sitting and especially in the standing position. The method of gastrodiaphany with fluorescent media is therefore unquestionably a decided advance in technique. Moreover, during the course of a large number of examinations with the gastrodiaphane, it became evident that certain improvements could be made in the instrument itself. The Lockwood light possessed the advantages of being small and easy to manipulate. The cable was rather short for a thorough exploration in dilated stomach and in addition the light is under no definite control and frequently

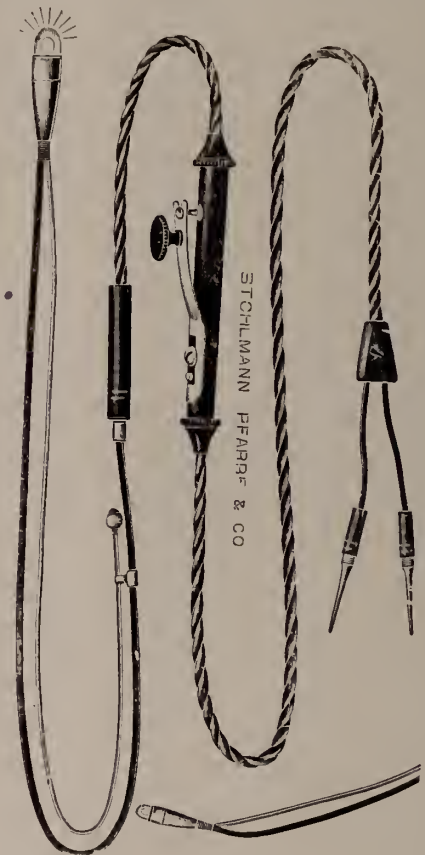


Fig. 1.—MODIFIED GASTRODIAPHANE (KEMP'S).

passes to the cardiac end when it is desirable to explore the pylorus. This, at times, necessitates considerable manipulation, resulting in discomfort to the patient and occasionally in vomiting. In addition it was not possible to explore in the region of the costal margins with this instrument—near the lesser curvature—nor to make the light approach the anterior wall of the stomach except along the greater curvature.

For this purpose I have devised a simple modification. See Fig. 1.

The light is slightly larger and more powerful than Lockwood's and the cable of the same small caliber, but longer. At the base of the light is attached a fine rubber-coated accessory cable—parallel to the main cable. The latter is slightly

more flexible near the light—for about half an inch—in effect a joint. The instrument is introduced by the usual method. By drawing gently on the accessory cable and rotating the main cable, the instrument may be made to take the direction required. In addition, by the manipulations such as I demonstrate to you with the bottle, which represents the stomach, the light may be made to explore the entire anterior wall and the upper part near the borders of the ribs. I believe that this simple device has thus greatly increased the efficiency of gastrodiaphany. I recently demonstrated the practicability of this method at my clinic at the Manhattan State Hospital, West, Ward's Island, on two cases.

To secure a correct diagnosis in any case we should not only examine the contents of the stomach, but investigate the motor functions and the position of the organ itself. For example, Rose has demonstrated that certain symptoms attributed to gastritis may be due to gastroptosis.

Furthermore, we cannot always depend upon the splashing sound as a means of locating the lower margin of the stomach. This fact has been demonstrated by extensive investigations by Drs. Einhorn and Rose, and by further experiments by Dr. Rose and the author at Ward's Island. To quote from my article entitled "Observations on Dilatation of the Stomach and on Gastroptosis," *Medical News*, August 6, 1904:

In effect, when do we consider a stomach to be dilated? Is it to be measured by its capacity alone, or by its capacity plus the alteration of its functions?

The capacity of the stomach is an extremely variable quantity. Ziemssen has shown that a stomach may be normal and only contain eight ounces, whereas another stomach, also normal, may possess a capacity of a couple of quarts. Boas has demonstrated that an apparently dilated stomach may really be in a condition of compensatory hypertrophy. We may, therefore, state the rule, *As long as the functions of the organ are normal, we cannot regard the conditions met with as pathological.*

In reference to the stomach itself, what is the chief point of differential diagnosis between dilatation of the organ and gastroptosis? Is it the degree of the descent of the lower border of the stomach? By no means. We see cases in whom the lower margin of the dilated stomach may have descended further than a stomach which is in the condition of ptosis.

In dilatation of the stomach the lesser curvature maintains its relation to the diaphragm. The muscular fibers first elongate in the vertical direction and the distance between the lesser and the greater curvature is increased. Dilatation may also ensue in the transverse and anteroposterior dimensions and the pylorus may be a little further to the right and in a slightly lower plane—but in general, the lesser curvature maintains its relation to the diaphragm, and this is the differential point between dilatation and gastroptosis. This

feature is best demonstrated by transillumination of the stomach. Some authorities also claim that during transillumination the light follows the respiratory movements with dilatation, but does not do so with gastroptosis, and consider this a second differential point. My own observations do not confirm this view.

On the other hand, with gastroptosis the suspensory ligaments of the stomach are relaxed and the entire organ sinks; the lesser curvature as well as the greater, and in aggravated cases the lesser curvature looks inward, to the right; the greater curvature, outward, to the left, and the pylorus may often lie below the level of the umbilicus.

When the functions of the stomach are abnormal, motor insufficiency exists and the lower margin of the stomach is on a level with the umbilicus or below it, the lesser curvature maintaining its relation to the diaphragm—we may consider the organ to be *dilated*.

In many cases of gastroptosis, nephroptosis may not be present and enteroptosis cannot be detected by the ordinary methods of physical examination. When ptosis of the stomach is present, of necessity enteroptosis accompanies it. Transillumination of the stomach gives us practically the only accurate method. It has been of invaluable aid to me in the investigation of mucus colic.

Furthermore, in gastroptosis, I believe we have the chief etiological factor in "mucus colic." Ewald has pointed out that ptosis of the colon frequently exists in this condition and Einhorn has demonstrated that gastroptosis is present in a large percentage of cases of "mucus colic," as is also achylia gastrica. Mucus colic is present also in many cases of Glenard's disease. Mucus colic is not present in all cases of gastroptosis, any more than is hemorrhage in all case of typhoid fever. All cases of mucus colic are neurasthenic, but all cases of neurasthenia do not suffer from mucus colic.

On the other hand, there must be an underlying cause both for the neurasthenia and the mucus colic—since these two constitute, I believe, a "vicious circle" and react on each other.* As far as my own experience is concerned, I have been able to demonstrate gastroptosis as an etiological factor of mucus colic. The abnormal secretion of the stomach undoubtedly aggravates this condition.

It would seem that the ptosis of the intestines, which of necessity accompanies the gastroptosis and the resulting changes in the caliber of the lumen of the gut at various points, fully explain the cramp-like effort to expel the mucus and the tubular-cast shape of the mucus which we see at

*To further substantiate this view, I have under observation a patient with typical attacks of mucus colic, which began only two months ago. These commenced a month after confinement. She has enteroptosis and gastroptosis, due to insufficient support of the abdomen after the birth of her child. The attacks began a month after she was confined. She is not neurasthenic and is only nervous at the time of her attack. This is certainly significant.

times. Furthermore, injections of olive oil appear to relieve the attacks of colic, just as it does given by mouth, in the case of stenosis of the pylorus. I do not believe the mucus discharge is due to a true inflammatory condition, but to changes in the circulation due to the abnormal position of the intestines. Where there is a narrowing at one point there must of necessity be a dilatation and congestion in the intestine above it.

I believe that adhesions, rectal obstruction, or irritation and other such causes given by our authorities, are merely accessory factors in the vicious circle.

I pass around Fig. A, which demonstrates this view.

You will also kindly observe the numerous drawings which I show you, demonstrating the frequent fallacies of the ordinary methods of examination, by percussion, auscultatory percussion, inflation with air, water, etc. Fig. B further demonstrates the fallacy of air inflation in some cases of gastroptosis. You will also note illustrations of cases demonstrated by this method.

Transillumination of the stomach absolutely enables us to differentiate between dilatation of the stomach and gastroptosis. In addition it accurately demonstrates the degree of dilatation and enables us to determine the prognosis with a greater degree of accuracy. Laparotomy on my service at Ward's Island has demonstrated the absolute correctness of the method.

I believe that the domain of surgery should be somewhat enlarged, for example, in some cases of gastroptosis and stomach dilatation and that a certain class of cases of chronic gastritis with marked dilatation and excessive production of mucus, which do not yield to prolonged treatment, might receive benefit, from proper drainage by gastro-enterostomy.

Before closing, and as a matter of interest, I should mention the belt of my friend Dr. Achilles Rose, which has proved invaluable in the treatment of dilatation of the stomach and gastroptosis. I show you the method of cutting the belt and of its application. I have found rubber adhesive plaster, or zinc oxide on mole-skin to be least irritating varieties.

To summarize the value of transillumination of the stomach as an aid to diagnosis:

1. Exploration of the anterior wall of the stomach, the greater curvature and the pylorus—for tumors, thickening or stenosis.

2. Exploration at and beneath the costal margins in the epigastrium.

3. Differentiation between carcinoma of pylorus, small intestines and liver.

4. Determination of marked distention of gall bladder, associated with dilatation of stomach, reported by Dr. Solis-Cohen.

5. Determination of hour-glass contraction and adhesions.

6. Differential diagnosis between dilatation of the stomach and gastroptosis.

7. An accurate determination of the degree of dilatation—often enabling a prognosis—and suggestion as to operation.

8. Has proved an invaluable aid in the study of the etiology of mucus colic.

In conclusion let me say that the procedure of gastrodiaphany has proved to be an undoubted scientific advance, and if I have succeeded in convincing you of its value, I shall feel that I am well repaid.

CALCULI IN BLANDIN'S AND SUBMAXILLARY GLANDS—REPORT OF CASES.*

BY HERMAN JARECKY, M.D.,
New York.

CALCULI are found in all of the salivary glands, while not very frequently, yet often enough to cause one to be on the outlook for their presence.

In 1896, Futterer¹ collected the reports of 160 and Roberg,² in January, 1904, added 47; since then I have found in the literature mention of three^{3,4,5}, making the total including my three, of 213 cases up to date.

They occur most frequently in the submaxillary gland or its duct known as Wharton's. This may be due to the secretion being more viscid from a larger proportion of mucin or perhaps to its situation. The openings of the ducts on each side of the frenum in the papillæ, under the tip of the tongue, are so situated that foreign bodies, as pieces of toothpicks, bristles from tooth-brushes, micro-organisms can easily enter, and become nuclei for the concretions. The openings of the ducts may become obliterated or obstructed, and lead to the formation of inspissated mucus in which the deposits of calcareous particles may take place. The calculi consist chiefly of calcium carbonate and phosphate, and usually assume the shape of the duct in which they lie. They vary in size from the smallest granule to those attaining a large size—as the one Puzey⁶ reports— $1\frac{1}{2}$ " in length and $\frac{1}{2}$ " in thickness, weighing 115 grains.

The diagnosis of the calculus in the Wharton's duct is easily made by passing one finger along the floor of the mouth, and another of the opposite hand below the jaw, so as to compress the duct between the fingers gradually throughout its entire length. Any hard concretion is bound to be felt. The calculus stops the flow of saliva and causes a distention of the duct and gland behind it, and a swelling under the angle of the jaw in the submaxillary, or by pressure, in the sublingual region. A fine probe can also be passed through the duct and the gritty feeling will reveal the nature of the obstruction.

These can easily be removed under local anesthesia. For operations around the ducts, I employ a fine-pointed camula with syringe and inject about one-half drachm of a solution of adrenalin, 1-1000 and follow this by 5 to 20

*Read before the New York State Medical Association at the Twenty-first Annual Meeting, New York, October 17-20, 1904.

drops of a 5 per cent solution of cocaine directly into the canal. This makes the work absolutely bloodless and painless. Of course, general anesthesia can be employed when patients insist upon it, as was done in these cases which I herewith report.

CASE I.—*Calculus in Blandin's Duct associated with one in Wharton's Duct.* This case is extremely interesting from its rarity. Blandin¹, in 1823, and Nuhn², in 1845, described underneath the tip of the tongue, on each side of the middle line, a gland the size and shape of an almond, having vessels and nerves but quite distinct from the sublingual.

If the tip of the tongue be curled up and the surface dried, pits marking the opening of the ducts, two or more on each side, may be seen.

In a general search through the literature, I find two cases reported of calculi in this situation. Gurlt³ refers to Zacutus Lusitanus, who mentions that a smooth, hard stone the size of a hazel-nut had been removed from the tip of the tongue.

Godlee⁴ reports a case of a woman, 24 years old, with a tumor on the left side of the under-surface of the tongue, near the tip. He passed in a trocar, felt a hard substance which he removed. He then cut out the growth with a scissors. The wound healed readily and soundly. The examination of the mass revealed a calculus with an adeno sarcoma surrounding it.

The patient of mine was Mr. M. S., aged 34, a German, referred by Dr. A. Sturm. He complained of a swelling extending from the tip of the tongue along the right side to beneath the jaw. It had been noticed three years prior as a small, soft swelling, which had gradually grown much larger and harder. The swollen part under the tip of the tongue caused excessive pain while eating. A diagnosis of calculi was made and an operation advised. As he objected to local anesthesia, a general anesthetic was given. Beneath the tip of the tongue, a small calculus was removed by a slight incision into a part of Blandin's glands, and a larger one was found on opening Wharton's duct. Quite a large quantity of pus escaped. The calculus from Wharton's duct is pear-shaped, weighs four grains and is of a yellowish color, while the one from Blandin's is rod-shaped, weighs one-half grain and is of a reddish color. The parts healed nicely within a short time, a mild antiseptic wash being used.

Eight months later, the patient consulted me again, on account of a swelling on the same side, but this time limited to the side of the tongue. The cut into Blandin's gland had thoroughly healed. Upon probing Wharton's duct, no calcareous particles were found, but quite a quantity of pus and saliva escaped. Since then, he has been perfectly well. It might be interesting to add that when he consulted me the first time, he told me he had been informed that the swelling was in all probability malignant, and as a consequence, he had been exposed to the X-rays

for their curative value, but naturally, without result.

This is the only case on record of the association of a calculus in Blandin's gland with one of the submaxillary.

CASE II.—*Calculus in Wharton's Duct attaining a large size without symptoms.* The patient, Abraham L., aged 43, called at my office complaining of a swelling on the left side of the tongue, and a small one under the jaw on the same side. Upon examining with a probe a calculus was discovered. A general anesthetic, ethyl chloride, as the patient absolutely insisted upon it, was administered by Dr. Milton Simon. Dr. B. M. Feldman, who referred the case, assisted during the operation. The calculus was removed from the anterior third of Wharton's duct and about two drachms of thickish, yellowish pus accompanied it. The small swelling under the jaw was due to the pressure on the ducts of Rivinus of the sublingual gland. The calculus weighs six grains, having the general appearance of a large orange pit.

The gentleman is one of the most prominent members of the criminal bar in New York City, and is constantly pleading in the courts; therefore, it is remarkable that the calculus should have attained such a size before it caused any annoying symptoms, as he had only noticed it about three weeks before he sought relief.

CASE III.—*Small calculus with intermittent swelling of submaxillary gland.* Mr. I. S., aged 37, of El Paso, Texas, complained of a swelling beneath the jaw, which would increase in size and then decrease again. The swelling was annoying and painful. Various applications, massage with camphorated oil, liniments, etc., had been employed unsuccessfully. He had been suffering from ethmoiditis, and nasal polypi, but these had been attended to.

Examination revealed a swelling below angle of the jaw, somewhat painful, but no fluctuation. Through the mouth at the beginning of Wharton's duct, a small, hard substance was felt and a diagnosis of possible calculus was made. Under general anesthesia administered by Dr. M. Packard, the duct was opened and a calculus the size of a pea was found.

The reaction in this case was severe, the gland became swollen, and for a few days there was quite some difficulty in swallowing. This condition rapidly improved, the patient simply using a mild mouth wash. The duct was probed and found to be perfectly clear before the patient left for home a week after the operation. About one month later, I received a letter stating that the swelling of the gland had subsided in a few days, but that he felt something hard in the duct. Three months subsequently, I removed a small calculus from the opening of Wharton's duct, under cocaine anesthesia. The second calculus must have been in the gland, and being so small worked its way out to the end of the duct. The first calculus must have acted as a valve at the

beginning of the duct, causing obstruction and distention from time to time. There was no pus in this case.

Both these calculi are exceedingly small and rough. Their roughness is due perhaps to the fact that they were not in the duct long enough to be worn smooth by the action of the saliva and the muscles constricting the tube. The cause of the severe reaction must certainly have been due to the ethmoiditis, as during the operation quantities of muco-pus poured out, making the administration of the anesthetic quite difficult.

In concluding the paper, I would suggest in every case of swelling beneath or around the angle of the jaw, with a doubtful diagnosis, a routine examination of the floor of the mouth be made. A calculus would then be easily discovered, and the patient saved the annoyance of any unnecessary treatment of the worry of supposed malignancy.

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VACCINATION IN THE PUBLIC SCHOOLS.

Vaccination in the public schools has received constitutional standing by recent decision of the highest court in the State upholding our law in this respect, Sec. 210, 211, of the Public Health law, which requires that all unvaccinated persons shall be excluded from the public schools. This is the nearest approach to compulsory vaccination in this State. Having passed the lower courts and been affirmed by the Court of Appeals, the full force of the law is established. It was contended on the trial that the mandatory clause of the constitution of the State requiring school attendance forbade legislation restricting it to vaccinated children, and that every child has a constitutional right to an education; and evidence was adduced on the trial that vaccination does not confer immunity to smallpox and that it is offset by ills worse than smallpox. This last contention has been constantly controverted by the reports, investigations and records of this department. On this point Judge Vaun, who wrote the opinion of the Court, with remarkable clearness, says:

"The appellant claims that vaccination does not tend to prevent smallpox, but tends to bring about other diseases, and that it does much harm with no good. It must be conceded that some laymen, both learned and unlearned, and some physicians of great skill and repute, do not believe that vaccination is a preventive of smallpox. The common belief, however, is that it has a decided tendency to prevent the spread of this fearful disease and to render it less dangerous to those who contract it. While not accepted by all, it is accepted by the mass of the people as well as by most members of the medical profession. It has been general in our State and in most civilized nations for generations. It is generally accepted in theory and in obedience to

the command of the law. Nearly every State in the Union has statutes to encourage or directly or indirectly to require vaccination, and this is true of most nations in Europe. It is required in nearly all the armies and navies of the world. Vaccination has been compulsory in England since 1854, and the last act upon the subject, passed in 1898, requires every child born in England to be vaccinated within six months of its birth. It is compulsory, or is aided, encouraged, and to some extent compelled in the other European nations. It is compulsory in but few States and cities in this country, but it is countenanced or promoted in substantially all, and statutes requiring children to be vaccinated in order to attend the public schools have generally been sustained by the courts."

The opinion further states that, a common belief like common knowledge may be acted on by the Legislature and courts without proof, and the fact that it is not universal is not controlling, for there is scarcely any belief that is accepted by every one, and what the people believe is for the common welfare must be accepted as for the common welfare. "While we do not decide and cannot decide that vaccination is a preventive of smallpox, we take judicial notice that this is the common belief of the people of the State, and with this fact as a foundation, we hold that the statute in question is a health law, enacted in a reasonable and proper exercise of the police power."

As to whether the Legislature is prohibited by the constitution from enacting a law excluding unvaccinated children from the public schools, the opinion holds that right to attend public schools is necessarily subject to restrictions in the interest of the public health, as in the case of those having a contagious disease, and if vaccination strongly tends to prevent spread of smallpox it logically follows that children may be refused admission until they have been vaccinated. The police power which belongs to every sovereign state effects no invasion of the constitution when the sole object and general tendency of legislation is to promote the public health.

Medical Society of the State of New York.—The ninety-ninth annual meeting of this society was held at Albany on January 31st to February 2d. The following papers were read: "Dermatitis Seborrhoeica and Its Relation to Alopecia, and other Conditions," L. Duncan Bulkeley, New York; "To What Extent Are Cycloplegics Necessary in Determining the Refraction of the Eye and in the Prescribing of Lenses," Frank Van Fleet, New York; "Rheumatism and the Eye Muscles," Francis Valk, New York; "Loss of Vision from Disuse of the Eye (Amblyopia ex Anopsia)," D. B. St. John Roosa, New York; "The Simulation of Appendicitis by Cholelithiasis," George G. Lempe, Albany; "Biliary Drainage in Operations on the Gall Bladder and Biliary Ducts," Eugene A. Smith, Buffalo; "Report of a Case of Vaso Motor Disturbance Caused by Exposure to Sunlight," Samuel B. Ward, Albany; "Report of a Case of Angio Neurotic Edema," Clayton K. Haskell, Bath; "The Status of Suprarenal Therapy," Samuel Floersheim, New York; "Aortitis," Thomas E. Satterthwaite, New York; "The Antitoxine Laboratory," Herbert D. Pease, Albany; "Recognition of Incipient Pulmonary Tuberculosis," John H. Pryor, Ray Brook, Essex County; "Phosphaturia," James Pederson, New York; "The Correction of Nasal Deformities by Simultaneous Operation," John O. Roe, Rochester; "The Middle Turbinate in Diseases of the Accessory Sinuses," W. J. Stucky, Lexington, Ky.; "Inferior Turbinate Bone, Its Function, Diseases and Treatment," Wendell C. Phillips, New York; "Treatment of Chronic Otitis-Media, with Illustrative Cases," W. Sohler Brvant, New York; "The Family Physician," Robert P. Bush, Horseheads; "The Various Methods of Opening the Skull for the Removal of Tumors of the Brain," Charles H. Frazier, Philadelphia; "Railway Spine," Edward B. Angell, Rochester.

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CANCER.

In spite of much time, thought and profound investigation, cancer remains an unsolved enigma. It is indeed the defiant sphinx of histological and pathological science, as well as the healing art. The careful study that has been bestowed upon the subject has, however, revealed many important features of cancer, in spite of the fact that one vital point—the cause—still escapes our grasp. The ultimate causative factor in the life history of a cancer cell is as great a mystery as the great primal cause of the universe. When the cause of a cancer shall have been discovered and demonstrated beyond peradventure, we may feel that we have secured a dominant position that commands the situation. Until then, the treatment must continue empirical.

What do we know? First, we know that cancer is a progressively fatal disease; unless arrested by some artificial intervention it will surely cause death.

Second, we know that cancer is primarily a local disease, and, if completely removed before constitutional infection has occurred, is within the possibility of cure.

Third, we know that early operation depends upon early recognition, and that the responsibility therefore rests primarily with the family physician. He can discharge this responsibility by keeping himself ever mindful of the possibility of the development of cancer and promptly submitting all doubtful or suspicious cases to a microscopic test, and, when once the diagnosis has been made, with the same promptness subjecting the patient to the most radical operation the condition demands or justifies. The family physician need not fear being denounced as an alarmist; as Mayo Robson in his Bradshaw lecture before the Royal College of Surgeons re-

cently said, "It is better to alarm and cure than to lull into false security and have to operate later under less favorable conditions. It is certainly wrong to wait for a doubtful growth to become unquestionably malignant."

Fourth, we know that clinical observation has established the fact that *chronic irritation* is the conditional, the exciting or predisposing cause of cancer. It therefore becomes possible to recognize a precancerous condition and by prompt intervention avail ourselves of prophylactic measures. Here the educational function of the physician has its highest expression. People should be taught that the pipe, cigarette inhalations and excessive smoking are productive of cancer of the lip, mouth and throat; that apparently simple spots and growths in or under the skin may be a source of danger to be promptly removed or at least carefully watched. Injuries to the breast or tumors therein especially demand scientific professional attention. When we come to the uterus, where more or less serious injuries are so general and cancer so frequent, especial vigilance is imperative. Lacerations of the cervix, especially if extensive, should be repaired before the woman approaches the menopause. Another source of chronic irritation in the uterus which has been attracting attention of the best observers as a probable cause of cancer is fibroid tumor. A number of cases of cancer of the fundus have been observed in maiden ladies (virgins) associated with fibroid tumor, in which the tumor was apparently the only source of irritation. Since attention has been attracted to this association of fibroid and cancer many cases have been observed and evidence in favor of a causal relation is steadily growing. If further observation confirms this hypothesis the dictum that all fibroid tumors of the uterus, large or small, and wherever situated, should be removed on discovery will rest upon a still more secure foundation. Prompt operation in cases of fibroid tumor of the uterus will take its place as a prophylactic not only against well-known degenerations and complications but also against cancer.

OSTEOPATHIC BILL.

Dr. E. Eliot Harris, chairman of the Committee on Legislation, calls the attention of the medical profession of this State to a bill introduced in the Legislature by Senator Davis, of Buffalo, entitled an "Act Regulating the Practice of Osteopathy in the State of New York," and asks that the members of the Senate and Assembly be petitioned in the interest of individual and public health to defeat the osteopathic bill for the following reasons:

This bill grants to certain persons permission to treat diseases by the so-called osteopathic method, and exempts them from the educational qualifications demanded by the act governing the right to practice medicine in this State, by permitting the so-called osteopaths, who are members of the Osteopathic Society, to be registered and receive a license, without any examination. It allows licensed osteopaths of other States maintaining standards equal to those provided in this bill to practice in this State, without an examination, on the payment of \$10.

The bill also allows them to sign birth and death certificates and to control contagious diseases, which must be considered as a positive danger to the community at large, because the bill prohibits the osteopaths from using valuable drugs or medicines. (See abstract of the bill annexed.)

The tendency of modern times is to raise, rather than to lower, the standard of the educational qualifications of professional men. The public has so long suffered from poorly educated physicians that the legislatures of nearly every State in the Union have enacted laws raising the educational qualifications of the candidates to be examined for a license to practice medicine. We claim osteopathy, so-called, is an agent used in the treatment of disease, and as such has no greater claim to be separated from the general practice of medicine than electricity, mechanical exercise, bathing, nursing, massage, X-ray, or any other valuable agent or method used in the treatment of disease, and is not entitled to a special examining board. The eye, ear, nose, throat, electro-therapeutic and other specialists do not ask exemption from the examination in the general science of medicine demanded by the Regents of the University of the State of New York of all candidates who apply for a license to practice medicine or any branch of medicine, and they do not ask for a special examining board in their specialty. If the so-called osteopaths desire to establish a special branch of medicine, then they, too, should possess at least that average of the knowledge of the general science of medicine demanded by the present law governing the granting of a license to practice medicine in this State; and they should not try to escape the preliminary and final examinations for a license to treat the diseases of the human body by securing the enactment of the so-called osteopathic bill, which permits them to treat all such diseases and prohibits

them from using medicines or to perform surgery.

Nearly every part of the human body is connected sympathetically with nearly every other part; an affection of the eyes or stomach may be due to disease of the kidneys; persistent cough or pain in the knee may be due to disease in the pelvic region; eye-strain may produce disturbances in distant parts of the body, and so on, indefinitely. The protection of individual and public health demands that no one should be allowed to practice medicine in this State unless he can make a diagnosis of the condition of the disease to be treated; and to do which requires the study of the general science of medicine, as taught in the incorporated medical colleges of this State.

The medical laws of the State of New York were enacted to protect the people of the State from charlatans, quacks and pretenders of all sorts. The four years spent in the study of medicine prepares the mind and molds the character along the lines of truth and science and away from commercialism in medicine. A reaction from commercialism in medicine was a factor in causing the Legislature to enact the laws which prevent any person, not presenting the intellectual and moral qualifications required by the Board of Regents, from practicing medicine in this State. The public is protected by discouraging commercialism in medicine and is benefited by fostering the science of medicine.

To summarize the objections to the osteopathic bill: First. Osteopathy, so-called, is an agent or method used in the treatment of disease, and is included in the general practice of medicine.

Second. Osteopathy should not be made a special branch of medicine, by an act of the Legislature, but should come under the present State laws, which govern all the special branches as well as the general practice of medicine. Any licensed physician has now the right to practice osteopathy as a specialty.

Third. The Legislature should protect the public by denying the endorsement of the State to any person, as being capable of treating the diseases of the human body, unless such person can make a diagnosis of the condition of the human body, to do which requires a full knowledge of the science of medicine as taught in the medical colleges of this State, including the use of drugs and other valuable therapeutic agents.

Fourth. If the so-called osteopathic bill becomes a law all candidates who fail to pass the Regents' examinations to obtain a license to practice medicine in this State may in this State treat all diseases of the human body by holding a diploma from any regular osteopathic college in the United States, a privilege which would lower the standing of this State in the educational world.

And finally it would be more reasonable for the Legislature to separate the special branches of criminal, corporation, and real estate law from the general practice of law and establish for

each of them a special examining board, so as to make it easier for the candidates for admission to the Bar who desired to practice as specialists, than it would be for the Legislature to select one special therapeutic agent used in the treatment of disease and separate it from the general practice of medicine as a panacea for all diseases at the request of those enthusiasts who now ask for a special osteopathic examining board.

ABSTRACT OF OSTEOPATHIC BILL.

AN ACT

Regulating the practice of osteopathy in the State of New York.

Section 1. As used in this act, university means university of the State of New York; regents, means board of regents of the university of the State of New York; board, means the state board of osteopathic examiners; examiner, means a member of the state board of osteopathic examiners; osteopathy, means that science or system of healing which treats diseases of the human body by manual therapeutics for the stimulation of the vital remedial forces within the body itself, for the correction of misplaced tissue and the removal of obstructions or interferences with the fluids of the body, all without the internal administration of drugs or medicines; osteopathist or osteopath, means a person who has been licensed, registered and legally authorized to practice osteopathy in this state.

Sec. 11. *Osteopathists when duly licensed and registered in accordance with this act shall have all the rights and privileges and be subject to the rules and regulations that govern other physicians or medical practitioners in matters pertaining to public health; but they shall not be authorized to prescribe drugs or to perform surgery.*

Sec. 6. Any person, who at the time of the passage of this act shall be actually engaged in the practice of osteopathy in this state, and who is a reputable graduate of a regularly conducted school of osteopathy, and who shall be recommended to the regents by the state board of osteopathy examiners, shall upon application and payment of twenty-five dollars, without examination, be granted a license to practice osteopathy provided application for such license be made within ninety days after the passage of this act.

Sec. 7. Applicants examined and licensed by other state examining boards, registered by the regents as maintaining standards not lower than those provided by this act, on payment of ten dollars to the regents, shall, on submitting such evidence as they may require, receive from them an endorsement of their licenses conferring all the rights and privileges of a regents' license issued after examination.

The board shall submit to the regents, as required, lists of suitable questions for thorough examination in anatomy, physiology, hygiene, obstetrics, pathology, chemistry, diagnosis, and theory and practice of osteopathy. From these

lists the regents shall prepare question papers for all these subjects which at any examination shall be the same for all candidates; and in anatomy, physiology, hygiene, obstetrics and pathology shall be the same as for candidates for license to practice medicine.

Requirements. First, candidate is more than twenty-one years of age; second, is of good moral character; third, has the general education required preliminary to admission to examination to practice medicine and dentistry in this state; and, fourth, has been graduated from a regularly conducted school of osteopathy maintaining the standard approved by the American osteopathic association in its requirements for matriculation and graduation, requiring personal attendance of three years of nine months each and conferring the degree of doctor of osteopathy. The regents, may, in their discretion, accept as the equivalent for any part or all of the third and fourth requirements evidence of five or more years' reputable practice of osteopathy provided such substitution be specified in the license.

Sec. 13. All acts and parts of acts inconsistent with this act are hereby repealed.

Sec. 14. This act shall take effect immediately.

BILLS IN THE SENATE.

AN ACT

Introduced by Senator Brackett to amend the penal code by adding thereto a new section to be known as section two hundred and ninety-two-c, prohibiting the exhibition of infants undergoing the process of artificial incubation.

Introduced by Senator Cooper—read twice and ordered printed, and when printed to be committed to the Committee on Finance.

AN ACT

Making an appropriation for the quarantine stations of Hoffman and Swinburne Islands.

Introduced by Senator Davis—read twice and ordered printed, and when printed to be committed to the Committee on the Judiciary—reported from said committee with amendments, and ordered reprinted as amended, and when reprinted to be recommitted to said committee.

AN ACT

To amend chapter six hundred and thirty-two, of the laws of nineteen hundred and three, entitled "An act to regulate the practice of barbering in the State of New York; to establish a state board of barber examiners, and to provide for the sanitary inspection of barber shops," in relation to the renewal of certificates of registration and qualification, return of moneys, apprentices and sub-boards.

AN ACT

Introduced by Senator Brackett to amend the code of civil procedure relative to the disclosure of information acquired by physicians and nurses tending to show the commission of crimes of

which children under sixteen have been the victims.

Sec. 1. Section eight hundred and thirty-four of the code of civil procedure is hereby amended so as to read as follows:

Sec. 834. Physicians not to disclose professional information. A person duly authorized to practice physic or surgery, or a professional or registered nurse, shall not be allowed to disclose any information which he acquired in attending a patient, in a professional capacity, and which was necessary to enable him to act in that capacity [.] ; unless, where the patient is a child under the age of sixteen, the information so acquired indicates that the patient has been the victim or subject of a crime, in which case it shall be the duty of the physician to immediately disclose such information to the proper authorities, and to testify fully in relation thereto upon any examination, trial or other proceeding in which the commission of such crime is a subject of inquiry.

Sec. 2. This act shall take effect immediately.

BILLS IN THE ASSEMBLY.

AN ACT

Introduced by Mr. C. R. Matthews—read once and referred to the Committee on Public Health.

To amend the agricultural law, relative to foods adulterated with methyl or wood alcohol.

AN ACT

Introduced by Mr. Maier—read once and referred to the Committee on Public Health.

To amend the public health law, in relation to the prosecution of violations of the law, in regard to the practice of medicine.

When any prosecution under this article is made in the complaint of any incorporated medical society of the state, or any county medical society of such county entitled to representation in a state society, the fines when collected shall be paid to the society making the complaint, and any excess of the amount of fines so paid over the expense incurred by the said society in enforcing the medical laws of this state, shall be paid at the end of the year to the county treasurer. When an alleged criminal violation of any provision of this article is brought to the attention of the district attorney of any county, either on the complaint of a state or county medical society, or otherwise, he shall cause such alleged violation to be investigated and if satisfied that probable cause exists for the belief that such a crime has been committed, he shall cause the person committing such alleged violation to be prosecuted as provided by law.

Sec. 2. This act shall take effect immediately.

AN ACT

Introduced by Mr. Fish—read once and referred to the Committee on the Judiciary.

To amend the insanity law, relating to the management of state hospitals, abolishing the boards of visitation and creating boards of man-

agers thereof, and defining the powers and duties of the boards of managers and of the state commission in lunacy.

AN ACT

Introduced by Mr. Sheldon, to amend the poor law, in relation to the relief of Indians in case of epidemic.

AN ACT

Introduced by Mr. Pendry—read once and referred to the Committee on Public Health.

Regulating the sanitary condition of bathing establishments, and amending section two hundred and twelve of chapter twenty-five of the general public health laws, as amended by the laws of eighteen hundred and ninety-three; being renumbered by the laws of nineteen hundred, chapter six hundred and sixty-seven; number of section being originally two hundred and two.

THE CORONERS TO BE ABOLISHED.

Dr. E. Eliot Harris asks for a special letter to be sent to each Senator and Assemblyman, as he believes that the enactment into a law of the bill which abolishes the office of Coroner in the City of New York will be accomplished this year, if the members of the medical profession will back up the work of the committee, by writing a personal letter to the representative of their district in the Senate and Assembly.

The Coroners in the City of New York and the jury system connected therewith are abolished by the provisions of Senator Elsberg's bill, which 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, a special branch is created to do the medical work and 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. It now remains for the Legislature 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.

PURE WATER FOR NEW YORK.

Dr. Thomas Darlington, Commissioner of Health, New York City, will present a brief to the State Legislature, a portion of which will contain the following:

In connection with the abundance in the character of the water supply, it should never be forgotten that a deficiency in the supply due to drought is not simply serious because of the

alarming decrease, perhaps, in the per capita allowance which this involves and of the indirect but most important effects which decreased quantity of water has upon the sanitary conditions and death rate of the city, but also because with a decrease in quantity in a water supply which is derived from the collection of surface waters there is likely also to be a marked depreciation in quality and a serious concentration of the impurities already previously existent in it. Thus as the reservoirs and streams are drained, the sources of pollution-contamination in the immediate vicinity of these are also concentrated and frequently drained into the sources of supply and a doubly dangerous result is thus brought about, both by the concentration of impurities and the defects in quantity.

It is an old idea that flowing water purifies itself. Within half a mile of its impure source, the impurities which may be discovered by chemical methods, may be entirely lost; bacteriologically, however, it does not change perceptibly. Where we have human contamination in the water, we may look for human diseases to follow.

In this connection it is of vital importance that each great community should have absolute control over its water supply, as occasions might arise calling for prompt and immediate action, which could not be had if it were necessary to obtain the approval of some body of officials outside of such city, not subject to its control, and having no direct interest in its affairs.

MEETING OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, 1905.

The ninety-ninth annual meeting of the Medical Society of the State of New York was held in Albany, January 31, February 1 and 2, 1905. The scientific program was printed in the February issue of this JOURNAL.

The amalgamation agreement of the Joint Committee of Conference was passed by the Society.

Dr. Joseph D. Bryant, of New York, was elected president. The other officers are Dr. H. R. Ainsworth, of Addison, vice-president; Dr. F. C. Curtis, of Albany, secretary; Dr. O. D. Ball, of Albany, treasurer.

Under the presidency of Dr. Bryant it is certain that the Society will do all in its power to promote the union of the two State medical organizations. His many friends in the Association extend congratulations.

Report of the Committee of Conference.

The Committee of Conference, Dr. H. L. Elsner, chairman, presented its report, and the Society passed anew the amalgamation agreement of the Joint Committee of Conference, at the regular meeting of January 31st and again at a special meeting held February 2d, after the adjournment of the annual session.

This action was taken upon the advice of Mr. Frederick Collin, an attorney of Elmira, selected by the president of the Society at the request of the Committee of Conference, who rendered the following opinion, which was concurred in by Ex-Chief Justice Andrews, of the Court of Appeals of the State of New York.

"First. Did the Medical Society of the State of New York, by its resolution adopted January 26, 1904, legally and effectively approve and direct the execution of the proposed agreement for the consolidation of that Society and The New York State Medical Association?"

"You state that the notice to members of that meeting did not specify the date or hour or place of meeting; also that such notice was not served personally upon the members. Additional facts are: The Legislature by Chapter 1 of the Laws of 1904 had authorized the proposed agreement and directed that before the court could by its order consolidate the signatories 'the agreement must be approved by a majority of the vote lawfully cast at an annual meeting of each corporation separately, or at a meeting of each corporation separately and specially called pursuant to its by-laws for that purpose, and a certificate of such approval, verified by the president and secretary of that meeting, shall be annexed to the petition' to the court. Section 3 of Chapter 94 of the Laws of 1813 (into which chapter Chapter 133 of Laws of 1806 with its amendments was adopted) provides that the members of the Medical Society 'shall meet together at the time and place appointed by the said Society for that purpose, and being met, not less than fifteen in number, may annually elect by ballot,' etc. Section 4 of said Chapter 94 provided that the Medical Society may agree upon and determine the time and place of its meeting; and the time so agreed upon shall forever thereafter be the anniversary day of holding its meeting and the secretary of the Society shall lodge in the office of the secretary of State of New York a copy of the proceedings of the Society had at its first general meeting. Chapters 228 of Laws of 1823 and 5 of Laws of 1876 gave the Society power to change from time to time the day of holding its annual meeting by a two-thirds vote of all the members present at any anniversary or annual meeting, provided at the previous annual meeting notice of the intention to change such time shall have been given. Section 14 of said Chapter 94 empowers the Society to make by-laws and regulation relative to its affairs, concerns and property, the admission and expulsion of members, and donations or contributions as the members at their annual meeting shall think fit and proper. Chapter 544 of the Laws of 1904 empowered the Society to adopt a constitution and by-laws relative to the admission and expulsion of members and the regulation of its affairs. Chapter 2 of the by-laws adopted in 1900 provides, 'The annual meeting of this Society shall be held in the city of Albany on the last Tuesday

in January in each year, and all other meetings shall be held at such time and place as may be determined by a majority of the Society convened at any legal meeting.' Section 16 of Chapter 94 of Laws of 1813 prescribing the duties of the secretary contains no requirement that he shall give notices of the annual meetings. The by-laws, however (Section 4, Chapter 3), make it the duty of the secretary to give notice of the meetings of the Society, and further provide (Section 2, Chapter 4) that the Committee of Arrangements shall provide convenient rooms for the meetings of the Society. At the annual meeting of 1895, the time of the annual meeting was changed from the 'first Tuesday in February to the last Tuesday in January.' There is no provision in the statutes or by-laws fixing the place within the city of Albany or the hour of the annual meeting.

"Under the facts above stated, I am of the opinion, the resolution adopted January 26, 1904, did not legally and effectively approve and direct the execution of the proposed agreement for the consolidation of that Society and The New York State Medical Association. Each member of the Society is entitled to know the precise time and place of the annual meeting. Neither the statutes nor the by-laws designate the place within the city of Albany or the hour on the last Tuesday of January of each year. Each member has the right to be informed of that place and that hour. It may be that custom or usage has fixed that place and that hour and each member has knowledge of them. But this leaves room for doubt and contention. In the absence of a statute or by-laws designating the precise time and place, notice thereof must be given to each member. Statute or by-laws does not prescribe what shall be a sufficient notice. The result of the legal decision is, that in the absence of express provisions, actual notice must be given each member. The important thing is to bring to the knowledge of each member the fact that the meeting is to be held at a certain place at a certain time. Because such knowledge was not imparted to each member prior to the meeting of January 26, 1904, the proposed agreement was not there approved by the lawful vote of the Society. When a matter as extraordinary and important as this agreement is to be acted upon, the notice of the meeting should express that fact.

"It is not essential that the notice be personal. Notice by mail creates the presumption that the addressee received the notice and so was actually notified. He could, however, show affirmatively that he did not receive it.

"I would advise that the secretary prepare notice of the meeting to be held on the last Tuesday of January, 1905, stating therein that this proposed agreement will be brought for action thereon before that meeting, and mail a notice to each member; that he likewise send with such notice a printed paper, to be signed by the member, reading as follows:

"I hereby admit due and actual service upon me of a due notice that the annual meeting of the Medical Society of the State of New York will be held on the last Tuesday of January, 1905, at — o'clock in the —noon of that day at ——— in the city of Albany, N. Y., and that the proposed agreement for the consolidation of said Society and The New York State Medical Association will be brought for approval before that meeting.

"Dated, 190 .'

"In case the member does not within a reasonable time sign and return such admission to the secretary, the secretary shall send to a trustworthy physician of the county of the non-complying member a notice of the meeting to be served upon that member and with it the admission of service. The member serving the notice should, in case the member will not at his request sign the admission, note the date of the service so that he may make affidavit of it. Notice given ten days prior to the meeting is reasonable and sufficient.

"At the meeting the action taken under the resolution of Dr. Jacobi can be rescinded, and a like resolution adopted. Irregularities in the proceedings leading up to this agreement and its approval will have no effect if the agreement be legally approved."

HERNIA OF THE BLADDER, COMPLICATING INGUINAL HERNIA.

The author calls attention to cases of inguinal hernia in which there is an accompanying hernia of the bladder. Wounding of the bladder during operations for hernia are more common than the number of published cases would lead us to believe. Attention is called to the elements which influence wounding of the bladder and its consequences. The commonest form of hernia of the bladder is the extra-peritoneal. The author reports four successful operations for inguinal hernia in which a hernia of the bladder was present. On the first one of these cases the bladder was opened accidentally. Shepherd concludes his essay by calling attention to several features which he observed and which should enable one to avoid mistakes. "First, the inguinal opening is always large, out of proportion to the size of the protruding intestines. Second, the cord is not intimately associated with the sac of the tumor, but can be readily held aside without dissection; it is usually to the outer side of the tumor. Third, in two at least of his cases the hernia was a direct one, and in all had been produced by a sudden strain. Fourth, the difficulty of finding a neck to the sac, for the anterior portion of the sac stretches away toward the pubis and is perhaps covered with granular and very vascular fat." Having once wounded the bladder, the surgeon is always on the lookout for this complication and readily recognizes it.—*Francis J. Shepherd, Annals of Surgery, Vol. XL. 921.*

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR MARCH.

Wayne County, Tuesday, March 7th.
 Orange County, Wednesday, March 8th.
 Erie County, Monday, March 13th (annual).
 Cortland County, Friday, March 17th.
 New York County, Monday, March 20th.
 Westchester County, Thursday, March 23d (annual).
 Monroe County, Tuesday, March 28th.
 Saratoga County, Tuesday, March 28th.

COUNCIL MEETING.

At a meeting of the Council, held February 25th, the following resolutions were unanimously adopted:

WHEREAS, The Council of The New York State Medical Association favor the union with the Medical Society of the State of New York upon the plan proposed by the Joint Committee of Conference, which was prevented by legal complications;

Resolved, That the president of The New York State Medical Association is hereby empowered to employ associate counsel, who with the counsel of the Association shall investigate and report upon all the legal questions relating to the vested rights of the members, the By-Laws, and the calling and holding of meetings;

Resolved, That before engaging associate counsel and incurring any expense to The New York State Medical Association, the president shall first secure the approval of the Finance Committee for such expense.

Fifth District Branch.—A special meeting of the Fifth District Branch was held at the Palatine Hotel, Newburg, N. Y., February 2, 1905.

The meeting of the Executive Committee was called to order at 2.20 P. M., Dr. Van Hovenberg presiding. Those present were Drs. Van Hovenberg, Dobin, Acker, Woodhull, Leitner and Kline.

The resignation of Dr. J. Riddle Goffe as president of the Fifth District Branch was read and accepted.

The resignation of Dr. J. J. Kindred was accepted. Motion by Dr. Leitner that the treasurer of the district branch pay the expenses necessary for this meeting upon the proper certification of the Committee of Arrangements; seconded by Dr. Woodhull. Carried.

At 2.35 P. M. the scientific session was called to order by the president, Dr. Van Hovenberg. Thirty-five members were present.

The following resolution, offered by Dr. Redfield, was seconded and unanimously carried:

Resolved, That the bill now pending in Congress for the national incorporation of the American Medical Association is heartily endorsed by the Fifth District Branch Association of The New York State Medical Association; and be it further

Resolved, That a copy of these resolutions be sent to each of the Senators and Members of the House of Representatives from the several districts within the Fifth District Branch.

The first paper read was by Dr. Alexander Lambert on "Some Considerations in the Treatment of Various Cardiac Conditions," which was discussed by Dr. S. W. S. Toms.

Dr. Joseph Brown Cooke followed with some very interesting remarks on "Inertia Uteri" which were discussed by Dr. George P. Shears.

Dr. Robert H. Dawbarn then read a paper on "How Should We Handle Chronic Deformities from the Commonest of Major Fractures (Colles)?" and gave a very interesting demonstration of his method of splinting. Discussion followed by Drs. Bodine, Townsend, Howell, Bailey and Dawbarn.

Motion made by Dr. Toms, that a vote of thanks be tendered the gentlemen from New York for the very interesting and instructive papers, was seconded and carried.

(Signed) CHAS. D. KLINE,
 Secretary.

* * *

Monroe County Association.—The Monroe County Medical Association held its regular monthly meeting at 74 So. Fitzhugh street on November 29th, the president, Dr. Thomas A. O'Hare in the chair. On roll call the following members answered to their names: Drs. Jones, Curtis, E. Mott Moore, Richard M. Moore, O'Hare and Davis.

Minutes of previous meeting were read and approved. A certificate of membership in good standing was received from Dr. Howard A. Maynard, secretary of Orleans County Association, certifying to the standing of Eli H. Vail, of Barre Center, removed to Churchville, Monroe County. The certificate was ordered placed on file. A motion to renew the invitation to the Fourth District Branch to hold its annual meeting in Rochester, on June 6th, and this association to furnish a place of meeting and lunch, was unanimously carried.

The secretary was instructed to notify the members of the Committee on Legislation of any pending bills. It was moved and seconded that our next regular meeting should be held on the last Tuesday in January. Motion carried. Motion to adjourn carried.

Dr. Emil Mayer, adjunct at Mt. Sinai Hospital, has also been appointed chief of the Ear, Nose and Throat Department in the dispensary of that institution.

Lewis County Association.—The annual meeting of this association was held in the Bingham Block, Lowville, January 31st. There was a good attendance. The following officers were elected for the ensuing year: President, Alexander H. Crosby; vice-president, George H. Littlefield; secretary, LeRoy W. King; treasurer, Charles E. Douglass; Fellow to the annual meeting of the State Association, Ira D. Spencer, and Alternate, Alexander H. Crosby; Member Nominating Committee, First District Branch, G. H. Littlefield.

In the report of the business session, the treasurer reported a balance on hand of twenty-nine dollars and twenty-nine cents (\$29.29).

In the scientific session, Dr. A. H. Crosby reported a case of brachycardia in a man 53 years old previously diagnosed as fibroid heart; the pulse was recorded as low as 18 per minute with Stokes-Adam Syndrome. The patient has improved, the pulse now being 31 per minute.

The Executive Committee is made up of the officers and Drs. I. D. Spencer, Frank M. Ringrose and Charles R. Bartlett. The president appointed the following committees:

Committee on Legislation, Drs. I. D. Spencer, D. J. Culver, F. M. Ringrose.

Committee on Public Health, L. W. King, M. S. Hadsall, C. E. Douglass, George H. Littlefield.

Committee on Membership, George H. Littlefield, C. R. Bartlett, I. D. Spencer.

A motion was made and carried that Article IX of the By-Laws be so amended as to read one dollar (\$1.00) county dues in place of two dollars (\$2.00). Also, that Article VII, Meetings, be so amended as to read that the stated meetings of this Association shall be held on the last Tuesday of January, April, June and September, the same to be voted upon at the next regular meeting, February 28, 1905.

(Signed) L. W. KING,
Secretary.

* * *

Monroe County Association.—The Monroe County Medical Association held its regular monthly meeting on January 31st at 74 So. Fitzhugh street, with the president, Dr. Thomas A. O'Hare in the chair. The following members answered to roll call: Drs. E. Mott Moore, Richard M. Moore, Goddard, Stocksclaeder and Davis. The minutes of the last meeting were read and approved. Dr. Peter Stocksclaeder read a paper on the "Water Treatment of Pneumonia," and the paper was freely discussed.

Three new names were presented and elected: Drs. Joseph H. Hathaway, Henry T. Williams and Parker H. Murphy, all of Rochester. Drs. E. Mott Moore, S. Case Jones and James C. Davis were appointed on Committee on Arrangements to the annual meeting of the Fourth District Branch to be held in Rochester on June 6th.

(Signed) JAMES C. DAVIS,

Secretary.

New York County Association.—The stated meeting for February was held at the New York Academy of Medicine, 17 West 43d street, on Monday evening, February 20, 1905, Dr. Francis J. Quinlan, presiding. The executive session was called to order at 8.15, and the following resolution was proposed by Dr. E. Eliot Harris, seconded by Dr. J. Riddle Goffe:

Resolved, That the Association approve the Elsberg bill, now before the Assembly, looking to the abolishing of the office of Coroner in the City of New York.

The minutes of the previous meeting were read by the Secretary, and, on approval by the Association, were ordered on file. Sixteen new members were elected. There being no further business before the Association, the president announced at 8.45 that the meeting would go into scientific session.

Dr. Emil Mayer read a memorial to Dr. M. L. Maduro, and on the vote of the Association this paper was ordered to be published in THE NEW YORK STATE JOURNAL OF MEDICINE.

The second paper of the evening was read by Dr. George L. Peabody on the subject of "Alcohol in Disease." Dr. Peabody said, in part, that most of the recent work that had been done upon alcohol in disease was as regards its food value, and that little work had been done upon its therapeutic use or value, either as to its local or systemic affection; that some little work had been done in its local effect upon cancer by the superficial injection of small quantities of alcohol. In the treatment of hernia and kindred diseases alcohol had been used to overcome the conditions. It had also been widely used of late as a local antiseptic among physicians now using it is a counterirritant in superficial inflammations. In phlebitis and herpes zoster the author had used it with great success. Suppuration may be averted by the early local application of alcohol. Its power to relieve pain was due to its dilating effect upon the blood vessels, thereby equalizing the blood pressure in the parts. In one case of coccydina the application of alcohol had been followed by a slough. There is a tendency to recede from the former free internal use of alcohol nowadays, and most physicians are limiting its use to febrile conditions. Among those who favor its use to-day may be mentioned Meltzer, Curshman, Von Jach and Von Leyden; and J. Bintz has found it to be of great value as a food, and it is a favorable aid in cardiac and respiratory asthenias. Bonner, in 1899, advised that it be given only in small doses for the purpose of stimulating the heart. All clinical evidence points to the fact that in all cases where cardiac stimulants are required, there is nothing that will take the place of alcohol. Many cases of pneumonia require no stimulant, but where stimulation is necessary there is no drug which has the same beneficial effect as alcohol. Fever and delirium with soft pulse also call for alcohol. Bronchitis of the senile with the characteristic atheroma demands it.

There is little danger of engendering the alcohol habit in fever patients, but just as soon as the fever subsides the alcohol should be taken away. In conclusion; Dr. Peabody remarked that alcohol in disease was a blessing when properly used, and absolutely useless in health.

The third paper of the evening was read by Prof. Russell H. Chittenden, of Yale University, New Haven, entitled, "Alcohol in Health." Does alcohol in moderate quantities act as a food, and on oxidation act as carbohydrates or fats to form heat and energy? This was the chief theme of Dr. Chittenden's paper. He had shown that large quantities of alcohol caused the excess to be excreted in the lungs and kidneys, and there may be found aldehyde and acetic acid in the expired air and in the renal excretion. A few months ago Dr. Goddard, in the *British Lancet*, stated that when 1/750 of a body weight of alcohol was injected 95 per cent. of it was oxidized in the body of man. This would mean that a man weighing 160 pounds was capable of oxidizing about six ounces of pure whisky. Taking a light wine the same individual in the same time would be able to thoroughly oxidize one quart in quantity. Proteid makes tissue, but fats and carbohydrates go to form energy; and since alcohol does the same, it is a food. It also stimulates proteid metabolism and protects the same process. The pharmacopeial action of alcohol may take place before the oxidation, and therefore interfere with its value as a food. Dr. S. P. Beebe, a few years ago, while doing laboratory work on dogs, demonstrated that alcohol in man, even in moderate amounts, may cause an increase in the output of uric acid and purin bodies, not due to the accompanying diuresis from the increased quantity of liquid taken in the body. This increase of uric acid is not endogenous in origin, but is due to increased rate of production in the precursors of uric acid in the food taken in. The absorption of alcohol in the liver influences this function to produce the nuclein-producing tissues. It may also interfere with the normal processes in the liver, thereby producing substances of a harmful nature. It may not only cause trouble in the liver itself, but in other parts of the body. It also has a disturbing influence upon the oxidation of foods in the liver and upon the oxidation of the purin producing foods taken into the body. In conclusion, Dr. Chittenden said that as part of the daily food of healthy men, alcohol does not play any part as a non-nitrogenous food.

The next paper of the evening was by Mr. J. P. Atchinson, Chemist to the New York Board of Health. His subject was "Wood Alcohol." This paper will appear later in THE NEW YORK STATE JOURNAL OF MEDICINE.

A paper entitled "Legislative Aspects of Alcohol" was next read by the Hon. Maynard Y. Clement, New York State Deputy Commissioner of Excise. It will appear shortly in the pages of the JOURNAL.

The final paper of the evening was read by Dr. Charles B. Fitzpatrick, entitled "Substitutes for Alcohol."

The discussion on these papers was opened by Prof. Graham Lusk, followed by Dr. Crothers, of Hartford, Conn.; the Hon. DeLancey Nicoll, Drs. Mason, Lambert and others.

There being no further business before the Association, upon motion the meeting adjourned at 11.45.

WILLIAM RIDGELY STONE, Secretary.

* * *

Orange County Association.—The regular monthly meeting of the Orange County Medical Association was held at the Russell House, on Wednesday afternoon, February 8th, at 2 P. M. There was an average attendance. President Dr. E. D. Woodhull, of Monroe, presided.

Dr. Redfield reported an interesting supra-condyloid fracture of the humerus in a young lady of 17, the result in this particular case being very gratifying, most all the movements of the arm, even to the carrying of coat, being now possible.

Dr. Redfield also reported a case of dislocation of the ulna posteriorly without dislocation of the radius.

Dr. Douglas reported having seen a supra-condyloid fracture of the humerus and a dislocation of the elbow in the same arm.

Dr. Mary E. Dunning, of Newburg, read a practical and instructive paper, entitled "Urine and Urinalysis," giving a complete résumé of the subject. The doctor laid particular stress upon the significance of the urine in disease; also the importance of testing for indicon as a general routine along with the tests for albumin and sugar. For instance, in a case of neurasthenia its presence aided the doctor materially in the treatment of the case. The paper was discussed by all present.

Dr. Roy E. Mitchell, of the State Hospital, followed with a paper, "A Case of Military Tuberculosis," with a report of autopsy. This was the first case of this disease discovered in the treatment of 7,000 patients at this institution, every organ in the body except the pancreas being affected. The report of the autopsy was very interesting to the physicians present, owing to the thorough manner in which it had been performed and minutely reported.

The paper was discussed by Drs. Redfield, Fancher, Douglas, Purdy and Distler.

After the discussion of this paper, the Association extended a hearty vote of thanks to Drs. Dunning and Mitchell for their able and instructive papers.

At the business session Dr. Distler, secretary, in the absence of Dr. F. W. Dennis, of Unionville, chairman of the committee, reported favorably on the following resolution, and it was adopted by the Association.

Resolved, That on and after the 1st day of

January, 1905, no member of this society shall accept the position of club, society or organization physician, or agree, or continue to do any medical or surgical work for any club, society or organization at less rate than the regular or customary charge for like services rendered by other physicians for patients not members of such club, society or organization.

Also, that in no case shall any physician agree to attend the families of the members of such club, society or organization at half price or at less price than the regular rate.

Nothing in this action shall be construed as preventing any member from attending the worthy poor at a less rate or to give free service to those who are too poor to pay anything, or acting as city, county or town physician, health officer, or under any political appointments.

Any violation of this by-law shall be considered unprofessional conduct, and render the member guilty thereof liable to suspension or expulsion from this society, as the society may determine.

Dr. Mary E. Dunning, of Newburg, read a clipping from the *New York Times* in reference to the Kinesepathy bill introduced by Senator Sullivan, the purport of which is that a certain lot of shakers and rubbers be legalized to practice medicine and to be examined by their own board and accepted by the State Board of Regents. The *New York Times* wanted to know when the medical societies were going to become active and prevent such legislation. The clipping was referred to Dr. W. S. Gleason, of Newburg, chairman of the Committee on Legislation. Dr. Redfield, secretary of the State Association, requested the members to write individually to Chauncey M. Depew, favoring national incorporation of the American Medical Association.

The meeting then adjourned to March 8, 1905, the place of meeting to be announced later.

Respectfully submitted,

(Signed) LAWRENCE G. DISTLER.

* * *

Ulster County Association.—The annual meeting of the Ulster County Medical Association was held at the Kingston City Hospital, February 20th at 2 P. M. Dr. Henry van Hoevenberg, the president, occupied the chair and after the reading the minutes of the preceding meeting declared the polls open for the election of officers for the coming year. The election resulted as follows:

President, Dr. James L. Preston, Kingston; vice-president, Dr. Frederick Hulme, Kingston; secretary, Dr. Mary Gage-Day, Kingston; treasurer, Alice Divine, Ellenville; member Executive Committee at Large, Cornelius I. Hasbrouck, Rosendale; member Nominating Committee, Fifth District Branch, J. Freston, Milton-on-Hudson; Fellow, A. H. Palmer, Marlboro; Alternative, Elijah Osterhout, Plattekill.

The annual reports of secretary and treasurer were read and accepted. The secretary read a personal communication from the Congressman

from this district, George J. Smith, in which he pledged himself to use all his influence toward getting the bill passed for the national incorporation of the American Medical Association. A vote of thanks was passed to Congressman Smith and also to Philip Elting (the chairman of the Ulster County Republican Committee) through whose influence the pledge for support was secured. A resolution by Dr. Van Hoevenberg to oppose certain bills now before the Legislature in Albany and to use all efforts to secure the passage of other bills as published in the February JOURNAL, was unanimously carried and the secretary instructed to communicate with the Senator and two Assemblymen from this district in reference to those bills. The secretary introduced a resolution (which was unanimously carried) that the president of the Fifth District Branch, Dr. Henry van Hoevenberg, and the president of the County Association, Dr. James L. Preston, and the vice-president of the County Association, Dr. Frederick Hulme, be a committee with full power to act, to prosecute illegal practitioners.

Dr. J. Freston, of Milton-on-Hudson, and Dr. David Mosher, of Marlboro, were elected to membership.

The newly elected president announced the standing committees:

Committee on Public Health, Albert H. Rood, E. J. Gallagher, C. V. Hasbrouck.

Committee on Legislation, Eber H. Heston, Elijah Osterhout, J. Freston.

Committee on Ethics, A. H. Palmer, Alexander Stilwell, David Mosher.

Dr. Van Hoevenberg, the retiring president, introduced his address on "Puerperal Sepsis," with the following remarks:

"In retiring from the office with which I have been honored by you for two terms, I desire to thank you for your courtesy to me, and the assistance you have given in my efforts to maintain the high standard of scientific work which is the main object of this Association. Since its organization four years ago our meetings have been full of interest, and I feel that we can all say that they have well repaid us for time spent in attending them. We have received cordial cooperation from the officers of the State Association, and no call has been made upon them for speakers to make our meetings profitable that has not been promptly responded to. Our membership was varied, owing to many changes of residence of those who have joined us, but we have not lost ground and that is an encouraging feature. The union of the two State bodies has been postponed by technicalities unforeseen, but which will soon be obviated. The election as president by the State Society at its last meeting of Dr. Joseph D. Bryant, an ex-president of the State Association, is a guarantee in itself that the movement is progressing favorably. The joint meetings which have been held in this county have certainly brought about a better feel-

ing between the members of the two organizations, and we are better prepared now to work together as one body for the uplifting and ennobling of the profession and the human race."

MARY GAGE-DAY,
Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

SECOND DISTRICT BRANCH.

Columbia County—John T. Wheeler, Chatham.

FOURTH DISTRICT BRANCH.

Monroe County—Joseph H. Hathaway, Rochester; Parker Herbert Murphy, Rochester; Henry T. Williams, Rochester.

Onondaga County—Thomas B. Dwyer, Syracuse; Stewart S. Bibbens, Syracuse.

FIFTH DISTRICT BRANCH.

New York County—Carmelo Atonna, New York; Joseph Hector Bainton, New York; Gioachino Barabini, New York; Frederick Earl Beal, New York; Frederick F. R. Berlin, New York; Peter C. Blasi, New York; Geoffrey R. Bourke, New York; A. Vernon Clarke, New York; Herbert C. De V. Cornwell, New York; G. A. Crump, New York; Pasquale Giliberti, New York; H. A. Haubold, New York; J. Herbert Lawson, New York; Cesare Mondini, New York; Pietro Pellegrini, New York; William Braddus Pritchard, New York.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Aronson, Moses, New York City.

Bauer, Frederick E., New York City.

Belt, Henry, New York City.

Blanchard, George W., Highland Falls, N. Y.

Branth, John Hermann, New York City.

Fernandez-Ybarra, Augustin M., New York City.

Foerster, Francis, New York City.

Friedman, Samuel, New York City.

Hoving, Johannes, New York City.

Laidlaw, Frank W., Hurleyville, N. Y.

Mayne, Frank H., Lockport, N. Y.

Ochs, Benjamin, New York City.

Price, Norman W., Niagara Falls, N. Y.

Schneider, Louis H. A., New York City.

Sohmer, Alphonse, E. J., Buffalo, N. Y.

Stocker, George B., Buffalo, N. Y.

Wilkens, Ernst A. W., New York City.

OBITUARY.

Dr. Cordelia A. Greene, of Castle, N. Y., died on Saturday, January 28th, at the Presbyterian Hospital, N. Y. C. Dr. Greene was a graduate of the Western Reserve University, Class of 1857. She also graduated from the Women's College of Philadelphia. Dr. Greene had for years been the proprietor of a sanitarium at Castle, N. Y. She was a member of the American Medical Association, The New York State Medical Association and the Physicians' League of Buffalo.

Dr. Mary Alice Brownell, vice-president of the Wayne County Medical Association and one of its most active members, died at her home in Newark, N. Y., on January 30, 1905. Dr. Brownell was a graduate of the University of Michigan, Class of 1885. She was a member of The New York State Medical Association and of the Medical Society of the County of Wayne.

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Dr. George Tremont Hunter, New York City, died at St. Augustine, Fla., February 11, 1905. Dr. Hunter was a graduate of the New York University, Class of 1891. He was a member of the American Medical Association, The New York State Medical Association, Medical Society of the County of New York and the New York Academy of Medicine.

MEMORIAL OF DR. M. L. MADURO.

Read before the New York County Medical Association, New York, February 20, 1905, by Emil Mayer, M.D.

Montefiore L. Maduro, M.D., was born in St. Thomas, Danish West Indies, in 1873, his grandfather having settled there from Portugal.

At the age of 10, his parents having meanwhile made their home in Panama, the boy was sent to the Great Ealing School in England, where he remained for four years.

He then came to New York City where his education was continued in private schools, until he entered the College of Physicians and Surgeons, where he was graduated in 1895, with the degree of M.D.

He then entered the service of the Lebanon Hospital, where he remained the full term.

Following his hospital work he spent a year in postgraduate instruction, mainly in Berlin and Vienna.

Returning to New York he began the practice of medicine.

In July 1898, one year later, as a result of a distressing accident, he sustained severe lacerated wounds.

By reason of a wonderful constitution, coupled with unremitting attention and a high degree of surgical skill on the part of his attending surgeon, he recovered to such an extent as to enable him once more to assume the responsibilities of life. His recovery was indeed remarkable, and the medical history of his injuries is recorded in the *Annals of Surgerv* (April, 1899) and is one of those rare triumphs of modern surgery, showing what may be done under proper auspices, for suffering humanity.

From the time of his recovery until his death, while actively engaged in the practice of medicine, he was compelled from time to time to desist from his work because of the need of attention to some of the sequelæ of his injuries.

It was in one of these attempts at repair, extensive suppuration having occurred, his already weakened constitution being no longer able to assist, that he was compelled to give up the

fight, and he died on October 22, 1904, at the early age of 31.

Dr. Maduro was an active member of The New York State Medical Association, was the corresponding secretary of the New York County Association of that body, and was twice elected Fellow to the State Medical Association.

At the time of his death he was anesthetist to the Mount Sinai Hospital, which position he had held for two years past.

Some of his contributions to medical literature were:

"A New Method of General Anesthesia," *Medical News*, 1897, Vol. 71.

"The Status of General Anesthesia in 1900," *Medical News*, September 8, 1900.

"General Anesthesia in the Plethoric," *Medical News*, April 19, 1902.

"The Administration of Chloroform in Special Cases, by a New Method," *Medical Critic*, New York, 1903, Vol. iii, p. 1034.

Although he made a special study of anesthesia, it was not his intent to make that his life work, but rather the general practice of medicine, and his growing and successful practice gave every evidence of his ultimate good fortune in this regard.

Those of us who remember Dr. Maduro in the first years of his practice readily recall his stalwart physique and commanding personality.

He was tall, broad-shouldered, strong and healthy, had a complexion as fair as a woman's, and large brown eyes that bespoke the most gentle and kindly disposition.

Favored as he was by Nature, he was one of the most retiring and unassuming of men, always chivalrous, gentle, kind and faithful.

In the last years of his life he bore uncomplainingly much that would have embittered many another less gentle spirit.

The nature of his injuries required much attention from his colleagues, and he was ever grateful to them for their skilful and ungrudging service.

Dr. Maduro gathered about him scores of friends among his patients for his skill and his gentle, kindly ways, and from among his colleagues for his determined efforts to help toward the scientific work of his profession, for his consideration of his associates, and for his strict adherence to the conduct of his life wherein he was as he ever hoped to be—the true physician.

SOCIETY NOTES.

Academy of Pathological Science.—At a meeting held February 24th, the following subjects were discussed: "Membranous Enteritis," by Dr. William H. Dieffenbach; "Sarcoma of Choroid," by Dr. Charles Deady; "Calcarious Degeneration of Fibroid Tumor," by Dr. William F. Honan; "Tumor of Sarcum," by Dr. Milton Powell; "Splenic Leukaemia," by Dr. George F. Laidlaw.

Aesculapian Club, Buffalo.—At a meeting held February 16th, Dr. Julius Ullman read a paper on "Nephrothiasis."

Brooklyn Gynecological Society.—At a meeting held February 3d, a paper was read by Dr. Charles Jewett.

Brooklyn Pathological Society.—At a meeting held February 16th, Dr. George R. Fowler read a paper on "Observations on Gun-Shot Injuries," with lantern-slide illustrations.

Buffalo Academy of Medicine.—At a meeting held February 7th, the following papers were read: "Time as an Element in Abdominal Surgery," by Dr. Maurice H. Richardson, of Boston, Mass.; "Classic Art in Medicine and Surgery" (lantern exhibit), by Dr. Roswell Park.

Elmira Academy of Medicine.—At a meeting held February 8th, Dr. G. M. Case read a paper on "Goitre;" Dr. S. E. Palmer, on "Ozone"; Dr. Isabel Stanley, on "Hysteria"; Dr. A. H. Baker, on "Feeding in Acute Diseases"; Dr. John C. Fisher, on "Internal Use of Water"; Dr. A. J. Westlake, on "Non-Operative Treatment of Hemorrhoids."

Harlem Medical Association.—At a meeting held February 1st, Dr. A. A. Berg read a paper on "Some Clinical and Diagnostic Features of Acute Jaundice"; Dr. Charles A. Elsborg, on "Some Clinical and Diagnostic Features of Chronic Jaundice."

Jenkins Medical Association.—At a meeting held February 9th, Dr. E. M. Hermance read a paper on "Cancer of the Uterus."

Medical Association of Greater New York.—At a meeting held February 15th, Dr. J. Milton Mabbott read a paper on "Asepsis and Antisepsis in Obstetrics; Sterile Gauze and Sterile Water"; Dr. Arnold Sturmdorf, on "Perineum, Perineorrhaphy and Prolapse"; Dr. Brooks H. Wells, on "The Gynecologist and the General Surgeon—Their Respective Fields."

New York Surgical Society.—At a meeting held February 8th, Dr. Walker read a paper on "The Undescended Testis in Relation to Hernia."

Rochester Academy of Medicine.—At a meeting held February 15th, Dr. J. H. Musser read a paper on "Some Considerations of Endarteritis." and at a meeting held February 22d, D. W. W. Smith read a paper on "Oral Prophylaxis," and Dr. Paul F. Sondern on "Respiratory Prophylaxis."

Rochester Pathological Society.—At a meeting held February 9th, Dr. W. L. Conklin read a paper on "The Scientific Spirit versus Commercialism in Medicine."

Saratoga Springs Medical Society.—At a meeting held on February 17th, in the Symposium on Arterio-Sclerosis, Dr. Towne read a paper on "Etiology and Pathology"; Dr. Sanford, on "Symptoms and Diagnosis," and Dr. Resseguie on "Prognosis and Treatment."

Society of Internal Medicine.—At a meeting held February 15th, Dr. Bovaird read a paper on "Weight and Function of Thymus."

Society of Medical Jurisprudence.—At a meeting held February 20th, Dr. Reynold Webb Wilcox read a paper on "Why Quackery Thrives."

Society of the Alumni of City Hospital.—At a meeting held February 8th, Dr. C. T. Dade read a paper on "Cases of Nævus Treated by Liquid Air."

Syracuse Academy of Medicine.—At a meeting held February 21st, in the Symposium on Scarlet Fever, Dr. J. L. Heffron read a paper on "Prophylaxis"; Dr. A. C. Mercer, on "Contagion and Etiology"; Dr. W. J. Werfelman, on "Diagnosis"; Dr. S. F. Snow, on "Ear and Throat Complications"; Dr. J. R. Johnson, on "Renal, Cardiac and Cerebral Complications," and Dr. John Shoudy on "Treatment."

West End Medical Society.—At a meeting held February 25th, Dr. F. Spencer Halsey read a paper on "The History and Use of the Forceps."

Women's Medical Association of New York City.—At a meeting held February 15th, Dr. Flora Pollock read a paper on "The Hidden Plague," and Dr. Helen Baldwin on "The Origin of Gall-Stones."

Book Reviews.

THE SURGICAL TREATMENT OF BRIGHT'S DISEASE. By George M. Edebohls, A.M., LL.D., Professor of the Diseases of Women in the New York Post-Graduate Medical School and Hospital; Consulting Surgeon to St. Francis' Hospital, New York; Consulting Gynecologist to St. John's Riverside Hospital, Yonkers, N. Y., and to the Nyack Hospital, Nyack, N. Y.; Fellow of the New York Academy of Medicine, and of the American Gynecological Society; Honorary Fellow of the Surgical Society of Bucharest; Permanent Member of the Medical Society of the State of New York, etc. New York: Frank F. Lisecki, publisher, 9 to 15 Murray street, 1904.

Little, if anything, is added to the knowledge of the surgical aspects of nephritis in this book. Almost all that Dr. Edebohls has learned by his large experience in the decapsulation of the kidneys in Bright's disease has been told in his numerous articles contributed to the medical journals since his first preliminary communication appeared in 1899.

The real value of a book of this nature lies in the fact that the author has collected all of his own papers upon the subject in one volume and added a most complete list of the writings of other authors upon the subject.

TEXT-BOOK OF HUMAN HISTOLOGY, including Microscopic Technic. By Drs. A. A. Böhm and M. von Davidoff, of Munich, and G. Carl Huber, M.D., Professor of Histology and Embryology in the University of Michigan, Ann Arbor. Second edition, thoroughly revised and enlarged. Handsome octavo of 525 pages, with 376 original illustrations. Philadelphia, New York and London: W. B. Saunders & Co., 1904. Flexible cloth, \$3.50 net.

This work of Drs. Böhm and Davidoff is one of the most practically useful books on the subject ever written. The editor has introduced valuable microscopic technic, which is concise and clear. Part 1 gives general histology, Part 2 special histology. Dr. Huber in editing the American edition has added much useful matter, the practical results of his own extensive experience in histologic endeavor. This new second edition has been in large part reset, all the newest methods of technic being incorporated. The large number of illustrations makes the book more valuable for use in the laboratory, and, being bound in flexible cloth, is very serviceable.

A COMPEND OF MEDICAL LATIN. Designed expressly for Elementary Training of Medical Students. By W. T. St. Clair, A.M., Professor of the Latin language in the Male High School of Louisville, Ky.; Author of "Cæsar for Beginners," "Notes to Cæsar's Gallic War, Book Three," etc. Second edition, revised. Philadelphia: P. Blakiston's Sons & Co., 1012 Walnut street, 1904.

An excellent little book for the use of the student of medicine, and will be a great help to him who has little or no knowledge of Latin. It is concise and practical and is arranged for ready reference and exact in details.

LECTURES TO GENERAL PRACTITIONERS ON DISEASES OF THE STOMACH AND INTESTINES, with an account of their relations to other diseases and of the most recent methods applicable to the diagnosis and treatment of them in general; also "The Gastro-Intestinal Clinic," in which all such diseases are separately considered. By Boardman Reed, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Hygiene and Climatology in the Department of Medicine of Temple College, Philadelphia; Attending Physician to the Samaritan Hospital; Member of the American Medical Association, American Climatological Association, American Academy of Medicine, American Electro-Therapeutic Association; Foreign Member of the French Société d'Electrotherapie, etc. Illustrated. Published by E. B. Treat & Co., 243 West 23d street, New York.

The author's large experience in this work, having

been over twenty years in general practice, justifies the excellent volume he has published. Part I treats of the anatomic, physiologic, chemic and diagnostic data; Part II the methods of examination; Part III methods of treatment; Part IV of the gastro-intestinal clinic. His methods of examination are excellent, being devised to meet with the least possible objection and yet compatible for an accurate diagnosis. The book is well adapted for the general practitioner of medicine and is one he cannot well afford to be without.

STRABISMUS, OR SQUINT. Latent and Fixed. A Supplement to "The Errors of Refraction." By Francis Valk, M.D., Professor of Diseases of the Eye, New York Post-Graduate School and Hospital; Consulting Ophthalmologist, Thrall Hospital, and formerly Assistant Surgeon Manhattan Eye and Ear Hospital; Visiting Ophthalmologist Randall's Island Hospitals, and Ophthalmologist to the New York Dispensary; Fellow of the New York Academy of Medicine and of the State and County Medical Societies; Member of the Greater New York Medical Society and the Society of Medical Jurisprudence, etc. G. P. Putnam's Sons, New York and London: The Knickerbocker Press, 1904.

In this excellent monograph the author has clearly and concisely stated his views and theories, basing his conclusion on past experience and present work. Particular stress is laid in the imbalance of the external muscles of the eye, and having a measure of originality that will stand a fair and crucial test. Due credit is given for assistance and suggestions in the preparation of the work to Drs. E. M. Alger and Gertrude Allen.

A TEXT-BOOK OF DISEASES OF WOMEN. By Charles B. Penrose, M.D., Ph.D. Formerly Professor of Gynecology in the University of Pennsylvania; Surgeon to the Gynecean Hospital, Philadelphia. With 225 illustrations. Fifth edition, revised. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

The popularity of this work is shown by the fact that this fifth edition so quickly follows the reprint of two years ago. It is carefully rewritten and revised and much new matter has been added. The author presents in most instances but one line of treatment, making it easier for the student and less confusing to the physician. It is a work that will meet the necessities of the specialist and the general practitioner of medicine in equal degree. A number of new original illustrations have been introduced.

A COMPEND OF THE DISEASES OF THE EYE AND REFRACTION, INCLUDING TREATMENT AND SURGERY. By George M. Gould, A.M., M.D., Editor *American Medicine*; formerly Ophthalmologist to the Philadelphia Hospital, etc.; and Walter L. Pyle, A.M., M.D., Assistant Surgeon to Willis Eye Hospital, Philadelphia; Associate Member of the American Ophthalmological Society, etc. Third edition, revised and corrected; 109 illustrations, several of which are in colors. Philadelphia: P. Blakiston's Sons & Co., 1012 Walnut street, 1904.

This third edition is well written and would repay the general practitioner of medicine to read. It is more complete than is usually found in a compend, and might reasonably be resumed. The first part is complete in the examination and refraction of the eye, the second as fully describes and treats of the diseases of the eye. Many of the 109 illustrations are colored, which adds much to their value.

A TEXT-BOOK OF HUMAN PHYSIOLOGY. By Albert P. Brubaker, A.M., M.D., Professor of Physiology and Hygiene in the Jefferson Medical College; Professor of Physiology in the Pennsylvania College of Dental Surgery; Lecturer on Physiology and Hygiene in the Drexel Institute of Art, Science and Industry. With colored plates and 334 illustrations. Price, \$4.00 net. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1904.

The author's experience as a teacher in physiology for over twenty years has been his guide in the presentation of the facts, the object being to help the students

and general practitioner of medicine in the useful knowledge of physiology. Such facts have been selected as will give the normal functions of the tissues and organs of the body, and thus show the abdominal conditions presented at the bedside.

The author has omitted much of the physiologic apparatus with the methods of investigation which are found in books devoted to laboratory instruction. The line of work is devoted to that of older physiologies, no mention being made of the new facts in physiology, more especially relating to physical and chemical methods. To the general practitioner who wishes to review his knowledge in physiology this book is well worth the reading.

A TEXT-BOOK OF ALKALOIDAL THERAPEUTICS, Being a Condensed Résumé of All Available Literature on the Subject of the Active Principles, Added to the Personal Experience of the Authors. By W. F. Waugh, M.D., and W. C. Abbott, M.D., with the collaboration of E. M. Epstein, M.D. Chicago: The Clinic Publishing Company, 1904.

This work is a complete reference book on the present knowledge of alkaloidal therapeutics. The authors have sought all the available literature on this subject and have succeeded in collating all the facts concerning alkaloids in a book of about four hundred pages.

A TEXT-BOOK OF PRACTICAL THERAPEUTICS, with Especial Reference to the Application of Remedial Measures to Disease and Their Employment Upon a Rational Basis. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one-time Clinical Professor of Diseases of Children in the University of Pennsylvania; Laureate of the Royal Academy of Medicine in Belgium, of the Medical Society of London; and author of "A Text-Book of Practical Diagnosis," etc. Tenth edition, enlarged, thoroughly revised and largely rewritten, illustrated with 113 engravings and 4 colored plates. Philadelphia and New York: Lea Bros. & Co., 1904.

As a guide to the general practice of medicine in rational therapeutics the author maintains the high standard in this tenth edition. It has been revised and reset, much new material being added. The author first considers general therapeutics, followed by the drugs, then remedial agents other than drugs, and feeding the sick. Particular attention is given to the treatment of diseases. It is one of the best books of practical therapeutics yet published.

A TEXT-BOOK OF LEGAL MEDICINE AND TOXICOLOGY. Edited by Frederick Peterson, M.D., President of the New York State Commission of Lunacy; Clinical Professor of Psychiatry, Columbia University, New York; General Consultant to the Craig Colony for Epileptics, Sonyea, N. Y., and Walter S. Haines, M.D., Professor of Chemistry, Pharmacy and Toxicology in Rush Medical College, Chicago; Professorial Lecturer on Toxicology in the University of Chicago. In two volumes, containing 1,500 pages, fully illustrated. Vol. II. Philadelphia, New York and London: W. B. Saunders & Co., 1904. Cloth, \$5 net; sheep or morocco, \$6.

This work presents to the medical and legal professions a comprehensive survey of forensic medicine and toxicology in moderate compass.

For convenience of reference the treatise has been divided into two sections, Part I and Part II, the latter being devoted to toxicology and all other portions of legal medicine in which laboratory investigation is an essential feature. Under "Expert Evidence" not only is advice given to medical experts, but suggestions are also made to attorneys as to the best methods of obtaining the desired information from the witness. The Bertillon and Greenleaf-Smart systems of identification are concisely and intelligently described, and the advantages of each stated. An interesting and important chapter is that on "The Destruction and Attempted Destruction of the Human Body by Fire and Chemicals," for on the determination of the human or animal source of the

remains frequently depends the legal conduct of a given case and the guilt or innocence of the accused. A chapter not usually found in works on legal medicine, though of far more than passing significance to both the medical expert and the attorney, is that on the medico-legal relations of the X-ray. The responsibility of pharmacists in the compounding of prescriptions, in the selling of poisons, in substituting drugs other than those prescribed, etc., furnishes a chapter of the greatest interest to every one concerned with questions of medical jurisprudence. Also included in the work is the enumeration of the laws of the various States relating to the commitment and retention of the insane. In fact, the entire work is overflowing with matters of the utmost importance, and expresses clearly, concisely and accurately the very latest opinions on all branches of forensic medicine and toxicology.

BOOKS RECEIVED.

A TEXT-BOOK OF LEGAL MEDICINE. By Frank Winthrop Draper, A.M., M.D. (Harv.), Professor of Legal Medicine in Harvard University; Medical Examiner for the County of Suffolk, Massachusetts; Medico-Legal Pathologist at the Boston City Hospital; Fellow of the American Academy of Arts and Sciences, etc. Fully illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

ATLAS AND ÉPITOME OF OPERATIVE OPHTHALMOLOGY. By Dr. O. Haab, of Zurich. Edited, with additions, by George E. de Schweinitz, M.D., Professor of Ophthalmology in the University of Pennsylvania. With 30 colored lithographic plates, 154 text cuts and 377 pages of text. Philadelphia, New York and London: W. B. Saunders & Co., 1905. Cloth, \$3.50 net.

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. 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, Leipzig, Brussels and Carlsbad. Vol. IV, Fourteenth Series, 1905. Philadelphia and London: J. B. Lippincott Company, 1905.

BACTERIOLOGY AND SURGICAL TECHNIC FOR NURSES. By Emily M. A. Stoney, Superintendent of the Training School for Nurses, St. Anthony's Hospital, Rock Island, Ill.; Author of "Practical Points in Nursing," "Practical Materia Medica for Nurses," etc. Second edition, thoroughly revised and enlarged, by Frederick Richardson Griffith, M.D. (Univ. of Penn.), of New York; Surgeon, Fellow of the New York Academy of Medicine. Illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

APPLIED PHYSIOLOGY, Including the Effects of Alcohol and Narcotics. By Frank Overton, A.M., M.D., Primary Grade, Intermediate Grade and Advanced Grade. Published by American Book Company, New York, Cincinnati, Chicago.

A GENERAL PHYSIOLOGY, FOR HIGH SCHOOLS, BASED UPON THE NERVOUS SYSTEM. By M. L. Macy, L.B., assisted by H. W. Morris, M.D., Professor of Biology, Iowa College. Published by American Book Company, New York, Cincinnati and Chicago.

TRANSACTIONS OF THE SECTION ON LARYNGOLOGY AND OTOTOLOGY OF THE AMERICAN MEDICAL ASSOCIATION AT THE FIFTY-FIFTH ANNUAL SESSION, held at Atlantic City, N. J., June 7 to 10, 1904. American Medical Association Press, Chicago.

Original Articles.

PNEUMONIA.*

BY ALEXANDER LAMBERT, M.D.

MR. PRESIDENT and Gentlemen: Permit me to thank you for the pleasure it has given me to accept your invitation to read a paper here, and to express my appreciation of the compliment that it implies. I have chosen the subject of pneumonia, not that there is anything new or startling to offer in our knowledge of the disease or in its treatment, but because it is at times worth while to bring part of our knowledge together concerning any disease, and to discuss it, and, by interchanging our views on the subject, each one in the end may learn something new from another's experience. For the experience, great as it may be, of any one man in any disease is limited. We hear it very generally stated that pneumonia is increasing year by year. While this may be true in certain cities during certain years, considering the country as a whole, it does not seem to hold good. Comparing the United States census of 1900 with that of 1890, we find that in the last census year 105,971 deaths from pneumonia were recorded; 58,340 were males and 47,631 were females, and the proportion of deaths from this disease in 1,000 deaths from all known causes was 106 1-10, corresponding to 96 6-10 for 1890. This would seem to be a distinct increase for the whole country, but a more minute glance at the statistics does not bear this out, as Fulton¹ shows in a recent article. The great increase in the last census has been due to an increase in the deaths from this disease in children under 15 years of age. This increase has been due, in a great measure, to the fact that many cases formerly recorded under nervous diseases in children, because of the convulsions and other symptoms present, are now recorded where they belong, under pneumonia. The record of deaths from pneumonia between 15 years and 60 is smaller in the last census than in that of 1890. For the ages over 60 several pathologic conditions, not provided for in statistics, have been added to the group of pneumonia, and have thus influenced the apparent increase of mortality from this disease in this 6 per cent. of our total population. It seems, therefore, that from these statistics alone, when carefully analyzed, there is no proof of the increase of pneumonia. It is true that in certain years pneumonia is often more prevalent than in others. This is well shown in the occurrence of pneumonia in New York during the winter of 1903 and 1904 and during the present winter. During December and January of 1903 and 1904 there were admitted, died and discharged in Bellevue Hospital 143 cases of lobar pneumonia, while during this winter in the same months there have been but 119. The statistics

of any large city hospital will show even greater variation from year to year in the number of patients suffering from pneumonia admitted, and also large variation in the percentage of deaths. Considering the mortality rate of pneumonia in the United States as a whole, we see that it is greatest in the southern Mississippi belt (parts of Arkansas, Louisiana, Mississippi, Tennessee), in the Middle Atlantic coast region (the littoral of New York, New Jersey, Delaware, Maryland, Pennsylvania and the District of Columbia), and the Cordilleran region, that is in the States through which the Rocky Mountains run (parts of Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming). It is lowest in the Pacific Coast region (the littoral of Washington, Oregon and California), in the heavily timbered region of the Northwest (northern Wisconsin, Minnesota and Michigan), and in the Gulf Coast region (parts of Alabama, Florida, Louisiana, Mississippi and Texas). While habits of life change the death-rate from this disease, there is also a distinct racial sensitiveness or immunity to its infection. For it is very noticeable that the death-rate is higher among the colored than among the whites, and it is higher in the foreign whites than in the native whites. It is also higher in the native whites with foreign parents than in the native whites with native parents. In children under 15 years of age it is highest in those whose mothers were born in Italy, Russia and Hungary, and lowest in those whose mothers were born in Scotland, England and Wales and the United States. From 15 to 40 years of age it is highest in those whose mothers were born in Ireland, Italy and Bohemia, and lowest in those whose mothers were born in Poland, Russia and the United States. From 45 to 64 years of age it is highest in those whose mothers were born in Ireland, Italy, Hungary and Russia, and lowest in those whose mothers were born in Poland, the United States, France and Canada. For those over 65 years of age it is highest in those whose mothers were born in Russia, Italy and Ireland, and lowest in those whose mothers were born in Hungary, France, Canada and the United States. The ratio in each one of these nationalities varies in the order given. This variation in the different nationalities at different ages may be due in some measure in the older ages to the proneness of certain races to alcoholism, but not entirely so, for while the greatest number of deaths from alcoholism occur among the Irish, the Italians show the lowest alcoholic death-rate, although they show so noticeably high a death-rate from pneumonia. Pneumonia is more frequent in males than in females, though the mortality rate seems to be distinctly higher for women than for men. From the census, it would seem that at each age under 65 the total number of deaths was higher in males than in females, but after 65 the total number of deaths in females exceeded that of the males. Considering

*Delivered before the Hartford, Conn., Medical Society, February 6, 1905.

the death-rate in pneumonia from the standpoint of occupation, we notice among professional men that it is highest in clergymen and physicians. Without going too much into detail concerning the many other occupations, it is very high in certain occupations where dust seems to be an element in the daily work, such as millers and tobacco workers. It is very high among the laboring and servant classes, and it seems higher among those exposed to outdoor life and varying temperatures; this last factor, variation in the temperature, is also a noticeable feature in the occurrence of pneumonia in the different months of the year. While the occurrence of pneumonia runs high in the cold winter months, it is highest in March and April and lowest in July, August and September. Mere cold does not seem to be sufficient to cause the prevalence of the disease, for it is not common in Iceland nor among the whites in the winter months of Alaska, and it is common in Arabia, India and Italy, where the temperature ranges high. The frequency of the occurrence of pneumonia throughout the world coincides in all places with that time of the year in which the temperature is most variable.

For the past twenty years we have realized that the disease we call pneumonia in its various forms has for part of its causal factors the invasion of bacteria into the lung tissue. While the presence of pneumococcus is usually considered as practically the sole incitant of diffuse lobar lesions, it is probably more accurate to say that it is the incitant in over 90 per cent. of this form of the disease. The influenza bacillus, Friedlander's pneumo-bacillus, streptococci, staphylococci at times may form mixed infections with the pneumococcus in the lobar lesions, and may be the sole incitant in the lobular and broncho-pneumonic forms. The streptococcus is the most frequent incitant in the secondary pneumonias, developing in the course of the exanthemata. From clinical observations alone in either the lobar pneumonia or the broncho-pneumonia, the lesions produced by these different bacteria cannot always be differentiated.

In the mixed infections in which the pneumococcus predominates it also seems to dominate the clinical features, and the disease may run the same course as the pure pneumococcus infection, terminating by crisis, but the mixture of Friedlander's bacillus and the influenza bacillus with the pneumococcus renders the disease much more often fatal than in the simple pneumococcus pneumonia. Anatomically in the pneumonia caused by the influenza bacillus there is a maximum of congestion and a minimum of consolidation, the congestion being out of all proportion to the inflammatory exudate. The pneumococcus lesions are in general more diffuse, fibrinous and hemorrhagic and less necrotic than those induced by either streptococcus or pneumo-bacillus. Gangrene rarely results from pure pneumococcus lesions, and when the necrotic condition appears in a pneumococcus infection it is almost invari-

ably due to some secondary infection. From the studies of Stuhler² it is evident that the pneumo-bacillus of Friedlander can produce a lobar pneumonia, which clinically pursues an atypical course and anatomically shows lesions exceedingly mucigenous in character. The exudate appears like the gray hepatization in the genuine pneumococcus pneumonia. The leucocytes are found grouped along the alveolar walls and infiltrating the alveolar septa, gangrene not uncommonly resulting from these lesions. The sputum of Friedlander's bacillus is more viscid and bloody than with the pure pneumococcus. The lesions produced by the streptococcus are more similar to those produced by the pneumococcus, but the streptococci rarely give rise to the lobar form of pneumonia.

For many years it did not seem possible to produce in animal experimentation the same lesions as those found in the diffuse lobar pneumonia of man. Recently, however, Dr. Augustus Wadsworth, Alumni Fellow in Pathology in the College of Physicians and Surgeons, New York, has succeeded in obtaining in laboratory animals the same lesions that occur in man. In a most excellent and suggestive review on the subject of the etiology of acute pneumonitis, Wadsworth³ has brought out many interesting facts in pneumococcus infection as it occurs in man and in animals. In animal experimentation, the great difficulty has been that by using pneumococci of low virulence, no pulmonary lesions were produced; by using pneumococci of high virulence only slightly diffused or patchy pulmonary lesions occurred and the animals died of acute pneumococcus septicemia. By varying the virulence of the bacterial incitant and permitting the susceptibility of the animal to remain about the same, the results were always unsatisfactory. The pneumonic lesions, while analogous in their morbid processes to pneumonia in man, could not be said to be anatomically similar. Wadsworth, by immunizing his rabbits, and thus varying the susceptibility of the animal organism, found that by using cultures of low virulence no lesions were produced, but by using cultures of high virulence he obtained diffuse lobar lesions, similar to lobar pneumonia in man. It is evident from these experimental facts that the lesions in pneumonia in man vary, according to the virulence of the infecting bacteria and the susceptibility of the individual patient. Adult man is, as a rule, a resistant organism to pneumococcus infections. But in infancy and old age he is much more susceptible, and for that reason broncho-pneumonias are more common at the extremes of life; for with virulent bacteria and susceptible patients the lesions in the lung are but patchy and of small extent, while the general infection is marked and the mortality from pneumonia in infancy and old age is high. After infancy has been passed, we find the organism more resistant to the pneumococcus infection, and therefore the local lesion is more diffuse and the general infection less severe, and the mortal-

ity in childhood is low. In adult life the conditions are more evenly balanced, and while there are diffuse lobar lesions, there is a tendency for the bacteria to go beyond the point of their local lesion, and to kill by general infection. Undoubtedly besides the racial sensitiveness and resistance to the pneumococcus infection there is the individual resistance, which varies in power at various times, and is at times diminished by various causes, as starvation, exposure, fatigue and various morbid processes in the body from whatever cause. This explanation of the pneumococcus infection welds together the facts of animal experimentation and a mass of clinical observation which heretofore did not seem to coincide and often seemed at variance.

There is still much difference of opinion as to the path by which the infection goes to the lungs in man. In some secondary pneumonias of the metastatic type it undoubtedly goes through the blood to the lungs. Pneumonia of the bubonic plague is the only form which seems to have the infection through the lymphatics. Many are today of the opinion that pneumonia is a general infection, and the lungs are only a secondary involvement of the general septicemia. Others still believe that in the vast majority of cases the infection is through the air passages. Normally we find in the upper air passages, extending down into the trachea, bacteria which are deposited there from inspired dust-laden air. The normal mucous membrane and its secretions are unfavorable environments for the growth of bacteria, and while when thus deposited they may grow and live as parasites, the majority of them, however, are undoubtedly destroyed. In the trachea, the cilia tend to move them upwards, and the lower part of the trachea is practically sterile. The air spaces of the lungs in normal conditions are also sterile. The pneumococci, streptococci, staphylococci and Friedlander's bacilli have been found in the upper air passages. The pneumococcus has been found in from 4 to 100 per cent. of the individuals in which it has been sought by different observers. Netter, dividing his cases into those who had had pneumonia and those who had not, found these organisms in the proportion of four out of five and one out of five respectively, and he also claims to have found the organisms virulent five to ten years or more after the pneumococcus infection, though there does not seem to be any proof that they had been there continuously. Taking these facts and remembering that experience has proved that exposure to cold may give rise to hyperemia congestion, exudation, or even hemorrhage, and remembering also that the structure of the lung is such that these circulatory disturbances are especially well marked in this organ, it is not difficult to understand how exposure to cold may give the necessary opportunity for the bacterial infection to spread broadcast in these tissues, and it is a proved fact that exposure to cold predisposes to many infections. This seems the most common manner of infection. On the other hand,

those who believe that the disease is a general septicemia with hematogenous infection of the lung, emphasize the fact that at some time during the disease the pneumococcus can usually be found circulating in the blood, for with improved methods of technique these bacteria have been found in the blood in an increasing proportion of the cases, the most recent observers reporting over 90 per cent. of positive findings. This does not prove that the bacteria were in the general circulation before the infection in the lung took place, and the experimental proof of hematogenous infection in lobar pneumonia is meager, uncorroborated and relatively insignificant. After reviewing all the facts, Wadsworth concludes that in the absence of reliable and positive data the possibility of lobar pneumonia arising by hematogenous or lymphatic infections must be considered as not yet established. This, of course, does not include the possibility of a metastatic pneumonia taking on a diffuse lobar form. Though one can readily understand how, after exposure to smoke or after prolonged anæsthesia or when the general resistance of the body is lowered by some previous disease process or when there is already an influenza bronchitis existing, pneumonia may supervene. But after considering all the facts at our command, there are many points in the mechanism of pneumococcus infection which are still obscure.

The symptoms of the disease are too familiar to need minute description. There is one peculiarity about pneumococcus infections which is worthy of remembrance, and that is the frequency with which the infection is marked by a severe chill, followed by a distinct fever, and the development of a herpetic eruption. Other infections develop with a chill followed by fever, but herpes is rare except in pneumococcus infection, malaria and epidemic cerebro-spinal meningitis. It is the combination of the three symptoms above which is so common with the pneumococcus infections. The herpes as a diagnostic sign is very significant; as a prognostic sign it is of little importance. For herpes occurs more often in the young. Pneumonia is much less fatal in the young, except in infants, so that the old idea that a child with herpes had a favorable prognosis is simply due to the fact that the prognosis in children is more favorable than at other ages. Pain in the abdomen is another symptom, which I think is worthy of being emphasized, and which is mentioned as being common in children with pneumonia. In my experience, it is not at all uncommon in adults, and is due, I believe, to the irritation, by pressure on the trunk of some intercostal nerve, the pain being referred to the nerve endings of that nerve in the skin, so that one has but to remember to what point in the abdomen the intercostal nerves go, and, tracing backward, one will almost invariably find the pleurisy situated close to the vertebral column. For the pressure on the intercostals in these cases is most often found as they go under the pleura from the vertebral open-

ings, just before they go into their costal canals. I have seen this pain so severe in adults as to simulate a perforation of the intestines when a severe pleurisy developed in typhoid fever. A symptom in the pneumonia of the aged is worthy of mention, and that is that with a sudden malaise, a subnormal temperature is often the first symptom of a beginning pneumonia, and in a few cases in the aged the temperature never rises above normal throughout the course of the disease. In broncho-pneumonia it is important to remember that the disease may run its course with high temperature, frequent pulse and intense prostration, and yet give no physical signs or only the signs of a general bronchitis. These symptoms are the only ones which seem to me to require special emphasis, for the ordinary symptoms and the picture of the course of the disease is a familiar one to you all.

It would seem that in a disease so common in its occurrence as pneumonia, that all would agree as to the physical signs due to the various changes in the lung. This, however, does not seem to be the case, and there is still a question as to the ordinary physical signs of a beginning pneumonia. The conclusions expressed by Conner⁴ seem to be the most accurate on this point, that the first sign is a circumscribed area of feeble breathing as compared with the breathing at a corresponding point on the other side, with the patient, if possible, in a sitting position, a circumscribed area of impaired resonance with or without the tympanic quality, the crepitant r le, slight increase in the intensity and clearance of the vocal resonance, the frequency in occurrence and the importance of these signs being in the order named. When bronchial breathing begins, the bronchial quality is first heard at the beginning of expiration, and this form of bronchial coo is often the first sign of a central pneumonia that we can hear. In my experience, I have most often heard the beginning bronchial breathing high up in the axilla when pneumonia was developing in the upper lobe and at a point at the posterior axillary line just under the angle of the scapula, when it was developing in the lower lobe. This refers to those cases in which one searches for a long time to find a pneumonia which one believes to exist and not to those cases in which the whole lobe is affected at once.

The leucocytosis of pneumonia is an interesting study, and is a phenomenon which often gives us many useful hints as to the resisting powers of the patient, the intensity of the infection and the development of complications. To obtain the full value from the study of the leucocytosis, one must take it daily and watch its varying conditions. This I know is a procedure which is often impossible in a private practice. This was done for me by my house physicians in Bellevue Hospital in eighty-five cases of pneumonia. A normal leucocyte count of 7,500 or a low count up to 12,000 means a very mild infection or a very resistant or-

ganism. A leucocyte count below normal and decreasing always carries with it, in my experience, a fatal prognosis. A marked leucocytosis of 25,000 or 50,000 shows an intense infection with a vigorous resistance. The size of the leucocyte count will vary to a certain extent in direct ratio to the amount of lung tissue involved. A sudden increase in the leucocytes is observed when there is an extension of the disease or when there is a large amount of detritus being poured into the circulation from the resolving lung, and especially if there is an extension in one lobe simultaneously going on with resolution in another. It is also noticeable that the leucocytes rise just before the crisis occurs and fall to normal after the temperature, when this falls by crisis and together with it, when it comes down by lysis. It is also noticeable that the leucocytes do not fall to normal when resolution is delayed, but run along between 12,000 and 19,000, until the lung is cleared of its exudate. The most important information that the leucocytes can give us is when empyema develops as a complication during the progress of pneumonia. It is usually said that empyema is a sequela more often than a complication of pneumonia. My experience is that it is more frequently a complication than a sequela. In the six cases in which empyema developed during the time that we counted the daily leucocytes it was a very striking and suggestive sign that the leucocytes always increased over 100 per cent. in the twenty-four hours in which the empyema developed, so that I believe that a sudden doubling of the leucocytes in a single day means a purulent complication. The leucocytes may double in forty-eight to seventy-two hours, when a large area of lung is rapidly resolving, but the sudden doubling in a single twenty-four hours is, I believe, a significant indication of empyema. Pleurisy with serous infusion causes but a slight rise in the leucocytes, for example, from 19,000 to 25,000. If one looks at the different forms of leucocytes, it seems to be true that the eosinophiles disappear in the early stages of the disease, and when they reappear it is of good prognostic significance. The leucocytosis of pneumonia is usually a polymorphonuclear leucocytosis. There have been some cases reported in which the leucocytosis was mainly in the small mononuclear lymphocytes.

In any given case, however, what interests us most is the treatment and the prognosis. As far as treatment is concerned, there are almost as many different opinions as there are different physicians. The difficulty of judging accurately of any special line of treatment is that the virulence of the infection varies from year to year in the different epidemics, and the resistance of the individual patient varies so much according to age, habits of life and the unknown resistance to disease in general, that it is almost impossible to form an accurate estimate of any specialized form of treatment. There is no successful specific treat-

ment for pneumonia. We had all hoped at one time that the serum treatment of pneumonia might give us a specific, but we are dealing with a micro-organism that carries its poisons within its body and does not seem to set free a soluble toxin, and thus allow the formation of a definite antitoxin such as we see in diphtheria. We are dealing with a serum that is bactericidal in its actions; we are pouring into the blood of the patient a so-called immune body which requires the combination of the so-called complement to make it an effective deadly substance to the bacteria, and it is just this complement, this one essential substance in the body, which seems to be lacking in many of the infectious diseases. We have no means at present, or method of immunization, by which we can increase this complement. The body must move on in its own way; we do not seem to be able to help it, and, if you will pardon my expression, we must stand on the side lines and watch the opposing forces fight out the game. I do not mean that we are helpless and hopeless, but I do mean that we can only help and assist the organism to keep life intact, and must let the organism work out its own salvation. There is one feature in pneumonia which I think is very prominent, and that is the low arterial pressure which develops in the course of the disease. In mild cases, this is not a prominent feature, but in severe cases it is very noticeable and is, I believe, due to the effect of the poison on the vasomotor system. In general it seems to me that in our endeavors to sustain the heart we have to try to help the right heart do extra work and to assist the left heart to keep up its muscular contractions, and besides we must endeavor to keep as near as possible the normal tone in the circulation. In mild cases strychnin seems to be sufficient for the purpose, especially when given by the hypodermic, both for cardiac stimulation and for keeping up the tone of the blood pressure. In severer cases the question arises of the use of alcohol. Formerly we were taught to believe that alcohol was a heart stimulant, but the stern, unyielding facts of scientific investigation and proof have shown that it does not stimulate the heart. It dilates the capillaries and small arteries and tends to prevent a congestion in the splanchnic areas, and tends to keep the blood in the peripheral circulation, where it will be of most use to the patient. It gives the patient a sense of well-being, it benumbs reflex irritation and tends to keep the patient quieter, and in not too excessive an amount it stimulates digestion. Although the use of alcohol is not as widely extended as it was formerly, the consensus of opinion to-day among the best clinicians seems to be that in moderation its effect is good, rather than harmful, but there is no question that in excessive doses it dilates the vessels too much, and will increase or cause delirium. What is excess and what is moderation in the use of alcohol differs for different individuals, and I think that it requires the most careful judgment to decide this in each individual case. I do

not hesitate to say that my personal opinion is that, even in alcoholic patients, most patients are more benefited by cutting off their whisky than by giving it to them. The use of glonoin in this country in pneumonia is very extensive. It is a pure arterial dilator, and I think has been altogether too freely used in a disease such as pneumonia, in which the low arterial tension is part of the poisoning. It has its uses in patients who have arteriosclerosis with high tension and in whom we desire to assist the heart by reducing the blood pressure. Digitalis has been much vaunted, especially abroad, but the most favorable reports concerning it have come from those who have used it in large military hospitals, where their cases of pneumonia are in young adults in whom the prognosis is good, and their apparent good results seem to be more due to the general tendency of youth to recover than from any specific character of the drug. It does raise blood pressure, and is a most useful drug for this end and for cardiac stimulation, but Lauder Brunton has pointed out that it loses its effect on the vagus endings in the heart when the temperature is over 103, and this may account for the fact that it often fails us in pneumonia, when we need it most. One often obtains excellent results in sustaining the blood pressure and in preventing cyanosis and congestion by using ergot hypodermatically. This drug acts especially well in alcoholic patients and prevents the reaction produced by cutting off their alcohol. Adrenalin has also been recommended for this purpose. To obtain the best results with this substance one must use it intravenously or by well-diluted rectal injections. When given subcutaneously it causes a local contraction of the vessels, and is too slowly absorbed to give much effect. Henry Elsner, of Syracuse, recommends in desperate cases the treatment by diffusible stimulants. He gives fifteen drops each of aromatic ammonia and Hoffman's anodyne in two drams of tokay wine every twenty minutes. This seems to be most excellent treatment in many severe cases, but unfortunately there is a tendency for the Hoffmann's anodyne to cause vomiting, and in alcoholic patients I have seen after a few hours "coffee-ground" vomiting from this treatment. Some desperate cases have, however, recovered in my hands, with this treatment. In the beginning stage of pneumonia, I think we make a favorable impression on the disease by limiting the congestion of the lung. This I think will sometimes result from the large dose of calomel which is sometimes given. The same results are obtained with one-quarter grain of tartar emetic with five grains of Dover's powders and repeated once at the end of an hour. The drug which has best accomplished this limitation of congestion at my hands is the hypodermic use of Livingston's solution of ergot in thirty doses every two hours for six or eight doses. This solution is a drachm of the watery extract of ergot dissolved in one ounce of sterile water and three minims of chloroform and three

grains of chlorotone added. The whole solution is then filtered through sterile filter paper. This solution should be given direct into the deltoid or gluteal muscles, sending the needle at right angles through the skin into the muscular tissue, not subcutaneously. For the relief of the pleuritic pain, cold or heat is the usual procedure, and the old-fashioned flaxseed poultice, when properly applied, can be further kept warm by hot-water bags on the outside, and is of the greatest comfort to the patient. Manges,⁵ of New York, recommends the Paquelin cautery over the area affected by the pleurisy, and says that in his hands it has been much more efficient than any other method. If the pain is great we have to resort to morphine, sufficiently to dull its intensity, though benumbing the patient by morphine is, I think, a dangerous practice. Often five or ten grains Dover's powders is an excellent method of giving this drug. Cough is often a distressing symptom, and we must treat it directly in the pneumonias in which the bronchitis is the predominant feature. The administration of terpine hydrate and of creosote carbonate will often materially diminish the bronchitis. In old people, however, with chronic nephritis I believe I have seen creosote cause suppression of urine with fatal results. In the influenza pneumonia, with an excess of bronchitis, ten or twenty drops of tincture of nux vomica will often diminish the excessive secretion. Osborne,⁶ of New Haven, recommends ipecac and ammonium chloride in acid vehicles, such as dilute phosphoric acid as being very efficacious and least objectionable to the stomach. There is one symptom in pneumonia which is very distressing and equally dangerous to life, and that is excessive distension of the abdomen, due in severe cases to paralysis of the muscles of the intestines. High turpentine enemata or copious warm saline irrigations, repeated every few hours, will often be sufficient to overcome this. These saline irrigations are excellent cardiac stimulants in themselves, and increase the action of the kidneys, and are often of great benefit. Here in my experience the hypodermic injections of ergot have aided in regaining the tone in intestinal musculature. Hyperpyrexia is another symptom which at times requires treatment. Temperatures from 103° F. to 105° F. are temperatures normal to pneumococcus pneumonia, and it is only when such symptoms as increased delirium and restlessness or stupor and prostration occur with the high temperature that the hyperpyrexia needs treatment. Personally I do not believe here in the use of coal-tar antipyretics or guaiacol. I prefer cool sponging in adults and a warm bath with or without mustard for young children. When delirium tremens is also a complication a cold bath is best, and often quiets the delirium and induces sleep. An effective bed bath is obtained by slipping a rubber sheet under the patient, covering him with a cotton sheet from his neck to his feet, and then by forcibly sprinkling him on the sheet with very cold water

thrown from a whisk-broom one obtains the necessary cutaneous irritation to stimulate the circulation and reduce the temperature. From five to eleven minutes is sufficient length of time for the duration of such a bath, and I have never seen untoward effects from its use.

Manges has recently emphasized the necessity of obtaining sleep for pneumonia patients, and I think this cannot be too strongly insisted upon. By careful consideration in administering food and drugs at stated intervals and allowing undisturbed quiet between the necessary administrations much can be done in this regard. The careful choice among the newer hypnotics will usually suffice, and if morphine or codeine must be given to allay pain, one often obtains sleep at the same time.

This meager presentation must suffice for the consideration of treatment. An essay on the treatment alone in pneumonia could well occupy an entire evening's discussion of the disease. I have taken it for granted that all are agreed on the value of the most watchful nursing, of the necessity of a well-ventilated and moderately cool room, and of the fact that each patient requires rules and routine for himself. A robust young adult with an overcrowded right heart may require bleeding, but with a weak and aged patient one would refrain from this procedure. When one sees a partially consolidated lung cramped by a serous effusion one should never hesitate to aspirate the fluid, nor hesitate to drain an empyema. The only accurate method of differentiating the character of a pleural effusion is to draw off a small sample, and one must act according to the nature of the fluid found.

The most important consideration to the family of a patient is the prognosis. There are many factors which influence one in predicting the probability of recovery in any given case of pneumonia. E. F. Wells⁷, of Chicago, has published the record of 465,400 cases of pneumonia, collected from the reports of many hospitals and from many physicians in private practice. There were 94,826 deaths in this collection of cases, a mortality record of 20.4 per cent. Preble⁸ concludes after reviewing the mortality rate over many years from a large number of statistics that the mortality varies greatly in short series of cases, such as occur in one hospital from year to year, but that in series large enough to counteract the influence of mere chance the mortality does not vary much from time to time. Sex seems to influence the prognosis, for while pneumonia is much more frequent in men than in women, the number of deaths in the last census year in men was 58,430 and in women 47,631, which would seem to indicate a distinctly higher death-rate for women than for men. These figures are for the entire United States, and are more significant than the statistics from various hospitals. Age exerts a great influence on the prognosis. In infants the death from bronchopneumonia is very high, but in childhood, be-

tween 5 and 10 years of age, the mortality from lobar pneumonia is less than 4 per cent. From 10 years of age onward to old age the death-rate with each year rises steadily, until in old age it is exceedingly high. The extent of the pulmonary involvement influences the prognosis more than the site of the lesion, except in chronic alcoholics, in whom, in my experience, a right upper lobe pneumonia carries with it an especially bad prognosis. In the aged a temperature below 100, and in all ages temperatures above 105, a pulse above 130, and respirations above 50 are dangerous signs. Irregularity of pulse-rhythm is of bad prognostic significance; the earlier the irregularity develops the greater the danger, and Mackenzie states that he has never seen a young adult recover who had an irregular pulse in whom the temperature was 103 or over. Chronic alcoholism in a patient greatly reduces the chances of recovery. In 667 alcoholic patients with pneumonia in Bellevue Hospital in 1904 the death-rate was 50 per cent., in 334 non-alcoholic patients in the hospital during the same time the death-rate was 23 per cent. In patients suffering from previous diseases, as nephritis, myocarditis, anemia or tuberculosis, a pneumonia is always a very serious disease. Of the complications in pneumonia a meningitis or endocarditis developing from the pneumococcus infection are almost invariably fatal. Pericarditis shows a death-rate of 50 to 75 per cent. Serous effusion raises the mortality rate but little, while empyema directly reduces the chances of recovery.

Some sad experiences in our care of pneumonia patients has forced many of us to realize that pneumonia is a communicable disease, and that no one who hourly cares for a patient suffering from pneumonia is free from the danger of infection from the patient. Habit and custom have made us accept the chances and dangers of infection, and I fear that habit has usually made us careless in the necessary prophylaxis against the spread of this disease. Much, I believe, can be done to limit the numbers that are yearly sacrificed by this infection. It seems not improbable that the time is not far distant when careful disinfection of pneumonic sputum will become routine. It is of the greatest significance to remember that it has been experimentally proved by several observers that the pneumococcus in sputum may remain alive and virulent for two to four months. How little in the past we have stopped to realize that the incessant coughing of a patient sprays the air freely with the minute particles which may carry the infection. This is unavoidable, but it clearly points to the wisdom of room disinfection after pneumonia, to the wisdom of having nurses in self-protection impressed with the value of mouth and throat disinfection. Far be it from me to preach bacteriophobia or to increase the often senseless panic that the mere mention of some infectious disease creates, but I am convinced that we should quietly insist on the disinfection of pneumonic sputum, and endeavor

to carry out room disinfection after pneumonia. Pneumonia is to-day the most common and fatal of the acute infections, and I believe it is as much our duty to study the prophylaxis of this disease as it is to treat and endeavor to cure it.

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THE HEALTH OF THE NATION.¹

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THE health of the nation seems rather a large topic, yet not too large for hopeful and practical consideration, nor yet so large as would be a kindred topic, the health of all nations, which is likewise one for serious and hopeful consideration. Indeed, these two subjects have a direct bearing one upon another, and one cannot be adequately considered without considering the other.

It is a somewhat trite idea, but one whose significance is of great present import, that the nations of the earth to-day are more nearly related than ever before in the world's history. "Not only has the 'narrow frith' been practically abolished," says a recent writer, "but the wide ocean is traversed by passenger ships in five days, and by thoughts put into words in a few seconds. All the world has become one neighborhood so far as relates to distances." In no manner has this been more strikingly shown than in the warfare against contagious disease. But a few years ago a violent epidemic of yellow fever in Cuba would excite no more than passing notice, while to-day the news of two cases in the far-off neighborhood of Santiago is immediately wired throughout the United States and foreign countries. A few cases of bubonic plague in the Orient, which a few years ago would receive no attention, are instantly reported and published throughout the United States, and one case of cholera in a ship in the Mediterranean is likewise immediately telegraphed to the principal cities of the world. International congresses, conferences and conventions are frequent, bringing the nations together as one family in the struggle against these foes of mankind. As in 1892, when a case of cholera appeared in Jersey City, the New York Board of Health took active interest therein, so is the United States Government interested when epidemic disease is reported in England, France, Germany, Turkey, Egypt, or any port in the Orient, for communication therewith is now swift

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and frequent. And so closely related are we in health matters to our neighbors of Mexico, Central and South America, that periodical international sanitary conventions have been agreed upon by the several republics, and a permanent international sanitary bureau of American republics has been established and is maintained. I need further to refer only to the international congresses of Medicine, of Hygiene and Demography, of Tuberculosis, Leprosy, and other allied subjects, to show how closely the nations are getting together in the efforts to prevent and suppress disease.

We hear much at the present time of international peace conferences and arbitration treaties. Is it too much to expect, as a corollary parallel movement, the cooperation of nations to prevent and suppress communicable disease? There is at present pending before the Senate of the United States a convention—practically a treaty—subscribing to the findings of the international conference of Paris, 1903, embodying the principles and practice necessary on the part of all nations for successful warfare against plague and cholera.

The International Sanitary Conventions of American Republics, previously mentioned, were instigated by the obvious advantage of an agreement for the sanitation of all yellow-fever infected seaports. Seaports being the points of contact between nations, would properly be the first objective points in international sanitation, and their undoubted consequent prosperity would cause the sanitary movement to extend to other cities.

International sanitation might well be considered as adjunctive to the movement for universal peace. I believe it would be less difficult of achievement than absolute arbitration, or at any rate it could be made a powerful influence in establishing the latter. A former President of the French Republic, Monsieur Casimir Perier, at the opening of the Hygienic Conference in Paris, in 1894, said: "The international principles which had their origin in the laboratory and are based on science are the only ones which bind nations together with strong ties and establish equitable and immutable laws."

This principle may be well considered by those who are seeking universal peace, and international responsibility with regard to disease is a subject worthy of the attention of those interested in the development of international law. So far as I know there is no mention in the treaties on international law of the responsibilities of governments to one another in matters of public health, but the time is ripe for adding such a chapter.

I quote from a recent writer: It seems "that nations are beginning to develop a conscience and a sense of justice for the rights of other nations. As a whole the peace movement is another step toward the actual attainment of the ideal perfection of government." With this growing sentiment of harmony and fraternity among the nations there should be developed an international sentiment regarding sanitation and suppression

of disease. If, as Tolstoi says, the only substitute for war is religion, international sanitation would be a powerful weapon in the hands of religion, if, indeed, it could not itself be made a substitute for war. It surely would furnish a plain upon which nations might meet. It suggests a common enemy—disease—against which all might combine without fear of international complications, and would furnish a more worthy object than war for the expenditure of energy and money.

As to the health of this nation, the subject may be considered under two heads, the exclusion of disease and the extinction of disease. The former, which embraces the subject of quarantine, I will not discuss, as it may be considered by the distinguished gentleman who is to address you on "The Health of the Port." As to the extinction of the ordinary communicable diseases, is the idea one that is visionary or has it a good basis in scientific achievements and in practical results already attained?

It is not my purpose to burden you with statistics, but surely enough has been published to show a marked diminution as the direct result of special effort, and to encourage the belief that in future most of these diseases may be as rare as they are now common. Their subsidence or disappearance will be due chiefly to good laws and effective administration. Good laws imply good organization, and it may be profitable to consider for a moment the health organization of the United States as it exists to-day.

In general, I believe, this organization is a proper one, but defective in many of its details. The United States Public Health and Marine Hospital Service has, under various acts of Congress, certain maritime quarantine functions and interstate quarantine functions. It has also a hygienic laboratory for the investigation of contagious and infectious diseases and matters pertaining to the public health. This last is generous and broad legislation, but is limited to laboratory investigations. Therefore, certain other investigations, which are desirable, cannot be made; for example, an investigation into the sanitary conditions at certain health resorts where tuberculosis patients are gathered in great numbers. I mention this as simply an illustration, but efforts will be made to meet this difficulty. The epidemic appropriation, under which investigations other than laboratory can be made, is limited to certain specified diseases, namely, cholera, yellow fever, smallpox, typhus fever, and bubonic plague. The laboratory has an advisory board, through which it is brought into relation with the medical departments of the Army and Navy, the Bureau of Animal Industry of the Agricultural Department, and through five distinguished scientists with the laboratories of leading institutions of learning. Thus the scientific work of the Service is brought in contact with the profession.

In the practical administrative work of a sanitary character, the Service is brought into relation with State boards of health and quarantine

officers, through annual conferences required by law, and occasional conferences called either by the Surgeon-General or on request of the State health authorities.

Every State and Territory has a health department, consisting either of health commissioner or State board of health, which has about the same relation to county and municipal boards of health as the national service has to the State organizations.

The chain of organization, therefore, seems theoretically a good one, and it would appear to be the part of wisdom to perfect or strengthen every link in the chain. This chain has not been forged all at once. Link after link has been added, and the several links strengthened as occasion seemed to demand. In a growing country this seems to be the natural and proper method. The other method has been tried and failed. So that our sanitary system must be one of gradual growth.

Thus far I have spoken only of the official health organizations, which are, of course, the most potent of all, based upon the statutes of the States and the nation, continuous in their operations and not dependent upon spasmodic effort or ephemeral enthusiasm. Yet it is impossible to ignore the valuable results of auxiliary organizations, voluntary in character, but inspired by noble and patriotic motives. They are too numerous to mention in detail, but I may refer to such organizations as the great American Medical Association, the American Public Health Association, State, county and city medical societies, and the auxiliary sanitary associations that exist in so many of our States and cities. Through these public sentiment is developed, which crystallizes into statutory laws and organizations.

One of the most common pleas of the sanitarian of to-day is for a wider diffusion of knowledge of hygienic and sanitary principles. It has been frequently said that sanitary science is far in advance of its practical application. The facts are known, but not to a sufficient number, and appeals are often heard for the introduction into schools and colleges of more instruction in these essential and easily comprehended subjects. The plea is justified by every consideration, but I should like to call attention to the necessity of the spread of sanitary information among intelligent adults, among the learned, and the wise; among the men who govern our cities and our States, and among our legislators. The knowledge I would seek to have impressed upon them is the value of sanitation in the advancement of individual happiness and national, State and municipal welfare. Too many regard sanitation as an ideal matter, efficacious theoretically. They should be impressed with the knowledge that improved conditions can and must be attained, and that bad sanitary conditions indicate sloth, a willingness to endure and ignore, characteristic of the least civilized and cultivated communities.

The possibilities of sanitation in the advancement of civilization should be impressed upon them, so that in addition to their high ideals of civil government they may also entertain ideals of sanitary advancement far beyond their present standards. Their influence and aid will then be more readily given when measures are brought before them for consideration or action.

There is one method of popular diffusion of knowledge which I have referred to on previous occasions and which seems worthy of further consideration. It is the making of sanitation an issue in local politics. Issues might be made on efforts to suppress the ordinary diseases by municipal improvements, particularly in the worst portions of a city. I am aware that these improvements are liable to be unpopular among those whose excessive profits on investments would be unfavorably affected thereby, and even among those whose individual physical welfare is to be improved. But these difficulties can be overcome if the political movement is shrewdly and fairly managed; and these issues being the subject of popular discussion, hygienic and sanitary knowledge would be brought out and broadly diffused. This idea has already been given expression by an association great in numbers and influence. At a recent annual meeting in San Francisco (last November) of the American Federation of Labor three hundred delegates were present, representing one hundred national and international labor unions, with a membership of about two million. In that convention was passed the following resolutions, which seem to me significant of the earnest and laudable attitude of these unions toward the sanitary movement.

The resolutions were referred to the Committee on Resolutions and adopted by the convention on the tenth day of its sessions:

RESOLUTION NO. 157.

WHEREAS, In the proper embellishment of our towns and cities, by parks, monuments, ornamental buildings, boulevards, and driveways, there is too frequently an utter neglect in the removal of insanitary and unhealthful conditions in the less favored localities, and

WHEREAS, In our opinion one of the first duties of town and city governments is to make wholesome, by good drainage, paving, water supply, and correct tenement-house construction, those portions of cities and towns that are now neglected in these respects, thus imperiling the health and happiness of the working people; therefore be it

Resolved, In the interest of the poor and well-to-do also, town and municipal councils should give greater legislative attention with adequate appropriations to the removal of these evil conditions in the less favored localities, and be it further

Resolved, That the labor unions, by supporting candidates pledged in advance to the support of necessary and wise ordinances, according with

the foregoing principles, will advance the health conditions and material prosperity of the country; and the American Federation of Labor in this convention assembled recommends these principles to its affiliated national, State, district and local bodies.

The foregoing resolutions seem to confirm the ideas I have endeavored to express as to injecting sanitation as a live issue in municipal politics, and you will recall that one effect of such injection would be a wider diffusion of sanitary knowledge among the working people and a deeper impression of its importance among the more highly educated.

But there is more in these resolutions than the spread of sanitary knowledge. They express what seems to me to be a cardinal principle for guidance in practical measures to improve health conditions in the United States. They practically assert that the low, unsewered, unpaved, filthiest parts of our cities should receive the very first consideration in all plans for municipal improvements.

It should be the ambition of all those who take special interest in the health of the nation to bring about a slumless country. I have given expression to these views before, but they require repeated iteration. As stated in a former address, "there is no adequate reason why slums should exist anywhere, and by slums I mean places where, through bad drainage, imperfect sewerage, inadequate air space, lack of pure water, and lack of sunlight, human beings are subject to disease and crime-inducing conditions."

Following this all sanitary administration would be much easier and more effective.

Now, in the elimination of slums, there are one or two principles involved, which should be carefully considered lest fatal mistakes be made. Such mistakes have been made, as may be seen in the reports of the commission on the housing problem in London. The right of the owner of the insanitary dwelling should be considered, and whether compensation should or should not be allowed him seems to be a matter dependent upon local considerations. But the rights of the tenants, however poor, must also be considered, and ordinarily it would seem wise to defer their ejection until provision is made for their housing in quarters equal in size, at no greater rent, and as convenient in locality as they have been occupying.

The bureau of which I have charge is now receiving through the State Department, from the United States consuls abroad, and is collating the experiences and laws in foreign countries relating to these matters. The statement from one city contains a confession of mistake, in that while buildings are being put in sanitary condition respectable workmen are driven into localities foreign to their trades and among a foreign element, all of which is detrimental to their self-respect. This difficulty suggests the possibility of a coor-

dination of effort between the municipalities and our wealthy philanthropists. The municipalities can well afford to pass ordinances for the destruction or reconstruction of insanitary dwellings, with a proviso for a possible delay of execution until proper quarters as before indicated are provided.

I would not undertake to say whether or not a plan of this character is applicable to a great city like New York, but with regard to other cities I believe it is. If municipal ownership of tenement houses is objectionable, then would be very available the efforts of the millionaire philanthropist, who, not as a giver of charity, but as one willing to accept a very moderate return on his investment, would erect the necessary buildings.

I have said that the health of this nation might be considered under two heads, the exclusion of disease and the extinction of disease. There is another consideration worthy of attention, namely, the development of a healthy and robust individual organism. The elimination of the ordinary diseases and the development of a higher average of individual health and strength would practically mean life on a higher plane in all its features. It would mean a greater average of mental aptitude for work in the higher fields of human activity—in all the arts and sciences.

When thus we review the good results of sanitation, and survey the field and realize that improved conditions are within our reach, we certainly must feel a desire to hasten the day when they may be realized.

In dealing with my topic, "The Health of the Nation," I have preferred to express these general ideas and principles, rather than go into those details and statistics of disease and sanitary work which are narrated in the medical journals, reports of State and city boards of health, and of the Public Health and Marine Hospital Service.

Knowing that other speakers are to follow, whom we are all anxious to hear, I feel that I have fully occupied all the time due me, and in closing I wish to say that it is a rare pleasure and an opportunity greatly appreciated to meet and thus exchange ideas with the members of this society. I wish to thank your president for his kind invitation for this evening and to thank you all heartily for your kind attention.

TUBERCULOSIS SANATORIA.

F. L. Hills, Concord, N. H., (*Journal A. M. A.*, February 18th), outlines the essentials of sanatorium treatment of pulmonary tuberculosis. He would make six months the minimum term of residence, excepting in the very incipient cases. He insists on the importance of following up the cases after discharge; this would give us valuable facts as to the ultimate results of sanatorium treatment, the percentage of permanent cures, duration of arrests and other facts of importance for the guidance of future therapeutic work.

THE HEALTH OF THE CITY.¹

BY THOMAS DARLINGTON, M.D.,
Commissioner of Health, City of New York.

THE health of the city of New York during the past year has to my mind been far from satisfactory. The number of deaths reported during the year 1904 was 77,985, an increase of 10,121 deaths as compared with the year 1903 and of 9,403 deaths as compared with the average for the preceding five years.

The year 1903 was remarkable for the lowest death-rate on record for the city—18.18 per 1,000—and for the remarkable absence of a severe epidemic in any of the communicable diseases—an experience shared by all the principal cities of the world; on the other hand, the year 1904 was remarkable for a directly opposite condition of affairs, the pendulum having swung to the other extreme.

The increase in the number of deaths has been due, first, to the increase of population. Upon this point I believe that there are at least 200,000 or 300,000 more people in the city of New York than are accounted for in the increase on the census returns of the year 1900, and I trust that during the year a census will be taken. Among the principal increases in the deaths have been those due to the acute respiratory diseases, pneumonia and broncho-pneumonia, and acute bronchitis. The totals of deaths from these causes were 14,518, as against 11,540 in 1903, showing an increase of 2,978, or nearly one-third of the total increased number of deaths. The prevalent influenza in the first quarter of the year, the severe epidemic of measles, and the unusual severity of the weather account largely for this increase. The severity of the winter of 1903-1904 was reflected in an increase during the first quarter of the year of 2,725 deaths at the ages of 5-85 years above the average for the same quarter of the previous five years.

During the second quarter, the severest epidemic of cerebro-spinal meningitis for thirty-two years served to increase the deaths 1,200 over the previous year, and there was an increase of 200 deaths from simple spinal meningitis, which were probably deaths from cerebro-spinal meningitis, making the increase from this source probably 1,400 deaths.

The next in importance as a cause of death was the increase in diarrheal diseases, especially among children under 2 years. As to the exact reason why this should have occurred, we have not been able to determine. There were more inspectors on the Summer Corps, and more nurses, and they did as good work as, if not better than, ever before. The St. John's Guild, the Straus Milk Charity, the Diet Kitchen Association, and other philanthropic institutions, did as much work as ever, and still, in the face of all this, there was an increase in the deaths from diarrhea under 2 years of age of 1,196, or one-

ninth of the increased mortality. This alone is sufficient reason for the strenuous efforts which have been put forth by the department this fall both in milk and water inspections.

The increase in deaths from tuberculosis of the lungs was 475. A portion of this has undoubtedly been due to the prolonged and cold winter, so that the patients have been compelled to keep their windows closed in order to have sufficient warmth.

In Bright's disease (nephritis) there was an increase of 568 cases, and organic heart disease 226 cases. There has been a steady increase in the deaths from these diseases ever since 1868. Possibly a slight proportion of this has been due to better diagnosis, and undoubtedly the greater portion of it is due to the rate at which the average New Yorker is living, increasing the work of his heart and kidneys; too much food, too little proper exercise, too many stimulants, and too much worry and fret. Possibly also, the adulteration of whisky with wood alcohol has had something to do with it, for we do not know how long such a condition has existed. And has not the drug adulteration of phenacetine and the less poisonous coal-tar products by substituting those which are more poisonous something to do with the increased rate of deaths from heart disease?

The number of cases of typhoid fever has been less—300 fewer than the previous year. Fully 25 per cent., if not more, have acquired the disease outside of the city, while the rest are accounted for by water, milk, the use of green vegetables and oysters.

The number of cases of diphtheria increased about 1,500, and the deaths decreased 150, reducing the case fatality about 1 per cent. What are we doing to overcome these conditions?

While the general mortality of New York City and of the United States as a whole has steadily decreased in the last thirty years, owing to the improved sanitary conditions and the increase in our knowledge as to the cause and nature of diseases, yet in the case of several diseases the mortality rate has not fallen, but has actually increased. Of these the most notable and important examples are pneumonia and cancer. The death-rate from pneumonia has risen steadily, from 1.95 per 1,000 in 1870 to 2.89 per 1,000 in 1903, and the deaths which in 1870 constituted only about 7 per cent. of the total death-rate, in 1903 equaled 15 per cent. and had still further increased in 1904—19½ per cent.

In 1870 the deaths from pulmonary tuberculosis in the Boroughs of Manhattan and the Bronx numbered 4,030—a death-rate of 4.27 per 1,000. In 1903, although thirty-three years had elapsed and the population increased from 943,000 to 2,186,017, the deaths from tuberculosis were only 5,262, and the death-rate was 2.41. Pneumonia now leads all other diseases as a cause of death. Yet the improved conditions of life and the advance in preventive medicine of the past thirty years should have had the same effect (in kind

¹Read before the New York County Medical Association, New York, January 16, 1905.

if not in degree) on the prevalence of pneumonia as on that of diarrheal diseases and tuberculosis, both of which have been markedly reduced.

The disease has in some respects been quite thoroughly studied. It has been known for some years that lobar pneumonia is an infection usually caused by the pneumococcus, the predisposition to such being usually due to exposure to sudden changes of temperature or cold and to over-exertion, exhaustion, alcoholism, etc. It is especially fatal in waterside and low, damp districts, is very prevalent among negroes and persons of Irish descent and in those whose occupations keep them subject to sudden changes of temperature, as a rule it is feebly communicable, but may even become epidemic.

Notwithstanding the increased knowledge of its causation applicable to the prophylaxis of the disease, its incidence and death-rate have steadily increased, and the problem of its prevention has become the most urgent one in preventive medicine. At the request of the Board of Health, the Board of Estimate and Apportionment has appropriated a sum of money for the special investigation of the acute respiratory diseases, and the Board of Health has appointed the following commission to conduct the inquiry: Edward G. Janeway, M.D.; William Osler, M.D.; T. Mitchell Prudden, M.D.; L. Emmett Holt, M.D.; William H. Welch, M.D.; Frank Billings, M.D.; J. H. Musser, M.D.; Theobald Smith, M.D., and Herman M. Biggs, M.D.

The investigations will proceed along two main lines—clinical and bacteriological. Information is especially desired on the following points:

1. The occurrence and virulence of the pneumococcus and organisms related to or resembling it, in the human mouth in health and disease.
2. The evidence and the extent of variations in virulence of the pneumococcus under different conditions.
3. The occurrence of the pneumococcus in children's hospitals, homes and asylums, and the bacteriology of the mouth before and after outbreaks of pneumonia.
4. The vitality of the pneumococcus under various conditions.
5. The value of mouth disinfection.
6. The bacteriology of the air of public places, conveyances and buildings and private dwellings, especially in reference to its dust content, the public buildings to embrace stores, factories, large office buildings, public schools, theaters, hospitals, tenements and private houses.
7. The clinical evidence of the communicability of pneumonia as shown by the collection of cases in private houses and public institutions.
8. The seasonal relations of pneumonia.
9. The collection of statistics of pneumonia of the different varieties occurring in hospitals, special attention being paid to terminal pneumonia.
10. The collection of evidence as to the proportion of cases in which pneumonia can be regarded as an auto-infection, and the proportion of cases

in which there is evidence of the communicability of the infectious agent.

11. The study of sporadic cases of pneumonia, special attention being given to the relationships of the individual to crowds or to exposure to other cases of pneumonia, and the determination of the presence of the pneumococcus in the mouth in those cases and cases associated with them.

12. The evidence for the belief that pneumonia is infrequent in Arctic regions.

13. A statistical study of pneumonia, covering its prevalence in different latitudes and in different countries and cities, its yearly and seasonal variations and its types and mortality.

We have at present working on the problem two men in the Boston City Hospital; one in Philadelphia under Dr. Welch; one man at Saranac Lake under Dr. Trudeau; one in Mt. Sinai; one in the Babies' Hospital; one at Bellevue; seven in East 16th street, and two in the laboratory of Dr. Prudden, which is the clearing-house for all bacteriological investigations of this character.

We are studying particularly methods of identification and distribution under various conditions—in hospitals, medical students, laboratory workers; those in outside employment, at the Sea Side Sanitarium; at Saranac Lake under the tuberculosis patients and under the normal condition of the town. We find the pneumococcus in 30 to 70 per cent. of these cases in the mouths, while the influenza bacilli are of very wide distribution, causing, of course, acute respiratory diseases, etc.

The cases of tuberculosis reported this year to the department, added to those already known, and making allowance for those cases unreported and those who died during the year, render it probable that within the limits of Greater New York there are between 28,000 and 30,000 living cases. The Board of Health is making every effort to prevent the spread of the disease, and to assist in the cure of those now suffering from it. A clinic has been established in connection with the department for the study and cure of this disease. If the patients be so far advanced as to be incurable, then they are taught how to live so that they may be as comfortable as possible, and to prevent them from spreading the disease. A corps of trained nurses has been attached to this clinic for the supervision of the patients at their homes.

For the further care of these cases it is necessary to establish a municipal sanitarium. Many times during the year we have endeavored to locate a site for such an institution, and much time has been spent in this endeavor, but as yet no proper place has been secured, as the present law relative to the locating of a sanitarium is practically prohibitive.

The great volume of work done in the division of contagious diseases renders it practicable by being divided into district medical inspection, medical inspection of schools, district nursing, school nursing, vaccinating, summer corps and

the diagnosis of contagious diseases. The increase in the number of contagious diseases during the first six months of 1904, added largely to the work in this division. The number of cases during the year 1904, in comparison with the year 1903, is shown in the following table:

	1903.	1904.
Measles	13,689	32,803
Diphtheria	18,317	19,816
Tuberculosis	15,214	18,567
Scarlet fever	10,887	13,383
Typhoid	3,671	3,379
Smallpox	67	82

The work of the administration of antitoxin has been carried on day and night by selected men especially trained for the work, and the physicians of the city have taken advantage of this free distribution of antitoxin to such an extent that it has been necessary to assign four more physicians to this duty. These curative injections of antitoxin number one-half more than any previous year, and the case fatality has been decreased 1 per cent. The case fatality in Manhattan is over 10 per cent., while the case fatality in tenement houses treated by the inspectors of the department at the request of the attending physician (which cases amount to over 3,700 for the year), was only 5.7 per cent.

In addition to the work already accomplished by the school inspectors, we feel that the health of the city would be greatly improved by a further inspection of the proper care of the children's outer garments at schools, the proper aeration of the classrooms, the proper lighting of the classrooms, ample accommodation for each school child, sufficient playground facilities, establishment of baths in the public schools, examination and compulsory care of the children's teeth and oral cavities, examination and correction of error of refraction (about 30 per cent. of 981 children examined showed refractive error in one or both eyes), correction of deformity of locomotive apparatus, exclusion of all nervous diseases from class attendance, removal of all hypertrophied tonsils and other adenoid vegetation. It seems to me quite important that we should examine all children for deafness. Many a so-called backward child in school is not so stupid, as he is often supposed to be, but owing to deafness from adenoids or otherwise, does not readily catch the question put to him, and so hesitates, and in this way is regarded as lacking intelligence. We have been loath to impose all this work upon the school inspectors, as they were not receiving the salary sufficient to compensate them for the time necessary.

With the increased work of the medical inspectors in schools, the finishing of the new hospitals for contagious diseases, the erection of a sanitarium for consumptives, better water and milk supplies, and the passage of the Pure Food Bill by Congress, and, above all, the cooperation of the physicians of the city with the Department

of Health, we may hope for a larger reduction in the death-rate than ever before and a greater improvement in the health of the city.

THE HEALTH OF THE PORT.¹

BY ALVAH M. DOTY, M.D.,
Health Officer of the Port of New York.

THE health of the port of New York, which has been assigned to me as the title of a paper to be presented at this meeting, can best be considered in connection with a description of the diseases which are dealt with at the New York Quarantine Station, and the methods employed to prevent their entrance into this country.

Quarantine officers, while expecting to deal with almost any form of infection, usually regard some one disease as the most constant visitor, which comes under their observation, and the one which presents the greatest danger to the public. The character of this depends upon the ports with which the various quarantine stations are in frequent and direct communication. For instance, yellow fever, which has been almost continuously present in South American and Cuban ports, is looked upon as a special menace to this country, particularly the southern portion of it, where ports of entry have made unusual and extensive preparation for the detection and care of this disease. Although New York and its vicinity have little or nothing to fear from yellow fever, it is necessary to bear in mind that a case of this disease in its early stage, or in a mild or ambulant form, if allowed to pass the New York Quarantine Station unrecognized, may reach one of the Southern cities and possibly cause an outbreak. For this reason great care is taken at this port to detect the presence of yellow fever on incoming vessels. It may be truthfully said that in the past no disease which has visited the United States has caused such consternation and so great a loss of life or has been responsible for such stringent rules and regulations on the part of health authorities as yellow fever. Not only just but unjust means have been employed to prevent its extension. This has been carried to such an extent during the presence of epidemics in the South that the commerce of that section has been at times practically paralyzed. The enforcement of drastic measures was largely due to the belief that yellow fever was transmitted by personal contact with the patient, by discharges, the clothing and effects of the sick, cargoes of vessels, merchandise, etc.—even iron rails have been regarded as a medium of infection and have been subjected to disinfection. To-day we know that such regulations are unnecessary, as it has been conclusively proven by the most careful and thorough investigations that yellow fever is conveyed from one person to another by the mosquito. It is

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but proper to say that there are still some who believe that there may be other means of transmitting the disease. However, there is at present no proof of it, and for practical purposes it may be regarded as safe to assume that the mosquito is the only means by which the disease is conveyed. The importance of this knowledge cannot be overestimated, inasmuch as it places in our hands means by which formidable and dangerous epidemics of yellow fever can be prevented. The means to which I refer consist principally in confining the patient sick with yellow fever in an apartment completely protected by screens to prevent the entrance or exit of mosquitoes. This measure of protection is easily carried out, and in order to be eminently successful it is required that cases of yellow fever shall be very early detected. Aside from the use of agents such as sulphur dioxide in apartments to destroy the *stegomyia fasciata*, the variety of mosquito which transmits yellow fever, disinfection is now regarded as unnecessary. Exhaustive experiments which were made at the New York Quarantine Station conclusively proved that the mosquito will not live in closed trunks, bags and other receptacles more than twenty-four or thirty hours; therefore the disinfection of baggage which has been in transit more than two days would seem to be uncalled for. This not only simplifies the methods employed in the treatment of outbreaks of yellow fever, but relieves commerce of the long delays and great expense which general disinfection has heretofore involved. No one welcomes this change so earnestly as the quarantine officer, inasmuch as the problem of securing a thorough and safe disinfection without unnecessary delay to vessels and their passengers is now practically eliminated.

Another factor which has recently made considerable change in quarantine methods, particularly at the port of New York, are the means employed to prevent the entrance of bubonic plague into this country. The appearance of this disease in European and South American ports during the past five or six years caused considerable apprehension, as it was believed that these outbreaks would be followed by results similar to those reported from India, where the mortality from this disease is very great. The anxiety was largely due to the meager knowledge we then possessed of the character and habits of this disease. Furthermore modern methods of sanitation are not in force in India, and the health authorities not only do not receive the support of the people in efforts to enforce proper regulations, but have their opposition instead. The people there are extremely poor and ignorant, and are herded together in great numbers, thus giving any infectious disease every opportunity to extend. Under these conditions typhus fever would, I am sure, be fully as dangerous as plague. In Santos and Rio Janeiro, where outbreaks of plague assumed an epidemic form, and where sanitary regulations, although fairly good, are far inferior to our own,

the disease was soon brought under control. In efforts to detect the presence of this disease, it is necessary to bear in mind that it may appear either as the "bubonic" form, which is associated with enlargement of the superficial glands, particularly the inguinal and axillary ones, or the "pulmonary" form, which principally affects the lungs. Aside from the transmission of the disease by personal contagion, it is necessary that proper consideration be given to the rat, which has been regarded as a common means of conveying the disease from one person to another. Although there is no doubt as to the truth of this, there is also no doubt that the importance of the rat in the transmission of bubonic plague is overestimated. In addition to vermin we have yet to consider the probability of the disease being conveyed by insects. During the past four or five years a number of cases of bubonic plague have been removed at the New York Quarantine from vessels arriving from South American and Indian ports. In no instance did secondary cases occur among those who were in contact with the patient, either on shipboard or on Swinburne Island. This instance tends to show that bubonic plague, when modern sanitary regulations are in force, is not easily transmitted. The pulmonary form, which is common and very fatal in India, is not usually seen on shipboard.

In vessels arriving from cholera ports great care is taken to detect the disease in its various manifestations. The ship's log is carefully examined, and all cases recorded as heart disease, diarrhea, dysentery, etc., which may either have died or recovered in transit to this country, are regarded as suspicious and as a rule justify the detention of the crew, besides a thorough disinfection of the vessel. Fortunately, vessels coming from cholera and plague infected ports as a rule carry no passengers.

Typhus fever and smallpox which complete the list of five diseases that are specially subject to quarantine regulation are also carefully watched for, particularly if there is reason to believe that they exist at the ports of departure.

In order to insure the detention of infectious diseases in the stage of invasion all persons arriving at this port on foreign vessels having fever as indicated by the thermometer, and which cannot be satisfactorily accounted for, are subject to removal to Swinburne Island for observation. In this manner many cases of infectious disease have been prevented from reaching the city.

Success on the part of quarantine officials in the detection of infectious disease and the treatment of passengers, crews and vessels depends upon the character of inspection performed, and an intimate knowledge of the principles which govern modern and practical sanitation, which it can be said is now placed on a scientific basis. We are therefore dealing mainly with facts and not theories. Many of the latter which have long held sway have been repudiated by practical sanitarians.

I am confident that the clothing worn by well persons, textile fabrics, other than those used about the sick, merchandise, cargoes of vessels, etc., etc., rarely act as a medium of infection. I am convinced of this as a result of careful investigation and practical experience. The theory that this material transmits disease undoubtedly receives its chief support from the fact that it is the only plausible explanation of the presence in a community of a case of infectious disease, the origin of which cannot be satisfactorily accounted for. While this theory is apparently reasonable and easily accepted, it is associated with great danger to the public, inasmuch as it discourages a careful and thorough inspection to ascertain the real origin of the outbreak which I believe is frequently due to the presence of mild, ambulant or unrecognized cases. This statement I am quite sure will be indorsed by many who have had long practical experience with infectious disease. In support of the statement which I have just made, I will cite the following instances from my own experience: During the prevalence of typhus fever in New York City in 1893, a thorough investigation was made as to the origin of each case brought to the notice of the Health Department. The investigation frequently covered a period of a week or more, and in the great majority of cases the most satisfactory and conclusive proof was obtained that the disease was contracted by personal contagion. Typhus fever also existed in New York during the previous year, 1892. During the period referred to (1892-1893) there were 71½ cases of typhus fever, and 81½ cases of smallpox under the observation of the Health Department. The bureau of infectious disease of this department at the time referred to consisted of from sixty to seventy-five officers and employees, including diagnosticians, vaccinators, ambulance drivers, etc., all of whom were more or less constantly in direct contact with the above cases and their apartments. It was frequently necessary for the diagnosticians to undress the patient in order to make a thorough examination. Ambulance drivers and other attendants carried the patients from their apartments to the ambulance, and afterwards from it to the hospital wards. Gowns were not used, and the officers and employees referred to went freely to and from their homes to the seat of infection; yet in no instance during this entire period of almost two years was either typhus fever or smallpox transmitted to the families of these men, or to the other occupants of houses in which they lived. Fourteen of the employees contracted typhus fever, and seven died. The fact that the fourteen men referred to were promptly removed to the hospital on the appearance of the first symptoms of the disease will, I believe, explain why members of their families and others were not infected, inasmuch as there is good reason to believe that typhus fever does not usually transmit infection during its very early stage. If infection were commonly communicated by the clothing worn by well persons,

it seems reasonable to infer that it would have been demonstrated in the instance just referred to.

During the past six or seven years a number of cases of bubonic plague have been brought to this station by vessels coming from South American and Indian ports. In all but one instance the disease was in a mild or ambulant form, which under the ordinary inspection of passengers would have passed unrecognized. The persons affected were able to stand erect on the deck of the vessel, answer all questions, and presented no evidence of the disease. However, when their clothing was removed and a glandular inspection made, the disease was recognized and the diagnosis confirmed by bacteriological examination; moreover, at no time during their detention at Swinburne Island did their general condition or appearance indicate that they were affected with the plague. The presence of a case of this kind in a crowded boarding-house in a large city would be likely to transmit the disease, and inasmuch as no record of a previous case was forthcoming, the infection would probably be attributed to clothing or cargo. Cases of the mild or ambulant form of yellow fever, or in the early stage of this disease, have been detected at this station by the use of the clinical thermometer, when the ordinary methods of examination would probably have allowed them to pass unrecognized.

The opening of the school season largely increases the number of cases of diphtheria, scarlatina and measles, and it is the belief of many that they are transmitted by the clothing of well children who are members of families where infectious disease exist. That this belief has not been well founded has been clearly demonstrated by the Health Department of New York and other cities. Inspectors connected with the school corps are constantly finding in the schools mild and ambulant cases of the above diseases, which have not been recognized and which are unquestionably largely responsible for the increased number of cases of infectious diseases which follow the opening of schools. What I have said regarding the necessity of a careful inspection in outbreaks of infectious diseases applies in the most forcible way to quarantine inspection, inasmuch as after the release of a ship no further opportunity for examination is, as a rule, afforded.

In referring particularly to this part of the subject, it is not my intention to discourage the use of every reasonable and sensible measure necessary to prevent the extension of infectious disease, but rather to indicate in what direction our energies should be directed for this important purpose. I am certain that the full acceptance of the theory that the clothing worn by well persons, merchandise, cargoes of vessels, etc., commonly transmit infectious disease militates against the careful inspection, which I believe is imperative in order to discover the true origin of outbreaks of infectious disease and to promptly and successfully control them.

The inspection of passengers and crews at the

New York Quarantine Station is of the most rigid character. Neither the bill of health, the statement of the ship's captain, or surgeon, or of any one else is taken in lieu of a careful personal examination when called for by the regulations of the department. The use of carefully registered thermometers constitutes a part of the inspection of passengers and crews coming from infected districts. If plague is suspected all on board are subjected to a glandular examination, and special attention is given to the presence of any pulmonary affection. The former examination necessitates the removal of all clothing, inasmuch as it cannot be properly performed in any other way. The use of the thermometer is also included in the inspection of plague suspects. A passenger or member of crew having an elevation of temperature, which cannot be satisfactorily accounted for, is subject to removal to Swinburne Island for observation. Those who have been in contact with infectious disease on shipboard are also held for observation. So-called cases of malarial fever, particularly from southern ports, are detained until an examination of the blood shows the presence of the malarial plasmodium, or until the disease has been shown not to be yellow fever. The clothing of the crew and passengers, bedding and fore-castle, etc., of vessels coming from plague or cholera ports, which have been long in transit, are on their arrival here thoroughly disinfected; not on the assumption that this material may have conveyed infection from the ports of departure, but on the ground that in the long voyage there may have been cases of infectious disease which have recovered and are not properly reported.

When disinfection is necessary steam at a temperature of 230° F. with an exposure of fifteen minutes is used for the treatment of clothing, bedding, and other textile fabrics, inasmuch as it is the only agent which can be depended upon to thoroughly penetrate the materials referred to. When furs, silks, satins, and other delicate fabrics, and also leather goods, etc., which are destroyed or injured by steam are to be disinfected, formaldehyde gas is employed. In these instances, however, every article is carefully hung up and spread out in order that all surfaces shall be exposed to the gas. Formaldehyde is also used in the disinfection of saloon apartments, which contain fine fabrics, gilding, etc. Hot water and soap, sulphur dioxide, bichloride of mercury and carbolic acid are variously used in the cleansing and disinfecting of the ship's fore-castle and other apartments after the removal of all textile fabrics, merchandise, etc.

However, the thorough use of soap and water by scrubbing, followed by the generation of sulphur dioxide, or formaldehyde gas in the closed apartment, is as a rule all that is required to insure safety against infection. I am sure that the value of soap and water in the treatment of filthy and greasy woodwork, which is almost always found in the ship's fore-castle, and commonly in schoolrooms, etc., is not properly appreciated.

Under these conditions, the use of a solution of bichloride of mercury or carbolic acid certainly does not cleanse the woodwork, nor can it be depended upon to insure disinfection.

The disinfecting steamer, "James W. Wadsworth," which is always under steam at the New York Quarantine Station, contains all the apparatus which is used in modern disinfection. In this way the treatment of vessels is properly carried out with very little detention. After the removal of a case of infectious disease, and also those who have been exposed to it, as in small-pox, or where all passengers and crews are subject to removal, as in the presence of plague, cholera or typhus fever, thorough disinfection of the vessel is performed, and the latter promptly released. The further detention of a vessel is not only unnecessary, but it entails a serious expense to the owners. The detention of a case of infectious disease on shipboard is in violation of one of the cardinal principles of marine sanitation, inasmuch as segregation and quarantine cannot properly be carried out, and the infection is further extended. Besides, under these circumstances, the time for the release of the vessel cannot be determined.

In transatlantic mail steamships, the deposition of the captain and surgeon that the saloon passengers and crew of the vessel are well is, under ordinary conditions and where no epidemic or infectious disease is prevalent at the port of departure, accepted in lieu of an examination. However, under no conditions are steerage passengers exempt from examination. Experience has shown that this procedure is safe. Furthermore, the examination of two or three hundred saloon passengers and four to six hundred members of a crew, who are constantly needed in the movement of the vessel, would involve a detention, which is not under ordinary circumstances justified.

If success has attended the efforts of the Health Officers' Department of the State of New York, to prevent the entrance of infectious disease into the United States, it has been due to a strict observance of the principles which govern modern sanitation.

HEALTH OF THE STATE.

BY DANIEL LEWIS, M.D.,
Commissioner of Health, State of New York.

Dr. Lewis said in part:

The old State Board of Health was abolished over four years ago and now all of its duties are under the control of the new Department of Health, presided over by a single commissioner. Since its inception, there have been established: (1) State Cancer Laboratory, which is under the control of the State Department. (2) The State Antitoxin Laboratory, which supplies its own antitoxin to State inspectors all over the State. There are now over 1,400 municipalities thus supplied. (3) There is a State Pathological Laboratory, which examines free of charge vari-

ous excreta and tissue, the same as is done in the laboratory here in New York City. The potability of waters from the various summer resorts are here reported upon. (4) There is also a State chemist (who has always existed) to examine drugs and illuminating oils. This latter has interested the Department, as there averages one death a day in this State from the explosion of petroleum of some sort. (5) The examination of food stuff for adulteration is now in the hands of the Agricultural Commission.

The local health officer is the representative of the State Department and is appointed by the office in Albany for four years' service. He can only be removed for cause and after trial. His dismissal must be O. K.'d by the Commissioner. (6) The consulting engineer of the State inspects all sewers and waterworks in towns and villages and no bonds can be issued for such construction until this has been done by him.

In 1902, the State Department of Health secured the passage of a bill forbidding the throwing of refuse of any sort into the State waters.

Further, cities cannot increase their sewage without the consent of the consulting engineer.

Potable waters are under the care of the Department and there are rules which protect all watersheds. The State Department has succeeded in securing \$100,000 per annum as against the \$30,000 yearly appropriated for the old board.

There is maintained a Bureau of Vital Statistics in almost all of the municipalities and many of the cities keep their records at Albany, where fire-proof vaults are provided for them by the State Department.

DISCUSSION.

The discussion of these papers was opened by Dr. Stephen Smith, who said that forty years ago there was no organized department of health in this city, nor were there any health laws in this State. The unification of the entire country on this subject began with the first law passed in this State in 1868.

Soon after leaving Bellevue Hospital the speaker was sent to Blackwell's Island to take charge of the typhus fever patients which were all sent there at that time. It was noticed that twenty cases came from one house on East 22d street. This house was visited. No one resided there. There were bundles of straw upon the floor. On investigating further the author learned that immigrants were sent there from ships to await transportation to other points in the country, and those who developed typhus were sent over to Blackwell's Island for treatment.

The speaker said he appealed to the owner to close the house but he refused to do so. Mr. Acton, a prominent lawyer was then appealed to, but said that there were no laws in the country which could compel the owner either to clean it or to close it. Mr. Bryant, editor of the *Evening Post*, became interested in the matter and ad-

vised that the owner of the house be arrested on other charges. While the owner was in court several reporters of the *Evening Post* approached him and in a public manner asked him for the story of the 22d street house. The owner thereupon promised to have it remodeled.

Dr. Smith then gave a short history of the formation of the first Committee on Public Health in the city.

Dr. Darlington, in closing the discussion, said that to prevent pneumonia one must study the habits and occupations of those especially susceptible to the disease.

OCULAR REFLEXES.¹

Their Effects in the Production of Ill Health.

BY S. W. S. TOMS, M.D.,
Nyack, N. Y.

IN accepting the invitation of your secretary to prepare a paper for this meeting of the Association, I concluded to submit some observations I had made in the course of a busy general practice: the cause of many symptoms from which nervous patients frequently suffer, the importance of these symptoms correctly interpreted, and the indications for treatment. I wish to state at the outset that I do not approach the subject from the standpoint of a specialist, and that I disclaim any extremist's or prejudiced views on the subject. I have tried to study my cases most thoroughly, and in so doing have examined all other organs as carefully as I have the eyes; in fact, in many of them, this was the last thought of after other therapeutical measures had been tried in vain. It is a fact that every general practitioner is called upon to treat more derangements than diseases; and "neurotics" are a very considerable portion of his clientèle. Do we regard this class of cases "as sufficiently interesting" to claim our best thought and care? I fear they are often "treated on general principles," because our text-book authorities have not yet given us all the etiological factors for *hysterical* and *neurotic* states (and I believe one of the most prolific is eye-strain), and in consequence there is a resort to haphazard therapeutics instead of selective measures. I believe I have found through a systematic examination by exclusion, indications that lead to the employment of rational measures in a pretty large percentage of these cases. Without doubt these patients do suffer. They go from one physician to another—and often we are glad to get rid of them—they vainly seek relief until they eventually lose faith in regular medicine and turn to quackery in one form or another. My plea is that we take hold of these cases and study them as we would those entering a hospital to report their history for the visiting staff's inspection. A thorough examination is usually very fruitful and always "interesting."

My last series of one thousand eye examina-

¹Read before The New York State Medical Association, at the Twenty-first Annual Meeting, New York, October 17-20, 1904.

tions—most of which were made as part of routine work—convince me that many patients who complain of symptoms, other than those directly referable to the eyes, would have gone unrelieved had I not made eye examinations. There are no text-book types of this class of sufferers, and it must be understood that I am not referring to or including those patients with organic disease whose eye conditions are only part of their systemic malady. The reflexes from which these cases suffer and their symptoms are often very anomalous and curious. The conditions as found on examination may be equally so, as we rarely detect relationship between the amount or kind of eye defects and the disturbances produced; in fact, it is often in inverse ratio, a slight visual defect may create serious and profound nerve racking disturbances of one kind or another; depending, not upon the kind of defect, but upon the peculiarity of the individual idiosyncrasy. For instance, a slight astigmatism or hyperopia (such as recently witnessed by me in a young woman) may cause uncontrollable hysterical emotions which develop shortly after removing her glasses. Another condition: that of muscular anomalies, which is puzzling, is an exophoria in distance with an esophoria in accommodation—or conversely. Careful studies of duction of all the muscles, rotations in all directions, and the study of the principal meridians in relation to the horopter are absolutely necessary in attempts to solve these apparently contradictory conditions. The ocular defects mostly productive of nervous disturbances are astigmatism in oblique or unsymmetrical axes (and usually the hyperopic types), anisometropia or unequal refraction of the two eyes, astigmatism against the rule and mixed astigmatism. Muscular imbalances are quite as potent in their influence as those of refraction and often exist independently of the latter. The symptoms complained of are frequently legion, and a catalogue of them would carry me far beyond the time-limit of this paper. The more frequent and common symptoms are the different types of headache, vertigo, nausea, vomiting attacks, "bilious spells," nervous dyspepsia (so called), symptomatic migraine, cardiac neuroses, "nervous spells," clonic muscular twitchings symptomatic of chorea and epilepsy, insomnia, neurasthenia, lassitude, sea and car sickness, night terrors in children, and others which simulate organic nervous diseases.

Frequently a lowered state of the system from disease, overwork or worry, will rupture a compensated eye defect, and eye-strain will follow, with its train of nervous phenomena. Pregnancy and miscarriage I have observed to be conditions that unmask eye defects. Occasionally the eyes themselves suffer from peripheral irritation, producing styes, blepharitis, meibomian cysts, watering and suffusion, pains in eyes, etc. Certain anomalies of the ocular muscles induce malpositions of the head. A wry-neck from hyperphoria (where one eye is in a higher plane than

its fellow). Both eyes being too high causes a "ducking" of the chin against the chest; but where they are too low the opposite condition may result. Esophoria causes an *intense* expression, with wrinkled forehead and "crowsfeet" at the outer canthi. Exophoria often produces a "blank" expression. "Whether physiologic or pathologic the eye is necessarily actively functional during every instant of the waking life. It is bound up with every emotion and guides every concept; our thinking is by photographic images, even the letters of the alphabet are conventional pictures. When vision is morbid, there is therefore no limit to the kind and extent of the resultant harm to the organism and to the life." (Preface to 1st series of Biographic Clinics—Gould.)

I have not neglected general hygiene, and occasionally the temporary employment of drugs in the treatment of my cases—as a crutch would be used to assist in regaining strength and function for a disabled limb. The nervous system is often depleted of its reserve, and requires every means of assistance, together with the removal of the cause of depletion while stopping the leak, in our efforts to assist recuperation.

Right here I want to put myself on record with the statement that no absolute refraction of the eyes can be accurately determined under presbyopic age, without the employment of a mydriatic. Ciliary spasm often precludes a retinoscopic test, and also a minus glass occasionally being preferred instead of a plus glass; but where the pupils are paralyzed the true condition is revealed.

TYPES—NERVOUS PROSTRATION.

Case No. 1.—F. L. W., female, aged 26, school-teacher, single; father living and vigorous (mentally and physically). Mother neurotic; has been a martyr to headaches, bilious attacks, insomnia and dyspepsia all her life. Has had to wear glasses for some years. Two brothers have visual muscular defects. Patient came to me June, 1900, after suffering some weeks from a nervous breakdown which compelled her to give up her school. At first she noticed that she became very tired and exhausted early in the afternoons, with restless nights and unrefreshed in the mornings. Severe occipital headaches ensued and a tender spine developed. A trembling sensation in the epigastrium, indigestion, uncontrollable hysteria and depression followed, so that she had to stop work and go to bed. This was her condition when she came to me. I carefully examined her, finding her physical condition good and apparently nothing existed to account for her symptoms. Her visual tests were negative. She would not accept any lenses whatever, her vision being 20/20 for distance and she read No. 1 Jager at 8 to 20 inches without effort. The muscular anomalies were 9° of exophoria in distance, with abduction of 15°. She had diplopia at 6 inches, and both eyes deviated outwards under the exclusion test. After wearing 2° prisms, bases in, for two weeks,

with much relief, I did a partial tenotomy on the left externus, which reduced the exophoria to 2°. On the fourth day I operated on the other eye, slightly overcorrecting. Two weeks after she had 2° of esophoria, with abduction of 5°, adduction of 34°, without diplopia in convergence. On the completion of the second operation she remarked that she felt as if the "world had been lifted off her shoulders." Her insomnia, nervous and dyspeptic symptoms were magically relieved, and she left for home within a month, free from all her symptoms except some nervous dread if she exerted herself. I examined her two years later, when she stated she had not had any return of her trouble, and her eye tests showed perfect balance—adduction, 30°; abduction, 7°; sursumduction, 2°. (I have operated on her brother for exophoria within a few months and another brother is using prisms for muscular asthenopia.)

TYPE—CARDIAC NEUROSIS.

Case No. 2.—B. F. G., aged 34, married; clergyman. I have known patient for fifteen years. I have seen him faint and carried out of his church. He has been treated for heart disease by several physicians. He never has complained of eye symptoms or headache except some blurring after prolonged use of eyes, frequent bilious attacks (monthly), pain in stomach and indigestion. Has been of a nervous disposition and has fainting attacks when overworked, nervously excited or in a close room. These attacks are accompanied by cold extremities, feeble pulse, vasomotor paresis, unconsciousness and slight clonic convulsions. Physical examination is negative, excepting for an indistinct aortic first sound. Pulse normal and of good tension. Vision 20/20—accepts +.75 axis 90° = 20/15. This he has been wearing for years. Muscular tests show homonymous diplopia with red glass with an excessive convergence—esophoria of 10° in distance, and 24° in accommodation. Adduction, 40°; abduction, 0°. A 2° prism over each eye, bases out, relieved him of much nervous tension. These were increased gradually to 4° over each eye. He has worn these for over a year and reported only a week ago that he had not had any return of his old trouble, had gained 10 pounds, and has felt perfectly well—but cannot go without his glasses. He was so well pleased that he brought a friend 150 miles to me, hoping I might find ocular defects as the cause of similar nervous trouble.

TYPE—SPASMODIC.

Case No. 3.—W. A. J., aged 27, married. Freight conductor. Father alive and well. Mother alive; has eye defects and belongs to a pronounced neurotic family. Patient came to me September, 1903, with spasmodic tic, affecting the facial and cervical muscles of the left side, mostly. His present attack had lasted three months. He had been treated for chorea with arsenic until his eyelids were edematous and conjunctivæ suffused. He had his first attack two

years before, and subsequently slight recurrences at different times. There was no rheumatic, syphilitic or alcoholic personal history. He had a maternal uncle die of epilepsy, and a maternal aunt of some nervous disease. The patient is a strong, healthy looking and well-developed man, his manner not indicating a nervous temperament. I at once tested his eyes, finding a compound farsighted astigmatism—against the rule, with 9° of esophoria; adduction, excessive and abduction deficient. I deemed it necessary to employ acyclopegic, which revealed a deficiency of vision of 20/200, with +2.75 D.^s \subset +.75 cy. axis 180° = 20/15. One-half of the hyperopic correction was prescribed with full astigmatic lenses for constant wear. *Two hours after the atropine had been instilled into his eyes these spasmodic twitchings were much lessened and he slept during the night without an hypnotic, a thing he had not done before for weeks.* I was enabled on the second day to complete the examination without difficulty, whereas the first attempt was unsatisfactory and tedious. His glasses gave him immediate relief, and after two weeks he attempted to go without them. A recurrence followed, and having to lose sleep with night runs, I found it necessary to administer bromides for a week to assist the work of the glasses. I would have used the midriatic again instead of bromides had it been possible for him to stop work.

He has had no recurrences since. None of the text-books on nervous diseases that I have consulted has given eye-strain as an etiological factor in producing facial, tic or any other spasmodic affections simulating chorea.

TYPE—NERVOUS INSOMNIA.

Case No. 4.—On September 12th last I was called to see a colored woman suffering from an uncompleted abortion in the fourth month.

I found she was exceedingly nervous, which sedatives and hypnotics failed to relieve. After being affected in this way for several days and nights, and being told my medicines were "no good," I asked her what made her nervous since her sufferings had terminated. She could give me no information in her reply.

I noticed that she had put on her spectacles and that her head was tied up. These observations gave me a clue. I looked at the lenses, finding one of a different refraction from the other. I noticed also that she received the light from the windows directly into her eyes and at night a lamp burned on the mantel. When the hyper-sensitive retinae are irritated by rays of light imperfectly focused, the brain often is affected through the optic nerves and headaches result.

I had her bed turned around so that she faced the wall and the shutters closed, with the result she fell asleep within an hour and no more medication was required.

Next morning I found her asleep at 10 o'clock, and she told me she had had a full night's restful sleep.

HOSPITALS OF NEW YORK.

Criticisms and Suggestions by a Physician.

To the Editor of *The Sun*:

Sir—During the past few weeks a number of the most prominent quasi-private New York hospitals have issued their annual reports, in which are contained the usual appeals for additional financial support. In one it is stated that "unless the people of New York awake to the necessity of supporting their hospitals, and unless the public conscience is quickened and larger means for current expenses provided, the hospital system of New York must at some date not long distant be changed." In other words, these institutions will be compelled to depend on the municipality and be maintained by taxation. Suppose, for the benefit of the public and to quicken its conscience, the hospital system as it exists, outside of that controlled by the city, be somewhat carefully scrutinized from various viewpoints.

1. Large and small, sectarian or non-sectarian, the number of quasi-private hospitals in the boroughs of Manhattan and the Bronx is forty-nine. No one can deny the immense deal of good which they accomplish. It would be odious to belittle by a word the work they have done and are doing, yet it is a debatable question if their management, almost without exception, is along lines which are productive of the best results.

Many have large endowments, but not a year ends that the balance sheets of a majority do not show a deficit. This is not necessarily due to extravagance, for a modern hospital is conducted according to strict business principles; but in many instances it is accounted for by unnecessarily elaborate and expensive buildings and equipment, which leave a comparatively insignificant sum for maintenance.

A fact which is not generally known by the laity is that, with three exceptions, every hospital in Manhattan and the Bronx is a "trust" by itself. No physician or surgeon not a member of its staff, no matter of what repute, is permitted to attend a patient within its walls. If a private patient is in need of hospital care the unattached medical attendant is forced to send him to one of the three small hospitals mentioned, or to an expensive sanitarium where he may retain charge of the case, or to one of the large institutions, in which event his attendance perforce ceases.

Appointments to the staffs of these hospitals, as is well known in the profession, are secured, first, because of a "pull" with the governing board, and second, because of a private practice of such size, numerically and financially, that the appointee may directly contribute to the support of the hospital by sending patients to occupy the wards and high-priced private rooms. It is natural under the circumstances that a constant effort should be made by the physicians to keep the quota of patients at as near the capacity of the hospital as possible, yet I venture the assertion that, with the possible exception of the large hospitals under Jewish and Roman Catholic management, there is not one in which there are not empty wards and empty private rooms during practically the entire year. For instance, the annual report of one hospital, recently issued, shows a large deficit during the past year, and that two ward floors, containing more than a hundred beds, cannot be used until sufficient income is forthcoming to

increase the service. The deficit of the Presbyterian Hospital was \$72,936, and its annual report shows that it has vacant wards for the same reason.

Scarcely a week passes that the daily papers do not chronicle an instance in which one of the great philanthropic institutions has refused admission to a needy patient, or has transferred one to Bellevue—not because of lack of room, be it known, but because his care will increase the deficit at the end of the year! Yet the wards at Bellevue are so overcrowded that many of the 859 patients are compelled to occupy mattresses on the floors. Surely the conscience of the public needs quickening.

2. Besides taking care of the sick poor at its own hospitals, the city of New York has entered into an arrangement with certain private hospitals whereby this class of patients, under certain conditions, is cared for. For this service it pays 80 cents a day for adult surgical patients, 60 cents for medical patients and 38 cents for children. The cost for each patient for food alone, at the average hospital, is from \$1.40 to \$1.60 per diem. Attendance, dressings, etc., increase this expense to about \$2.50 per day, or \$17.50 per week. The average charge for a patient occupying a bed in a ward is \$9 per week, for a private room from \$25 or \$35 to \$50. Practically every large hospital derives an income from invested funds sufficient to meet a reasonable deficit, if its private rooms are constantly occupied.

3. Many persons, and especially the poor, have a sentimental abhorrence of municipal hospitals. And many of those admitted as patients, as is well known, could well afford to pay a reasonable amount weekly and would do so, or their friends would pay for them, if admitted to an institution not controlled by the city, where they could retain the services of their family physician. If our readers think for a moment that this class does not indulge in the luxury of a family physician, let them investigate medical conditions on the lower East Side.

4. According to the latest edition of the *Medical Directory*, there are 4,215 practicing physicians in the boroughs of Manhattan and the Bronx. Of this number, perhaps 500 serve in one or another capacity on the staffs of the forty-nine hospitals referred to. All of the remaining 3,715 are absolutely excluded from hospital practice, except as I have already specified. The importance and prestige of a hospital connection are well exemplified by the host of applications for a vacancy on an attending staff. Yet there is no chance whatever of an average general practitioner or specialist receiving an appointment unless he has a pull.

In many of the large cities of this country both municipal and semi-private hospitals are conducted on an entirely different plan, and one which is productive of immeasurably better results. To every physician of good standing is accorded the privilege of attending his own patients in the wards and private rooms. The result of this policy is that the public receives fairer treatment, patients are satisfied at being enabled to retain the services of their family physicians, the latter appreciate that they are not discriminated against by a small but powerful minority in their own profession, and empty beds and consequent deficits between incomes and expenditures are almost unknown.

Instead of attempting to quicken the conscience of the long-suffering public, instead of calling on the municipal authorities for help, let every one of these forty-nine hospitals do away with the exclusive attending medical and surgical staff, retaining its consulting staff if it will; let it open wide its doors to the medical profession at large, to the sick poor whose desire it is to retain the services of a medical attendant in whom they have confidence, and, instead of empty wards, empty rooms and a yearly deficit, it will greatly extend the sphere of its usefulness and accomplish the mission designed by its founder.

I will add that this is not the wail of a disappointed physician, as my own hospital connections are sufficiently numerous to be entirely satisfactory.

M. D.

New York, December 22d.

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THE TURMOIL OF STATISTICS.

The lay press unthinkingly has stirred up a controversy which seems to have shaken the world. Strange to say, it is a question which has caused humanity to throb with its self-importance, and even put more than one canyon-like community upon its mettle. So too the patriarch has been put to the shame of his deferred senility and made an inviting target of the alert humor of metropolitan sidewalks. A joke stigmatized by some as feeble seems to have originated a towering reputation, suggesting a throe of nature—or, to speak less extravagantly, a greatness thrust upon the most modest of men. Of course, no matter how deep the guilt, every culprit should be accorded the solace of a joke. Even the rollicking poet on a broader theme asks What is life without it? Still all concede the danger of explaining one. It is a misdemeanor more gross than any degree of premeditation. But even here the tedium may be relieved by the satisfaction of accomplishment. To many the fate of a witticism is of more account than any depth of ethics. The error, if any, is not one of taste, so that even the humblest physician need not lose his dignity by a suspected playing to the gallery gods.

The case in question needs no debate so far as reflection upon age is concerned, even though the reward of merit for toil be submitted for calculation. Figured down closely the challenge, as presented to men over 60, is the inutility of life—the terms—chloroform or death. All of which is absurd on its face, inasmuch as so many fence around so grave a question. That the whole matter was an adroit contribution to an autobiography is not worth a moment's consideration.

But statistics must be adjudged by different standards, the object being to glorify ancestors

and to appease posterity. Schoolboys may put them forth as puzzles and deal with them in the elucidation of the most frivolous topics. They may group in one class the heroes of every age, they may muddle dates, genealogies and tribes. They may yet withal be correct in general principles and produce shining examples. Let us, as members of a much aggrieved profession, try an exchange of the strenuous for the simple life. In brief, statistics are muddled—they are neither as clear nor as valuable as maxims. Fame, too, may be intoned by a self-owned megaphone or thrilled through an angelic trumpet, and at a proper distance may seem merely the roar of traffic.

It may perhaps be admitted that a wide dividing line might exist between the Anglo-Saxon and the Celtic sense of humor. In other words, that the antithesis of presentation might vary—that the former maintains a more solemn demeanor towards the emotional, and that the latter affects a more joyous frivolity. What boots it? Does not every one seek to maintain a reputation for wit at all hazards? Is there not an inborn longing on the part of the faddist for the grotesque? But it need not sustain the spirit of levity needlessly, carelessly and detrimentally. The lesson of all ages which appal in the count is to the effect that the admiration of the public is based upon achievement, opportunity, perseverance and the economy of time. Many a scholar has carried to the grave the most priceless of treasures; many a strategist might have been a world-renowned hero but for his unfought battles; and still another class might have been fabulously rich but for the unused talents of scripture. Therefore let all of us in the present age of velocity not especially court the dangers of the crowd for the sake of the solitude of the pinnacle. Mankind until the crack of doom will have gentle quarrels with statisticians, patriarchs will laugh prophets to scorn, but the despised populace will safely course their way under the arch of the bridge and above the curve of its foundation. Posterity will always be fond of choruses, which are denied to present ears.

COMMON SENSE VERSUS NONSENSE.

In a recent issue of the *New York Medical Journal*, there was published an article condemning the action of the New York Board of Health in its anti-spitting crusade. To one who has read this article, it is perfectly evident that it must have escaped the critical eye of the editor in order to have ever reached a galley proof.

The gentleman who has written this article thoroughly condemns the action of the Board of Health to make it illegal to expectorate upon our sidewalks, and declares that the habit of spitting is absolutely necessary to health. He evidently overlooked the fact that laws are made for the protection of the greatest number, and not for individual comfort. That a physician should advance any such theory as this, not only seems ridiculous, but shows evidence of absolute ignorance of the modern ideas of the transmission of disease. The statement is made that not over one in one hundred of the persons who traverse the streets are tuberculous. It is a well-known fact that in all large cities tuberculosis forms 10 per cent. of the mortality. One can readily calculate the total number of inhabitants of a city from this, should he be given the total number of deaths which have occurred from tuberculosis. In other words, one person in every ten, who dies, is tuberculous.

It is stated that the cold temperature of winter is sufficient to cause the death of the bacilli or germs of any sort which might be contained in excretions. This is sheer nonsense. "Is it absolutely essential under the conditions in which we live, for us to expectorate?" The gentleman in question answers, "emphatically, yes!" Why is it, then, if such is the fact, that one never has occasion to call to the members of the gentler sex for transgressions of this section of the sanitary code? Women do not spit upon the street, and there is no excuse for the "lords of creation" to indulge in this vile and filthy habit.

It is well known that in the morning there is an accumulation of mucus in the larger bronchi due to the emptying of the bronchial glands, and to those dwelling in large cities where dust and soot are inhaled with great freedom, it may be perhaps necessary to expectorate in order to get rid of these foreign particles. However, it is usually early in the morning when this necessity arises, and the expectoration can perfectly well take place in the privacy of one's own home, where the sputum may be properly disposed of. It is stated that tubercle bacilli and other infectious organisms which are contained in the sputum are most readily killed by the action of the sunlight, hence the writer argues that it is most proper to expectorate on the sidewalk, where the sun can readily reach these organisms with its rays. To a certain extent this may be so, but it is still better known that at least all the organisms which are pathologic to any portion of the respiratory tract are not propagated outside of the human body, therefore when we meet

with such organisms outside of the human body, it is a self-evident fact that they must come from the respiratory tracts of some offending citizen.

Again, "There is no question but many infectious germs had located in my mouth and throat; now should I have brought this infectious material home to my family expectorated into my handkerchief, and have put it in my wash basket, where the bacilli would have had time to develop?" Yes, Doctor, by all means, for when your handkerchief had gone through the laundry, provided your laundry was properly done, your bacilli and germs would have undergone a very excellent parboiling, which would have probably destroyed their pathogenicity.

The author denies that street cleaners are especially liable to tuberculosis. A special commission of physicians has been appointed to look into the question of infection by tuberculosis of the employees of the Street Cleaning Department. It has come to our knowledge that a very large percentage of our despised "white wings" have become infected with tuberculosis. This knowledge has been obtained by the actual examination of many of this class of individuals as they have applied for examination and treatment in one of the medical dispensaries of this city.

It is inconceivable that a physician at this late day should be willing to place his name over an article of such a nonsensical character. Surely the doctor in question did not mean what he said, for the whole paper teems with ideas, scintillating, not with intelligence, but with ignorance of all the laws and rules of modern hygiene and sanitation. That the gentleman would expect modern physicians to even so much as tolerate any of his numerous false statements is beyond the question of possibility; but, as to the laity, the years that have been spent in teaching the simplest ideas of hygiene could be put to nought by the false doctrines and erroneous teachings of such stupid, nonsensical articles.

HEARING ON CORONERS' BILL.

Introductory Remarks of Dr. E. Eliot Harris.

Mr. Chairman and Members of the Senate Committee on Cities:

The members of the Committee on Legislation of The New York State Medical Association have always maintained before the several committees of the Senate and the Assembly that they represent the interests of the general public on all medical questions contained in the various bills before the Legislature. I am here as chairman of that committee to continue to apply this principle in the argument favoring Senate Bill No. 504, otherwise known as Senator Elsberg's Coroners' Bill.

The office of the Coroner in the City of New York, and the jury system connected therewith, are abolished by the provisions of this bill, which transfers the judicial functions of the Coroner to the 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. A special branch is created in the Department to do the medical work under a chief medical examiner, who shall be a skilled and practical bacteriologist and pathologist, and selected after a special civil-service examination to be held therefor.

The legal duties which are necessary for conducting the inquests properly, including the examination of witnesses, are transferred by the bill to the District Attorney, an officer of the Government who is in every way qualified for the proper presentation of the case before the magistrate, and for submitting the evidence, when a crime is suspected, to the Grand Jury, thereby saving the expense of the work of the Coroner and his useless jury which even to-day, in criminal cases, is considered of little or no value and must be duplicated and elaborated by competent experts before going to trial.

The civil duties connected with the office of Coroner have been transferred to the City Chamberlain, an officer of the City Government already qualified for the responsibility imposed upon him. The question may be asked, Why is the office of Coroner in the City of New York 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 of the City of New York acts the part of a magistrate, district attorney, sheriff in civil cases, and determines the scientific cause of death; in fact, he exercises extraordinary authority and has too many duties imposed upon him. 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 judge, deciding the kind of evidence that shall be submitted 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 adjourns a case to go to a fire or leaves the bench to answer a summons to take the ante-mortem statement of some injured person and who may be suddenly called to examine a body, and decide the question of the cause of death, incorporating in his decision the latest researches in chemistry, bacteriology, toxicology and pathology. It may readily be seen why it is difficult to get satisfactory men for such an office.

And let me say right here that some Coroners who are now in office in the City of New York are the equals of any Coroners who have held the office within my recollection, but the numerous duties imposed by law upon the Coroner in the City of New York must surely at some time in his official career make him the subject of ridicule. The Coroner is an expensive relic of by-gone ages and seems to exist only because he has existed over 800 years.

The office of Coroner was eliminated from the Constitution of this State in 1894 and it exists to-day at the pleasure of the Legislature. It is

still a constitutional office in Pennsylvania, but Massachusetts many years ago adopted the medical examiners' law after which this bill is modeled.

The judicial character of the duties of the office of Coroner may be shown by quoting from Section 773 of the Code of Criminal Procedure, which says: "Whenever a Coroner is informed that a person has been killed or dangerously wounded by another, or has committed suicide, the Coroner must go to the place where the person is, and forthwith inquire into the cause of death or wounding, and in the City of New York must summon not less than nine nor more than fifteen persons qualified by law to serve as jurors." Section 775 says: "He must summon, and examine as witnesses, every person who in his opinion, or that of any of the jury, has any knowledge of the facts, and he must summon as a witness, a physician who must in the presence of the jury, inspect the body and give a professional opinion as to the cause of death." Section 776 says: "A witness served with the subpoena may be compelled to attend and testify, or be punished by the Coroner for disobedience as upon a subpoena issued by a magistrate."

The discretionary powers given to the Coroner to issue warrants for the arrest of any person whom he suspects of causing the death of another, to subpoena witnesses and punish them for disobedience, are in harmony with the highest judicial functions of the State, and are inconsistent with the other duties imposed upon the office of Coroner. Of the eleven Coroners who exercise such judicial functions in the City of New York I am informed that only one is a lawyer. This bill separates the judicial duties from the other duties associated with the office of Coroner and provides for the proper conduct of the inquests before the existing city magistrates, who need not cut short a hearing or adjourn his court in order to go to a fire or to a scene of accident.

Section 777 of the same code says: "After inspecting the body and hearing the testimony, the jury must render their verdict, and certify it by an inquisition in writing signed by them setting forth who the person killed or wounded is; and when, where, and by what means he came to his death."

I have served more than once on a Coroner's jury and know from personal experience that the scientific determination of the cause of death was not attempted, as the Coroner's office has no laboratories at its disposal for conducting such scientific work. The Department of Health in the City of New York to which the medical duties are transferred by this bill has a new six-story, up-to-date laboratory building, 40x180 feet, devoted to bacteriology, chemistry and toxicology, which is now completed and will be in full operation before next June.

This new laboratory, judging from the character of the scientific work which has already been done by the Health Department, promises

to equal if not to surpass the best work in the great laboratories of the world. Then why not place the medical duties of determining the cause of death in so-called Coroners' cases, of which there are about twelve thousand each year in the City of New York, in the existing Health Department, which has, under the present law, full control of all deaths from contagious and many other diseases, and with the aid of its laboratories can efficiently cooperate with the District Attorney in all Coroners' cases where a crime is suspected, and forever remove the scandal and horror now associated with sudden death in New York City, which the dread of the Coroner and his jury has produced?

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.

See page 33 of THE NEW YORK STATE JOURNAL OF MEDICINE (February, 1905, issue) for abstract of Senator Elsberg's Coroners' bill.

BILLS IN THE SENATE AND ASSEMBLY.

Introduced by Senator McCarren—(by request)—to be committed to the committee on Public Health.

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, which rules shall, among other things, provide for an examination in mental science as a means of promoting and preserving health.

Introduced by Senator Cassidy—(by request) and by Assemblyman Monroe—read twice and ordered printed, and when printed to be committed to the committee on Public Health. An act, No. 1075, to amend the public health law, relative to admission to medical examinations.

The regents may also admit to such examination an applicant who meets the first and second requirements, who has been admitted to practice medicine in another state after graduation from a medical school of such other state, which school prior to his graduation or within one year thereafter was registered by the regents as maintaining a satisfactory standard, if they are satisfied that such applicant has a general education equivalent to that required in this state as preliminary to receiving the degree of bachelor or doctor of medicine. In case of the refusal of the regents to admit such an applicant to examination, the applicant may present a verified petition to a special term of the supreme court in the third judicial district, on eight days' notice to the regents, stating the facts on which his claim to admission is based, and such court may, after hearing the parties to such proceeding, if satisfied that such applicant is entitled to be admitted to examination, order such applicant to be admitted to examination accordingly which order shall be

final; and in determining whether a general education is equivalent to that required in this state as preliminary to receiving the degree of bachelor or doctor of medicine, the regents or court, as the case may be, may base the determination on the general courses of instruction pursued by such applicant, without regard to specified counts or as to whether or not the institutions in which such education was acquired were registered by the regents of this state.

Section 2. This act shall take effect immediately.

An act to amend the public health law, in relation to the sale of wood alcohol. Introduced by Assemblyman Yale—read once and referred to the committee on Public Health—reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee—reported from said committee with amendments, ordered reprinted as amended and placed on the order of second reading.

Section 218-b. Reports of sales in state of wood alcohol.—Every manufacturer, jobber, wholesale dealer, or other person selling wood alcohol within the state, other than at retail to consumers, shall on the first day of each month report to the state commissioner of health, on blanks furnished by him, if requested, the name and address of each person, firm or corporation within the state to whom wood alcohol was sold by such manufacturer, jobber or wholesale dealer during the preceding month, and the quantity sold to such person, firm or corporation. Every such manufacturer, jobber or wholesale dealer who shall sell wood alcohol within the state without making the report required by this section shall be liable to a penalty of fifty dollars for each sale not so reported; and any contract for payment for wood alcohol sold within the state, the sale of which is not so reported, shall be absolutely void and unenforceable.

Sec. 218-c. State tax on sales of wood alcohol to consumers.—Every person, firm or corporation selling wood alcohol within the state to distillers, refiners, jobbers or consumers shall on the first day of each month report to the state commissioner of health, on blanks furnished by him, if requested, the quantity of wood alcohol sold by such person, firm or corporation during the preceding month, and the price paid to such person, firm or corporation therefor; and shall pay to the state commissioner of health a tax equal to thirty-three and one-third per centum of the selling price of all wood alcohol sold during the preceding month. Every person, firm or corporation failing to make the report required by this section on or before the tenth day of any month, or failing, within such time, to pay any tax due as provided therein, shall be liable to a penalty of fifty dollars for every such failure, and the additional sum of five dollars for every day that such failure continues. Such tax shall be a lien upon and bind all the real and personal property of the person, firm or corporation from the time

when it is payable until the same is paid in full; and may be recovered by the state commissioner of health in any court of competent jurisdiction; and it shall be lawful to join a cause of action for accrued penalties or failure to make a report required by this section, with a cause of action to recover a tax due. All taxes collected and fines or penalties recovered under the provisions of this section shall be paid by the commissioner of health into the state treasury to the credit of the general fund.

Sec. 2. This act shall take effect July first, nineteen hundred and five.

An act, 1027, directing that all articles of canned food shall bear a stamp of date when same was preserved. Introduced by Assemblyman Sammon, and referred to the committee on Public Health.

Section 1. No individual, copartnership or corporation engaged in the sale or manufacture of any article or articles of canned food, shall sell or expose for sale any such article or articles of canned food unless the package or packages containing such article or articles of food bear the day, month and year when such article or articles were canned, bottled, preserved or packed.

Sec. 2. Any and all articles referred to in the preceding section that are sold or offered for sale as canned goods, must be contained in a can or cans that shall have stamped upon it or them the day, month and year when the same was canned.

Sec. 3. Any and all articles referred to in section one of this act that are sold or offered for sale in glass packages, must have the day, month and year blown in the glass package containing such article or articles of food.

Sec. 4. Every other article or articles of food sold or exposed for sale in wooden or paper packages must have printed thereon the day, month, and year when the same were put up or preserved.

Sec. 5. Nothing in this act shall apply to the label or labels placed upon the packages containing such article of food.

Sec. 6. Any person or persons, copartnership or corporation who shall violate any of the provisions of the act shall be guilty of a misdemeanor and shall be punished according to law.

Sec. 7. This act shall take effect October first, nineteen hundred and five.

An act to relieve Elizabeth G. Wright of Newburgh from certain requirements of the public health law relative to the practice of nursing. Introduced by Senator Goodsell—committed to the committee on Public Health.

CONFERENCE CLUB.

A very successful dinner was held February 25th, which was attended by a large number of members from the city and out of town. The concluding dinner for 1905 will be held at the Yale Club April 29th.

LEGAL NOTES.

The List of Successful Defense of Malpractice Suits Brought Against Members of the Association Remains Unbroken.

Another attempt to compel a doctor to answer for an alleged malpractice has been interfered with, and the jury in the case of Mary Smith vs. Martin Cavana has brought in a verdict in favor of the defendant.

On Tuesday last, in the Supreme Court at Rome, Oneida County, N. Y., the trial of this action was begun before Mr. Justice William E. Scripture, presiding, and Messrs. Henry E. Haynes, John C. Allen, David Abels, Chauncey Hulburd, H. M. Rupert, E. G. Coleman, Frank Snell, John Donnelly, Albert Youmans, Alfred G. Burt, William Plunkitt and Matthews Whalen, as the jury. The plaintiff was represented by P. H. Fitzgerald, Esq., of Martin Building, Utica, N. Y., and the defendant by the Counsel to the Association. Mr. Lewis was assisted by J. T. Durham, of Oneida, and John Mason, of Rome.

The contention of the plaintiff in the action was that on the 25th day of July she was thrown from a carriage off a bridge, falling twelve feet to the bottom of a creek, and received a fracture of the left radius about one and one-half inches from its head, and a dislocation of the ulna; she also claimed that the ulna had broken through the skin and protruded one-quarter of an inch. She was carried about five miles to the hospital of the defendant in the action, Dr. Cavana, at Sylvan Beach; she was under treatment by Dr. Cavana for about seven weeks and was allowed to go home, but instructed to return for further dressings and reapplication of splints.

The testimony of the plaintiff herself was to the effect that there was absolutely no swelling of the wrist, and that Dr. Cavana did not undertake to set her arm for twelve days after the injury, but that from time to time he took off a straight splint which had been applied, and pulled and hauled her arm, and would not allow it to heal; that when she left his hospital the bones of the arm were not in their proper place, and five days after she had arrived home she called in another physician. This physician reapplied the splint two or three times, told her he could do nothing for her arm, and she was taken to the office of Dr. Glass, of Utica, about three or four weeks later.

There was no question about the condition of the arm at the trial, for it was indeed in a serious plight; the only question was as to what had been done by Dr. Cavana toward a repair, and what had been the result of his manipulations. The doctor made a very favorable impression upon the Court and upon the jury, and stated in an extremely fair way the whole history of the case from the time the plaintiff was brought to his office, explaining that the lacerations in the wrist were so extensive, and the swelling was of such severity, extending up to the fingers and

back of the hand, as to make a permanent and complete reduction of the fracture an impossibility. The doctor then testified that the plaintiff was in a collapse, suffering from shock; that she was passing bloody urine, three ribs had been torn from the sternum and the abdomen swollen, and that her general physical condition was so grave that her life was despaired of for two or three days.

As soon as the swelling had in a measure subsided, and as soon as the general physical condition of the patient had improved, the doctor proceeded to and did, by the application of a pistol-shaped splint, succeed in making an accurate and complete reduction of the fracture of the radius and of the dislocation to the ulna, which was further complicated by a fracture on the top of the ulna and the misplacement of the cartilage upon it. The hospital records were conclusive as to all his statements, and showed that the ulna had not pierced the skin. The preliminary splint which had been used was a straight splint.

The repair process to the bone was somewhat delayed by the physical condition of the plaintiff, but finally a complete and successful repair manifested itself, and the patient was allowed to go to her home, with directions from the doctor to return in five days; this the patient neglected to do, and the explanation of the unfortunate deformity which subsequently followed was that the patient, instead of returning to the doctor, took off the splints and bandages, the fracture doubled in on itself, again redislocating the ulna, and leaving the arm in the condition in which it now appears to be.

The two physicians who appeared for the plaintiff were Dr. Glass, of Utica, and Dr. Tousey, of Oneida County. Two physicians of Rome were called for the defense, one being Dr. Thomas G. Nock, the present Mayor of Rome and an active member of the New York State Medical Society, and Dr. J. O. Stranahan, one of the fellows and secretary of the Oneida County Medical Association. Dr. C. F. Nichols, of Vienna, New York, saw the fracture several times during its progress, and substantiated the contention of Dr. Cavana.

The Judge, in his charge to the jury, showed a quick perception and complete understanding of the exact situation, which could have been only the result of long experience on the bench, as well as much valuable information in cases of a similar kind.

Upon a motion to non-suit and dismiss the complaint the Judge reserved his decision, but the result of the jury's deliberation made a decision upon the motion unnecessary.

Dr. Cavana expressed himself as being extremely grateful to the Association, and appreciative of all that had been done in his behalf.

The next case to be tried will probably be at

Utica in May, and is the case of Capron vs. Douglass.

Since the beginning of the defense for malpractice suits under the auspices of the Association not a single dollar has been secured by way of a verdict against any one of the members.

OSTEOPATHIC BILL REPORTED FAVORABLY.

The time has come when the physicians of this State must act in the interest of individual and public health, and save the high standing of the Empire State in the educational world, by defeating the Osteopathic Bill, which has been reported favorably by the Senate Committee on Judiciary, of which the following Senators are members: Patrick H. McCarren, of Brooklyn; Thomas F. Grady, of New York; Nathaniel A. Elsberg, of New York; Jacob Marks, of New York; Alfred R. Page, of New York; Jotham P. Allds, of Norwich; Spencer K. Warnick, of Amsterdam; Edgar T. Brackett, of Saratoga Springs; George H. Cobb, of Watertown; John Raines, of Canandaigua; Merton E. Lewis, of Rochester; William W. Armstrong, of Rochester, and George A. Davis, of Buffalo.

The Osteopathic Bill was introduced in the Senate by George A. Davis, of Buffalo, and in the Assembly by Charles W. Mead, of Albany. It requires personal work with your Senator and Assemblyman to defeat this bill.

VACCINATION IS COMPULSORY.

Supreme Court Says the Constitution Does Not Guarantee That Much Liberty.

Compulsory vaccination ordered by local boards of health on authority of State Legislatures was held by the U. S. Supreme Court, February 20th, to be valid because it is for the public good. The Constitutional guarantee of personal liberty, the court holds, is not infringed.

The case was brought by Henning Jacobsen, of Cambridge, Mass., who declined to submit to vaccination in an outbreak of smallpox and was fined. He contended the law was contrary to the preamble to the Constitution, its spirit, and to the fourteenth amendment; that vaccination did not protect, and that it was dangerous, sometimes causing permanent injury to health and occasionally death.

In delivering the opinion of the court Justice Harlan said they were unwilling to hold it to be an element in the liberty secured by the Constitution that one person or a minority residing in any county and enjoying the benefits of its local government should have the power thus to dominate the majority in such matters.

The safety and the health of the people of Massachusetts were, in the first instance, for the Commonwealth to guard and protect. They were matters that did not ordinarily concern the national Government. The liberty secured by the Constitution to every person within its jurisdiction did not import an absolute right in each person to be at all times and in all circumstances wholly freed from restraint.

Justices Brewer and Peckham dissented.

The Senate Committee Reports Coroner's Bill Favorably.

On March 28th, the Senate Committee on Cities voted to report favorably Senator Elsberg's bill which abolishes the office of Coroner in the City of New York.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR APRIL.

- Albany County—Tuesday, April 4th (annual).
 Cattaraugus County—Tuesday, April 4th (annual).
 Herkimer County—Tuesday, April 4th (annual).
 Rensselaer County—Tuesday, April 4th.
 Seneca County—Thursday, April 6th (annual).
 Broome County—Tuesday, April 11th (annual).
 Kings County—Tuesday, April 11th.
 Niagara County—Tuesday, April 11th.
 Oneida County—Tuesday, April 11th.
 Otsego County—Tuesday, April 11th (annual).
 Sullivan County—Tuesday, April 11th (annual).
 Wyoming County—Tuesday, April 11th.
 Orange County—Wednesday, April 12th.
 Orleans County, Wednesday, April 12th (annual).
 New York County—Monday, April 17th.
 Essex County—Tuesday, April 18th (annual).
 Genesee County—Tuesday, April 18th (annual).
 Tompkins County—Tuesday, April 18th (annual).
 Rockland County—Wednesday, April 19th (annual).
 Cortland County—Friday, April 21st.
 Lewis County—Tuesday, April 25th.
 Monroe County—Tuesday, April 25th.
 Dutchess County—Wednesday, April 26th.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The annual meeting of the American Medical Association will be held in Portland, Ore., July 11 to 14, 1905. In the May number of this JOURNAL full particulars will be given of the railroad route and rates. The special-train party (details of which were printed in the December number of this JOURNAL, page 396) is rapidly filling up, and as the party will positively be limited to 125 all those desiring to avail themselves of this most excellent opportunity to attend the meeting at Portland, and in addition to visit many points of interest en route, including six and one-half days' trip throughout Yellowstone Park, should communicate at once with Dr. F. H. Wiggin, 55 West 36th street, New York City.

New York County Association.—The stated meeting of this Association was held March 20, 1905, at the New York Academy of Medicine. The meeting was called to order at 8.15, the president, Dr. Francis J. Quinlan, presiding. The reports of the Executive Committee were read by the corresponding secretary, and on motion, which was duly seconded, were ordered on file. The minutes of the preceding meeting were read by the secretary and there being no dissenting vote were adopted by the Association. Fifteen new members were elected in the Association. The president, Dr. Quinlan, then declared that the nomination for officers and delegates and their alternates to the State Association and also the nomination for the member of the Nominating Committee of the Fifth District Branch were now in order. The following officers were nominated: Dr. Francis J. Quinlan for president, Dr. D. Bryson Delavan for first vice-president, Dr. H. H. Seabrooke for second vice-president, Dr. William Ridgely Stone for secretary, Drs. William Payne Simpson and Bruce G. Phillips for corresponding secretary, Dr. Charles Ellery Denison for treasurer, Dr. Henry A. Dodin for member of the Executive Committee for three years, Dr. Wisner R. Townsend for member of the Nominating Committee of the Fifth District Branch. The Association then proceeded to scientific session. The first paper of the evening was read by Dr. John A. Bodine, entitled "A Plea for Local Anesthesia in the Radical Cure of Inguinal Hernia. A Study Based on 300 Cases." The abstract of this paper will be found in the issue of the Journal for this month. The discussion of this paper was opened by Dr. John L. Rodman, of Philadelphia, followed by Drs. George E. Brewer, R. H. M. Dabarn, W. B. Coley and others. The second paper of the evening, on "The Administrative Control of Tuberculosis," was read by Dr. Herman M. Biggs; the discussion was opened by Dr. John Winters Brennan, followed by Drs. Egbert LeFevre, Thomas Darlington, Cooper and Bryan. At the close of this discussion a motion sanctioning the action of the Board of Health in the control of tuberculosis in New York City for the past five years was unanimously passed by the Association. The meeting adjourned at 11.15 P. M.

WILLIAM RIDGELY STONE, M.D.,
Secretary.

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Onondaga County Association.—The annual meeting of this Association was held on Monday, February 20, 1905, at Syracuse. The following officers were elected: President, Dr. George A. Edwards; vice-president, Dr. Charles B. Gay; secretary, Dr. Thomas B. Dwyer; treasurer, Dr. A. J. Campbell. The committees appointed were as follows: Committee on Legislation, Dr. A. S. Edwards, Dr. A. D. Head and Dr. J. B. Allen; Committee on Public Health, Dr. A. J. Campbell, Dr. T. B. Dwyer and Dr. F. O. Donohue;

Committee on Membership and Ethics and Discipline, Dr. F. J. Kaufmann, Dr. H. T. G. Clark and Dr. S. S. Bibbens.

Dr. Stewart S. Bibbens was elected to membership.
CHARLES B. GAY, Secretary.

* * *

Orange County Association.—The regular monthly meeting of the Orange County Medical Association was held at the Fowler House, Port Jervis, N. Y., March 8th, 1905.

There were present Drs. Lambert, Gessner, Best and Cuddeback, of Port Jervis; Drs. Redfield, Hulett, Purdy and Fancher, of Middletown; Dr. J. C. Taylor, of New York City; Dr. E. D. Woodhull, of Monroe, and Dr. L. G. Distler, of Westtown.

The meeting was called to order by the president, Dr. E. D. Woodhull, of Monroe.

Under report of cases and specimens, Dr. Charles I. Redfield presented a specimen of hydatidiform mole; Dr. E. D. Woodhull reported a similar case.

At the scientific session Dr. J. C. Taylor, of New York City, read a very instructive paper on "Puerperal Sepsis," also demonstrating the operative procedure, which in his hands has given the best results. The paper was discussed by all present.

Dr. J. B. Hulett, of Middletown, followed with a paper on "Extra Uterine Pregnancies." The doctor gave a complete and practical description of the various causes, symptoms and surgical treatment of this condition. This paper was also generally discussed.

Drs. Taylor and Hulett were given a hearty vote of thanks for their excellent papers.

The business session was begun with the reading of the minutes by the secretary, and the approval of the same by the Association.

The following resolution was proposed by Dr. Redfield, seconded by Dr. Fancher, and carried:

Resolved, That the Orange County Medical Association indorses the action of the Committee on Legislation of The New York State Medical Association in endeavoring to secure the passage of certain bills and in opposing several pernicious bills now in the Legislature; and be it further

Resolved, That the members of the Committee on Legislation of the Orange County Medical Association be furnished with a copy of this resolution and urged to communicate with the Senator and Assemblyman from this county in regard to these bills; and be it further

Resolved, That the members of the Orange County Medical Association, individually and collectively, agree to give this committee their hearty support, in all matters pertaining to the work of the Committee on Legislation.

The meeting then adjourned to April 12, 1905, to be held at the Palatine Hotel, Newburg, N. Y.
(Signed) L. G. DISTLER, Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Herkimer County—Irving O. Nellis, Herkimer.

THIRD DISTRICT BRANCH.

Seneca County—Lester W. Bellows, Waterloo; James E. Lovell, Lodi.

Tompkins County—Royden Mandeville Bose, Ithaca; Isedor Mack Unger, Ithaca.

FOURTH DISTRICT BRANCH.

Chautauqua County—Bergen F. Illston, Jamestown.

Erie County—Leonard E. Curtice, Buffalo; Lee Maston Francis, Francis Michael O'Gorman, Buffalo; James Francis Rice, Buffalo.

FIFTH DISTRICT BRANCH.

Dutchess County — Johannes von Tiling, Poughkeepsie.

New York County—Andrew Corsiglia, New York; Thomas Hayes Curtin, New York; Edgar William Danner, New York; Emanuel Danzi, New York; Joseph W. Droogan, New York; Louis A. Friedman, New York; J. Frank Gillespie, New York; James Joseph Grady, New York; Frank Sargent Grant, New York; Edward L. Kellogg, New York; Aloysius Kessler, New York; J. Monroe Liebermann, New York; S. B. Newton, New York; Louis D. Riggio, New York; Percy W. Roberts, New York; Drahomir Joseph Ruzicka, New York; Alexander Trautman, New York; Joseph Storer Wheelwright, New York.

Ulster County—David Mosher, Marlborough; Joseph Freston, Milton.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Bischof, Louis F., New York City.

Nathan, P. William, New York City.

O'Neil D. Edwin, New York City.

Stubbs, Roland H., Waterford.

OBITUARY.

Dr. James E. Crisfield died at his home at Dansville, N. Y., on February 21, 1905. Dr. Crisfield was a graduate of the College of Physicians and Surgeons, Class of 1873. He was a member of The New York State Medical Association, Medical Society of the County of Livingston and the Western New York Medical Society.

Dr. James Alva Dingman died at his home, Spring Valley, N. Y., on February 25, 1905. He was a graduate of the Eclectic Medical Institute, Cincinnati, Class of 1871. He was a member of The New York State Medical Association.

News Items.

ABSTRACT FROM DR. JOHN A. BODINE'S PAPER.

"A Plea for Local Anesthesia in the Radical Cure of Inguinal Hernia—A Study Based on 300 Cases."

Dr. Bodine stated that the statistics of this article were combined from the result of 284 cases of inguinal hernia, 16 of which were double. The amount of cocain, as employed by the essayist, had never been over one-half grain. There had been suppuration in not a single case; there were no deaths. When properly administered, the anatomy of the inguinal region was such that the anesthetization was so simple that any one familiar with the same could perform the infiltration. The ileoinguinal, genitocrural and ileohypogastric nerves should be anesthetized. But the ileohypogastric nerve is sometimes absent and if it is small it may be ignored, for it is often outside the field of incision in operation. In safety to the patient, the mortality in the hands of clean operators, is that of the anesthetic. Cocain mortality is less than that from chloroform or ether. In strangulated hernia, with profound shock and toxemia, it is the method indicated. Fewer wounds will suppurate under local anesthesia, and primary healing takes place provided the solution of cocain is fresh and sterile. Much of the prevalent idea of the toxicity of cocain is fanciful, due to the former use of large amounts of the drug. The maximum safe doses had not yet been determined, but one-half grain in solution injected at intervals of from one to one and a half hours was not harmful. Half a grain of cocain with a quarter grain of morphine sulphate was given before the operation, and this dose both quieted the patient nervously and at the same time gave a sort of mental exhilaration which would be favorable for local anesthesia. The cutting and tying of the omental vessels gave no pain. Children were not fitted for this form of anesthesia, because of their natural fright at any sort of an operation. Pain varied with the temperament of the patient. It had now come to pass that patients requested this form of anesthesia for the pain was very much less than the discomfort caused by the ether nausea.

Technic: One grain to an ounce of normal saline was used in the skin, and then half strength of this preparation was used to anesthetize the deeper tissues. If the needle was properly introduced into the skin, anesthesia rapidly took place. The solution should always be made fresh, and the saline should be warm as it is more effective than in cold solution. Care should be taken not to scare the patient by rattling instruments or calling, in a pompous voice, for a knife; the term bistoury is preferable, as the patient would probably not understand it. The line of skin incision should be injected with some tension, and should stop at the suprapubic skin fold. If the fat was thick, it should be anesthe-

tized with a 1 to 10,000th solution. The aponeurosis of the external oblique need not be anesthetized, as the cutting of it caused no pain. The neck of the hernial sac should be infiltrated. The ileoinguinal nerve should then be sought for, for the anesthetization of this nerve was most important, and the operation might then be terminated according to the plans or desires of the operator.

Dr. W. L. Rodman, of Philadelphia, in opening the discussion, stated that he had done but few cases under local anesthesia, and those had been only for strangulated hernia. One had been a large umbilical hernia, which had existed, strangulated, for five days. The only portion of the operation to give pain was the parietal layer of the peritoneum and this in the pinching caused by the forceps. He believed that this (inguinal hernia) was one of the best fields for local anesthesia, as the nerves were so readily found. After the blocking of the ileoinguinal nerve, there was no pain. It was not always easy to find the genital branch of the ileoinguinal. He did not think it wise to operate upon nervous patients with this form of anesthesia. Considering the comparative safety of general anesthesia, the speaker preferred not to use local anesthesia for all cases of inguinal hernia. The operations upon children demanded general anesthesia. Cocain solution should always be made fresh. Local anesthesia would always have a limited field, and would never take the place of general anesthesia.

Dr. R. H. M. Dawbarn, in discussing Dr. Bodine's paper, said that one of the chief advantages of the method by weak cocain locally is that it helps the operator to accomplish safely the only really difficult part of an operation for radical cure of inguinal hernia: namely, the dissection of the spermatic cord from the sac. In children this is usually easy; not so often with adults. Due to old adhesions between the two, and also to the fact that the cord is commonly found spread out into a thin fold and wrapped around a large part of the sac, the most expert dissectors sometimes do damage here. Under cocain the surgeon at any time can, by asking the patient to cough or strain, refill the sac in case the contents slip back. With ether this is, of course, impossible.

The true reason many patients refuse radical cure is their fear of being made unconscious by major anesthesia.

The cases to whom it is applicable must be wisely selected, however. There is a small minority in whom it would be objectionable; for example, extremely nervous people, and those very hysterical. He knew of one case where, during the cocain operation in question the patient—a woman—lost control of herself from increasing nervousness, and, with the bowel out in the wound, screamed and sprang from the table, having to be seized and held down until forced under major anesthesia to finish the job.

Again, in cases of strangulated hernia, because

of the long delay before calling in the surgeon, such a patient is likely to reach the table with so bad a pulse that every minute of operation added to the risk. On the average it takes half again as long—to avoid suffering by it, repeatedly injecting more and more as needed—as an ether operation would require.

In little children the cocain plan is obviously objectionable. Though not in pain they will be frightened and much excited. And the trifling amount of chloroform needed under these circumstances will surprise a doctor who has never tried it—perhaps from one-tenth to one-fifth of the amount needed if given to a frightened, struggling, excited child.

Cocain begins decomposing at exactly 212° F., but not below boiling point, into ecgonine and several other alkaloids, all anesthetic, but none so much so as cocain. Therefore, Dr. Dawbarn does not approve of Dr. Bodine's method of preparing his cocain solution, and believes that occasional instances where the anesthesia locally has proved somewhat inefficient to prevent all pain are due, very likely, to prolonged boiling, thus breaking up the cocain.

Dr. William B. Coley followed this speaker and remarked that he had had no practical experience with cocain in inguinal hernia, but we could not get away from the fact that general anesthesia is dangerous. In his experience, he knew that he had lost one case in a child from ether pneumonia. This child had previously had measles with bronchitis. It was a disadvantage to permit the patient to cough during the operation to show up the hernial sac, which was only too easily found. Sutures would not break loose after general anesthesia from coughing, provided they had been properly introduced and tied. The mortality in inguinal hernia in general anesthesia was due to sepsis, and not to the anesthetic. Not a single death under ether anesthetization had taken place during his many years' experience at the Hospital for Ruptured and Crippled.

Dr. George E. Brewer, the last speaker in the discussion, said that his unhappy experiences in the use of cocain anesthesia for hernia had been due to the fact that some ten years ago he had operated upon three cases with strong solution and every case had suppurated. In these cases not so much care was taken in the preparation of the solution; old, inert, infected solutions were used. Later he had tried Cushing's methods in two cases, both of which had had a great deal of pain during the operation. He had thought that this was due to the fault of the technic. He had never known a single patient who had not experienced some pain. However, since hearing the essayist's paper he had come to the conclusion that it would be possible to perform the operation without pain, and that where pain existed in every case, the operator was to blame. He did not see the advantage of doing the operation under local anesthesia as it could be done under general anesthesia with more readiness, the only

possible advantages he might see, was to prevent the possibility of an ether pneumonia or to prevent the stirring up of some latent Bright's disease. He did think, however, that the measure was indicated in hernia in the old.

In closing the discussion Dr. Bodine remarked that ether killed one in twenty-one hundred cases, chloroform killed one in five thousand cases, but half a grain of cocain injected intermittently, over a period of an hour gave no mortality.

EMPYEMA OF FRONTAL SINUS.

W. Freudenthal, New York City (*Journal A. M. A.*, February 11th), describes the diagnosis, treatment, etc., of chronic frontal sinusitis. He points out that most cases will improve under intranasal treatment and this should be exhausted before resorting to more radical measures. The diagnosis is not always easy. The symptoms may be absent or deceptive; even the best and safest way, that of probing and washing for pus, has its difficulties, and one is likely to get into the fronto-ethmoidal cells or fail to find the canal altogether. The anomalies of the frontal sinus are also to be considered. His conclusions are substantially: 1. Regarding the conservative treatment of these cases, we should endeavor to be as conservative as possible. He refers with approval to the views of Kuttner of Berlin on this point. 2. In operative cases Killian's method seems to give the best results at present. 3. The first opening into the frontal sinus must always be below the outlined bridge and only after exploring the sinus should another above it be made. 4. In the latter case we leave a bony bridge which aids toward improving the cosmetic effect. 5. Closing the external wound immediately after the operation is by far preferable for such cosmetic effect. He reports cases illustrating the operation and its results.

PATENT MEDICINE BILL.

BOSTON, Feb. 2, 1905.

Mr. Editor—A bill is pending in the Massachusetts Legislature to require that every patent medicine shall have the formula of its ingredients printed on the label of the bottle. Laws to this effect exist in Germany and France, and a similar regulation has just gone into effect in New Zealand.

The bill was introduced on petition of Mrs. Julia Ward Howe and others. It is fought by the Druggists' Association, because they think that people would not take so much patent medicine if they knew what they were swallowing.

A hearing on the bill will be given at the State House on February 13th, at 10.30 A. M., in Room 439. The measure ought to have the support of the doctors, and it is hoped that as many as possible of those interested will attend.

Very truly yours, ALICE STONE BLACKWELL.
—*Boston Med. and Surg. Jour.*

PROPRIETARY MEDICINES.

The wide use of many proprietary pills or mixtures is distinct evidence of the great power of foolishness and fraud, even when directly opposed to honesty and instructed wisdom. How shall we best explain it? On any rational grounds it is difficult. On the other hand, it is certainly true, practically, that many people, despite reasoning, enjoy deception. At all events, they love mystery in medicine, quick remedies, cure-alls. Again, even well-educated men and women think of disease somewhat as they do of a person, viz., as having an entity which may be and is properly combated by a certain remedy, simple or combined. This means to them that, given a disease, or even the name thereof, it must be immediately attacked with its antidote, under the form of some much-advertised preparation. No matter that they know nothing of the maker of the preparation, of his character or capability; no matter who the person to be treated is, old or young, rich or poor, a person ordinarily blessed with good health, or a delicate, broken-down individual with a personal history of many previous ailments; the medicine is good for all equally and must be beneficial if taken as advised on the bottle's label. Of course, there are a few who will be considerate enough to add, after extolling the virtues of the proprietary mixture, that they advise you to consult your physician before taking it: as though he could tell anything more than one who reads the papers, lay or religious, daily. Of course, many of these medicines are of good appearance, taste, and smell, and in some cases may be beneficial. On the other hand, we do not become familiar with the great number of persons who have been injured by taking them or to whom they have proved valueless.

Far be it from the promoters of proprietary medicines to vaunt their failures or their injurious results! And certainly the brainless victims of quackery are not going to herald abroad, as a rule, the evidences of their own stupidity, obstinacy, or utter lack of ordinary common sense, especially as they are credited with making use of reasoning faculties almost hourly in their conduct toward other matters far less important to their welfare. We must admit also that the number of these proprietary medicines is ever increasing, and that we are literally swamped with their number and with the effrontery of their agents. All manner of appeals are made to use, direct and indirect. Personal interviews, circulars, advertisements with colored and alluring headings, so-called scientific articles by real or unreal medical brethren, reports of hypothetical or occasionally true cases, in which the contents of one or more bottles have produced wonderful curative results, are innumerable. Again, we have good business men and eminent divines so lacking in proper conscience or reasoning as to indorse cordially things of which they know absolutely nothing, and thus help to do untold harm to many who rely upon their statements and who apparently

have not learned as yet "the wisdom of the serpent," which it is so essential to possess. If these leaders of the blind would only stop with their pernicious indorsements of quack medicines! But, alas, they go far beyond that and let their names be peddled about as indorsers of institutes for curing with secret remedies alcoholism and all narcotic appetites. No attention is paid by these "good men and true" (God save the mark!) to the moral turpitude of their conduct, but only to the simple fact that possibly good has come to some poor fellow by swallowing, or taking in another way, an unknown something, and therefore it may be proclaimed, vaunted, and upheld as the salvation of all afflicted ones. Among proprietary medicines, some come from wholly obscure houses, trying to foist a new patent stuff of doubtful nature and origin upon the public; others undoubtedly have a certain badge of respectability in a commercial sense, and yet the manufacturers are unwilling to make known the component parts of their pills or drug mixtures. From other firms the different ingredients may be found on the bottle labels, but the quantity of each one is withheld. In rare instances the drugs and their doses are printed fully on the labels. In the latter examples, if we may rely upon the character of the advertising firm, and if the printed formula appears unobjectionable or desirable for any given case, we may, in my judgment, under certain circumstances, properly prescribe them. There are times when to formulate a mixture rapidly, one that is suitable to a particular patient, is very difficult to accomplish in a satisfactory manner, and if we know or firmly believe that a proprietary combination will do as well as anything we can write for immediately, perhaps better, on account of the great care in its preparation and its precise and accurate combinations, we are justified in selecting it. Evil may be done, of course, to the ignorant and unreasoning by the tacit permission, so to speak, thus given to others to prescribe things which are of no value and which come from unreliable sources. In addition, we may find that once a special preparation is thus indorsed, it will be taken many times without the advice of the physician and recommended to friends and others on many occasions and for numerous and various ailments. Of course, taken in this blind, unconscionable way, it is far more likely to be harmful than beneficial.

How, then, may we avoid the use of proprietary medicines and at the same time be most useful to our patients? One way is to have on hand at some reliable druggist's a mixture formulated by the physician himself, to meet best in treatment certain aspects of the disease. To do so saves more than one perplexity in actual practice. Seemingly, to act thus has the appearance of trade and is liable to be misunderstood; and yet, as I know, it is resorted to by some honorable specialists, and even a few general practitioners, and has, as I have written, its favorable or strong

and also its weak or unfavorable side. To be wholly fair or unprejudiced we must admit that there are a certain number of combinations of drugs from well-known pharmacists which are unquestionably useful and reliable. Again, there are methods of preparation probably, or a certain special skill or care as to the nature, use and compounding of agents of the *materia medica*, which render a particular combination or single remedy of one firm more active or powerful than a similar preparation or drug sold by other firms.

If it were permissible, I could cite many examples to justify my assertion. Now the problem presents itself, How shall we abridge or stop quackery, fraud, the preying on the public by the ignorant and soulless, in the matter of drug merchandise, and yet not deny our patients the benefits derived from our own acquired knowledge? Practically, I know to-day of but one method, viz., never to deal with or encourage houses of which the character or reliability is at all questionable, never to prescribe mixtures or pills of which the components parts or doses are unknown. Now, then, as to the precise way in which a particular pharmaceutical house has acquired possibly a special skill or knowledge about the preparation of a drug or a combination of drugs, or how it has become honored by its prominent rivals—that I do not believe we should attempt to-day, as practicing physicians, to investigate too closely. Let it suffice for us to know that with firms of standing the best drugs are used, the published formulas reliable, and the methods of compounding beyond criticism or reproach. Further, it is for us solely to determine clinically, with the use of their products in suitable cases, what effects we obtain. As to druggists, as with physicians themselves, the primary, all-important consideration always is—*character*. Without it the druggist, like the physician, is a source of untold harm in many ways. With it, the harm done by him is reduced to a minimum, and the good accomplished may be considerable.—BEVERLEY ROBINSON, in the *N. Y. Med. Jour.*

MEDICAL ETHICS.

For convenience, medical ethics may be divided in two great subdivisions. The relations between the physician and the patient, and the relation of physicians to one another. It is of prime importance that the former should be at all times cordial and congenial. The best of feeling should at all times exist between them. As soon as these conditions cease the relations between physician and patient should also cease. No doctor should try to hold a patron longer than the friendly feeling exists. As soon as an estrangement of doctor and patient takes place it is better that they mutually agree to part company. Any attempt to hold a patient longer than you have his good-will will prove to be a boomerang to both parties. We too often forget that our patients are employers and we are the employees. That they are the masters and we are the servants.

That our employers are people who are physically ill, and while such illness is on they are mentally feeble, and as such are hard to please, very easily disheartened, and are, therefore, entitled to all the courtesy and forbearance we are able to give.

It is an old axiom, Never to get mad at a patient, nor to ever indulge in scolding them. Control your patient, but rule them with a gentle hand. If your directions have been disobeyed try to find the cause, and if possible remove it. Reason with your patients. If you find that you cannot control them, you had better withdraw from the case in an honorable way. Don't get mad and show the bad side of your character. If you have been discharged from the case, and another doctor has been called in without due notice having been given you, tell your employers that you have been unfairly treated in the matter; that you should have been given notice of the desired change; that your honor and dignity have been wounded, your feelings have been hurt; that you hold no ill-will toward them, but that you expect a prompt payment of your bill. Thereafter treat them friendly and with respect, but it is not necessary to show them any great favors, or to impress them with the idea that your success depends wholly or even in part on their patronage.

Life is too short for you to take revenge for real or imaginary wrongs done you. Revenge is a passion you should never attempt to satisfy. If a man smite you on one cheek, try to get the other one out of his reach as quickly as you can, and congratulate yourself on the agility with which you do so. Afterward stay out of his way. Fighting, whether physically or professionally, is hard work, poor pay and a still poorer way to success; therefore keep out of it, unless it is absolutely necessary for the preservice of your life or honor. The even-tempered and well-balanced man, the one who is in full control of his passions, can generally keep out if he tries to do so. One thing we all ought to do is to talk less about other people's business, and think and talk more concerning the relations between doctor and patient, not as they are, but as they should be. This would tend much to enlighten the laity in proper channels, and would educate them up to the standard as to how they should treat the attending physician in any case.

As to the relation which should exist between doctors, it would seem entirely unnecessary to say anything. Such a smooth and polished set of gentlemen as doctors pretend to be, ought to require no rules for their action. There ought to be no friction between them. We wish it could be said, there never is. If we could eliminate from our physiological make-up all professional jealousy and all self-conceit, we would not need a set of medical ethics to guide our steps through professional life. But, alas, the very Satan, in his most Satanic skeleton, is stalking around among the doctors, to see in whose heart he may put professional jealousy, that he may

lower his prestige with the people. Oh, brother, if you have any of this jealousy, it is as uncomfortable as hot ashes in your shoes in summer-time. My advice is, rid your bosom of it as you would rid your shoes of ashes. Both make you feel uncomfortable, cause you to draw a long face with the wrinkles all running down, when they should run up; make you look like you had been eating apple-vinegar pie with a sulphuric-acid stew. Kick at the world, and it will kick back at you, but smile upon it and it will smile on you. Be sweet and you will have sweet surroundings. Scatter the sweet scent of roses and lilacs and forget-me-nots, and you will be a welcome visitor as long as your old carcass hangs together, and when you will finally meet the old, grim monster called death, whom you have for so many years tried to keep away from your patients, when it finally comes up to you, when you are up against it, then, my brother, don't get scared, it won't do you any good. You may avoid him for sixty, seventy or eighty years, or maybe longer, but you cannot avoid him always, you will finally be compelled to meet him. At that time you will wish you had always lived a just, honest and upright life. Live every day as though it were your last day on earth, and your first day in heaven. Treat every one kindly, justly and generously, just as though this were the last time you would see him.—*The Medical Herald*, December.

SPLEENLESS MEN.

According to Carstens, splenectomy in malaria is seldom justifiable. Cysts, inflammatory conditions and abscesses can often be cured without splenectomy. In leukemia, the operation should not be performed if the red blood corpuscles have been diminished one-half or more. Rare cases of so-called splenic anemia are cured by splenectomy. A floating spleen, if otherwise healthy, should not be removed. In injuries, splenectomy often affords the only chance for recovery. Malignant growths of the spleen, if the organ is not too adherent, call for splenectomy. The author reports the histories of two cases, one of sarcoma of the spleen and one of splenic anemia. In both cases splenectomy was successful and of great benefit to the patients. Stress is laid upon the great value of blood examination in those obscure cases. It will help in making a diagnosis and decide in favor or against an operation. In conclusion he points to the fact that spleenless men can live in perfect health, as the blood of such men and the blood of those who have not been subjected to splenectomy does not show any difference.—*J. H. Carstens, Medical Record*, 1905, Vol. 67, 11.

PROSTATECTOMY.

In the weakest and most run-down cases M. B. Tinker, Ithaca, N. Y. (*Journal A. M. A.*, February 11th), has employed permanent suprapubic drainage. This is rapidly performed under

eucain, and he thinks it is the safest of all procedures. Except in absolutely desperate cases, he believes prostatectomy under local anesthesia is safe as compared with the operation under general anesthesia. The use of adrenalin with the ordinary local anesthesia greatly prolongs and adds to its efficiency, prevents the pain and congestion following, and renders the operation almost bloodless. The knowledge of the nervous anatomy of the parts is, of course, absolutely essential, and the course of the pudic nerve and the long pudendal nerve close to the base of the tuberosity of the ischium are important. He favors the use of Young's tractor, and recommends allowing sufficient time for the anesthetic to act before making the incision. With sensitive or nervous patients he finds it often better to use a little nitrous oxid gas of primary ether anesthesia, as the infiltrating solution can not reach the parts involved in the deeper enucleation. These parts, however, are supplied by the hypogastric plexus of the sympathetic and the discomfort is not necessarily great. He reports a case in which he thinks this method of operation was directly life saving.

"GRAFTS."

A couple of years ago there was a good deal of discussion in the American and home journals on the question of the legitimacy of what was called the "division" of the consultant's fee. It was the custom, not, we are glad to say, in this country, for the consultant to return a portion of the fee to the practitioner who had called him in. The good sense of the profession, both here and in America, condemned the practice as being highly objectionable, if for no other reason than that it introduced in the selection of a consultant considerations other than the interest of the patient. Nevertheless, the system has persisted in America, and we learn from our transatlantic contemporaries that it is by no means unusual for the practitioner to demand a "graft," as it is called, from a particular consultant, in consideration of recommending him. In some cases, indeed, the "graft" is by far the major portion of the fee paid by the patient. For instance, *American Medicine* relates the story of a surgeon who agreed to perform a certain operation for a sum of \$500. Some time after he learned that the patient had actually paid \$2,000, of which the practitioner had pocketed the balance. We learn from our contemporary that customs such as this are not contrary to business morality in the States, but we trust it may be long before they are accepted by either professional or business men in this country.—*The Medical Press and Circular*, London.

SOCIETY NOTES.

Æsculapian Club, Buffalo.—At a meeting held March 16th Dr. J. G. Ernest read a paper on "Cerebral Abscess."

Brooklyn Pathological Society.—At a meeting held March 9th, Dr. James P. Warbasse read a paper on "Observations on the Pathology of Peritonitis."

Buffalo Academy of Medicine.—At a meeting held March 7th Dr. Vertner Kenerson read a paper on "Treatment of Hallux Valgus," and Dr. A. L. Benedict on "Movable Kidney." At a meeting held March 14th the following papers were read: "Some of the Newer Problems in Diabetes Mellitus," by Dr. Elliott T. Joslin, of Boston, Mass.; "The Care of Premature Infants," by Dr. DeWitt H. Sherman; "A Discussion of Humidity in Artificial Heating and Its Relation to Disease," by Dr. B. F. Herr, of Millersville, Pa.

Harlem Medical Association.—At a meeting held March 1st Dr. William M. Leszynsky read a paper on "The Involvement of the Nervous System in Patients with Chronic Nephritis"; Dr. M. Manges on "The Dietetics of Chronic Nephritis," and Dr. Martin W. Ware on "A Résumé of the Issues Concerned in the Diagnosis and Treatment of Renal Tuberculosis and Calculus."

Harvard Medical Society.—At a meeting held March 25th Dr. Henry C. Coe read a paper on "Appendicitis, Complicating Pregnancy and the Puerperium."

Manhattan Clinical Society.—At a meeting held March 3d Dr. Heinrich Stern read a paper on "National Character."

Medical Association of Greater New York.—At a meeting held March 13th the following papers were read: "The Constitutional Treatment of Bright's Disease," by Dr. William H. Porter; "The Treatment of Bright's Disease by Lavage of the Renal Pelves," by Dr. Winfield Ayres; "The Treatment of Pyelitis," by Dr. Howard A. Kelly.

Medical Union.—At a meeting held March 22d Dr. G. H. Westinghouse read a paper on "Charities of Buffalo."

New York Academy of Medicine.—At a meeting held February 2d, the following papers were read: "The Limitations of the Value of Nitro-Glycerine as a Therapeutic Agent," by H. P. Loomis; "The Hypodermatic Use of Adrenalin Chloride in Asthmatic Attacks," by D. M. Kaplan; "Anæmia Due to Intestinal Parasites," by W. Gilman Thompson; "Cases of Anæmia Due to Intestinal Parasites," by Alfred Meyer and W. P. Northrup. At a meeting held February 3d, the following: "The Present Status of Blood Examination in Surgical Diagnosis," by Frederic E. Sondern; "On the Treatment of Chronic Osteomyelitis and of Chronic Bone Cavities by the Iodoform-Wax Filling," by C. A. Elsberg; "Treatment of Keloid by the X-Ray," by Henry Perkins Moseley. At a meeting held February 9th, the following: "The Digestion of Caseins, and Its Relation to Certain Problems in Infant Feeding," by Thomas S. Southworth. At a meeting held February 15th, the following: "A Consideration of the Advantages and Disadvantages of the Old and New Cystoscopes," by W. K. Otis; "A New Method as an Aid in Detecting Stones in the Ureters and Kidneys," by Follen Cabot, Jr. At a meeting held February 16th, the following: "A Contribution to the Pathology of Sciatica," by J. Ramsay Hunt; "The Treatment of Acne," by George T. Jackson. At a meeting held February 20th, the following: "The Advantages of Roentgen-Ray Diagnosis in Ocular Injuries from Foreign Bodies, with Demonstration of Method of Localization," by Wm. M. Sweet, of Philadelphia; "Unilateral and Other Unusual Forms of Nystagmus," by Alexander Duane. At a meeting held February 21st, the following: "Contribution to the Alcohol Question," by S. T. Beebe; "The Treatment of Renal Inadequacy Complicated by an Apparent Nephritis," by W. J. Pulley. At a meeting held February 22d, Dr. C. G. Coakley read a paper on "Report on the Use of Stovaine."

Newburgh Bay Medical Society.—At a meeting held March 14th the president of the society, Dr. H. A. Waldron, delivered an address.

New York Academy of Medicine.—At a meeting held March 2d Dr. L. Emmett Holt read a paper on "Gonococcus Infections in Children," and Dr. William P. Northrup on "Roof Playgrounds on City Roofs." At a meeting held March 9th Dr. H. A. Alderton read a paper on "A Few Remarks on the Proper Treatment of a Running Ear," and Dr. C. G. Coakley on "A Condensed Report of a Case of Streptococcal Otitis Media, followed by Mastoiditis; Operation; General Septicæmia; Death." At a meeting held March 21st the following papers were read: "The Present Clinical and Bacteriological Status of Vincent's Angina," by Dr. W. N. Berkeley; "Recent Studies in the Diagnosis of Rabies," by Dr. B. W. Poor. At a meeting held March 20th Dr. Alexander Duane read a paper on "Unilateral and Other Unusual Forms of Nystagmus," and Dr. E. S. Thomson on "The Advantages of Transillumination, with Demonstration of the Sachs Lamp." At a meeting held March 23d Dr. J. A. Schmitt read a paper on "Morbid Processes in the Right Abdominal and Pelvic Regions of the Female and Their Differentiation."

New York Pathological Society.—At a meeting held March 8th Dr. Mary E. Goodwin read a paper on "The Practical Value of R. Sterns' Bactericidal Test of Typhoid Sera"; Dr. Edwin Beer on "Concerning the Causes of Gall Stones"; Dr. Martha Woolstein on "A Bacteriological Study of Pertussis."

New York Surgical Society.—At a meeting held March 22d Dr. Hartwell read a paper on "The Radical Treatment of Cancer of the Rectum, with Particular Reference to the Inguinal Colostomy."

Rochester Academy of Medicine.—At a meeting held March 8th, in the Symposium on "Treatment of Brain Disease," Dr. R. G. Cook read a paper on "Drainage of the Ventricles," and Dr. Edward B. Angell on "Lumbar Puncture." At a meeting held March 22d Dr. William S. Ely read a paper on "Is Natural Labor an Easier and Less Painful Process Than Thirty Years Ago?"

Rochester Pathological Society.—At a meeting held March 9th Dr. P. D. Carpenter read a paper on "The Preventive Treatment of Disease."

Saratoga Springs Medical Society.—At a meeting held March 17th, in the Symposium on "La Grippe," Dr. Van Aernem read a paper on "History, Etiology and Pathology"; Dr. Comstock on "Symptoms and Types of Disease," and Dr. Fish on "Diagnosis and Treatment."

Society of Internal Medicine.—At a meeting held March 15th Dr. Tuttle read a paper on "Review of Theories of Immunity."

Society of Medical Jurisprudence.—At a meeting held March 13th Dr. Ferdinand C. Valentine read a paper on "Some Forensic Problems Regarding Venereal Diseases."

Syracuse Academy of Medicine.—At a meeting held March 7th Dr. I. Harris Levy read a paper on "Two Cases of Splenic Anæmia (twin sisters), One with Achylia Gastrica," and Dr. E. J. Wynkoop on "Hip Joint Disease in Children, with Special Reference to the Bilateral Form."

The Binghamton Academy of Medicine.—At a meeting held March 21st the following papers were read: "Some Salient Points in the Treatment of Catarrhal Deafness," by Dr. G. B. Stanwix; "Malarial Infections," by Dr. Ray Beardsley, and "Physicians as Business Men; If Not, Why Not?" by Dr. J. H. Martin.

Utica Medical Club.—At a meeting held March 23d the president gave an address.

West End Medical Society.—At a meeting held March 25th Robert H. M. Dawbarn read a paper on "The Correction, Both of Deformity and Loss of Function, in Old Colles' Fractures; Sixteen Cases Personally and Thirteen More by the Author's Technique."

Women's Medical Association.—At a meeting held March 15th Dr. Dorothy M. Reed read a paper on "Epidemic Cerebro-Spinal Meningitis," and Dr. Emily Lewi on "Minor Cardiac Neuroses."

Book Reviews.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and other topics of interest to students and practitioners. Edited by A. O. J. Kelly, M.D., Philadelphia. Vol. IV, Fourteenth Series. Philadelphia: J. B. Lippincott Company, 1905.

The present volume of International Clinics is quite up to the average and contains much that is interesting and instructive. The opening paper, on The Excessive Use of Drugs in the Treatment of Chronic Diseases, with Reference to Medicinal Intoxications, is by Hayem, of Paris; is short and is full of good, common sense. He sums up as follows: "In the present state of our knowledge it is our duty to treat chronic disorders that cannot be relieved by specific or serotherapeutic agents by what are known as hygienic modifiers—food, fresh air, the specific conditions that can be realized by climates, physical agents (thermic, electric), rest, movements and by the judicious use of mineral resorts or of the artificial saline solutions, by which in certain cases the latter can be replaced."

Indications for the Dechloridation Treatment is by Javal, of Paris. It should be studied carefully by every medical man that is interested—and which one is not?—in the rational treatment of Bright's disease. The cases cited are extremely instructive. The action of theobromin in conjunction with diet is enlarged upon. The author says: "As is the case in giving digitalin to cardiac patients, it is unnecessary to put them on a milk diet; we have only to prescribe a diet without chlorides, and it is even indispensable to begin by this, as it would not be logical, in order to free a nephritic patient from edema, to give him a dechloridating and dishydrating remedy like theobromin, and at the same time the most active hydropigenous substance—salt. If we begin by putting our edematous patients on a diet without chlorides, all medication can often be avoided. If, furthermore, we follow closely the course of their dropsy we can also avoid useless doses and will know how to stop short of harmful doses." In neither Hayem's or Javal's paper is there a word or sentence unnecessary to the elucidation of the subjects treated; each is a model of conciseness which many American writers might well copy. In pronounced contrast, in this respect, is the succeeding paper by Metzenbaum, of Cleveland, on Radium; Its Value in the Treatment of Lupus, Rodent Ulcer and Epithelioma, with Reports of Cases. It is interesting, but its English is faulty, as for instance: "Fully 30 per cent. of all cases have healed," etc. It is devoutly to be hoped that medical writers in the very near future may be brought to realize that a *case* is a state or condition, and therefore impersonal. To state that a "case" after a certain period was able to walk about the ward, or left the hospital, is as idiotic as pathetic. Alice in Wonderland could not have improved on such a statement. A certain well-known writer in the ken of this reviewer invariably records the fact that "the case was operated." A kindergarten course in elementary English appears to be indicated.

The Treatment of Patients Who Seem Desperately Ill in Consequence of Accident, Hemorrhage or Infection is the report of a clinical lecture by Lejars, of Paris, and contains much that is practical. It is to be regretted that lack of space forbids extensive quotations. Chronic Polycythemia with Enlarged Spleen, the succeeding paper, is by Weber and Watson, of London, and is the most scientific, from many points of view, contained in the book. It is freely illustrated by reproductions of microscopic sections. S. Solis Cohen, of Philadelphia, contributes a report of a clinical lecture—The Importance of Pathologic Diagnosis and of Etiologic Diagnosis, as Illustrated by Several Cases of Joint Disease—Arthritis Deformans, Pneumococic Arthritis, Gonococic

Arthritis and Sciatic Neuritis, miscalled Rheumatism, and Duckworth, of London, a paper on The Incidence of Gout in the United States and in New Communities. Senator, of Paris, contributes a lecture on The Clinical Significance of Albumosuria, and Crombie, of London, one delivered at the London School of Tropical Medicine on The Differential Diagnosis of the General Enlargements of the Liver.

The next paper, on Functional Heart Murmurs; Their Causation and Diagnosis, is by Rudolf, of Toronto, and contains much valuable matter, as for instance: "Functional cardiac murmurs are always systolic in time, and the importance of this point can hardly be overestimated. In spite of an occasional statement to the contrary, it is extremely unlikely that a murmur occurring in any part of the cardiac cycle other than that occupied by the ventricular systole is of a functional nature, and the few cases placed on record in which diastolic murmurs are explained as functional must be considered as open to doubt." That functional murmurs are extremely common is proved by the fact that the author found them in 60 per cent. of the inmates of the surgical wards of the Sick Children's Hospital, Toronto, while an associate found them in 50 per cent. of patients taken at random in the General Hospital.

Lateral Curvature of the Spine is the title of a paper by Bradford, of Boston, and is profusely illustrated by well-executed plates. The succeeding paper, a report of a clinical lecture at the New York Polyclinic, is by Townsend, of New York, and deals with Chronic Arthritis and Linear Osteotomy for Ankylosis After Tuberculous Arthritis. Porter, of Chicago, writes on Tuberculous Spondylitis and Tuberculous Coxitis, and Young, of Philadelphia, on Nerve Anastomosis for the Cure of Infantile Palsy. The case reported by this author is of much interest and would seem to open up great possibilities to the surgeon and nerve specialist in the treatment of this lamentable affection. The Operative Treatment of Constipation is the subject chosen by Lane, of London, for a clinical lecture. The opening of the abdominal cavity and production of anastomosis between a loop of the ileum and the sigmoid, thus eliminating the large intestine entirely from function, appears a somewhat radical procedure under the circumstances, but, as Metchnikoff regards the large bowel as a serious defect in human anatomy, and septic absorption from it as the chief cause of degenerative changes which produce old age and death, it perhaps is likely that many subjects may be willing to submit to it in order to delay the inevitable which, sooner or later, comes to us all.

Bowlby, of London, reports Some Cases of Gastric Surgery. It is curious that so many medical writers think it necessary to state, in order to elucidate their text, that the patient was "an *old* woman, 70 years of age," or "a *young* woman, aged 20." This is on a par with "widow lady," or, as stated recently in the public press, "Mr. So-and-So has obtained a divorce from his wife." It would have been a bit odd if he had obtained it from some other man's wife, to say the least. Verily, as a wit once said: "A woman is as young as her power for mischief, and when that passes she is old," but it is not necessarily necessary, as it were, to tack an adverb on to her. It adds insult to injury. Bowlby also states that the gall-bladder of a patient was "shrunken up"! Oh, Kelly, Kelly! Where was your blue pencil?

The Symptomatology and Diagnosis of Glenard's Disease is by Gallant, of New York, and Post-Climateric Hemorrhages; Their Cause and Treatment, by Lockhart, of Montreal. Then follows a clinical lecture by Brower, of Chicago, on Traumatic Injury of the Spinal Cord, Syringomyelia and several other subjects. One of the most valuable and well-written contributions to this volume is entitled Recent Investigations Concerning the Pathology of the Infectious Diseases, by Warthin, of the University of Michigan. This author systematically reviews recent literature on pathology, and then treats in turn of infectious diseases of unknown etiology, those of recently discovered etiology, and finally those of known etiology, the whole making a comprehensive and up-to-date treatise which should be read *in toto* to be ap-

preciated. The concluding as well as the longest paper of the book is on The Etiology and Pathology of Amebic Infection of the Intestine and Liver, by Charles F. Craig, of the United States Army, stationed at San Francisco. He discusses the etiology of amebic infections, entamebic dysentery, the pathology of amebic infection of the intestine and the pathology of amebic infection of the liver. The article shows an immense amount of investigation and careful analysis. It is freely illustrated, one plate being in colors.

A LABORATORY MANUAL OF HUMAN ANATOMY. By Lewellys F. Barker, M.B., Tor., Professor and head of the Department of Anatomy in the University of Chicago and Rush Medical College, assisted by Dean De Witt Lewis, A.B., M.D., and Daniel Graisberry Revell, A.B., M.B., Instructors in Anatomy in the University of Chicago. Illustrated. Philadelphia and London: J. B. Lippincott Company, 1904. Price, \$5.

The changed and improved methods of medical education are largely responsible of late years for many new and valuable books. Greater thoroughness in all departments is demanded, and many of the older text-books, prepared with the idea that the student should graduate in two or three years, are to-day found inadequate when the course has been lengthened to four years. More time is now given to the study of anatomy in the Dissecting Room and the Laboratory Manual, by Barker, besides giving full and complete directions for beginners, has been also written with a view to its utility for more advanced students. The aim is to encourage the study of anatomy and make the worker familiar also with the literature and history by reference to the best works of all authors. The text shows a thorough knowledge of the subject, and the illustrations have been selected with great care from the best of American and foreign works. In addition many new and valuable drawings have been added by the author. The presswork is most excellent, and in addition to an Index of Illustrations there are an Index to the Older Terms and an Index to New Terms, which will be found both interesting and valuable. We take great pleasure in recommending it to our readers as a book in which every physician or surgeon can find much that is of value.

BACTERIOLOGY AND SURGICAL TECHNIC FOR NURSES. By Emily M. A. Stoney, Superintendent of the Training School for Nurses, St. Anthony's Hospital, Rock Island, Ill.; Author of "Practical Points in Nursing," "Practical Materia Medica for Nurses," etc. Second edition, thoroughly revised and enlarged, by Frederick Richardson Griffith, M.D. (Univ. of Penn.), of New York; Surgeon, Fellow of the New York Academy of Medicine. Illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

It is questionable whether it is well to put in the hands of nurses any extensive knowledge of the subject of bacteriology. In this little manual the subject of germs and germ diseases has been gone into to a degree which is almost sufficient for the proper preparation of a medical student to advanced courses in the subject of bacteriology. The use of such a manual for nurses is therefore to be condemned. It is not of practical value, neither will the knowledge it affords increase the efficiency of a trained nurse in the performance of her duties. As to the book itself, it is a most excellent manual upon the subject of bacteriology.

BOOKS RECEIVED.

THE VERMIFORM APPENDIX AND ITS DISEASES. By Howard A. Kelly, A.B., M.D., Professor of Gynecology in the Johns Hopkins University, Baltimore, and E. Hurdon, M.D., assistant in Gynecology in the Johns Hopkins University, Baltimore. With 399 original illustrations, some in colors, and 3 lithographic plates. Philadelphia and London: W. B. Saunders & Co., 1905. Price, cloth, \$10 net.

MEDICAL COMMUNICATIONS OF THE MASSACHUSETTS MEDICAL SOCIETY. Vol. XIX, No. 3, 1904. Boston: Printed by David Clapp & Son, 291 Congress street, 1904.

THE NEW YORK SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN. Thirteenth Annual Report. December 31, 1904. Offices of the Society, 297 Fourth avenue. New York, 1905.

TRANSACTIONS OF THE STATE MEDICAL ASSOCIATION OF TEXAS. Thirty-sixth Annual Session, held at Austin, Tex., April 25, 26, 27, 28 and 29, 1904.

A PRACTICAL TREATISE ON NERVOUS EXHAUSTION, ITS SYMPTOMS, NATURE, SEQUENCES AND TREATMENT. By George M. Beard, A.M., M.D., Fellow of the New York Academy of Medicine, of the New York Academy of Sciences; vice-president of the American Academy of Medicine; Member of the American Neurological Association, of the American Medical Association, the New York Neurological Society, etc. Edited, with notes and additions, by A. D. Rockwell, A.M., M.D., Neurologist and Electro-Therapeutist in the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy; Member of the American Neurological Association, of the Neurological Society, etc. Fifth edition, enlarged. New York: E. B. Treat & Co., 241-243 West 23d street. Price, \$2.

SAUNDERS' QUESTION-COMPENDS, NOS. 8 AND 9. Essentials of the Practice of Medicine, Prepared Especially for Students of Medicine. By William R. Williams, A.M., M.D., formerly Instructor in Medicine and Lecturer in Hygiene, Cornell University Medical College; Tutor in Therapeutics, Columbia University (College of Physicians and Surgeons), New York. Arranged with questions following each chapter. Philadelphia and London: W. B. Saunders & Co., 1905.

GYNECOLOGY, MEDICAL AND SURGICAL OUTLINES, FOR STUDENTS AND PRACTITIONERS. By Henry J. Garrigues, A.M., M.D., Gynecologist to St. Mark's Hospital in New York City; Consulting Obstetric Surgeon to the New York Maternity Hospital; Consulting Physician to the New York Mothers' Home and Maternity; Honorary Fellow of the American Gynecological Society; Honorary Fellow of the Obstetric Society of Edinburgh; Honorary Member of the College of Physicians of the German Dispensary; ex-President of the German Medical Society; formerly Professor of Gynecology and Obstetrics in the School for Clinical Medicine, and Professor of Obstetrics in the Post-Graduate School and Hospital. With 343 illustrations. Philadelphia and London: J. B. Lippincott Company, 1905.

TRANSACTIONS OF THE RHODE ISLAND MEDICAL SOCIETY. Vol. VII, Part 1, 1904.

THE URINE AND FECES IN DIAGNOSIS. By Otto Hensel, Ph.G., M.D., Bacteriologist, German Hospital, New York, and Richard Weil, A.M., M.D., Pathologist, German Hospital, New York, in collaboration with Smith Ely Jelliffe, M.D., Ph.D., Instructor in Pharmacology and Therapeutics, Columbia University; Visiting Neurologist, City Hospital, New York. Illustrated with 116 engravings and 10 colored plates. Philadelphia and New York: Lea Bros. & Co., 1905.

REPORT ON THE ORIGIN AND SPREAD OF TYPHOID FEVER IN UNITED STATES MILITARY CAMPS DURING THE SPANISH WAR OF 1898. By Walter Reed, Major and Surgeon, United States Army; Victor C. Vaughan, Major and Division Surgeon, United States Volunteers, and Edward O. Shakespeare, Major and Brigade Surgeon, United States Volunteers. Vol. I. Prepared in accordance with act of Congress under the direction of Surgeon-General Robert M. O'Reilly, United States Army. Washington: Government Printing Office, 1904.

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Original Articles.

ACUTE APPENDICITIS AND ABSCESS OF THE LIVER.¹

BY ADOLPH RUPP, M.D.,
New York.

AT several of the many memorable meetings of this society, within recent years, appendicitis has been discussed, from the medical and surgical points of view, by our own members and distinguished guests; but at none of the meetings did any of the physicians or surgeons refer to the possibility of abscess of the liver being either a concomitant or post-appendicitis affection. This is not strange when we reflect that surgeons have operated more than a thousand cases of appendicitis without having met a case of appendicitis complicated with or followed by liver abscesses. Within the last five years, however, observers in various countries have been drawing attention to the occurrence of liver abscesses as a sequence of appendicitis; and Dr. John C. Monroe and Ralph Thompson, A.M., M.D., of Boston, teach that liver abscesses "caused by appendicitis are not so rare as many would have us believe." And R. D. Rollston, in his treatise on liver diseases, tells us that "appendicitis is the most frequent cause of pylephlebitis and liver abscess," and that the frequency of this association has coined the phrase "appendicular liver." Statistics demonstrate that the association of appendicitis and liver abscesses is fortunately very rare. Thus Dr. Arpad Gerster found noted at Mt. Sinai Hospital nine cases of pylephlebitis and liver abscesses in 1,189 operated cases of appendicitis (*N. Y. Medical Record*, June, 1902). Treves' London experience, in this connection, is about that which Gerster reports.

The following statistics illustrate the relative frequency of liver abscesses generally, and their occurrence in connection with appendicitis: Dudley found 12 cases of liver abscesses recorded at the Zurich Clinic among 28,034 patients; 2 of the 12 cases of liver abscesses followed appendicitis. Baerensprung, at Berlin, found 108 cases of liver abscesses in 7,326 autopsies, and 8 cases are recorded as having followed appendicitis. These figures demonstrate the rarity of liver abscesses in connection with appendicitis; but the rarity of their occurrence generally, and their exceptional rarity in connection with appendicitis in particular, in no way renders them the less important and interesting pathologically and clinically. How and why this is so is not clear. It is assumed, rather than demonstrated, that liver abscesses, in connection with appendicitis, are not only secondary to, but caused by the appendicular disease. However, it is also usually assumed, rather than demonstrated, that the veins leading from the cæcum and appendix are attacked prior

to any liver implication. It is plain that neither abundant suppurative, nor severe and extensive gangrenous, appendicitis is necessarily followed by, or causes, liver abscesses. Huebner, speaking of hepatic dysentery, says (*Ziemsen's Cyclo-pædia of Medicine*, N. Y., 1880, pp. 155 and 156): "Simultaneously or even before intestinal lesions manifest themselves, an inflammatory affection of the liver develops gradually, and finally ends in the formation of an abscess." And these abscesses, Huebner goes on to say, are not to be confounded with abscesses of embolic origin.

Abscesses of the liver, in connection with appendicitis, cannot be satisfactorily thought of as being the effect of "some morbid product of inflammation," originating in the diseased appendix; for it seems more in harmony with clinical facts and bacterial pathology to assume that both the appendicitis and the liver abscesses are due to the same infection, at least in some cases, because appendicular suppuration, per se, has no relevancy (absolute and unexceptional) to the development of liver abscesses, nor has gangrene of the appendix, nor a phlebitis that is secondary to appendicitis. Analogously, we may reasonably hold the same pathological and etiological belief with reference to the relationship of liver abscess and appendicitis, that Heubner held concerning liver abscess and hepatic dysentery.

Diagnosis.—The diagnosis of acute liver abscesses is never certain and definite under any circumstances; and, when associated with acute appendicitis, the dignity of a diagnosis of liver abscesses is scarcely more than that of suspicion or possibility in the greater proportion of the cases. Neither the symptoms nor the signs pointing to the possible liver implication in the presence of an acute appendicitis are pathognomonic or definite; because, signs and symptoms which may arouse suspicion of liver complication may be caused by some lesion elsewhere in the abdomen, or in the thorax. Even in acute cases, and those are the ones to which reference is here made, *pain* in the liver region may or may not be due to abscess formation or perihepatitis, and even when the liver is inflamed, pain may be absent, and in no way indicates the gravity of the pathological processes that may be going on. Jaundice may be present and may not be due to hepatitis. Vomiting is not of much significance when appendicitis is present, as a diagnostic of liver disease. When the bowels are distended and flatulent it is not easy to mark any definite enlargement of the liver; and, moreover, the liver is not always enlarged in cases of liver abscesses. When the intermittency and irregularity of the temperature chart indicate a septic or pyæmic condition, these may be due, as well as not, to other sources of infection than in the liver. Aspirating on suspicion may fail to confirm a suspicion of liver affection or abscess. The previous history of the particular case, and the clinical course before and after operation for appen-

¹Read at the meeting of the Society of the Alumni of City (Charity) Hospital, New York, February 9, 1905.

dicitis, may develop symptoms and signs that justify a suspicion of liver complication; but they may not be clear and positive enough to justify a belief strong enough to justify radical surgical procedures. The case which I am about to report was of this nature:

CLINICAL AND SURGICAL HISTORY.

Sam L., merchant, aged 48 years, consulted me at my office on the 8th of October, 1904, giving a history of acute indigestion. He had dined at a friend's house the night before. He had vomited. He complained of cramps in the belly, the abdominal pain was intermittent, and had no particular location. The tongue was furred, and the whites of his eyes were very slightly jaundiced. The urine was examined; but, excepting its dark color, was normal, and contained neither albumin nor sugar. He complained of pain in the lumbar region, and of feeling tired. I advised him to go home and to rest abed, and gave him a mixture of codein, gr. one-half every two to four hours, in a bismuth and ess. of caroid mixture. He was to send for me if he was not feeling better by evening. . . . The patient had ridden that morning on horseback from Nyack to this city, a distance of about thirty miles. He had consulted me at the office at 2 P. M.; at 6 P. M. I was called to see him at his house, because the abdominal pains persisted. He had defecated (in the meantime), the effect of a dose of castor oil taken in the morning before undertaking his journey on horseback to this city. His pains were as bad as when I saw him four hours previously. I had my suspicions aroused, and made a careful physical examination of the abdomen, but with negative results. There was no localized tenderness anywhere, nor was there any discoverable intumescence over the appendicular region. At 9 P. M. I saw him again. He felt a little easier. I had given him a half grain of morphia at 6 o'clock, and I repeated the dose (hypodermically). There was now no nausea. All he complained of was a general abdominal pain, intermittent in character. The codein mixture was continued. Diet only water. There was no fever, no rapid pulse, and abdominal exploration proved negative.

October 9th, 9 A. M.—Subjectively the patient felt much better; but after examining his abdomen I found tension along the ascending colon, and a distinct localizable intumescence in the appendicular region, and McBurney's point of tenderness. At my previous visits he had developed no abnormal temperature. Now his temperature was 101° F. I pronounced a diagnosis of acute appendicitis, and advised consultation with a surgeon. Before calling in a surgeon, the patient and his family asked that I consult with their old family physician, Dr. B. F. Vosburgh. At 11 A. M. Dr. V. saw the patient with me, and agreed with all I had found, and also with my advice, that the patient go into the hands of some surgeon. The patient desired to go under

the hands of Dr. William T. Bull, and at 3 P. M. he entered Dr. Bull's Hospital, and was operated there at 8.30 P. M., by Dr. Poole and Dr. Walker (Dr. Bull was out of town). The operation was done in a way that left nothing to be desired, and from start to finish lasted about an hour. The patient bore the ether well. For the remainder of the clinical history I am indebted to the courtesy of Drs. Bull, Walker and Poole. They are in no way responsible for my way of telling it.

The surgical history of this case lasted about one month, from the 9th of October to the 10th of November, when the patient died in collapse. In looking over the tracing of the temperature chart, it will be noticed that the run of the fever can easily be divided into five sections, each succeeding section being an aggravation over the preceding one. Each section is of unequal time duration as compared with the others; and it is quite natural to assume that some special pathological cause intervened to produce the change, in the course of the general pyæmic infection. But the records, dictated to and marked down by the nurse from day to day, besides the observations treasured in the memories of the physicians and surgeons interested in the case, do not make it possible, in any satisfactory way, to supply clinico-pathological data which reflect the pathological-anatomical basis of these temperature variations. Constant watchfulness, and repeated physical examinations of the abdominal and thoracic organs, frequent analysis of the urine, the blood, and fæces, resulted negatively in so far as getting a rational or satisfactory explanation of the temperature variations is concerned.

First Stage of Surgical Illness.—The day following the operation the temperature fell to 100 1-5, and then crept up to 100½ in the evening. On the 12th, it fell to 99, and by midnight crept up to 101. From the 13th to the 19th of October the temperature varied between normal and 100°. But on October 12th, when the patient was feeling comfortably well, when he had refreshing naps of six hours' duration, and the temperature at 99°, the respirations were 34 and the pulse 116. But as a rule the pulse was under 100, and the respirations usually 20 or at most 24 per minute. All this allowed the assumption of there being no peritonitis, although there was much bowel torpor and distention. Patient complained a good deal of stomach distress, and vomited several times. The abdominal bandages felt tight. There was no abdominal tenderness, but pain across the small of the back was complained of, but not persistently. Alimentary symptoms were treated as they arose, but the most satisfactory relief was admitted to come from stomach washings, and he asked to have them repeated. The patient was often restless and sleepless, which symptoms were relieved by codein and trionol, as occasion called for. The bowel distention was relieved by means of enema of ox-gall, oil and turpentine. The

operation wound was kept clean by being dressed several times a day, the discharges being not profuse, but free. During this period he often complained of nausea, but the pulse remained good. During this stage it may be assumed that the noxious bacteria were at work disorganizing the blood and promoting the formation of liver abscesses.

Second Stage.—From October 19th to 22d he had a twenty-minutes' chill every day, and the temperature ranged from normal to 102° F.; next day 103 and 104. The respirations were scarcely influenced by the chills and ascending temperatures, and the pulse-rate only slightly so. During this stage subsultus developed, and the pulse became frequently intermittent. On October 19th much severe pain was complained of on the right side of the belly, and on the evening of this day he had his first chill. Pain in the wound was complained of a good deal, and on the 21st he was taken to the operating room, given chloroform, and the wound thoroughly explored in order to determine the source of pus discharge. Liver abscess had been suspected by Dr. Bull as having possibly developed, but no satisfactory evidence of liver implication was found. A localized swelling, above and to the left of the umbilicus, was cut into, but nothing was found. The patient was left none the worse by these operations and the chloroform, but he felt easier and rested. Pyæmia was well established, and the leucocytosis was found, by Dr. Poole, to be 16,200, it having increased somewhat over the count made a week previously. The spleen was not large nor tender, and no increased liver dulness could be made out.

Third Stage.—From October 22d to October 29th the temperature varied between about normal and 100° F., except on the 25th (fourth day after second operation, and twentieth after the appendectomy), when it was 101½° F., which seemed to have been due to obstructed drainage. On October 26th there occurred a very profuse and sudden discharge of extremely offensive pus to the great relief of the patient. During this stage the pulse was usually under 100 and the respirations as low as 18, and at no time over 24. No increased area of liver or splenic dulness. The abdomen had become less distended, and a number of large and very foetid alvine discharges, helped on by enemata. Patient weaker in every way. During this stage there were no chills.

Fourth Stage.—From October 29th to October 31st there were no chills, and the wound continued to discharge profusely. During these three days the temperature varied between 101 and 102, but on the evening of the 31st it went up to 103, preceded by a severe chill. On October 30th he began to cry out because of severe pain in the neighborhood of and above the wound. Respirations remain about 22, but the pulse goes up to about 130. Hot compresses mitigate the pain. Restlessness and discomfort

increase. Stools continue large and contain much undigested matter. No increased liver enlargement, nor splenic enlargement.

Fifth Stage.—October 31st to day of death in collapse, November 10, 1904. Now occurred severe chills every day, the temperature ranging from 97½ to 104 or 105° F. The pulse running up with the fever to 138 and dropping with the fever to 90 or less, but the respirations keeping on in the same indifferent way until pleuro-pneumonia was discovered to have developed three days before death, and extended very rapidly, when the respirations numbered 34 to 44, with an associate pulse-rate of 134 to 144. The chills were agonizing to the patient, and he anticipated them with fear. Hypodermics of morphia mitigated their severity, at least in so far as the feelings of the patient were concerned. During this stage the discharge of pus continued very freely and very foetid.

On the evening of November 6th a consultation was held, present being Drs. Janeway, Bull, Walker, Poole and Rupp. Dr. Janeway thought the origin of the troubles, subsequent to the operation, to be pyæmia and pylephlebitis, and possibly liver abscess. The pyæmia had been evident enough. The diagnosis of pylephlebitis was but an inference from the clinical history, but not supported by physical signs. During this stage several days before death and the day after consultation, Dr. Bull aspirated the thorax (the diagnosis of pleuro-pneumonia had been made) and no pus but bloody serum was obtained. The liver was searched with the aspirating needle in three or four directions, but every time with a negative result. These explorations were borne by the patient without complaint. The blood had been examined by an expert for bacteria, but he found none. Methyl blue was given to patient to swallow to determine whether or no there was stomach or intestinal leakage; the fæces turned blue, but the pus from the wound remained unchanged.

Post Mortem.—It was not possible to get the relatives to consent to a complete post-mortem examination. The incomplete examination revealed the following state of affairs: After the original operative incision was extended up to the free border of the ribs, and to the left across the epigastrium, a large portion of the abdominal cavity was exposed. After pushing away the somewhat distended intestines, the liver came in sight, and thereupon a great gush of puro-sanguinous fluid of a very bad odor. There was no general peritonitis. The appendicular stump was in good condition. Turning up the liver revealed two large abscesses in the right lobe, and many smaller ones everywhere, and the liver generally infiltrated with pus. The larger of the two was somewhat larger than a good-sized fist, and the other about one-half that size; they were located on the under surface, more towards the anterior than towards the posterior border. Both these

large abscesses had ruptured. There were also evidences of perihepatitis. So much of the portal vein as could be seen appeared normal, signs of inflammation, pus or thrombi, not being discovered. The right lung was very adherent at its base and to the ribs, and found to be congested, infiltrated with pus and solidified, at least, throughout its lower two-thirds; and, on making cross-sections, sero-blood and pus freely oozed away.

The *vermiform appendix*, at the time of its removal, was about three inches long, about the size of a man's little finger, club-shaped and tapering off towards its insertion at the cæcum. It was hypertrophied throughout, but its opening not occluded. At the distal end, and half-way up, at various points were various small-sized points of gangrene. It was not markedly congested, and, excepting for the hypertrophic condition, the proximal portion was normal in appearance. Hydrostatic testing proved it to be non-perforated. It had been slightly adherent to the omentum, but without any trouble was easily detached. The bed of the appendix was located backwards near the spine. There was no pus here, but only a small quantity of serum and lymph.

Remarks.—It will have been noticed that there were symptoms of nausea from start to finish, and there was vomiting also off and on all along. At times these symptoms were distressing, but at all times they were relieved or meliorated. Pain in the back, in the lumbar region, was present from the start, and there was epigastric pain, as well as pain, not of a very acute character, anywhere and everywhere all over the abdomen. All of these symptoms are as characteristic of appendicular disease as of liver trouble. On the 9th of October, the second day of medical attendance, he developed tenderness in the appendicular region. The day before I had noticed a slight icterus of the skin and sclera, and this I attributed to gastric catarrh and duodinitis. Liver abscess, authorities tell us, does not give rise to icterus unless the duodenum is implicated. This icterus cleared away during the first week after operation. So in this case none of the usual symptoms of liver disease had occasion to arouse suspicion of liver complication. Schoenlein ascribed much importance to pain referred to the region between the zyphoid cartilage and the umbilicus as a diagnostic of liver abscess, but Bamberger (Virchow's *H'dbuch*, B'd VI, p. 371) surmised that such pain, associated with swelling or intumescence, might rather be caused by some collection of pus caught between a coil of small intestine and the transverse colon. I mention these surmises because, as you may recall, the seat of the second operation was near a point above the umbilicus and to the left of the umbilical or median line. Localized pain and swelling here suggested operation to relieve a possible cause

for the pyæmia. After incisions had here been made, nothing was found. Possibly coils of intestine, liquid filled, became, for a time, fixed, and pressed the overlying abdominal wall up, and thus the pain and swelling were caused; or, possibly, some of the liquid contents of the abdominal cavity may have been caught between coils of intestine and the transverse colon, as was surmised by Bamberger in referring to Schoenlein's sign. Opening the abdominal cavity and exploring it, no doubt dislocated the intestines and removed the cause of the localized pain and tumescence.

Concerning the gush of liquid from the abdominal cavity at the time of the autopsy, it might reasonably be assumed that it was due to rupture of the intestines, and that the bloody, ill-smelling liquid was intestinal. But that assumption had this fact against it: Dr. Bull had surmised that possibly liver abscess had ruptured into the bowels or stomach, which might account for the extremely malodorous stools which the patient had the last four or five days of his life. To confirm or negative this supposition, the patient was given, by Dr. Bull's order, capsules of methyl blue per os, morning and evening, for two or three days prior to death. The blue coloring showed in the fæces, but not in the least in the discharges from the wound, nor was the abdominal cavity or its contents at the time of the autopsy discolored blue.

When the patient was transferred to the hospital, I told Drs. Walker and Poole that I considered the case a complicated one. They called it "one of the twenty-four-hour cases." I based my idea of complication of some kind on the jaundice, and, what was ordinarily foreign to the habit of the patient, a sort of reminiscent melancholia. Furthermore, because the signs and symptoms of appendicitis, once definitely established, they progressed rapidly without being in any way fulminant. A few hours prior to the operation Dr. Poole examined the blood for leucocytosis and found it about 14,000. This increased as the diseases progressed, but at no time reached 18,000. When Dr. Poole removed the appendix he found no pus on it, nor in its bed. But the gangrenous spots certainly meant severe infection, and pathologists now teach that the severity of an inflammation, rather infection, is not proportioned to the amount of pus formation, any more than the gravity of a pneumonia is dependent on the extent of consolidation of lung tissue or the high temperature. Close upon the operation the formation of pus became rapid and profuse, as well as malodorous, and soon the edges of the operation wound lost their healthy appearance and assumed an infected aspect. A day or so later the mental depression grew worse, and it continued so throughout all the month and few days of his sickness. He tried to "*will*" away this depression, but he could not do this any more than he could by the exertion of will in-

hibit the formation of liver abscesses, or prevent the formation of pus, because the basis of his mental depression was organic and not fancied.

Conclusions.—From the foregoing statement of facts, inferences, etc., I believe it may be claimed that the appendicular disease was only an incident, and that no "inflammatory product" originating in the appendicitis "caused" the liver abscesses; but that the same original infecting cause or causes which gave rise to the early mental depression, which lasted throughout, and became aggravated as the disease advanced, gave rise simultaneously or in rapid succession to the appendicitis, engendered the rapid formation of infected pus, which in turn affected the wound, and developed the liver abscesses and the septic pneumonia. The septic developments were rapid. The temperature chart shows that when the outflow of pus was facilitated the temperature rise was lessened; but when the strength of the patient was rapidly declining, and conditions unavoidably became such that the escape of pus was impossible, and became stored, as in the lungs, the temperature rise and fall became abrupt, and intermitted with very brief intermissions.

Therapeutics.—In this case the surgical operation, done with all due care and attention to every necessary detail, was necessarily only an expectant remedy. It removed but one infected organ, and that organ was not the source of the subsequent complications. Dr. William T. Bull had suggested the use of anti-streptococcic serum. But from his experience, he said, he was afraid of it; however, he left its application for me to decide. I decided negatively, because, even if a remedial serum were at hand, it could have been of no curative value, in this case . . . the sources of the toxic and patho-anatomical changes could not be affected by it. The rest of the therapy has been detailed in the clinical history of the case.

IODIN IN THE TREATMENT OF POST-OPERATIVE SEPSIS.*

BY JAMES HAWLEY BURTONSHAW, M.D.,
New York.

THE iodine treatment of sepsis during the puerperium was first proposed by Dr. T. J. Alloway, in 1883. During that year he published a paper in the *Canada Medical and Surgical Journal* (vol. xi, page 526), in which he advocated the introduction within the uterus of suppositories containing from ten to twenty grains of iodoform night and morning, "the idea being," as he said, "to replace the frequent and often unsatisfactory intrauterine injection of antiseptic fluids." He reported three cases successfully treated by this method. In 1884, Dr. W. E. Boardman reported a successful case in the *Boston Medical and Surgical Journal* (September 11, 1884, page 246), in which he had employed

iodoform insufflation within the uterus. But to the late W. R. Pryor, of New York, belongs the credit for having placed this method of treatment on a scientific basis which, in the writer's opinion, is unassailable from a deductive as well as from a resultant point of view when our present knowledge of the pus-producing organisms and their action is given due consideration.

Pryor's last paper on the subject was published in the *New York Medical Journal* for January 23, 1904. In cases in which the constitutional symptoms are pronounced, or in which it is suspected that the infection has passed beyond the uterus, he advocated thorough dilatation of the cervix, curetting of the uterus, irrigation with salt solution, and packing of the cavity with 10 per cent. iodoform gauze. He then opened Douglas's pouch and packed the pelvis with iodoform gauze of 5 per cent. strength. He removed the gauze from the uterus at the expiration of three days; usually it was unnecessary to renew it; that in the pelvis was permitted to remain in place one week, and was renewed at the end of that period. The iodine reaction usually was demonstrable in the urine of the patient in from three to five hours. Pryor reported thirty-seven cases in which this method of treatment was adopted. "Twenty-seven of the patients had not been operated on previously, and but one died; ten had been curetted before coming under observation, and three of these died."

The blood changes in septicemia are of extreme interest. While, as pointed out by many observers, the proportion of cases in which the pathogenic germs are demonstrable in the blood current is relatively small, there is no morbid condition known, with one exception, in which the destruction of the red blood cells is more constant. The average loss has been estimated by different observers as being from 200,000 to 1,000,000 a week in ordinary cases. Leucocytosis, as is well known, is not always present. Da Costa has pointed out¹ that this is an extremely inconstant sign, as the blood in case after case of undoubted sepsis has been examined without finding any increase in the leucocytes above normal.

The pronounced affinity which the protoplasm of the leucocytes shows for iodine has been demonstrated many times. Goldberger and Weiss,² in reporting the result of many microscopic examinations of normal and infected blood stained with a combination of iodine, 1 part; potassium iodid, 3 parts, and distilled water, 100 parts, state that "in the case of normal blood the protoplasm of the leucocytes is stained a pale yellow and the nuclei remain almost colorless; in all purulent conditions, and especially in puerperal sepsis, the protoplasm is stained a slight or intense brown, or contains numerous intensely stained reddish-brown granules, the latter change being the more common."

In a great majority of cases, in puerperal sepsis, the infection spreads from the uterus through

*Read before the New York State Medical Association, October 19, 1904.

the medium of the lymphatics. Pryor concluded that "that method of treatment which secures sterilization of the original wound and accomplishes the absorption by the infected lymphatics of a potent yet harmless antiseptic, if at the same time accompanied by such treatment as will promote the eliminative functions, will succeed best." In post-operative sepsis having its origin in the abdominal cavity it is probable that the blood vessels play as important a rôle as the lymphatics in the dissemination of the toxins. It has been abundantly proved that iodine and its congeners, under certain well-defined conditions, exert a marked bactericidal effect on pathogenic germs, although in what way the agent directly influences the toxic products of germ activity is not known. Pryor has shown that if the pelvis is packed with iodoform gauze, in puerperal sepsis, the absorption of the iodine is rapid, the growth of the germs at the point of development is inhibited, and the course of the infection is greatly shortened. These points being given due consideration, the question naturally arises: In post-operative sepsis of abdominal origin is it not rational to suppose that iodoform introduced into the abdominal cavity will exert the same beneficial influence? It is a well-known fact that a person suffering from septic infection will tolerate vastly larger doses of iodine in one or another form without showing evidences of iodism than under normal conditions, and therefore, under these circumstances, if such a procedure is adopted there need be little apprehension of poisoning.

I must confess that my own experience with iodine in these cases has been distinctly disappointing; yet I am convinced that further development of treatment along the lines indicated will, in the near future, yield brilliant results. During the past year I have had three cases of post-operative sepsis in my practice, two of which resulted fatally. The first case was probably due to the use of defective ligatures, but the patient finally recovered, a result, in my opinion, to be attributed more to the degree of infection and to her robust constitution than to the curative measures employed. The infection in one of the fatal cases was traceable to the unavoidable soiling of the peritoneum from the rupture during operation of an enormous pelvic abscess; in the other case the source of infection was undiscoverable. It was in this case that the iodine treatment was given its most extended trial, and with absolutely negative results. Briefly, the details are as follows:

On August 17th last I removed a large pedunculated uterine fibroid, the right ovary and tube and the appendix, and resected the left ovary, in the case of Mrs. M. N., a widow, aged 32 years. The abdominal wound was closed by layer sutures. Her progress was eminently satisfactory during the succeeding twelve days, when, without warning, her temperature rose to 103° F., and her pulse-rate to 110. I immediately reopened the lower third of the abdominal wound,

introduced a sterilized rubber tube, and at frequent intervals during the following seven days flushed the cavity with hot normal salt solution. Twice a day, after this irrigation, I injected about two drams of a 10 per cent. solution of iodoform through the tube. Ergone, a recently introduced preparation of ergot, was given hypodermatically every four hours. Her temperature and pulse-rate subsided to near normal within twenty-four hours of the institution of this treatment, but on September 2d she developed the reflex vomiting characteristic of sepsis, which continued until her death on September 13th.

On September 5th the drainage tube was removed and the abdominal irrigation discontinued, because of the agglutination of the intestines. I then began the administration of iodine by another route. The condition of the patient precluded the opening of the posterior vaginal culdesac, and, therefore, I was prevented from applying the drug directly to the peritoneal surfaces. A suppository containing one and one-half drams of iodoform was introduced into the vagina twice daily, and half an ounce of iodipin was injected high into the bowel every three hours during the day. Seven hours after the beginning of this treatment her urine was analyzed carefully, but no iodine reaction was demonstrable. On September 7th a suppository containing 30 grains of iodoform was introduced into the uterine cavity, the amount contained in the vaginal suppository was increased to two drams, and one ounce of iodipin was given every three hours by the bowel. Deep subcutaneous injections of 30 minims of ergone were given three times daily. This treatment was persisted in for three days, yet not in a single instance in which the urine was examined was it possible to detect the presence of iodine.

I am well aware that this method of treatment was empirical to a degree, but those who have had experience in septic cases of this character will bear testimony to the avidity with which one will have recourse to any plan which offers the slightest hope of success.

It has been questioned if iodoform can be rightly classed among the genuine antiseptics, as the fact has been proved many times that germs of various kinds will grow upon it, but it is equally well known that when brought in contact with animal secretions it is broken up and the iodine which is liberated is inimical to bacteria, either by inhibiting their growth, neutralizing their toxins, or by stimulating the protective power of the cells. In the case to which I have referred in this paper I am ignorant as to why a certain proportion of the iodine was not absorbed from the vagina and bowel, as shown by the failure to obtain the reaction in the urine. It would appear that, with the exception of the peritoneum, no more favorable site for absorption than these mucous surfaces could be desired. That iodine in the form of iodoform is readily absorbed even from the skin surface has been proved by Yeo.

In the *Lancet* for March 16, 1901, he reported four cases of tuberculous peritonitis successfully treated by daily applications to the skin of the abdomen of an ointment containing equal parts of iodoform and cod-liver oil. He believes that the iodine not only enters the blood and is eliminated by the secretions, but, also, that the secretions of the serous cavities absorb the drug, and as these do not pass out of the body, they probably become so charged with iodine compounds that the latter may exert an antitoxic or an antibacterial action.

Iodipin, which was used in this case by the rectum, the patient's stomach being unretentive, is an iodine-fat combination, entirely free from irritating properties, which is said to be broken up in an alkaline medium and the iodine set free. I have used it in other cases as a substitute for potassium iodide with very gratifying results.

The use of ergot in these cases undoubtedly is distinctly beneficial. The contributions to the subject of ergot therapeutics³ by Dr. Alfred T. Livingston, of Jamestown, N. Y., a member of this Association, are so valuable that they mark an era in medical progress. In the cases to which I have referred I employed ergone, a preparation of ergot from which the sclerotic acid has been removed. The injections, though so frequently repeated, were invariably painless.

No more appalling condition can confront a surgeon than general sepsis following an operation. There are no circumstances under which he more thoroughly appreciates his utter helplessness to ameliorate symptoms or to save life. The variety of measures advocated from time to time bear witness to the desperate inadequacy of our resources in this respect. The practice of surgery has taken giant strides forward within a period in the memory of us all, but as an art or as a science it cannot reach the highest plane of humanitarian endeavor until the successful treatment of sepsis has been evolved.

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THE BRIEF STORY OF A SMALLPOX EPIDEMIC.¹

BY EDWARD MUNSON, M.D.,
Medina, N. Y.

IT is my purpose in this paper to recount what was, to me and to my fellow practitioners in the village of Medina, a unique bit of personal experience. It embodied some mistakes in diagnosis, and made necessary a recasting of our old ideas concerning the symptomatology of smallpox.

It is conceivable that there are some among my hearers who, under like conditions, might make the same mistake, and they will, perhaps, be grateful for this note of warning. As for those who

are incapable of committing such an error, they, at least, will be "happy in their anger" over any description of what they already know so well.

In the last edition of his "Diseases of the Skin" Stelwagon says: "During the past few years there has appeared in this country an epidemic of smallpox so unprecedentedly and uniformly mild as to constitute an unwritten chapter in the history of this disease." It is to the brief description of such an epidemic that I invite your attention.

Case I.—On August 11, 1903, I visited Mr. S—, aged 57. He had headache, backache, a temperature of 103°, and a papulo-vesicular eruption scattered rather thickly over the face, hands and chest. The vesicles contained a clear serum. He had not been out of town for many weeks, nor had he had guests at his home. He said that some children, broken out with chicken-pox, had been at play recently in his shop. My suspicions being aroused, I called in the health officer, and together we studied the case for two or three days. The fever subsided steadily. The vesicles, which were unilocular, became slightly more turbid, but never purulent; neither could we make out any umbilication. There was absolutely no secondary fever, and the man went on to an uninterrupted convalescence. We regarded the case as a severe form of chicken-pox.

Case II.—On September 1st, I visited Charles D—, aged 47. This man presented a clinical picture identical with Case I. There were the same headache, backache, fever and rash. This patient had had no communication whatever with the first case. Again I summoned the health officer, and for three days we watched his progress. The eruption was especially thick on forehead and nose, and there were a few vesicles on palms of hands and between the fingers. There was, however, no pustulation, the vesicles were unilocular, and after two or three days the man felt perfectly well. There was no secondary fever. Diagnosis as before.

Case III.—October 10th, Anna B—, aged 2½, taken suddenly with a severe convulsion, in which the tongue was bitten. Temperature 104°. Two brothers in the house were recovering from supposed chicken-pox. This young lady developed on the following day a very sparse eruption on face and chest. She had no secondary fever, no pustulation, and after two or three days was free from symptoms. I would remark, in passing, that this was the only case in which a convulsion occurred during the entire epidemic.

Being now thoroughly convinced that we were dealing with something more than chicken-pox, I requested the Board of Health to hold a joint meeting with all of the local physicians. The health officer chanced to be in Albany, but the meeting was arranged and well attended. Most of the doctors had seen one or more cases of the disease, which, without exception, they had diagnosed as varicella. To settle the vexed question, Dr. Johnson was summoned from the State

¹Read at Twenty-first Annual Meeting of The New York State Medical Association, New York, October 17-19, 1904.

Board of Health. He visited three or four of the patients then ailing, and pronounced them cases of mild, but undoubted, smallpox.

From that date, October 16, 1903, until May 10th following, 179 cases of this disease were officially reported to the health officer. Of these all were discrete except two. One of these two was confluent; the other semi-confluent. With very few exceptions, there was scarcely more pitting than is seen after chicken-pox.

There was no mortality.

Of the 179 cases reported, 159 gave no history of vaccination.

In 9 cases there were present scars of old vaccination.

Ten cases claimed previous vaccination, but presented no scars.

One case claimed to have had smallpox in early life, but no scars of this disease were apparent.

The youngest patient was 10 days old; the oldest 80 years.

In one case a test vaccination was twice performed, but to no effect.

Scores of unreported cases were so mild that the patients went about the streets unnoticed, having, perhaps, six or eight blotches, unconscious to themselves of blame.

Owing to the fact of its extreme mildness, it was an epidemic most difficult to quarantine and suppress. Patients and public were alike sceptical concerning the true nature of the disease, and even to-day there are many who jest about it, and some who assert that they would much rather take their chances with the disease than suffer vaccination. At last, however, by dint of wholesale vaccination and thorough fumigation, the epidemic was conquered, and since May 10th last there has not been a single case in the village.

To recapitulate, the following are worthy of emphasis:

1. The epidemic was undoubtedly smallpox. This is proved by the fact that it attacked adults and children indiscriminately, and, with very few exceptions, the unvaccinated portion of the community; that unvaccinated patients were immune to the vaccine virus, and, most strongly, perhaps, by the further fact that there were a few cases of the confluent and semi-confluent type.

2. It was variola or varioloid of the "unprecedentedly and uniformly mild" variety. It would be interesting in this connection to speculate upon the possible causes of the mildness of these modern epidemics, but it is outside the scope of this paper. I may mention, however, as probable factors in the mitigation of their severity, present-day sanitation and the influence of ancestral vaccination in conferring a partial immunity upon unvaccinated descendants.

3. The vesicles were unilocular.

4. There was secondary fever in only two or three cases. This was, of course, due to the fact that the outer layers of the skin alone were in-

involved, and there was no pustular infection. For the same reason there was rarely any umbilication or pitting.

5. The exceptionally mild character of the disease rendered thorough isolation of all patients well-nigh impossible.

6. It afforded a fresh illustration, if any were needed, of the value of vaccination in stamping out this pest.

In conclusion, I would say that in recounting the story of this epidemic, I am not laboring under the delusion that I am acting the part of a pioneer. I am well aware that a few other like instances have been correctly reported during the past five years.

I am convinced, however, that similar epidemics have raged in this and other States, which have been lightly regarded, and tagged with the label of "Cuban itch," or "Trinidad fever," or some other title. I make, therefore, no apology for once more calling the attention of the profession to this old scourge masquerading in deceptive costume, fraught as it is with material damage to the community, and not devoid of possible danger to human life.

PROLONGED FASTING AS A FACTOR IN THE TREATMENT OF ACUTE DISEASES.¹

With Special Reference to Affections of the Alimentary Canal.

BY NORTON J. SANDS, M.D.,
Portchester, N. Y.

Mr. President and Fellow Members of The New York State Medical Association:

IN the light of recent investigation, when the attention of the medical profession is being directed to the subject of over-eating in health, it may not be an inappropriate time to raise the question as to whether in disease, also, we do not eat too much. So greatly have I been impressed with this latter belief, and so amply justified in it by clinical results, that for many years I have advocated and practiced the opposite extreme of over-feeding—namely, absolute fasting in acute diseases of any grade of severity.

My experience with prolonged abstinence from food as an aid in the management of acute illnesses dates back twenty-one years. In 1883 I was called to take charge of a case of typhoid fever, in the person of a young adult, of two weeks' duration, in which the most distressing feature complained of by the patient was excessive and persistent diarrhea. I had hitherto allowed my typhoid patients the usual amount of liquid nourishment, but in this instance it was so manifestly doing more harm than good, that I decided to withdraw it entirely, allowing only cool water, and that in as large a daily quantity as could be taken. A marked improvement in all intestinal symptoms began immediately, and in

¹Read before The New York State Medical Association, at the Twenty-first Annual Meeting, held in New York City, October 17-19, 1904.

the course of two days the movements had ceased. Profiting by this happy result and fortified by the experience of Dr. Tanner in his six weeks' fast, I prolonged the fasting period in this case to ten days, when, the general conditions warranting it, nourishment was resumed, and she went on to an uneventful recovery.

Since this date, with few exceptions (and such to my regret), I have pursued this plan of treatment with all my typhoid cases, and have gradually extended it until I have made it a part of the management of *all* acute illnesses of any gravity.

The results in affections not of gastro-intestinal origin, as in pneumonia, diphtheria, eruptive diseases, after injuries, operations, etc., are evidently less apparent. These illnesses, however, though affected only secondarily by the starvation treatment, run a more comfortable course, inasmuch as the patients are saved the alimentary disturbance so commonly incident to the taking of food, which a diseased system does not seem to be able to manage. It has been my experience that the digestive and assimilative powers of a patient are in abeyance in proportion to the severity of the sickness, and, on account of fever, possibly of toxins in the blood and of shock to the nervous system following the sudden invasion of disease (especially in a vital organ), nourishment fails to be appropriated to the benefit of the system, and only handicaps the patient's chances of recovery. For this reason I wish to enter my protest against the indiscriminate feeding of all patients suffering with any profound, acute illness.

The duration of the fasting period varies with the nature and severity of the disease. Inasmuch as typhoid cases run the longest course, and there is here most ample opportunity to observe the effects of prolonged abstinence from food, I will go somewhat into detail in regard to what I consider the most important part of my treatment of these patients, and my conclusions therefrom.

My rule, when called to take charge of a typhoid case, is to tell the family frankly, at the outset, that patient will be kept on a strict "water diet" for about twenty-one days, at the same time assuring them of a less severe illness and a more certain recovery. If seen early in the attack, I always direct that the patient shall be freely purged—preferably with an ounce dose of castor oil, to be repeated if there is any reason to suspect that the alimentary canal is not fairly clear. In so doing, we have removed as much infection as is possible and have reduced a culture medium for the growth and multiplication of the bacilli that are left behind. The amount of water which is ordered and insisted upon for the patient to drink is, at least, two quarts in the twenty-four hours until long in the third week, when, with the falling temperature, less is desired, it may be reduced a little. It should be taken pleasantly cool, not iced.

With this method of treatment the disease loses

its terrors and the patient has, as was assured in the beginning, a comfortable illness.

The abdominal symptoms are practically nil; there is no diarrhea, as a rule, after the purging has been completed; on the contrary, the bowels usually do not move after the first week, which condition is not interfered with. Tympanites is absent; pain and tenderness so conspicuously diminished (often, indeed, absent after the early stage is passed), that, to the impartial observer, these symptoms must be set down as due in large measure to indigestion and not to typhoid fever. I have known some few cases, very few, where considerable pain in the right iliac fossa persisted throughout the first week, but it invariably subsided after the last remnant of fecal matter had been removed by purging, and long before the height of the disease had been reached. As to those graver complications, hemorrhage and perforation, I can say that for the past twenty-one years I have never had a case of profuse hemorrhage nor one of perforation.

The nervous system suffers little. Sleeplessness is rare; delirium absent in almost all cases—in severest cases hardly amounting to more than a little confusion in the night hours when the patient awakens from sleep.

The effect on the temperature is marked; it runs from 2° to 3° F. lower than the average temperature of the text-books and the employment of cold sponging for its reduction is rarely necessary after the first week; the pulse is correspondingly slower and regularly of good quality.

At the end of the third week the temperature has usually been subnormal for a day or two, the tongue has become fairly clean, and abnormal symptoms have long since been absent. Liquid nourishment is now begun. At the end of the fourth week solid food is allowed and the patient's recovery is uninterrupted.

Manifestly the improvement in the symptoms above contemplated is vast. But it may be asked: "Is not the gain more than counterbalanced by the loss of strength of the patient?" In answer I would say that, as nearly as I have been able to judge by comparing similar cases (for I have tried both methods and have gone contrary to my medical training in adopting the plan of starvation), the patient does not seem to be so weak at the end of the disease as when he is fed throughout.

It has already been shown by experiments in the starvation of animals that the loss in weight is chiefly in fat and muscle, the heart, the brain and the spinal cord remaining practically unchanged. These organs are, therefore, supposed to have derived their nourishment from other organs and tissues. This fact will account for the continued good condition of the nervous and the circulatory systems in fasting patients.

I have taken patients at the close of the first week of typhoid where they had been fed according to accepted methods, starved them for a

week, and, at the end of the second week of the disease, when they would ordinarily be feeling worse, have had them assure me of feeling vastly better and vastly stronger than they did the week before.

It is worthy of remark at this point, too, that while deprived of nourishment, but furnished with plenty of water, the patients do not apparently lose flesh more rapidly than under the usual régime of feeding. It would be an interesting field for investigation to study the metabolism of a patient fasting, but taking an abundance of water, and compare with it that of a patient being fed, in the same disease. It is possible from such research we might have theoretical confirmation of a plan of treatment abundantly justified clinically.

In gastro-intestinal disorders other than typhoid, as in dysentery, gastritis, enteritis, acute infantile diarrhea, etc., without mentioning medicinal measures, food is withheld until the symptoms have subsided. We all know what a revolution of improvement has been brought about in surgery by asepsis. While no one would claim to be able to render the alimentary canal aseptic, still it is in strict accordance with this idea, that I believe that the ulcers of dysentery and typhoid and the inflammatory conditions present in the various affections of the gastro-intestinal tract will be less severe in extent and duration in a comparatively clean bowel, than in one contaminated and irritated by half-digested, fermenting and decomposing food. If the food were digested perfectly, or, if even with imperfect digestion, its good effects overbalance the evil, then it is rational to feed. If, on the other hand, the withholding of food does not markedly diminish the strength of the patient, but does eliminate many complicating and distressing conditions, then feeding is not rational.

The mistake is to emphasize the point that the patient will get "weak" if not fed, and that the more ill the patient, the more he needs food "to keep up his strength." This idea of "keeping up the strength of the patient" is the stumbling block of the old régime. I have yet to see a case where "weakness" has resulted from fasting, at all commensurate with that which is produced by adding to the initial illness a gastro-intestinal irritation, due to the allowance of food, which the system cannot handle, often indeed in an already overtaxed alimentary canal.

The more grave the illness, I must insist, as indicated by anorexia, coated tongue, high temperature, restlessness and prostration, the less able is the patient to digest, assimilate and make tissue of food; and to allow it to any such acutely sick person, with the idea of giving him strength, seems to one, who has observed the benefits of the prolonged fast of the typhoid patient, without justification.

To summarize briefly:

1. In acute illnesses in general, of any great

severity, food should not be given, for the reason that the digestive and assimilative powers of the patient are impaired to such a degree that, by feeding we only take the chances of adding a gastro-intestinal disturbance to the already existing disease.

2. In affections of the alimentary canal in particular, all nourishment should be withheld until complete subsidence of symptoms, as indicated by a clean tongue, quiet bowels, and a continuously normal or subnormal temperature.

3. It is quite possible for a patient to fast three, or even four, weeks without the development of a more pronounced weakness than would be expected in any acute, exhausting disease of such a duration.

CLINICAL OBSERVATIONS IN SCARLET FEVER, WITH ESPECIAL REFERENCE TO THE HEART AND OTHER COMPLICATIONS; THERAPEUTIC SUGGESTIONS.¹

BY LOUIS FISCHER, M.D.,
New York City.

THE influence of the temperature in estimating the severity of a disease is universally recognized. There are times, however, when the temperature alone, as a guide in the prognosis or in estimating the degree of infection, is sadly deficient.

Physicians are frequently misled in believing that a very high temperature means a fatal condition. On the other hand, we find the severest types of septic conditions in which the body temperature may even be normal.

In studying this condition I invariably found that we should bestow less attention to the temperature and more attention to the heart as manifested by the pulse.

The thermic center in a normal child is very sensitive. It is more sensitive, however, if the child is abnormal, as in rickets. To illustrate pyrexia in children, and see the rise and fall of a high temperature in a short time, we need only think of the ordinary type of acute milk poisoning. The toxemia will frequently cause a temperature of 105° F. to appear within twenty-four hours after partaking of impure milk.

Under appropriate treatment, such as stomach washing, colon flushing, and eliminative treatment, a temperature of 105° F. can frequently be reduced to normal in twenty-four hours. As in a case just cited the rise and fall of the temperature is a clear instance of the appearance and disappearance of the acute infection.

During my service at the Riverside Hospital, and also in private practice, a few important questions arose which are worth submitting to your consideration:

(1.) Is the temperature a positive indication of the condition of the patient?

(2.) Does fever invariably indicate disease?

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(3.) Is the decline of temperature always a favorable sign?

(4.) By which symptom should we be guided in determining a favorable or unfavorable termination in this disease?

(1.) Coming back to the first question—Is the temperature a positive guide?—I desire to lay especial stress on the fact that we frequently encounter the most malignant forms of scarlet fever with a moderate rise of temperature. This does not imply that we are dealing with the afebrile type of scarlet fever. I have frequently seen septic scarlet fever with the temperature no higher than 100° F. in the rectum. On the other hand, the mildest forms of scarlet fever sometimes begin with a temperature of 102° to 105° F. We cannot, therefore, say that very high fever is the guide to the severity of a given case.

(2.) Does fever invariably indicate disease? No. That this is a positive fact I have frequently verified at the bedside. In the scarlet fever wards of the Riverside Hospital I have operated on cases of empyema which had had a normal temperature for days and have seen other suppurative complications without a trace of fever. I have therefore in recent years laid less stress on the temperature curve especially during convalescence. I know that I am not in accord with the teachings of many observers and authors on this subject, but careful bedside observation has convinced me that we *lay too much stress on the fever*, and give the temperature curve far more credit during convalescence than it deserves.

Von Jürgensen, in Nothnagle's Encyclopedia, says: "The thermometer becomes a matter of course; every rise of temperature invites a searching examination, though often enough this is without result, either for the time being or for the general outcome of the case. A rise of temperature above the normal merely indicates that something is not as it should be—and that is all." "A satisfactory and perfect understanding of the fever in scarlatina is, to my mind, impossible. The use of the thermometer until late in the convalescence—and this must be repeated again and again—is indispensable, if we would follow out the course of the disease. Sometimes it is only by such measures that we recognize impending dangers, and perhaps combat them."

Rotch says: "The higher the temperature at the beginning of the disease, the more active the symptoms, and the shorter the prodromal period, the more severe will be the case. An initial temperature of 40° C. (104° F.) points toward a severe case."

(3.) Is the decline of temperature always a favorable sign? In a case of scarlet fever a drop of several degrees in the temperature does not indicate improvement in all cases. Very frequently a complication will be detected when the temperature would indicate improvement. I believe that the toxins of scarlet fever inhibit the proper action of the thermic center in the brain because the most malignant form of scarlet fever

frequently shows no rise or only a slight rise above the normal.

(4.) By which symptom should we be guided in determining a favorable or unfavorable termination? The greatest attention should be bestowed on the condition of the heart. The pulse, its character, its frequency, its tension, is the most important guide. The moment systemic weakness exists it can be detected by its effect on the heart. A pulse-rate that gradually increases from 120 to 130, 140, 150 and upwards is always a grave condition. A careful examination of the heart will usually reveal a complication, and if a systolic murmur is present, then endocarditis has set in. When the pulse-rate drops from 100 to 90, 80, 70, or even 60 in a child, during the course of an acute infectious disease, then danger is ahead, for very likely myocarditis will be detected. The necessity for immediate support of the system is apparent if we study the heart and the pulse-rate.

HEART SOUNDS AND MURMURS.—FIRST SOUND.

In infectious fevers there is an increase in the length and intensity of the first sound heard at the apex.

In continued fevers causing degeneration of the heart muscles there is a shortening and weakening of the first sound heard at the apex.

In exhaustive heart strain seen in myocarditis the first sound is feeble and merges into the second sound. This condition is met with in diphtheria, scarlet fever and typhoid, although any condition of the body which devitalizes may cause it.

A very instructive case of a child $4\frac{1}{2}$ years old was seen by me last August at the Riverside Hospital. This child passed through a regular course of scarlet fever. Mastoid symptoms developed, although the temperature was normal. The case was operated by Dr. Rea. Several weeks later symptoms developed in the opposite ear without any *febrile temperature*. A double mastitis existed without *showing any specific effect* on the temperature.

I do not wish to infer that we should discard temperature taking, but I wish to maintain that we should direct more attention to the condition of the heart, in addition to the temperature in children.

My experience has taught me that we are facing a danger point when noting feeble or muffled heart sounds, or by the presence of a bruit, when during this same time guided by a normal temperature would have been a misleading factor.

I have clinical records of a great many cases of sudden death following complications of scarlet fever, owing to leniency on the part of the physician during convalescence. The mortality in private practice is high, and I can account for it simply by the one fact that *children are not kept in bed long enough to permit the toxemia to be modified*.

A weakened heart damaged by the toxins of

scarlet fever cannot stand the strain if the body is devitalized, as it could before the scarlet infection. The streptococcus, we know, is one of the most dangerous pathogenic microorganisms with which we have to contend. It is imperative, therefore, to treat every scarlet fever case vigorously for at least six weeks indoors, and then be less strict, if we wish to have successful results.

The statistics of the Riverside Hospital are very interesting. The children are usually the poorest class of tenement-house cases, or children who are brought to this country in the steerage as immigrants.

CASES OF SCARLET FEVER TREATED IN THE RIVERSIDE HOSPITAL, NEW YORK CITY.

Year	Number		Mortality Per cent.
	of cases.	Deaths.	
1903	835	76	9.1
1904—Jan. to Oct.	718	46	6.4

I am indebted to Dr. Watson, the resident physician, for compiling the statistics in this article.

Statistics for the District of Columbia show the average per annum mortality in scarlet fever for the ten years ending December 31, 1903, to be 13.1 per cent.

The reason for the low mortality in New York City is very interesting.

First.—All children are kept in bed under strict medical supervision, aided by competent nurses.

Second.—No child is permitted to walk about until the heart's action warrants it.

Third.—The feeding is given at regular intervals and nothing permitted that will disorder the stomach.

Fourth.—All complications such as heart, ear and kidney, are expected, and if possible avoided. In private practice the mortality is much higher. I have seen many cases that were permitted to romp about as soon as the temperature became normal, or after the first week of the disease. The systematic effect of the scarlatinal poisoning, particularly noted in the heart, requires serious consideration. It emphasizes the necessity for absolute rest for at least three or four weeks. I have frequently seen severe scarlet fever cases both in private practice as well as in my hospital service successfully escape complications when the routine treatment was aided by a bland diet and most of all when rest in bed was strictly enforced.

Joseph E., 2½ years old, was admitted to the Riverside Hospital August 9, 1904, on the second day of illness. He was poorly nourished and undeveloped. Chest barrel-shaped and tapering in front.

Eyes and ears normal, throat congested, slight exudate on tonsils, eruption moderate in intensity, scarlatinal erythema mostly on thighs and elbows. The urine showed no albumin.

EXAMINATION OF THE HEART.

The upper border is at the level of the third

rib from parasternal line on right side to mammary line on left side. Apex in fifth intercostal space about one-fourth of an inch outside of left mammary line.

MURMUR.

Loud blowing systolic murmur, maximum intensity at apex, also very loud at pulmonic orifice, less so over aortic. Heard over vessels of the neck and over entire chest in front and back, also transmitted to the side. Pulse ranges between 108 and 130.

August 22d.—Developed nasal discharge. Culture does not show Klebs-Löffler bacilli.

August 23d.—Double otitis media. Circulation poor. Pulse rapid and weak.

In this case a heart complication, endocarditis, existed without any evidence of fever, during the second week of the disease. When symptoms of heart failure were very pronounced, during the fourth week of the disease, the pulse-rate ranged between 96 and 108. During this time the temperature was practically normal.

Elaine K., female, 5 years old, had vomiting, followed by an eruption of scarlet fever covering the entire body. The rash was distinct for three days, then faded. The physician in attendance said it was a case of mild scarlet fever. The child was up and about during the second week following the eruption. The stomach was not carefully guarded, as the child was given too liberal a diet. On the twelfth day from the beginning of her illness she suddenly had what the family called a "sinking spell."

Evidences of heart weakness were noted. Two days later, or on the fourteenth day of her illness, she was again put to bed. At this time she complained of pains in her joints. The glands of the neck were swollen. The urine was somewhat scanty. On the seventeenth day she had three very severe convulsions.

She was a well-nourished girl and had been very carefully looked after until this disease began.

She was seen by me on the twenty-first day of the disease in consultation with Dr. Marvin Pechner. Severe toxic symptoms were noted with marked anuria. Hardly an ounce of urine was passed during the day. She was edematous and had the waxy appearance seen in acute nephritis. The heart sounds were muffled. The pulse-rate slow and irregular. The temperature was very slightly elevated (100° F.), although a severe myocarditis existed. The highest temperature during the first week of her illness was 103°.

A résumé of this case shows the following:

1st.—That the child was allowed out of bed too soon.

2d.—That improper diet was permitted.

3d.—That the temperature did not indicate the severity of the complication.

4th.—That the heart and pulse showed the true condition.

5th.—The case illustrates the ease with which

we can be misled during the second or third week after the commencement of the disease, if a normal temperature is found.

TREATMENT.

First and foremost, put every scarlet-fever case in bed and keep it there at least four weeks. The temperature of the room should be between 68 and 70. Ventilate frequently. It is safer to protect the body with sweet oil, lanoline or carbolized vaseline.

Second.—The temperature is no guide as to the time when a child should be permitted out of bed.

Third.—The heart and the pulse should be the true determining guide as to the prognosis and the condition of the patient.

Fourth.—The diet should be liquid and should consist principally of milk and alkaline waters.

Fifth.—Stimulate the emunctories, as we know that we can eliminate toxins through the kidney, bowel and skin.

Sixth.—A hot saline colon flushing—one or two quarts, temperature 115° to 120° F.—should be given once a day after the first week, regardless of the necessity of the same. It will stimulate diuresis, also cleanse the bowel and nourish the blood.

The following drugs are preferred by me during scarlet fever:

Antipyretics, none. Avoid them, owing to their depressing the heart's action.

Sulpho carbolate of soda, 5 to 20 grains, three or four times a day is valuable for scarlatinal necrosis.

For the kidneys, hot salines and diuretin liberally.

For the heart, spartein, strophanthus and 5 to 10 drops of a 1-5,000 solution of adrenalin. This last-named drug has a very stimulating effect on the heart's action, besides it does not irritate the gastric mucosa, nor has it a cumulative effect like digitalis. If the pulse is watched, we can frequently reduce a rapid pulse-rate and steady the heart's action by the use of adrenalin. Hot baths, and especially the hot-air baths, seem to weaken the heart's action. It is a good plan to assist those organs in which complications are expected, long before the actual complication has set in, and thus try to avoid all complications.

DISCUSSION.

Dr. Kimball.—I think that the temperature is of prime importance in the prognosis of scarlet fever. I certainly agree in everything that has been said. If you have a child who has a temperature of 102 or 103, and the pulse is about 100 or 110, if under these circumstances the temperature goes on about the same and the pulse-rate drops, there is trouble ahead. In regard to the good points brought about by keeping the child in bed, I think if some physicians would keep the child in bed that there would be less trouble with the heart. There is a very important physician who always prefaces his remarks with

"Keep the patient in bed." In regard to digitalis in children, I do not believe in it. I think that it distresses the stomach. Take the stomach away from the child and there is nothing left. Rest and diet are the principal treatment in scarlet fever.

Dr. Fischer.—I mentioned the case of a child who had an empyema and one who had a double otitis. These are the cases which give trouble and in which there is a doubtful temperature, and I said that you will be misled if you rely upon the temperature. In the case which I have reported the child had a pulse with a normal temperature.

METHYL (WOOD) ALCOHOL.¹

BY J. P. ATCHINSON,
Chemist to the New York Board of Health.

WHEN wood is subjected to the process of decomposition, known as "dry distillation," there result a number of compounds, some of which are gaseous, some liquid at ordinary temperature and some solid.

Among the liquid compounds is methyl or wood alcohol. Methyl alcohol distills over in the first groups of compounds between the temperature of 150° C. and 280° C. together with acetone and acetic acid. Boyle discovered (1661) in this liquid portion, which he obtained by dry distillation of wood, two constituents—an acid and a neutral spirit. It was not until 1834 that Dumas and Péligot determined the character of this neutral spirit, though Phillips Taylor, in 1812, recognized it as alcohol different from ethyl alcohol. Dumas and Péligot named this alcohol methyl alcohol from the Greek, $\mu\acute{\epsilon}$ the wine, and $\delta\lambda\gamma$ wood.

The method of manufacture from wood is, in general, as follows: Iron retorts are charged with wood, such as beech, birch and oak, and are heated slowly at first in order that the greatest amount of methyl alcohol and acetic acid may be obtained. The methyl alcohol is found by experiments on small portions of wood, to vary from 5 per cent. to 1 per cent. of the weight of the wood after the water is driven off. The yield depends upon the variety of wood and regulation of the temperature. After the methyl alcohol and acetic acid are driven off the temperature is slowly raised until the temperature of 430° C. is reached, when charcoal alone is left in the retort. The condensed distillate, on standing, separates into distinct layers—a tarry, oily, resinous lower layer, and a watery upper layer. This upper layer is drawn off, and contains, besides methyl alcohol, acetic acid, acetone and homologous ketones, acetates and other compounds. The methyl alcohol may be distilled off from this "crude vinegar" after its neutralization with lime, whereby the tarry matters are left behind with the calcium acetate in the retort. To the impure methyl alcohol, which may contain some unneu-

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tralized acetic acid, as well as methyl acetate and acetone, is added milk of lime, and the mixture is allowed to stand: By this means the acetic acid is completely neutralized and the methyl acetate decomposed. By repeated distillation over lime the methyl alcohol is freed from everything but acetone. The acetone may be removed either after formation of iodoform by the addition of iodine and sodium hydroxide and distillation, or the formation of methyl oxalate, which is decomposed by water, or by converting the acetone into chloroform by distilling over chloride of lime, or by passing dry chlorine through the alcohol, which is heated in a flask with a reflux condenser. The acetone is converted into high boiling chloroacetone ($\text{CH}_3\text{-CO-CH}_2\text{CL}$), from which the methyl alcohol can be distilled. Another source of methyl alcohol is by distilling the residue obtained by evaporation of the spent waste in the preparation of ethyl alcohol from beet sugar and molasses. A large proportion of ethyl alcohol is now prepared from molasses. The distillate contains ammonia compounds, methylamine, methyl cyanide and methyl alcohol. The ammonia and amine are removed by neutralizing with sulphuric acid and distillation. The distillate carries the methyl alcohol and methyl cyanide. The cyanide is decomposed by rectification over lime, and the methyl alcohol is distilled off and dehydrated with lime.

The strength of wood spirit varies from 35 per cent. to 95 per cent. Its usual impurities are acetone ($\text{AH}_3\text{-CO CH}_3$), higher ketones, aldehyde, methyl acetate ($\text{C}_2\text{H}_5\text{-OH. CH}_2\text{CH-CH}_2\text{-OH.}$), allyl alcohol and empyreumatic bodies. The purer the alcohol the better its solvent power. Its solvent power is about the same as ethyl alcohol, and hence is often substituted for it for burning in lamps and for varnishes. Also sometimes it is substituted by druggists for ethyl alcohol.

Animal experiments give us our most reliable data in regard to the physiological action of methyl alcohol. Methyl alcohol is a powerful poison, causing death if taken in sufficient quantities. It produces coma more slowly than ethyl alcohol, but the coma is of longer duration. It causes a drop in body temperature and hemorrhages in the stomach and bowels. I noticed this condition in the stomachs of five men supposed to have been killed by drinking whisky adulterated with methyl alcohol, and from which I recovered enough methyl alcohol to give decided reactions. It causes partial or total blindness in men.

Animals given small doses of methyl alcohol, not sufficient to kill within a few days, cannot withstand the toxic action for more than a few weeks. The fatal dose for the dog has been placed at 6.36 gms. to 7.2 gms. per kilo of body weight, whether given intravenously or injected into the muscle tissue. For the rabbit the fatal dose is placed at 7.2 gms. to 9 gms. per kilo body weight.

The M. L. D. of ethyl alcohol is about the same as that of methyl alcohol for dogs and rabbits. It seems to make little difference whether the methyl alcohol is given by the mouth or injected into the vein or muscle tissue; the M. L. D. is quite constant.

Reid Hunt (*Johns Hopkins Bulletin*, for August and September, 1902) gave the result of a series of experiments, comparing the toxicity of ethyl and methyl alcohols.

He used, in most of his experiments, Kahlbaum's purest methyl alcohol, perfectly colorless and entirely free from substances, giving an iodoform reaction. The ethyl alcohol used was for the most part Squibbs' absolute alcohol. The alcohols were diluted and introduced into the stomachs by means of a soft rubber catheter. He used, also, Columbian spirits of a light yellow color, giving the iodoform reaction, and of about 98 per cent. strength. He used rabbits as test animals. His results indicate that ethyl alcohol is a little more toxic than methyl alcohol for rabbits. These alcoholic doses, it must be remembered, were fatal doses. In doses termed by Hunt as "subacute" methyl alcohol was always fatal to the dog when used as the test animal, while it will be noticed the ethyl alcohol failed to kill. Where the rabbit was used, the animal fed with ethyl alcohol either survived or its death was delayed, whereas each animal given methyl alcohol died promptly except the last two of the series, which Hunt does not consider "subacute poisoning cases," since much smaller doses were given. One animal died after seventeen days, the other became ill but recovered.

One may judge by these experiments that poisoning was not due to impurities in the methyl alcohol but to the alcohol itself. It has been found that methyl alcohol is partially oxidized in the body, and is found in the urine as formic acid. It is possible that formaldehyde, the intermediate step in this oxidation process, is formed.

Methyl alcohol is sometimes substituted for ethyl alcohol by druggists in preparation for external use. It has been also used to adulterate whisky. A bill is now before the Legislature forbidding the use of methyl alcohol in any preparation for external or internal use, as a medicine or beverage, and should receive the backing of every one having any knowledge whatever of the poisonous property of methyl alcohol.

In conclusion, let me give the method of detecting the presence of methyl alcohol. The method depends upon the fact that methyl alcohol is oxidized to formaldehyde by hot copper oxide, and the formaldehyde may then be detected if in sufficient quantities by the odor; if not in sufficient quantities, by one of the following tests: First. Hehner's test, delicacy, 1-500-000. Second. Phloroglucin. Third. Sulphuric acid morphine test. A little of the suspected liquid in a test tube (after distillation, preferably) is oxidized

by plunging a hot copper spiral into the vapor repeatedly. Formaldehyde is formed, and one or more of the above tests is used to identify it.

Hehner's.—A little of the solution is added to milk (about 5 c. c.), shaken thoroughly; 95 per cent. H_2SO_4 , containing trace of iron (about 5 c. c.), is poured gently down the side of the tube. H c. c. and P_2 also give reaction. A purple ring between the acid and milk develops almost instantly in presence of formaldehyde.

Morphine Sulphuric Acid Test.—A few crystals of morphine or its sulphate are placed on a little concentrated H_2SO_4 , the oxidized liquid is slowly added, a violet color develops in presence of formaldehyde, an orange color develops in presence of ethyl aldehyde.

Phloroglucin.—Test for formaldehyde reagent: 0.1000 gms. of phloroglucin is dissolved in 100 c. c. water. To 5 or 10 c. c. of solution to be tested, add 1 or 2 c. c. phloroglucin solution, and make alkaline with a few drops NaOH solution. A red color indicates formaldehyde. If one gets a formaldehyde reaction it does not necessarily follow that methyl alcohol is present. We have recently been examining medicines in the Health Department Laboratory, and in those preparations containing ether or chloroform we get a strong formaldehyde reaction. Mr. Durand, one of the chemists, suggested that we test the ether alone. One of the best-known ethers from an unopened can gave the formaldehyde reaction very strongly. Other cans of ether gave the same results. We purchased an ether equally well known of another make and obtained the same results. Chloroform oxidized by the copper spiral also gave formaldehyde. One must bear this in mind, therefore, and separate the interfering substances before passing judgment upon the honesty of the druggist. These reactions between copper oxide and ether and chloroform seem to be generally unknown, and we are continuing our investigations regarding them.

government is not only necessary to an intelligent criticism of conditions that have grown up under that system, but absolutely indispensable to a practical and lasting reform of those conditions.

The same is true as to the character of any business regulated or restricted by statute under the police power of the State by reason of the public harm involved.

It is the testimony of all students of criminology, including such eminent witnesses as Lord Chancellor Bacon, given in 1602, Sir Matthew Hale in 1700, the late Chief Justice Coleridge in 1891, Dr. Forel of Switzerland in 1899, the Chaplain of the Preston House of Correction, and also the State Board of Charities of Massachusetts in 1869, Dr. Harris of the Prison Association of New York, and all judges of large experience the world over, that not only is the liquor traffic dangerous to public morals and fraught with public burdens, but it is the cause of from 75 to 90 per cent. of all crime that is committed—a mass of overwhelming and uncontradicted evidence that is corroborated and sustained by the story of crime written in the dockets of the courts of this city and of this State.

We do well, therefore, to bear in mind that in dealing with the liquor problem we are dealing with the most fruitful source of crime instead of the personal liberty of the citizen, as sentimental and superficial statesmen appear to think and would have us believe, because as against society no man has the right to make of himself a criminal and a public burden.

In this view, the Legislature in 1896 made radical changes in the excise system of the State by the enactment of the enforceable Liquor Tax Law in the place of the Act of 1892, which Theodore Roosevelt, in speaking of his experience as Police Commissioner of this city, said, "was drawn by Tammany legislators so as to make it easy of enforcement for the purposes of blackmail, but not easy of enforcement generally, certain provisions being deliberately inserted with the intention to make it difficult of universal execution."

Since Chief Justice Marshall promulgated the economic truth that "the power to tax is the power to destroy" it has been the policy of the State and the nation to tax the liquor business, in order to destroy or minimize those evils which inevitably result from the traffic.

The Raines Law is the first piece of excise legislation in this State which ever attempted to deal fairly between the liquor interests and the taxpayers, and to treat this phase of the question as a business proposition by raising, through high license for the State and localities, a revenue adequate to reimburse, in part at least, the taxpayers for the sum that they had been called upon to pay for the support of the police departments, criminal courts, asylums and penal institutions, populated very largely by victims and products of the saloon, thus placing on the business mainly

THE LEGISLATIVE ASPECTS OF ALCOHOL.¹

BY MAYNARD N. CLEMENT,
New York State Deputy Commissioner of Excise.

KING ALCOHOL has waged continuous and unending warfare against all excise legislation of the nation and the State since the dawn of civil government.

From the time of the Whisky Rebellion in 1794, led by a judge of the court to the very cannon's mouth of the nation's power, there has been no peace between excise law and excise lawlessness, and though ingenious methods of evasion have taken the place of armed resistance, they are not less harmful because less open in mode of attack; on the contrary, they are more dangerous to society, because more subtle and less understood.

A correct understanding of our methods of

¹Read before the New York County Medical Association, New York, February 20, 1905.

responsible for the burden of crime and pauperism the maintenance thereof, instead of leaving it as theretofore for the general taxpayer, who is not in any degree accountable for the effects of the liquor traffic, and who has no share in its inordinate profits.

It seems eminently fair that the State should step in and take from him who voluntarily engages for gain in a business that is dangerous to his fellow-man sufficient tribute for the benefit of society to repair the financial damage done.

The most violent critics of the present law admit the success of its revenue and tax-equalizing provisions.

While the net revenue under the old law was less than three millions, no part of which went to the State, the Raines Law is now producing an annual revenue of \$18,000,000, one-half of which goes to the locality where collected, for the payment of police officers and other local expenses, and one-half to the State, which is applied to the reduction of taxation for State purposes, which would otherwise have to be met by a direct tax on the localities.

At the close of the fiscal year, in September, 30, 1904, the Raines Law had produced the enormous revenue of \$121,736,687.71; \$54,029,673.01 was collected in the old County of New York (now the Boroughs of Manhattan and The Bronx). After allowing for \$2,286,958.19 of this, which was paid back to the liquor dealers of New York as rebates on surrendered certificates, \$19,731,261.13 was paid over to the State Treasurer and applied to meet State expenses, thereby decreasing State taxation, and \$32,011,453.69 was paid into the city treasury.

The law has been unfairly criticized under the false claim that it taxes the city for the benefit of the State. Before answering the criticism, let us see how it works out as against the city.

From the vehement denunciations of this feature of the statute, we might suppose it to be a clear case of grand larceny for the benefit of the rural parts of the State; but it is nothing of the sort. The State takes a part of the revenue, it is true, but in *trust* for the taxpayers of the entire State. And why should not the general taxpayer share in a part of the excise revenue? He is taxed for the support of the penal and charitable institutions of the State and for her asylums, where the unfortunate made so by drink are cared for.

We have seen that the Special Deputy Commissioner for the Boroughs of Manhattan and The Bronx has collected a net revenue of \$51,742,714.82—after providing for rebates—and handed over to the State the sum of \$19,731,261.13. What does the State do with it? She puts it with the excise revenue received from all other localities, making a grand total of \$44,512,205.95, which has reduced direct State taxation by that amount, because every cent of it has been applied to the expenses of the State.

And now let us examine the schedule of the assessed valuation of the property in the State and in Manhattan and The Bronx, and we shall find that on the ratio of its assessed valuation Manhattan and The Bronx have, by way of reduced taxation, derived an indirect benefit from the \$44,512,205.95 paid to the State in trust, of \$22,708,372.06; or \$2,977,110.93 more than has been paid by the city to the State. Almost any individual or locality would be willing to be robbed in this way.

The explanation of the discrepancy between the amount paid to the State and the indirect benefit in reduced taxation lies in the fact that it seems to have been the policy of the local government in New York to increase assessed valuations accordingly as local expenditures have increased year by year, and thus avoid an alarming increase in the local tax-rate, notwithstanding a very large increase in local taxation. Of course, the amount paid the State in trust and the amount of indirect benefit would be the same if assessments were uniform throughout the State, but they fluctuate greatly, and, as a result, localities that are assessed comparatively high, gain, and those assessed comparatively low, lose thereby, so far as indirect benefits under the Raines Law are concerned.

But it is untrue and misleading to say that the State collects an excise tax from the city. The excise tax is assessed only against the liquor business wherever conducted, and not against either the city or the county, but is paid by the citizen who elects to engage in it as a money-making enterprise.

Under the old law, New York County collected annually \$1,190,303.37, and had 8,906 licensed places. During the year ending April 30, 1904, the Special Deputy collected as excise taxes in the same territory \$7,727,601.93. Of this, \$3,863,800.97 was paid into the local treasury in cash, or \$2,673,497.60 more than she ever received from the old law, and there were 1,989 less licensed places. In addition to this, the indirect benefit during the same year was \$4,634,027.41, making a total increased yearly benefit to Manhattan and The Bronx under the Raines Law of \$7,307,525.01, more than ever received under the old law, and more than ever could have been received under that statute, at a local expense under the Raines Law of \$31,715.34, as against \$134,290.27 under the old law. The increased revenue would have remained in the pockets of your liquor dealers as additional profits, and no part of it would have found its way into the local treasury, except for the Raines Law. That is how the city has been robbed.

The Raines Law has not only produced gratifying results as a revenue and tax-equalizing measure, but its high license feature has decreased the number of places in the State by 7,250, and in the County of New York by 1,989—an achievement in line with the views of ad-

vanced sociologists and practical reformers, because a decrease in the facilities for excessive drinking has, according to statistics, operated to decrease public intoxication and crime generally, and in line with the views of the old Board of Excise of New York City and County, as expressed at its meeting in December, 1895, in a resolution setting forth the fact that the number of licensed places then in the city was "wholly inconsistent with a high degree of public morality and safety, but directly conducive to poverty, wretchedness and crime," and thereupon it was resolved that thereafter the license fee should be fixed at the highest limit allowed by law.

There were 33,437 licensed places in the State during 1895, the last year of the Tammany Law; for the year ending April 30, 1904, there were 26,187 certificates in force, a reduction of 21½ per cent.

During the fiscal year ending September 30, 1897, according to the public prison records, there were 53,200 commitments for intoxication in the State; for the year ending September 30, 1903, there were only 32,153, a decrease of 21,047, or more than 39½ per cent.

The total prison population of the State on October 1, 1895, was 12,661. A prison census taken October 1, 1903, shows only 10,987, a reduction of 1,674, or more than 13 per cent.

If we take into account the fact that our population is increasing approximately 2 per cent. each year, it is clear that the decrease in public intoxication, prison population and the number of licensed places is actually greater, according to our present population, than the above statistics fully indicate.

METHOD OF ENFORCEMENT.

The Liquor Tax Law provides two distinct remedies for enforcement. The *criminal*, which is under the control of local police and prosecuting officers, as in the case of all other laws against crime; and the *civil remedy*, practically under the control of the State Commissioner of Excise, who has prosecuted nearly 3,000 civil actions, and collected half a million of dollars in costs and penalties since 1896, in addition to the supervision of the annual collection of \$18,000,000 in excise taxes.

While the department, aided by only sixty special agents, has been, to say the least, fairly successful in the enforcement of the civil side of the law, home rule as to the enforcement of its criminal provisions—and especially in this city—has been a conspicuous failure, and is bound to continue a failure until the difficulty is correctly understood and the right remedy applied.

It has been urged that willing obedience is not yielded to the Raines Law, and that, therefore, it cannot be enforced. The same has been said of every law that has ever been enacted that taxes or restricts the liquor interests, and might be said with equal reason concerning the laws against murder, larceny, forgery, gambling, and

so on through the whole category of criminal law.

Does anybody suppose that liquor dealers who, for sordid reasons, engage in the business branded by our judges, from the Court of Appeals down, as the hotbed of crime and pauperism, yield willing obedience to the provisions of law that exact from them an annual tribute of \$18,000,000? Of course not. But the State Commissioner of Excise, with the aid of only sixty men, compels unwilling compliance with this provision. Does any sane man believe that the 16,000 police officers in the State—the 7,000 in this city—would, if they honestly made the same good faith effort, meet with a less degree of success in the enforcement of the criminal law in excise cases?

Your District Attorney says the law can be enforced, but that it would mean political suicide to do it. Well, Police Commissioner Roosevelt enforced the excise law. He said he would because he took his oath of office seriously, and he did it. I apprehend that when the rolls of Mr. Roosevelt's political suicide club are opened for membership there will be no dearth of candidates for admission, notwithstanding the District Attorney's dire prophecy.

Ex-Superintendent Byrnes says the law can be enforced by reorganizing the police force so that the dishonest men can be put out and kept out, and the honest men have a chance.

The Raines Law has been denounced to the limit of language as a vice-breeder, and its author held up to opprobrium because of the so-called ten-room hotels. It seems to have escaped the notice of these frenzied critics that the Tammany Law of 1892 contained a ten-room provision as to hotels, and it also seems to be an undiscovered fact that under Section 647 of the Charter of Greater New York, the Municipal Assembly of the city has enacted Section 10 of the Building Code, which provides that "A hotel shall be taken to mean and include every building or part thereof, intended, designed or used for supplying food and shelter to residents or guests, and having a general public dining-room or a café, or both, and containing also more than *fifteen sleeping rooms above the first story.*" The enforcement by successful home rule of the hotel provisions of the Building Code would close every ten-room Raines Law hotel in the city; that is to say, the honest enforcement by the city of her city-made law, known as the Building Code, would abate every so-called Raines Law hotel nuisance within her borders.

Diagnostic infallibility is not less important when the body politic is ailing than in the case of the individual citizen, who is the unit of the State.

Suppose a case: The city, under the provisions of an elaborate law, at great expense, installs an adequate electric lighting plant, modern and complete in all of its equipment, and puts its opera-

tion in the hands of a superintendent, with all necessary help. The service is bad at first, speedily grows worse, and finally the street lamps are black night after night—the city in darkness. An investigation discloses that the fires are out in the engines, and that the superintendent and his helpers pay no attention to the business, except to draw their salaries regularly. How would you diagnose the trouble—as a defect in the charter requiring additional legislation, or as a fault of the superintendent, to be remedied by putting a competent and honest man in his place?

With its demoralized police force the city is sick with flagrant abuses in violation of various statutes, including the excise, and a complete recovery is not possible until the majority of citizens discover for themselves that not in the amendment or multiplicity of laws is the relief sought, but rather in the amendment of the character and conduct of local public servants who have been tried and found wanting.

The solution of the problem is a question of home rule—of self-government. A question of *men* and not of measures, because in honest public service, rather than in public measures, must the safety of the country lie.

The law is an instrument—a mere tool—and, as in the case of other tools, everything depends on the workman who uses it. If the workman is incompetent or dishonest changing the tools is not likely to mend the difficulty.

Don't declare for Sunday opening as a matter of expediency, unless you can conscientiously support the principle of giving the greatest liberty to the worst trade, while you bar by law the doors of dealers who furnish bread, meat, groceries and the other necessities of life.

Dr. Forel, if I may quote him again, says, as an incident of the Continental Sabbath, that in England the mass of crimes are committed on Sunday, Saturday evening and Monday.

Mr. Roosevelt says that when he enforced the excise law in New York "the number of Sunday arrests sank about one-half of what they had been under the Tammany rule, and yet the saloons were practically closed, whereas under Tammany most of them had been open."

Are you going to correct a bad condition by a worse remedy? Don't concede so much to the poor man's club that you can't look the poor man's wife and children in the face.

Don't think you can increase the *capacity* and *working* hours of the business that now furnishes more than 75 per cent. of all our criminals and paupers, without a corresponding increase in the undesirable criminal and pauper output; and don't adopt a remedy that is worse than the disease. It would seem to be far better, if it had been thoroughly demonstrated that police service under home rule is a hopeless failure, to look for more perfect police service in the direction of State police supervision, rather than pursue a course that must inevitably lead to greater disorder and worse demoralization.

ALCOHOL IN DISEASE.

Dr. George L. Peabody, of New York, contributed a paper before the New York County Medical Association February 20, 1905, which was limited to fifteen minutes' in length, to the subject of the "Use of Alcohol in Disease."

After alluding to the fact that most of the recent work on alcohol related not to its use in disease, but to its food-value and its toxicity, to alcoholism and the pathological conditions which it induces, he called attention to the modern local uses of alcohol. It had been found of value as an interstitial injection in the treatment of inoperable uterine carcinomata and also of angiomata; and its power to permeate the epidermis and skin and thus to disinfect the skin and effect changes in the blood supply even in deeper regions was also explained. The influence of this penetrating power of alcohol had been extensively used in many conditions of superficial inflammation and pain. Alcohol embrocations had given great relief in tubercular peritonitis, in peripheral neuritis, in phlebitis, in herpes zoster; and a similar use had been found in averting suppuration in inflammation of lymphatic glands, of the breast, in beginning carbuncle and furuncle, in paronychia, in bubo and in phlegmonous inflammation involving the external ear as well as the temporal and mastoid regions. It probably acts in all of these conditions by causing a dilatation of blood-vessels and thus diminishing congestion and pressure. To accomplish this purpose the skin must be continuously saturated with it. He called attention to the danger of causing destruction of skin and even deep sloughing if it be applied pure in regions where the epidermis is thin.

He then spoke of its use in poisoning by carbolic acid as a modern application of it, and one of great value. He spoke of its internal use in febrile conditions, such as typhoid fever and pneumonia; and while admitting that many modern clinicians had discarded it as toxic under all circumstances, among whom were Kassowitz, Bunge, v. Noorden, Rosemann and C. Fränkel, nevertheless equally high authorities still ardently advocated its utility. Among these were v. Leiden, Binz, Georg Boune and Meltzer.

The speaker believed it to be of value in stimulating the heart and respiration in many pathological processes. While admitting that it was often very carelessly and even recklessly prescribed, he believed that in many conditions of feeble circulation it was indispensable, and that while digitalis, strophanthus, strychnine, adrenalin, caffeine and others might often be of great value, and might add to the effects which it undoubtedly caused, no one of them could replace it—nor could they all together. It had seemed to him to be of distinctly greater value than any of the others in the presence of fever. He then spoke at some length of dosage and of effects in detail, and concluded by quoting Meltzer's statement to the effect that in health it is often a curse and in disease usually a blessing.

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IMPORTANT NOTICE TO ALL MEMBERS.

In this issue of the JOURNAL will be found a report from the Associate Counsel, Mr. Charles F. Brown, ex-judge Supreme Court, and the Counsel of the Association, Mr. James Taylor Lewis, which should be carefully read by all the members.

To comply with the recommendation of the lawyers, the Council of the Association finds it necessary to serve a personal notice on each member of the Association, giving the date, place, and time of the annual meeting. Each member is requested to acknowledge the service by promptly signing and returning the blank which will be sent to him by the secretary. This is a duty each member owes the Association and no one should fail to comply. Those who fail to acknowledge such service will put the Association to great trouble and expense in order to comply with the law.

To provide for a majority vote in favor of the ratification of the Joint Agreement, the members are requested to sign a proxy, properly witnessed according to directions, which proxy will insure their votes in favor of the amalgamation plan as provided in the joint agreement, appoint the Committee as named in the agreement and confirm the amendments to the by-laws offered at the last annual meeting.

The full agreement, including the new constitution and by-laws, will be sent with the proxy, in order that each member may clearly understand the resolution for which his vote is cast. Any

one who is present at the annual meeting may vote in person and thereby cancel his proxy. All proxies should be promptly returned, so that they may be filed with the secretary of the Association and voted at the meeting by either Drs. J. Riddle Goffe, A. A. Jones, F. A. Baldwin, C. I. Redfield or C. E. Denison. It is desirable that all proxies be returned within ten days with the notice of service properly signed.

OPINION OF COUNSEL.

APRIL 19, 1905.

NEW YORK STATE MEDICAL ASSOCIATION,

Dr. J. Riddle Goffe, President, 64 Madison Avenue, N. Y.

Gentlemen—Pursuant to the resolution of the Council of The New State Medical Association, passed at the meeting thereof held February 25, 1905, the undersigned have made an investigation upon the legal questions relating to the vested rights of the members of the Association, the legal questions relating to the By-Laws, and to the calling and holding of meetings.

There are acquired, by such persons as become members of The New York State Medical Association, certain privileges and rights of property, and each member, so long as he continues as such and obeys the By-Laws of the Association, is entitled to share the same with every other member, and in order to deprive any member of such privileges or rights so acquired, it becomes imperative to give such member sufficient notice of the calling of any meeting at which action may be taken for such a purpose. If such purpose is to be carried out at a special meeting of the corporation, the intention must be expressed by means of clearly stating such intention in the call for such special meeting. At an annual meeting such intention may not be especially called to the attention of a member.

If there is a provision in the by-laws of a corporation providing for the manner of giving no-

tice to each member for either of this class of meetings, such method must be adopted in calling them, but where there is lacking any specific provision in the by-laws stating the method of giving such notice, the law seems to require that actual notice in some form, specifying the date, place and hour for holding such meeting, must be given each member, where at such meeting it is contemplated or desired to make any disposition of the privileges or rights in property of the individual members of such corporation.

From an examination of the By-Laws of The New York State Medical Association there appears no provision in the By-Laws for the service of a notice for the calling of special or annual meetings. It is necessary, therefore, that so far as possible each member should be personally served with a notice of the meeting. Where, however, a member is absent from the State, or evades service of notice, or for any other reason personal service cannot be made, then notice of the meeting should be left at the last known residence of such member with some person of mature age residing there, and a copy of the notice mailed to the member by registered letter to his last known post-office address within or without this State.

There seems also an absence of a provision in the By-Laws with reference to what number shall constitute a quorum so that business of the Association can be legally conducted, and in view of this fact, in order that business may be properly conducted, a majority at least must be present.

It is oftentimes difficult in membership corporations to secure the attendance of a quorum, which in all cases must be at least a majority of the entire membership, unless otherwise provided in the by-laws, but where any question of importance is contemplated or where the legal right of the Association to pass a resolution may be questioned, the actual physical presence of each member may be substituted by such member sending to any person or persons his proxy, duly witnessed, either couched in general terms or specifically stating in what direction or for what purposes the proxy is to be employed or exercised, which proxy must be filed with the Association.

Personal service of the notice of a meeting may be acknowledged or admitted, when the same has been mailed, thus obviating in many instances the expense of the service personally, but upon those who fail to admit personal service such personal service must be made and proved by affidavit, and when personal service cannot be made, then substituted service as hereinbefore defined, must be made and proved by affidavit.

Respectfully yours,

CHARLES F. BROWN,
Counsel.

JAMES TAYLOR LEWIS,
Counsel, The New York State Medical Association.

DISPENSARY LAW.

Confidential information having been received by Dr. E. Eliot Harris, chairman of the Committee on Legislation, that many dispensaries have disregarded the rules and regulations made by the State Board of Charities, as provided in Section 21 of Chapter 368 of the Laws of 1899, known as the Dispensary Law, *in e.*, upon submitting the matter to the president of the association, Dr. J. Riddle Goffe, the chairman of the Committee on Legislation was authorized by the president to begin an investigation of the practical working of the Dispensary Law, with power to cooperate with any committee of the State Board of Charities and any committee of the Charity Organization Society with the object of securing the proper enforcement of the Dispensary Law.

The chairman of the Committee on Legislation is pleased to announce that Mr. James Taylor Lewis, counsel of the State Medical Association, has volunteered his professional services to the Committee of this Association.

Dr. Harris appeared before a sub-committee of the State Board of Charities on April 20th, and was assured of the cooperation of the Committee on Dispensaries of the State Board of Charities, of which Dr. Stephen Smith is chairman. The joint committee will go over the whole dispensary question in the hope of securing a more thorough cooperation on the part of the dispensaries to carry out the spirit of the law, which is declared to be in harmony with modern sociology. Complaints in regard to the abuse of dispensary charity will be gladly received by Dr. E. E. Harris, 64 Madison avenue, as they will aid him in his work in the joint committee.

BILLS BEFORE THE LEGISLATURE.

Introduced by Senator Brackett.

AN ACT

To amend the code of civil procedure, relative to the disclosure of information acquired by physicians and nurses tending to show the commission of crimes, of which children under sixteen have been victims.

... unless, where the patient is a child under the age of sixteen, the information so acquired indicates that the patient has been the victim or subject of a crime, in which case the physician or nurses may be required to testify fully in relation thereto upon any examination, trial or other proceeding in which the commission of such crime is a subject of inquiry.

Sec. 2. Nothing in this act contained shall affect any actions or proceedings now pending.

Assembly Bill No. 1,844, introduced by Mr. Platt.

AN ACT

To amend the public health law, relative to the manufacture and sale of patent or proprietary medicines.

Sec. 218-b. Patent or proprietary medicines; formula to be filed; when sale prohibited.—The

manufacture of a drug, medicine, or mixture of drugs, herbs or medicines, commonly known as patent or proprietary medicine, shall file in the office of the State Commissioner of Health a verified statement containing the name under which such medicine is to be sold, the place where manufactured and an analysis or formula specifying the ingredients thereof and the quality of such ingredients.

No. 1,156, introduced by Senator Hill, of Buffalo.

AN ACT

To amend the Penal Code in relation to crimes against the public health and safety.

Selling poisons without labeling and recording the sale.—It shall be unlawful for any person to sell at retail or furnish any of the poisons named in the schedules hereinafter set forth, without affixing or causing to be affixed, to the bottle, box, vessel or package, a label containing the name of the article and the word "poison" distinctly shown, with the name and place of business of the seller, all printed in red ink, together with the name of such poisons printed or written thereupon in plain, legible characters, which schedules are as follows, to wit:

SCHEDULE A.

Arsenic, cyanide of potassium, hydrocyanic acid, cocaine, morphine, strychnia and all other poisonous vegetable alkaloids and their salts, oil of bitter almonds, containing hydrocyanic acid, opium and its preparations, except paregoric and such others as contain less than two grains of opium to the ounce.

SCHEDULE B.

Aconite, belladonna, cantharides, colchicum, conium, cotton root, digitalis, ergot, hellebore, henbane, phytolacca, strophanthus, oil of tansy, veratrum viride and their pharmaceutical preparations, arsenical solutions, carbolic acid, chloral hydrate, chloroform, corrosive sublimate, creosote, croton oil, mineral acids, oxalic acid, paris green, salts of lead, salts of zinc, white hellebore or any drug, chemical or preparation which, according to standard works on medicine or materia medica, is liable to be destructive to adult human life in quantities of sixty grains or less, and such other poisons as the State Board of Pharmacy, under the authority given to it by the public health law, may from time to time add to either of said schedules. Every person who shall dispose of or sell at retail or furnish any poisons included under Schedule A shall, before delivering the same, make or cause to be made an entry in a book kept for that purpose, stating the date of sale, the name and address of the purchaser, the name and the quantity of the poison, the purpose for which it is represented by the purchaser to be required, and the name of the dispenser, such books to be always open for inspection by the proper authorities, and to be preserved for at least five years after the last entry. He shall not deliver any of said poisons without satisfying himself that the purchaser is aware of its poisonous

character and that the said poison is to be used for a legitimate purpose. The foregoing portions of this section shall not apply to the dispensing of medicines or poisons on physicians' prescriptions. Wholesale dealers in drugs, medicines, pharmaceutical preparations or chemicals shall affix or cause to be affixed to every bottle, box, parcel or outer enclosure of an original package containing any of the articles enumerated under said Schedule A, a suitable label or brand in red ink with the word "poison" upon it. Any person who violates any of the provisions of this section shall be guilty of a misdemeanor.

No. 2,156, introduced by Assemblyman McManus.

AN ACT

To provide for the treatment of persons, residents of the City of New York, male and female, in the City of New York, who are habitually intoxicated or who are found guilty of intoxication or who become incompetent or dangerous from the use of alcoholic stimulants, opiates or drugs of any description, as follows:

No. 937, introduced by Senator Fitzgerald.

AN ACT

To regulate the practice of kinesipathy in the State of New York.

Sec. 15. The word or term kinesipathy in this act shall be understood to mean and embrace the manipulation or movements applied to the human body by hand or mechanical contrivances and including such procedures known as massage, therapeutic gymnastics, Swedish movements, mechano-neural therapy, somatopathy, seismotherapy, vibration, vibrassage, or under any other names or terms now employed or which shall hereafter be invented or applied to signify and cover some method or procedure for applying manipulations or movements for above purposes.

Sec. 16. This act shall take effect immediately.

AN ACT

To amend section one hundred and sixty-five of the agricultural law, entitled, "An act in relation to agriculture constituting articles one, two, three, four and five of chapter thirty-three of the general laws."

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section one hundred and sixty-five of the agricultural law, entitled "An act in relation to agriculture constituting articles one, two, three, four and five of chapter thirty-three of the general laws," is hereby amended so as to read as follows. Sec. 165. Definition of adulterated or misbranded food.—In the case of confectionery, an article shall be deemed to be adulterated if it contains terra alba, barytes, talc, chrome yellow, or other mineral substances or poisonous colors or flavors, or other ingredients deleterious or detrimental to health. In the case of food an article shall be deemed to be adulterated:

First—If any substance or substances has or

have been mixed or packed with it so as to reduce or lower or injuriously affect its quality or strength, so that such product, when offered for sale, shall deceive or tend to deceive the purchaser.

Second—If any substance or substances has or have been substituted wholly or in part for the article, so that the product, when sold or offered for sale, shall deceive or tend to deceive the purchaser.

Third—If any valuable constituent of the article has been wholly or in part abstracted, so that the product, when sold or offered for sale, shall deceive or tend to deceive the purchaser.

Fourth—If it contain any added poisonous ingredient or any ingredient which may render such article injurious to the health of the person consuming it.

Fifth—If it consists in whole or in part of a filthy, decomposed, or putrid animal or vegetable substance, or any portion of an animal unfit for food, whether manufactured or not, or if it is the product of a diseased animal, or one that has died otherwise than by slaughter.

Sixth—If it consists of any slaughtered game, animal, poultry or fowl unless the carcasses of such slaughtered game, animal, poultry or fowl shall have been divested of its lung tissues, entire digestive and intestinal tracts, gall receptacle, craw, and gizzard lining, within forty-eight hours after its slaughter.

Sec. 2. This act shall take effect immediately.

J. T. LEWIS ON CORONERS.

Expects to See Office Abolished at Last, He Says.

James Taylor Lewis, counsel for the New York State Medical Association, which has led the fight for the abolition of the office of coroner in this county, is much encouraged at the outlook for the success of the crusade. He has high hopes of the passage of Senator Elsberg's bill, now pending at Albany, which would put an end to the obsolete "crown's quest." Speaking of the efforts to abolish the coroner's office, Mr. Lewis said:

It was the public criticism of the acts of the coroners in office which originally brought to the attention of the medical men the conditions present in greater New York, and which especially urged the County Medical Association of this county to appoint a special committee to investigate the plans in use in the State of Massachusetts, Connecticut and Rhode Island, as well as the systems which had been after several years established in the cities of Vienna, Berlin and Paris.

As a result of this study and research, a bill was framed in 1903 by this committee, and was presented in the State Legislature by Senator Elsberg, who has continued to foster the measure through its various stages of development.

Suggestions have been received from many sources, many of which had been adopted even up to the last moment of the report of the bill from the Cities Committee, and it is believed now that the plan provided for in this bill is a complete, practical working plan, substituting for the office of coroner a bureau in the Department of Health of this city, whereby the scien-

tific and accurate immediate cause of death can be ascertained without the possibility of criticism and unsatisfactory results which have made the office of coroner a laughing stock in our community.

At a recent meeting of the committee of the County Medical Association, held at the Bar Association, final suggestions were received from Coroner Scholer, ex-Coroner Tuthill and Coroner Williams, of Brooklyn, and as far as was possible their suggestions, many of them very valuable ones, have been added to the bill, until now this committee feels that, as nearly as it can be made, the system as outlined in this bill is a perfect one.

In spite of all this courtesy extended, the friends of the Coroner's office have introduced a so-called coroner's bill supply to impede this measure, but owing to its wholly inadequate provisions, added to the fact that it merely continues the present system and is hastily and crudely drawn, it can mislead no one as to its purpose.

Mr. Lewis said he did not feel it necessary to go into the subject of "graft," but the recent conviction of one of the coroners in a criminal court spoke more forcibly against the present system than any argumentation which could possibly be offered.

The bill would, Mr. Lewis said, probably be brought up for final passage in the Senate about March 1st, and would be speedily pushed through both houses, presented again to Mayor McClellan and, if vetoed, as last year, would doubtless be passed over his veto.

SPITTING ON STREETS.

April 12, 1905.

Dear Dr. Denison—The recent editorial entitled, "Common Sense Versus Nonsense," does not treat with sufficient fairness those who may have a slightly different view.

The position of our Board of Health in regard to the spitting nuisance, while admirable in its purpose, does not seem to be practicable. The great danger to the community of promiscuous spitting is a matter of common knowledge to every well-informed individual, but to demand that no one shall expectorate except in the privacy of his own house, or into a sputum cup which he carries about with him, is to ask more than is reasonable, or at least more than will be granted.

Many of our citizens are suffering from catarrhal conditions of the nasopharynx, larynx and bronchi, of varying degrees of severity, which render spitting necessary. To swallow the expectoration as women commonly do is to say the least of questionable desirability.

What shall we do with the man who smokes? Shall we forbid him to smoke on the street, or require that the saliva saturated with the juices of tobacco be swallowed?

Why not meet the need sensibly, and provide at the center or corner of each block some suitable receptacle containing an antiseptic solution and then insist on the strict enforcement of the Board of Health ruling. If this were done there would be some prospect of preventing expectorations on pavements and sidewalks.

Very truly yours,

The Health Department of New York does not object to spitting. The objection was to spitting on the sidewalk; there it is unnecessary and not defensible. It is earnestly desired that the physician would read the rules and regulations issued by the Health Department. That has not been done evidently, and hence the misunderstanding.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

DISTRICT BRANCH MEETINGS FOR MAY.

- First District Branch, Tuesday, May 2d.
- Fifth District Branch, Tuesday, May 2d.
- Second District Branch—Thursday, May 25th.

COUNTY ASSOCIATION MEETINGS FOR MAY.

- Orange County—Tuesday, May 9th.
- New York County—Monday, May 15th.
- Onondaga County—Monday, May 15th.
- Ulster County—Monday, May 15th.
- Cortland County—Friday, May 19th.
- Chautauqua County—Tuesday, May 30th.
- Lewis County—Tuesday, May 30th.
- Monroe County—Tuesday, May 30th.

ANNUAL MEETING OF THE A. M. A., PORTLAND, ORE., JULY 11-14, 1905.

The following rates have been authorized to Portland, Ore., and return going via any regular direct route, returning via same route, or any other regular direct route:

Fares from New York, via St. Louis or Chicago, via New York Central or Pennsylvania lines, \$77.50; via all other lines, \$74.50.

Changes of Cars in all instances must be made at St. Louis or Chicago, unless special cars are chartered.

Sleeping-Car Rates between New York and Portland, lower or upper berth, \$19; section, \$38; drawing-room, \$71; stateroom, \$53.

Note—Tickets can be made good to return via San Francisco or Los Angeles or both at an additional cost of \$11.

Sleeping-Car Rates, Portland and San Francisco, lower or upper berth, \$7; section, \$14; drawing-room, \$22.

Fares from St. Louis, Mo., and return, \$52.50; Chicago, Ill., and return, \$56.50.

Tickets on Sale—June 1st, 12th, 13th, 14th, 18th, 22d, 23d, 26th, 27th, 28th, 29th, 30th; July 1st, 2d, 5th, 6th.

Direct Routes from New York to St. Louis or Chicago—New York Central & Hudson River Railroad, Pennsylvania lines, Baltimore & Ohio Railroad, Chesapeake & Ohio Railroad, Delaware, Lackawanna & Western Railroad, Erie Railroad, Lehigh Valley Railroad, New York, Ontario & Western Railroad, West Shore Railroad.

Direct Routes from St. Louis—Missouri Pacific to Pueblo, Denver & Rio Grande, through Rocky Mountains to Ogden, Oregon Short Line to Portland. Missouri Pacific to Kansas City or

Omaha, Union Pacific, Rock Island, Burlington to Denver, Denver & Rio Grande to Ogden, Oregon Short Line to Portland. Missouri Pacific or Wabash to Omaha, Union Pacific via Cheyenne and Granger to Ogden, Oregon Short Line to Portland. Burlington or Rock Island to Denver, Denver & Rio Grande or Union Pacific to Ogden, Oregon Short Line to Portland.

Direct Routes from Chicago—Burlington, Rock Island, Chicago & Northwestern, Chicago, Milwaukee & St. Paul to Denver, Denver & Rio Grande or Union Pacific to Ogden, Oregon Short Line to Portland. Chicago & Northwestern, Chicago, Milwaukee & St. Paul, Chicago Great Western, Burlington, Rock Island, to Omaha, Union Pacific and Oregon Short Line to Portland.

Direct Routes from Chicago, via St. Paul—Chicago & Northwestern, Chicago, Milwaukee & St. Paul, Chicago Great Western, Rock Island, Burlington, Illinois Central, Wisconsin Central to St. Paul, Northern Pacific, Great Northern, or Canadian Pacific to Portland.

Time—Between New York and Portland, about five days and four nights.

Meals—About \$3 per day in the dining car.

Approximate Cost of Railroad Trip:

Fare, New York to Portland and return	\$77.50
Berths both ways	38.00
Meals both ways	30.00

Total

Limit of Tickets—The tickets will be good to return ninety days after date of departure with liberal stopovers.

Side Trip—To Yellowstone Park and return for five and one-half days (5½), trip including board and room at the hotels in the Park and stage transportation from Livingston on the Northern Pacific, or from Monida on the Oregon Short Line, extra cost, \$49.50.

Arrangements can also be made by those holding tickets over the Great Northern, Northern Pacific or Canadian Pacific to travel from Duluth to Buffalo by lake steamers.

Special Train—Attention is called to advertising *page iv*, of this issue, giving particulars of the special train trip to Portland and return. Those desiring to join should apply at once, as it is necessary to make berth reservations and arrange for rooms in Portland, etc., the party being limited to one hundred and twenty-five (125).

Albany County Association.—The annual meeting of this Association was held at Water-vliet, on April 4, 1905. There were three members present. There not being a quorum present, no new officers could be elected, and the old officers were held over for another year. One new member was elected.

M. J. ZEH, Secretary.

Monroe County Association.—This Association held its annual meeting on February 28th at Rochester, and elected the following officers for the ensuing year: President, E. Mott Moore; vice-president, S. Case Jones; secretary and treasurer, James Clement Davis; member of the Executive Committee for three years, George W. Goler. Richard M. Moore was elected member of the Nominating Committee of the Fourth District Branch; alternate, George M. Snook.

On motion, the minutes of the previous meeting were not read. Present, Drs. Goddard, Richard M. Moore, E. Mott Moore, Stocksclaeder, S. Case Jones, Curtis, O'Hare and Davis.

The treasurer presented the following report: Cash on hand, February, 1904, \$12.00; receipts, members' dues, \$120.00; receipts, interest, .24; disbursements, State dues, \$106.35; cash on hand, February, 1905, \$29.89.

JAMES CLEMENT DAVIS, Secretary.

* * *

Monroe County Association.—This Association held its regular monthly meeting March 28th at Rochester, the president presiding, with the following members present: Drs. Stedman, O'Hare, Jones, Davis, Curtis and E. Mott Moore. The meeting was of a social character and a short session. No new names were presented; nothing of importance transacted. Motion to adjourn was carried.

JAMES CLEMENT DAVIS, Secretary.

* * *

New York County Association.—The annual meeting of this Association was held at the New York Academy of Medicine, 17 West 43d street, on Monday evening, April 17, 1905, the president, Dr. Francis J. Quinlan, presiding. The executive session was called to order at 8.25, and minutes of the previous meeting were read and approved by the Association. President Quinlan appointed as inspectors of election of officers Drs. J. R. Graham, B. G. Phillips and F. C. Keller, and thereupon declared the polls open for election. Dr. F. P. Hammond moved, that inasmuch as two of the candidates who had been nominated for election to offices at the previous meeting in March, had withdrawn their names, that Section 2 of Article VIII of the By-Laws, which is as follows: "Nominations for officers, for member of the Executive Committee, for Fellows to the State Association and for member of the Nominating Committee of the Fifth District Branch shall be made at the stated meeting in March," be suspended for the evening. This was unanimously carried by the Association. Dr. F. P. Hammond nominated for the office of first vice-president Dr. John A. Bodine. Seconded by Dr. Ellery Denison. Dr. Bruce G. Phillips nominated for the office of corresponding secretary Dr. Charles Gardner Childs, Jr. Seconded by Dr. D. S. Dougherty. The report of the corresponding secretary was then read, and there being no dissent-

ing vote, was approved and ordered on file. There were elected to membership nineteen new members. The annual report of the secretary was then read and approved by the Association. This was followed by the annual report of the treasurer. The reports of the standing committees showed, first, that the Committee on Legislation had worked vigorously for the Elsberg Bill, which tends toward the abolition of the office of Coroner in the city of New York, and the substitution therefor of a system of Medical Examiners. Also this committee advised that every member of the Association make a personal effort to thwart the passage of the Osteopathic Bill, legalizing the practice of this procedure under a special license granted by the State authorities. This report received the unanimous approval of the Association. The report of the Committee on Ethics was read, and on motion duly seconded. The resolutions passed by this committee were referred to the Executive Committee of the Association for further action. As there was no further business before the executive session, the president, Dr. Francis J. Quinlan, announced as the first paper of the evening in the scientific session, one entitled "Galvanism as a Curative Agent in Nervous Diseases; the Importance of Equipment and Technique," by Dr. W. B. Pritchard. An abstract of this paper will very shortly appear in the JOURNAL. This paper was discussed by Drs. G. W. Jacoby, J. J. MacPhee, Milton Franklin and W. M. Leszynsky. The second paper of the evening was on "The Clinical Features and Treatment of Epidemic Cerebro-Spinal Meningitis," by Dr. Francis Huber. For abstract of this paper see the JOURNAL. This paper was discussed by Drs. Morris Manges, Harlow Brooks, C. J. Colles, Thomas W. Darlington and Hermann M. Biggs. At the close of the scientific session, the tellers of election announced that the following candidates for office were elected: For president, Francis J. Quinlan; for first vice-president, John A. Bodine; for second vice-president, Harry Hartshorne Seabrook; for secretary, William Ridgely Stone; for corresponding secretary, Charles Gardner Child, Jr.; for treasurer, Charles Ellery Denison; for member of the Executive Committee for three years, Henry A. Dodin; for member of the Nominating Committee of the Fifth District Branch, Wisner R. Townsend. The following fellows and alternates were elected:

ELLOWS.

Abbe, Robert,
Austin, David P.,
Bang, Richard T.,
Benedict, Charles S.,
Bennett, Beach S.,
Biggs, Hermann M.,
Bissell, Joseph B.,
Bodine, John A.,
Brannan, John W.,
Brill, Nathan E.,
Bryant, Joseph D.,
Burtenshaw, James H.,
Chetwood, Charles H.,
Coley, William B.,

ALTERNATES.

Ayme, Edward,
Baker, S. J.,
Barnes, George E.,
Barrows, Charles C.,
Bennett, Thomas L.,
Berg, Henry W.,
Blake, Joseph A.,
Boldt, Herman J.,
Bozeman, Nathan G.,
Brennan, John W.
Brothers, Abram,
Carlisle, Robert J.,
Cherry, George A.,
Child, Charles G., Jr.,

FELLOWS.

Delavan, D. Bryson,
 Darlington, Thomas,
 Denison, C. E.,
 Denison, Ellery,
 Dodin, Henry A.,
 Dougherty, Daniel S.,
 Erdmann, John F.,
 Forbes, Henry H.,
 Fordyce, John A.,
 Gibb, W. Travis,
 Goffe, J. Riddle,
 Gouley, John W. S.,
 Guiteras, Ramon,
 Harris, E. Eliot,
 Hartley, Frank,
 Hammond, Frederick P.,
 Harrison, George T.,
 Haynes, Irving S.,
 Heller, Isaac M.,
 Herrick, W. P.,
 Hotchkiss, Lucius W.,
 Jamison, M. W.,
 Jelliffe, S. Ely,
 Kalish, Richard,
 Keyes, Edward L., Jr.,
 Kirchhof, Charles G.,
 Kopetzky, S. J.,
 Lambert, Alexander,
 Leale, Charles A.,
 Le Boutillier, William G.,
 LeFevre, Egbert,
 Leo, Johanna B.,
 Leszynsky, William M.,
 Lewingood, Samuel,
 Lombard, Guy D.,
 Loughran, Frederick,
 McAuliffe, George B.,
 MacGuire, C. J.,
 Maury, J. W. D.,
 Mayer, Emil,
 Messenger, Joseph E.,
 Murray, Francis W.,
 Nutt, John J.,
 O'Brien, Michael C.,
 Purdy, Harry R.,
 Quimby, Charles E.,
 Quinlan, Francis J.,
 Reilly, Thomas F.,
 Roth, Henry,
 Sayre, Reginald H.,
 Seabrook, Harry H.,
 Shrady, John,
 Smith, Stephen,
 Stewart, George D.,
 Stone, William R.,
 Syms, Parker,
 Townsend, W. R.,
 Tuttle, James P.,
 Walsh, James J.,
 Wiggin, Frederick H.,
 Wyeth, John A.

ALTERNATES.

Cocks, Edmund L.,
 Collins, George W.,
 Cooke, Joseph B.,
 Davis, Francis W.,
 Dench, Edward B.,
 Dudley, A. Palmer,
 Ehlers, Edward C.,
 Eversfield, Frank J.,
 Farrington, Joseph O.,
 Fernandez-Ybarra, A. M.,
 Fielder, Frank S.,
 Fischer, Louis,
 Gallagher, Edward J.,
 Gallant, A. Ernest,
 Goldan, S. Ormand,
 Gottheil, William S.,
 Graff, Edward J., Jr.,
 Halsey, F. Spencer,
 Hemingway, William H.,
 Hepburn, Neil J.,
 Hope, George B.,
 Howell, Carlyle H.,
 Hurd, Edward F.,
 Jarecky, Herman,
 Jewett, Mary B.,
 Keller, Frederick C.,
 Kilmer, Theron W.,
 Lisle, Justin de,
 Loucks, Frank H.,
 Lukens, Anna,
 McChristie, William,
 McKernon, James F.,
 Mackenzie, James C.,
 Minor, S. Carrington,
 Morgan, Forde,
 Newman, Alvah H.,
 Oppenheimer, Henry S.,
 Parsons, John,
 Phillips, Bruce G.,
 Rupp, Adolph,
 Rochester, Gertrude,
 Rogers, John, Jr.,
 Schminke, John C.,
 Seward, W. M.,
 Silver, Lewis Mann,
 Smith, A. A.,
 Swan, William E.,
 Terribery, William S.,
 Teschner, Jacob,
 Tucker, Alfred B.,
 Valentine, F. C.,
 Wainwright, John W.,
 Walsh, S. J.,
 Weeks, John E.,
 White, William A.,
 Wilzin, Isaac M.,
 Wootton, Herbert W.,
 Wright, Jonathan,
 Woodward, Julius H.,
 Yankauer, Sidney,
 Zweighaft, Bernard.

There being no further business before the Association, the meeting adjourned at 11.30 p. m.

WILLIAM RIDGELY STONE, Secretary.

ANNUAL REPORT OF THE SECRETARY.

Mr. President and Members of the Association:

Your Secretary takes great pleasure in reporting to you that to-night witnesses the close of the most successful year that the Association has seen for a long time. The attendance at the stated meetings has been unsurpassed in the history of the Association. It has been the policy of the

Executive Committee to invite all the regular practitioners in this county to each stated meeting. The interest shown by our guests is evidenced in the large number of new members that have come into the Association since the first of last April. Some sixty new members have been elected and there are now before your body and the Executive Committee the names of sixty-three more candidates for membership.

The Elsberg Bill, looking to the abolition of the office of Coroner in the City of New York, which was passed by the Assembly in Albany last year to be vetoed by the Mayor, has once more been offered to the Assembly and at the stated meeting for February of this year the Association unanimously passed a resolution heartily approving and sanctioning the same and praying the Assembly to pass it.

During the present year eighteen papers have been read before the Association on medical, surgical and pathological subjects.

In November, Dr. Louis L. Seaman told the Association of his personal experiences while observing the work of the Medical Department of the Japanese Army in Manchuria and Japan. This paper was discussed by many prominent physicians and army officers.

At the scientific session of your January meeting a most excellent symposium was arranged on public and municipal hygiene, including the Health of the Nation, the Health of the State, the Health of the City and the Health of the Port.

For February, a Symposium on Alcohol was given and papers were read by Dr. George L. Peabody, Prof. Russel H. Chittenden, of Yale University, Dr. Charles B. Fitzpatrick and the Hon. Maynard C. Clement, New York State Deputy Commissioner of Excise.

It has been the endeavor of your Executive Committee to invite eminent men from other cities both to read papers and to take part in their discussion. It is believed that this has been a means of heightening the interest of the members of the Association in its meeting and surely has proved a valuable increase to our medical knowledge.

Respectfully submitted,

(Signed) WILLIAM RIDGELY STONE,
 Secretary.

ANNUAL REPORT OF THE EXECUTIVE COMMITTEE.

Since last April, the Executive Committee has held its regular monthly meetings. It has also held two special meetings and one hearing upon the credentials of a candidate which was conducted by the Committee on Ethics. The meetings have been well attended.

Eighty-three applicants for membership in the Association have been recommended for election, as compared with forty-nine recommended last

year. Furthermore, twelve old members have been reinstated.

The following members have died during the past year:

1. Grant H. Richtmyer, M.D., on April 21, 1904.
2. John Hustis Barry, M.D., on May 25, 1904.
3. William Rice Pryor, M.D., on August 25, 1904.
4. Montefiore L. Maduro, M.D., on October 22, 1904.
5. Clarence S. Elebash, M.D., on December 20, 1904.
6. Churchill Carmalt, M.D., on January 8, 1905.
7. Louis de Plasse, M.D., on January 23, 1905.

The following members have removed from the county:

- J. Bergen Ogden, to Boston, Mass.
 Milton A. Shlenker, to New Orleans, La.
 Flavius Packer, to Astoria, N. Y.
 Arthur L. Sherrill, to Chicago, Ill.
 Samuel Murtland, to Denver, Col.
 Von B. Thompson, to Poughkeepsie, N. Y.
 George Gibier Rambaud, to Saranac Lake, N. Y.

- Arthur F. Holding, to Albany, N. Y.
 Louis R. Eichberg, to Yonkers, N. Y.
 The following members have resigned:
 Drs. H. G. Piffard, E. A. Bogue, S. Houghton,
 H. W. Wandless, A. T. Swan, D. C. Lewinthal,
 E. M. Alger.

Respectfully submitted,
 (Signed) JOHN JOSEPH NUTT,
 Corresponding Secretary.

REPORT OF THE COMMITTEE ON LEGISLATION

Mr. President and Members of the New York County Medical Association:

Gentlemen—During the past year there have been introduced at Albany but two bills which were of special interest to the members of our profession in this country, namely the Osteopathic and Coroner's Bills.

The former is intended to place the so-called Osteopaths on the same level as regularly graduated and licensed physicians, and the latter favoring the abolishment of the office of Coroner.

The Osteopathic bill has advanced to its third reading and I would strongly urge all members of this Association to write without delay, letters of protest to the Assemblymen and State Senators of their districts urging them to vote against this pernicious measure. Members of the Committee on Legislation have visited Albany in an endeavor to defeat this bill.

The passage of the Coroner's bill has again been urged by the Special Committee and the Committee on Legislation of the County Medical Association. Several members of the Committee on Legislation attended meetings called in New York by the Senator who introduced the bill and they also went to Albany and appeared before the

Senate Committee on Cities to urge the passage of this bill.

The Coroner's bill has passed the Senate and awaits the Governor's signature. Last year the bill was advanced to this stage but was vetoed by the Mayor.

The Committee on Legislation has written many letters to Senators and Assemblymen urging the vetoing of the Osteopathic bill and the passing of the Coroner's bill.

Respectfully submitted,
 W. TRAVIS GIBB,
 Chairman.

* * *

Orange County Association.—The regular monthly meeting of this Association was held at the Palatine Hotel, Newburgh, Wednesday, April 12th, at 2 P. M.

The following were present: Dr. Winfield Ayres, of New York City; Drs. Benedict, Carr, Howell, Townsend, Thompson, Adams, Pierce, Dunning, Harris and Jova, of Newburgh; Dr. Dennis, of Goshen; Dr. Wise, of Tuxedo; Dr. Blanchard, of Highland Falls; Dr. Woodhull, of Monroe, and Dr. Distler, of Westtown.

The meeting was called to order by the president, Dr. E. D. Woodhull, who announced as the first speaker Dr. Winfield Ayres, of New York City. The doctor read an able and comprehensive paper on "Catheterism of the Ureters," also giving a practical demonstration before the Association. Dr. Ayres is one of the pioneer investigators in this line of work and has catheterized over three thousand patients. Dr. Ayres' method opens up a new field for the treatment of the diseases of the kidneys, and should be of service in the successful treatment of heretofore incurable kidney conditions. The paper was discussed by Drs. Townsend and Howell. The next paper was read by Dr. E. G. Thompson, of Newburgh, the subject being "Tumors of the Breast." Dr. Thompson gave a complete résumé of the subject and was highly complimented by all present for his interesting paper. Drs. Townsend, Howell, Pierce and Dunning discussed the paper, after which a hearty vote of thanks was given Drs. Ayres and Thompson for their excellent efforts.

At the business session Dr. Distler, secretary, read the minutes of the previous meeting and they were approved as read. As there was no business of importance to transact the meeting adjourned. The next and last meeting before the summer vacation, which comprises the months of June, July and August, will be held at the Russell House, Middletown, on May 10th.

LAWRENCE G. DISTLER,
 Secretary.

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Saratoga County Association.—The annual meeting of this Association was held at Ballston Spa on March 28th. There was an attendance of seventeen members. The following officers were elected: For president, F. F. Gow; for vice-president, J. R. McElroy; for secretary, J. T.

Sweetman, Jr.; for treasurer, D. R. Kathan; for member of the Executive Committee, three years, F. W. St. John; for member of the Executive Committee to the Second District Branch, F. J. Ressequie. Fellows to the State Association, D. C. Moriarta, F. J. Sherman, G. F. Comstock, D. R. Kathan and F. H. Palmer, elected with power to appoint their own alternates. In the scientific session Dr. D. C. Moriarta read a paper on "Acute Intestinal Intussusception." Dr. J. R. McElroy read a paper entitled "My Italian Twins," and Dr. R. H. Stubbs one on "The Feeding of Infants." The following Committee on Ethics and Discipline was appointed: F. J. Sherman, Adelbert Hewitt, Edgar Zeh. The next meeting will be held at Schuylerville, September 26, 1905.

J. T. SWEETMAN, JR., Secretary.

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Sullivan County Association.—The annual meeting of this Association was held at the Liberty House, Liberty, N. Y., April 12, 1905. There were present Drs. H. P. Deady, Charles S. Payne, L. C. Payne, J. L. C. Whitcomb, W. S. Webster, S. W. Wells, Charles E. McDonald, of Liberty; Dr. William Racoosin, of Centreville Station; Dr. Frank W. Laidlaw, of Hurleyville. The Association was honored by the presence of Dr. Charles I. Redfield, of Middletown, secretary of the State Association.

The meeting was called to order by Dr. H. P. Deady, vice-president. The following officers were elected for the ensuing year: For president, H. P. Deady, of Liberty; for first vice-president, Stephen W. Wells, of Liberty; for second vice-president, George C. Gould, of Bethel; for secretary, Frank W. Laidlaw, of Hurleyville; for treasurer, Charles S. Payne, of Liberty; for fellow to the State Association, Frank W. Laidlaw; for alternate, Charles E. McDonald; for member of Nominating Committee, Fifth District Branch, Charles S. Payne.

Two new members were elected to membership in the Association.

A very interesting paper was read by Dr. McDonald, entitled "The Treatment of Gunshot Wounds in the Tropics." Dr. McDonald's recent service in the Philippines renders him particularly qualified to write upon this subject.

Dr. C. S. Payne read a very able and valuable paper on "Acute Otitis Media."

Dr. Frank W. Laidlaw reported six cases of "Epidemic Cerebro-Spinal Meningitis." All these papers were fully discussed by those present.

Dr. Charles I. Redfield made a very able address, urging the importance of the Association and the necessity of a greater interest being taken. He discussed various means of arousing interest.

Dr. Redfield was given a hearty vote of thanks.

FRANK W. LAIDLAW, M.D., Secretary.

Tompkins County Association.—The regular annual meeting was held on Tuesday, April 18, 1905. The following officers were elected for the ensuing year. For president, Chauncey Pratt Briggs; for vice-president, Edward Meany; for secretary and treasurer, Royden Mandeville Vose; for member of the Executive Committee, Howard B. Besemer. A most interesting paper was read by Dr. Miles D. Goodyear, on "A Case of Insomnia."

HOWARD B. BESEMER,
Secretary.

* * *

Warren County Association.—The annual meeting of this Association was held at the Rockwell House, Glens Falls, on January 11, 1905. There were twelve members present and seven guests. The following officers were elected for the ensuing year: For president, William J. Hunt; for vice-president, W. R. Keyes; for secretary and treasurer, Frederick G. Fielding. There were seven new members elected, and Dr. Floyd Palmer was transferred from the Third District Branch to membership in the Association. In the business session the treasurer read his annual report. In the scientific session Dr. George A. Chapman read an interesting paper.

FREDERICK G. FIELDING, Secretary.

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Westchester County Association.—The annual meeting of this Association was held at White Plains on March 23, 1905. There was a good attendance. Two new members were elected to membership. In the business session the treasurer read his annual report. The following officers were elected for the ensuing year: For president, Thomas J. Acker; for vice-president, Benjamin J. Sands; for secretary and treasurer, Donald T. McPhail; for members of the Executive Committee, Georgiana J. Sands and William J. Meyer; for member of the Nominating Committee of the Fifth District Branch, Thomas J. Acker. Fellows to the State Association, William J. Meyer and Norton J. Sands; alternates, H. Eugene Smith and George C. Weiss. In the scientific session Dr. Thomas J. Acker spoke on the subject of cerebro-spinal meningitis, and a general discussion followed, which was joined by all the members present.

DONALD T. MCPHAIL, Secretary.

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NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Beal, Frederick Earl, New York City.
Greeff, J. G. William, New York City.
Howell, Carlyle Herbert, New York City.
Nellis, Irving O., Herkimer, N. Y.
Pick, Charles J., New York City.
Reich, Adolph, New York City.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Oneida County—Arthur Alfred Gillette, Rome.

SECOND DISTRICT BRANCH.

Rensselaer County—John N. Berry, Troy; Harry Wardwell Carey, Troy; John Trotter, Jr., Troy.

Warren County—John Alexander Bean, Caldwell; Charles K. Burt, Caldwell; John J. Dever, Glens Falls; John M. Griffen, Warrensburg; Morrison LeRoy Haviland, Glens Falls; C. F. Hoffman, Glens Falls; Alexander McKee, Glens Falls; Daniel Lee Rogers, Glens Falls; Elizabeth Pope Westcott, Glens Falls.

FIFTH DISTRICT BRANCH.

New York County—William F. Bullman, New York; Charles Edgerton Carter, New York; Samuel Webb Clason, New York; Israel S. Feinberg, New York; Louis Friedman, New York; Joseph D. Harrigan, New York; Arthur L. Holland, New York; Julius Jarcho, New York; William J. Jones, New York; Gustav Langmann, New York; John Radway Le Comte, New York; William M. Lesem, New York; Walter F. Machlin, New York; Albert S. Maddox, New York; Harold Denman Meeker, New York; William J. Narey, New York; George Lawrence Nicholas, New York; Eduardo Perugini, New York; Shirley E. Sprague, New York.

Rockland County—Arthur A. Doig, Nyack.

Sullivan County—Charles E. McDonald, Liberty; William Racoosin, Centerville Station.

Westchester County—Harry William Hyatt, White Plains; Joseph John Sinnott, Mt. Vernon.

OBITUARY.

Dr. Patrick Joseph Lynch died at his home in New York City, on Saturday, April 22d. Dr. Lynch was born in Ireland in 1828, but came to this country as a boy and studied medicine at the New York University, where he took his degree in 1857. He was a member of the American Medical Association, The New York State Medical Association, New York Academy of Medicine, Medical Society of the County of New York, Physicians' Mutual Aid Association and the Medical Union.

SOCIETY NOTES.

Brooklyn Gynecological Society.—At a meeting held April 7th, Dr. H. C. Keenan read a paper on "Treatment of Salpingitis."

Brooklyn Pathological Society.—At a meeting held April 13th, Dr. Walter C. Wood read a paper on "Cysts of the Breast," which was discussed by Drs. J. B. Bogart and W. F. Campbell.

Buffalo Academy of Medicine.—At a meeting held March 28th, Dr. Charles E. Congdon read a paper on "Caesarian Section." At a meeting held April 4th, Dr. Bernard Bartow read a paper on "Congenital Dislocations of the Hip," and Dr. Herman Hayd on "Orificial Surgery: Its Absurdities, Philosophy and Merit." At a meeting held April 11th, Dr. Henry Dwight Chapin, Professor of Diseases of Children in the Post-Graduate

Medical School, New York City, read a paper on "The Future View-Point and Practice of Infant Feeding," and Dr. A. W. Bayliss on "The Treatment of Disease by Means Other Than Drugs." At a meeting held April 18th, Dr. Torald Sollmann, of Cleveland, O., read a paper on "Mechanical Factors of Urine Formation."

Elmira Academy of Medicine.—At a meeting held April 5th, the following papers were read: "A Foreign Body in the Conjunctiva," by Dr. A. R. Ainsworth; "Calculus Hydronephrosis," by Dr. La Rue Colegrove; "Prostate, Its Diseases and Treatment," by Dr. C. L. Squire.

Harlem Medical Association.—At a meeting held April 5th, Dr. B. Lapowski read a paper on "The Treatment of Syphilis, with Clinical Demonstration."

Harvard Medical Society.—At a meeting held April 22d, Dr. Henry Coggeshall read a paper on "Asthma."

Jenkins Medical Association.—At a meeting held April 13th, Dr. R. J. Wilson, of New York City, read a paper on the "Improved Methods of Disinfection."

Medical Association of Greater New York.—At a meeting held April 10th, the following papers were read: "Introductory on Immunity," by Dr. Edward K. Dunham; "Phagocytosis in Its Relation to Immunity," by Dr. Eugene L. Opie; "Therapeutic Value of Antitoxic Sera," by Dr. H. T. Marshall; "Therapeutic Value of Bactericidal Sera," by Dr. H. D. Pease; "Diphtheria Antitoxin in Cerebro-Spinal Meningitis," by Dr. Arthur J. Wolff; "Limitations of Serum Therapy," by Dr. Henry W. Berg.

Medico-Surgical Society.—At a meeting held March 25th, Dr. William M. Leszynsky read a paper on "Remarks on Sciatica and Its Treatment."

New York Pathological Society.—At a meeting held April 12th, the following papers were read: "Demonstration of a Case of Hydatid Cysts of the Liver. A Case of Eclampsia with Rupture of the Diaphragm," by Dr. J. E. Welch; "Demonstration of a Case of Rarefying Ostitis," by Dr. E. S. McSweeney; "Demonstration of an Unusual Blood Condition," by Dr. L. B. Goldhorn; "Demonstration of Cases of Mycotic Aneurisms," by Dr. E. Libman; "Observations on the Subway Air," by Dr. E. E. Smith; "Report on Some Observations on Fatty Extracts from Organs," by Dr. E. K. Dunham.

New York Surgical Society.—At a meeting held April 12th Dr. Blake read a paper on "Malposition of the Appendix as a Cause of Functional Disturbances of the Intestine."

Rochester Academy of Medicine.—At a meeting held March 29th, Dr. Albert C. Snell read a paper on "The Systematic Examination of School Children's Eyes." At a meeting held April 5th, Dr. Robert G. Cook read a paper on "Drainage of the Lateral Ventricles." At a meeting held April 12th, Dr. Lewis W. Rose read a paper on "Surgical Observations Made at Johns Hopkins Hospital." At a meeting held April 19th, Dr. William B. Jones read a paper on "Operations on Pregnant Women," and Dr. Charles O. Boswell on "Scarlatinal-Nephritis."

Rochester Pathological Society.—At a meeting held April 6th, Dr. Alvah C. Remington read a paper on "Climate as a Therapeutic Agent," and at a meeting held April 20th, Dr. Parker Murphy read a paper on "Headache and Its Clinical Significance."

Saratoga Springs Medical Society.—At a meeting held March 31st, in the Symposium on Gastric Ulcer, Dr. Thompson read a paper on "Etiology and Pathology." Dr. Ledlie on "Symptoms and Diagnosis," and Dr. Sanford on "Treatment."

Society of Medical Jurisprudence.—At a meeting held April 10th, Dr. W. Freudenthal read a paper on "Tuberculosis and some of its Features."

Syracuse Academy of Medicine.—At a meeting held April 4th, Hon. Frank H. Hiscock gave an address on "Expert Testimony." At a meeting held April 18th, the following papers were read: "Lumber Puncture in Epidemic Cerebro-Spinal Meningitis with a Bacteriological Demonstration," by Dr. Francis A. Hulst;

"Blood Pressure," by Dr. Frank P. Knowlton; "Value of Blood Pressure in Clinical Medicine," by Dr. H. L. Elsner.

Women's Medical Association.—At a meeting held April 19th, Dr. Jessie T. Bogle read a paper on "Chorea, Complicating Pregnancy," and Dr. Anna S. Wilner on "Fever in Child-bed, Due to Other Causes Than Sepsis."

THE NECESSITY OF CONSENT TO SURGICAL OPERATIONS.

A great deal of interest and some anxiety have been aroused among members of the medical profession in this country by a recent lawsuit in Minnesota involving the question of the necessity of obtaining the patient's consent to a surgical operation. The plaintiff, a young woman, complained that the defendant, a surgeon, had been employed by her to perform an operation upon her right ear; but that after she was etherized he had operated upon the left ear, although she had never given her consent that any operation should be performed upon that organ. The defence appears to have been that although the original intention of the surgeon was to operate upon the right ear he discovered, upon the fuller examination which he was enabled to make when the patient was put under ether, that the left ear was the more seriously diseased of the two, and that he operated upon the left ear upon the understanding that the patient by placing herself in his hands had tacitly consented that he might do so if he deemed it advisable in the exercise of his best judgment. The Judge who presided at the trial held that no such consent could be implied from the circumstances of the case, and that the defendant was at all events liable for a technical assault. The jury gave the plaintiff a verdict for more than \$14,000.

A new trial was granted on the ground that these damages were excessive; but the case as it stands is a judicial declaration to the effect that where a patient expressly consents to a specified surgical operation, or an operation upon a specified organ, the surgeon cannot perform a different operation, or operate upon a different organ, without rendering himself legally liable to respond in money damages to the patient.

While medical men generally are willing enough to concede the justice and propriety of the rule of law which denies to a surgeon the right to operate upon any patient without the permission of that patient, or of some one standing in a relation of authority to the patient, it is very commonly insisted by medical writers on the subject that the law ought to allow the surgeon to exercise a reasonable discretion, so that if he finds a condition demanding operative interference different from that contemplated by the patient, and possibly the removal of an organ not suspected to be diseased prior to the operation, he should have the legal right to operate as he thinks for the best interests of the patient under the circumstances.

Up to the present time, however, the general tendency of judicial decision in America is op-

posed to the exercise of such a right. In the excellent little treatise on the Law in its Relations to Physicians, written by Mr. Arthur N. Taylor, of the New York bar, about five years ago, it is stated as a general proposition of law that a surgeon must have consent before operating upon a patient; and the author's discussion of the question results in the conclusion that whether there has been a tacit consent to a given operation or not—that is to say whether consent may be implied from all the circumstances under which the operation was undertaken—is in most cases to be decided as a question of fact by the jury rather than to be determined as a question of law by the court.

The most recent case involving this question which has come before the courts of this State was decided by the Appellate Division of the Supreme Court in Brooklyn at the February term in 1903. The plaintiff was the mother of a boy who had died under chloroform while submitting to an operation in a charitable hospital in this city. The mother contended that the boy was sent to the hospital merely to be examined and not for surgical treatment, and that the operation which was subsequently undertaken, and which resulted in his death, was performed without her consent or the consent of the maid whom she sent to the hospital with the lad. It did not appear, however, that the maid informed the surgeons at the hospital of any limitation upon her authority. She merely submitted the boy for their examination and, as they supposed, for treatment; whereupon, having ascertained that the lad was suffering from blood poisoning and that a simple operation was necessary, they proceeded to perform it, with the result already stated. It was insisted that they ought to have informed the maid of their intention to perform the operation; and in reference to this contention Mr. Justice Woodward said:

"Under the facts here disclosed the defendants had a right to assume that the boy was there for treatment; that his case was submitted for their judgment and action, and it would be contrary to law to hold that the fact that they did not disclose their intention of operating upon the boy, if this was a fact, to Agnes Evans (the maid who accompanied him), who does not appear to have suggested any limitation upon their right to treat the patient under their employment as alleged in the complaint, rendered them liable in an action of this character. We find no authority holding a contrary doctrine, and it would be holding the employees of a charitable hospital to a high degree of responsibility to say that they must notify the guardians of every patient brought to them for treatment before they can perform the simplest of surgical operations, under pain of being called upon to pay damages in the event of unexpected fatalities."

This judicial utterance, however, is found in a dissenting opinion, in which Presiding Justice Goodrich concurred. It did not receive the sanc-

tion of the three other members of the court, who voted for a reversal of the order of the trial court dismissing the complaint, and who must therefore have held that the surgeons were not authorized to operate without at least disclosing their intention to do so to the person who accompanied the patient, and thus giving her an opportunity to refuse to permit the operation.

Where the patient is a child, the consent which the law requires must be obtained from the parent, or from some person standing in the relation of parent or guardian to the patient. Where the patient is a married woman it has been held in some cases that the consent of the husband is necessary; but this proposition has been denied by the Supreme Court of Maryland in a leading case on the subject, in which the court said:

"Surely the law does not authorize the husband to say to his wife, 'You shall die of the cancer; you cannot be cured, and a surgical operation affording only temporary relief will result in useless expense.' The husband has no right to withhold from his wife the medical assistance which her case might require."

A simple and practicable method of avoiding all question in cases of the character which we have discussed is suggested by Dr. Burnside Foster in a communication to the *New York Medical Journal*, in which he says that it would probably be wise for the surgeon to provide himself with a blank form, which, when filled out, signed by the patient and properly witnessed, would give him authority to do whatever he believed it necessary and proper to do in each individual case.—*The Sun*.

The case here referred to in Brooklyn is one against a member of the Association, though begun before the defense proposition was in force. The Counsel of the Association, however, accepted the invitation of the attorney of record and the surgeon to assist at the second trial of the case. At this trial the question of technical assault was entirely eliminated by Justice Marean, who presided, for it appeared by the complaint that the defendant had been employed to treat the child, and the court held that evidence tending to show assault was no admissible. The question of care and skill employed was, however, submitted to the jury, who promptly brought in a verdict in the defendant's favor. The plaintiff has appealed chiefly upon alleged errors committed by the Justice in his charge to the jury.

The suggestion of Dr. Burnside is a very good one.

J. T. L.

UNAUTHORIZED OPERATION BY SURGEON.

The first authority on the question of a surgeon's liability for performing an unauthorized operation on a patient is, we think, the decision in *Pratt v. Davis* by the Appellate Court of Illinois, reported in 37 *Chicago Legal News*, 213. This was a case in which a woman went to a hospital or sanitarium for some slight operation and afterwards returned and submitted, as she supposed,

to another of the same character, being deliberately deceived by the surgeon in this respect, while his purpose, which he executed, was to perform a far more serious, and, as it was called, major operation, removing some of the organs of the body. This operation was, therefore, performed without her consent, and she was induced to submit by misrepresentation as to the doctor's intention. The doctor claimed that he did not deem her "worthy"—that is, he thought she was "unfit"—to be informed of his purpose, and that "her mental condition was such that it was impossible to take her into advisement on her own case." On this state of facts, suit was brought by her for damages, and the doctor's counsel insisted that he was justified in performing the operation for her good, and in failing to inform her of his purpose, because she was not in such a mental condition that she could be properly taken into consultation. Counsel put forth the broad proposition that "when a patient places herself in the care of a surgeon for treatment, without instructions or limitations upon his authority, she thereby in law consents that he may perform such operation as in his best judgment is proper and essential to her welfare," and that "the employment of a physician or surgeon gives him implied license to do whatever, in the exercise of his judgment, may be necessary." In contesting the judgment against the surgeon, counsel strenuously contended that it was unjust to mulct in damages one who can in no view of the case have been actuated by any purpose other than that of using his best efforts in a sincere desire to heal the afflicted.

The court held that the judgment was right; that, "except in cases where the consent of the patient is expressed, or is implied by circumstances and occasions other than a mere general retainer for medical examination and treatment, and except, also, where there is a superior authority which can legally and rightfully dispose of the person of the patient, and which gives consent, a surgeon has no right to violate the person of the patient by a serious major operation, or one removing an important part of the body." The court also said: "Under a free government, at least, the free citizen's first and greatest right, which underlies all others—the right to inviolability of his person—in other words, the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a surgeon or physician, however skilful or eminent, who has been asked to examine, diagnose, advise, and prescribe (which are at least necessary first steps in treatment and care) to violate, without permission, the bodily integrity of his patient by a major or capital operation, placing him under an anesthetic for that purpose, and operating on him without his consent or knowledge."

The justice of this decision seems too obvious for reasonable dispute. Unquestionably there are surgeons who assume the right to decide as to

the necessity of heroic operations and of executing them without the consent of their patients in some cases. But this is an arrogant assumption, which probably most members of the medical profession would discountenance. It comes a little short, indeed, of the claim made by some extremists in the profession that they ought to have the right to terminate the life of patients when, in their judgment, it would be better for the patients to die than to live. This assumption of the infallibility of the professional judgment in such matters is sadly out of harmony with the many astonishing recoveries of persons after recovery had been declared impossible by physicians. The claim of a right to exercise their own judgment in respect to operations is also given bad support by numerous blunders in operating under erroneous diagnosis.

Physicians have little love for the law generally, and loudly exclaim against what they think its injustice to them. But the extravagance and arrogance of such claims as that made by the defendant in this case, of a right to be protected by law in mutilating the bodies of other persons without consent of the victims, need no comment.

The court cites an English *nisi prius* decision in *Beatty v. Cullingworth*, 44 Cent. L. J. 153, which seems, however, to have turned, in the judge's charge to the jury, chiefly on the question of fact as to the consent of the patient to the extent to which the surgeon carried the operation. It seems to have no value as an authority. The decisions in *M'Clallen v. Adams*, 19 Pick. 333, 31 Am. Dec. 140, and *State use of Janney v. House-keeper*, 70 Md. 162, 2 L. R. A. 587, 14 Am. St. Rep. 340, 16 Atl. 382, are both referred to, but these were cases in which it was held that the consent of a wife to an operation upon herself was sufficient without any express consent of her husband.

The amount of damages recovered in this case was \$3,000. This was given as punitive or exemplary damages. Of course, in such a case the impossibility of proving the amount of actual damages makes such a recovery necessary if the patient is to have any real remedy, and, if any recovery was justifiable, \$3,000 can hardly be deemed excessive. The measure of damages may, however, be open to some question, as the primary question of the right to recover at all can hardly be.

The multiplicity of surgical operations in these days makes it of great importance to have a judicial decision on the question involved in this case.—*Case and Comment*, for March.

THE SECRET NOSTRUM VS. THE ETHICAL PROPRIETARY PREPARATION.*

For years the proprietary medicine question has been a perplexing problem for physicians, and as the articles of this class increase in number, the question becomes more vexed and more serious, and its solution more urgent. In taking up the

subject, it may be stated at the outset that there is no more serious objection to a proprietary medicine *per se* (*i. e.*, one protected by copyright or by a trademark) than to one that is protected by a patent; for example, one of the synthetic chemicals.¹

Technically, there is no difference between the proprietary medicines manufactured for physicians' use and the "patent medicines" exploited to the public, both being protected simply through copyright or trademark names. Yet the relation of the physician to these preparations is very different; about the latter he has little direct concern, save that he regrets that our laws permit the foisting on a suffering and unsuspecting public of preparations that are usually dangerous and always irrational. In the former he is directly and intensely interested, for they compose a part of the armamentarium which he is expected to use. On them he often has to depend, or at least does depend, consequently on them rest his success and the health, sometimes the lives, of those who place themselves in his care. In theory, they reflect the advance made in pharmaceutical science; in fact, if we take the greater number of them as our criterion, they discredit pharmaceutical science, for the character of this greater number is such that they are creditable neither to those who make them nor to those who use them.

At first, these preparations were introduced under pharmaceutical or descriptive names; they were of well-known composition, represented elegant preparations of standard formulæ, and were manufactured by pharmaceutical houses which took pride in their products. These preparations the physician welcomed as an advance in pharmacy, and he gladly specified in his prescriptions the name of the manufacturer whose product he desired.

Such were the original prescriptions for elixirs, syrups, pills, etc., of the manufacturing pharmacists. Some thirty years ago, however, there appeared, one by one, preparations bearing coined names, protected from imitation by copyright or trademark, with formulæ more or less mysterious and fictitious—in other words, secret. By making extravagant claims and by persistent exploitation in various ways, the manufacturers induced physicians to use them, and as they were usually the simplest kind of mixtures, requiring little, if any, machinery or skill in their compounding, and being composed of inexpensive drugs, the profits were large. Thus the field for commercial enterprise became an enticing one. The manufacturer might be an individual with no pharmaceutical knowledge and with his identity hidden under the anonymous name of some chemical company; thus, the better to impose on the credulous doctor, he combined the secrecy of his preparation with the mystery surrounding its manufacturer. With

¹It is acknowledged that the manufacturer should be protected when he has originated something of value to the public or to the profession. It is not acknowledged, however, that this protection should be unlimited, as is the case with the trademarked or copyright-named articles; a protection for a limited period, such as a patent gives, is just and fair, but an unlimited protection is not.

*Editorial from *A. M. A. Journal*.

their fancy therapeutic or disease-suggesting names and with extravagant claims regarding their therapeutic value, these medicines appealed to a certain class of doctors; they were convenient, palatable, and, at least, satisfactory placebos. Further, they saved the doctor the trouble of writing a full prescription. It was not long, however, after these preparations became popular with the physician before they became popular in the true sense. The fancy, catchy names which caught the physician caught the layman as well, and the latter, finding not only full directions for use, but the names of the diseases in which the remedies were indicated, naturally bought them in preference to the so-called "patent medicines," for were these remedies not endorsed by the "faculty," and had they not testimonials from "the most prominent physicians"? Thus the physician became the unpaid pedler of secret nostrums; thus he encouraged his patient to prescribe for himself, and thus, as the secret nostrum manufacturer became richer, the physician became poorer.

The Board of Trustees of the American Medical Association have authorized the creation of the Council on Pharmacy and Chemistry. The preliminary announcement has been sent to the manufacturing pharmacists of the country.

COUNCIL ON PHARMACY AND CHEMISTRY.

CHICAGO, February 28, 1905.

To the Manufacturing Pharmacists and Chemists of the United States and to Others Concerned:

As the culmination of plans which have been under consideration for the past two years, the Board of Trustees at a meeting held February 3, 1905, created by resolution an advisory board to be known as the Council on Pharmacy and Chemistry of the American Medical Association. The organization of the council was perfected at Pittsburg, Pa., February 11, 1905, and it herewith presents the following statement:

PRELIMINARY ANNOUNCEMENT.

It is the immediate purpose of the council to examine into the composition and the status of the various medicinal preparations which are offered to physicians, and which are not included in the United States Pharmacopœia, or in other standard text-books or formularies. These preparations will include the synthetic chemical compounds, as well as the so-called proprietaries and pharmaceutical specialties put out under trademarked names. Preparations which conform to the standard established by the ten rules governing the matter will be incorporated in "New and Non-Official Remedies," a book to be published by *The Journal of the American Medical Association*.

The general need of an accessible, authoritative work of reference of this character is obvious, for at present there is no such book to which the physician can refer. Its value will be proportional to its completeness. It is, therefore, proposed to be as liberal in approving articles for the book as is consistent with justice and equity to the public, to the manufacturing pharmacist and chemist and to the physician. The acceptance of articles will be determined by the appended rules, an examination of which will show that they are sufficiently liberal to permit the admission of all articles offered to the medical profession that are honestly made, ethically exploited and worthy of patronage by intelligent physicians.

The acceptance of an article will be based on a careful and unprejudiced examination of the accessible information from all sources, and in compliance with the adopted rules. An acceptance, however, is not to be interpreted as an indorsement, neither is omission from the list to

be construed, in every case, as condemning an article; it may mean that the necessary information has not been obtained. The council does not pass judgment on the therapeutic value; but on the ethical status only. The council does not presume to dictate what preparations should be prescribed; nor is it the present intention to conduct an active campaign against fraudulent products, but merely to *supply necessary and desirable information concerning those which it considers unobjectionable*.

The plan for the work is briefly as follows: All available information regarding a product will be secured from the manufacturer and from other sources. This information, together with specimens of the article, will be submitted to a committee of experts, who will examine critically into the product, consider the claims made for it, and make a report. On the basis of this report the council will accept, reject or hold for further consideration. If accepted, the information will be condensed and arranged somewhat on the plan of the United States Pharmacopœia, but with the addition of brief pharmacologic and therapeutic data. The council believes that there are many articles, at present not recognized by the Pharmacopœia, which comply with the required standard and do not need any further investigation. In this class come many of the synthetics as well as many well-known pharmaceutical specialties. These are now being written up, and it is proposed to issue the first edition of the book as soon as possible. No charge will be made for representation in the book.

As fast as new articles are accepted, all information regarding them will be published in *The Journal of the American Medical Association*, and will be incorporated in the next edition of the book.

The council appreciates the importance and difficulties of the work to be undertaken and does not expect to take a step forward without being sure that it is right and just to all concerned. It does not dare to hope for perfect results and can only promise to strive earnestly, honestly and impartially to avoid serious errors of commission and omission. It asks for the hearty cooperation and assistance of those it believes to be interested in the work—the entire medical profession and all honorable manufacturing pharmacists and chemists. Criticisms and suggestions will be welcome.

RULES GOVERNING THE ADMISSION OF ARTICLES.

The following rules are adopted to guide the Council on Pharmacy and Chemistry of the American Medical Association:

(The term "article" shall mean any drug, chemical or preparation used in the treatment of disease.)

RULE 1.—No article will be admitted unless its active medicinal ingredients and the amounts of such ingredients in a given quantity of the article be furnished for publication. (Sufficient information should be supplied to permit the council to verify the statements regarding the article and to determine its status from time to time.)

RULE 2.—No chemical compound will be admitted unless information be furnished regarding tests for identity, purity and strength, and, if a synthetic compound, the rational formula.

RULE 3.—No article that is advertised to the public will be admitted; but this rule will not apply to disinfectants, cosmetics, foods and mineral waters, except when advertised in an objectionable manner.

RULE 4.—No article will be admitted whose label, package or circular accompanying the package contains the names of diseases, in the treatment of which the article is indicated. The therapeutic indications, properties and doses may be stated. (This rule does not apply to vaccines and antitoxins nor to advertising in medical journals, nor to literature distributed solely to physicians.)

RULE 5.—No article will be admitted or retained about which the manufacturer, or his agents, make false or misleading statements regarding the country of origin, raw material from which made, method of collection or preparation.

RULE 6.—No article will be admitted or retained about whose therapeutic value the manufacturer, or

his agents, make unwarranted, exaggerated or misleading statements.

RULE 7.—Labels on articles containing "heroic" or "poisonous" substances should show the amounts of each of such ingredients in a given quantity of the product.

RULE 8.—Every article should have a name or title indicative of its chemical composition or pharmaceutical character, in addition to its trade name, when such trade name is not sufficiently descriptive.

RULE 9.—If the name of an article is registered, or the label copyrighted, the date of registration should be furnished the council.

RULE 10.—If the article is patented—either process or product—the number and date of such patent or patents should be furnished. If patented in other countries, the name of each country in which patent is held should be supplied, together with the name under which the article is there registered.

EXPLANATORY COMMENTS ON THE RULES.

Rule 1.—Certainly no one can object to this rule. The physician not only has the right to know, but it is his duty to know, the composition of medicine he prescribes for his patients. He may not be interested in the details of the method or of the process of manufacture of an article, but he should know what medicinal agents it contains, and the amounts represented in a given quantity of the article.

Only in exceptional instances is it necessary for the physician to know the solvent, vehicle or other diluent, or the particular flavoring agent which may have been employed. For this reason, while the council desires the formula and the details as to the method of preparation to be sufficiently complete to enable it to verify the correctness of the assertions made regarding an article, the description to be published will usually consist only of a statement of the amount of each medicinal agent or ingredient in a certain quantity—generally the ordinary dose—of the article, and in some instances the general character of the solvent or vehicle and flavors.

In preparations for external use the therapeutic efficiency is greatly influenced by the nature of the vehicle. Therefore, in such preparations, the character of the vehicle or base should be stated, so that it may be known whether the article is penetrative or simply protective.

Rule 2.—In order to avoid errors in the case of chemical compounds and to guard against adulterations, lack of potency or strength and mistaking one chemical for another, it is necessary to have at hand suitable identity tests. Where these facts have appeared in the literature, or in standard text-books, reference to them will be sufficient, but with new chemicals, especially synthetics, the manufacturer or his representatives will be required to supply such tests to the council, together with the rational or structural formula, in order that an intelligent opinion of these products may be obtained.

Rule 3.—While the correctness of the principle that physicians cannot be expected to favor any medicine which is exploited to the lay public will be readily conceded, this rule is to be modified in its application to articles not strictly medicinal.

Rule 4.—This rule may appear to some as radical, and yet on consideration it will be found just to the public, to the physician, to the manufacturing pharmacist and chemist, and also to the retail druggist. It must be remembered that it applies only to the package, and to the labels, circulars, etc., accompanying it. It does not in any way interfere with advertising, circulars, literature, etc., furnished to physicians. Experience has clearly shown, however, that it is not safe to enumerate on the package the diseases in which an article may be indicated, since this is also the means by which the laity, who are not competent to determine whether or not its employment is safe and proper, may be induced to continue its use or to recommend it to others quite regardless of the evident dangers of forming drug habits or of doing serious injury by employing a remedy that in reality may be contraindicated. It is the physician's prerogative to determine in what disease the article may be indicated, and he is not supposed to go to the drug store for his

knowledge regarding this. It is not the function of the pharmacist to recommend or to prescribe medicines, but only to be familiar with their pharmaceutical and chemical characters, strength and dosage and with the best forms of administration.

It is asserted that the naming of diseases on the label of the package is necessary, because many physicians will be unable to tell from the therapeutic properties alone in what disease a medicinal article may be indicated. This may be true with a certain class of doctors, but it is certainly not true with the vast majority of the educated, progressive physicians of America, and this is the class whose interests are concerned in this movement. There may be some exceptional articles, such as foods, digestants and mineral waters, in which the therapeutic properties alone may not sufficiently indicate the use, and in these cases, perhaps, reference may be made to certain symptoms; if such references appear they will be carefully considered. Antitoxins and vaccines come under this exemption. The council, however, is unanimously of the opinion that this method of exploiting the medical profession is one of the principal causes which have made the best physicians hesitate to prescribe any proprietary medicines, have led others into irrational therapeutics, have made pharmaceutical tyros believe that they could prescribe just as well as the physicians, and have been the means of causing scores of these medicines to be used for self-medication by the laity, to the detriment and sometimes to the serious and permanent injury of the person taking them. The physician would prefer that the manufacturer confine himself to furnishing the articles and reasonable information regarding their identity, quality, strength and pharmaceutical and chemical character, leaving the physician to indicate in what diseases they should be used.

It is believed that the application of this rule will most quickly determine what manufacturers would rather have the preference and favor of the vast majority of the medical profession and of the members of the American Medical Association than the doubtful support of a rapidly disappearing minority of practitioners.

Ample time will be given manufacturers to conform to this rule, and also to Rule 8, entailing changes in labels or in other printed matter.

Rule 5.—While this is a rare contingency, yet in the past many rank frauds of this nature have been perpetrated on the profession, and this rule will have a tendency to prevent such attempts in the future.

Rule 6.—As in the preceding instance, this rule will have the tendency to restrict manufacturers or agents in their claims as to the therapeutic superiority of their products, without interfering with any reasonable assertions, especially when such are confined to clinical data from responsible medical men.

Rule 7.—For the information of the pharmacist or dispenser, and to enable him to act as a safeguard to the patient and to the physician, all medicinal articles containing such potent agents as the poisonous alkaloids and other organic substances and the salts of some of the metals, should have the exact amount of these ingredients contained in the average adult dose stated on the label. A list of these potent substances will be prepared for more specific information.

Rule 8.—In order to prevent the confusion now existing with reference to many articles known only by more or less arbitrarily selected or coined, usually protected, names, it is necessary that every article which is intended solely for physicians' use or prescription be designated by a scientific title or by a name descriptive of its pharmaceutical character, and, as far as practicable, of its principal medicinal constituents. Synthetic chemical products should give the true chemical constitutional or structural name, in addition to the trade name. The application of this rule will enable physicians to use many of these articles which at present they are afraid to use because of uncertainty as to the identity—owing to the similarity in the names of many of these entirely different products—or prefer not to describe in order to avoid criticism and the danger of self-prescription by their patients. This provision will thus be of great benefit to

manufacturers of meritorious products, will relieve pharmacists of many trying situations in interpreting correctly the names of articles desired by physicians, and will protect both physicians and laity from the evils named.

The council will use reasonable discretion in enforcing this rule with reference to trade names of long-established articles.

Rules 9 and 10.—This information is desired to enable the council and others interested to determine the legal status of these articles and for ready reference through publication. Respectfully submitted,

ARTHUR R. CUSHNY, Ann Arbor.
 C. LEWIS DIEHL, Louisville.
 C. S. N. HALLBERG, Chicago.
 ROBERT A. HATCHER, New York.
 L. F. KEBLER, Washington.
 J. H. LONG, Chicago.
 F. G. NOVY, Ann Arbor.
 W. A. PUCKNER, Chicago.
 SAMUEL P. SADTLER, Philadelphia.
 J. O. SCHLOTTERBECK, Ann Arbor.
 GEO. H. SIMMONS, Chicago.
 TORALD SOLLMANN, Cleveland.
 JULIUS STIEGLITZ, Chicago.
 M. I. WILBERT, Philadelphia.
 H. W. WILEY, Washington.

Members of the Council on Pharmacy and Chemistry,
 American Medical Association.

SIDE TRIPS IN CONNECTION WITH THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The following letter has been received by a member of the Association from Dr. Kenneth J. Mackenzie, of Portland, Ore., chairman, Committee on Arrangements, of the American Medical Association:

"We are planning several trips at the present time, and we are contemplating giving the Association a nice trip on the Colorado River, to enable them to see the best part of the scenery. We may have also an excursion to Alaska and expect to be able to charter a steamer, which will leave at a convenient date following the meeting of the American Medical Association. The regular excursion rates are \$100 from Seattle or Tacoma and return. We have arranged a special rate of \$70 for our trip. The steamer will stop at southeastern Alaska points, including Ketchikan, Wrangel, Douglas Island, Treadwell, Juneau, Skagway and Sitka. This trip will consume about twelve days, and is the finest trip that we can offer, and it is one of the finest in the world. We have also made arrangements with the Pacific Mail Steamship Company, and they have placed at our disposal accommodations for fifty excursionists on the "Korea," which sails from San Francisco on July 22d. The rate from San Francisco to Honolulu and return will be \$110, from San Francisco to Yokohama and return will be \$240, from San Francisco to Hong Kong and return will be \$270, the regular rate to Hong Kong being \$347. We are also planning to give the members of the Association a side trip to the coast of Portland, which will enable them to see a Pacific Ocean seaside resort, with a run of 100 miles on the Columbia River by rail or boat. The meeting promises to be well attended and to be a most successful one."

A CONTRIBUTION TO THE TREATMENT OF TUBERCULAR ASCITES.

During the last three years the author employed the following method: He taps the abdomen with a medium-sized trocar and canula, evacuating as much ascitic fluid as will escape spontaneously and injects into the peritoneal cavity a sterile emulsion of iodoform and glycerine. He begins with $\frac{1}{2}$ cg. of a 1 per cent. emulsion and increases the strength and does with each subsequent injection, according to the nature of the case. The injections are repeated after intervals of four to eight days. So far he treated only seven female patients, the ages ranging from 2 to 19 years. After a period of three to ten weeks they were all considered cured. In two cases (children, 2 and 8 years old, respectively) the ascites failed to return after the second injection, in one, a girl of 19, five injections were necessary, in the others three to four. One patient had involvement of the left apex, but was nevertheless cured. The duration of treatment was from three to seven weeks. In none of them did the ascites return; in one case nine months have elapsed since treatment was discontinued and still no return. The diagnosis was confirmed by tuberculin injections. No complications were observed as the result of this treatment. In all of these patients medical treatment was tried without result. The author was formerly an advocate of laparotomy, and points out his reasons for choosing the above treatment. Puncture and injection is simple, almost painless and conservative. Anesthesia and its consequences are avoided; the puncture heals quickly and if repetition is necessary is seldom objected to. The results are to be ascribed to the action of the iodoform.—*Schömann, Zentralblatt für Chirurgie*, 1904, 1409.

ADVERTISING IN LAY DIRECTORY.

Many physicians of the old school in this city are discussing with much interest the departure on the part of men high in the profession from the code of ethics which prevented any respectable physician from advertising himself. The character of the men who are setting this old-established rule at naught is food for much thought for those who would not dream of violating it.

In this discussion attention is directed to a directory which recently has made its appearance. It is said canvassers for this publication have called on physicians, saying that any desired data would be printed for a payment of \$10. Some have taken advantage of this and beneath their names are found data which hitherto had not been given even in medical directories.—*Sun*.

Original Articles.

PROSTATECTOMY IN EMERGENCY CASES.¹

BY JOHN F. ERDMANN, M.D.,
New York.

THERE is no intention on my part to enter into the historical aspect of so thoroughly discussed a subject as the surgical procedures advocated in prostatectomy is at the present date, but to call attention to the advantages of doing a prostatectomy in every instance possible when the prostate is in part the cause of obstruction in cases coming under the head of emergency drainage of the bladder. I cite records of eight cases in this paper that belong distinctly to this class in which relatively six different emergency indications are dealt with. They are as follows:

I. Impassable urethra due to stricture with rupture and gangrene of the entire scrotum and perineum.

II. Retrograde hemorrhage, bladder being full of clots and bloody urine, with malignancy of the prostate.

III. False passage; retrograde hemorrhage; suprapubic aspiration with infiltration of the abdominal wall extending to the thorax and to the gluteal regions.

IV. Acute obstruction due to exposure to cold and wet, inability to catheterize; trauma of the urethra.

V. Trauma of the urethra; catheterization for several days, retrograde hemorrhage, etc.

VI. Deep stricture of the urethra; obstruction; catheterization; cystitis with absorption.

In each case cited above drainage alone by perineal or suprapubic section would have been the operative procedure in former years and in the hands of the ultra conservative I am quite satisfied is still advised. I am of the opinion that drainage by prostatectomy in these cases is the only method of procedure and have come to the conclusion that the perineal route is the one to be selected in practically every instance. Urethral section, *i. e.*, internal urethrotomy with a Bottini operation, is impracticable in all of these cases.

Suprapubic section can only be considered in those cases where the prostate is not removable due to extensive malignancy. Personally I would limit myself to the selection of the suprapubic route to cases of inoperable malignancy of this gland when obstruction to the urine outflow is complete or when the conditions of urinary decomposition, etc., are such as to demand operative relief. The type of perineal operation performed by me in each of these cases and in all ordinary or elective prostatectomies is that after the method of the late Dr. Bryson, and performed and advocated by Dr. Goodfellow, of San Francisco, a perpendicular incision in the raphe of the deep urethra upon a guide when possible, then

enucleating the gland by attacking it from the prostatic urethra. I never have seen the profound sepsis or symptoms of toxemia when the perineal type of operation was done as we see in suprapubic cases.

The patient is not compelled to assume the prone, or almost prone, position, but is ordered to sit up in bed as early as the second day, proper precautions being taken to prevent pinching or kinking of the tube, and is in the upright posture or out of bed, provided that bladder conditions permit of removal of the tube, on the third or fifth day. There is no question but that this posture and method of treatment are advantageous, providing not only for proper drainage, but also preventing hypostasis, a condition often seen in the feeble and aged when occupying the recumbent posture. As a secondary matter the patient is not lying constantly in wet dressings, risking early decubitus, etc. A much earlier flow of urine by the anterior urethra is insured by the posture, as a constant state of apposition of the buttocks is produced while the patient is sitting, thereby insuring a more rapid adhesion of the surfaces of the wound and repair of the incised floor of the urethra.

Of the eight cases reported in this paper, six have made recoveries. The two deaths, for argument from a statistical standpoint, should have no bearing upon the justifiability of the emergency operations, as can be seen by reading the histories, but they are included in this paper to show the type of cases one has occasionally to contend with.

Case I. Impassable urethra due to stricture with rupture of the urethra, gangrene of the entire scrotum and portion of the perineum, etc.

Unfortunately, an over-zealous house surgeon assumed responsibility in this case for two days before reporting the patient, although daily visits were made by myself to the wards.

David G., 62 years of age, admitted September 3d, with a history of having had difficulty in voiding his urine for eight days previous to admission, noticed considerable difficulty in passing his urine, then that the scrotum and tissues roundabout began to swell and continued doing so until the day of his admission. On this day it was observed that the scrotum and perineum were in a foul and gangrenous condition. The house surgeon made numerous free incisions, inserting gauze drain. The cause not having been understood by him, no attempt was made to give free exit to the urine. When seen by me September 5th, owing to the complete destruction of a portion of the bulbous and deep urethra, no instruments could be passed. A filiform was finally made to pass into the bladder and a perineal section then done upon this as a guide. The prostate was found enormously enlarged and was readily removed, tube inserted, bladder irrigated. The patient, in addition to having the gangrenous condition mentioned, was also suffering from

¹Read before The New York State Medical Association, at the Twenty-first Annual Meeting, New York, October 17-19, 1904.

a delirium, which we were lead to believe was due to alcohol, as some of his friends stated that he had been rather a hard drinker. The condition of delirium deepened, the patient dying upon the 9th of September, four days after the operation. The sloughing area did not extend after the operation.

It will readily be understood that in this case, although from a statistical standpoint it must be included in the mortality rate of prostatectomies, that the conditions were such that death would have followed without question had a simple perineal section been done, as the prostatectomy did not take more than six minutes and the hemorrhage not being of any extent whatever.

Case II. Retrograde hemorrhage filling the bladder with clot and bloody urine.

Patient 71 years of age; seen by me on September 16th. Had been a sufferer from frequent urination for ten years, arising at night two or three times and voiding quite frequently during the day. For several weeks before he had had a diarrhea, which was finally controlled by quinine, he having given a distinct malarial history. Ten days before being seen by me he had a slight hemorrhage from the urethra. This latter portion of his history was obtained three weeks after the operation. The day before being seen by me he had a complete obstruction, for which he was readily catheterized by his physician. Again on the following morning it was necessary to catheterize him. As a result of these two catheterizations, a very large amount of bloody urine was passed, and accompanied by straining and expelling of clots and blood by the urethra. When seen by the family physician on the 16th ordinary catheters could not be introduced. When seen by me prostatic catheters passed without any difficulty, but no urinary outflow followed. The bladder was found to extend fully five inches above the pubis, rather firm and painful to sense of touch. Diagnosis of a retrograde hemorrhage, with in all probability clot filling the bladder, was made. Irrigations were made washing away blood clot and some bloody urine. Operation was advised, and was done at 8 o'clock that evening.

At the time I opened the bladder no difficulty was met with in introducing an instrument. Perineal section was done, with practically no hemorrhage. A large quantity of clot was extruded; a dull uterine curette was then used to evacuate a still greater quantity of clot. The bladder was irrigated and the prostate removed. Upon examination at the patient's house, the prostate was found to be as large as an orange, hard, stony in character with evidence of invasion of the sides of the pelvis. A tentative diagnosis of malignancy was made at that time.

At the time of the operation it was found that the prostate, although invading the tissues pretty thoroughly, could be removed. Feeling that the

patient's condition demanded free outflow of urine, we decided upon its removal.

Upon opening the capsule of the prostate a very vigorous hemorrhage took place; in fact, so profound that for a time it was felt that no further interference should be made. By packing for two or three minutes though and continuing the enucleation from above and then removing the packing, the hemorrhage was found to be controlled; in fact, after the first three minutes there was no further hemorrhage worthy of mention. The prostate by microscopic examination was proved to be carcinomatous. The tube in this case was removed upon the fourth day, the patient sitting up each day following through a period of one-half to two hours. October 12th patient is up and about daily improving rapidly.

Case III. False passage, retrograde hemorrhage, suprapubic aspiration with extravasation of urine into the space of Retzius, also in the abdominal wall up to the costal arch, upon the back down to the gluteal region, complicated by delirium tremens.

Patient 65 years of age, hard drinker, occupation outside man, suffering from delirium tremens. Was seen by the family physician two days before calling me, at which time he was unable to catheterize the patient, so aspirated him with a trocar and canula, entering about five inches above the symphysis. When I saw the patient his condition was one demanding an immediate drainage of the bladder. Owing to the suprapubic extravasation, I deemed it advisable to recommend free incisions of the abdominal wall, also of the dorsum and gluteal regions to open the space of Retzius and to drain the bladder by means of the perineum. This latter step seemed to me to be advisable owing to the conditions of delirium from which the patient was suffering. In other words that drainage by the perineal route could be better taken care of with the patient in this condition than drainage by the suprapubic. This was done three hours after being seen by me; the prostate, readily palpable, was removed within six minutes; five large incisions were made upon the abdominal wall, the medium one of which entered the space of Retzius, the others simply going down to the aponeurosis of the external oblique, while posteriorly several incisions were made through the cellular tissues. The hemorrhage was slight from these wounds, while the elimination of urine was considerable. A tube was introduced into the bladder and gauze packed in the abdominal and dorsal incisions. The condition of delirium which was exceptionally great before the operation was progressive afterwards, the patient dying within two days.

This was the second case of death, and also from a statistical standpoint increased the mortality rate, but from the moribund condition of the patient previous to the operation should not

be included under the head of death due to prostatectomy, as here again we have a case which, without question, would have terminated fatally with a simple perineal or suprapubic section.

Case IV. Acute obstruction due to exposure to cold and wet, inability to catheterize, trauma to the urethra.

Patient 67 years of age, laborer by occupation, constantly exposed to the changes of the weather, became wet and chilled as a result of his occupation, and could not void his urine as a result, this being the first manifestation of any bladder trouble whatever. When seen by his family physician and another in consultation, both found it absolutely impossible to catheterize. As a result of the efforts, trauma was induced and bloody urine overflow followed. On examination the prostate was found somewhat enlarged, chiefly involving the left lobe, the bladder extending within two inches of the umbilicus. The patient was prepared for operation by the family physician. When under the anesthetic an instrument passed into the bladder without difficulty. Some bloody urine withdrawn, perineal section made, prostate removed, tube introduced, bladder irrigated, tube removed on the second day, patient made a recovery.

Case V. Trauma by catheter. Catheterization for three days. Large prostatic obstruction, retrograde hemorrhage.

Patient 74 years of age. History of relatively little or no bladder trouble. Sudden onset; first attempt at catheterization readily accomplished by the family physician, but followed by some blood; second attempt at catheterization obstructed evidently by spasm of the urethra, passing some amount of bloody urine; patient suffering now from overflow. When called to see him, found to have an overflow of bloody urine. Catheterization readily accomplished. Suggested operation; interference refused. Catheterization continued by the family physician for three days; obstruction at the end of the third day was well marked with inability to catheterize by the family physician. Operation accepted.

Patient large, well-preserved person for his age. Prostate size of an egg; perineal section made, prostate removed within a few minutes, fair amount of hemorrhage, tube introduced, bladder irrigated, tube removed on the fourth day and patient sitting up. Discharged from the hospital on the tenth day. Perfect recovery.

It was observed while doing the prostatectomy that a false passage had been made between the rectum and the neck of the bladder of an extent sufficient to introduce a large English walnut. This in all probability accounted to a degree for the moderate amount of hemorrhage at the time of the removal of the gland.

Case VI. Deep stricture of urethra, obstruction, catheterization, cystitis with pronounced absorption.

This case demanded drainage and washing due to infection. Patient's age 68; admitted on March 4th; history of having been catheterized, etc. For two days before admission he could not urinate; was catheterized by his family physician. For thirty-six hours previous to his admission to the hospital no urine was removed or passed. Bladder was aspirated suprapubic on date of admission. On the 6th the patient presented symptoms of absorption. Rectal examination showed that the patient had quite a large prostate. Suggestions were made to him that it would be to his interest to have his prostate removed at the same time that his bladder was drained. This was accepted. A filiform guide was passed into the bladder, perineal section done, through which the prostate was removed. Patient sitting up in bed the third day, although his tube, owing to the condition of the bladder was retained until a week later. He was finally discharged from the hospital cured within about eight weeks.

Cases VII and VIII were obstructions with slight trauma to the urethra, in which it was advisable to operate for reasons both of trauma and for drainage.

Case VII was a patient 65 years of age; admitted the 18th day of August. Conditions were such that a perineal drainage was demanded. Prostate found enlarged and removal advised at the same sitting; accepted. Patient made a recovery.

Case VIII was a patient of 68 years of age with obstruction, cystitis, impassable urethra, perineal section done without guide. Prostate removed at same sitting. Patient recovered.

The emergency operative procedure is recommended because:

A. Only a few minutes more are required to remove the gland; that the hemorrhage as a rule is not excessive, and that the operative procedure itself does not increase the shock to any degree.

B. The removal of the prostate gives proper exit to the urinary outflow and admits of easy drainage.

C. Washing the bladder is much facilitated.

We recommend the perineal route in emergency operations because:

A. The opening is practically at the lowest point of the bladder and complicated devices for drainage such as are necessary in suprapubic sections are not required.

B. The old, being irritable and feeble, requiring to be moved frequently, the drainage in the suprapubic method is constantly interfered with, while in the perineal method it is readily controlled.

C. The after soiling when the tube is removed is slight and easily controlled in the perineal method as compared with the suprapubic.

D. Bladder irrigations are more readily done with less soiling to the bed, etc., in this method, etc., etc.

PROSTATIC HYPERTROPHY.¹

BY WILLIAM B. JONES, M.D.,
Rochester, N. Y.

DEVELOPMENT of the treatment of almost every disease is interesting. Like all human progress it is first uncertain, but pioneers try the results of their imagination and reason, retain what proves good, then, with added knowledge, draw new conclusions, invent new methods and so finally get to understand the problem and control the situation. So has been the subject of prostatic hypertrophy, although the changes have come so rapidly that the later method has sometimes reached one before the earlier, and confused him about which is better. Its principles are now so well established that they are fundamental and not likely ever to be changed, and the methods of applying those principles are uniformly successful. I will not say that the methods cannot be improved. Progress stops when that is attained, but when the physical basis of the processes of nature, normal or diseased, becomes known that knowledge is final. The processes of this condition and its recovery are known and the principles of its treatment are established for all time.

Permit me to digress and mention the wealth of information about the course of various diseases that we obtain only in the operating room. The demonstrations are in models better than clay and colored wax, and in all stages. After a number of operations, the surgeon has a mental picture complete. He has read all the chapters of an intensely interesting serial story. Unless you operate or stand at the elbow of an operator, you only know of the disease what you can surmise from its external manifestations, its symptoms. Do I need to remind you that they are unreliable reporters of what is occurring within? With only symptoms to depend upon we are often uncertain in diagnosis and sometimes wrong even in those diseases best understood. Before surgery was applied to pelvic inflammation the whole medical world was wrong about what it is. There were learned discussions about the treatment of parametritis and cellulitis, but when they began to operate for ovarian tumors they got a chance to study pelvic diseases and learned that almost always pelvic abscess was a pus tube in its origin, and they learned how to treat those patients. Ectopic gestation was misunderstood and wretchedly neglected until its true nature and progress were discovered by the investigation of operators who saw it in all its stages. Now we seldom hear of a death because physicians are intelligent regarding it. They know its fatal tendency and how to prevent it. There are still a few who will not inform themselves by this best of methods of study, the few whose unfortunate results are the exception to the successes of intelligent management and the proof of the better

way. The opportunity to study abdominal diseases in the same way has radically changed the death-rate. One might cite the whole list of them. In the treatment of appendicitis it has allowed us to abandon the old questions of typhlitis, perityphlitis, presence of abscess, formation of adhesions, development of gangrene, suppuration, occurrence of rupture and all those other stumbling blocks that have cost so many lives, and to offer certain cure of every patient, as certain as anything can be in ordinary human affairs. I would like to carry the assertion to greater length, but it is not part of this subject.

As a result of experience in the surgical amphitheater on the living model we have learned that the important part of prostatic hypertrophy is not prostatic hypertrophy directly at all, but its secondary effects, and that these are not due to the size of the gland, and we may disregard the enlargement entirely if the patient's condition otherwise can be properly healed; also conversely that one having a prostate normal in size may urgently need its removal, that that will cure and nothing else will. I will explain later. The prostate lies against the neck of the bladder and the urethra passes through near the upper surface. I speak as if the patient lay on his back. There are openings in the floor of the prostatic urethra, the mouths of the prostatic ducts, through which the prostatic secretion is discharged, and near them also the openings of the ejaculatory ducts. These are all very near the median line, and it is possible to avoid injuring any of them during prostatectomy and to preserve the functions of all. The muscle fibers of the bladder are many and strong at its neck and have a two-fold action. They are a sphincter and normally competent. If they are intact there is no incontinence whatever the condition of the urethra. Also they collapse the bladder and gather it up against the outlet, thus helping to empty it, and if they are not injured there is no retention. There is only a little prostatic tissue above and that very seldom needs consideration, but the gland encircles the urethra so that it may compress it by increase in bulk; general enlargement may lengthen the canal and make it tortuous; a nodule may form where it may press hard enough to close it without hypertrophy of the gland as a whole, or higher up, may project into its inlet and obstruct it like a cork inside a bottle. Most of the prostate is underneath the neck of the bladder, and if it grows larger it bulges into the bladder and leaves below and behind a depression that cannot be raised to the outlet to be emptied. It sometimes holds nearly a quart. A prostate that is enlarged protrudes upward because it is firmly supported underneath by the pelvic fascia, which in men is especially strong.

The tissues of the prostate are mainly musculo-fibrous and glandular, which explains its tendency when hypertrophied to form nodules and irregularly shaped masses. In its glandular structure it

¹Read at the Annual Meeting of the Elmira Academy of Medicine, Elmira, January 4, 1905.

somewhat resembles the tonsils and is subject to similar acute and chronic inflammations, with or without suppuration. In its muscular and fibrous structure it resembles the uterus. The organs are not analogous, but similarity of tissue makes an hypertrophied prostate strikingly resemble the uterus with multiple fibroids. There is the same irregular enlargement with multiple nodules all through the mass, and often some are prominent on the surface. The more fibrous tissue, the harder it is; the more muscular and glandular elements, the softer. A small prostate may cause extreme symptoms, and a very large one none. It all depends upon where it obtrudes and intrudes.

Now we can understand how the harm comes from prostatic hypertrophy. In a case typical of general enlargement the bladder floor behind and near the vesical outlet is pushed upward. For a while the muscles contract enough to empty the organ and nothing happens. The projection increases, greater effort is required, bladder muscle hypertrophies and still accomplishes evacuation, but with difficulty and hesitation. A little more increase of the obstruction and it can no longer be overcome. After this there is always a pool of urine at the base of the bladder. From constant distention follow relaxation and weakness of the tissues. Catheter life begins soon. Exposure to cold or wet, unusual fatigue, or depression following dissipation brings on sudden congestion of the pelvic veins, the prostate is swollen and voluntary micuration is impossible. This is temporary, and after a while the catheter can be dispensed with or perhaps it is only needed once, but these attacks gradually become more frequent until the condition is almost or quite continuous. When you give your patient the catheter it is his warning to prepare for death. Some cannot learn its proper care and soon begin to suffer; others are teachable and careful and postpone the inevitable, but there are few who live catheter life long, and there is great misery in store for almost every one. Even with greatest care of the instrument cystitis begins after a while because the abnormal condition of the bladder lessens the natural vitality. Inflammation frequently comes to these people without the use of any instrument, and I never saw one in consultation who did not have it chronic or acute. Cystitis with obstruction means that the bladder always contains urine, mucus and pus in varying quantities and condition, at times not very foul, at others vile beyond description, and there is also exfoliation of epithelium, absorption of these and general septicemia. This with pain, the torment of vesical spasm and urethral irritability, loss of sleep and appetite, increasing anemia and feebleness, make up the latter stages of this most wretched complaint. If a man still lives the infection continues up the ureters into the kidneys and they also become profoundly septic. Uremia is then added

and is merciful, for it benumbs sensibilities and shortens life.

Of course, a man who comes for relief should obtain it medically, if possible. He should always be warmly clothed and avoid getting chilled or wet. He should not be exposed to severe storms or become over-tired and should not use alcoholic stimulants. If the residual urine is more than four ounces, he should use a catheter twice a day. If retention occurs, one should be used before the patient is distressed, and if there is a large amount, part of it should be left in the bladder for a few hours. His diet should be plain and wholesome. He should have plenty of sleep and keep regular hours. If the urine becomes irritating or abnormal in any way appropriate medicines should be administered. It will seldom be acid, but if it is sodium phosphate or bicarbonate in large doses will correct it. If alkaline, mineral acids and benzoate of sodium will be useful; if decomposed, whether acid or alkaline, urotropin or cystogen should be added to the other remedies. He should be kept quiet, but not confined to bed. Surgery is not to be considered if other remedies keep the patient symptomatically well, but it should be advised as soon as they fail to do so. This is the answer to the question, "When to operate." Unless operation is resorted to as soon as medical treatment fails to give relief, the patient will have suffered to an extent that will lessen his chances of cure. When with all that can be done there is residual urine constantly present, or difficult urination, or occasional need of a catheter, there should be an operation. Castration and vasectomy seemed at one time to be of some use, but the successes were so few and the failures so many that they are not worth trying. The prostate itself must be attacked.

There are three ways of doing this with various modifications and combinations, viz.: cauterizing grooves through it on the bladder surface through which the urine may escape into the urethra; removal of the gland through a suprapubic cystotomy, and removal by perineal section.

Cauterization is not removal of the abnormal gland, and its incompleteness renders it unscientific. It is work in the dark with severe measures and with instruments that are unreliable. There is danger of uncontrollable hemorrhage, of disarrangement of the instrument to such an extent that it can only be removed by an operation for that purpose, of shock, embolism and secondary septicemia. The mortality is too high to be satisfactory, and there is no certainty of cure in any case, quite a proportion having been operated upon two or three times. It does great violence to the muscles at the neck of the bladder.

Removal through a suprapubic cystotomy is a radical cure, but it is the most serious of all the operations under discussion, death occurring most often from hemorrhage and septicemia. In-

fection may occur at two places, the cystotomy wound and the cavity from which the prostate is removed. The latter is a dependent cup in wounded tissues, the most favorable condition for absorption and suppuration. It becomes a cesspool of decomposing urine, blood and tissue shreds, foul and filthy. A catheter left in situ does not drain this cavity, because it lies below the catheter, and it is often necessary to provide drainage by an incision through the perineum. It is much farther away from the abdominal surface than it is from the perineal. It may undermine the urethra, which is in danger on this account.

The cautery has been used through a suprapubic cystotomy, protecting the remaining tissues with a cylindrical speculum, but the intention here is to remove most of the gland in this way, which is quite different from cutting grooves through it as in the former operation. It is open to all the objections of suprapubic operations. The only advantages claimed for it are that there is less hemorrhage and that the charred surface does not absorb sepsis. I think the first of these is true to a limited extent, but the second is not. There is no condition of the bladder more foul than one containing a slough that is decomposing and loosening up and there is no wound more septic than a burn after the slough has separated. Cautery has also been applied through perineal section, both with the idea of burning grooves in the gland, as in the Bottini operation, and with that of removing most of the gland.

The remaining type of operation is perineal prostatectomy. It consists in making a perineal section to gain access to the prostate, and after opening its capsule shelling it out, using the fingers to dislodge it. It is what any one would naturally think of as the simplest and most reasonable procedure, and would have been the chosen method from the first if it were not so difficult to accomplish without counter-pressure to hold the gland within reach, for its range of motion is great enough, especially after perineal section, to allow it to get entirely away from the operating finger. It can be steadied and depressed by two fingers introduced through a suprapubic incision either into the bladder or into the prevesical space. This double operation can be well done, but the death-rate is altogether too high. The upper wound often becomes septic, and septicemia is the most frequent cause of death. Counter-pressure is perfectly secured by the rubber bulb invented by Dr. Parker Syms, introduced collapsed through an opening made into the membranous urethra, and when within the bladder distended with water. The tube leading to it is then clamped and used as a tractor. Moderate force brings the prostate within an inch or less of the skin, and the rest of the operation is easy. When finished a tube is to be left in for drainage and the whole cavity packed with gauze.

After treatment consists of ordinary cleanliness and nothing else. It is not necessary to remove all of every prostate, but only to restore normal relation of parts, and it is well to avoid injuring the parts along and beneath the floor of the prostate urethra, and the neck of the bladder with its double acting muscle. Dr. Hugh Young especially recognized this and found that it is easy to do if you make two longitudinal incisions deep into the prostate, each far enough to one side of the median line to leave between them about one-half inch of tissue undisturbed. The enucleation is outward from these incisions toward either side. If the bladder wall is torn or if pressure of the retractor is hard enough to bruise and cause subsequent sloughing, there may be permanent urinary fistula. It can be avoided. If the rectum be torn there may be a permanent rectal fistula, but that also can be avoided, although the prostate is in contact with the rectum.

There is no mortality to this operation among men ordinarily strong, but there are a few deaths of those who, from long retention, pain and cystitis, have become weak and anemic. Anemia and premature decrepitude are characteristic of these people. Indeed, the advanced cases are near death anyway, and without operation certain ones would live only a short time. If all are operated upon, those certain ones and a few more will succumb not to hemorrhage, inflammation or septicemia, but from asthenia alone, just as people die of old age. If the operator excludes those with one foot in the grave, all cases will recover. And yet I have no more satisfactory result than in the case of one man who had been refused by an excellent surgeon only because he was too feeble.

It is my custom to advise operation confidently to all who are in poor condition or anything better than that, and to those who are almost or quite bedridden I would decline if they can be made comfortable or nearly so. As a matter of fact, every one I have yet seen in that extreme condition suffered terribly day and night, so that they have pleaded for something to be done at all hazard, welcoming death to relieve them if cure was impossible. I have operated on every case presented to me but one, and nearly every one recovered. While the best time to cure a man is before complications have arisen, yet if inflammation has invaded the prostate, bladder, ureters, or kidneys the case is urgent, and still more so if their contents are decomposing and of disgusting odor with great pain. Drainage is then imperatively demanded. The one best remedy is drainage of the filth to give the tissues a chance to resume healthy repair, and the only adequate drainage is by perineal section. That is the best remedy in the world for cystitis. Do it before the infection ascends to the kidneys. Prevent suppurative nephritis. Those who have become so feeble that they cannot undergo even a ten-minute operation for prostatectomy can have peritoneal section and drainage. It will quickly cure the cystitis, im-

mediately stop the suffering of tenesmus, permit sleep and nourishment, secure comfort at least, and usually will enable the patient to become strong enough for prostatectomy, but often that will not be necessary. Section and drainage can be done in three minutes, under primary anesthesia, on a man 80 years old, or 90, or 100. Had I selected this measure for all my cases that were considered too old and feeble for any operation I would have had no mortality, and I would just as surely have relieved the great suffering which was the justification and imperative indication for the unusual risk taken by some.

I have been surprised at the number of people sent me with other genito-urinary diseases. That is not my specialty, and before I became interested in prostatic surgery I did not know there were so many. Stricture is common, ulceration in the deep urethra without stricture is not rare. Calculus, prostatic, vesical, ureteral and renal, have all come my way. I have treated abscess of the prostate, and others deep in the perineum, but external to the prostate; vesical ulcers, both tuberculous and otherwise; cancer and other tumors of all these organs. Of these conditions I will only say that diagnosis of all of them has been made certain by modern methods. We can see every part of the surface of the urethra and bladder and their contents brilliantly illumined by the electric urethroscope and cystoscope; we can recognize calculi and some tumors there, in the ureter and the kidney by use of X-rays, and we can by ureteral catheterization discover stricture of the ureter and collect separately the urine from each, to determine whether one kidney is diseased or both.

Perineal prostatectomy permits treatment at the same time of all these complications that are within and below the bladder, and no other operation does. That alone is a strong argument, because so many prostatic cases have also one or more of them.

When one has to decide what to do about a case of prostatic hypertrophy it should depend upon the results of treatment, regardless of anything else. Every patient has been satisfied, grateful and enthusiastic in his gratitude. The few who have died have suffered so they were glad of the relief and their friends were for them. Some of the others are writing to me every little while just to tell how well they are, and they are sending others afflicted as they had been. No others remember me so long and with such warm regard as these old men.

“The general practitioner is progressive and a necessity; the specialist the same. Wherever and whenever the general practitioner has the greatest respect for the specialist, and at the same time and in the same place the specialist has the greatest respect for the general practitioner, there and then the profession will be the most progressive and prosperous and the public the best served.”—*N. Y. Med. Jour.*

THE ALEXANDER OPERATION.¹

Its Results, Immediate and Remote.

BY JAMES E. KING, M.D.,
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MY object, or perhaps better my apology, for asking your attention to the much-discussed Alexander operation, is not that I have a new technique to offer, but to consider a few of the clinical features which are the results, immediate or remote, of the operation. The operation has been much criticized, favorably and unfavorably, but the results of the discussion and the experience of many operators, whose cases number in the hundreds, has been to place the operation upon a firm foundation in gynecology. Successful results are only possible when the indication for it is carefully observed. It is agreed by all that this should never be undertaken in the presence of any complicating condition of the uterus or annexa unless such condition may be treated satisfactorily at the same time. This reduces, then, the indications to very simple terms, namely, simple uncomplicated retroversion which implies a most careful diagnosis. We do not expect an Alexander operation to relieve symptoms with complicating disease of uterus or annexa, and it is therefore unfair to condemn the operation when done under such circumstances. In the correction of retroversion we are dealing with tissue which is in no sense pathologic, and the operation aims at a mechanical result. The correction of the retroversion is usually permanent. Cases of relapse may often be traced to suppuration or to the presence of unusually small ligaments. The latter failure should not be charged to the operation, but to the unfortunate choice of the operation in those particular cases.

Granting that relapse may occasionally occur, it is rather from the patient's viewpoint than from the mechanical results that the few clinical features will be discussed. It is unfortunate that the surgeon and patient cannot agree always as to the successful result in operations.

One of the unpleasant sequelæ of the operation is pain—pain in the wound usually unilateral extending up in the abdominal wall about three inches. It is sometimes quite severe, and is intensified by pressure or walking. It may come on directly following the operation or it may be delayed for a few days. It often remains four or five months, gradually improving until ultimately it entirely disappears. Where it is severe the patient may be unable to wear her corset, but fortunately it disappears entirely after a longer or shorter period.

The cause of this pain seems to be injury to the ilioinguinal nerve. The nerve, as it passes through the inguinal canal from the abdominal muscles to its cutaneous distribution, lies in very

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intimate relation to the round ligament. It may be injured in its separation from the cord, or in pulling the ligament out, and finally it may be sewed in with the fascia when the canal is closed. It is also often seen in the wounds that have suppurated, the nerve doubtless being held in the resulting scar tissue. Great care ought to be observed in avoiding any further handling of the nerve than is necessary for its separation from the ligament, and in closing the canal the nerve should be carefully placed and not sewed in with the fascia. To the patient the pain is often very troublesome and unpleasant, and unfortunately there is little that can be done for its relief.

Another result which is sometimes seen, and which is far from satisfactory to the patient or surgeon, is the failure of the corrected retroversion to relieve all the symptoms. The fundus may be well forward and held so, but the patient is conscious of a feeling of dragging and weight in the pelvis. Most all cases of retroversion are accompanied by some relaxation of the utero-sacral ligaments and consequent descent of the uterus, depending upon the amount of relaxation, and the condition of the pelvic floor. In some cases the symptoms seem largely to be due to the condition of these utero-sacral ligaments. Two cases of my own will best illustrate:

Mrs. B., age 27, married five years. Three years ago labor was induced at seven months for dangerous kidney symptoms; eighteen months later became again pregnant, but aborted at four months, the fetus giving the appearance of having been dead about ten days. When I saw patient she gave symptoms of retroversion and history indicating its existence for some time before marriage. Examination showed a freely movable displaced uterus; no prolapsed ovary could be felt, nor was there evidence of uterine or annexal disease. The utero-sacral ligaments were much relaxed, allowing descent of uterus. Examination at time of operation verified previous findings. The Alexander operation was done, the ligaments being found of good size. Following the operation a pessary was worn for three months, during which time the patient was quite free from unpleasant pelvic symptoms. A short time after removal of the pessary, symptoms of weight and dragging in pelvis were complained of. Examination showed fundus of uterus well forward and normal in size; ovaries apparently in position. There was, however, still marked relaxation of utero-sacral ligaments and descent of cervix. A pessary was again placed with the relief of symptoms. Removal of the pessary was each time soon followed by recurrence of symptoms, so that for one and one-half years the pessary has been necessary for the patient's comfort.

The second case is Miss M., age 22. She gave the usual history of retroversion and dysmenorrhea of four years' standing. Examination finds a freely movable retroverted uterus, no annexal

disease, but marked relaxation of utero-sacral ligaments. Examination under ether at the time of operation gave same results. Alexander's operation was done, and a pessary worn for two months following operation. Three weeks after its removal patient returned complaining of backache with dragging and weight in the pelvis. Fundus of uterus was found well forward, but cervix low due to the relaxation of utero-sacral ligaments. Pessary fitted with complete relief. For six months now she has worn the pessary, and has no complaint.

These two cases may be regarded as a type of the "successful operation" that does not cure the patient. That the symptoms in both cases were due to the relaxation of utero-sacral ligaments seems conclusive, inasmuch as refitting pessary afforded relief. Such a sequence does not, however, always follow in the presence of relaxation of these ligaments, for in many cases in which there is marked descent the symptoms are completely relieved by the operation alone. It is simply a difficulty which results from the lack of uniformity in the symptoms produced by the same condition in different individuals.

The appearance of hernia following the operation is sometimes seen. Many cases have been collected. Faulty technique and suppuration are in nine cases out of ten responsible for it. The same care should be observed in sewing up the canal as in the radical operation for the cure of hernia. When so done hernia must be a rare sequelæ; suppuration should never occur. One's technique in sewing up the canals and treatment of the ligaments must be modified somewhat by the size of the cord and extent to which the canal has been opened.

The operation is admitted to have no influence upon pregnancy or labor, and, so far as my experience goes, pregnancy and labor do not cause recurrence of the displacement. I have confined five women in labors occurring a variable length of time following the operation. In two cases the operations were performed by other operators; three cases were my own. Four of the five cases I have been able to observe after the puerperium. In each case a pessary was fitted as a precautionary measure, and worn for two months during the period of complete involution. In none of these cases has there been any return of the displacement. One patient, during the early weeks of pregnancy, complained of "pulling" at site of wounds, which was relieved by support until the uterus became large enough to rise out of the pelvis.

To gather statistics to determine what percentage of recurrence follows the Alexander operations is rather uncertain in its results. In hospital work it is impossible to follow many of the cases we operate upon, but I believe that recurrence should be very rare, if the technique of the operation is varied according to what in the judgment of the surgeon seems to be the requirements

of the case, as determined by the size of the ligaments.

When all is said and done, it must be admitted that the Alexander operation has a prominent place in the treatment of uncomplicated retroversion, and reference to our case-book will bear evidence of many patients who may say with the surgeon that the operation is a "perfect success."

HOW AND WHEN TO USE ANTITOXIN IN DIPHTHERIA.¹

BY CHARLES GILMORE KERLEY, M.D.,
New York.

THE short paper which I will read this afternoon was written in the hope that it might be of service in removing from the minds of many physicians the fear that still prevails relating to the use of antitoxin in diphtheria. At the same time I desire to call attention to certain points bearing on the administration of antitoxin that are not appreciated as fully as they should be. It is my experience in consultation work that it is the exception when antitoxin was given as early as was possible, or that it was given in sufficiently large dosage, or that it had been repeated at as short intervals as the best interests of the case required.

When to Use Antitoxin.—It should be used in every case of acute illness in which there is pseudo-membrane present in the patient's throat or nose. When there is doubt in the mind of the physician as to whether the exudation is diphtheritic or not, give the antitoxin and take a culture. An error frequently made is to wait for the report on the culture, or to wait for positive clinical signs. By the time a diagnosis is clinically beyond doubt, or by the time a report is received from the laboratory, the disease may have gained great headway. In not a few instances I have known such delay to be fatal to the patient. The earlier the antitoxin is given, the less will be the amount that a given case will require.

Sixty-six cases of diphtheria comprise the number which I have treated with antitoxin in private work; the ages of the patients ranged from 9 months to 10 years:

Fifty were non-operative cases.

Sixteen were operative (intubation) cases.

There were fourteen non-operative first-day injection cases.

In thirteen of these one injection was sufficient. In one only was it necessary to repeat the serum on the second day of the illness.

Non-operative second-day injection cases, twenty-four in number.

In nineteen one injection was required.

In four the antitoxin was repeated on the third day.

In one—a very severe case—four injections, 14,500 units in all, were required. Had the initial injection of 4,500 been delayed the time re-

quired for a culture report, the child would certainly have lost its life.

Non-operative third-day injection cases, five in number, all required from two to three injections in order to control the disease.

Those injected for the first time on the fourth, fifth, sixth and eighth day received from one to five injections. Those which received but one injection were cases, evidently, of mild infection. In one case first seen on the sixth day the child, a girl of 6 years, required five injections—14,000 units in all.

My first and only fatal non-operative case of diphtheria treated with antitoxin was given 1,000 units on the fourth day of the illness. The child died on the eighth day. This was the first case in which I used the serum. I did not know how to use it; and it was not of the high order of efficiency that we have at the present time.

It will be seen that of fifty non-operative cases, all of which showed the Klebs-Loeffler bacillus on culture, one died; and this case, for the reason already given, should really not be included in the statistics. Considering this case as one, we have a death-rate of 2 per cent.

Antitoxin should be given in persistent laryngeal stenosis of gradual onset; cases which do not respond promptly to emesis, cold applications to the throat, steaming, and antispasmodics. Antitoxin should be given at once in croup cases which show obstruction to both inspiration and expiration—a most valuable sign of pseudo-membrane in the larynx.

The laryngeal (operative) cases, of these there were sixteen:

Thirteen recovered, three died.

The three fatal cases received the antitoxin too late and in too small a quantity to be of service. In two the first injection was given on the fifth day, 3,000 units being given. The remaining fatal case was injected on the second day, 2,000 units being given. The child died from complicating lobar pneumonia a few hours after receiving the injection.

Antitoxin should be given in immunizing doses of at least 1,000 units to all children who have in any way been exposed to diphtheria.

Dosage.—In either tonsillar, pharyngeal or nasal cases, if seen early, on or before the second day, at least 3,000 units should be given, regardless of the age of the patient. If seen on or after the third day, my practice is to give 5,000 units as the initial dose, the amount in any case to be repeated in twelve hours if improvement is not positive, as indicated by a fall of the temperature, and a change in the appearance of the membrane, which takes on a granular, broken appearance when the antitoxin has been effective. If these signs are present, there will almost invariably be an improvement in the general well-being of the child. The patient is seen again at not longer than an interval of twelve hours. If the improvement be not continued, as evidenced

¹Read at the Twenty-first Annual Meeting of The New York State Medical Association, New York, October 17-19, 1904.

by a further breaking down of the membrane and a lower temperature, the amount given at the first injection should be repeated. Then at intervals of twelve or twenty-four hours, depending upon the progress of the case, the serum is administered until a sufficient amount has been given to act as an effective antidote to the diphtheritic poison.

I have never been obliged to administer more than 14,500 units in any one case. In a laryngeal (intubation) case, in a boy 5 years of age, seen for the first time on the fifth day, I gave 11,000 units in nine hours. The first injection was 5,000 units. In three hours an injection of 3,000 units, and in six hours another injection of 3,000. The child coughed up the tube on the fourth day of the antitoxin treatment, and made a perfect recovery.

In laryngeal diphtheria 5,000 units are given as the initial dose, and repeated in from eight to twelve hours if the stenosis is not relieved. If the case required intubation, 5,000 units were given at once, and repeated in from three to five hours. For immunizing purposes 1,000 units are given. The site usually selected for the injection of the serum is the loose subcutaneous tissue over the abdomen. The field is prepared by cleansing the skin thoroughly with green soap and alcohol or ether. A piece of oxide of zinc plaster is placed over the site of the puncture. Among the hundreds of injections that have been made by me or under my directions for immunizing purposes, in private work or in institutions in my service, there has never been a local lesion produced by the injection, such as cellulitis or abscess. About 20 per cent. of the patients developed an urticaria, which is of little or no consequence.

I have injected suspicious cases which did not have diphtheria. No harm came to them, and I have no reason to regret having so treated them. None of the patients developed nephritis. In four there were diphtheritic paralysis of a mild degree. In two the muscles of deglutition were involved, and in two one of the lower extremities.

In our management of this disease it must be kept in mind that in diphtheria we are dealing with a child who is poisoned. In antitoxin we have the antidote. One child may require 3,000 units of the antidote; another, 30,000 units. The dosage is thus not fixed by the age of the patient; it is determined by the severity of the infection and by the duration of the disease when first seen.

MEDICAL COMMUNISM.

An interesting medical innovation has just been made by the town of Zurich. It has created a medical tax of 3s. 7½d. per head of the population with a view to raising £20,000. Forty doctors in the town will share this money, each receiving an annual sum of £500. In return for this salary they will be expected to give their services to "all" the inhabitants of Zurich.—*Advertiser.*

THE GYNECOLOGICAL IMPORTANCE OF PROLAPSED KIDNEY.¹

BY AUGUSTIN H. GOELET, M.D.,
New York.

THAT prolapse of the kidney has an important bearing on gynecological conditions there can be no question; that it is often overlooked as an etiological factor, both in producing and maintaining congestion of the pelvic organs and diseased conditions coincident thereto, and in producing symptoms which are referred erroneously to the pelvic organs is very true also, and is constantly observed in cases coming to me from other gynecologists.

I first expressed my views publicly on this point at the Saratoga meeting of the American Medical Association in 1902, and my paper was published in the *Journal of the Association*, August 23d of the same year. They were received with some scepticism by some who discussed the paper, and who I hope have gained wisdom in the light of riper experience.

In that paper I pointed out that the kidney, when prolapsed, overlaps the ovarian vein as it ascends along the spine and compresses this vein, thus obstructing the return circulation from the pelvis when the waist is constricted by the corset or clothing. It is not necessary that the constriction at the waist be more than sufficient to support the clothing, for the intestinal distention, always associated with this condition, is an important factor in forcing the kidney back against the spine. It would seem that the kidney, being movable, would escape such compression. But the colon, being attached to the kidney, drags upon it when it is distended, and holds it in position at the waistline favorable for compression. The distended bowel must necessarily become displaced below the waistline since there is no room for it above.

Even in the early stages of prolapse, the kidney may retard the circulation in the ovarian vein; because when the kidney descends its lower pole swings inward toward the spine, overlapping the vein, as shown in the drawing (Fig. 1) by the dotted outline.

Compression and consequent obstruction of the circulation of the ovarian vein may be brought about in another manner by prolapse of the kidney. Bear in mind the relation of the ovarian vein to the ureter. The vein is in front and the ureter behind it where they cross. Therefore, when the kidney descends, the ureter becomes bent upon and drags on the vein.

Distention of the ureter from accumulation of urine in consequence of obstruction at the point of flexure will also cause pressure on the ovarian vein.

Thus it will be seen that prolapse of the kidney is an important element in maintaining congestion of the pelvic organs, and is to be regarded as

¹Read at the Twenty-first Annual Meeting of The New York State Medical Association, New York, October 17-19, 1904.

a factor, and a very important one, in causing diseased conditions arising therefrom.

It is certainly true that in most every woman having prolapse of the kidney there is some associated pelvic disease. The position of the kidney may not be always the sole cause, but I contend that it is an important etiological factor in these conditions, and when so, a cure is not possible without fixation of the kidney. This has been so frequently demonstrated that I am thoroughly convinced upon this point.

Prolapse of the kidney may have a strong influence in causing or maintaining such conditions as persistent leucorrhœa, endometritis, uterine hemorrhage, uterine displacements, even ovaritis and salpingitis, and hemorrhages into the pelvis (hematoma and hematocele), irritable bladder and even cystitis.

The gynecologist in particular should hence make a special point of recognizing this condition or excluding it in making his diagnosis, and should, as a matter of routine, examine all his patients for this purpose, not once, but repeatedly if necessary, until he can be convinced of its presence or absence. Repeated examination is sometimes necessary before a positive diagnosis can be made, because the colon, when distended, is interposed between the kidney and the abdominal wall, acting like an air cushion through which it is impossible to distinguish the kidney, and this distention must be dispelled before satisfactory palpation can be made.

The frequency of prolapse of the kidney in women, especially gynecological patients, is another cogent reason for thus examining every female patient and not considering the examination and diagnosis complete without it.

Prolapse of the kidney should never be overlooked in these patients, for unless it is recognized and its importance in relation to the pelvic organs is appreciated, not only will such oversight give rise to embarrassment on the part of the gynecologist when it is discovered that he has overlooked so important a condition, but he will often, in consequence of ignorance of the whole trouble, give advice that may prove harmful to his patient.

This point is emphasized by the following cases:

A patient who consulted me had been examined by another gynecologist most carefully under anesthesia, and he discovered nothing but a chronic colitis. He advised horseback exercise, telling her to select the hardest riding horse she could find. She protested that she could not even walk or step down suddenly without experiencing discomfort, and was sure such exercise would add to her discomfort and aggravate her condition. She did not think she could ride even an easy horse. There was not the slightest difficulty in making out prolapse of the right kidney in the erect position, and it was well down below the ribs. She presented typical symptoms of pro-

lapse of the kidney, and pain in the right ovarian region led to suspicion of pelvic trouble, for which she was examined under anesthesia.

Another patient who consulted me three years ago when a diagnosis of prolapse of both kidneys was made and operation urged, because there was evidence of commencing nephritis, refused operation and passed from under my observation. Three months ago she returned, and begged me to operate on the kidneys, admitting she had made a mistake in not acting on my advice before. After leaving me she had been examined by another surgeon, who told her one of her ovaries should be removed, and that was the whole trouble. When told of the prolapsed kidneys I had found, he admitted the possibility of the condition, but did not consider it worthy of attention. One operation seemed less formidable to her than two, so she consented, and had the ovary removed, but had not experienced the relief promised, and she was in many ways worse than ever; for, after waiting two years for some good result to be manifested, she broke down completely, and was unfit for her ordinary duties.

I fixed her kidneys, and she has made an excellent recovery, feeling already better than she has done in years.

Another patient who, besides the usual symptoms, had at every menstrual period profuse hemorrhage or an excessive menstruation which exhausted her, consented to operation eighteen months before, when I first made the diagnosis of prolapse of both kidneys. But unfortunately she had a brother and a brother-in-law both physicians, who opposed the operation, as well as her husband and mother.

She submitted to curettage, which afforded only temporary relief, menstruation becoming excessive again within a few months. She was then sent to a prominent neurologist in this city because of her nervous symptoms. He could not find either kidney prolapsed, and said if they were it was of no consequence. He advised a trip to Europe. She protested that she could not bear the motion of the ship and did not see how that could benefit her.

I saw the patient with this neurologist, and succeeded in convincing him that both kidneys were prolapsed. I then told him that I would prove that all her symptoms were due to the kidneys, and would cure her, for she had taken the matter into her own hands and decided to have the operation, despite opposition.

The operation was done only four months ago, and the patient is a perfectly well woman to-day; no longer a sufferer from nervous symptoms, her menstruation is normal, and she is rapidly regaining her lost weight.

Another patient who consulted me recently, and who has submitted to the operation for fixation of both kidneys with gratifying result, complained several years ago of the same symptoms for which she now sought relief. She had under-

gone curettage and trachelorrhaphy at that time upon promise of relief with disappointment and had been urged to have the right ovary removed, with which I could find nothing wrong except some slight enlargement due to congestion.

Another patient who consulted me had worn a belt for three years, and suffered continually until she discovered she could be cured by having the kidneys fixed. The operation gave complete relief of all the pelvic symptoms of which she complained.

I might enumerate dozens of other cases similar to the above, where the patients have suffered for years because the kidneys were either overlooked or their importance disregarded, and were subsequently cured by operation.

In view of the importance of the kidney as an excretory organ, and with the knowledge that its function is seriously impaired by its prolapsed position, it is really a matter of surprise that it is so often disregarded or made light of. I had one patient tell me that her former physician, a very prominent practitioner and consultant, told her that prolapse of both her kidneys, which he made out, was of no consequence; that they would go back into place eventually and cease to trouble her; that an operation should not be thought of. She continued to suffer, however, and was, and had been for years, a chronic invalid in consequence. She was finally restored to health after she consented to operation.

How otherwise sensible men can disregard this condition and express themselves thus is truly astonishing to the surgeon who is constantly observing results quite the contrary, and who has the opportunity to see the good results of these operations.

It is quite true that many of these patients exist for years with their kidneys out of place, but they are more or less chronic invalids and their kidneys are diseased. We should ever bear in mind that the prolapse leads to disease of the organ, owing to the continual interference with its circulation and function, and that from constant congestion a chronic inflammation results that may remain in a quiescent or mild state for a while, but eventually atrophy of the organ, or hydro-nephrosis or pyo-nephrosis may result. It is fortunate that the kidney becomes replaced by the recumbent position, and that during this time it may functionate normally, and its circulation be restored, but during the greater part of every twenty-four hours, when the patient is up and about, the kidney must suffer. Besides this, in consequence of its low position in the abdomen, it is constantly subjected to irritation and injury from compression, and dragging of the distended colon to which it is attached.

We should not forget also that flexure of the ureter permits accumulation of the urine in the pelvis and consequent distention with pressure upon the secreting structure of the organ and arrest of function.

During the last three years I have had the urine of all these patients, coming to me with prolapse of the kidney, examined systematically with the microscope, and find that the majority (75 per cent.) show evidence of already existing inflammation of either the pelvis or urinary tubules. In a paper presented to The New York State Medical Association, October 20 to 23, 1902, I urged this as a strong indication for operation.*

If others could see these kidneys, as the surgeon does, exposed on the operating table, there would be less hesitancy in advising operation for correction of the displacement when it is discovered, and the operation would be more uniformly successful in affording relief. The operation would not be then, as is so often the case now, postponed until structural disease of the kidney has occurred, which may perhaps be incurable.

I find the patient is often given an erroneous idea of the gravity of this operation, as she has been told it is not altogether free from danger. If I can do 197 consecutive nephropexies, in forty-seven of these fixing both kidneys at the same time, without mortality, any other painstaking surgeon should do as well. Hence, it cannot be said that this operation has any mortality.

DISCUSSION.

Dr. Cohen.—The paper of Dr. Goelet is very interesting to me. I have now in my care two patients, both of whom have had operations performed on one kidney. A year and a half ago, one patient claims that she slipped, and since that time that kidney has begun to swell and distress her very much.

The other is a case where an operation was performed and where the right kidney was prolapsed, and also pressing above. But I am quite sure that this case was a case of extra capsule. The urine also gives evidence of both casts, and there is a great deal of pain over the left side. Oftentimes she will go a week or two without albumen, then again it will appear in her right kidney. The questions in my mind are: Why is it that the kidney slipped back again, and why is it that she gives symptoms a great deal worse than before? Is it the method of operation, or is it the operation itself?

Dr. Stranahan.—I am not a surgeon, but I want to speak a word from the medical side. There are a great many cases to-day of nephrop-tosis, and I am very thoroughly in sympathy with the operation, although in quite a number of cases I believe that the operation is not a success. In two cases I have in mind the kidney is now freely movable and prolapsed three years after operation. Now, there are some cases in which we find a slight prolapse and cannot persuade our patient to be operated upon. And

*"A Study of the Indications for Nephropexy."—*Medical Record*, December 20, 1902.

what are we to do to relieve our patients who object most strenuously to being operated upon after we have told them what danger there may be from delay? Now we all have these cases, and in many we find that the patients are very thin, and we also have the experience that by putting our patients to bed that the kidney goes back into place. Sometimes I also elevate the foot of the bed. By keeping my patients in bed four, five or six weeks, and by paying special attention to every ailment, I find that they will gain ten or fifteen pounds. There is an increase of fat about the kidney and this, in cases where the prolapse is not marked, helps to support that organ. The symptoms disappear in some cases. I am not recommending this in every case, but in those cases where you cannot persuade the patient to go to the surgeon.

Dr. G. E. Barnes.—It is my lot to meet with a large number of cases of nephroptosis, and it certainly is a very important subject. It seems to me that an important aspect of the subject can be found in considering fully its etiology with a view to its prophylaxis, and I would like to ask Dr. Goelet his ideas relating thereto.

Dr. Goelet, in closing the discussion, said: In regard to the conditions being as bad or worse after the operation, in the cases referred to by Dr. Cohen, I believe that may be due to two things—either to injury done the kidney at the time of the operation, or else fixation of the kidney too low down. I believe the latter is more often the cause of trouble after operation than anything else. The object of the operation is to restore the kidney to its normal position, because the abnormally low position of the kidney permits constant interference with its circulation and function. Hence fixation of the kidney lower than normal, permits this interference with its circulation and function to continue. Therefore it must be expected that the patient whose kidney is fixed too low down is in worse condition after the operation than before, since the mal-position is then permanent, whereas before operation, normal replacement of the kidney takes place when the patient resumes the recumbent position. When the kidney is fixed too low down, it is in position where it is continually compressed and irritated by the clothing or corset constricting the waist. Before operation it may escape such irritation, hence the importance of fixing the kidney in its normal position.

I believe, and have always contended, that splitting or peeling off the fibrous capsule at the time of operation is entirely unnecessary, and have had but one failure in 197 nephropexies, and that was my fault and not the fault of the operation. In that case I fixed two kidneys in a very delicate patient, intending to do an abdominal operation afterwards, but found the patient in no condition for it, and was obliged to postpone the abdominal operation until ten days later. The excessive vomiting following this second operation loosened one of the kidneys.

I have never seen a case of prolapsed kidney cured by confining the patient to bed, or by putting on flesh. My experience is that these patients do not put on flesh when the kidney is prolapsed. Furthermore I have never seen a case cured by wearing a belt or corset, no matter how well they are adjusted. Such appliances, in my experience, aggravate the condition by causing irritation of the kidney in consequence of compression. The fat which surrounds these kidneys offers no support whatever, because as a rule it is dragged down with the kidney.

As to the etiology of this condition, it occurs most frequently in women, and I believe that it is due mainly to their method of dress. A woman suspends her clothing from the waist, consequently there must always be more or less constriction, which is increased after a full meal, or when distention of the intestine occurs. The colon, being attached to the kidney, drags upon it constantly, when there is distention, because when the waist is constricted the expansion mostly takes place below that line. I consider the diagnosis of this condition extremely easy, but it requires constant practice and experience, and these patients must be examined in the erect position, else the condition will often escape observation.

Before closing my remarks, I desire to relate, briefly, a case which came under my observation a little over six weeks ago. A patient was brought to me for examination, his physician stating that a diagnosis of chronic appendicitis had been made in the case. I could find no trouble with the appendix, but both kidneys were prolapsed. The urine was loaded with albumen and contained epithelium from the kidney, but there were no casts. I operated on this patient six weeks ago. The right kidney was in a bad condition of inflammation and there was evidence of long-standing peri-nephritis. The left kidney, which was not so badly prolapsed, was in better condition. In operating I split the capsule of the right kidney from pole to pole, but did not strip it back. Three days after the operation there was no albumen in the urine and there was still none present three weeks later, when the patient got out of bed. I am confident, however, that this improvement was due more to the replacement of the kidney and careful dieting than to the splitting of the capsule, and believe that the same result would have been obtained if the capsule had not been disturbed.

FREE PATIENTS FOR INSTRUCTION ONLY.

A public hospital should serve three purposes, and it does not fulfill its duty if it neglects any one: First, the care of the sick. Secondly, the scientific study of disease. Thirdly, the clinical instruction of those who are to be our successors. The offering of their cases for instruction is the return the hospital patient makes for the free and often costly treatment he receives.—*Med. Council.*

THE PASSING OF THE OLD PHYSICIAN.¹

BY ELIAS LESTER, M.D.,
Seneca Falls, N. Y.

THE subject given me on which to make a few remarks is "The Passing of the Old Physician." First, what do we mean by the term "old physician"? Let us see. Fifty years ago, it seems to me, the physician was a more important character in the community than he is to-day. Next to the clergyman, he was the man to be consulted in all the affairs and troubles of life. He was the friend of the unfortunate, and usually at the head of all good work. The schools and public charities looked to him for their support and he was busy for their success.

His professional work was hard and poorly paid, but he visited the poor and rich alike, giving to both his best professional skill, and looked to a kind Providence for that compensation which would give him a living and make his old age comfortable.

He grew up with the generation about him, sharing their pleasures and suffering, and was their friend when sorrow visited the family circle and took away some loved one or hard times pinched them in their financial matters.

His advantages for study were limited to a few months of reading in the office of some older physician with perhaps a short term at some medical college, where the advantages for instruction were limited to only a few branches. His success in his profession was due to carefully studying the cases he had after he began business, in good common-sense and in courteous and honorable dealing with his patrons.

His surgery was limited to reduction of fractures, sewing up of wounds, and rare cases of amputation. These cases, however, were his own usually. He had little chance for consultation and had to be self-reliant, and hold himself responsible for mistakes. He procured the best books as they were published, and Watson's "Practice" and Gross's "Surgery" were his guides in his daily business. After the use of ether and chloroform became common he ventured a little more in his surgical work, and the surgeons of those days who used anesthetics were considered the great men of their time. In 1861 I assisted at an amputation where no anesthetic was used. It was a distressing sight—the man strapped to a board, and his struggles and screams were heartrending.

The "old physician" also compounded his own medicines. He bought the drugs and made his own pills and powders. Tablets were unknown to him. He was content to make professional calls for 50 or 75 cents a visit, and to give much office advice free of charge. The charges for special work and surgical operations were lower than now, and the old horse and half-worn wagon were the best "turnout" a physician could afford to keep.

We are now living in the time of the passing of the *old* condition of things, both in the way the public regards the physician and the physician regards his clientage. I need not speak of the advancement of modern surgery or the progress of medical science; others have written more ably than I can upon these subjects. During the past fifty years the advancement along these lines has been wonderful. Life has been prolonged and robbed of much of its suffering by the timely aid of the surgeon's knife and the neutralizing of poisons by antitoxins and other preventives to the ravages of disease. The question now arises, Is there a corresponding progress in physicians as a class? Is the physician as well read in his profession, as close to the family circle, as much looked up to, as he was fifty years ago? Does he study his cases and make his diagnosis as closely with all his modern advantages as did the self-reliant physician of half a century ago? Doesn't it happen that the patient makes the diagnosis and the physician furnishes the tablets that some other physician or some druggist has compounded? Is it not true that we study our cases less and devote less time to reading the literature of the profession than was done fifty years ago? Diagnosis, and your own diagnosis after careful studying of your case, is what we want, for as Prof. Alonzo Clark said to us in the class in the "P. and S.," in 1861, "Find out what ails your patient and any old woman can doctor him."

The large number of specialists has made physicians feel it less necessary for them to be well up in every branch of the profession nowadays. As fifty years ago the physician gave over the pulling of teeth to the dentist, now he gives up surgery to the special operator, or treatment of the throat and nasal troubles to the specialist. Thus the general practitioner is narrowing his own field over that of his predecessors.

The large number of hospitals, too, is changing the character of professional life, and while the old physician marvels at the cures effected he prays that the tendency to commercialism may not increase in the same proportion.

Thus, while we glance with pride, mingled with sadness, at the work of the old physician, appreciating how much he accomplished with rude facilities and under great difficulties, and realizing that his day is past, or at least passing—and that rapidly—we look forward with confidence to the future, where we see the young physician with superior educational advantages, hospital practice, and professional equipment, and we see him accomplishing things that half a century ago were hardly dreamed of.

A tyro writes us that anatomy changes its name with every environment into which it enters, so that it is impossible for any sleuth to trace its whereabouts.

¹Read at the Semi-Annual Meeting of the Seneca County Medical Association, September 8, 1904.

DIARRHOEA AND BOWEL TROUBLES IN INFANTS AND ADULTS.¹

BY B. W. STEARNS, M.D.,
Binghamton, N. Y.

THE season during which these ailments are most prevalent has just past, and by re-counting and discussing our successes and failures, while the experience of each one is fresh in the mind, we may all derive benefit from our meeting and be better prepared to handle such cases hereafter. I mention the disease as affecting both infants and adults because with increasing experience I am convinced that there is not the difference in the conditions present in the two classes of patients that I was led to believe, by works on general practice, and again by authors on diseases of children, in the early years of my practice. And I am afraid that I signed death certificates in some cases during the earlier years of my practice that to-day with a more distinct idea of the conditions present in these cases I would be able to handle more successfully.

With one or two exceptions, diarrhœa is due to imperfect or arrested digestion, and is an effort of nature to rid the system of material which, if retained, works harm rather than good to the individual. The indigestion may arise from various causes in both the adult and infant, which cause in the individual case may generally be determined through a little investigation by the physician, and, of course, should be corrected if possible, in order to secure the desired result. To begin with, the physician should have a comprehensive idea of the conditions present.

I will state my own views of the conditions we have to contend with, and hope that the fellows present will be free to express themselves whether in support or at variance with mine.

The first point to consider is that in practically all cases of acute indigestion there is an arrested secretion of bile. Suggestive symptoms may not be present, that is, a coated tongue, headache and gray stools, and it may be vomiting for the first twelve or twenty-four hours. If the diarrhœa sets in early the headache may not come on. With the digestive process and the secretion of bile arrested we have the process of fermentation and possibly putrefaction going on in the contents of the bowels, with the generation of ptomaines. The ptomaines add to the gravity of the case, either by absorption into the system as indicated by a marked rise of temperature as in cholera infantum, or by local irritation, lighting up an enteritis.

Treatment.—Certain variations in treatment are necessary according to the duration of the disease in the individual case. But I find that no matter at what stage of the disease the physician may be called, in case it has not already been administered, there is nothing that will, as it were, clear the foundation for the after treatment as

successfully as a few $\frac{1}{4}$ gr. tablets of calomel, say, anywhere from four to eight, according to the age and condition of the patient.

If vomiting be troublesome, lime water and milk in teaspoonful doses every half hour will allay the trouble better than anything I have ever tried.

One hour after the last dose of calomel, or when the vomiting has stopped, I find nothing does so well to prevent further putrefaction within the bowels as the sulpho-carbolate of lime, zinc or soda. In those cases with a tendency to vomit the lime salt will be retained by the stomach best. I sometimes add bismuth salicyl and syrup of rhubarb. The rhubarb is very effective in overcoming tenesmus. In administering food we must remember that the secretion of the digestive fluids has been arrested, and it becomes necessary to administer some digestive agent for a time. The feeding of infants is all-important in handling the cases we are constantly called upon to treat, but that in itself is too extensive a subject to include in this paper. Diarrhœa in adults caused by indigestion due to mental anxiety or to improper mastication of the food with poor teeth must be managed in accordance with the underlying cause.

I have made some statements in a somewhat positive manner, for the reason that I have obtained very satisfactory results following out the views and treatment above indicated for the past four years, not having lost a single case in that length of time. With the improvement in results I no longer feel a dread on being called to a severe case.

I have omitted any reference to authors or any long synopsis of statistics, it being my intention to simply state a few facts that I have crystallized from my own experience.

INFANTILE CEREBRAL PALSY IN ITS RELATION TO EPILEPSY.¹

BY EDWARD SHARP, M.D.,
Katonah, N. Y.

IN looking for a cause for epilepsy, we have to consider various immediate and remote conditions which are generally supposed to be etiological factors. Many of these so-called causes are purely conjectural, but there is one factor, infantile cerebral palsy, which, when present in an epileptic, is almost invariably considered as a real cause. No one single cause of epilepsy developing during infancy is more important than these cerebral palsies which show themselves in the form of hemiplegia, diplegia or paraplegia. It is especially in the hemiplegic cases that epilepsy is liable to develop. This occurs in about 50 per cent. of the cases.

Most cases of cerebral palsy occur during the first three years of life, at a time when serious damage is done to the developing brain. In a

¹Read before the Broome County Medical Association, October 11, 1904.

¹Read at the meeting of the Orange County Medical Association, Newburgh, Wednesday, November 16, 1904.

series of 82 cases of infantile cerebral palsy which I have recently tabulated, 71 occurred during the first three years, while 17 of these were congenital or occurred at birth.

When a palsy is noticed at birth or soon afterward it may have been caused by injury to the gravid uterus, or to an injury occurring to the child at birth due to difficult labor or to the use of instruments. As a rule it is the condition requiring the use of forceps and not the forceps themselves which does the damage. After birth such factors as the acute infectious diseases, trauma, etc., may cause a cerebral palsy.

These factors produce minute hemorrhages into the brain cortex or meninges, and if the motor region is involved a paralysis results. Many cases of so-called idiopathic epilepsy probably owe their origin to these minute hemorrhages, which are not suitably located to cause a motor paralysis, but sufficient to interfere with the normal growth and development of a portion of the brain, leaving it in an unstable condition.

A careful examination of every case of epilepsy for evidences of cerebral hemorrhage will frequently reveal the true cause of the convulsions. In many cases the evidence is only too plain, as is seen by the paralyzed extremities, the deformed, contracted limb and the spastic rigidity. In some of the slighter cases it is more difficult, and even impossible, to determine the presence of a former paralysis. The paralysis may have been so slight that the patient presents no deformity, and he believes that one side is just as well and strong as the other. A few careful tests, however, will generally decide the question. The finer movements of the defective side are more restricted and awkward. He is unable to pick up small objects as pins or shot as rapidly with one hand as with the other. This hand becomes more easily fatigued, as is shown by actual comparative tests with the dynamometer. Slight associated movements are seen in the defective hand when an attempt is made to hold it quietly, while the other is put through certain rapid movements. Athetoid or choreiform movements are also frequently observed, especially after fatigue. The reflexes are exaggerated or more active on the paralyzed side.

If the patient is seen immediately after a convulsion or a series of convulsions, it will be found that the palsied side shows proportionately more weakness and exhaustion than the other. This exhaustion paralysis has been carefully studied and described by Clark, and it is a valuable aid in the diagnosis of cerebral palsies.

During the convulsive paroxysm the paralyzed side is frequently first and most involved in the convulsion, and in some cases the spasm may be limited to this side.

All cases of infantile cerebral palsy do not de-

velop epilepsy, and we must therefore look for some contributing cause in those cases that do. This may be an hereditary instability of the cerebral cortex, an impoverished condition of the blood from lack of proper nourishment, auto-toxemia, etc. It may be due to overwork and overstimulation of a brain already weakened by the palsy.

During the past five and one-half years there were 11,303 cases treated in the Neurological Department of the Vanderbilt Clinic. Of these there were 82 cases of infantile cerebral palsy. Thirty of these had developed epilepsy up to the time they were first brought to the clinic. Epilepsy may develop immediately after the initial convulsions of the hemiplegia or it may be delayed for months or years. As the average interval between the onset of the hemiplegia and that of the epilepsy is about two years we may expect some of the remaining 52 cases to develop epilepsy sooner or later. This will bring the percentage up more nearly to the usual statistics of 50 per cent.

At the Craig Colony, where all cases are epileptics, there were 116, out of the first 1,070 cases, having epilepsy as a result of infantile cerebral palsy.

The treatment of infantile cerebral palsy after the initial symptoms have subsided, should be largely directed toward the prevention of epilepsy with its consequences.

A proper supervision of the child should be maintained during the period of development and even for years afterward.

Prevention of contractures and deformities by systematic exercise, massage, electricity and baths should always be attempted.

The patient should lead a quiet life, preferably in the country, under proper hygienic surroundings, and avoid worry or excitement. His employment should be mostly in the open air, and should never be carried beyond the point of pleasurable fatigue. The diet should be carefully regulated. All unwholesome and indigestible food, excesses of all kinds, alcoholic stimulants, etc., should be absolutely prohibited.

When such favorable conditions can be properly enforced the child may never develop epilepsy. The palsy may not have been sufficient to produce epilepsy if other harmful influences are not active.

LARGE TYPE UNETHICAL.

At a meeting of the Medical Society of the County of New York, December 27, 1904, the following resolution was unanimously adopted: "That in any directory or list other than a medical one, it is undesirable that any data should appear other than the name, address and telephone number, and that the use of more prominent type for one name than another is to be severely deprecated."

SYMPTOMS OF CEREBRO-SPINAL MENINGITIS.¹

BY GEORGE H. FISH, M.D.,
Saratoga Springs, N. Y.

THE onset of lepto meningitis may be preceded by a few days of malaise with headache, myalgia and perhaps nausea and vomiting, but is most often abrupt, being ushered in by a severe chill, followed by high fever, raging headache and vomiting. In children, one or more convulsions usually mark the beginning of the attack. Spinal pain, especially in cervical region, soon follows, superseded by contraction of cervical muscles, causing patient great pain on attempting to turn his head, and later on the muscles may contract sufficiently to cause opisthotonos. The headache of meningitis is persistent and intense, usually aggravated by light and noise. Hyperesthesia is usually present, and the patient complains of general myalgic pains in extremities and in cervical and dorsal regions of spine; there may be pain in the abdomen and some retraction of abdomen, though usually slight. Delirium may or may not be present, may occur early or late and range from that of a mild grade to an active delirium accompanied by hallucinations or the maudlin delirium of the drunkard.

Muscular twitchings are common, and clonic or tonic contractions of muscles; slight trismus may be observed in fatal cases. Hemiplegia and monoplegias are not very uncommon; and convulsions are frequent in children.

The pupils are usually unequal and sluggish in response to light. Strabismus occurs occasionally, is usually transitory, but may be permanent. In some cases partial, or complete, blindness is noted, due to neuritis of optic nerve, and may be permanent. Photophobia is always present. Tinnitus aurium followed by deafness is common and may be complicated by purulent otitis media and rupture of tympanum.

Usually the tongue is slightly coated, the appetite lost, vomiting is present at the onset, but usually lasts but a brief time; constipation is the rule. The spleen is enlarged, and may be felt below the margin of the ribs. Renal symptoms are not prominent; albumen or sugar may occasionally be met with.

Herpes facialis is a characteristic symptom soon after the onset of cerebro-spinal meningitis; a petechial eruption is often observed and has given the name of spotted fever to this disease.

The temperature is usually high at the onset, but soon after drops to 102° or 103° Fahrenheit, and runs a comparatively moderate grade. Just before dissolution, it may rise rapidly to 108° or 110°.

The pulse is, at the beginning of the disease, usually slow in proportion to severity of other symptoms, but becomes more rapid after the second or third day, and may go to 140 or more in severe cases.

Respirations are slightly accelerated and may be irregular. Cheque-Stokes breathing may be present.

Anthritis is not uncommon in severe cases.

Kernig's sign is present in the majority of cases, and may persist long after other symptoms, and so be an aid in making a retrospective diagnosis.

The diagnosis may be based on the abrupt onset, vomiting, vertigo, intense muscular pains, excruciating headache, muscular twitchings, tonic or clonic convulsions, tonic contraction of neck muscles, cutaneous eruptions, marked hyperesthesia and photophobia.

Diagnosis may be confirmed by bacteriological examination of spinal fluid obtained by lumbar puncture.

Tubercular meningitis may be differentiated from lepto meningitis by the usual presence of a tubercular history, by the insidious onset, long stage of prodroms, greater retraction of abdomen, absence of eruptions, less complaint of myalgias and by hyperesthesia.

Some cases of lepto meningitis simulate typhoid, but may be differentiated by the abrupt onset, vomiting, muscular spasms, hyperesthesia and absence of typhoid, temperature curve and rose spots. The splenic enlargement is greater in typhoid.

SOME OBSERVATIONS ON THE USE OF FORCEPS.¹

BY E. M. SCOFIELD, M.D.,
Jamestown, N. Y.

DURING my student days I was taught a number of things which I have since learned to change somewhat, one of which was to consider a case of labor perfectly natural if it did not last longer than twenty-four hours. In some cases, I think, the rule still holds good, but I can look back to not a few cases where I waited patiently hour after hour, while the cervix had been well dilated, but a hard and resisting head was pounding away against the soft tissues of the mother and she was becoming more and more unable to bear the suffering and the pains less effective. We were also led to think that the application of the forceps was a thing to be dreaded and avoided if possible. That their use was "meddlesome midwifery." Do not understand me to advocate the promiscuous use of instruments without proper indications, either on the part of the mother or child, but I do believe their skilful use in case of difficult or delayed labor will do much more good than harm. After securing proper dilatation of the cervix (and if artificial means are to be employed the hand is far superior to any instrument or forceps I know of) the head refuses to descend, or if it becomes lodged at any point along the canal and remains stationary for an hour, say, I would apply the forceps and slowly deliver. You know that the

¹Paper read at a meeting of the Saratoga Medical Society, January 6, 1905.

¹Read at the meeting of the Chautauqua County Medical Association, Jamestown, N. Y., January 17, 1905.

laity has been led to believe that the danger of laceration is greater if instruments be used, and, in fact, I have heard more than one doctor condemned by a brother practitioner because his patient had been torn, and insinuated to the family that instruments were to blame. Of course, in some confinements the chances of laceration are greater—cases of small pelves, large child, etc.—and these are the cases where instruments are necessary to complete the labor. The tearing is due to the difficulties mentioned, and not the instruments. In fact, I thin that we can save tearing in a percentage of case. by the proper use of the forceps. For a number of years past, I have carried three different sizes of obstetrical forceps in my bag: a pair of the ordinary size, the axis traction, and a pair with short handles. This may seem superfluous, as a kitten could go through the same cathole as its mother, but it is often a great convenience to have the small pair along. To illustrate, labor has progressed until the head is crowding against the floor of the pelvis, and you have already learned that the ostium vagina is small. The perineal muscles are rigid. The patient is tired, discouraged and perhaps frightened for her own safety, is one who dreads the exposure of her person, which would be necessary if the larger instruments were used. I would administer sufficient chloroform to render the patient manageable, and apply the short forceps. You can control the oncoming head and avoid that sudden splitting of the perineum that often happens from an extra violent pain. By slowly distending the muscles between the regular contractions one can in many cases avoid tears of any consequence. But supposing a case has resulted in a more or less tearing of the perineal tissues. I believe great care should be taken in immediately placing stitches so as to get coaptation of the torn muscles. I have seen quite a number of cases where the stitches had been simply taken through the external skin. This is worse, if possible, than no stitches at all, as the perineal muscles will not have been united, leaving the floor of the pelvis weak and non-supporting. The plea of my paper is for the careful and intelligent use of the forceps in these tedious and delayed cases. If the head has entered the vagina and has remained stationary for an hour or more, the pressure against the tissues causes a condition of blood stasis, a swelling of the parts that retards labor, and if allowed to continue serious results may occur. I remember a case of several years ago, which illustrates the point. A woman in her second labor, dilatation was evidently easily accomplished and the head was advanced to the floor of the pelvis, but on account of some abnormal condition of the presenting part it remained stationary and the medical attendant sat idly by for some hours allowing nature to take its course. The husband became worried and anxious for the safety of his wife, and another physician was called in counsel, forceps were applied

and the child delivered inside of twenty minutes. It was dead, and the continued pressure upon the maternal tissues resulted in a vesicovaginal fistula, which remains to this day, although three separate operations in skilful hands have been performed for her relief. This was a number of years ago, and I do not believe it would occur at the present time. We should be sure and have thorough dilatation of the cervix, and, of course, I take it for granted that strict antisepsis would be observed.

ABSTRACT OF DR. HERMAN M. BIGGS' PAPER

"The Administrative Control of Tuberculosis."

In assuming the municipal control of tuberculosis, the New York Department of Health had adopted the following plan of procedure some ten years ago:

First, it was made compulsory that all cases of tuberculosis coming under the observation of charitable institutions and practicing physicians should be reported to the Board of Health and there registered. Where the patient was under the care of a private physician, no further cognizance would be taken by the department of the case after the physician had reported its existence.

Second, to facilitate the early diagnosis of this disease, the Department should establish a private laboratory where the sputum and other secretions of patients might be examined free of charge. This laboratory was started by the Department in 1894. In 1904 alone, 17,000 specimens had been examined in this branch of the Department.

Third, that the sanitary organization should have for its duty the education of the people in general on the subject of tuberculosis. Papers giving this information, as circulars in various languages, should be published in the newspapers and distributed by the Department of Health to hospitals and by all organizations which might be interested in the care of these unfortunate individuals.

Fourth, it should be the duty of the Department to educate infected individuals in their own homes, where they were not in charge of physicians. This should be done by physicians and trained nurses in the employ of the Department, and further that these physicians and nurses could thereby collect various data as to the surroundings and history of the patients and their families, which might be valuable as information in statistics. Under this rule, it would be possible to find out whether the patient could be properly cared for in his own home, and if not, he could be removed to a place where he might be cared for, even if force were necessary to carry out the orders of the Department.

Fifth, that the Department should disinfect the rooms or apartments which had lately been vacated by the patients through removal to other places or by death. This was often difficult, as

these patients were constantly moving, and it was the most troublesome problem that the Department had had to meet. The essayist suggested that it should be compulsory for landlords to notify the Department when tuberculosis patients or families removed from their houses.

Sixth, that provision should be made to revisit patients when, for some reason, it was not possible or desirable to move the patient elsewhere.

Seventh, suitable food should be provided if the family were destitute. Where the family could not be broken up, because one individual was infected, and the rest of the conditions surrounding the patient were good and hygienic, it was the duty of the Department to supply food and medical assistance to this individual.

Eighth, the sanitary authorities should also provide such institutions: 1st, free dispensaries for the treatment of ambulatory cases; 2d, hospitals for the care of advanced cases. All of the hospitals should not be under the municipal authorities, but there should be at least one place where advanced cases could be confined, especially the homeless, dissipated and criminals, who were infected with tuberculosis. Inmates of public institutions, who refuse to go into an institution should be compelled to go under the authority of the Department of Health. These patients are not difficult to control, many have been removed by force from such institutions, and have been retained under the care of the Department for months without giving the slightest trouble; 3d, sanatoria should be maintained in the country by the Department for incipient cases. For the last two years the Department has had funds sufficient for the carrying out of this idea, but because of a certain bill, which was introduced into the Legislature and passed, it had been impossible to secure suitable locations for such institutions.

Ninth, the admission of tuberculosis patients into the general wards of the general hospitals, asylums, prisons or homes of any sort, must not be permitted.

Tenth, the Department should prevent the expectoration in public places and streets. It was well known that these organisms, which infected the respiratory tract did not propagate themselves outside of the human body, hence when they were found in the dust and dirt of public places, their origin was only too well known.

Each year the Department had taken the census of the cases of tuberculosis under the care of public institutions, and the physicians who had reported cases were communicated with, in order that the Department might keep track of the progress of the cases which had come under their observation. A large number of unreported cases had been found by means of a house-to-house investigation by the special inspectors.

In conclusion, the speaker said that this scheme had been found to be not only feasible but in every way practicable, and there were no serious

valid objections to the carrying out of this plan. It had met with violent opposition by physicians, but to-day the majority of the physicians in this city approved of the work of the Department, while the rest were acquiescent. There had been a more rapid fall in the tuberculosis death rate in New York City than in any other great city in the world. In the last ten years there had been a decrease of 40 per cent. from pulmonary tuberculosis and tuberculous meningitis in children under fifteen years of age. The total decrease in mortality during the last seventeen years had been almost 40 per cent.

The discussion of this paper was opened by Dr. John W. Brennan, who remarked that only some five years ago a gathering of physicians had met at the Academy of Medicine to protest against the plan adopted by the Board of Health. In Philadelphia and Boston the physicians are now asking that the measures at present employed by the Department of Health in New York City be put into practice there. Boston has accomplished more toward this than Philadelphia, where politicians have prevented and blocked these plans.

Dr. Egbert Le Fevre, in discussing this paper, added that some years ago there had been a misunderstanding between the Department of Health and the physicians, which was due to over-zealousness on both sides. The physicians thought that the pressing of these measures would cause a panic among the laity. The problem to-day was the control of those chronic cases which are still economic factors in the community. This had been touched upon by the establishment of dispensaries for the treatment of their special troubles. Now the public in general no longer hesitated or feared to apply for treatment to such institutions. The time would come when even insurance companies would find it cheaper to establish suitable sanatoria for the treatment of incipient cases, which had been insured by them, than to pay their policies at death.

Dr. Darlington remarked that he regretted very much that the Department was compelled to litter up the walls of public places with signs, asking people not to spit, that he doubted whether these signs were of any benefit or use. He also felt that these signs were a disgrace to the American people. This paper was also discussed by Drs. Cooper and Bryan.

Dr. Biggs in closing the discussion remarked that his experience in autopsy had been to find that only 30 per cent. of cases having tuberculosis of any sort died of that disease.

ABSTRACT OF DR. FRANCIS HUBER'S PAPER.

"Clinical Features and Treatment of Epidemic Cerebro-Spinal Meningitis."

Dr. Huber remarked in part, that recent observations had somewhat altered the opinion that this disease was not communicable. Nasal ca-

tarrh, conjunctivitis and bronchitis had been noticed in a large number of cases. Otitis was not rare. The speaker presented charts of an intermittent type, which he described as being characteristic in certain cases. Some authors had denied that there was any such type of this disease. Charts illustrating the aborted, mild, chronic and fulminant varieties were also shown. In the chronic type, irregular fever with periods of remission and relief, and subnormal temperature for days, and even weeks, had often been noted. One case which had come under the author's observation had had a very low pulse rate, which was contrary to the usual rapid pulse rate in this disease. The writer thought that a low pulse probably assured recovery. In prolonged cases the temperature might suddenly rise seven or eight degrees, with a correspondingly sudden and decided drop. In these cases recrudescence was most common. Lumbar puncture had produced consciousness in a case where there had existed somnolence and almost complete coma. It was not well to permit a prolonged case to get out of bed too soon, as this might bring about a sudden relapse. The prolongation of the disease was usually due to either brain abscess or a chronic hydrocephalus. Retraction in chronic hydrocephalus might be either slight or wonderfully extreme. In one case, where the scaphoid abdomen was marked, there had also been an abnormal growth of hair over the whole body and extremities, whereas the hair on the head had almost entirely fallen away. The number of deaths in the essayist's series had been seventy-four, and they had taken place from fifteen hours to two hundred and thirty days after the onset of the disease. Of those who died in the first seven days, there were 32 or 43 5-10 per cent. of the total number of these mentioned cases. The temperature did not follow any particular course and its curve was liable to be irregular and variable. The pulse in children was usually rapid, and there were no characteristic respiratory manifestations. Cyanosis had been observed now and then. In many fatal cases death had been brought about by paralysis of the respiratory centers. Respiration in these cases had been known to fall as low as three to the minute, and even after respiration had ceased, the heart had continued to beat for some time in a number of instances. Retention of the urine was present quite frequently. Albumen and casts with hematuria had been noted, but the quantity of albumen had usually been slight. Constipation was the rule. The leucocyte count had been as high as 42,000, but it was usually from 15,000 to 30,000. In the majority of cases, the history of spots had been obtained from the parents of the children. Eruption usually took place in the first fifteen hours. Pettechiæ had been noted often in the conjunctiva. Diffuse mottling of the extremities was most common. Erythema of the forehead, face and ears had been frequently met with. Herpes was encountered on the third or fourth day about the lips,

nose and ears, and was present in one-third of the cases ending fatally. Herpes zoster had been present in one case. The treatment to be employed in these cases was a general one. The patient should be isolated in a well-ventilated room, which would not necessarily have to be darkened, as the patient's eyes might be bandaged. Ice bags should be applied to the head. The raising of the head of the bed from six to eight inches would give great relief. Water should be administered freely. Nasal irrigations were important. Pain and restlessness were relieved by the administration of codein and morphine. Phenacetin was beneficial in relieving the headache. The employment of ergot by mouth gave the same old story of no benefit. Lumbar puncture was beneficial where the spaces between the ventricles and the subarachnoid spaces remained patent, but if the foramen of Magendie was closed, lumbar puncture gave no abatement in the severity of the symptoms. In the fifty-one cases, where it had been sought for, the meningococcus intracellularis had been found in forty-four instances. In four late cases where puncture had been employed, the organisms were not found. The pneumococcus was present in one case. If polynuclear cells were found in the fluid the case was one of meningococcus infection. The organisms could be found as early as twelve hours after the onset of the disease. Iodids in small doses and in large doses had given no results in the author's cases. The anti-toxin treatment gave results no better than those obtained in cases treated by other methods. The mental condition, however, seemed improved after the injection of the anti-toxin. Intraspinal methods of injection had encouraged the author in two cases, where there had been a decided drop in the temperature after the administration of the anti-toxin. In another case the child had died on the twenty-first day. In three other cases, where the anti-toxin had been used and which were now under observation, one showed a beginning hydrocephalus, another a recrudescence of the disease, the third was now in a very critical condition. Cerebro-spinal meningitis was not a disease to be treated by physicians; it lay in the field of the sanitarian and it should be under the control of the Department of Health.

The discussion of this paper was opened by Dr. Morris Manges, who said that in his experience at the Mt. Sinai Hospital, nephritis had been exceedingly common, and a large quantity of albumen in the urine had been usual; so much so was this the case, that in the onset of the disease the condition might be mistaken for one of a beginning eclamptic seizure. The presence of sugar in the urine at the onset was exceedingly common and might lead to a diagnosis of diabetic coma, provided the patient was unconscious when first seen. The presence of sugar was due to the involvement of the floor of the fourth ventricle by the exudate. Nowadays spots were so infrequently seen, that it made one doubt the reasons

why the early authors called this disease "spotted fever." Herpes is more often met with than in any other disease except pneumonia and was important in the diagnosis of the condition. Rash about the elbows and knees was not uncommon and looked like ordinary goose-flesh where the pimples had been rubbed off, and the condition was due to the constant moving about in the bed by the patient, causing a wearing away of the epidermis at these points. The leucocyte count was always high and usually ran about 20,000. Nothing was more striking than the variation in the fever curve. The afebrile cases might drop dead without warning, and death was due to the sudden closing of the foramen of Magendie. Complications had been rare in the cases seen at Mt. Sinai, and there had been not a single case of a complicating pneumonia. Lumbar puncture had always given good results. One should never hesitate to use chloroform in the performance of lumbar puncture if the patient was restless and hard to manage. A point to be insisted upon in these cases was forced feeding. It had been shown in cases of tetanus that the best results and the lowest mortality had been obtained in those cases which had been heartily fed. He confessed that he was partial to baths at a temperature of 104, where the patient was not especially restless. The prognosis in this disease was indefinite. Cases that started hard might have a favorable termination and vice versa. Lysol injected might give good results, but the results could not be proved. One case which had come under the speaker's observation where the meningococcus was associated with the streptococcus, had gotten well with the lysol treatment. There was nothing to be sought for in the anti-toxin treatment.

Dr. Harlow Brooks, in the discussion, said that the symptoms were not due to a specific toxin, but were rather due to mechanical action of the organs on the parts affected. No toxins had been obtained from growths in the cerebro-spinal fluids of animals, therefore it was not reasonable to suppose that an anti-toxin could be obtained to antagonize the effects of a toxin which did not exist. The epidemics had varied from year to year. In 1896-1897, when the speaker first commenced to take an interest in these cases at Bellevue Hospital, the patients presented very commonly a spotted condition. This year he had seen spots in but one or two cases. Hence, he reasoned that the organism varied in its ability to produce symptoms. The organism is found in the nasal secretions of normal individuals, and we must necessarily have conditions other than the organs in itself to set up a meningitis. It was also true that it was difficult to produce the disease in animals. One should be very careful in making a definite diagnosis of cerebro-spinal meningitis due to the meningococcus, because only by the most excellent and careful laboratory methods was it possible to differentiate this organism from the micrococcus catarrhalis and the pneumococ-

cus. Another fact with regard to the organism was that it did not commonly set up metastatic abscesses in the other organs. The kidney alone was the organ of the general viscera involved in this disease. It is truly a disease of the central nervous system and as such it comes properly under the care of the neurologist.

Dr. Leszynsky had, in his service at the Lebanon Hospital, thirty-five cases and the mortality had been 45 per cent. In the first three cases he had used morphine to relieve the pain and hyperesthesia, but since then, in all of the other cases, he had used an aseptic solution of ergot, given subcutaneously every three or four hours. The ergot has proved so satisfactory that he had entirely dispensed with the use of morphine, chloral or bromide in these cases.

Dr. Alfred T. Livingston, of Jamestown, at the request of the president, discussed the paper and remarked that ergot contracted the abnormally dilated blood vessels and if supplied sufficiently early it would in this way control the body organism; but it should be given before the infiltration of the tissues with inflammatory products had taken place, otherwise this effect would not be produced.

Dr. Huber in closing the discussion said that many new points had been brought out by the gentlemen discussing his paper, which had been known by him, but the scope of the subject was so large, that he had felt it necessary to leave out some portion of the matter in order that the speakers following him might have a chance to say something.

IMMUNITY.

In a special article now running through several issues of *The Journal A. M. A.*, the subject of immunity is treated in an elementary way. It makes interesting reading for the general practitioner, who is apt to be dazed by the terms used in scientific articles on this subject. Our knowledge of immunity comes into play in all branches of medical practice, and the physician who does not keep in touch with the advances on this subject is apt to feel left behind. *The Journal* explains the difference between natural and acquired, active and passive immunity. The powers of the sera of animals' after being inoculated by various diseases have made wonderful changes in the practice of medicine. This branch of science is only in its infancy. Some physicians have expressed the hope that science would yet master all infectious diseases. Progress, however, is baffled in many respects, and the things that we do not yet know leave a wonderfully stimulating field of observation open for the student to enter.

BOOKS RECEIVED.

FIRST ANNUAL REPORT OF THE HENRY PHIPPS INSTITUTE, FOR THE STUDY, TREATMENT AND PREVENTION OF TUBERCULOSIS. A brief account of the work of the first year and a reprint of the lectures delivered under the auspices of the institute during the year. Published by the Henry Phipps Institute, 238 Pine street, Philadelphia, 1905.

TRANSACTIONS OF THE LUZERNE COUNTY, PA., MEDICAL SOCIETY FOR THE YEAR ENDING DECEMBER 31, 1904. Vol. XII. Organized March, 1881. Wilkes-Barre, Pa.; The E. B. Yordy Company, printing and blank bookmaking, 1904.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Third series. Vol. XXVI. Philadelphia: Printed for the college, 1904.

THE OPHTHALMIC YEAR-BOOK. A Digest of the Literature of Ophthalmology, with Index of Publications for the Year 1903. By Edward Jackson, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic; President of the American Academy of Ophthalmology and Oto-Laryngology; Ophthalmologist to the Denver County Hospital, St. Anthony's Hospital and Mercy Hospital, Denver, etc. With forty-five illustrations. The Herrick Book and Stationery Company, Denver, Col., 1904.

THE INFLUENCE OF GROWTH ON CONGENITAL AND ACQUIRED DEFORMITIES. By Adoniram Brown Judson, A.M., M.D., Orthopædic Surgeon to the Outpatient Department, New York Hospital, 1878-1903; Statistical Secretary of the New York Academy of Medicine; formerly Chairman of the Orthopædic Section, New York Academy of Medicine; formerly President of the American Orthopædic Association; Member of the American Medical Association; Fellow of the American Academy of Medicine; formerly Surgeon U. S. Navy. Profusely illustrated. New York: William Wood & Co.

A HAND-BOOK OF NURSING, REVISED EDITION FOR HOSPITAL AND GENERAL USE. Published under the direction of the Connecticut Training School for Nurses, connected with the General Hospital Society, New Haven, Conn. Philadelphia and London: J. B. Lippincott Company, 1905.

A REFERENCE HAND-BOOK FOR NURSES. By Amanda K. Beck, Graduate of the Illinois Training School for Nurses. Philadelphia and London: W. B. Saunders & Co., 1905.

DISEASES OF THE BLOOD. By Prof. Dr. P. Ehrlich, Director of the Royal Institute for Experimental Medicine, Frankfurt a./M.; Prof. K. von Noorden, Professor in the Medical Clinic of the Frankfurt City Hospital; Dr. A. Lazarus, Privat Docent in Internal Medicine, University of Berlin; Dr. F. Pinkus, formerly of the University of Berlin. Edited with additions by Alfred Stengel, 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., 1905.

A TEXT-BOOK OF MEDICAL CHEMISTRY AND TOXICOLOGY. By James W. Holland, A.M., M.D., Professor of Medical Chemistry and Toxicology, and Dean, Jefferson Medical College, Philadelphia. Fully illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

NINETEENTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH AND VITAL STATISTICS OF THE COMMONWEALTH OF PENNSYLVANIA. Transmitted to the Governor, December 7, 1903. William Stanley Ray, State Printer of Pennsylvania, 1904.

NINETEENTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH AND VITAL STATISTICS OF THE COMMONWEALTH OF PENNSYLVANIA. Vol. II. Transmitted to the Gov-

ernor December 7, 1903. William Stanley Ray, State Printer of Pennsylvania, 1904.

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. Collected and arranged with critical editorial comments by J. M. Baldy, M.D.; Samuel Horton Brown, M.D.; J. Chalmers DaCosta, M.D.; J. Leslie Davis, M.D.; W. A. Newman Dorland, M.D.; John H. Gibbon, M.D.; Virgil P. Gibney, M.D.; C. A. Hamann, M.D.; Barton Cooke Hirst, M.D.; D. Braden Kyle, M.D.; Walter L. Pyle, M.D.; J. Hilton Waterman, M.D. Under the general editorial charge of George M. Gould, M.D. Surgery. Philadelphia and London: W. B. Saunders & Co., 1905.

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. 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.; J. Claxton Gittings, M.D.; J. P. Crozer Griffith, M. D.; Reid Hunt, M.D.; Walter Jones, Ph.D.; A. O. J. Kelly, M.D.; John Marshall, M.D.; Nat. Sc.D.; J. H. W. Rhein, M.D.; Davis Riesman, M.D.; Alfred Stengel, M.D.; A. A. Stevens, M.D.; G. N. Stewart, M.D.; Reynolds Webb Wilcox, M.D. Under the general editorial charge of George M. Gould, M.D. Medicine. Philadelphia and London: W. B. Saunders & Co., 1905.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE, FOR STUDENTS AND PRACTITIONERS. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; Laureate of the Royal Academy of Medicine in Belgium; of the Medical Society of London; Author of "A Text-Book of Practical Therapeutics," and "A Text-Book of Practical Diagnosis." Illustrated with 129 engravings and 10 plates in colors and monochrome. Philadelphia and New York: Lea Bros. & Co., 1905.

THE INTERNATIONAL MEDICAL ANNUAL. A Year-Book of Treatment and Practitioner's Index. 1905, twenty-third year. A résumé of the year's medical literature, by thirty-six department editors, with added articles by noted specialists. New York: E. B. Treat & Co., Price, \$3.

MONOGRAPH-MOSQUITOS, or Culicidal of New York State Bulletin. Published by the University of the State of New York. Issued by the New York State Museum. Ephraim Porter Felt, State Entomologist. Albany, New York State Education Department, 1904.

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. 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. Balantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Krcetz, M.D., Vienna. with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Vol. I. Fifteenth series, 1905. Philadelphia and London: J. B. Lippincott Company, 1905.

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EDITORIAL COMMUNICATIONS.

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THE SURGICAL TREATMENT OF TUBERCULOUS PERITONITIS.

Laparotomy for the cure of tuberculous peritonitis was first advocated by König in 1884. Inspired by his experience, surgeons performed laparotomy with increasing frequency, and in 1889 König reported the results of a study of 131 operated cases. From the time of his publications laparotomy was accepted as a curative agent by most surgeons and clinicians. Later a reaction set in, and it was claimed by some observers that many patients with tuberculous peritonitis would recover spontaneously and some claimed that more patients would get well under medical treatment than after operation. Careful study of recent literature warrants the conclusion that most observers still believe that laparotomy has a legitimate place in the treatment of tuberculous peritonitis if the disease is not too far advanced. Nor is it established that laparotomy per se is dangerous unless it is done too late. Most clinicians agree that to wait for spontaneous recovery, which is very uncertain, is to expose the patient to dissemination of the tuberculosis and thus allow the favorable moment for operation to pass. Recent statistics show that the ultimate results after surgical treatment are better than after so-called conservative treatment. Tuberculous peritonitis is a symptomatic condition, due to a primary focus of infection in the uterine appendages, appendix, intestines or mesenteric glands. This focus of infection should be removed whenever it can be done without unduly breaking up adhesions or if section can be made in healthy tissues. Relapses following laparot-

omy are frequently due to non-removal of the focus of infection, which then acts as a source of reinfection. This is convincingly pointed out in a masterly address on the subject by William J. Mayo (*Journal of American Medical Association*, April 15, 1905), whose wide experience enables him to speak with authority. In St. Mary's Hospital, Rochester, Minn., in a period of ten years, there have been 6,408 abdominal operations performed. Of this number 184 were for some variety of abdominal tuberculosis, and of these 89 were cases of tuberculous peritonitis, with 3 deaths. Many of these patients returned several times with a relapse of the peritoneal condition or some other form of tuberculosis. It became evident that tuberculous peritonitis in the large majority of women was secondary to lupus of the mucous membrane of the fallopian tube, and if the latter was not removed it would surely act as a source of reinfection. By patience and care they were able to enucleate tuberculous tubes in 26 cases of tuberculous peritonitis, with 25 recoveries. Whereas 7 of these patients had been operated on by simple laparotomy one to four times previously, not one of them had to be operated on after removal of the tubes. The good results obtained in these cases are very striking, and fully sustain the conclusion that the treatment of tuberculous peritonitis should embrace not only the treatment of the peritonitis, which is symptomatic, but the removal of the source of infection as well, which, in the majority of cases, will be found in the uterine adnexa, appendix, intestines or mesenteric glands.

SPECIAL TRAIN TO A. M. A. MEETING.

The trip on the American Medical Association Special is attracting a great deal of attention, and invitations have been received from various local societies throughout the country providing for the entertainment of the members of the party.

CORONERS' BILL.

27 WILLIAM STREET,
NEW YORK, May 8, 1905.

DR. H. R. PURDY,
149 Lexington Avenue, New York City.

My Dear Dr. Purdy—I regret more than I can tell you to have to advise you that the Coroners' Bill did not pass. As you may be aware, I was away from Albany nearly two weeks on account of illness, and only returned for the last week of the session. In the closing days the Assembly Committee on Rules declined to report the bill on account of the objection of the Kings County Republican organization, which had passed resolutions against it. Under the circumstances it was impossible to get the bill through the Assembly, as the Committee on Rules practically dominates that body during the last ten days of the legislative session.

However, we shall have to consider the fight only postponed, and must renew it next year.

Yours faithfully,

N. A. ELSBERG.

PATENT MEDICINES.

We publish a letter from Mr. Bok, editor of the *Ladies' Home Journal*, to the *American Medical Association Journal*. It is a strong and earnest protest of the physician's lax methods in support of good measures before the legislative bodies. It is desirable for all members of our Association to read carefully and prepare to assist the Committee on Legislation. It is the duty of the Committee on Legislation to be ready and work. There is time, but none too much, to get ready and to earnestly secure cooperation of the profession of this State. There will be the opportunity next year.

FOR A PURER MILK SUPPLY.**A Milk Commission for Rockland County.**

The Rockland County Milk Commission was formed at New City on Wednesday, for the purpose of looking after the milk supply in this county and seeing that the milk is furnished under more sanitary conditions than in the past. The health officers of the different towns in the county were requested to meet with the members of the Rockland County Medical Association at this time, and Orangetown, Clarkstown and Haverstraw responded, but Ramapo and Stony Point were not represented.

Those present at the meeting were: Dr. G. A. Leitner, president of the County Medical Association; Dr. Crosby, Haverstraw, secretary of the County Medical Association; Dr. C. D. Kline, Nyack health officer; Dr. Carter, health officer of Haverstraw; Dr. J. W. Giles, South Nyack health officer; Dr. N. B. Bayley, of Haverstraw; Dr. S. W. S. Toms, of Nyack, and a representative from Clarkstown. The milk commission was formed, with Dr. Leitner as president and Dr. Crosby as secretary, and its object is to recommend to boards of health that they adopt regulations controlling the milk supply of Rockland County and issuing licenses to milk dealers and venders.

The organization of this commission is the

result of an examination made by Dr. Toms, in which he found that the milk producers and dealers were sadly deficient in sanitary knowledge. He says that not a single cow stable he visited was in proper condition; all were poorly ventilated and dirty. Dr. Toms showed that from a single germ in the milk, coming from a hair or a bit of excreta, 200 germs will develop in three hours, 10,000 in six hours, 10,000,000 in nine hours, and 200,000,000 in eighteen hours. He showed the extreme danger to children and grown people from dirty milk and efforts will be made to bring about a better condition.

The commission organized will consist of all the health officers of the county, with representatives from the two medical societies and from the milk dealers and dairymen.—*Nyack Evening Journal*.

The Health Commissioner of New York City, Dr. Thomas Darlington, said he is in hearty sympathy with the formation of the Rockland County Milk Commission for the maintenance of sanitary conditions on the premises of milk producers. He also hopes to see other counties in this and neighboring States take the same public interest that Rockland County has taken.

LIBRARY FOR THE BLIND.

At the corner of Fourth avenue and Pacific street, Brooklyn, there has been opened a public library for the blind. The books with raised letters are so expensive that few blind people can afford a library. At the same time, deprived of one avenue to the outside world, the mind of the afflicted ones would seem to need literature even more than the mind of him who can see. These people are said to prefer light reading, telling of the sunshine and flowers, to profounder subjects. Perhaps some patient of yours would like to add a volume to this library.

SAYS DOCTORS SCARE PEOPLE.

At the annual meeting of the Connecticut Eclectic Medical Association, Dr. S. B. Munn, of Waterbury, in a report on contagious and infectious diseases, declared that smallpox and spotted fever were not contagious.

"The greatest disease of to-day," he said, "is fear which physicians inoculate into the community. There is an epidemic of everything with the old school physicians except one of common sense."

He said that he had noticed since the State Board of Health had been organized the death-rate had increased rather than decreased. "Doctors," he said, "do more to frighten people into disease than any other one cause." He gave it as his opinion that vaccination was generally advocated because it meant money in the doctor's pocket.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and personals of the members.

DISTRICT BRANCH MEETINGS FOR JUNE.

Fourth District Branch—Tuesday, June 6th.

COUNTY ASSOCIATION MEETINGS FOR JUNE.

Wayne County—Tuesday, June 6th.

Erie County—Monday, June 12th.

Tompkins County—Tuesday, June 13th.

Cortland County—Friday, June 16th.

Lewis County—Tuesday, June 27th.

Monroe County—Tuesday, June 27th.

COUNCIL MEETING.

Council meeting of The New York State Medical Association, held at 64 Madison avenue, New York, April 29, 1905.

The president, Dr. J. Riddle Goffe, reported that in accordance with the instruction of the Council, Mr. Charles F. Brown, ex-Judge of the Supreme Court, had been selected by him and engaged as associate counsel; that several conferences had been held with Judge Brown and Mr. Lewis regarding the technicalities and difficulties of amalgamation; that a careful written opinion had been given by these lawyers, a copy of which would appear in the May number of the JOURNAL.

Briefly this opinion may be summarized as follows: As there is no article in the By-Laws of the Association stating how many members shall constitute a quorum at the meeting of the Association, the corporation law of the State obtains—viz., a majority of the members of the entire organization shall constitute a quorum. No action of the Association, therefore, is legal unless a majority is present either in person or by proxy. The vested rights of no member can be voted away against his will unless he is personally notified of the meeting at which such action is to be taken, the exact time and place of such meeting, and its object. As it is manifestly impossible to personally serve such notice in all instances, the courts recognize that an acknowledgment of the receipt of notice by mail is equivalent to a personal notice.

It has therefore been arranged in accordance with instruction of the Council to send out notices of the meeting by mail, enclosing an acknowledgment of service of such notice, which each member is asked to return signed and witnessed. If this acknowledgment of service is not returned it then becomes necessary to serve a personal notice. This will be expensive, and it is hoped that every member will have an eye to this feature and return the acknowledgment,

signed and witnessed, at the earliest possible moment.

With the notice of the meeting will be included a proxy, which, if returned signed and witnessed, will insure each member a vote in favor of amalgamation. If a majority vote in the affirmative at the October meeting, either personally or by proxy, the question of amalgamation will be declared carried and an application made to the court to consummate the act. In case opposition develops at that time, the majority may appeal to the court to have a receiver appointed and the affairs of the Association wound up as in any corporation. Those who demand it may take their share of the proceeds of the corporation's effects and the majority will take the balance and cast their lot with the State Society.

What we ask now is the authorization of the Council to put this process into execution and the funds to meet the expense.

Dr. Ferguson asked the question as to whether there had been any action taken in placing the Principles of Ethics of the American Medical Association before the profession of the State so that the members of each medical organization would be instructed as to the status of this document when the amalgamation occurs.

Dr. Goffe stated that the Council had already voted to send copies of the Principles of Ethics to every member of the Association and the Society, but the time of sending them out had been held in abeyance until the legal technicalities had been settled and the president of the Medical Society of the State of New York has been consulted. All members of The New York State Medical Association and The Medical Society of the State of New York and its component county societies will receive a copy. Accompanying this copy there will be a circular letter explaining reasons for the vote of the amalgamated society upon the Principles of Ethics.

Dr. Ferguson said: "That is all I want to know. If that is done I have no doubt at all in the matter, and am with you heart and soul for amalgamation."

Dr. Ferguson moved:

"That the report of the President in the matter of the amalgamation proceedings relative to The New York State Medical Association and The Medical Society of the State of New York be approved, both in relation to special legal advice and in the notification of members of the Association, and that the expenses connected therewith be authorized, so far as two hundred and fifty dollars for special counsel and the printing, mailing or other service of notice are concerned." Seconded, and carried.

CHARLES I. REDFIELD, Secretary.

The following circular letter, notice of meeting and vote on agreement, etc., were ordered issued by the Council:

THE NEW YORK STATE MEDICAL ASSOCIATION,

May 1, 1905.

You will please take notice that a regular annual meeting of The New York State Medical Association will

be held, pursuant to Section 1, Article VI, of its By-Laws, in the City of New York, Borough of Manhattan, at the Academy of Medicine, 17 West 43d street, on Tuesday, the 17th day of October, 1905, at 10 o'clock in the forenoon.

J. RIDDLE GOFFE, President,

The New York State Medical Association.

CHARLES I. REDFIELD, Secretary,

The New York State Medical Association.

My Dear Doctor—Enclosed herewith you will receive a copy of the agreement of consolidation prepared by the Joint Committee of Conference of The New York State Medical Association and The Medical Society of the State of New York, which agreement has been unanimously adopted by The Medical Society of the State of New York at its annual meeting, as well as at a special meeting called for that purpose.

I feel sure that there is a unanimous desire on the part of the members of The New York State Medical Association to have in the State of New York a united profession, and with this end in view, and under the advice of counsel, there is sent to you herewith a notice of the meeting, giving place, day and hour, together with a proxy authorizing certain gentlemen therein named to vote as directed in such proxy; also an acknowledgment of the receipt by you of the notice of the meeting, all of which papers are important for you to consider and take action thereon as requested.

Unquestionably every member should be given the privilege of voting upon this amalgamation or consolidation question, and therefore the Council has authorized sending proxies directing the gentlemen named therein to vote for the project, thus giving you an opportunity of registering your voice and vote.

Owing to the failure of the matter in the courts last year, this acknowledgment of the receipt of the notice by you is imperative, otherwise the Association will be put to the expense of paying some one to serve you personally with this notice and making an affidavit of such service; therefore I respectfully urge that immediately upon receipt by you of these documents you give them, one and all, your careful consideration.

In the May JOURNAL of the Association will be found the opinion of the attorneys, showing the necessity for this action. Do your part toward complying with the requirements prescribed by them for this meeting by signing the acknowledgment of personal service and the proxy and returning them promptly.

It is unnecessary for me to add that we hope every member will be present at the meeting. But you are requested to sign and return the acknowledgment of the receipt of the notice and the proxy at once. Your presence at the meeting will annul the proxy and you will cast your own vote.

J. RIDDLE GOFFE, President,

The New York State Medical Association.

TO THE NEW YORK STATE MEDICAL ASSOCIATION,
64 Madison Avenue, New York City.

Gentlemen—I hereby admit this day of May, 1905, personal service upon me of a notice in writing of a regular annual meeting of The New York State Medical Association, to be held in the City and County of New York, Borough of Manhattan, on Tuesday, the 17th day of October, 1905, at the Academy of Medicine, 17 West 43d street, at 10 o'clock in the forenoon.

Dated, May, 1905.

Witness.

Member.

Know All Men by These Presents, That I, do hereby constitute and appoint J. Riddle Goffe, A. A. Jones, F. A. Baldwin and C. I. Redfield, or a majority of them, to be my lawful attorneys, substitute and proxy for me and, in my name, to vote at the regular annual meeting of the members of The New York State Medical Association, to be held in the City of New York, Borough of Manhattan, at the Academy of Medicine, 17 West 43d street, on Tuesday, the 17th day of October, 1905, at 10 o'clock in the forenoon, and at any adjourned meeting thereof, as fully and with the same effect as I might or could do were I personally present at such meeting, as follows and not otherwise: First—To vote in

favor of the agreement of consolidation prepared by the Joint Committee of Conference appointed by The New York State Medical Association and The Medical Society of the State of New York, dated January 23, 1904, and heretofore adopted at the regular and a special meeting of The Medical Society of the State of New York in the year 1905; a copy of which agreement has been served upon me, and with the contents of which I am familiar. Second—To vote in favor of the appointment at such annual meeting of a committee, consisting of E. Eliot Harris, Julius C. Bierwith, Alexander Lambert, Parker Syms and Wisner R. Townsend, or, in case of the disability of any of them, then for such persons as the president may appoint in his or their place and stead, to carry out the purposes of said agreement and with full and absolute power to take any and all legal steps necessary in the premises, in the place of the said The New York State Medical Association, as may be necessary, to complete the consolidation of The New York State Medical Association and The Medical Society of the State of New York. Third—To vote in favor of each and all of the proposed amendments to the by-laws of The New York State Medical Association as presented at the regular annual meeting of The New York State Medical Association held in October, 1904.

I hereby revoke any proxy or proxies heretofore given by me to any person or persons whatsoever.

In witness whereof I have hereunto set my hand and seal this day of May, 1905.

In presence of
Member.
.....
Witness.

Second District Branch.—The twenty-third annual meeting was held in Arrowhead Hotel, Saratoga Lake, Saratoga Springs, Thursday, May 25, 1905.

The meeting was called to order at 10.30 A. M.

The following papers were read: "Late Capillary Hemorrhage in Gall Stone Operations with Jaundice," by Dr. E. D. Ferguson, Troy; "Exophthalmic Goitre, Peculiar Complications and Post Mortem Findings," by Dr. R. H. Irish, Troy; "Report of a Case of Chronic Eczema, Involving the Whole Skin Surface," by Dr. H. W. Cary, Troy; "The Report of a Case of Perforating Thoracic Aneurism, with Non-Fatal Rupture," by Dr. H. C. Gordinier, Troy; "Two Interesting Cases," by Dr. William Finder, Jr., Troy; "The Early Recognition of Gall Stones," by Dr. John B. Harvey, Troy; "The Report of Two Cases," by Dr. G. F. Comstock, Saratoga Springs; "An Investigation of the Influences of Adrenalin Chloride on Toxic Doses of Cocaine," by Dr. J. M. Berry, Troy; "Early Diagnosis of Cancer of the Womb," by Dr. J. A. Simpson, Albany; "Chronic Suppurative Otitis," by Dr. B. S. Booth, Troy; "The Sewage Disposal Proposition at Saratoga Springs," by Dr. D. C. Moriarta, Saratoga Springs.

The Committee on Arrangements, consisting of members of the Association residing in Saratoga Springs, with Dr. George F. Comstock as chairman, provided transportation by trolley to the Arrowhead Hotel, where a delightful fish dinner was served. At the conclusion of the meeting the party was taken to inspect the provision for sewage disposal at Saratoga Springs.

* * *

Fifth District Branch.—The twenty-first annual meeting of the Fifth District Branch of The

New York State Medical Association was held in the library of the Vassar Brothers' Hospital, Poughkeepsie, N. Y., May 2, 1905.

The Executive Committee meeting was called to order at 11 A. M., Dr. Van Hoesenberg presiding. A quorum being present, the minutes of the last meeting were read and approved. On motion, duly seconded and carried, it was resolved that the bills against the Branch Association, after proper certification, be referred to the treasurer for payment.

There were no reports from committees. The treasurer, Dr. Dodin, read his report for the year, which, on motion, duly seconded and carried, was accepted. The president appointed Drs. LeRoy and Preston as an auditing committee for this report. Adjournment followed.

The annual meeting of the Fifth District Branch was called to order, Dr. Van Hoesenberg presiding. Several members of the Nominating Committee being absent, the president made the following appointments to that committee:

Dutchess County, Dr. Guy C. Bayley; Rockland County, Dr. G. A. Leitner; New York County, Dr. E. Eliot Harris; Ulster County, Dr. Mary Gage-Day; Orange County, Dr. G. W. Blanchard; Westchester County, Dr. T. J. Acker.

The president then delivered his address.

Dr. Goffe, president of The New York State Medical Association, was asked to make some remarks on amalgamation of the State Association and the State Society, which he did, and they were freely discussed by Drs. Bayley and Harris.

The scientific session opened at 12 o'clock with Dr. Bayley's paper, "A Dislocation of the Foot Backward Which Is not Explained or Understood." Dr. Hastings then read a paper on "The Bacteriological Findings in the Spinal Fluid of Fifty Cases of Cerebro-Spinal Meningitis." Discussed by Dr. Von Tiling.

Recess was then taken, and a collation was served to the members in the hospital building.

Session resumed at 1.55 P. M. The Nominating Committee made the following report:

For president, Dr. Irving D. LeRoy, Dutchess County.

For vice-president, Dr. Elizabeth Burr Thelberg, Dutchess County.

For secretary, Dr. Mary Gage-Day, Ulster County.

For treasurer, Dr. Henry A. Dodin, New York County.

For member of Nominating Committee to State Association, Dr. E. Eliot Harris, New York County, and Dr. Thomas J. Acker, Westchester County.

Motion made, seconded and carried that the secretary cast a ballot for same.

The scientific session was resumed with the Symposium on Gastric Ulcer. Dr. William Van Valzah Hayes opened with "The Diagnosis and Medical Treatment of Gastric Ulcer," followed

by Dr. John Erdman, on "The Surgical Treatment of Gastric Ulcer." These papers were discussed by Drs. Conner, Townsend and Grad.

Dr. Harris moved that a vote of thanks be given Dr. Bayley and the trustees of the Vassar Brothers' Hospital for the hospitality shown to the members of the Fifth District Branch at this meeting. Seconded and carried.

The retiring president then introduced the officers-elect and adjournment was taken.

(Signed) CHARLES D. KLINE, Secretary.

* * *

Broome County Association.—The annual meeting of this Association was held at Dr. Orton's office, Binghamton, on April 11, 1905, at 10.30 A. M., the president, Dr. Farnham, presiding. There were eleven members present.

In the scientific session, a paper was read by Dr. John H. Martin, reporting two cases of diphtheria, which was discussed by nearly all the members present. Dr. Francis M. Michael reported two cases of epilepsy and chorea; a discussion followed by several of the members. Dr. LeRoy D. Farnham gave a most interesting address on "Success in Medicine." The name of Dr. G. Francis Lape was presented for membership, and the secretary was instructed to cast a vote for him and he was declared elected.

The following officers were elected for the ensuing year: President, LeRoy D. Farnham; vice-president, John H. Martin; secretary, Clarke W. Greene; treasurer, William H. Knapp; Fellows, J. G. Orton and C. W. Greene; Alternates, B. W. Stearns and L. H. Quackenbush. Dr. L. D. Farnham was elected member of the Nominating Committee of the Third District Branch.

(Signed) CLARKE W. GREENE,
Secretary.

* * *

Erie County Association.—The annual meeting of this Association was held at the University Club, Buffalo, on March 13, 1905. There was an attendance of fifty-five.

On motion, Drs. A. A. Jones, Marcel Hartwig and J. W. Grosvenor were appointed a committee to draw up a protest against the Davis Osteopathic Bill.

The following officers were elected for the ensuing year: President, Arthur G. Bennett; vice-president, Grover W. Wende; secretary, David E. Wheeler; treasurer, Adolph H. Urban; member of the Executive Committee, Vertner Kenson; member of the Nominating Committee of the Fourth District Branch, William H. Chase; Fellows, A. A. Hubbell, W. H. Thornton, C. G. Stockton, DeLancey Rochester, Bernard Cohen, Julius Ullman, F. Park Lewis, Charles A. Wall, George F. Cott, Grover Wende, Arthur G. Bennett, Marshall Clinton, Earl Lothrop and H. G. Hunt; Alternates, W. Scott Renner, E. Burrows, H. E. Buswell, E. Starr, Thomas G. Allen, Marcel Hartwig, A. E. Diehl, E. L. Frost, P.

LeBreton, A. E. Woehnert, W. C. Phelps, R. H. Johnson, C. C. Frederick and J. S. Otto.

In the scientific session, Dr. Prescott LeBreton presented a case of Pott's disease of the axis and atlas. Dr. A. J. Colton presented a drainage tube designated to obviate resecting a rib for empyema. The following papers were read: "Experimental Work to Devise an Operation Which Would Simplify the Treatment of Advanced Cases of Lateral Curvature of the Spine," by Dr. Prescott LeBreton; "Treatment of Acute Otitis Media," by Dr. W. Scott Renner; "The Busy Practitioner, from the Business Point of View," by Dr. Albert J. Colton. A collation was served at the close of the meeting.

(Signed) DAVID WHEELER,
Secretary.

* * *

Essex County Association.—The annual meeting of this Association was held at Port Henry, N. Y., on April 18, 1905.

In the scientific session the following papers were read: "Chronic Gastric Catarrh, Its Symptoms and Treatment," by Dr. V. A. Marshall, Moriah; "A Case of Multiple Neuritis and Diabetes Mellitus, with Remarks on Treatment," by Dr. W. T. Sherman, Crownpoint; "An Inquiry into the Mechanism of Obstetric Forceps, with Exhibition of a New Instrument Involving a New Principle," by Dr. A. A. Wheelock, Elizabethtown.

The following officers were elected for the ensuing year:

President, W. E. Pattison, Westport.

Vice-president, J. P. J. Cummins, Ticonderoga.

Secretary and treasurer, A. A. Wheelock, Elizabethtown.

Fellow, G. H. Beers, Ticonderoga.

Alternate, W. T. Sherman, Crownpoint.

The next annual meeting of this Association will be held at Westport, the third Tuesday in April, 1906.

(Signed) A. A. WHEELOCK, Secretary.

* * *

Jefferson County Association.—The annual meeting of this Association was held at the City Hall, Watertown, on January 12, 1905. The following officers were elected for the ensuing year: President, Andrew J. Dick, Watertown; vice-president, Michael J. Lawler, Carthage; secretary, W. D. Pineseault, Watertown; treasurer, Charles Campbell Kimball, Watertown.

(Signed) W. D. PINSENEAULT,
Secretary.

* * *

New York County Association.—The regular monthly meeting of the New York County Medical Association was held Monday, May 15, 1905, at the Academy of Medicine, 17 West 43d street. The president, Dr. Francis J. Quinlan, presided. Twenty-one new members were elected by the Association. A memorial to the late

Patrick J. Lynch was read by Frederick P. Hammond, M.D. The first regular paper of the evening was read by E. L. Keyes, Jr., M.D., entitled "The Need of Sexual Education." This paper will appear in the JOURNAL. The second paper of the evening was on the "Social Prophylaxis and the Medical Profession," by Prince A. Morrow, M.D.

Dr. Morrow said in part, that it would be the purpose of the paper to disclose the objects and ideals of the Society of Moral and Social Prophylaxis, which had but recently been organized. It was proposed that they should work out the principles for the prevention of the spread of venereal diseases. Venereal diseases were the cause of one-eighth of all the ills that humanity was heir to and invaded all portions of the body in its pathological lesions. Syphilis was the cause of 90 per cent. of all cases of tabes dorsalis and the parent of 70 per cent. of ocular paralyses. A very large proportion of hemiplegias were due to this disease and all cases of hemiplegia under 40, which were not of alcoholic, were of syphilitic origin. It was the cause of 42 per cent. of all abortions; 60 per cent. of children of syphilitic parents die in utero. Besides inflammatory and articular troubles, the gonococcus infection was the cause of 80 per cent. of all deaths due to inflammatory diseases in women; 50 per cent. of all gynecological operations were due to gonococcus infection. The effects upon conception and pregnancy were to render 55 per cent. of the women sterile and to bring about 20 per cent. of the abortions in the other cases; 80 per cent. of all blindness in the new-born, and 20 per cent. of all that of humanity were due to the gonococcus. In the light of these and other terrible facts the speaker thought it about time that these scourges should be attacked, in the hope that some means might be found to prevent their further spread. Prevention was difficult because of moral, etiological and ethical reasons. This was not a class of contagious diseases suitable for control by the sanitary authorities. The Society included medical men, sociologists, those of the clergy who might be interested, business men, and all members of the laity who might contribute something of some sort to the success of the movement. Neither virtue nor marriage was a protection against infection by venereal diseases.

In almost every instance, cases of infection carried into married life were due to ignorance, and it was the object of this Society to correct this ignorance. Prevention of a venereal disease could only be accomplished by voluntary action. The public should be aroused to the dangers of infection by venereal diseases. The rising generation should be the one to be enlightened, as they were the most liable to infection. This was not an impossibility. Whatever strengthened the moral tone of the individual helped to prevent infection. To prevent the spread of the diseases it was necessary to reorganize the dispensaries and hospitals where they were treated. The

Society could send out literature which would disseminate the knowledge to the ignorant. This education must be undertaken by the personal propagandization of the physician to the family.

The Society will treat it as a matter for sociological investigation. The present popular conception of the various venereal diseases is but the reflection of the discarded theories of the past generations of physicians. This misconception is due to the fact that it is only recently that this branch of medicine has been put on a scientific basis. Veneriology had been always held as subordinate in medical colleges. Even to-day this branch is not compulsory for graduation. Only a very few colleges permit its teacher to ask questions to the graduating student. The education should begin in the medical profession and in the medical schools and societies. The idea of the Society was a generally moral one and an essentially humane one. Humanity demanded that marriage should not be made that Moloch of human sacrifice. More papers on syphilis and gonorrhœa had been read at the Academy of Medicine in the last twelve months than in the previous twelve years.

Dr. E. H. Grandin, in discussing this paper, said that we have yet to fight the worst of scourges that attack the human animal. When once the gonococcus gets beyond the internal os, the disease is incurable; 66 $\frac{2}{3}$ per cent. of the speaker's gynecologic operations were due to the gonococcus. The chief phase of the race suicide problem was the gonococcus. The requisite to carry on the crusade lay in the education of the people, and every physician should teach his son the use and abuse of his genital organs. The girl should be taught, and the proper person to teach the girl was her mother. Prostitution should be looked upon in the proper light; the male prostitute should be more scorned than the female, as he was the more licensed. We should insist that the boards of health investigate these diseases.

The Very Rev. Dr. Lavelle, Vicar-General of the Archdiocese of New York, was then introduced and spoke in part as follows: It would be well if more of the clergy were present at such meetings. It had been the aim of the speaker's life to take the work of the Society in hand. The Catholic priests came close to the human heart through the confessional and it had been in this way that they had taught moral sanitation to its children. The Church had not yet entertained the idea of public sexual instruction, as it was afraid of the consequences of such teaching. The remarkable prevalence was not known to the average clergyman. He thought that the public held male licentiousness as a weakness that should be winked at. In closing, he wished to state that the Catholic clergy most heartily endorsed the proposed work of the Society; that they were prepared to assist the movement and to swell the ranks of the organization.

Dr. Herman J. Klotz remarked that years of active practice had shown him enough to make him deplore the fact that society had so far refused to do more than ignore the prevalence of venereal diseases. The work of the Society must of necessity be slow. The medical profession should start the work of educating the public. The physician should first of all be sure that his patient is cured before discharging him. If the doctor made light of the disease, the patient would adopt the same view. On the other hand, it was not well for the physician to be too harsh with the patient, as such a procedure might drive the patient into the hands of the quack. There were but few beds in the hospitals where this class of patients could be taken care of. He did not believe that it was wise to report this class of cases to the Department of Health. It was impossible to attempt to segregate these patients, as there was no island large enough to hold one-half of the living syphilitics.

Dr. L. E. LaFetra said that it was well known that syphilis produces a large number of abortions and was the cause of many deaths in the young, but that it was not known, even by the average physician, that gonorrhœal infection was very prevalent among children; 6 to 10 per cent. of the children who had applied to the Vanderbilt Clinic were syphilitics; 1 to 2 per cent. were infected with the gonococcus. This did not take into account the cases of ophthalmia neonatorum. The vaginitis was most severe and most difficult to cure. Such being the case, it was our duty to teach the mothers the means to prevent infection in the future. Gonococcus vaginitis was very common in the many "day nurseries." Moral and physiological education of the young was most urgent in the prophylaxis of venereal diseases. Efforts should be made to forestall the false physiology of the sexual organs of the street corners. This could be accomplished by lectures to the boys in school, as had already been tried with success in the University of Pennsylvania and in various schools in Germany.

Dr. L. Bolton Bangs rejoiced that the subject which had been so much tabooed for years was now spoken of openly and in public. The Society would reach by its literature all but the most ignorant. The boy should not be left in ignorance until puberty. The medical man was not only the conservator of morals, but he should be the teacher of sexual physiology, hygiene and sanitation. There were poorly guided physicians who had taught their patients to masturbate so that they might not indulge in fornication.

Dr. E. L. Keyes, Sr., said that at the present moment he was in the receptive stage with regard to the subject of moral and social prophylaxis. The good in such a movement would come from teaching the young, as it was impossible to break an old man from any such habits.

Mr. Champe S. Andrews said that it was his belief that part of the work that the Society should attend to was the closing of offices of

those quacks who advertised to cure venereal diseases.

Dr. Andrew H. Smith said that he was glad that the time had come when these diseases could be openly discussed. Like the curiosity of "Bluebeard's wives" all interest in it would be lost to young boys provided the secrecy which in the past had surrounded their genital functions could be removed.

Dr. Lapowski said that he did not think that it was true that all men must do without sexual relations with women before marriage, as to a certain class of men such a function was a necessity. The Rev. Dr. Duval, of Winnipeg, Manitoba, also addressed the Association.

The discussion was closed by the two essayists.

Dr. E. E. Harris moved that the New York County Medical Association express its hearty approval of the movement which the Society for Moral and Social Prophylaxis was to carry out. This was duly seconded and unanimously passed.

Dr. Daniel S. Dougherty moved that a vote of thanks be tendered to the essayists and to those gentlemen that had taken part in the discussion of the papers.

The Association then adjourned until October.

(Signed) WM. RIDGELY STONE,
Secretary.

REPORT OF THE EXECUTIVE COMMITTEE.

The following resolution was read and adopted:

Resolved, That in the action of certain members of the New York County Medical Association, who have patronized a certain red telephone book by publishing therein the data of their hospital and honorary appointments, it is the opinion of the Executive Committee that such action cannot be construed as other than an intention to publicly advertise themselves for the purpose of commercialism, and that said action is entirely inconsistent with the high standing and objects which have ever governed our Association and have been adopted as the Principles of Ethics of the American Medical Association; and be it further

Resolved, That we hereby request these members to adopt every means possible to have all such data discontinued therein.

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Orange County Association.—The May meeting of this Association was held at the Russell House on Wednesday, May 10, 1905. A large number of the members were present. The meeting was called to order by the president, Dr. E. D. Woodhull, of Monroe. Under report of cases, Dr. Mary E. Dunning, of Newburgh, presented an interesting case of pseudomuscular hypertrophy in a girl 11 years of age. The child is now under treatment by Dr. Dunning, and the results thus far are very encouraging.

Dr. Many, of Florida, presented a case of

phimoses, which developed peculiar mental complications. The treatment of Bright's disease was discussed by the members, at the suggestion of Dr. Conner, of Middletown, and many important points concerning this disease were elicited.

At the business session the minutes of the previous meeting were approved as read. A committee consisting of Drs. Fancher, Howell and Distler were appointed to make arrangements for an outing, to be held some time in June, and the same committee to act with a similar committee of the Orange County Medical Society, to the end that a joint outing be held.

Dr. Redfield called attention to certain papers that every member will soon receive, and urged each one to attend to them and return within ten days from the time they are received. Especially should each member sign the proxy vote for amalgamation. A large vote is necessary and by signing the proxy, whether you are able to attend or not, you will have the satisfaction of knowing that you voted on the matter. Furthermore, every member who fails to return papers served by mail will be served in person, by an officer authorized by law, as it is absolutely necessary that each member of the Association be served with aforesaid notice.

An assessment of \$1 was ordered on each member to pay expenses of the current year. Meeting then adjourned to September 13, 1905.

(Signed) L. G. DISTLER,
Secretary.

* * *

Otsego County Association.—The annual meeting of this Association was held on April 25, 1905. The officers of the preceding year were all reelected.

In the scientific session, Dr. Arthur W. Cutler read a paper on "The Treatment of Gonorrhœa," and Dr. J. C. Smith gave a résumé of the recent literature on pneumonia. Both these papers were generally discussed. The afternoon closed with a report of some interesting cases and a discussion of the same.

(Signed) ARTHUR H. BROWNELL,
Secretary.

* * *

Ulster County Association.—The regular quarterly meeting of the Ulster County Medical Association was held at the Huntington, Kingston, May 15th, at 8 P. M. The Ulster County Medical Society had been invited to be present, and a goodly number responded. The first paper on the program was by Dr. Charles Gardner Child, Jr., of New York, on "The Dynamics of the Female Pelvis, with Special Reference to Mal-Positions of the Uterus and Their Treatment." The anatomy of the pelvis was illustrated on the blackboard, also the various displacements of the uterus and his method of replacement in simple, uncomplicated cases of retro-deviation, by causing downward traction on the

posterior lip of the cervix by means of his specially devised instrument, and one finger pressing up on the fundus through the rectum. The discussion was opened by Dr. Gallagher, followed by Dr. Preston. The full paper will be published in the JOURNAL. The second paper was by Dr. Harlow Brooks, of New York, on "Cerebro-Spinal Meningitis" (the paper will be published, the demonstrations accompanying the paper), which he was aided in giving by his laboratory assistant, Mr. Donald Turnbull, was of the greatest possible interest to the physicians, because of their absence from great centers where such specimens are obtainable. The demonstration was both macroscopic and microscopic; of the former a brain showing the appearance and character of the exudate over its surface and pieces of the spinal cord showing the same. A bottled specimen of purulent spinal fluid, taken by lumbar puncture from a patient who died at the end of twenty-four hours' duration of the disease. Several Petri dishes showing different forms of the growth of the organism, also a number of different cultures in test tubes. In the microscopic demonstration there were six microscopes showing the following specimens: 1, showing the infiltration of pus cells around blood vessels into the brain substance; 2, the purulent exudate over cortex of brain, showing fibrinous character of the pus; 3, meningitis from the pneumococcus and from the microscopic appearance without bacteriological test, it cannot be differentiated; 4, degenerate ganglion cells in the anterior horn of the spinal cord from a case of short duration; 5 and 6, meningococci in spinal fluid. The paper was discussed by Drs. Loughran, Gallagher, Sebring and Mambert. Dr. E. H. Loughran proposed a vote of thanks to the doctors from New York, which was most heartily given.

After the scientific session, dinner was served in the handsome dining-room of the Huntington. After the last course and the cigars had been passed, Dr. James L. Preston, the president, arose and spoke of the friendly feeling which existed between the two county organizations and of the benefit and pleasure which all had received from the papers and lectures which had been given from time to time by prominent physicians from other cities. He then called on Dr. A. H. Vrooman, president of the County Society, to speak on the "Association," which he did in a happy manner, complimenting it especially on its good business methods and its possession of a code of ethics. Dr. H. Van Hoevenberg spoke on the "Society," and dwelt especially on its longevity. Dr. Mary Gage-Day discussed "The Amalgamation." Dr. Philip Bronk Collier spoke on "The Family Doctor," and in closing proposed a toast to him, which all drank standing. Dr. W. C. Sebring spoke on "The Specialist"; Dr. James R. Nelsen, "City Practice as Compared to Country"; Dr. E. H. Loughran, "Medical Finance"; Dr. E. E. Norwood, "Medical Literature"; Dr. N. A. Stern, "Dietetics"; Dr. S. H.

Mambert, "The Trained Nurse." Dr. E. J. Gallagher, formerly of this city, now of Yonkers, closed the speech-making.

Dr. George W. Ross, Port Ewen, Drs. Vrooman, Collier, Loughran, Sebring, Mambert, Nelsen, Norwood, Stern, Gates, Van Gasbeeck, Chappell, Robinson, Linson, Preston, Van Hoevenberg and Gage-Day, of Kingston.

In the business session it was decided to omit the August meeting, and the Association adjourned until November.

(Signed) MARY GAGE-DAY,
Secretary.

* * *

Wyoming County Association.—The regular meeting of this Association was held at the Walker House, Silver Springs, April 11, 1905. There was an attendance of fourteen. In the business session, resolutions were adopted protesting against the passage of the Osteopathic Bill, and copies sent to our Senators and Assemblymen asking them to use their influence to defeat the bill.

The scientific session consisted of a Symposium on La Grippe or Influenza: History, Dr. J. G. Truesdell; Etiology, Dr. P. S. Goodwin. Discussion was opened by Dr. G. E. Peddle. Diagnosis, Dr. L. C. Broughton. Discussion opened by Dr. Z. G. Lusk. Prognosis and Complications, Dr. M. J. Wilson. Discussion opened by Dr. G. S. Skiff. Treatment, by Dr. J. C. Randall. Discussion opened by Dr. L. E. Stage. Date of next meeting, June 11, 1905.

(Signed) LESTER HAYDEN HUMPHREY,
Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Oneida County—Edward M. Hyland, Utica; William Ezra Wetmore, Utica.

SECOND DISTRICT BRANCH.

Albany County—Richard Miller Pearse, Albany.

THIRD DISTRICT BRANCH.

Broome County—George Spencer Lape, Binghamton.

Delaware County—Elwin Champlin, Griffin Corners.

FOURTH DISTRICT BRANCH.

Genesee County—Ray C. Conklin, Batavia; Sophie E. Page, East Bethany.

Wyoming County—Jessie O. Randall, Silver Springs.

FIFTH DISTRICT BRANCH.

Dutchess County—George Huntington, Hopewell Junction.

New York County—J. Bayard Clark, New York City; Hugh M. Cox, New York City; Julien August Gehrung, New York City; Herman R. A. Graeser, New York City; Luther Reeve Hallock, New York City; Frank Tucker Hop-

kins, New York City; Gernaro Ippolito, New York City; Gabriele Miglionico, New York City; Edward R. Pfarre, New York City; William Richter, New York City; Giacomo Rosapepe, New York City; Samuel William Schapira, New York City; Enrico Scimeca, New York City; Cornelius James Seay, New York City; Vincenzo Sellaro, New York City; Henry B. Shaw, New York City; Clinton Stevenson, New York City; Antonio Vernoglia, New York City; M. Viggiani, New York City; John J. White, New York City; Shirley Wilmotte Wynne, New York City.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Birmingham, Francis John, Brooklyn.
Cohn, Felix, New York City.
Cook, Finley R., New York City.
Eversfield, Frank John, New York City.
Francis Lee Masten, Buffalo, N. Y.
Griffin, John M., Warrensburg, N. Y.
Gould, James P., New York City.
Haas, Leopold F. W., New York City.
Halpern, Julius, New York City.
Horn, John, New York City.
Riggio, Louis D., New York City.
Ruzicka, Drahomar Joseph, New York City.
Stern, Abram Richard, New York City.
Townsend, Charles E., Newburgh, N. Y.
Wells, Stephen Whitaker, Liberty, N. Y.
Willard, Thomas H., New York City.

OBITUARY.

Dr. Jacob H. Asch died at his home in New York City on May 19, 1905. Dr. Asch was a graduate of the University of Berlin, Class of 1864. He was a member of the American Medical Association, The New York State Medical Association and the New York Academy of Medicine.

Dr. Heber Nelson Hoople, of Brooklyn, died on May 8, 1905. Dr. Hoople was a graduate of the Bellevue Medical College, Class of 1885. He also took a second degree later in the same year at the Toronto University. He was a member of the American Medical Association, American Laryngological, Rhinological and Otological Society, British Medical Association, The New York State Medical Association, Medical Society of the County of Kings and the Brooklyn Pathological Society.

MEMORIAM.*

Patrick Joseph Lynch, M.D.

Patrick Joseph Lynch, M.D., was born in Virginia, County Caron, Ireland, March 11, 1828. He died at his residence in this city on April 21, 1905.

His early preliminary and academic education

was received at Black Rock College, under the Jesuit Fathers, from which institution he graduated in due time with the degree of A.B.

In 1852 he emigrated to the United States, and two years later entered upon the study of medicine at the University Medical College in this city, from which he graduated in 1857, entering at once upon the practice of his profession in East 13th street, and his entire professional life, covering a period of over forty-eight years, was passed in this one street.

Dr. Lynch was Chief of Clinic to Dr. Valentine Mott during the last seven years of this great surgeon's life, and was for several years associated in the same capacity with the late Dr. Wm. H. Van Buren. It was while serving in these positions that many men came under his observation to receive their first clinical instruction whose names have since been written high upon the tablet of fame in their chosen specialties. When the present Dr. E. L. Keyes, Sr., first came to this city and was introduced to Dr. Van Buren, he was placed in the charge of Dr. Lynch to receive his first practical instruction in genito-urinary surgery, in which specialty he has since rendered such distinguished service. Dr. Lynch was a member of the American and The New York State Medical Associations, the Academy of Medicine, County Medical Society and the Physicians' Mutual Aid Association, of which last institution he was one of the founders. He was president of the Medical Union for two terms, and was physician to the Board of Education for a continuous period from 1887 to 1902, during which time he examined thousands of teachers who today preside over our public schools.

As a physician he was of kind and gentlemanly bearing, yet of stable purpose, carrying with him at all times that calm and dignified bearing which commands the highest degree of respect from all. In professional life he had held consultations with the younger Mott, Kernochan, Willard Parker and the late Dr. O'Rourke. As an obstetrician he had few equals, his early training having been gained as a clinical assistant and associate to the late Dr. Gunning S. Bedford, at the old New York College, and his extensive service in this line gave him such prestige that he was widely sought as an operator by his professional brethren of the East Side.

Dr. Lynch was truly one of those physicians which we now recognize as the dignified old school. To him the honor and integrity of his profession were a sacred trust given into his keeping, from which any departure was a sacrifice of personal honor. Hence do we find him one of the founders of our own Association, and he was for many years one of the active workers in everything pertaining to its welfare.

In stature he was almost a physical giant, standing six feet high, and until his fatal illness, which was of only eight hours' duration, he had never seen a sick day. Yet, to a degree he had

*Read at the stated meeting of the New York County Medical Association, May 15, 1905, by Frederick P. Hammond, M.D.

been hampered in his professional work throughout his lifetime by defective eyesight, and for this reason was he prevented from serving in the late war of the rebellion, although his services were early offered to the Government at the breaking out of hostilities.

He died after a busy life, and his fatal illness seized him only at the close of his usual day's labor. As a friend, physician and kindly father none was more widely known upon the East Side, and none will be more widely mourned than him to whom we pay this last tribute of our affection and esteem. A widow and seven children survive him, one of whom, Charles, is a practicing physician.

SOCIETY NOTES.

Brooklyn Gynecological Society.—At a meeting, held May 5th, Dr. L. G. Langstaff read a paper on "The Treatment of Inevitable and Incomplete Abortion."

Brooklyn Pathological Society.—At a meeting, held May 11th, Dr. R. L. Dickinson read a paper on "The Intractable Hemorrhages of Arteriosclerosis in the Uterus," and Dr. J. Richard Taylor on "An Unusual Cause of Death After Laparotomy."

Buffalo Academy of Medicine.—At a meeting, held May 2d, Dr. William C. Phelps read a paper on "Massage of the Heart in Cases of Impending Death," and Dr. Prescott Le Breton on "Manifestations of Lithæmia in the Spine and Lower Extremities, Simulating Orthopedic Conditions." At a meeting, held May 9th, Dr. Albert T. Lytle read a paper on "The Nurse or the Doctor?" and Dr. A. W. Bayliss on "The Treatment of Disease by Means Other than Drugs." At a meeting, held May 16th, Dr. Prescott Le Breton read a paper on "Some Experiments on Rabbits in Connection with the Correction of Spinal Curvature," and at a meeting, held May 23d, Dr. H. P. Jack read a paper on "Alcohol in Puerperal Sepsis."

East Side Physicians' Association of the City of New York.—At a meeting, held May 19th, in the Symposium on Anæsthesia, the following papers were read: "Nitrous Oxide and Ether," by Dr. H. W. Carter; "Ethyl Chloride," by Dr. Martin W. Ware; "Chloroform," by Dr. H. M. Kalvin; "Local Anæsthesia," by Dr. J. A. Bodine; "Accidents of Anæsthesia: Their Causation, Manifestation and Treatment," by Dr. S. O. Goldan; "The Selection and Administration of the Anæsthetic," by Dr. J. T. Gwathmey, and "Improvements in Anæsthetic Apparatus," by Dr. M. Stark.

Elmira Academy of Medicine.—At a meeting, held May 3d, the following papers were read: "A Foreign Body in the Lungs," by Dr. E. A. Reilly; "Report of a Case of Myxedema," by Dr. Ross G. Loop; "Diet in Pregnancy," by Dr. Anna M. Stuart. Also a paper by Dr. O. S. Nye, of Rutland, Pa.

Harlem Medical Association.—At a meeting, held May 3d, the following papers were read: "Clinical Bacteriologic and Metabolic Aspects of a Case of Traumatic Tetanus. Treatment with Tetanus Antitoxin. Recovery," by Drs. D. Herman, Leo Buerger and Edward A. Aronson. "Conclusions Drawn from Thirty-five Cases of Prostatic Enlargement Treated Within the Last Two and One-half Years by Means of the Three Standard Operations Now Recognized," by Dr. Willy Meyer.

Harvard Medical Society.—At a meeting, held May 27th Dr. George T. Chase read a paper on "Report of a Case of Gunshot Wounds of the Abdomen."

Medical Society of the County of New York.—At a meeting, held April 24th, the following papers were read: "The Nose and Its Accessory Sinuses," by Dr. C. G. Coakley; "The Non-Suppurative Conditions of the Ear Leading to Deafness," by Dr. A. B. Duel, and "The Etiology, Diagnosis and Treatment of Mastoiditis," by Dr. Wendell C. Phillips.

Metropolitan Medical Society.—At a meeting, held May 23d, Dr. M. S. Kakels read a paper on "The Present

Status of the Different Methods of Estimating the Functioning Capacity of the Kidneys, with a Brief Account of Chromocystoscopy and Its Uses."

New York Pathological Society.—At a meeting, held May 10th, Dr. Robert T. Frank read a paper on "Chlorio-Epitheliomatous Proliferation in Teratomata," and Dr. R. J. Wilson on "Morphological Characteristics of the Bacillus Alvei (Bunge), Which Render It Desirable for Teaching Purposes."

New York Surgical Society.—At a meeting, held May 10th, Dr. Coley read a paper on "Final Results of the X-Ray Treatment of Malignant Tumors."

Newburgh Bay Medical Society.—At a meeting, held May 16th, Dr. A. V. Jova read a paper on "Acute Broncho-Pneumonia."

Rochester Academy of Medicine.—At a meeting, held May 10th, Dr. E. W. Ruggles read a paper on "Late Views Regarding Phosphaturia." At a meeting, held May 17th, Dr. Charles E. Darrow read a paper on "Broncho-Pneumonia in Infants and Children," and Dr. Edward G. Nugent on "Habitual Constipation in Infants."

Rochester Pathological Society.—At a meeting, held May 4th, Dr. Frank A. Jones read a paper on "Mechanical Vibratory Stimulation," and at a meeting, held May 18th, Dr. T. T. Mooney on "Society Contract Work by Physicians."

Saratoga Springs Medical Society.—At a meeting, held April 21st, in the Symposium on Chronic Gastritis, Dr. Van Aernem read a paper on "Etiology and Pathology," Dr. Palmer on "Symptoms and Diagnosis" and Dr. Humphrey on "Treatment." At a meeting, held May 5th, Drs. Bentley, Downs and Moriarta read papers in the Symposium on Intestinal Obstruction. At a meeting, held May 19th, Dr. Sanford read a paper on "Conservative Surgery of the Head," Dr. Moriarta on "Conservative Surgery of the Abdomen" and Dr. Fish on "Conservative Surgery of the Extremities."

Society of Internal Medicine.—At a meeting, held May 17th, Dr. Tuttle read a paper on "Immunity."

Society of Medical Jurisprudence.—At a meeting, held May 8th, Dr. Hon. Alfred E. Ommen read a paper on "Some Observations by a City Magistrate."

Society of Sanitary and Moral Prophylaxis.—At a meeting, held May 19th, the following papers were read: "The Preventive Value of Sexual Education for Boys," by E. M. Robinson, of the International Committee of the Y. M. C. A.; "Prophylactic Value of Normal Marriage," by Dr. Andrew H. Smith; "The Best Way to Treat the Social Evil," by Dr. Howard A. Kelly, of the Johns Hopkins Medical School.

Syracuse Academy of Medicine.—At a meeting, held May 2d, Dr. Charles A. Covell read a paper on "Some Results with the Direct Current in Pelvic Disease," and Dr. T. L. Deavor on "Puerperal Sepsis." At a meeting, held May 16th, Dr. Lawrason Brown gave an address on "The Sanitarium Treatment of Pulmonary Tuberculosis and Its Results at the Adirondack Cottage Sanitarium."

West End Medical Society.—At a meeting, held May 27th, Dr. LeRoy Broun read a paper on "A Review of the Modern Surgical Treatment of Fibroid Tumors of the Uterus."

Women's Medical Association.—At a meeting, held May 17th, Dr. Martha Wollstein, president, gave an address.

Utica Medical Club.—At a meeting, held May 18th, Dr. Senahan read a paper on "Diagnosis."

NEW YORK AMERICAN MEDICAL ASSOCIATION SPECIAL.

Appended is a list of those who have definitely decided at this date to become members of the special train party which intends making a forty-day tour from the Atlantic to the Pacific and return, visiting by way, among other places of interest, Yellowstone Park, Oregon, Colorado and California, in connection with the an-

nual meeting of the Association, to be held at Portland, Ore., July 11th to 14th.

The train containing this party will leave New York City Saturday evening, June 24th, and returning will probably reach this city Thursday morning, August 3d.

Attention is called to the fact that there are many others whose names have been received by the committee who are seriously considering joining this party, but who have not yet been fully able to make up their minds to do so on account of family or professional reasons; therefore, any others desiring to become members of this party should communicate at once with Dr. Frederick Holme Wiggin, 55 West 36th street, New York City, or Dr. Wisner R. Townsend, 125 West 58th street, New York City.

NEW YORK CITY, BOROUGH OF MANHATTAN.

Dr. and Mrs. Dexter D. Ashley.

Dr. J. Riddle Goffe, president of The New York State Medical Association.

Dr. and Mrs. John T. Nagle and sister-in-law.
Dr. Thomas F. Reilly.

Dr. E. Franklin Smith.

Dr. and Mrs. Wisner R. Townsend, the Masters Townsend.

Dr. Frederick Holme Wiggin.

BOROUGH OF BROOKLYN.

Dr. and Mrs. L. Grant Baldwin.

Dr. William Francis Campbell.

NEWBURGH, N. Y.

Dr. Mary E. Dunning.

Miss Harriet B. Hill.

Dr. and Mrs. C. E. Townsend.

ITHACA, N. Y.

Dr. Eugene Baker.

ROME, N. Y.

Dr. J. Orley Stranahan.

PORT JERVIS, N. Y.

Mr. C. E. Cuddeback.

BAYONNE, N. J.

Mr. and Mrs. Charles Landell.

Dr. and Mrs. Forman.

NEWARK, N. J.

Dr. and Mrs. Fewsmith.

Dr. and Mrs. William Fred. Seidler.

Miss Fewsmith.

Messrs. G. Gilbert and Alan H. Brown.

PEMBERTON, N. J.

Dr. and Mrs. E. Hollingshead.

Mrs. Rebecca Price.

Miss Martha J. Austin.

HARRISON, N. J.

Dr. and Mrs. Marcus F. Squier.

BRIDGEPORT, CONN.

Dr. Frank W. Stevens.

NORWICH, CONN.

Dr. and Mrs. William Witter.

ATHENS, PA.

Dr. and Mrs. C. L. Stevens.

EASTON, PA.

Dr. E. W. Evans.

LEHIGHTON, PA.

Dr. and Mrs. J. C. Zern.

PHILADELPHIA, PA.

Mrs. Wallace C. Hancock.

Dr. J. V. Kelly.

Dr. M. H. Fussell.

Dr. D. D. Custer.

Dr. H. K. Regar.

Dr. John Welsh Croskey.

HARRISBURG, PA.

Dr. and Mrs. J. W. Ellenberger.

Mr. Ellenberger, Jr.

YORK, PA.

Dr. and Mrs. I. C. Gable.

Mr. Gable, Jr.

Dr. and Mrs. Holtzapple.

Miss Holtzapple.

READING, PA.

Dr. and Mrs. F. W. Frankhauser.

SPRING FORGE, PA.

Mr. and Mrs. W. L. Glatfelter.

Mr. Glatfelter, Jr.

M'KEESPORT, PA.

Dr. and Mrs. S. L. Wiggins.

WILKES-BARRE, PA.

Mr. and Mrs. Granville J. Clark.

Dr. and Mrs. Kistler, and niece.

DANVERS, MASS.

Dr. and Mrs. Frederick Baldwin.

FITCHBURG, MASS.

Dr. F. H. Thompson and friend.

For further information see advertising page iv.

WORKS AND NOT WORDS.

An Appeal from Mr. Bok to the Medical Profession.

PHILADELPHIA, May 15, 1905.

To the Editor—During the last year I have received hundreds of letters from physicians in every part of the United States commending the attitude of the *Ladies' Home Journal* in its efforts to awaken the public to an understanding of the patent-medicine curse. Scores of commendatory resolutions from medical associations have likewise come to our company. All these have been gladly received and appreciated, and our acknowledgments in each case have tried to express this fullest feeling of satisfaction. It is, therefore, with no lack of appreciation that I say that, while these individual and association commendations have been pleasant, I could wish the sentiments therein expressed might have resulted in some effective cooperative work.

What I mean is this: During the past winter there were introduced into the Legislatures of not less than fourteen States bills which had for their object the regulation of the sales of injurious patent medicines, or the compulsory printing of the ingredients of those medicines on the label of each bottle, under penalty of fine or conviction. Committee hearings were given on these bills in each State. The proprietors of some of the patent medicines were exceedingly active—and effectively so—in their opposition to these bills. Associations interested in the patent-medicine traffic worked with unceasing vigil to defeat the bills—which they succeeded in doing. The newspapers in these States carrying the advertisements of patent medicines were notified that this legislation was not desirable. Skilful lawyers appeared before these committees in opposition to the bills. Every effort, in short, was made to defeat these measures, and in all save one State the bills were "killed."

Now, who appeared in favor of the bills at these hearings? Generally, members of the Woman's Christian Temperance Union, whose zeal usually exceeded

their discretion and judgment—well-intentioned, but ineffective. In one or two cases representatives of some liquor dealers' association appeared in behalf of the bills. But not in a single instance, and I speak by authority of personal representation at each of these hearings, did there appear a single physician or the representative of a single State, county or city medical association. There was not the slightest active interest taken by physicians in these hearings, and yet scores of physicians wrote me irate letters after the bills were defeated, deploring the corruption (?) of the Legislatures in their States!

These hearings were usually of the most perfunctory order, and, from the side of any advocacy of the bills, absolutely without interest, since scarcely any one appeared to give intelligent or convincing reasons why the bills should become laws. Now, I ask the physicians and medical associations of this country, How are we ever to secure effective legislation against patent medicines until some intelligent reasons are presented by intelligent people having the respect of a community, why such legislation should exist?

It is not only likely, but probable, that during the next fall and winter terms there will be introduced into the Legislature of nearly every State in the Union a regulative patent-medicine measure—bills which have a vital interest to every physician in the United States; and my object in this letter is to draw to the attention of every physician, and particularly every medical association, not only the need, but the necessity, for their cooperation in this legislative work.

It is not meeting this question for physicians and associations to contend that their appearance and arguments before these committees would be deemed as emanating from interested motives, and thus have no weight. Surely, the other side does not argue thus, and their appearance and arguments before these committees are certainly from "interested motives." The statements and arguments of reputable physicians of the communities concerned would have the greatest possible weight before these committees. In fact, in several cases members of these committees have asked and desired that some physicians of standing should appear at the hearings and marveled at their uniform and consistent absence.

Here is not only direct work for every medical association in America, but an actual crying need for such work, and, if I may speak a little frankly, a clear case of shirking responsibility where such work is not forthcoming.

I shall be in a position to know of the introduction of these legislative measures in any State where they are presented, and if in each State the leading medical association would appoint a committee, and a similar committee appointed by county and city associations, and the full name and address of the chairman of each committee can be forwarded to me, between now and October 1st next, it will afford me pleasure to communicate with such party immediately on the introduction of such a measure in the Legislature of the State and supply him with printed material, now being prepared, containing arguments for the regulation of the patent-medicine traffic in America and showing what has been done by other nations.

But the fact cannot be too strongly urged that the most representative physicians in the State, city or county, the men occupying the highest positions in their professions and having the unquestioned respect of their communities, should be members of such appearing committees. The greatest weight should be given to the arguments presented, insuring the most effective influence.

It should not be necessary to add—but still I will do so, in case of the exceptionally suspicious mind that is always with us—that no advertising element, so far as the magazine of which I am editor is concerned, enters into these desires on our part or into the material being prepared. The publishers of the *Ladies' Home Journal* have no desire that their periodical shall enter into these hearings as a periodical, mentioned, quoted, or commended; they do not crave such advertising; the magazine does not need it. The periodical entered on its

editorial treatment of the patent-medicine curse from principle and from no other motive. Its only interest is the interest of the great public at large, not the commendation either of it or its editor. Both have received that at the hands of the medical profession. It now asks at the hands of that profession works, not words.

EDWARD BOK,
Editor of the *Ladies' Home Journal*.

The Interurban Clinical Club meeting for the organization of the Interurban Club was held at the Johns Hopkins Hospital, Baltimore, on April 28-29, 1905. The purpose of this organization is similar to that of the Interurban Surgical Club. No special papers are to be read, but the members are to be given the opportunity to observe the methods and principles in teaching clinical work in the city in which the meeting may be held. The members of each city are limited to twenty-four, and have been selected from the four principal medical centers in the East, namely, Boston, New York, Philadelphia and Baltimore. The president of the new organization is Dr. Richard Cabot, of Boston, and the secretary, Dr. Thomas McCrea, of Baltimore. The next meeting of the club will be held in Boston in November. On Saturday, the 29th of April, Dr. William Osler gave a dinner to the organization at the Maryland Club in Baltimore, at which were present as guests Dr. William H. Welch, of Baltimore; Dr. Sandwich, of Cairo, Egypt, and Dr. Harvey Cushing, of Baltimore, who has been most active in the organization of the Interurban Surgical Club. The following is the list of members: Boston, Drs. Richard Cabot, E. A. Locke, Joseph Halsey Pratt, J. W. Lord, E. P. Joslin and Wilder Tileston; Baltimore, Drs. L. Franklyn Barker, William Sidney Thayer, Thomas B. Fitcher, Charles P. Emerson, Rufus I. Cole and Thomas MacRae; New York, Drs. Samuel Lambert, Walter B. James, L. A. Conner, F. S. Meara, Theodore C. Janeway and C. N. B. Camac; Philadelphia, Drs. David L. Edsall, Aloysius O. J. Kelly, Joseph Sailer, Alfred Stengel and David Reisman.

MEDICAL CHARITIES.

To the Editor of Charities:

The economical administration of medical charities is receiving more study just now than ever before. Every suggestion which offers to help in the solution of the vexed question should be worthy of consideration. It is not a question of passing importance, but one which involves all generations to come. Should means be discovered of erasing the existing debits of the several hospitals and the present system of their administration be continued, the relief would be but temporary.

It is undoubtedly wise to cut down expenses as far as compatible with efficient service. It is undoubtedly wise to obtain as great a list as possible of persons who will give some specified sum yearly. It is undoubtedly wise to increase interest in every hospital, by means of sewing circles,

etc. But is all this energy and money expended upon the sick poor for whom it is intended? Do semi-public hospitals increase the number of undeserving charity patients? That is to say: Is there a greater number of applications for medical charity than there would be were charity and private hospitals entirely separate? In other words: Do the pay patients in a semi-public hospital lend a cloak of respectability to those who seek and accept charity and yet could afford to do without alms?

It is probably true that any of your readers would much prefer that an employee should be treated at his or her "pet" hospital rather than taken to Bellevue. Bellevue is an almshouse; the patients are paupers. At Roosevelt or New York Hospital it does not need to cost a cent (if one can obtain admittance), and yet who would call it alms? Thus the feelings of both employer and employee are saved, for the employer would feel some shame at permitting an employee to be treated at an almshouse—at Bellevue or on "the Island."

Many of these charity patients are as able to pay for a physician's services as they are able to pay for their bread and coal. Not a few of these objects of medical charity own real estate, diamonds, carriages, etc. One of the advantages of living in a city like New York is, to them, the free medical services.

It is pathetic to think of the "auxiliaries" working to help this army of undeserving sick; of the men who are worrying over the finances of institutions which offer charity to undeserving as well as deserving; of the beds endowed in loving memory of some one who has gone before, and which are holding patients who could well afford to pay for all necessary services. It is pathetic, and yet there is a sort of humor about it.

To prove what has been said is not at all difficult: Let a poorly dressed individual, man or woman, one evidently in need of charity, go to any semi-public hospital, suffering from some such disease as rheumatism. If he or she is admitted at all, it will not be much over twenty-four hours before the patient will be in a city institution. Now, give this patient a letter from some member of the board of directors, or from some minister in sympathy with the hospital, or some capitalist, and, *voilà, tout est changé!*

It is inconvenient, and an expense, to have a sick person in a house, and, besides, "the hospital is the best place to be sick." It certainly is! But so is Sherry's the best place to dine. To relieve a pauper of hunger you do not give him the luxuries the market affords, but the necessities which he craves.

Physicians are more to blame than any other class for the present status of medical charities. It is mostly due to thoughtlessness. The surgeon who, by making use of a charity bed, can perform an operation for fifty dollars, nurses and dressings being provided by charity, forgets that

many a surgeon would gladly do the same operation at the patient's home for twenty-five dollars—and with equally good results. The physician who has "arrived," because a patient cannot pay his fee of four or five dollars, forgets there are many of his *confrères* who would gladly take the case at one dollar a visit.

Therefore, in order to arrive at the truth in the matter, I would suggest a commission. Let the information be carefully obtained and as carefully recorded: not listed under "deserved charity" or "disease needing hospital care," but let the financial standing of each patient in the hospitals on a certain day be as carefully examined as though for a mercantile firm or a banking-house.

A patient is unworthy of charity if he can pay a physician one dollar a visit, or fifty cents an office call. Under the list of diseases a full description of the malady should be made. Any case which necessitates confinement to bed for a week or longer is not necessarily a hospital case. If our charity hospitals contained only such patients as absolutely needed hospital care—either because of absolute poverty—with no home, or a much too crowded home, or because of the nature of the illness, which could not be as skilfully treated—not easily, but skilfully treated—outside of a hospital, then I believe the money given to-day for medical charities would be more than ample to meet all demands.

If this is shown to be a fact by a commission, then I believe the quickest way to eradicate this preying upon charity will lie in the absolute separation of charity hospitals from pay hospitals.

Whether the city or the State or benevolent societies should manage the charitable institutions is beside the question I am discussing. It is the total separation of medical charities from paid medical service which I wish to advocate.

JOHN JOSEPH NUTT, M.D.

New York.

*THE ONE HUNDRED AND THIRTEENTH ANNUAL MEETING OF THE CONNECTICUT MEDICAL SOCIETY was held at the Hunt Memorial Building, Hartford, Conn., May 24 and 25, 1905.

THE FIFTY-THIRD ANNUAL MEETING OF THE MAINE MEDICAL ASSOCIATION, to be held in the Common Council Chamber, Portland, Me., June 7, 8 and 9, 1905.

THE ONE HUNDRED AND FOURTEENTH ANNIVERSARY MEETING OF THE NEW HAMPSHIRE MEDICAL SOCIETY was held in Memorial Hall, Concord, N. H., May 18 and 19, 1905.

THE THIRTY-SECOND ANNUAL MEETING OF THE FLORIDA MEDICAL ASSOCIATION was held at Jacksonville, Fla., April 19, 20 and 21, 1905.

THE SEVENTY-SECOND ANNUAL MEETING OF THE TENNESSEE STATE MEDICAL ASSOCIATION was held in Nashville, Tenn., April 11, 12 and 13, 1905.

THE TWENTIETH ANNUAL MEETING OF THE ASSOCIATION OF AMERICAN PHYSICIANS was held in Washington, D. C., May 16 and 17, 1905.

The present trend of university teaching is that only the industrious apprentice gets to amount to something.

Book Reviews.

SAUNDERS' QUESTION COMPENDS, NOS. 8 AND 9. Essentials of the Practice of Medicine, Prepared Especially for Students of Medicine by William R. Williams, A.M., M.D. Philadelphia and London: W. B. Saunders & Co.

The excellence of this series of quiz compends has been added to by this little volume. It is up to date and as thoroughly comprehensive as such a book can well be. Dr. Williams has most intelligently performed the task set before him by the publishers.

TRANSACTIONS OF THE STATE MEDICAL ASSOCIATION OF TEXAS. Thirty-sixth Annual Session, 1905.

In this volume are included the transactions of the various Sections of the State Association for 1904. Many most interesting papers on the subjects of malarial and yellow fevers were read before the medical section by Dr. A. Woldert, Robert Westphal, J. T. Fitz-Simon, U. S. Surgeon R. S. Carter, of Baltimore, Md.; J. M. Reuss and R. S. Dinwiddie.

"A New Method of Intestinal Anastomosis," by A. C. Scott, M.D., is one of the many interesting papers which was read before the Section on Surgery. Dr. J. E. Thompson also read a paper on the "Successful Implantation of both Ureters in the Rectum." Mandel's method was employed. Throughout the whole book the papers are of an excellent character, and the subjects under discussion are on vital questions which to-day are facing the medical man in the various branches of the profession.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Third Series. Vol. XXVI, 1904.

The scientific proceedings of this well-known organization is always a welcome addition to the library of any physician, and this volume is no exception to the general excellence of its predecessors. It contains articles on various subjects by David L. Edsall, M.D.; J. Dutton Steele, M.D.; J. H. Musser, M.D.; William G. Spiller, M.D.; W. W. Keen, M.D.; Solomon Solis Cohen, M.D.; Joseph Sailer, M.D.; John B. Deaver, M.D., and Francis T. Stewart, M.D., besides the contributions of many others. With such able writers to furnish material for a book one can count himself fortunate to possess the volume.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE FOR STUDENTS AND PRACTITIONERS. By Hobart A. Hare, M.D., B.Sc., Professor of Therapeutics in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital, etc., etc. Illustrated with 129 engravings and 10 plates, in colors and monochrome. Philadelphia and New York: Lea Bros. & Co., 1905.

The uniform excellence of Dr. Hare's writing is so well known that it would seem superfluous to try to add further criticism than to say that the author has not parted company with this habit in this, his latest book.

It is a difficult task for any writer to undertake to produce a new book on the principles of medicine, and at the same time add to the already long list of valuable text-books on this subject; but in this volume we have not only recognized text-book material, but also the analytic study of long experience of one who has become prominent for his careful and painstaking work in all lines of medicine to which he has turned his versatile mind.

Dr. Hare has put into this book the excellent and valuable material gained as a teacher and careful student of many years' experience. His own personality is clearly evident throughout the whole book. Like the careful editor that he is, he has obtained his material from the best possible sources, and wherever it has become necessary he has sought and obtained the assistance of the most competent authorities.

From the publisher's standpoint, the volume is all that could be desired. The presswork is excellent and the

illustrations are excellent, and, what is more, are explanatory of the contents of the text.

THE URINE AND FECES IN DIAGNOSIS. By Otto Hensel, Ph.G., M.D., Bacteriologist, German Hospital, New York, and Richard Weil, A.M., M.D., Pathologist, German Hospital, New York, in collaboration with Smith Ely Jelliffe, M.D., Ph.D., Instructor in Pharmacology and Therapeutics, Columbia University; Visiting Neurologist City Hospital, New York. Illustrated with 116 engravings and 10 colored plates. Philadelphia and New York: Lea Bros. & Co., 1905.

So many text-books of this variety have been given the medical world to pass into oblivion, because of their incompleteness and uselessness, that it is difficult to realize that one of true value can be written in this day when clinical microscopy is an ever-changing subject. But in this we have a most admirable epitome of the subjects entered upon up to the present date. It is not only a valuable text-book, but it will serve as an index of the literature on the two subjects treated. It is, indeed, an encyclopedia.

Few, if any, text-books present the subject of the examination of feces as is to be found in this book. In preparing this chapter the work of Schmidt and Strasburger and the original work of Ford upon the bacteria to be found in the feces have been most carefully abstracted and incorporated into the text. In both the chapters on urine and feces the subjects are dealt with from the physiological, chemical and microscopic aspects. A feature of the book to be especially commended is the excellent index.

APPLIED PHYSIOLOGY, Including the Effects of Alcohol and Narcotics. By Frank Overton, A.M., M.D., Primary Grade, Intermediate Grade and Advanced Grade. Published by the American Book Company, New York, Cincinnati and Chicago.

A GENERAL PHYSIOLOGY, FOR HIGH SCHOOLS, BASED UPON THE NERVOUS SYSTEM. By M. L. Macy, L.B., assisted by H. W. Morris, M.D., Professor of Biology, Iowa College. Published by the American Book Company, New York, Cincinnati and Chicago.

A series of useful knowledge for the student, written in a plain and attractive manner that renders it suited to the needs of students. The authors have endeavored to make a school text-book that would meet the requirements of the young. They have succeeded in giving no statements that are beyond the comprehension of the mental powers for which each was intended, yet enough that a false impression may not be conveyed and enough to know the names of things and where they are and for what intended.

A MANUAL OF PERSONAL HYGIENE, PROPER LIVING UPON A PHYSIOLOGICAL BASIS. By American authors. Edited by Walter L. Pyle, A.M., M.D., Assistant Surgeon to the Willis Eye Hospital, Philadelphia; Secretary of the section on Ophthalmology, American Medical Association; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia, etc. Contributors, D. H. Bergey, M.D.; J. W. Courtney, M.D.; George Howard Fox, M.D.; E. Fletcher Ingals, M.D.; Walter L. Pyle, M.D.; B. Alexander Randall, M.D.; G. N. Stewart, M.D. (Edin.); Charles G. Stockton, M.D. Second edition, revised and enlarged. Philadelphia, New York and London: W. B. Saunders & Co., 1904.

In this new second edition there have been added and fully illustrated chapters on domestic hygiene and on home gymnastics, besides an appendix containing methods of hydrotherapy, thermotherapy, mechanotherapy and first-aid measures in medical and surgical accidents and emergencies.

Personal hygiene is applied physiology, and a proper understanding of certain elemental truths on practical human physiology must first be acquired before it can be applied. Knowledge of the normal functions of the body and simple methods of keeping them in healthy action is the one thing that no educated person should be excused from possessing. The ordinary instructions in physical

education, physiology, dietetics and exercise is not sufficient, and often faulty. Dr. Pyle has selected eight prominent American physicians, each writing upon his chosen specialty, and setting forth the means of health in this "Manual of Personal Hygiene" with a *simplicity, conciseness and authority* that has never been approached in any similar work.

A TEXT-BOOK OF LEGAL MEDICINE. By Frank Winthrop Draper, A.M., M.D. (Harv.), Professor of Legal Medicine in Harvard University; Medical Examiner for the County of Suffolk, Massachusetts; Medico-Legal Pathologist at the Boston City Hospital; Fellow of the American Academy of Arts and Sciences, etc. Fully illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

The subject of legal medicine is one of great importance, especially to the general practitioner, for it is to him that calls to attend cases which may prove to be medicolegal in character most frequently come. Dr. Draper has written his work both for the general practitioner and for the medical student. He has not only cited illustrative cases from standard treatises on forensic medicine, but these he has supplemented with details from his own exceptionally full experience—an experience gained during his service as medical examiner for the city of Boston for the past twenty-six years. During this time his investigations have comprised nearly eight thousand deaths under a suspicion of violence. The author's long teaching career has enabled him to state facts and detail procedures with a clearness rarely met in a work on legal medicine.

DIET IN HEALTH AND DISEASE. By Julius Friedenwald, M.D., Clinical Professor of Diseases of the Stomach in the College of Physicians and Surgeons, Baltimore, and John Ruhräh, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. "These few rules of diet he that keeps, shall surely find great ease and speedy remedy by it."—Burton. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

This latest work on diet is practical and comprehensive, prepared to meet the needs of the general practitioner, medical student, hospital interne and trained nurse. It contains a full account of foodstuffs, their uses and chemical compositions. Dietetic management in all diseases in which diet plays a part in treatment is carefully considered, the articles on diet in diseases of the digestive organs containing numerous diet lists and explicit instructions for administering. The feeding of infants and children, of patients before and after anesthesia and surgical operations, and the latest methods for feeding after gastro-intestinal operations have been discussed with such practical detail. The subject of rectal enemata is given completely, with recipes and full instructions as to technic. Diet is considered in its relations to age, occupation and environment, and the beneficial results from the rest cure have been accorded prominent consideration. There is also a section on food adulteration and the resultant diseases. Withal, this is a work well worthy the reputation of its authors.

DISEASES OF THE LIVER, GALL-BLADDER AND BILE-DUCTS.

By H. D. Rolleston, M.A., M.D (Contab.), F.R.C.P., Physician to St. George's Hospital, London; formerly Examiner in Medicine in the University of Durham and Fellow of St. John's College, Cambridge, England. Fully illustrated. Philadelphia, New York and London: W. B. Saunders & Co., 1905.

Dr. Rolleston's new work is undoubtedly the most voluminous treatise on diseases of the liver yet published in English. And, more than that, it is destined to become an authority on the subjects of which it treats. The author has for many years made a special study of diseases of the digestive system, and his reputation in the treatment of hepatic diseases is sufficient assurance of the practical usefulness of this new work. The text includes all the affections of the liver, completely and clearly discussed, special attention being given to pathology and treatment. A large number of clinical cases are quoted, which will be found of great value to the

practitioner in diagnosing individual cases. Besides diseases of the liver, the book contains articles on diseases of the gall-bladder and bile-ducts, which are equally as trustworthy and authoritative as the section on the liver. The illustrations, both those showing gross appearances and the microphotographs, are unusually excellent, and include seven colored insert plates of great merit. The mechanical appearance of the work is in keeping with the high standard of the text.

COMPEND OF DISEASES OF THE EAR, NOSE AND THROAT.

By John Johnson Kyle, B.S., M.D., etc., with 85 illustrations. Published by P. Blakiston's Son & Co., Philadelphia.

While not differing in general from most compends, it is particularly good for the exact and complete explanation given each subject. It is especially valuable to the student, the author having selected the best from many authors. The illustrations are good and materially help in the explanation of the text.

BOOKS RECEIVED.

MERCK'S 1905 MANUAL OF THE MATERIA MEDICA. A Ready Reference Pocketbook for the Physician and Surgeon, containing names of the chemicals and drugs used in modern medical practice, with their chief synonyms, physical form and appearance, solubilities, percentage strengths and physiological effects, therapeutic uses, modes of administration and application, regular and maximum dosage, incompatibles, antidotes, precautionary requirements, etc.; a table of therapeutic indications; a classification of medicaments, and miscellany, comprising poisoning and its treatment; a comprehensive dose table of chemicals, drugs and galenicals; urinalysis; metric system, and tables, etc. Compiled from the most recent authoritative sources and published by Merck & Co., New York.

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., Professor of Clinical Medicine in Jefferson Medical College; Physician to the Jefferson Medical College Hospital, and to the Philadelphia General, Jewish and Rush Hospitals, etc. Vol. XI, Serumtherapy. By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia. Organotherapy, by Oliver T. Osborne, M.A., M.D., Professor of Materia Medica and Therapeutics at Yale University. Radium, Thorium and Radioactivity, by Samuel G. Tracy, B.Sc., M.D., Radiologist, New York Skin and Cancer Hospital; Assistant Neurologist, Vanderbilt Clinic, Columbia University, New York City. Counter-Irritation, External Applications, Blood-Letting, by Frederick A. Packard, M.D., Late Physician to the Pennsylvania Hospital. An Outline of the Principles of Therapeutics, with Especial Reference to Physiologic Therapeutics, by the Editor, with Addendum on X-Ray Therapy and an Index-Digest of the complete system of eleven volumes. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1905.

ACUTE CONTAGIOUS DISEASES. By William M. Welch, M.D., Diagnostician to the Bureau of Health and Consulting Physician to the Philadelphia Municipal Hospital for Contagious and Infectious Diseases; for thirty-three years Physician-in-Charge of the Municipal Hospital; Fellow of the College of Physicians of Philadelphia; and Jay F. Schamberg, A.B., M.D., Professor of Dermatology and of Infectious Eruptive Diseases, Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Diagnostician to the Bureau of Health and Consulting Physician to the Municipal Hospital for Contagious and Infectious Diseases; Fellow of the College of Physicians of Philadelphia; Member of the American Dermatological Association. Illustrated with 109 engravings and 61 full-page plates. Philadelphia and New York: Lea Bros. & Co., 1905.

Original Articles.

PRESIDENT'S ADDRESS.¹

BY HENRY VAN HOEVENBERG, M.D.,
Kingston, N. Y.

AFTER an existence of twenty-one years it seems to me that a review of the work accomplished by the N. Y. S. M. A. during that time is eminently fitting for this occasion, and I have chosen it for the subject of my address to you to-day.

The cause of the organization of this Association was the rejection by the State Medical Society of the Code of Ethics of the A. M. A., for the reason that their action had left the medical profession of this State without any direct affiliation with that body.

I believe that the first meeting representative of the profession, at which the idea of organizing the Association took form, was when a few prominent members met at the Manhattan Club, in New York City, in December, 1883, at the request of Dr. Austin Flint. There the subject of organizing a State association was talked over. It is also interesting to note that at this meeting steps were taken which resulted in the organization of the New York County Association. In January, 1884, invitations to meet at the Delavan House, Albany, February 4th, at 8.30 o'clock, signed by over fifty permanent members and delegates of the State Society, were sent to members of the profession throughout the State. About one hundred responded, and at this meeting, after addresses had been made by Drs. Didama, Gouley and others, reviewing the situation, a full discussion of the condition of affairs took place. Dr. Gouley stated that a canvass of the profession in the State had been made, with the following result:

Total number of physicians in the State. . .	5,002
Total number of votes recorded.	3,860
For the National Code.	2,547
For new code, no code and unclassified. . .	1,313

This vote shows that the profession at large was not in favor of the change. After an attempt had been made to have the new code repealed, but without success, the completion of the organization was proceeded with, and at a meeting held February 6th the ship of the N. Y. S. M. A. was launched, with Dr. H. D. Didama, of Onondaga County, as president.

¹Read before the Fifth District Branch at the Twenty-first Annual Meeting, held at Poughkeepsie, N. Y., May 2, 1905.

The first meeting of the Association was held in New York City November 18, 19, 20, 1884, with a total membership of 514. Fifty papers and addresses were read and discussed. From the first the Association has had for its aim the elevation of the standards of the profession, and has put forth every effort to increase the interest and influence of its meetings. Not only have the ablest men in our own State presented papers for discussion, but representative physicians from other medical centers have joined with us in increasing our knowledge of the subjects under consideration. The introduction into our programs of symposia on various subjects has been the means of greatly increasing the interest of our meetings, and has drawn forth some of the best papers ever read on these subjects.

Our scheme of organization, while perhaps not perfect in all respects, is such as to have attracted the attention and received the approval of medical bodies throughout the country at large. The A. M. A. has adopted it, practically without any change, and has advised the other States to do so, and, to a large extent, this has been done. The question of an organized profession is one that every physician should take an active interest in, for it is only by such organization that we can wield the influence that we are entitled to by our position as students of the many subjects which influence the health and well-being of our fellow-men. Politicians pay very little attention to the wishes of one or two physicians, but let them join with the other members of their profession and make a united effort and they will find that some attention is paid to them. Does any one doubt, if all the members of our profession in this State should join in asking for, or protesting against, the passage of the various laws affecting the standard of our profession which annually appear in our State Legislature, that we would fail to gain the attention we wish to receive, or that our action would go unheeded? Let me give you an example: Meeting the Senator from my district one day I asked him how he stood on the Osteopathy bill. His reply was: "There are over two hundred doctors in my district and only three or four osteopaths; I cannot afford to antagonize the doctors." I have good reason for believing that he had been in favor of the bill, but he had heard from us through our organizations.

The Association has always stood for the highest and best in medicine. Its aim has always been to advance in every way the standard of requirements, not only for graduation from our schools, but in the extent of preliminary education, and to-day I believe those requirements are the highest of any State. We have taken an active interest in helping to pass laws

that benefit the community at large in many ways other than through our profession. While much has been accomplished, much remains to be, and can be done, if we will present a united front and each one do his part. As you all know, efforts have been made to unite the Association and the State Society, but just as we felt that our efforts had been crowned with success it was found that certain requirements of the law had not been complied with, and the expected union was postponed until these obstacles should be overcome. I believe that the great majority of members of both bodies desire the union to take place, and the probabilities are that it will soon be an accomplished fact.

Let us put our shoulders to the wheel, resolved that we will do all that we can to accomplish the objects of our Association. We have found in our county that much has been accomplished by holding joint meetings of the County Association and County Society, having good papers for the scientific session and a dinner for the social part. This has brought about a much better feeling between the members of the two bodies, and we expect to continue it in the future. I know we meet many discouragements, but we must be only the more determined to succeed, and I am sure that success will crown our efforts in the end. Every eligible physician in the State should be a member, and if each one will attend the meetings and do what he can, no matter how little it may appear to be, to help make them successful, he will find himself amply repaid for the time and money it has cost him. I believe that no physician can afford not to be a member of his local and State associations. He will find that what he learns from the papers and discussions and the benefit he receives from the personal contact with other men will give him renewed ardor for his work. Many make the excuse that they cannot leave their patients long enough to go to the meetings. I think very few patients will object to their physician absenting himself, if they know that he takes enough interest in his work to wish to improve his own knowledge, so that he may be better fitted to give them the care they wish to receive from him.

We may justly be proud of the past record of our Association, for, although we have not a century of existence behind us, we have accomplished much for the increase of knowledge of our profession and the elevation of its standards, and, in addition, our example has acted as a stimulus to other organizations, and led them to improve in many ways.

I thank you all for the uniform courtesy and willing assistance that I have received as your presiding officer in my efforts to make our meetings successful. It is my sincere wish that the time may soon come when we will see a united profession in this State, pressing forward to the goal of the highest and best of everything in medicine.

THE BACTERIOLOGICAL FINDINGS IN THE SPINAL FLUID OF FIFTY CASES OF CEREBRO-SPINAL MENINGITIS.¹

BY THOMAS WOOD HASTINGS, M.D.,

New York City.

DURING the last eighteen months spinal fluid from 150 cases has been received by us for examination of either the cellular elements or bacteria or both contained in these fluids, and from these 150 cases the 50 cases of acute meningitis and 5 cases of tuberculous meningitis were taken for presentation to-day.

Remarks concerning clinical study of the cases are purposely omitted, excepting the statement that they all ran the course of an acute disease, 60 per cent. resulting in death, 30 per cent. in recovery. Somewhat similar clinical symptoms of meningeal irritation in infection may be due to the two fundamentally different pathologic conditions to be differentiated during life by careful study only of the spinal fluid, viz., meningismus, an irritation probably due to bacterial toxins elaborated in some organ or tissue of the body other than the meninges, as in typhoid and pneumonia, both of which, however, may produce during their course a true meningeal infection; and meningitis, with the infective agent localized in the meninges; and these fluids from meningitis cases fall into two classes, the serous fluid from a serous meningitis, of which the tuberculous meningitis is the type; and the purulent meningitis, caused, maybe, by the meningococcus, streptococcus, pneumococcus or other organisms. In the study of fluids from cases of acute meningitis we have to look for and deal with the serous and purulent types. The serous type may be overlooked readily if slight changes in color are not noted and if careful examination of centrifugated specimens and cultures for bacteria are not carried out.

The purulent type is readily recognized from the turbidity of the spinal fluid. The normal spinal fluid obtained by lumbar puncture is absolutely clear and colorless, unless clouded and colored by hemorrhage from traumatism during puncture; free from coagulum and sediment; contains a few to a dozen small mononuclear cells after thorough centrifugation and searching through several preparations from the apparently clear fluid at the bottom of the centrifuge tube; and is free from bacteria, excepting contamination. The presence of micrococcus albus in cultures we have always considered due to skin contamination and have not considered it in our results.

The amount of fluid withdrawn varied from 5 to 60 c.c. The fluids were examined as soon after puncture as possible, usually within six hours, yet when collected in sterile tubes with cotton plugs, some specimens twenty-four hours old and three forty-eight hours old were fit for a satisfactory examination. It is well to allow the clear fluids

¹Read before the Fifth District Branch of The New York State Medical Association, at the Twenty-first Annual Meeting, at Poughkeepsie, N. Y., May 2, 1905.

to stand for five or six hours after puncture in order to allow time for the separation of a coagulum, which will occur in some specimens, particularly if tuberculous.

For study of cells and culture of the bacteria the fresh 6 to 8 hour fluids are preferable.

The fluids were examined as to (1) macroscopic characteristics, clearness, coagulum, color or absence of color, sediment; (2) as to cellular content, relative number of cells, types of cells, relative proportions of different types of cells (cytodiagnosis); (3) as to bacterial content.

After thorough study of the literature and of several fluids these three phases of examination were selected as of most importance from diagnostic and practical points of view, the chemical study being neglected with exception of qualitative tests for cholin, the results of which will be reported later with the remainder of the 150 fluids examined for cholin.

MACROSCOPIC EXAMINATION.

For a satisfactory macroscopic, cellular and bacteriological examination it is necessary to collect the fluid in at least two (or three) sterile tubes, preferably centrifuge tubes, so that sediment for bacterial cultures and subsequent study of cells may be obtained readily without exposure to contamination from unnecessary manipulation; and the collecting of the fluid in two or three tubes satisfies one at once in regard to slight accidental hemorrhage from traumatism from the lumbar puncture. If the bleeding is pathologic the second and third tubes will show a blood color and cloudiness similar to the first tube. With extensive bleeding which may occur from accident (*e. g.*, from a fall) to a meningitis case, the characteristics of the infected fluid may be obscured and the meningeal condition diagnosed only after the determination of the ratio of red and white cells and the differential count of the white cells and the finding of bacteria, as shown by one case related under cases due to the meningococcus.

With no exception the 50 acute non-tuberculous infections produced a turbid fluid, the turbidity varying from a faint opalescence due to bacteria in one fluid to a fine or coarse flaky suspension of fibrin flakes and leucocytes in the majority of fluids. The 5 tuberculous fluids were clear, without the faintest opalescence, save a delicate, veil-like coagulum (Mya's "cobweb coagulum") extending from the surface to the bottom of the fluid.

This "veil coagulum" is of importance in these tuberculous fluids, for during centrifugation it carries down some of the organisms and cells in suspension, and after centrifugation this coagulum is the part of the sediment in which one should search for the tubercle bacillus. If no coagulum is found in suspected tuberculous fluids, the albumin bodies which are increased in this condition may be thrown out by heating carefully after acidulating with one or two drops of 10 per cent. acetic acid, so that during centrifugation the precipitated albumin will carry down

the bacteria. Such a method, however, does not suffice for a study of cellular elements. These two simple methods do away with the necessity for employing Jousset's or any other similar methods of inoscopy, with their artificial precipitation and subsequent digestion of the precipitated material.

The color of the fluids was noted after centrifugating and decanting off the supernatant clear fluid into a test-tube or a Nessler tube in order that the observation for color might be made through a long column of fluid, for in this manner only is it possible at times to note the acquisition of color, pale yellow to a deep straw yellow, which occurs in the tuberculous cases.

Of the fifty non-tuberculous cases all showed a suspension of leucocytes and bacteria and fibrin flakes immediately after withdrawal, and a sediment upon standing or after centrifugation. The tuberculous cases rarely show a sediment other than the "veil coagulum" which is thrown down on centrifugation.

CYTOLOGICAL EXAMINATION.

The cellular content was examined after the method described in the *Medical Record* for January 23, 1904. The total number of red and white cells and the relative numbers of each were estimated by means of Ehrlich's eye-piece, the average of 100 fields being taken as a unit of comparison. For differential counting of the white cells two methods have been used; a wet method, in which a drop of the sediment is mixed with a drop of Löffler's methylene blue on a slide, covered with a cover-glass and examined with a magnification of 500 diameters; dry method, in which a drop of sediment on a slide is dried at 36° C. for half an hour and then stained with Wright's blood stain or a modified Nocht stain, or any other blood stain in solution in methylic alcohol, such as Jenner's, thus avoiding the necessity of previous separate fixation of specimen. There is no apparent advantage in searching for eosinophile and basophile cells, so that, as a rule, we have used the wet method, and for the infectious cases have classified the cells as polynuclears and small mononuclears (lymphocytes).

BACTERIOLOGICAL EXAMINATION.

For bacteriological examination, cultures upon glycerine-agar, plain-agar, occasionally upon ascitic-fluid-agar, and in broth, have been prepared from the sediment immediately after centrifugating and decanting off the supernatant fluid, and smears have been prepared and stained by Gram's method and for tubercle bacilli. In the following records under "smears," "meningococci" implies that the organisms were intracellular, and "pneumococci" that capsules were demonstrated. When cultures were later positive the records of smears are unimportant.

Of the 55 cases, 42 were due to the meningococcus (*diplococcus intracellularis meningitidis* of Weichselbaum), and 2 of these gave on culture the pneumococcus as well as the meningococcus; 5 were due to the pneumococcus, 6 to

the tubercle bacillus, and 3 to organisms not satisfactorily identified.

The first clinical diagnosis in all the cases was epidemic cerebro-spinal meningitis.

FORTY-TWO CASES DUE TO MENINGOCOCCUS.

The amount of fluid withdrawn varied from 1 to 20 c.c. So far as one may judge from the clinical history the fluid was first examined from three to ten days after onset, and in only one case was it impossible to make a correct bacteriological diagnosis from the fluid at this period of the disease. In this exception the meningococcus was found in the fluid from a second lumbar puncture during the second week, and a diagnosis of meningitis was justified from the cell content of the fluid obtained during the first week, although at this time the bacteriological diagnosis was obscured by contamination of the fluid.

The fluids from these 42 cases were turbid, varying from a fine flocculent, translucent cloudiness to a purulent opacity. In none of them did a coagulum separate out. The turbidity was due to fibrin flakes, leucocytes and bacteria, and upon standing a definite, thick sediment fell. The supernatant fluid, after centrifugation, was clear and colorless in 6 specimens, clear and of faint to deep yellow color in 6, and definitely blood-tinged in 8. The cells in 100 fields (the unit mentioned before) varied as follows:

Red cells, 20 to 1,440 in 100 fields.

White cells, 20 to 84,000 in 100 fields.

And the ratio of white to red cells varied from 1 to 30 to 2,000 to 1. In all the specimens containing more than a microscopic trace of blood, the second and third tubes, whenever a third tube was taken, contained comparatively few red cells when compared to tube 1, and in all of them the ratio of white to red cells was far greater than in normal blood.

Differential counts of white cells always gave a relatively high percentage of polynuclear cells, varying from 68 to 100 per cent. In two out of four cases which recovered, with repeated punctures, the mononuclear cells increased in percentage as the disease approached convalescence and late in convalescence the percentage of mononuclear was greater than the percentage of polynuclear cells, and in the other two cases the relative mononuclear increase did not occur. In three fatal cases with repeated puncture this gradual relative increase in mononuclear cells did not occur. The abundance of exudation as evidenced by this total number of cells and the variation in relative percentages of polynuclear and mononuclear cells bore no relation to the severity of the infection as manifested by clinical symptoms, to the prognosis, or fatality. In 6 cases the meningococcus was found in smears only and in the remaining 36 cases in smears and by culture.

In one case the diagnosis was obscured by extensive hemorrhage. The three tubes contained fresh blood and later a clot, yet the white cells far outnumbered the red cells (whites 81,000;

reds 1,440, a ratio of 1 red to 60 whites), and the polynuclear cells predominated (80 per cent.); bacteria were not found.

Two of these meningococcus cases were infected with the pneumococcus also, and the fluids were similar to those from the pure meningococcus cases. One of these two mixed cases recovered.

FIVE CASES DUE TO THE PNEUMOCOCCUS.

The amount of fluid withdrawn varied from 5 to 30 c.c. These fluids were cloudy, tinged yellow in supernatant portion after centrifugation and gave an abundant purulent sediment. The white cells varied from 300 to 3,000 in 100 fields and the polynuclears predominated, from 94 to 99 per cent. Pneumococci were found in smears and by culture. These fluids differed from those from the meningococcus cases in their bacteriological content only. The five were fatal.

FIVE CASES DUE TO TUBERCLE BACILLI.

The amount of fluid withdrawn varied from 10 to 60 c.c. In all four cases the fluids were clear, and after standing six to eight hours the delicate coagulum separated out. The color varied from a straw yellow to a deep yellow. After centrifugation the supernatant fluid was absolutely clear, but still colored, and the coagulum formed a small amount of sediment. A drop of fluid from the bottom of the centrifuge tube contained a few white cells, varying from 10 to 166 in 100 fields, and a differential count gave a preponderance of small mononuclears, varying from 68 to 100 per cent. In three cases tubercle bacilli were readily found in the coagulum after centrifugation; in a fourth case with only 10 white cells in 100 fields and 100 per cent. lymphocytes the diagnosis was borne out post-mortem; and in the fifth case with 166 white cells in 100 fields and 89 per cent. lymphocytes the diagnosis is uncertain, as post-mortem examination was not permitted.

THREE CASES NO BACTERIOLOGICAL DIAGNOSIS.

In three cases, one of them with four lumbar punctures, a diagnosis of purulent meningitis was justified from the macroscopic appearances and cell-content of the fluids. The one case with four lumbar punctures over a period of six weeks showed a gradual decrease in the white cells from 375 to 6 in 100 fields, and a gradual increase in percentage of mononuclear cells from 41 to 94 per cent. a few days preceding death. Tubercle bacilli were not found.

In none of these three cases were bacteria found, and therefore we have classed them as cases of purulent meningitis of undetermined origin. Three of the specimens were received for examination seventy-two hours after withdrawal and satisfactory examination was next to impossible with such material, since within this time disintegration of the cells had occurred and bacterial contamination had taken place.

Thus three cases which may have been due to the meningococcus failed to show the organism

in freshly drawn fluid at any time during their course.

These cases emphasize: The importance of examination of the spinal fluid in order to differentiate meningismus from true meningitis and serous from purulent meningitis; the importance of a careful method of examination for cells and bacilli in the tuberculous cases; the similar changes produced in the spinal fluid by the meningococcus and the pneumococcus; the value of cytodiagnosis in the study of spinal fluids; the readiness with which the diagnosis of epidemic cerebro-spinal meningitis may be made from the spinal fluid. The one case infected with both meningococcus and pneumococcus, which resulted in recovery, recalls the fact that the pneumococcus meningeal infection is not necessarily fatal, although its fatal result is more frequent than from the meningococcus infection.

A FEW CONSIDERATIONS IN THE TREATMENT OF VARIOUS CARDIAC CONDITIONS.¹

BY ALEXANDER LAMBERT, M.D.,
New York City.

IT is with a good deal of hesitancy that I have chosen the subject of this paper—A Few Considerations in the Treatment of Various Cardiac Conditions. It is a subject that has been gone over again and again by many writers, and each text-book has many well-filled pages on the subject. It is only for the reason that personal experience and personal observation are of more value than reading the experiences of others that I have ventured to bring this subject before you at all. I take my experience in the matter of medical education to be that of the majority of physicians who graduated some fifteen or twenty years ago. We were taught in the medical schools to be able to diagnosticate the various lesions that occur in the various valves of the heart, and then we listened in a puzzled way to the statements that this or that heart was dilated, or this or that heart showed various weaknesses in its various chambers. We accepted what was said to us by our teachers, but we wondered how it was made out. We were not taught to make it out for ourselves. We read glib sentences on hypertrophy and dilatation, and our teachers taught us the value of the two processes in a general way. We were therefore taught, what seems to me, the A, B, C of the morbid processes that go on under the various conditions called heart disease. But we were left mentally stranded as to any accurate conception of the changes on the heart under various conditions. We have had to acquire this knowledge from our own experience. There is no time to-day to take up separately the various causative factors of endocarditis and discuss in what varying ratio the different causal morbid processes at-

tack each separate valve. We will, therefore, consider only the most common, such as acute rheumatic endocarditis and its consequences, and in a general way the atheromatous lesions occurring in the course of arteriosclerosis. This, broadly speaking, separates the endocarditis of youth from the endocarditis of middle life and of old age. It is usually stated that the majority of children under 10 years of age suffering from rheumatism will show an involvement of the endocardium, and in young adult life the proportion is about one-third. This, of course, will vary more or less in the experience of each physician. In rheumatic endocarditis we must all realize that we are dealing with the structures of youth, with their recuperative powers at a maximum, and the tissues will show a predominant tendency to repair and the process of recuperation will even go on in excess of what is needed to produce the exact equilibrium for the mechanism of the circulation. I mean by this that the hearts of children or the hearts of young adults who have had their endocarditis since childhood may become overhypertrophied and go to pieces, simply because the coronary arteries cannot supply sufficient nourishment to the superfluous amount of tissue and often the breakdown of a cardiac compensation is, I think, due to the lack of nourishment to the muscle and the inability of the coronaries to supply it with food. It is a well-recognized fact that the mitral valve is the most commonly affected in the rheumatic endocarditis, and as long as simple regurgitation results it is the most benign of the lesions with which we have to deal. But if the inflammatory processes are so severe that a stenosis results we have a lesion which is a progressive one and is the most serious of all the rheumatic lesions. One factor in acute endocarditis from rheumatic and infectious diseases should not be lost sight of, and that is if the patient recovers from the acute attack it is a definite acute process which occurs and which ceases and which leaves behind it a definite healed scar, remaining permanent, it is true; but with the exception of mitral stenosis, it is not progressive. We therefore deal with a lesion, definite in its amount and therefore requiring a definite amount of hypertrophy and dilatation to compensate the changed equilibrium of the cardiac circulation. This is often lost sight of, but it is an essential difference between the rheumatic and the atheromatous processes, which latter are so distinctly progressive. In the treatment of an acute endocarditis, we have therefore to consider the therapeutic indications during the acute inflammatory process, the means of judging how to tell when that inflammatory process has subsided, the careful regulation of the life, habits and environments of the patient until the heart can go into stable equilibrium. After stable equilibrium has been established the best treatment is to let the heart alone, unless the equilibrium shows signs of

¹Read at the Special Meeting of the Fifth District Branch, Newburgh, N. Y., February 2, 1905.

breaking down. As to the first stage—the inflammatory stage—whether salicylates have any effect on the morbid processes going on in the valves or not is a question. The treatment by salicylates has certainly shortened the average length of rheumatic attacks from weeks to days, and I think that it can be said with equal truth that the number of cardiac involvements have become less under the salicylic treatment than was formerly true. As I believe that rheumatic endocarditis is one of the symptoms of the disease and not one of its complications, it would seem logical to suppose that salicylates would tend to limit, at least, the extension of the morbid processes, though they do not always prevent their occurrence. The main feature that we often notice in acute endocarditis is the sudden tumultuous action of the heart, unable to accommodate itself to the disturbed equilibrium of its circulation, and to the extra work suddenly thrown on some chamber or chambers. The extent of the damage and the rapidity with which the morbid processes go on are probably of equal moment to the heart in its ability to accept the new conditions. It seems wise, therefore, to continue the salicylates, remembering that both they and the disease itself tend to produce anæmia and thus render the blood less able to give nourishment. We must also remember that the heart is nourished during diastole, and if the systoles are much more frequent the heart has much less chance to gain its nourishment. If we therefore lengthen the diastole, even a little bit between each systole, we gain considerable in the twenty-four hours in the opportunities for the heart to be nourished. For this reason it has always seemed wise to me to quiet the tumultuous action and to go on further, for excessive stimulation at this time is likely to bring about excessive muscular action and excessive hypertrophy, and here it is that the wise or unwise use of the digitalis group may do good or may do damage. Personally, I have found the best combination to be a mixture of sparteine sulphate and powdered opium, a half-grain of the former and a quarter of the latter, going on with it or taking it away as the frequency of the pulse rate and the action of the heart showed the necessary demands. After the heart has quieted down and the patient is convalescent, when the rheumatism itself has disappeared from the various joints, the best criterion that we have is, I think, that of Broadbent's—that so long as the temperature does not go down to normal, but rests between 98 and 100, just so long are the inflammatory processes going on in the valves, and it is necessary to keep the patient in bed until the temperature remains normal. If we allow him to get up and to go about his ordinary vocations, he is sure to put extra strain on the swollen valve, and he will end with much greater damage in that valve than he would have had had we kept him quiet and in bed. This may lengthen the sojourn to six

weeks or two months flat on his back, with the patient rebelling vigorously because of such treatment, but the results are worthy of the struggle, and I believe that no patient in this condition should be allowed out of bed except against the vigorous protestations and blunt truthful warnings from his physician. Failure to follow this is the reason, I think, that we not unfrequently find patients who leave us with but slight slurring of the first sound of the heart return six months later with a very distinct and marked murmur in some valve. Much depends, if a person has had a cardiac valvular lesion, on whether that person can lead a quiet life, or must of necessity go back to hard manual labor, because all muscular development is a rather slow process and the necessary hypertrophy to compensate the lesion often takes months to develop.

Here, also, the habits of the man come into account, and the question of overeating and overdrinking, with the consequent strain on the heart, will materially change the growing compensation for good or ill. We realize that these remarks bear with double force, when we remember that the dilatation of some cavity is as important for compensation as the hypertrophy of its walls, and this is especially true of the left ventricle, whether it be mitral or aortic regurgitation, for if the blood must flow backward in the direction it does, the left ventricle must hold sufficient blood at each systole to permit of the reflux and yet send enough onward to satisfy the tissues of the body. It is for this reason, also, that the amount of change from the dilatation and hypertrophy is the best criterion, if not the only accurate criterion, we have of the extent of the lesion. The most powerful hearts with the smallest lesions often give the loudest murmurs, and the softest murmurs occur when but little valve is left to make a noise, so that the reverberation that a murmur makes is really a treacherous guide as to the extent of the lesion. Many lesions are found in persons who are unconscious and ignorant of any cardiac trouble, and I think that we should realize that as long as the heart is in good compensation and stable equilibrium, it is as much our duty to let that heart absolutely alone as it is to treat it when it shows signs of a breaking-down compensation. In patients in whom the heart shows this weakening compensation we will often find that simple rest in bed without drugs will soon be all that is necessary to permit the heart to entirely recover. Of course, when dilatation is going on and predominates over the hypertrophy we must give some drugs to help the heart regain its equilibrium. Here it is that some combination of the digitalis group is again the best means to this end. Often by giving equal parts of strophanthus and digitalis we obtain a double action on the heart and a single action on the arteries, obtaining thus the minimum of blood pressure with the maximum of cardiac effect. We can also obtain the

double action by adding glonoin or some of the arterial dilators to our cardiac tonics. It is well to remember in this connection that small doses of drugs continued over long lengths of time are vastly better than overwhelming doses for short periods.

Probably the greatest number of cardiac affections that we see are those resulting after middle life and coming on in the course of the arteriosclerosis that develops in the latter half of life. Of course, syphilis and alcoholism add a great deal toward bringing on these conditions earlier than the age of the individual would lead one to suppose that they should exist. All are agreed as to syphilis—that it is a late secondary manifestation, as far as the arteries are concerned. Whether alcohol produces it or not is still a disputed question. From Cabot's observations one would not expect to find much peripheral arteriosclerosis in more than 6 per cent. of the chronic alcoholics, but from my own observation I am equally convinced that the proportion of alcoholics who have atheromatous changes in their aortas and intestinal arteries is at least ten times as many. We must also realize in the atheromatous form of cardiac disease that the process is a progressive one, and that the lesion is most frequently situated around the aortic valve and that portion of the aorta from which the coronary arteries arise; that the disease extends into the coronary arteries themselves, and with the progressive valvular degeneration there is a progressive degeneration of the coronary arteries and a consequent increasing tendency to degeneration in the heart muscle itself. The best simile to bring this out is a homely one. In youth we are dealing with a pump, similar to a Davidson syringe, in which the valves are injured, but the rubber of the bulb is strong and intact; but in old age both the valves are defective and the rubber of the bulb refuses to contract and begins to crumble, and therefore your whole pump in mechanism and in substance has become useless. In this form of valvular disease the aortic valves are by far the most commonly involved; this may be denied, but if one will realize that most of the systolic murmurs heard at the apex in hearts affected with atheromatous disease are not mitral murmurs, but are transmitted from the aortic valves, the accuracy of this statement will be apparent. Formerly we were taught that all murmurs heard at the apex must necessarily be mitral, but this is essentially untrue, and unless the second pulmonary sound is sufficiently exaggerated to show an increased pressure in the pulmonary artery, I do not believe that we are justified in considering that there is a leak through the mitral valve. The study of post-mortem examinations will readily confirm this. Here, then, we have to deal with diseases of the heart muscle, as well as injuries to the heart valves. It is usually said to be impossible to tell from the sound of a heart whether the muscle is diseased or not. It is my personal be-

lieve that hearts with loud second aortic sounds, and in which the muscular first sound is diminished, are those hearts in which fibrous myocarditis will usually be found. In hearts showing a predominance of fatty degeneration it is more difficult to describe the change in the muscular tone. The change in the amount of sound is but slight; I think the pitch is lower-toned, is slightly muffled and less clearly defined than normal. This is the best description I can give of the way that it falls on my ear. Whether or not any of you will agree with this is hard to say, for the personal equation comes in here to the maximum extent. In treating these hearts we must realize that many of them are capable of doing their ordinary work under ordinary circumstances, but the range of their resistance and the range of their ability to do extra work are but limited, so that any extra strain, whether from increased blood pressure or from increased flow from muscular exertion, will cause them to give warning by spasmodic pain or to refuse to accept the extra burden and dilate. If a valvular lesion is added to the work that the degenerated muscle must do, there is a double burden to overcome, and it is therefore doubly hard to keep these hearts in compensation or to bring back the compensation when once it is broken. It often depends upon the unknown and unknowable amount of the coronary disease and the muscular degeneration from whatever cause. In general, therefore, we must regulate the patient's exertions—the patient's environment—more than nag the heart with drugs. If the compensation is broken, then rest in bed; if dilatation has taken place, we must go to the digitalis group to lengthen the diastolic pause, diminishing the number of systoles and thus increasing the time for cardiac nourishment. Small doses of the powdered leaves of digitalis with the extract of gentian are the least liable to disturb the stomach. A grain of the digitalis leaves in twelve hours is often sufficient and is better than larger doses. One can divide this grain in varying amounts at varying intervals in the twelve hours. Strychnine sulphate or tincture of nux vomica is also often of great value. It does seem, in some cases, as if small doses of potassium iodide had a beneficent effect in arresting the rapidity of the progress of the atheromatous changes. This drug is not always well borne, and often upsets digestion, and is, at best, disagreeable to take. There are many schemes recommended which will disguise the taste and which will diminish the digestive disturbance. What seems to me to be the best one is to give the drug in a mixture which contains aromatics and some artificial digestive substances. Often potassium iodide given in milk is well borne. Large doses, except in syphilis, are distinctly contraindicated. About five grains three times a day are sufficient. Often disturbances of blood pressure and the consequent arterial changes are due to

disturbances of digestion, and by treating these disturbances one obtains the same desired ends as by treating either the arteriosclerosis or the cardiac conditions direct. Here, also, the various kidney lesions come into account, and I have heard these patients styled cardio-nephritics, which is not a bad expression for some of these conditions. It is often impossible to say whether the cardiac or the nephritic lesion comes first, and it is often equally difficult to decide which demands the most urgent treatment. As good a rule as any is that if the heart is in reasonable compensation, let it alone and treat the kidneys; if the heart is out of compensation, treat it and let the kidneys alone for the time being, if they are doing a reasonable amount of work. Here it is that a careful estimate of blood pressure will often aid us, and often by reducing the excessively high pressure one will succeed in relieving both the cardiac strain and the nephritic incompetence. Here often glonoin or sodium nitrite will relieve the situation. Sometimes small doses of aconite act equally well as arterial dilators. In general, I think we will do better if we look at this form of heart disease as a disease of the heart muscle and, remembering the cardiac physics and the physics of the circulation, try to relieve the strain on the heart from whatever cause, whether external, from without the body or internally in the arteries, than we will do if we try to treat the heart directly. Of late years my own experience has forcibly drawn my attention to the number of patients suffering from chronic atheromatous disease, whose final illness runs with an irregular rise of temperature or a sufficient degree of temperature to be called an irregular fever. These on post-mortem examination show an acute lesion grafted on the chronic valvular trouble. This is generally the so-called verrucose form of acute endocarditis—that is, the terminal infection of many of these patients is an acute infective endocarditis added to the chronic valvular lesion. It seems to be more often of the vegetative type than of the ulcerative type, but it is the final infection that ends the scene. We have long realized that it is in this form of cardiac disease that the attacks of angina pectoris develop, and this syndrome is more dependable on the intangible diseases of the coronary arteries than it is on the valvular damages that are more easily made out. In fact, Balfour rightly says: "In every case of angina the greater the suffering of the patient and the less there is discoverable wrong with the heart, the greater the danger; hence the worse is the prognosis. A man with an intermittent or irregular heart *may* live for many years, but his life is handicapped by his heart, and if the cause of the myocardial development is irremediable or is carelessly allowed to continue its injurious influence in no long time the heart dilates and the declination becomes more rapid. At any age an intermittent or irregular heart is amenable to treatment and may be cured, but a heart

dilated after middle life is, to say the least of it, only rarely rehabilitated; it has taken the downward step which is seldom retraced. Any violent shock may force even a strong heart to intermit or become irregular, but in such the heart intermissions die away in from six months to a year. Any sudden shock acting on a feeble heart may prove immediately fatal, or a less severe shock, worry or anxiety may bring on intermittences and irregularity, or may precipitate various dilatations of the heart, terminating fatally in a few months, anticipating by more than a dozen years the natural progress of the affection." This prognostic summary from Balfour is worthy of consideration, and it is extraordinarily true in its shrewd accuracy. It is also well to remember the observations of Mackenzie, that irregularities in youthful hearts are due to irregularity in the length of the diastole, and the irregularities of hearts after middle life are due to an irregularity in the muscular contractions of the ventricles, and hence in later life its significance is of much more serious import, and really amplifies the prognostications of Balfour. These, then, are the few considerations which I have to offer you—a few considerations in the treatment of cardiac disease. I am fully conscious of the meagerness of much of the detail with which such a subject must be presented, and it is offered more to produce discussion and a general exchange of ideas among us than as any attempt at an essay on so broad a subject.

DISCUSSION.

BY S. W. S. TOMS, M.D.,
of Nyack.

From what has been so well presented by the writer of the paper and the investigations of the Leipsic School in recent years, it seems necessary new conceptions of cardiac disease should be entertained. Many of our cases in advancing life give no history of an acute infectious disease that would lead us to assume an acute endocarditis or pericarditis deformed the valves which resulted in the murmur and symptoms present.

We are not apt to estimate properly the cardiovascular changes going on in the system resulting in a myodegeneration and its direct effect in producing the symptoms, subjective or objective, which we are called upon to treat—or incidentally have discovered.

The myocardium and its integrity are, perhaps, too often overlooked in our conceptions of heart lesions; and our anatomy and physiology need revising and recasting if we study carefully the observations of Krehl, Romberg, Hesse and others on the mechanism of the cardiac valves and orifices.

These investigators have shown us that the orifices are not like a water pipe with valves, but are a complex muscular apparatus. The openings are not rings in a literal sense, but slits or button-holes, which are formed by the reflection of the muscle fibers from the base of the heart, and change their shape under the contraction of these

fibers. This exact knowledge, which must in the future be accepted, practically rules out what have been termed *relative insufficiencies*. The observers quoted have put it on record that the valves are practically always large enough to cover dilated orifices, even when cardiac insufficiency is in its terminal stage. What, then, is responsible for a murmur with normal valves, with apex beat displaced somewhat to the left or to the mammary line, with irregular pulse, dyspœa, etc.?

This is a true *muscular* insufficiency. "The essential factor in muscular insufficiency is the imperfect functioning of the muscular apparatus of the valve allowing of regurgitation . . . having the same physical signs as any other insufficiency of equally high grade."¹

In the recognition of this condition we conceive an etiology not endocarditic but myocarditic in origin, and a prognosis not of gravity but of hope, which well-directed treatment will abundantly confirm. Rest in bed, opening the emunctories, well-selected diet tonics and arterial dilators will within a few weeks perfectly transform the case from invalidism to comparatively good health. Not so with a so-called organic or endocarditic lesion. The causes of these myocarditic changes are, of course, the well-recognized etiological factors—viz., acute infections; and in the chronic states those of arteriosclerosis, Bright's disease, the toxic states of the system, arterio-capillary fibrosis and so forth.

Frequently the heart is the red-light signal of these insidious somatic changes; and it is incumbent on us in physical examinations—especially in middle and advancing years—to bear this in mind by carefully investigating the precordium. With such a heart to deal with there need be no speculation as to the ability of the heart muscle to regain tone. There are no characteristic symptoms of muscular over cardiac insufficiencies of a low grade, but they present themselves under different conditions. It is believed about "20 per cent. of myodegeneration develops muscular insufficiency."—*Loc. Cit.*

Dyspnoea, slight œdema of extremities, slight cyanosis of nose, ear-tips, and at times fingers, are fairly constant, but the epigastric and left hepatic tenderness are not always present. The physical signs are moderate dilatation of both ventricles and the apex beat within the mammary line, wider and less heaving than in cardiac hypertrophy.

The murmur in mitral muscular insufficiency is systolic, loudest at apex, and the first sound is audible. The pulmonary second sound is intensified, but a thrill is wanting. The pulse is irregular in a marked degree, and this is a pretty constant characteristic. Attacks of angina are frequent.

The tumultuous cardiac action in acute endocarditis mentioned by Dr. Lambert is due entirely to this myocardial insufficiency, which broadens

our conceptions of the processes and changes that are taking place. The pathological label of "cloudy swelling," etc., conveys but vague conceptions of the actual cardiac alterations from acute infectious processes on the myocardium.

"On the condition of the heart muscle, and on the development of arterio-capillary fibrosis much more depends in the diagnosis, prognosis and treatment of a case of so-called cardiac disease than is usually thought." The importance of careful and repeated urinalysis is urged; the estimations of area and specific gravity should be noted. "Not only do these renal conditions aid us in getting information concerning the probable condition of the heart muscle and of the blood vessel, but they also give us an insight into the ability of the kidneys to eliminate poisonous materials and drugs themselves, both of which, if retained to an abnormal degree, produce results which are disadvantageous."²

²Quotation of H. A. Hare, *Jour. A. M. A.*, September 27, 1902.

THE TREATMENT OF ACUTE LOBAR PNEUMONIA.¹

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IN discussing the treatment of acute lobar pneumonia before a society of physicians it is hardly necessary to more than allude to the prime necessity of securing the greatest possible bodily and mental rest to the patient. He should be protected from indiscreet and excitable friends. As sleep is more important than anything that we can do for him, no scheme of treatment should be insisted upon which would interrupt or prevent it. Next comes the free ventilation of the sick-room. While adequate amounts of fluid nourishment, adapted to the individual, should be given, it should be remembered that if more is given than can be digested abnormal distention from flatulence, with its serious interference with the action of the diaphragm, is sure to follow. The occurrence of this complication is to be watched for and guarded against by attention to the bowels and other measures such as are usually resorted to for this condition. One axiomatic principle of practice—viz., to at once discontinue any medication which is disturbing the stomach—is, I have had occasion to observe, too frequently overlooked.

It is my custom to make only one physical examination of the patient in the twenty-four hours, unless there is some special reason for doing otherwise. The disadvantages of any form of treatment which involves frequent disturbances of the patient should be borne in mind.

Turning from these general considerations we will now consider the more specific indications. The one great desideratum—an antidote to the toxins of the disease—we, unfortunately, do not yet possess. Anders², in a very recent article on

¹Williamson, *Jour. A. M. A.*, Vol. 39, No. 2.

¹Read at the Regular Meeting of the Harlem Medical Association, January 4, 1905.

²*Jour. of Am. Med. Assn.*, Dec. 10, '04.

the serum treatment, based on an extensive review of the literature of the subject, as well as on a small personal experience, comes to the same conclusion as have many previous writers—viz., that its utility has not been demonstrated. The creosote treatment, much lauded by some of our fellow townsmen, has, in my limited experience with it, proved unsatisfactory, though doubtless useful in broncho-pneumonias and lobar pneumonias complicated by much bronchial secretion. One observer claims remarkable results from large doses of iodide of potassium; another from salicylates. As a means of eliminating the toxins, the giving of as large quantities of water as the patient can take without derangement of digestion or overloading his circulation is to be recommended. Free use of acetate of potassium, as advocated by Dr. Reese³, or other mild diuretic, seems rational.

Large doses of quinine, fashionable at the beginning of my professional career, were found to do rather more harm than good, though Auffercht⁴ extols the virtues of half-gram doses of the hydrochlorate given hypodermically late in this disease once every twenty-four hours.

I have a personal prejudice in favor of the administration of small doses of aconite during the first twenty-four hours of this disease, and think that I have seen good results from salol given with or without the aconite during the same period in modifying the severity of the onset. In the absence of any antidotal treatment whose efficacy can be accepted as definitely established, we are obliged to rely mainly on symptomatic treatment. The first symptom which at the onset, in a majority of cases, is most apt to call for attention is pleuritic pain. This should be combated, if possible, by local applications of ice-bags or poultices, the latter preferably with associated counterirritation. In some cases in which I was induced by circumstances against what I considered my better judgment to use the proprietary remedy known as "Antiphlogistine," I was reluctantly obliged to concede that it seemed to increase materially the comfort of the patient. It at least has the great negative merit of being applied only once every twenty-four hours. Morphine and opiates generally are strongly contraindicated because they check excretion and diminish the irritability of the respiratory center, being especially objectionable when there is much bronchial secretion. Nevertheless, when suffering is extreme, in some cases of obstinate insomnia and occasionally in exhausting cough, the advantages may outweigh the objections to their use. The relief of pleuritic irritation often controls cough. The commonly used expectorants are, as a rule, worse than useless, because they disturb the

stomach and do no good in any way. If bronchial secretion is profuse some drug of the creosote order is indicated, carbonate of guaiacol being perhaps as efficient as and less likely to disturb the stomach than any other.

The chief object of our symptomatic treatment is to sustain the heart. As in a large majority of autopsies in cases of pneumonia the right heart is found distended with large clots, it is evident that this is the weak part of the chain. In the days of the fathers, and still, theoretically, in our own, this condition seemed obviously to call for relief by bleeding. It seemed rational to relieve the overburdened organ by reducing its load. The cause of its embarrassment is obviously the narrowing of the channel of the lesser circulation, owing to the obstruction to the circulation in the inflamed portion of the lung and the weakening of the heart muscle by the toxins of the disease. Of late years has come the use of the nitrites so ably advocated by Dr. A. H. Smith, by which it was proposed to lessen the work of the right ventricle by causing a general arterial dilatation, in which the arteries of the lesser circulation are supposed to participate. But the researches of Romberg and Pässler⁵ have shown that the problem is not so simple as it at first seems. They claim to have demonstrated that the embarrassment of the circulation in pneumonia is due primarily to vasomotor paralysis, the heart exhausting itself, owing to the rapidity of its contractions secondary to the abnormally low peripheral resistance. This rapidity of action implies an increased rapidity of circulation. The effect of this condition of affairs on the left heart, the vessels of the greater circulation being widely dilated, is small, compared to that on the right heart, which is forced to maintain this more rapid circulation through the partially obstructed pulmonary circuits. With these facts in mind the most rational way of lessening the work of the right heart under the conditions obtaining in pneumonia is apparently to increase the peripheral resistance in the greater circulation and thus slow down the action of the heart. The marked improvement which occurs at the time of the crisis in the circulation, before there is time for any material change in the physical condition of the lung or heart, seems best explained by the return of normal tone to the peripheral vessels. In searching for remedies to restore the normal balance of the circulation the one drug which seems most completely to meet the indications is digitalis. While it may have been true that, in the pneumococcus septicæmia produced by Romberg in his rabbits, the myocardium was affected late in the disease, in the human subject we have frequently to deal with myocardia which have been previously diseased, and a remedy which acts both on the myocardium and the vasomotors is called for. The enormous tolerance

³Med. Rec., II; '04, p. 829.

⁴Nothnagel's Spec. Pathol. & Thorop Bd., XIV.

⁵Verhandlungen des Congresses für Innerer Med., 1896.

for the remedy in this disease is shown by the doses given by Petresco—*i. e.*, an infusion from 4 to 12 grains of the leaves in the twenty-four hours. The form in which I have lately employed the drug is by hypodermic injections of the fluid extract, 2 to 10 drops, diluted, repeated once or possibly twice in the twenty-four hours. Fränkle warns against its use in cases of arteriosclerosis. I have seen an irregular pulse in such a subject rendered markedly worse by the drug. I have also seen 10 drops of the tincture given by the mouth followed by marked irregularity of the pulse, which disappeared on its discontinuance, the case being one that ran a benign course. In general, however, my experience confirms the experience of others in regard to the tolerance of the drug in large doses, and the at least temporary benefit often to be derived from its use. During the intervals between the administration of these doses the heart and vessels may be sustained by more quickly acting stimuli. For the vessels we have chloride of barium, ergot and suprarenal extract or adrenalin chloride, the last being fugitive in its effects and requiring frequent repetition of the dose to secure results. For the heart we have strophanthus, which may well be substituted for digitalis in cases complicated by arteriosclerosis; the soluble caffeine salts, which appear to me in other conditions in which the right heart is affected, particularly in asthma, to act well on that portion of the organ; camphor and strychnia. The last, which is supposed to stimulate both heart and vessels, is perhaps the least liable to abuse of the remedies at our service, is contra-indicated only in those cases in which the drug causes extreme nervousness and irritability, and may often be our sole reliance in milder cases which do not call for more heroic interference. One of the moot points of the day is the utility of alcohol. I am inclined to limit its use to occasional small doses as a hypnotic, as a stimulant in acute emergency and for continuous administration only in alcoholics in whom its abrupt discontinuance may prove disastrous. As a cardiac stimulant it can, I think, be advantageously replaced by the other remedies above enumerated, which do not share with it the grave drawbacks, when given in any excess, of acting in alliance with the toxins of the disease in paralyzing the vasomotors, causing parenchymatous changes in the viscera and blunting the sensibility of nerve centers, upon whose vigilance the life of the patient depends.

The external use of water is of great utility in sustaining both heart and vasomotors. The sponging of the body and limbs with water or alcohol and water at a temperature adjusted to the sensitiveness of the patient is of use under this heading, is the only antipyretic that should be employed and is a most decided sedative. Abdominal compresses act in similar ways and are useful in flatulence. The wet jacket applied to the entire chest is highly lauded by Dr. Baruch,

but personally I have been inclined to think that the disturbance of the patient incident to its frequent renewal was a serious offset to whatever good might be expected from it, though in this I may be mistaken.

The value of subcutaneous injections of normal salt solutions is insisted upon by several observers. It tends to flush out the toxins, but in so far as it temporarily increases the work of a possibly overburdened heart it is not to be resorted to without due weighing of its dangers.

Pulmonary œdema, not of inflammatory origin, the researches of Welch have demonstrated to be due to relative insufficiency of the left ventricle, the right heart forcing blood into the lungs which the left is not able to remove with sufficient rapidity. Here the indication for the use of nitroglycerine is much less equivocal than in right-heart failures. Quick-acting cardiac stimuli, such as the soluble caffeine salts and camphor given hypodermically, alcohol and cupping of the thorax, are called for.

Antipyretic drugs, used as antipyretics, are mentioned only to be unqualifiedly condemned. Temperatures not exceeding 103 or 104 degrees do not in themselves call for interference. Water is the only antipyretic to be allowed. An occasional small dose of phenacetine may, however, be safely used to control headache in cases in which its depressing effect is not to be feared.

Oxygen inhalations have seemed to me better calculated to demonstrate to the friends the resources of the physician rather than to be of benefit to the patient. In too concentrated a form oxygen has been shown to be an actual irritant to the lungs. Oxygen from an open window is infinitely more important than oxygen from a tank.

For insomnia hydrotherapy is to be relied on if possible. Most hypnotics are cardiac dependents. Bromide and hyoscyamine hydrobromate are perhaps the least objectionable. Morphia may be used as a last resort. In delirium occurring near the crisis, the so-called inanition delirium Fränkle recommends it highly. In complicating delirium tremens the generally used chloral hydrate and bromides may have to be resorted to.

In estimating the results of our treatment we must ever bear in mind that many uncomplicated cases recover without active interference, and that our potent remedies are two-edged swords, whose power for evil as well as good is always to be borne in mind. As pneumonia occurs so frequently as a terminal infection in patients broken down by other causes, its mortality will probably always be large. It is to be hoped that, pending the discovery of a remedy which can be relied on to exert a specific control over the disease, the indications for symptomatic treatment may become more sharply formulated and generally recognized, and that our present unsatisfactory results may be, as a consequence, improved upon.

A CASE OF MILIARY TUBERCULOSIS.¹

BY ROY E. MITCHELL, M.D.,
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PERHAPS I should offer an apology for reporting a case of tuberculosis. However, the miliary form of tuberculosis is not very common, and, so far as known, the following case is the first one that has been observed at the Middletown State Homœopathic Hospital in the treatment of nearly seven thousand patients. The rather atypical onset and course and some unusual associated features make the case especially interesting.

The patient, W. Y. (colored), age 35, single, a laborer of unknown habits, was admitted to the M. S. H. Hospital on October 27, 1904, the day after his formal commitment as an insane person. The facts contained in the commitment papers were as follows: "The onset of the present condition was sudden, three weeks ago, the symptoms gradually becoming more marked. The patient is depressed. He appears stupid and refuses to talk. He will not eat and when attempts to feed him are made, he resists actively. The general physical condition is good. He is kept in a straight-jacket. Habits uncleanly" (the last statement was interpreted to mean involuntary stool and urine). Further inquiries, directed to the hospital from which he came and to one of the committing physicians, brought forth a corroboration of the above facts and the additional statement that, up to three weeks previous he had been a laborer in a brickyard (an indication that he must have enjoyed fairly good health).

Upon admission, the patient was weak but able to walk. He seemed afraid of all newcomers, drawing back as if in fear, but was prevented from a more active demonstration by his reduced physical condition. The nurse who brought him reported that, while he had come readily, he had exhibited the same fear toward strangers all along the way. He did not speak voluntarily and paid no attention to questions other than to roll his eyes. He went readily to the ward and offered little resistance to being put to bed.

He remained mute up to, and during, his mental examination, the next day, and continued to do so until he died, with one exception, when, on the second day, he whispered with difficulty, "Yes, sir," in answer to a question. On the first day he was restless, would try to get out of bed and wander around, all apparently an aimless attempt to get away. After that, he remained quietly in bed, flat on his back, unless some one approached. He was fearful of every one, the facial expression being one of extreme fright at times. He steadily refused to eat or drink and when tube-fed, he resisted to the limit of his strength, at times screaming in terror.

A physical examination showed him to be a

large, well-built negro, rather poorly nourished. When in repose, his condition was suggestive of the so-called "typhoid state." The skin was dry, the lips cracked, the tongue dry, sordes on the teeth and offensive breath. The voice was weak. Hearing was probably good, for he looked at the questioner when spoken to. The pupillary reaction was normal. Both deep and superficial reflexes were active. The various movements were definite, although the muscles were weak, except that occasionally the eyes would converge. The examination of the thorax was unsatisfactory, owing to the patient's struggles and screaming. The inspiratory sound was harsh, but this was thought to be natural under the circumstances. Respiratory rate, 24. The heart was of normal size; no murmurs were detected. The pulse was weak but regular—rate, 90. The temperature was normal, 99 F. (R). Both urine and stool were involuntary. The stools were thin, yellowish and quite offensive. The urine was concentrated, sp. gr. 1030, urea 3 per cent.

The law demands, and medical practice requires, that some name be fitted to the condition which our patients present. In this case, we found ourselves at a loss to do this satisfactorily. The physical condition was one of exhaustion, the mental state that of probable confusion, fear, resistiveness, mutism and depression. Under the old mental classification, it was easy to push the case into the "melancholia acute" pigeonhole, but the real difficulty came when its place in the new classification had to be determined. Upon the whole, it was thought to be more closely allied to an "exhaustion" psychosis than any other.

There was no marked change in the patient's condition during his short stay at the hospital, other than a gradual physical failure. The respiratory rate continued along under 25. The daily temperature range varied under one degree, being highest in the afternoon. Toward the end, there was some aimless fumbling with the bed clothes. He persistently refused all food and drink and was tube-fed twice daily, struggling as best he could each time. As he grew more feeble, his apprehensiveness became less marked. During the morning of November 1, 1904, the sixth day after admission, he had what the nurse called a "weak spell." During this he became quieter than usual and his breathing became faster and rather loud. When seen, a short time after, he was comatose, the pulse rapid and weak, rate 120, the respirations were labored, rate 42. Temperature 99.4 F (R). Loud mucous rales were heard all over the chest—so loud were they that the heart sounds were obscured. He was perspiring freely. He choked when liquids were placed in his mouth. This comatose condition continued, the respiratory rate crept up until it reached 60, the pulse became weaker and irregular and the mucous rattle appeared in the throat. At 3.50 p. m. he died.

Four hours later an autopsy was performed, and then, for the first time, the real status of the

¹Read before the Orange County Medical Association, Middletown, February 10, 1905.

case was established. Following is the report of the autopsy:

EXTERNAL EXAMINATION.

A young colored man of large frame and well proportioned. Rather spare, but muscles are firm and of good size. Head long and narrow, forehead receding, chin prominent, lips thick, nose flat, with wide nostrils. Right leg a little shorter than the left, due to an old fracture of the bones at the junction of the middle and upper thirds of the leg, well-marked, bony callous. Skin thick and clear, brownish black in color. There are a few small old scars on the hands and shins, probably traumatic. There are two small granulating surfaces over the right clavicle; the skin about them is indurated and considerably pigmented. The hair is black, short and curly. The arms and legs are hairy. Eyes brown, cornea glazed. Lips dry and cracked. Teeth large and regular. Considerable reddish fluid escapes from the mouth. No rigor mortis or hypostasis, body still warm.

HEAD.

Scalp thick. Calvarium heavy. The inner surface of the dura, over the left hemisphere, presents a number of small, whitish tubercles, none more than an eighth of an inch in diameter. The dura is quite adherent to the pia along the superior longitudinal fissure. The cerebral sinuses appear normal. The pia is decidedly edematous. Throughout the distribution of the left Sylvian artery, on the convexity, numerous small tubercles similar to those on the dura are observed. The meningeal vessels are moderately congested. The brain is of normal size and appears normal in structure. Weight, 50 oz.

THORAX.

The diaphragm is at the normal level. The thoracic organs are in normal position. Moderate mediastinal fat. The mediastinal glands are enlarged, some as much as three-fourths of an inch in diameter. They are bluish in color and quite soft; when opened they are seen to be a thin membrane enclosing a cheesy mass.

Pleurae.—The pleural cavities are practically obliterated, both lungs are adherent, throughout their entire surface, by thin, firm adhesions. The lobes of the lungs are adherent to each other. An accumulation of about half an ounce of thick, yellow pus was found in this thickened pleura, between the second and third left ribs, about four inches from the median line. The walls of this cavity were about an eighth of an inch thick; but ruptured easily. Smears made from the contents revealed no tubercle bacilli.

Lungs.—Weights, R 36 oz., L 29 oz. Neither collapsed when the thorax was opened. Both are heavy and feel solid. They are deep red in color, presenting numerous small, white spots over the entire surface. A heavy mass of scar tissue is observed at the right apex; a similar though less marked condition is seen at the left apex. Upon section, both lungs are thickly studded with small tubercles about the size of

millet seeds. These tubercles are more frequent in the right upper lobe and less frequent in the left lower lobe. The intervening lung tissue is reddened and congested, deeply so in the left lower lobe. The dependent portions of both lungs are moderately congested. The upper portions are fairly well aerated, as considerable frothy, reddish fluid escapes on pressure. No cavities are found in either lung. The only purulent foci found were the softened mediastinal glands and the accumulation of pus in the pleura. The mucous coat of the bronchi, trachea and larynx is decidedly reddened; all contain considerable frothy fluid.

Pericardium.—The pericardial sac contains about an ounce of clear straw-colored fluid. The visceral layer presents several small, whitish areas.

Heart.—Weight, 11 oz. The heart is large but thin-walled and flabby. The right heart is dilated and filled with fluid blood; five fingers are easily introduced into the tricuspid orifice. The heart muscle is dark red in color and tough. The heart valves are normal. The coronary vessels are rather prominent. No clots are found anywhere in the circulatory system. No atheroma observed in the larger vessels.

ABDOMEN.

The upper surface of the left lobe of the liver and the adjacent portions of the right lobe are densely adherent to the diaphragm; the upper surface of the spleen is also adherent (old adhesions). The cæcum is pushed inward and several loops of the ileum lie between it and the outer pelvic wall. The bladder is distended to such an extent that it pushes the loops of gut out of true pelvis. The ileum joins the cæcum at a very acute angle; it lies almost parallel to it for several inches and is somewhat adhered (apparently a structural anomaly). The peritoneum is considerably thickened about the diaphragmatic adhesions, but there is no exudate. The mesenteric glands are moderately enlarged. They are reddish in color, rather soft and vary from an eighth to a fourth of an inch in diameter.

Stomach.—Normal in structure, empty.

Small Intestine.—Normal in structure except for the anomaly above noted. It contains a small amount of unformed debris. At many points along its course the wall of the gut is thickened and congested, and a few small superficial ulcers are observed, none more than an eighth of an inch in diameter. All of these are covered with a tenacious yellowish slough.

Large Intestine.—The large intestine is moderately filled with soft feces. The appendix is about two and a half inches long and one-fourth of an inch in diameter. It is curled upon itself and lies on the outer side of the cæcum.

Liver.—Weight, 70 oz. The liver is large and pale, but is of normal consistence. Numerous small tubercles present over the entire surface. The lower margin of the right lobe is only about a half-inch above the iliac crest. In the thickened

peritoneum, on the superior surface of the liver, a number of larger tubercles are seen, varying from one-eighth to one-fourth of an inch in diameter. Upon section, the liver tissue is pale; there is no oozing. The whole organ is thickly sprinkled with tubercles of millet-seed size. The gall bladder is of normal size and structure; it contains about two ounces of thick, greenish bile. Bile duct open.

Pancreas.—Large and pale; does not present macroscopic tubercles.

Adrenals.—Appear normal.

Spleen.—Weight, 15 oz. Very much enlarged. Capsule thickened, especially on the superior surface. The organ is pale red in color and very firm. On section, there is no oozing; the tissues are thickly studded with small, yellowish tubercles.

Kidneys.—Weights, R 5 oz., L 6 oz. Normal in size, pale red in color, rather soft. Both present numerous tubercles scattered about the cortex, none more than an eighth of an inch in diameter. The capsule strips readily, showing up well-congested cortical vessels. On section, the kidney markings are well preserved. The cortical vessels are prominent. Small tubercles are scattered about in the cortex. Pelves normal.

Ureters.—Normal. The bladder contains about one pint of clear urine.

Microscopic specimens, prepared later, confirmed the gross findings; typical tubercles were found in all the viscera.

From the pathological point of view the picture is complete. We found healed tubercular lesions at each apex and two sources of infection: the pleural accumulation and the softened mediastinal glands. While no direct communication between these and the blood stream was demonstrated, such undoubtedly existed, for under no other conditions would we find such a widespread distribution of tubercles of so nearly uniform size.

Clinically, the case resembles the typhoid form of miliary tuberculosis, but at the same time was decidedly typical. Most remarkable was the absence of cough while under our observation. No mention is made of this symptom earlier in the course. Almost as striking was the absence of profuse sweats and the marked daily range of temperature which most authorities emphasize. The duration, about four weeks, is an average time. It is to be regretted that the earlier history of the case is not more complete.

We who observed the patient thought that the symptoms presented corresponded very closely to those of a form of exhaustion occasionally seen in acute mental disease where physical debility and starvation are prominent factors. The absence of definite symptoms pointing to some other condition only helped to confirm us in this belief. While we should have been better pleased to have made the correct diagnosis on the ward we offer no apology for having made it on the autopsy table.

The cause of death was clearly miliary tuber-

culosis. Without an autopsy it would probably have been reported as "exhaustion accompanying acute melancholia."

So much for the consideration of the case itself. In conclusion the question naturally presents itself: Was the case really a suitable one for treatment at a State hospital? A fatal and speedy outcome was inevitable, no matter where the patient was treated, but I feel confident that, had the attending physician suspected the real condition, he would have kept the patient at the general hospital. He would no more have countenanced his transfer than he would have advised the removal of a late-stage typhoid case under similar circumstances. To my mind this is one of a steadily increasing number of cases that, sooner or later, are bound to destroy the indefinite and ill-advised line that for many years has separated the treatment of mental disease from the field of general medicine. When this is accomplished, and the general practitioner and the mental specialist meet on a common ground, then, indeed, we can assure ourselves that the *medical millennium* is at hand.

NON-DEFORMING CLUB FOOT.

The *New York Medical Journal*, January 14th, contains an article entitled, Differentiation in the Diagnosis of Non-Deforming Club Foot, by John Joseph Nutt, M.D. Although the writer quotes from "the surgeon who was the first to describe this condition," he does not give either name or reference. This would seem to be an error, both from a scientific and historical point of view.

The condition was first described by Newton M. Shaffer, M.D., in an article which was published in the *Medical Record* of May 23, 1885. Those who are especially interested in orthopedic surgery should avail themselves of the earliest opportunity to read that article if they are not already familiar with it.

Shaffer's club foot, according to Nutt, is a by no means rare condition, and the lack of a general understanding of the symptoms and conditions which it presents is the cause of much unnecessary suffering. Among the diseases which he mentions as being confounded with this condition are: Muscular and articular rheumatism, gout, metatarsalgia and chronic arthritis. He points out that the cause of much of the suffering from corns, bunions and distortions of the toes is primarily due to interference with the normal mechanical action of the foot and ankle when this condition exists. The rapidly increasing demands for rubber heels, cork soles, felt insoles and patent arch plates, and the increased number of anatomical shoemakers would seem to direct our attention to some cause or causes other than ill-fitting shoes. The shoes have been much to blame, but in last and material they have been improving rather than becoming more damaging. Yet the crimes with which they were charged are not diminishing.

FOOD AND DRUG ADULTERATION.¹

BY CHARLES IRA REDFIELD, M.D.,
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ACCORDING to the by-laws of this society, it becomes both my duty and privilege at the annual meeting to address you upon some scientific subject. In view of the fact that much attention is at present being directed to the quality of foods and drugs, as supplied to the public, it has not seemed inappropriate to review in a somewhat hasty manner the character and extent of the adulteration and misbranding of foods and drugs as practiced in defiance of many just and commendable pure food and drug laws now existing in this and other States.

That adulteration and sophistication exist in both the commercial and drug trade is apparent to all who give the fact a moment's consideration. Likewise such a condition of affairs could not have come to pass without just and sufficient cause.

The apparent cause of so much food adulteration lies in the fact that the food supply and the consumer have in late years been separated from each other by great distances instead of supply and consumer being in close contact.

Prior to the year 1874 nearly every one supplied his table with products raised at home or in the locality surrounding his home, but with the continued growth and expansion of the country, increase of population, unrestricted immigration and the consequent congregation of people in cities and towns, the plan of a direct food supply became less and less customary.

The building of great railroad systems and the introduction of refrigeration and refrigerator cars made possible the transportation of food products great distances, so that at the present day many of our tables are supplied with products from all points of the compass and even from subtropical climates. There naturally arose the necessity for base supply houses for all the great food commodities. Hence, in a few years were built great flour mills, supplanting the humble grist mill of the country side, enormous beef and pork packing-houses, with cold-storage rooms and cold-storage cars in place of the local butcher shop and slaughter-house. Creameries and butter factories supply these articles instead of the farmer's wife. Large canning establishments have replaced the housewife in her kitchen, so that every staple article of diet is now produced and handled on a mammoth scale by some syndicate formed for the purpose.

It is therefore manifestly impossible for the consumer ever to come in direct contact with the primary producer. From this very fact has arisen the opportunity for adulterating the food supply of the nation, thus cheapening the cost of production by imitation of many articles usually of value as wholesome foods.

Likewise sophistication of drugs has kept

pace with the adulteration of foods, so that at present it is a question which class has suffered most from adulteration and downright imitation.

Of course, the real cause for much of this evil is the desire of so large a portion of the people to amass great fortunes rapidly, a factor that plays a not unimportant part in the study of many of the methods of unscrupulous persons to foist upon the public these unwholesome foods and impure drugs.

Many States, and notably our own, have early recognized the dangers threatening the people and have framed and passed many just and effective laws regarding these adulterants; but the enforcement of such laws has often been extremely unsatisfactory. Thus this practice of tampering with the health and lives of 85,000,000 people has grown and been fostered, until now we are confronted with an extremely difficult problem as to how to eradicate the evil.

It is the purpose of this paper to show the extent and character of:

First.—Adulteration and misbranding of foods.

Second.—Prepared and proprietary foods for infants and invalids.

Third.—Impure drugs and chemicals.

Fourth.—Patent and proprietary medicines.

Fifth.—The remedies.

FOOD.

No better definition of what constitutes adulteration and misbranding can be given than that which results from a study of the provisions of the laws of various States of the United States and other countries in regard to pure food.

A composite definition would read somewhat as follows:

Adulteration of food consists in the mixing or packing with it any substance or substances, so as to reduce or lower or injuriously affect its quality or strength, substituting any substance or substances wholly or in part for a certain food product, imitation or offering for sale a substance which is not truly that article of food, or mixing, coloring, powdering, or staining a food product whereby damage or inferiority is concealed, or adding to any article of food poisonous ingredients, so as to render such article injurious to health, or if the food be the product of diseased, putrid or decomposed animal or vegetable matter, or in the case of confectionery, if terra alba, barytes, talc, chrome yellow or other mineral substances or poisonous colors or flavors or other ingredients deleterious to health have been added.

A prominent feature to be taken into consideration when giving a definition of food adulteration is misbranding. Misbranding may be defined as labeling or branding food products so as to thereby deceive the purchaser as to the true value of the article, or with the intent to mislead the purchaser as to whether the product is pure or a mixture or blend manufactured to take the place of a true food product. It would

¹Read before the Annual Meeting of the Medical Society of the County of Orange, May 9, 1905.

be manifestly impossible to cover the subject of all adulterants which have been from time to time used to deceive the consumer into believing them to be pure foods.

It will suffice to mention those in common use at present.

The chief adulteration to which meats are subject, exclusive of the sale of diseased and putrid animal tissue, is the addition of preservatives. In early times man learned to "smoke" and preserve meats with salt, but in these latter days "embalmed beef" and chemical preservation has flourished to a remarkable degree, which, in addition to the refrigerator cars and cold-storage rooms, has made it possible to deliver and sell meats raised on our Western plains in all the foreign countries and even in the tropical climates. The chemicals usually employed are boric acid, borax, salicylic acid and sulphites. These substances are sold commercially under the names of Freezem, Iceine, Preservaline, Bull Meat Flour, etc., and are used to dust on the surface of meats or mixed with them.—E. F. LADD, *Chemist, North Dakota*.

From recent experiments made at the United States Agricultural Station, Fargo, N. D., by E. F. Ladd, Chemist and Food Commissioner, it was found that these substances were present in ham, dried beef and like cured products from 5 to 15 grains to the pound; in sausages, bolognas and hamburger steak, from 20 to 50 grains of boric acid to the pound.

In many samples of sausages, sliced bacon, chicken loaf put up by some of the leading packers of this country, as Armour, Libby, Swift and Cudahy, boric acid, borates and sulphites were recovered in varying amounts.

In regard to the deleterious effect of borax and boron compounds, Dr. Wiley, of the Bureau of Chemistry, United States Agricultural Department, states "that doses not exceeding half a gram daily, or equivalent thereto, are prejudicial when consumed for long periods of time. It is undoubtedly true that no patent effects may be produced in persons of good health by the occasional use of preservatives of this kind, but the young, the debilitated and the sick must not be forgotten, and a safe rule to follow is to exclude these preservatives from foods of general consumption."

Dr. Charles Harrington, of Boston, in a recent series of experiments upon the use of boric acid in food products, found that when only dusted on the surface of the meat they are absorbed into its substance and no amount of boiling or soaking would eliminate them. He found in some samples of ham and corned beef as much as 28 grains of boric acid to the pound.

Regarding the use of sodium sulphite as a meat preservative, the same writer states that "it is classed as a food preservative, but its antiseptic properties are comparatively feeble. It is used more especially on account of its effect on the appearance of the food to which it is

added, its preservative influence being decidedly a minor consideration. It confers upon minced or chopped meat an abnormally brilliant red color, which conveys to the purchaser the idea of freshness. The red color persisting as it does, meat which is in reality well advanced in decomposition is readily disposed of as perfectly fresh, for although the number of bacteria per gram may run as high as 500,000,000, it may give no marked odor. It can be fairly said that, on this account of masking decomposition, it is an undesirable admixture."

Dr. Victor C. Vaughan, of University of Michigan, in a recent article on "Food Preservatives," gave as the essentials of a substance used as a food preservative before it receives legal sanction:

"1. It must be a real preservative, keeping the food in a wholesome condition and not merely retaining the appearance of freshness while bacterial changes continue.

"2. In the largest quantities used it must not impair any of the digestive processes.

"3. It must not be a cell poison, or if a cell poison in any amount it must be added to foods only by persons qualified by special training and officially authorized, and foods containing these substances must be plainly labeled, and the kind and amount of the preservative used must be known not only to the buyer, but to each consumer."

As regards boric acid, it is also a feeble antiseptic and must be added to food in comparatively large quantities to act as a preservative, so that, as one authority stated, "it is quite possible for a person to take as much as 3 grams, or about 46 grains daily, in his ordinary food."

Among the deleterious effects of boron compounds Dr. John V. Shoemaker, of Philadelphia, mentions "retardation of diastatic action of saliva upon starch lessens appetite, produces vomiting, gastric catarrh, diarrhoea, capable of inducing nephritis and various skin eruptions."

In addition to meats, fish, oysters, clams and other perishable animal food products are preserved with salicylic acid, borates and the like.

Meat and fish poisoning, however, do occur independently of the presence of artificial preservatives, due to bacterial action and the production of toxic products capable of inducing severe and even fatal poisoning. It may be of interest, however, to note that the so-called chemical germicides are in reality, as Vaughan states, "not true preservatives, but allow the bacterial action to go on just the same, although to the consumer they give a false impression of freshness, as the color and odor of the meat is kept intact. It is similar to removing a red lamp of danger on a dark street and substituting therefore a white light simply because the white light would look better and thus take away the warning signal placed there for the protection of life and limb."

Only recently a case came under my observa-

tion which was clearly due to the fact that the patient had eaten quite freely of potted ham, undoubtedly due to meat which had undergone bacterial changes just before being packed and a preservative added to keep the meat in the can, but which in reality allowed bacterial changes to go on just the same.

The most common adulterations of flour (wheat) and bread are the so-called "mixed" flours, consisting of admixture of wheat flour, with rye, cornmeal and blighted or molded wheat flour. Mineral substances, such as alum, copper, sulphate, borax, chalk and carbonate of magnesia, for the purpose of making a white flour, are more often added by the baker than at the flour mills. These substances are often used by bakers with the idea that they are not harmful and are really needed to whiten the bread; but alum has been proved to be a distinct inhibitor of gastric digestion, and copper sulphate is, of course, dangerous. Alum is also added to bread to produce a good-looking loaf from a poor and weak flour.

Butter has not been adulterated as much as it has been imitated. The chief adulteration has consisted of adding artificial color, but except this color is aniline no deleterious results can be attributed to the coloring. Starch has occasionally been added to butter to increase its bulk. However, butter has been sophisticated under the head of "renovated butter" and oleomargarine, both of which have been sold for genuine butter. Renovated butter consists of melting any of the dairy butters of indifferent quality and coming from various sources, allowing the curd and brine to settle, scumming off the top, blowing air through the molten oil, mixing of milk with the molten fat, rapid cooling and granulating of this mixture by running it into cold water, draining and ripening of the granulated mass for a number of hours, salting and working, packing and molding into prints the same as other butter.—G. E. PATRICK, *Farmers' Bulletin* 131, U. S. Department of Agriculture.

Glucose is often added to butter to increase its water-holding power, and thus increase its weight, likewise to act as a preservative. Saccharine is also used as a preservative.

Oleomargarine is really not as bad a substitute for butter as many think, as it consists of animal fat, which has been used for food for generations. Beef suet is cut into cubes melted at a temperature of 110 degrees Fahrenheit for several hours in order to separate the fat from the tissues. The fat is drawn off and allowed to cool and solidify. The remaining oleo, after the stearine has solidified, is obtained by pressure. This oleo is then churned with milk or with genuine butter and milk, colored with annatto and otherwise treated as butter. Neutral lard and cottonseed oil are often used for the same purpose. In reality oleomargarine is not such a bad food and is much better and cheaper for poor families than the poor grades of butter often sold for a

much higher price.—*Text-Book, Hygiene*.—HARRINGTON.

When attention is directed to the enormous production, sale and consumption of food products preserved in cans, it is at once apparent that adulteration is practiced among this class of provisions with the greatest of ease and without much chance of detection.

Some manufacturers have gone so far as to say that it is absolutely necessary to add preservatives and colors to canned goods, else they cannot preserve or sell their products. If this is true, certainly the public is sadly in need of education as to what constitute good and wholesome articles of diet.

The most common adulterations found in canned goods, according to Prof. E. F. Ladd, of the North Dakota United States Agricultural Experiment Station, are the addition of preservatives, such as boric acid and borates, sodium sulphite, salicylic acid, saccharine, benzoic acid, formaldehyde, copper sulphate and aluminum, and the addition of artificial coloring matters, usually the aniline dyes. Glucose and gelatine comprise the base of many jellies, jams and preserves, and some are sweetened with saccharine instead of cane sugar. These artificial preservatives are found in almost all of the canned vegetables, such as peas, succotash, tomatoes, canned meats of all kinds, and catsups, preserved fruits, jellies, jams, etc., and that, too, even if preserved in glass jars.

Artificial coloring is present in French peas, due to the "greening process" with copper sulphate, and most of the so-called French peas are manufactured in this country. Sweet corn is often made from "soaked corn"—that is, dried corn soaked in water and thickened with cornstarch, bleached with sulphites or sulphurous acid fumes and sold as sweet corn, after being suitably sweetened with saccharine.

Most of the preserved strawberries, raspberries, cherries and the various fruit jellies, jams, etc., are colored with aniline dye, preserved with salicylic acid, sweetened with saccharine or glucose.

Maraschino cherries are usually composed of California cherries (white), hardened, pitted and stemmed, bleached with sulphurous acid, colored with aniline dye and flavored with an artificial oil of bitter almonds. Cans of tomatoes have been found to be green tomatoes of very poor quality, colored with aniline and sold for ripe tomatoes.

Most of the catsups contained salicylic acid and are colored with aniline, and consisted of pulps, seeds, skins of tomatoes, waste products generally, including pumpkin; sometimes benzoate of soda is added as a preservative and often saccharine as a sweetener.

The various prepared gelatines in all flavors are frightfully adulterated, both as regards colors and flavors. Notable among these are such products as "Jellycon," "Jell-O" and the

different powdered jellies on the market. Regarding the presence of glucose in food products, it cannot be said that it is detrimental to health, as it occurs in natural state in many fruits, but food products containing glucose should be plainly labeled as to that fact and not endeavor to deceive the public into believing that the product is pure fruit.—E. F. LADD.

However, glucose can become injurious, and even poisonous, if in the process of manufacture the least trace of arsenic is introduced. This contamination usually comes from the use of impure sulphuric acid, which is used to convert starch into glucose. Instances of this kind have occurred with fatal results. In Manchester, Eng., in November, 1900, there were 3,000 cases of poisoning from beer, in which glucose was used during its preparation, the glucose being contaminated with arsenic from the sulphuric acid used to make the glucose. There were thirty-six deaths as a direct result of this contamination in Manchester.

The various prepared icings contain large amounts of artificial sweetening and artificial coloring.

According to Professor Ladd, not only canned goods, but dried fruits have come in for their share of adulteration, and prunes, apricots, raisins, peaches, etc., are artificially preserved with borates, have artificial sweetness added by saccharine and are artificially bleached with sulphurous acid fumes.

Mincemeat made from such fruits, and indeed mincemeat made from fresh materials has been found adulterated in the same manner.

Regarding the use of saccharine, granatose or coal-tar sugar, the universal opinion of therapeutists and health authorities is that it is in no sense a food, being eliminated from the body unchanged and may give rise to nephritis in passing out through the kidney. Dr. Wiley states that its use should be absolutely prohibited.

The manufacturers of saccharine advertise it as follows: "A perfect sweetener, pure, refined, five hundred and fifty times as sweet as sugar, healthful, economical, uniform, possesses antiseptic and preservative properties; will not ferment or sour."—E. F. LADD, *North Dakota*.

As to the other preservatives, including formaldehyde, found in canned goods, nothing but condemnation for the addition of such deleterious and poisonous chemicals can be said.

Molasses, honey and maple sugar are often adulterated with glucose. Maple sugar is flavored with an extract of hickory bark and largely made up of brown sugar.

Honey is often pure glucose flavored. Molasses may have poisonous properties, due to the "salt of tin" used in clearing and lightening the product, or may be present in the "foot" or sugar sediment from which often cheap candies are made, or as a contamination of sugar refineries where tin is used to whiten the sugar, the tin being carried over into the molasses. As re-

gards confectionery, especially the cheaper varieties, it suffices to say that candy made from the refuse of sugar refineries scraped from the floors, as it often is, artificially flavored and colored with aniline dyes or chromates of lead and potassium, cannot represent a proper diet for those of tender age.

The aniline colors often used are naphthalene yellow, metalin yellow, orange 11 or egg yellow D, azo-rubine, purple aniline, etc. The vegetable colors which are used and are perfectly harmless are named in the recent "Fruit Syrup Bill" introduced in Pennsylvania, and include, when not added in larger quantity than one-quarter of 1 per cent., such substances as cochineal, caramel, tumeric, cudbear, beets, saffron, spinachete. Of late a beautiful green vegetable color is said to be obtained by using hemp seed.

Not long since I was called to see a little girl of 2½ years who had eaten a large yellow Easter egg the evening previous and who was taken violently ill early in the morning with vomiting and purging, the stools being streaked with blood and watery. No other assignable cause could be found, and the supposition was that aniline or chromate of lead had entered into the coloring of the egg. She had a severe illness, lasting nearly a week, accompanied with much pain.

Glucose and saccharine are largely used, also paraffine, especially in the preparation of "butter scotch."

In the course of conversation with a candy-maker's family I was much amused to learn that when children required candy a "special without color" was brought from the candy shop, but the same candy was colored for the trade, clearly showing that the makers know the harmfulness of the artificial flavors and colors used.

The various flavoring extracts also come in for their share of adulteration.

The most common—extract of vanilla—is often nothing but an alcoholic extract of coumarin or tonka colored with caramel. Extract of lemon is often made of nothing but alcohol artificially flavored and colored with aniline yellow. In an interesting report of Wood and Buller in the *Journal* of the A. M. A. last year it was clearly shown, also, that some extracts of lemon did not contain even pure alcohol, but unscrupulous dealers had been base enough to further adulterate it by using Columbian spirits or deodorized wood alcohol, and they called attention to a number of cases of blindness and death resulting from the drinking of essence of lemon as a substitute for alcoholic liquors, with the above-stated results.

The other flavors, such as strawberry, pineapple, raspberry, are mainly made of alcohol and various ethers colored with coal-tar dyes the desired shade. Extract of almonds has been imitated by using a nitrobenzol, and many instances are on record of the poisonous effects resulting.

Dr. William J. Stone, of Toledo, O., describes nitrobenzol "as a product obtained in the intermediate stage in the production of benzine, a constituent of coal tar produced by the action of nitric acid on benzine, has the odor of oil of bitter almonds and is often used in flavoring almond cake, confectionery, cheap soaps, such as almond glycerine soap, and in cheap perfume."

A striking instance of the effects of nitrobenzol was noted last year in the *A. M. A. Journal* in the case of a lady who was tasting a bottle of flavor, but, finding the sensation burning and bitter, expectorated all but a drop or so, but spilled a tablespoonful on the closet shelf. The lady and a servant inhaled the fumes; both women were rendered unconscious and the lady was ill for many weeks. As these flavors are used in ice-cream, cake, candy, at the soda fountain and in bottled soft drinks, it can easily be seen how much harm can result. Many of the soft drinks, moreover, have an added danger from the fact that vegetable or mineral acids are used in their preparation as well as aniline colors, which, acting upon the usual lead stopper supplied with the bottles, presents the possibility of lead poisoning from a combination with the acid contents of the bottles.

When attention is directed to beverages as tea, coffee, cocoa, wine, beer, whisky, brandy and the various malt preparations, it is a wonder that these articles are not adulterated to a greater extent than at present, owing to the comparative ease with which such adulteration can be done. Dr. Wiley, of the United States Department of Agriculture, states that most of the coffee sold in this country under different names, as Java, Mocha, Maracaibo, etc., are nothing more or less than Brazilian coffee which can be bought at wholesale for 12 cents per pound. The same coffee retails often for 40 cents. Chicory is another common adulterant. Coffee beans are pressed out of a flour and water mixture into the shape of coffee and sold as coffee. Tea is mixed with leaves of other plants and herbs, but can be detected very easily by examining the leaves after steeping them. The most common practice is to color tea leaves which have been used once, dry and polish them and sell them as new tea. Of course, deleterious coloring matters are thus often used.

Cocoa and chocolate, instead of being cocoa nibs ground up and used pure, are often an admixture of cocoa, starch, cornstarch and foreign cereal fillers. When the subject of the adulteration of alcoholic beverages is examined it is obvious that an entire paper devoted to this investigation would not cover all that might be said concerning it.

Suffice, however, to say that the pure food law of this State represents and defines the character of most of these adulterants; the law specifies that spirituous and malt liquors shall not contain any substance or ingredient which

is not normal or healthful or that is deleterious or detrimental to health, and in the case of ales or beer any substitute for hops; in the case of wines it specially provides against any artificial preservatives, or which is the product of other than the fermentation of pure fruit juice, or the addition of such substances as alum, baryta, salts, caustic lime, carbonate of soda, carbonic acid, salts of lead, glycerine, salicylic acid or other antiseptic, artificial color or flavor, essence of ether or any other substance detrimental to health.

Yet in the face of such an admirable law we find almost all of these adulterations practiced to a surprising degree.

Whisky made of wood alcohol, a sad instance of which was furnished in New York City last fall, when twenty-five deaths occurred from the sale of this kind of whisky at a corner saloon. Wood and Buller report similar conditions in Indian Territory and various other localities in the United States. Wines preserved with salicylic acid are served at many of the restaurants in the larger cities.

Beer artificially bittered and charged with carbonic acid gas is sold for the real article.

A striking instance of preservatives in a non-alcoholic drink often ordered for the sick is grape juice, which was found by Professor Ladd, of North Dakota, to be preserved with salicylic acid and benzoic acid in varying quantities.

Root beer, birch beer and many other soft drinks are likewise preserved and artificially colored and flavored.

Blackberry cordials are invariably adulterated, preserved and colored with coal-tar dye.

It will thus be seen that the laws in regard to fermented and unfermented beverages in this and other States have very little effect on the manufacturers of these products.

Another interesting field still uninvestigated is the food value of prepared food products for infants and invalids.

Such articles as the various beef extracts made and exploited by many of the meat-packing establishments already alluded to as adulterating food products should be investigated. Is it to be supposed that these concerns would be any more eager to furnish a pure and wholesome product for the sick? In reality the beef extracts are little more than extractives and uric acid, representing no actual food value and probably acting merely as a stimulant, but throwing extra work on the excretory organs to eliminate the excess of uric acid taken into the system. As to the presence of preservatives, no analysis has as yet been made in this regard, but undoubtedly such adulteration exists. Various beef, iron and wines are on the market which are merely very poor wines, and the amount of beef and iron found in the residue after evaporation of the alcoholic portion is very infinitesimal.

Many of the peptonates of iron so largely used to-day are in reality merely aromatized wines, in which it would be impossible to find true pep-

tonate of iron; in fact, it is stated that many pharmacists put up peptonate of iron by mixing essence of pepsin and tincture ferri chloridi, making a so-called "peptonate of iron."

In addition to the beef extracts, the liquid preparations purporting to be concentrated beef and cereals predigested and in easily assimilable form for those sick and in need of nourishment at frequent intervals have proved to be of questionable value.

In this connection it is interesting to note how such bogus food products have been advertised and sampled by many of these firms who have adroitly sent emissaries in the shape of the ubiquitous traveling salesman to teach the physicians the value of preparations whose process of manufacture is known only to the firm. Of course, the agent heralds his preparation in glowing terms and can even produce testimonials of men prominent in the profession to substantiate his statements, and indeed he may explain how many pounds of beef are consumed in the manufacture of the product, but how few physicians have the time or take the pains to inquire as to the truth of these statements.

In January, 1903, Dr. Charles Harrington undertook some experiments regarding the alcoholic content of the proprietary foods for the sick, his attention being called to the fact by the semi-intoxicated condition of a patient under his care who was being fed largely upon one of these foods. The results of his analyses were published in the March, 1903, *Boston Medical and Surgical Journal*, and are as follows:

	Total Mineral		
	Alcohol,	Solids,	Matter,
	Per Ct.	Per Ct.	Per Ct.
Tonic Beef, S. & D.	15.58	18.16	1.04
Liquid Peptonoid	23.03	14.91	0.17
Panopepton	18.95	17.99	0.97
Hemapeptone	10.60	19.54	0.37
Nutritive Liq. Peptone	14.81	15.20	0.69
Hemaboloids	15.81	6.36	0.62
Mulford's Beef	19.72	10.39	0.20

It is very evident from these figures that a patient taking the maximum daily dose advised on the labels gets the equivalent of 1.25 ounces of nutriment and the alcoholic equivalent of six ounces of whisky. Is it any wonder that Dr. Harrington's patient was semi-intoxicated most of the time, and that, too, in the face of the fact that she was receiving no alcoholic stimulants?

It would seem in the light of these analyses that we as physicians are not giving the attention which is due to the question of proper food for invalids and those sick with acute diseases, and relying too much upon the statements of agents and firms in regard to actual food value of their products, thereby jeopardizing the lives of those under our care.

What with formalinized milk and alcoholic beef mixtures, a typhoid patient stands but a poor chance for life in these days. Personally, I have had several typhoid patients refuse abso-

lutely to take liquid peptonoids, predigested beef, etc., mainly on account of the large amount of alcohol in these proprietary foods.

When the subject of prepared foods for infants is mentioned, the wonder is that physicians are as fortunate as they are in making a selection from the many hundreds of such foods placed upon the market.

Many of these foods state absolutely that the starch is converted into dextrose, lactose, etc., but in reality most of them contain a goodly proportion of unchanged starch which any physician can demonstrate by making a solution of any one of them and adding a little Lugol's solution of iodine thereto. Personally, I have examined some of them and found starch frequently in preparations distinctly labeled as containing no starch.

It is impossible to trust to the manufacturers' statements as to this matter, and whenever the question of using these proprietary foods for an infant under our care is under consideration it would be just as well to use the simple starch test before advising the product as a proper food for an infant whose powers of digesting starch are not as yet developed. If every doctor did his duty in this regard, I am sure some, if not all, such so-called infant foods would disappear, and when we needed a dextrinized starch to dilute our modified milk mixtures to attenuate the curd the "prepared food" would be prepared at home under the supervision of the mother whose only interest would be her child, and not the rush after money in this age of "frenzied finance."

Diabetic flours have also been largely adulterated, and almost all, instead of being gluten, as claimed, contain very near as much starch as ordinary flours and are sold at enormous prices to diabetics by reckless misstatements and deliberate fraud.—*From New Hampshire State Board Analysis.*

Keeping pace with the food products the annual production and sale of drugs and chemicals has likewise increased to an enormous extent, and with even more opportunities for adulteration than in the case of food, with very much less chance of detection and very much greater prospects of financial emolument.

Professor Bailey, in the *Bulletin of Pharmacy* for January, 1905, mentions the different adulterations of drugs as accidental, necessary, C. P., chemicals of lowered standard and intentional adulterations. He very pertinently asks the question if any of the supposed necessary adulterations are really needed. As for instance, the addition of coloring agents, always useless and often injurious, to color syrups, tinctures, pills, and even soap and whisky. He claims that it is mainly that the public has been wrongly educated as to the proper appearance of many such articles.

In regard to the accidental adulterations, deteriorated and spent drugs he states that it is unfair to ask the purchaser to pay for 5 to 15 per

cent. waste and inert material which, with a little care, could be entirely eliminated. C. P. chemicals are too often *commercially pure* and do not conform to the high standard set by the U. S. Pharmacopœia. If the label really means what the manufacturers claim to be chemically pure we should not find arsenic in bismuth and glycerine, magnesium sulphate in oxalic acid, sodium bicarbonate in pure borax, potassium chloride in potassium bromide, or a dangerous quantity of arsenic in sodium phosphate.

Among intentional adulterations Professor Bailey mentions cornstarch, substituted for arrowroot, low-grade wheat flour for buckwheat starch, turpentine diluted with kerosene, tannic acid mixed with dextrin, sugar starch and flour, creosote diluted with carbolic acid, many extracts made up with wood spirit instead of alcohol, potassium chlorate mixed with potash alum, cream of tartar mixed with alum, starch and calcium sulphate.

In regard to this latter substance Professor Ladd, of North Dakota, has examined many bulk specimens obtained from grocery stores and has invariably found adulterants as above and also sulphates and sulphites.

Wood and Buller in an elaborate series of articles state to have found Columbian spirits or deodorized wood alcohol in such articles as Jamaica ginger, extract of bay rum, cologne water, witch hazel, essence of peppermint and in many official and proprietary medicines, from which many cases of absolute incurable blindness have resulted.

Dr. R. O. Brooks, State Chemist of New Jersey, reports finding wood alcohol in paregoric and in many commercial liniments. Dr. A. Greenwood, of Boston, found wood alcohol in official tinctures. The report of the pure food and drug department of the State of Minnesota states that lemon extract, vanilla, pineapple, strawberry and Jamaica ginger contained wood alcohol.

To prevent the production and sale of impure drugs and chemicals many States have formulated some very admirable laws. The prominent features of these laws are as follows:

Drugs shall be considered to be adulterated—

First.—If, when a drug is sold under or by a name recognized in the United States Pharmacopœia, it differs from the standard of strength, quality or purity, as determined by the test laid down in the United States Pharmacopœia as official at the time of the investigation.

Second.—If its strength or purity falls below the professional standard under which it is sold.

Third.—If it is an imitation of or offered for sale under the name of another article.

Fourth.—If the standard of any drug is not established in a national pharmacopœia the State Board of Health may from time to time fix the limit of variability permissible therein, and with the approval of the Governor exempt certain articles from those classed as adulterations.

Fifth.—It shall be unlawful to sell or offer for sale, or have any preparation or product, intended for the use of man, either for external or internal purposes, which contains methyl alcohol or "wood spirits," and in this State a further safeguard has been proposed requiring that on the first day of every month every manufacturer, jobber, wholesale dealer or other person selling wood alcohol within the State other than at retail shall report to the State Commissioner of Health on a suitable blank, if requested, the name and address of each person, firm or corporation within the State to whom wood alcohol was sold during the month preceding, under penalty of \$50 for every sale not so reported. Also a State tax is imposed of 33 1-3 per centum on the selling price of all wood alcohol sold by said person, firm or corporation during the month preceding the report. In these ways ample provision has been made to avoid illegal drug adulteration by various States.

The subject of drug adulteration naturally turns our attention to the vast array of so-called ethical proprietary medicines, proprietary medicines pure and simple, the "true patent" and the "trade-marked" medicines.

It will be manifestly impossible to discuss adequately a subject so wide and so complicated in the time already at our disposal; but in a general way we can at least get a faint idea of the magnitude and extent of their sale and use, as well as the detrimental effects of self-drugging as practiced indiscriminately by thousands of the people of the United States.

Dr. A. Emil Hiss, Ph.G., of Chicago, an authority on these preparations, states that "the present sales annually reach the enormous sum of \$60,000,000. This drain upon the substance of the people, attended with the infliction of injury incalculable, presents an economic problem vital to the people in general." One of our smaller Middle West cities manufactures 21,000,000 barrels of patent medicine annually.—F. J. QUINLAN, M.D., *President's Address, New York County Medical Association.*

Alexander Marshall, who claims to have an "inside view" of the patent medicine business, declares that the average cost of manufacturing the liquid preparations sold to dealers for 62 cents, retailed at \$1 per bottle, is about 15 cents. The profit, therefore, is over 300 per cent., less the cost of advertising.

These figures, applying as they do only to the secret or trade-marked medicines, how much greater must be the volume of annual sales of proprietary and so-called ethical preparations, fostered and promoted by physicians themselves and used largely by the people on the strength of the fact that at some time or other they had been given the stamp of approval by appearing upon the prescription blank of a prominent physician, or perchance exploited by a neat article of indorsement in some paper, attesting the vir-

tues of the preparation in the physician's own case and signed by him.

Is it any wonder, then, that these preparations are so multiform and of such divers names that the mere mention of them would be a volume in itself? In trying to get a definite idea of the subject it will be necessary to define what is meant by ethical preparations, proprietary medicines and patent medicines.

Dr. W. J. Robinson in a recent paper states the facts in this regard so plainly that I will quote verbatim:

"A patented medicine cannot be a secret medicine. Patent is derived from the Latin word *paterc*, which means to be open, and a patent medicine is an open and non-secret medicine. In order to maintain a patent on anything the inventor or manufacturer must disclose the process of manufacture to the minutest details. It must be described so fully and so explicitly that any person of ordinary skill in that line of business may be able, by following directions, to produce an identical product."

But when reference is made to the so-called patent medicines it is found that the thousand and one sarsaparillas, perunas, tonics, pain-killers, blood purifiers, favorite prescriptions, golden discoveries, antikammas, phenalgin, neurillas, manolas, sungs, chionas, etc., which are the curse of the American people and physicians, are not patented at all, simply trade-marked; that is, the name of the mixture is registered, and is claimed as a trade-mark. Many of these nostrums could never be patented, even if the owners wanted to; because in order to obtain a patent some novelty must be proved. Besides the nostrum manufacturers would never think of patenting any of their wares, as in order to do so they would have to disclose their exact composition, which would not be at all to their interest. It is secrecy which is the chief asset of these secret, but erroneously called patent, medicines.

In the case of patent medicines, also, the patent usually runs out in seventeen years, and then any one can manufacture the preparation. This is the case with Antipyrin, and now any one can make it; so also with Pitcher's Castoria; but with the secret proprietary medicine the trade-mark makes it a monopoly, and is perpetual. There are, however, ethical proprietary medicines made by firms of good repute, whose composition is known beyond a shadow of doubt as to the actual ingredients or chemical composition of the preparation. Such are valuable additions to our armamentarium. Of these drugs mention may be made of heroin, dionin, duotal, adrenalin, orthoform, collargol and the various products of reliable domestic and foreign chemical houses.

There can, therefore, be no doubt of the value of certain proprietary preparations whose composition is known and which are prepared by reliable pharmaceutical houses, but it is the secret

nostrum evil which must be fought and eliminated. It is not the true patent medicine which should be attacked, but rather the trade-marked and secret remedy, whose only merit often lies in secrecy as a means of profit for its owners.—ROBINSON.

In the light of many analyses and much that has been said and the many recent articles which have been appearing in the medical and lay press, the active ingredients of many cures have been found to be mostly a poor alcohol, a very little solid residue of a few inert drugs, or in some instances, large doses of very powerful drugs distinctly detrimental to health and life, or mere water used to act as a "fake cure" for persons often suffering from dangerous diseases and in need of active medicines to combat violent diseases.

A partial list of the percentage of alcohol content of some of these familiar cures may not be out of place here: Lydia Pinkham's Vegetable Compound, 20.6 per cent.; Paine's Celery Compound, 21 per cent.; Ayer's Sarsaparilla, 26.2 per cent.; Hood's, 21.5 per cent.; Peruna, 18 per cent.; Vinol, 18.8 per cent.; Parker's Tonic, 41.6 per cent.; Burdock Blood Bitters, 25.2 per cent.; Greene's Nervura, 17.2 per cent.; Hostetter's Bitters, 22.2; Warner's Safe Cure, 35.7 per cent.; Kaufman's Sulphur Bitters (contains no alcohol), 20.5 per cent.; Leithead's Peruvian Tonic, 24 per cent.; Richard's La Grippe Specific, 24.02 per cent.

In contrast to the secret remedies containing alcohol are the medicines claiming to cure this and that disease, which on analysis are found either to contain no active ingredient, but are pure fraud, or contain powerful drugs and chemicals absolutely harmful.

Among these may be mentioned Liquizone, which is largely advertised in the religious and lay press to cure fifty or more diseases, and then adds: "We will pay \$1,000 to the physician or scientist who discovers a disease germ which Liquizone cannot kill. Liquizone, liquid oxygen, invariably cures any trouble caused in any way by germs."

The analysis of this wonderful medicine is as follows:

Total acidity, 1.34 per cent., of which 1.18 per cent. was in the form of sulphuric and sulphurous acid. The total solid, a black residue of acid reaction, amounted to 1.82 per cent. and an ash residue of 0.025 per cent., both of which clearly indicated free acid. The free use of a product containing this amount of uncombined sulphuric acid cannot be looked upon as wholly without possible harmful effect upon the human system, and as to its claim to be a germ-killer and to contain liquid oxygen that is absolutely a fraudulent statement to further its sale.—E. F. LADD, *North Dakota Agricultural Report*.

As an illustration of another fraud may be mentioned Dr. Buckland's Scotch Oats Essence. It is sold as a cure for both the whisky and

opium habits. On analysis it is found to contain 35 per cent. alcohol and one-quarter grain of morphine to the ounce. "Danger and Harmfulness of Patent Medicines."—W. H. ALLEN, *President W. C. T. U.*

So with the various cough syrups, as Ayer's Cherry Pectoral, Dr. Bull's Cough Syrup, Jayne's Expectorant, Hooker's Cough Syrup, Moore's Essence of Life. They are all dependent on some preparation of opium for their activity. Mother Winslow's Soothing Syrup, advertised in this country as perfectly harmless, has been found to contain opium, and in England, where every patent remedy containing any poisonous substance must be labeled, the same soothing syrup bears a label stating that it contains a small amount of opium, and therefore, in accordance with the law, is labeled "Poison."—MR. BOK, *Ladies' Home Journal*.

It is not, however, the patent or the secret medicines which alone are a curse to the American people and the American physician, but the so-called ethical preparation sampled to the physician and exploited by the glib-tongued traveling man whose only object is to get the "doctor in line" and "push the goods." It is certainly time that a physician's office hours should cease to be monopolized by this sort of salesman to the detriment of good therapeutic knowledge which can be much better acquired by a study of any leading text-book or obtained by practical demonstration on the patient.

The list of these products is, suffice to say, "too numerous to mention." Among a few prominent ones, however, we note Antikamnia, which has been time and again proved to contain acetanilid, sodium bicarb. and caffeine, worth about three cents per ounce, but sold by the manufacturers for \$1 per ounce.

Salafene, acetanilid and soda bicarb., phenalgine, acetanilid, ammonium carb., soda bicarb. and caffeine.

Fancy names for well-known drugs is also another dodge of the manufacturer. Why name peroxide of hydrogen Katharol Dioxygen, Oxydol, etc.; Formin, Cystogen, Urotropin, Cystamine, Salol, Muscol, Magnesium Peroxide-Biogen?

The host of bromidias, neurillas, respitons, sanmettos, manolas, chionas grows in volume, and every twenty-four hours a new compound is born, to be foisted upon a gullible medical profession and a long-suffering public.

In this connection it is interesting to note a recent investigation as to the number of prescriptions for so-called proprietary articles found on file in various drug stores.

Dr. M. Clayton Thrush, among 500 prescriptions, found 36 per cent. contained proprietary formulas as an ingredient of the prescription, or in fully one-third of the physicians' prescriptions which he reviewed. In other words, the trend of modern prescription-writing points to the ex-

tensive use of proprietary medicines to the exclusion of the pharmacopœial remedies.

From the rather hasty review of the subject it may be stated that the so-called patent, or more correctly secret, remedies have very little value, and the chief reason for their popularity is secrecy, not true therapeutic worth. The trademarked tonics are mainly alcoholic and depend for their effect upon that alone.

There remains still another class of preparations so far not touched upon—namely, the local druggist's proprietary medicines, often modeled upon the formula of some standard proprietary medicine.

Among the chief of these remedies are the headache wafers so extensively and indiscriminately used by many persons. These are largely composed of acetanilid, which is a crude coal-tar product, and often the dose is made to fit all cases, so as to be a sure relief, thereby endangering the hearts of those susceptible individuals who employ them for headache, and indeed I am not so sure but that many attacks of so-called heart failure can be directly traced to the common use of these drugs for the relief of headache. Instant cold reliefs are also used to a marked degree. These are often nothing more or less than menthol, bismuth, with sometimes an addition of cocaine. This last substance certainly engenders the formation of the cocaine habit. White Pine Cough syrups are made up in carboy lots, and not only adults but little children are doped for the cold instead of a physician deciding as to whether an opiate is needed. It would certainly seem that the pushing of a druggist's proprietary remedy, both at his store and at numerous grocery stores in cities and towns, is highly objectionable. Many so-called paregorics and flavoring extracts are thus sold which are purely artificial and are prepared for the grocery trade. It would seem that some means to prevent this practice of medicine by the druggists could be found, as well as prohibiting the sale of drugs in a grocery store.

I have thus in a rather hasty and disconnected manner tried to prove that in spite of the existing laws regarding food and drug adulteration that food is frequently adulterated and artificially preserved; that drugs are often badly contaminated with extraneous materials, and that many of the secret and so-called proprietary medicines are largely sold by fraudulent misstatements, and their ingredients are either alcohol or opium or other powerful drugs advertised to the public as cures and as perfectly harmless. Admitting that the above facts are true, it remains to discuss the remedies for this anomalous condition of affairs.

First as to food adulteration. A more thorough meat inspection would prevent material unfit for market from being dumped upon the public.

Dr. E. Salmon, D.V.M., Chief of the Bureau of Animal Industry of the United States, states

that annually 37,000,000 cattle, sheep and swine are inspected at the packing-houses and large slaughter-houses. About 65,000 entire carcasses are condemned, 64,000 parts of carcasses are destroyed and thus taken out of the market. In addition 18,000,000 animals coming from districts infected by cattle disease are inspected and 66,000 infected cars disinfected. Nevertheless, small abattoirs exist in many cities, to which condemned cattle are sent and there killed and shipped into the market, where no inspection ever takes place. He recommends that, as far as possible, only one or two places for slaughtering animals be allowed in a city or town, and that rigid inspection of such places should be made regularly; thus only can all diseased meat be excluded from market.

In addition to the many existing pure food and drug laws there have been some valuable amendments and additions to the existing laws in various States proposed this year which should receive our support. In our own State a law relating to the stamping of the date of packing upon all canned goods was introduced. A bill providing for the printing of the active ingredients of proprietary medicines upon the label was introduced. North Dakota's pure food law, as amended and passed by its Legislature and reported in a pamphlet April, 1905, provides that all food and beverages must be free from coal-tar dyes and chemical preservatives as formaldehyde, benzoic acid, sulphuric or sulphurous acid, boracic acid, salicylic acid, hydrofluoric acid, saccharine, betanaphthol, or any salt or antiseptic derived from these substances, labeled true to name and have net weight and manufacturer's name on the package, mixed compounds must be so labeled. No essential constituent must be taken from the food product, nor must the food be prepared from diseased or decaying animal or vegetable material. Candies must not contain any poisonous dyes or other ingredients. Benzoate of soda in the proportion of one part in 2,000 is permissible in tomato catsup, crushed fruits for soda fountain and fruit syrups for the same purpose, also bulk ciders from natural fruits.

The Hepburn National Pure Food and Drug bill before the last session of Congress was again throttled in the interests of the packers, although it had the sanction and approval of the President and a number of influential Senators.

If a standard for food and drugs could be set by the United States Government, as was proposed in that bill, with a Government analysis station for the proper investigation of the quality of our food and drug products and the results published and goods which do not comply with the recognized standard withdrawn from the trade, a truly ideal arrangement would obtain. However, the plan is too Utopian to be entertained at the present stage of financial conditions in this country.

But the various States can do a great deal

within their jurisdiction to prohibit articles unfit for use as food and drugs from being placed upon the market; by passing laws prohibiting these adulterations; by enforcement of already existing laws by State analysis of articles sent for examination by any of its reputable citizens who may desire to know the quality of the article in question; by severe fines and imprisonment of all offenders who try to evade the law and place adulterated products on the market for sale; by encouraging legitimate producers to have frequent analyses of their goods made, thereby showing the people whose products are free from substances detrimental to health and thus creating a demand for pure articles; by education of the public by lectures and demonstrations and through the public press of the adulterations frequently practiced and the value of demanding pure goods for sound money. Insist that manufacturers correctly label all articles of food exactly as to what they are and affix a date of packing.

In the case of drugs. Physicians and pharmacists should be instructed as to the possible adulterations as practiced to-day, and wherever a drug is suspected to be contaminated have a State analysis made and expose the firm which sells inferior drugs by a publication of said analysis. Insist that C. P. drugs shall be just as labeled and not commercially pure.

A recent law in this State provides for a strict record of all sales of wood alcohol, and if enforced ought to be of great value in preventing the illegal use of this poison in official tinctures and in extracts used for flavoring and the like.

It is greatly to be regretted that the Mann Patent Law bill failed to pass this session of Congress, regulating as it did the issuing of patents to foreign manufacturers on medicinal products, thus prohibiting sale of the article other than through the manufacturer's agent in this country. It provided that within two years after the patent was granted any citizen could import and sell the drug in question, and also provided that a patent could only be obtained upon the process of manufacture and not upon the drug itself. This is the same law which prevails in other countries where these drugs are so largely produced and imported into this country. Thus phenacetine, which is a patented article in this country, has only a patent on the process of its manufacture in Germany. So, also, the adulteration of phenacetine with acetanilid, as practiced in New York City last year, should be strictly prohibited and all offenders in this regard properly punished.

In the case of the secret nostrums and non-ethical proprietary medicines the consensus of opinion is that every such medicine should have the exact guaranteed formula and the quantities of each ingredient plainly printed upon the label and sworn to before a notary as being the bonafide composition of the remedy in question. This is required by many governments of the world,

and shall our own favored country be left unprotected from this class of pernicious drugs?

Austria, Belgium, France, Germany, Russia and Norway either prohibit the sale of these nostrums entirely or require that the label tell the active ingredients. The United States and Canada, however, allow a wide-open door to all these "fake medicines" and have become a favorite dumping-ground for countless vaunted cure-alls produced by a horde of grasping manufacturers.

The public and the press should be educated in regard to the harmfulness of self-drugging by personal instruction from physicians, if need be, popular lectures upon the subject, and by judicious articles in the religious, medical and lay press.

An encouraging example of lay-press interest in the subject of patent remedies is found in the articles appearing from time to time from the pen of Edward Bok in *The Ladies' Home Journal*. In his latest article in the April number, 1905, Mr. Bok shows very conclusively that the secret remedy men have a regular plan for securing testimonials of the virtues of their nostrums, as well as the cunningly worded advertisement, so arranged as to suggest disease in those who may have a morbid predisposition to convert every symptom into a dreadful malady, thus directly making hypochondriacs, who will thus be induced to buy the much vaunted cures. He also rightly calls attention to the fact that no one is capable of making a diagnosis of his disease and prescribing therefor unless he has had a medical education. Such articles as Mr. Bok's should receive the approbation of all medical men, and, in fact, educated men of every profession.

It may be of interest to mention that a sort of federation of the medical journals of the different State medical societies has been entered into whereby they pledge themselves not to admit to their advertising pages any preparation whose composition and quantity of each of its active ingredients are not known. The *Journal of the American Medical Association* is also in line with this movement.

Advertising of these nostrums claiming fraudulently to cure all diseases and the incurable diseases should be brought to the attention of the public and the press. If need be, after due instruction, such advertisements constantly appearing in the daily newspapers, appeal for the enforcement of the postal law of the United States, which provides that such fraudulent advertisements be excluded from the mails. An active "press" committee of the county society could keep the editors informed as to whether such-and-such advertisements were strictly within the law. In this manner many of the sickening advertisements of cures for "lost manhood," drugs for producing "abortion," "consumption cures" and "cancer cures" would be suppressed.—*Journ. A. M. A.*

It is also a well-known fact that the religious press is a regular bonanza for the secret nostrum advertiser. It is, in fact, one of his most paying investments. Clergymen and editors of such papers should have their attention called to the fact that it is not in keeping with the other portions of these papers to advocate many of the best principles of the Christian religion on the inside pages and have the cover pages devoted to advertising remedies, which will in time bring the users into habits of life and action highly opposed to the tenets of religion.

In regard to the proprietary secret nostrums which are being presented to physicians every day, it suffices to say that we should insist on knowing the exact composition of the remedy and the quantity of its ingredients before we attempt to prescribe the same for ourselves or our patients. We should also satisfy ourselves that the firm producing the remedy has a reputation of being thoroughly reliable. The use of pharmacopœial preparations should be encouraged and the art of prescription writing revived. If possible, polypharmaceutical prescriptions should be abandoned and simple remedies given preference. Substitution in the druggist should be guarded against by selecting a reliable druggist and ordering any proprietary medicine whose formula appeals to us as valuable in original bottles only.

It is to be hoped that the efforts of the Council of Pharmacy of the American Medical Association, created by resolution of the Board of Trustees of A. M. A., February 3, 1905, and now engaged in the task of analyzing and classifying the various medicines upon the market, may succeed in separating the truly valuable ethical preparation from the nostrums, and that all right-minded manufacturers will aid the committee in providing samples and the formulas of their products, so that soon the medical profession can be able to discriminate between those preparations of value and the secret proprietary medicine and the medical journals all over the country may know what class of advertising matter to properly place before the medical profession.

It is the purpose of this Council to supply necessary and desirable information concerning all "new and non-official remedies," to be published in book form by the A. M. A. press, for the benefit of the profession, but does not presume to dictate what shall be prescribed and seeks only to point out the objectionable preparations.

The rules governing the admission of articles are as follows:

RULES GOVERNING THE ADMISSION OF ARTICLES.

The following rules are adopted to guide the Council on Pharmacy and Chemistry of the American Medical Association:

(The term "article" shall mean any drug, chemical or preparation used in the treatment of disease.)

RULE 1.—No article will be admitted unless its active medicinal ingredients and the amounts

of such ingredients in a given quantity of the article be furnished for publication. (Sufficient information should be supplied to permit the Council to verify the statements regarding the article and to determine its status from time to time.)

RULE 2.—No chemical compound will be admitted unless information be furnished regarding tests for identity, purity and strength, and, if a synthetic compound, the rational formula.

RULE 3.—No article that is advertised to the public will be admitted; but this article will not apply to disinfectants, cosmetics, foods and mineral waters, except when advertised in an objectional manner.

RULE 4.—No article will be admitted whose label, package or circular accompanying the package contains the names of diseases, in the treatment of which the article is indicated. The therapeutic indications, properties and doses may be stated. (This rule does not apply to vaccines and antitoxins nor to advertising in medical journals, nor to literature distributed solely to physicians.)

RULE 5.—No article will be admitted or retained about which the manufacturer, or his agents, make false or misleading statements regarding the country of origin, raw material from which made, method of collection or preparation.

RULE 6.—No article will be admitted or retained about whose therapeutic value the manufacturer, or his agents, make unwarranted, exaggerated or misleading statements.

RULE 7.—Labels on articles containing "heroic" or "poisonous" substances should show the amounts of each of such ingredients in a given quantity of the product.

RULE 8.—Every article should have a name or title indicative of its chemical composition or pharmaceutical character, in addition to its trade name, when such trade name is not sufficiently descriptive.

RULE 9.—If the name of an article is registered, or the label copyrighted, the date of registration should be furnished the Council.

RULE 10.—If the article is patented—either processor product—the number and date of such patent or patents should be furnished. If patented in other countries, the name of each country in which patent is held should be supplied, together with the name under which the article is there registered.

I have thus tried in a rather imperfect way to call attention to the intentional adulteration of food and drugs as exists to-day and suggested remedies for this condition of affairs in the United States, calling attention to the fact that enforcement of already existing laws would go a long way toward eradicating the evils present, as well as some amendments which would strengthen the position of the advocates for pure

food and drugs. If I have been in any way able to so present the subject as to influence the members of this society to take an active interest in helping to suppress criminal adulteration of and in the securing of unadulterated food and drugs for the American people, I shall consider the labor expended upon the paper has not been in vain.

RIGOR MORTIS IN STILL-BORN CHILDREN.

The conclusions I have arrived at are as follows:

1. That rigor mortis may occur *in utero* and (a) may pass off before labor terminates, or (b) may occur during and so hinder labor and continue after delivery.

2. That in deaths during the later stage of labor, where the child is expelled soon after death, rigor mortis may set in afterwards.

3. That in all cases of still-birth the character of the rigidity is the same, and that whereas in children that have been born alive the rigidity is that of ordinary rigor mortis, and the limbs stiffen in the position in which they may be then lying, in children still-born the rigidity always takes the same form, and the limbs, although lying loose and limp, are drawn up more or less into the position they took in the uterus, and even if the rigor mortis had passed off *in utero* before delivery, there would be evidence by pressure-marks, or the natural tendency of the body and limbs to adopt the intra-uterine position, that this has occurred.

4. Rigor mortis does not accompany still-birth always, but where it is not present there is no difficulty in deciding the fact from the signs of decomposition present. The mode of death probably influences the rigidity in still-births as it does the rigor mortis of adults, and the only suggestion I can make is that possibly the rupture of membranes and discharge of liquor amnii may be a factor.

The point I wish to press is that in a case of suspected infanticide, or where the question of live birth comes in, any evidence that the limbs and body have been drawn up while in a state of cadaveric rigidity into the shape in which the body is moulded *in utero* is a strong evidence of still-birth.—*British Med. Jour.*

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"If ever I become an Alderman," said the man who has to hunt up people, "the first thing I'll do is to have an ordinance passed making it a crime for a drug store to keep a city directory more than a year old. Whenever I want to find a man's address I drop into the nearest drug store and ask for the directory. You ought to see the volumes that have been handed out to me. The other day an apothecary put an 1894 one before me. Directories that aren't up to date are useless in a city where people move as often as in New York."—*Sun.*

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Articles for publication under Editorial Communications must be accompanied by the name of the author. No name will be used in the publication unless requested by the writer. All such articles can be sent to Dr. C. E. Denison, 68 West 71st street, New York City.

LEGAL IGNORANCE.

The decision of Justice Gaynor of the Supreme Court of the State of New York, giving the power to druggists to indiscriminately "jockey" the contents of a physician's prescription, would seem amusing were it not for the serious possibilities that will undoubtedly result from this action. The case in which this decision was made, was one where the prescribing physician had ordered Merrell's "elixir pinus cum heroin," and ordered a dose of a teaspoonful every four hours. The druggist, not having this specific combination in stock, took upon himself the task of making it. As he had on hand "elixir pinus compositus" (Merrell), he added 1/24 of a grain of heroin for each dose prescribed, thinking thereby to compound a prescription absolutely like the concoction ordered by the physician. The learned Judge, moreover, stated that the druggist, in doing this act, had literally filled the doctor's prescription by the adding of 1/24 of a grain of heroin. This, he said, "was plainly no negligence," because the doctor's "prescription was none too careful; it did not even correctly follow the words of the label of the patent medicine bottle it was to be filled from; but it was intelligently read and filled" (by the druggist).

Heroin is a preparation of morphine, as is also morphine acetate, which are contained in "elixir pinus compositus." The combined dose of morphine was equivalent to 1/10 of a grain. It was claimed in this case that it was impossible that 1/10 of a grain of morphine could have done any possible harm, or have brought about, given as it was every few hours, morphine poisoning. It is a well-known fact that various doses of morphine act in an entirely different physiological manner. We know that very small doses are

given as cardiac stimulants, whereas, large doses for narcotic effect or for other purposes. Some persons may take very large doses without any physiological results whatever, and in others minute doses may lead to acute morphine poisoning. Is it not possible that the interference of a druggist with the dosage as prescribed by a physician may bring about an entirely different physiological effect from one to be desired by the individual prescribing the drug? Such being the case, a physician is never safe in prescribing any toxic drug, if the druggist is privileged to use his own opinion as to the amount of dosage. It would seem to us that our learned Judge was taking upon himself a prerogative which does not belong to any layman, in adjudicating a matter of this importance. How much better would it have been had the Judge in question sought advice in this matter from those who have devoted years of work and toil to the intelligent administration of drugs and medicaments.

It has been the struggle of physicians for many years to have some legislation which may protect them in the prescribing of drugs. Associations and societies have been formed to make it impossible for inexperienced and careless druggists to prescribe medicines other than those which have been ordered. Bills have been introduced into our Assemblies for this purpose, but to no end. How, then, would it be possible for the public to have any protection against the deceit and dishonest practices which this decision gives possibility to? Why, then, would it not be possible for the druggist to carry into his prescription department the ever-ready expression, which is so well known, "I have not this article, but here is something just as good"? The principle is the same. Naturally this decision will be welcomed by the drug trade agent, but it is not a just one, as has been claimed by *The American Druggist and Pharmaceutical Record*. It is manifestly an unjust one. Physicians have no desire to antagonize druggists, but, on the contrary, wish most earnestly to work in harmony with them. But it is

not conceivable that a druggist can set the doses for a person whom he has neither seen nor heard of, nor is so much as conscious of the ailment with which the patient has been attacked. It is perfectly possible that the substitution of 1/24 of a grain of heroin in this case may not have done any harm. It is not that question which is involved—it is one of far greater importance; it is the question of the principle of the matter, which gives the druggist the right to interfere with the evident intention of the physician in his prescription. The druggist in question knew perfectly well what the doctor wanted in his prescription, and, not having the remedy in stock, took it upon himself to make something just as good, but he did not do so.

The American Druggist and Pharmaceutical Record says that "the court upholds the sanctity of the prescription, but condemns the carelessness of the prescriber, in so wording a prescription that when compounded in accordance with its specific terms, a result may be obtained different from that which was intended." Such was not the case; the doctor ordered a patent medicine, and when the druggist attempts to imitate that medicine he was infringing upon the rights of its patentee. We feel it our duty to criticize this decision, both because it is unjust to the medical man and because it will serve as a warning to the members of the profession to be absolutely and unequivocally definite in prescribing any and all of the so-called patent medicines. In the light of this, we can only make a plea that our brethren in the profession will adhere more closely to the pharmacopœia and the simple and efficacious remedies which are therein contained, and thereby avoid such dangers and errors, both to self and patient, which this case has brought about.

NECESSITY FOR REVISED MEDICAL LAWS.

James Taylor Lewis, Counsel of the New York State Medical Association.

During the past five years there has been conducted by reputable medical organizations of this county and State an active campaign against medical fakirs of various kinds, and from experience gained in this work it can be safely said that all that has been accomplished has been the saving to the public of any increase in the number of the medical law violators. They are still with us, and in the number about as they were in 1900, when the special effort was begun.

New methods of treatment, changed plans of operating have been assumed, and the field of operation altered and names changed, but after thousands of dollars have been spent by the medical organizations, these mountebanks are flourishing.

There remains two directions in which improvement can be looked for and without which little hope for a better protection to the public health can really be expected.

One of these is a change in the law relative to the punishment of this class of criminals. As the law now stands, there is no minimum fine or alternative term of imprisonment, which leaves an opportunity for the imposition of extremely small fines if any, or short terms of imprisonment. The result in this direction has been that many of the violators of the law keep a fund ready for the emergency of being arrested, and by pleading guilty impress the minds of the Court that the individual had made only the one mistake, plead for mercy and almost invariably receive a fine not to exceed \$50 or \$75, and so leave the culprits satisfied that they have done nothing of especial gravity and return to their work.

With the enormous amount of business which the judges of the Court of Special Sessions are called upon to conduct, it is impossible for them to give the medical cases which come before them the attention they really deserve and while they listen with care to each case presented and are especially courteous and attentive to the representative of the medical organizations, yet they are only human, and may not always appreciate exactly wherein lies the precise danger to the public health, in the practices of this class of lawbreakers.

There should be a minimum fine of not less than \$100 or a minimum term of imprisonment of not less than thirty days or both for a first offense fixed by law, and not less than a \$250 fine or not less than a six months term of imprisonment or both for any subsequent offense. There must be present one of two things for these characters to consider: either a substantial fine, which will make their business unprofitable, or a sufficiently long term of imprisonment to break up their associations and scatter their patients.

The public generally cannot conceive what amounts of money are made by this class, but when I say that one individual who was conducting an "anti-obesity cure" established in East 23d street under his own management, and another similar concern on the West Side under the management of a young woman, was making between \$30,000 and \$40,000 annually, the number of gullible people there are and the absolute futility—even absurdity—of the small fine, in cleaning out such danger spots becomes apparent. The principal and the young woman were, as I recall it, each fined \$25. There are scores, yes, hundreds, of similar cases.

There is in Oneida County in this State a "natural bone-setter," so-called, who has a larger practice in this branch of surgery than any regular physician in the vicinity. He is called into four or five counties, but I was informed that no grand jury would indict and no petit jury could be found who would convict him if he were indicted. This man has done more damage to the public indirectly than can be estimated, as regularly licensed physicians are refusing to treat patients because this man is called in surreptitiously and disturbs nature's repair and then advises the

blackmailing malpractice suit. He is called as an expert in malpractice cases after advising bringing the action, and, strange as it may seem, is allowed by courts to testify.

To make the violation of the medical law a felony would be a mistake because of the delay in the trial and difficulties of jury trials which would without doubt allow a great many violators of the medical law to escape entirely; but with amendments in the line which I have indicated lies one of the hopes of stamping out this class of law-breakers.

The other and perhaps more potent factor of the two is the public advertising which this class of criminals are allowed in our public press. If all advertisements referring to the practice of medicine were refused by the public-spirited daily periodicals, it would be impossible for this class of criminals to exist. Newspapers might possibly be allowed to advertise cures of licensed physicians even though it violates every chapter of the Code of Medical Ethics, and is not usually practiced by physicians of high professional standing; but if they would strike from their columns all advertisements of clairvoyants, midwives, spiritualists and fortune-tellers who are unable to produce a diploma licensing them to practice medicine, and have no medical knowledge, it would be impossible for them to continue their work. Some of the papers have expressed a willingness to refuse the advertisements from those who have once been convicted of practicing medicine illegally, but that rule is easily defeated by the individual simply changing his or her name, and the advertisement is continued. One of the daily papers of our city has neglected even to accede to this request of striking out advertisers who have once been convicted, and published in the face of opposition by the Association, the advertisements of those whom they are informed have been actually convicted of practicing medicine illegally.

When public sentiment is sufficiently aroused to demand that such advertisements as are daily advertising those who offer to commit unlawful abortion under the guise of curing female irregularities, or those who claim to cure sickness by removal of evil influences of wicked spirits, or who claim by the presence of the spirits of departed friends to receive suggestions as to medical treatment and thus undertake a cure, shall be omitted from our papers, a great step will have been taken toward the eradication of the class of criminals known as violators of the medical law.

There are many druggists who, by the use of prescriptions of reputable physicians and with their own knowledge of the influence of drugs contained in such prescriptions, undertake to examine and treat individuals who oftentimes come to them simply inquiring for the name of a good physician; but this class is not so dangerous to the public health as these other classes whose knowledge of medicine amounts to absolutely

nothing, and whose acts oftentimes drive the unfortunate to suicide, to prison or to the insane asylum; but such druggists are breaking the law and should be punished.

The exploiting of the work of medical organizations in the prosecution of illegal practitioners of medicine should be decried, because it not only renders undignified the work which is sought to be done, but oftentimes the location of the culprit puts into the minds of the ignorant public the idea that perhaps through some occult power or through some phenomenon which they do not undertake to explain, they can be cured of their ailments.

In other words, the medical organizations should avoid, by keeping from newspaper columns any notice of the work being done, and when requests are made for news the importance of keeping these notices away from the public should be made plain to the representatives of the various newspapers, and if all these papers accede to this request none will suffer and the public will be benefited.

There promises now to be a united profession in the State of New York, and anything which a united profession of this State requires will be granted by any Legislature. These matters are of vital importance, calling for earnest, careful thought on the part of the Legislative committee. Another year should see a revision of the public health laws referring to the practice of medicine prepared and presented.

NEIGHBORING STATE SOCIETIES.

The next annual meeting of the Connecticut Medical Society will be held in May or June, 1906; of the New Hampshire Medical Society, May 17 and 18, 1906; of the Medical Society of the State of Pennsylvania, September 26-28, 1905; of the Vermont State Medical Society, October 12, 1905.

It is earnestly requested that any member of the State Association who will be able to attend one of these annual meetings as delegate from The New York State Medical Association will immediately communicate with the secretary, Dr. Charles Ira Redfield, 44 East Main street, Middletown, N. Y.

COMMUNICATIONS.

_____, N. Y., June 10, 1905.

CHARLES E. DENISON, M.D., Chairman Committee on Publication:

My Dear Doctor—Several questions having occurred to me during the last few days and since sending my proxy, I have determined to write, asking you to answer them or publish my questions, so that others may answer.

If the two medical bodies in the State are combined, as proposed—

Will we have our JOURNAL, as heretofore?

Will we have our directory corrected annually and in as fine arrangement as now?

Will the malpractice defense feature continue?

Why was the old committee reappointed?

Why was there not a *new* committee appointed?

Last but not least—

Why is no proxy provided for "the other fellow," who *may* want to vote *against* the agreement?

These half-dozen problems having confronted me, I ask that you publish them, that I may find out if others have "seen visions."

Fraternally yours, C. W.

* * *

NEW YORK, June 12, 1905.

Editor NEW YORK STATE JOURNAL OF MEDICINE,
64 Madison Avenue, New York:

Dear Doctor—As a member, I wish to protest against endorsement of *Ladies' Home Journal*. Please see enclosed giving long-distance treatment. For a so-called reputable journal, it is quackery of the worst type.

Very truly yours, A MEMBER.

Mrs. L. K. T. asks if it is not dangerous to leave off the flannel band and substitute a knit one instead.

No, it is not now considered necessary to bind a baby's abdomen tightly to prevent rupture, especially after the third month. Warmth is needed over the abdomen to aid digestion, and the wool-ribbed knit band with shoulder-straps will answer this purpose admirably, and also be much more comfortable for baby than a tight flannel binder.

TO DR. C.'S READERS.

Doctor C. will, at all times, be glad to answer the questions of *Journal* readers. Where an answer is desired by mail a stamped and addressed envelope must be enclosed.

THE "NONMEDICAL PHYSICIAN'S" METHOD OF OPPOSING LEGAL CONTROL OF MEDICAL PRACTICE.

In one of our States there is a man who signs himself a "nonmedical physician." What a funny philologic jumble of contradictions inhabits his head! He wishes to imply that he does not give medicines. He says he is a physician, and yet he is not M.D., nor in any sense a qualified practitioner. He heads the opposition to medicine, the motley gathering of the parasites of the profession, who wish to abolish all legal control of the qualifications and conditions of medical practice. He is seeking, plainly, to oppose the legislation which makes special and general education the *sine qua non* of therapeutic practice. These are the questions to which he begs answers from all the irregulars and antimedicinals:

1. In your opinion, should the practitioners of any one method of treating the sick be given a practical monopoly on the "healing art"?

2. In view of the active hostility now existing between the advocates of the various methods of

curing the sick, would it be right and just to give to the advocates of any one method the privilege of deciding who might and who might not practice any of the other methods?

3. Does the best interest of the general public demand that the practitioners of all other methods of curing the sick be placed under direct or indirect control of the practitioners of the allopathic system of medicine?

4. In your opinion, are the medical practice laws now in force in some of the States drawn solely in behalf of the general public? If not, what other purpose do they serve?

5. Do you consider the practice of osteopathy, massage, the physical culture treatment, and other methods of curing disease without drugs or surgery, by persons not licensed by a medical board to practice medicine and surgery, a menace to the public health?

6. Should a practitioner of any of the various methods mentioned in question No. 5 be required to submit to examination before a board, the members of which are of the same school of practice as the person to be examined?

7. Please express any other views you may hold on the subject of medical legislation.

There is just enough tricky speciousness in these questions to befuddle the minds of the more ignorant members of State legislatures, and another organized movement should be instituted to tell them that (1) there is no such monopoly; (2) no such hostility among qualified practitioners; (3) no possibility of such control, and no "allopathic school"; (4) the most and best of the existing laws are drawn to protect the public against the uneducated and the quacks of all kinds; (5) these methods are only a small part of therapeutics, aids in a general medical practice, and knowledge of them alone would not qualify a man to practice medicine; (6) certainly; (7) get a good medical education and then practice quackery if you will; why do you feel that a partial education will fit a man to practice better or as well as a complete one? Why do you suspect that a sound education will prevent you thereafter from restricting your method of practice to "osteopathy, massage, and physical culture treatment"? How will you prevent the voodoo, rabbit foot and green goods practitioners from competing with you osteopaths, masseurs, and biceps worshippers? How do you distinguish yourself as a fraud from other frauds?—*American Medicine*.

STATE MONTHLY JOURNALS.

At its recent annual session, the Ohio State Medical Association decided to publish its transactions hereafter in a monthly medical journal that is at once to be established by the Association. The advantages of this plan over the conventional annual volume are so obvious that State after State is creating its own monthly publication.—*Jour. A. M. A.*

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, all items of interest, such as deaths, marriages and persons of the members.

COUNTY ASSOCIATION MEETINGS FOR JULY.

Jefferson County—Tuesday, July 5th.
 Allegany County—Tuesday, July 11th.
 Niagara County—Tuesday, July 11th.
 Wyoming County—Tuesday, July 11th.
 Warren County—Wednesday, July 12th.
 Rockland County—Wednesday, July 19th.

AMERICAN MEDICAL ASSOCIATION.

Papers to Be Read at the Meeting in Portland, Ore.,
 July 11-14, 1905.

The preliminary program published June 3d in the *Journal of the American Medical Association*, gave the following New York members who will read papers:

"Tubal Pregnancy, with Report of Instructive Case," J. Riddle Goffe, New York.

"Hysteromyomectomy versus Hysterectomy for Fibroids: A Plea for Conservatism When Operating on Women Under Forty," C. C. Fredrich, Buffalo.

"The Value of Skiagraphy in Lithiasis and Tuberculosis of the Kidney," Carl Bech, New York.

"Endothelio-Cylindroma of the Orbit, with Report of a Case; Removal and Preservation of the Vision and Mobility of the Eye," John E. Weeks, New York.

"Surgical Aspects of Disturbed Dentition of the Third Molar," M. L. Rhein, New York.

"The Etiology of Tooth Corrugations," G. Lenox Curtis, New York.

"Report of Committee on Drug Addictions," Smith Ely Jelliffe, New York.

"The Relation Between Auditory Hallucination and Tinnitus Aurium," W. S. Bryant, New York.

Laryngeal Edema," Harmon Smith, N. Y.

"The Vapor Method of Anesthesia," James T. Gwathmey, New York.

"Capital Operations for the Cure of Tinnitus Aurium," W. S. Bryant, New York.

"The Therapeutics of Linpulin," Thomas F. Reilly, New York.

"Some Preliminary Steps in the Investigation of Gastric Functions," B. Onuf, Sonyea, N. Y.

NEW YORK STATE ASSOCIATION MEETING.

The twenty-second annual meeting of the New York State Medical Association will be held on Monday, Tuesday, Wednesday and Thursday, October 16, 17, 18 and 19, 1905, at the New York Academy of Medicine, 17 West 43d street, N. Y.

The preliminary program as presented by the Committee of Arrangements is as follows:

Monday, 12.30 P. M.—Meeting of the Nominating Committee.

Monday, 1 P. M.—Meeting of the Council.

Monday, 2.30 P. M.—Meeting of the Council and Fellows.

Symposium on Hygiene and Preventative Medicine:

(a) "Protection of the Water Supply," Dr. Thomas Darlington.

(b) "Protection of the Milk Supply," Dr. Walter Benschel.

Symposium on the Toxæmia of Pregnancy:

1st. "The Acid Toxæmia of Pregnancy," by Dr. Henry G. McMahon Painter, New York.

2d. "The Pathology of Eclampsia," by Dr. James Ewing, of New York (illustrated by lantern slides).

3d. "Hyperemesis Gravidarum," by Dr. William S. Stone, of New York.

4th. "The Treatment of Eclampsia," by Dr. Bernard Cohen, Buffalo, N. Y.

5th. "Vaginal Cæsarean Section in Eclampsia," by Dr. M. Storm, of Fremont, O.

6th. "Resection of the Bladder," by Dr. Howard Kelly, of Baltimore, Md.

Banquet on Wednesday evening. Speakers of national reputation will make short addresses.

Symposium on Diabetes.

Symposium on Carcinoma:

1st. "Therapy of Carcinoma," by Dr. Samuel Lloyd, New York; discussion by Dr. William E. Coley, New York.

2d. "Carcinoma of the Stomach," by Dr. William A. Mayo, Rochester, Minn.; discussion by Dr. John B. Deaver, Philadelphia, Pa.

3d. "Carcinoma of Intestinal Tract," Dr. James P. Tuttle, New York; discussion by Dr. Arpad G. Gerster, New York.

4th. "Carcinoma of the Uterus," by Dr. George Ben. Johnston, Richmond, Va.; discussion by Dr. Charles P. Noble, Philadelphia, Pa.

5th. "Carcinoma of the Larynx," by Dr. John N. Mackenzie, Baltimore, Md.; discussion by Dr. D. Bryson Delevan, New York.

The railroad fares are reduced by the Trunk Line Association on the certificate plan—*i. e.*, full fare going and one-third fare returning to those who have paid 75 cents or over for their going journey, provided that at least one hundred persons shall have paid fares as above and hold certificates from ticket agents at starting point and shall be certified by the Association.

There are some members who have not returned the card acknowledging notice of the annual meeting of the State Association in October. It is earnestly requested that the members give this matter their earliest attention, in order to save the expense of the personal service.

It is requested that members desiring to read papers on any subject shall send the title of the paper to the chairman of the Committee on Arrangements, Dr. Frederic W. Loughran, 742 Prospect avenue, New York City, at once.

Papers should not exceed fifteen minutes' length in reading.

Third District Branch Association.—The twenty-first annual meeting of the Third District Branch Association was held at the Court House, Cortland, on Thursday, June 22d. The meeting was called to order at 10 o'clock. After the reading of the minutes of the last meeting, the appointment of committees, etc., Dr. Franklin J. Kaufmann read his presidential address, "Temperature as a Guide to the Repetition of the Dose of Antitoxin in Diphtheria." In the scientific session, the following papers were read: "Some recent Experiences in Acute Gangrenous Appendicitis," by Dr. M. M. Lucid; "Disease and Sin," by Dr. J. M. Farrington; "Hysteria," by Dr. James M. King; "Internal Use of Water," by Dr. J. C. Fisher; "Toxicosis, Resulting from Modern Cold Storage Practices," by Dr. M. Cayana; "Early Clinical Diagnosis of Cancer," by Dr. B. W. Stearns; "Final Result of Treatment of Inoperable Sarcoma with the Mixed Toxins of Erysipelas and Bacillus Prodigiosus," by Dr. William Bradley Coley; "Typhoid Fever," by Dr. S. J. Sornberger; "Value of Exercise as a Remedy," by Dr. L. D. Farnham; "Dysmenorrhœa—Uterine Fibroids," by Dr. Frank D. Reese.

CLARK W. GREENE, Secretary.

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Fourth District Branch Association.—The twenty-first annual meeting of the Fourth District Branch Association was held at the Genesee Club, Rochester, on Tuesday, June 6th. The visiting members of the Association were entertained by the Monroe County Association. In the scientific session the following papers were read: "Some Problems in Tuberculosis," by Dr. George W. Goler; "A Peep into the Medical Horoscope," by Dr. Charles N. Palmer; "Pneumonia in Children," by Dr. Joseph R. Culkins; "Diagnosis and Treatment of Valvular Diseases of the Heart," by Dr. DeLancey Rochester; "Some Peculiar Reflexes of Eye Strain," by Dr. Arthur G. Bennett; "The Dynamics of the Female Pelvis, in Relation to the Positions of the Uterus," by Dr. J. Riddle Goffe. An address was given by Mr. Henry W. Conklin, one of the most prominent lawyers in Rochester, on "Introspection."

WILLIAM IRVING THORNTON, Secretary.

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Third District Branch Meeting, reported by Dr. E. Eliot Harris, of New York.—Under the order of new business, the president announced that no more important subject could come before the meeting than the question of the agreement to unite the medical profession of this State. "The opposition in my county is well known, and this is the time and place for us to be told why the agreement should be ratified, and I will call on Dr. E. Eliot Harris, of New York, to open the discussion."

Dr. Harris, in speaking on the question of the consolidation of the Medical Society of the State of New York and The New York State Medical Association, said that he was prepared to answer

any question connected with the Principles of Ethics or any article contained in the report of the Joint Committee on Conference, but before going into the detailed explanation, he asked the president to call upon Dr. Ferguson to give the present status of the question of union of the medical profession.

Dr. Ferguson reviewed the opposition to union, and said that with Dr. Bryant as president of the Society, who was a classmate of his, he felt that the Ethical question would now be fairly and squarely presented to the profession of this State, and he urged approval of the agreement and the signing of the proxies that the union may take place under the presidency of Dr. Joseph D. Bryant, in whom "we" have perfect confidence, and believe that he will see that the referendum of the Ethical question is properly voted.

Dr. Harris then explained the work of the Joint Committee on Conference, and the solution of the difficult problems in the agreement.

The president announced that he had withdrawn all opposition to the agreement, and was satisfied with the explanation given, and he would attend the annual meeting in October with all the signed proxies of Onondaga County in his possession.

The meeting was unanimous in all opposition being withdrawn, and not one word spoken against the agreement as presented by the Committee for Ratification by the Members.

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Chautauqua County Association.—A regular meeting of this Association was held at Dunkirk, on Wednesday, May 31st. In the scientific session the following papers were read: "Gonorrhœa: Its Infectious Relations and Marriage," by Dr. John A. Weidman; "Report of Some Interesting Surgical Cases," by Dr. John W. Nelson; "Modern Aspects of Surgery of the Kidney," by Dr. Edward J. Meyer; "Diagnosis of Malignant Growths of the Stomach," by Dr. Henry C. Buswell. The next meeting will be held at Brocton the last Tuesday in September.

HENRY A. EASTMAN, Secretary.

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Genesee County Association.—On April 18, 1905, the Genesee County Medical Association held its annual meeting and following officers elected and committees appointed:

President, William A. Macpherson, Leroy; vice-president, Edward E. Hummel, Darien Center; secretary and treasurer, C. Louise Westlake, Leroy; Committee on Legislation, A. P. Jackson, F. L. Stone, H. E. Ganiard; Committee on Ethics and Discipline, C. D. Graney, R. C. Conklin, Sophie E. Page; Committee on Public Health, G. A. Neal, A. F. Miller; Executive Committee, A. F. G. Zurhorst, W. D. Johnson, E. E. Hummel.

We had a very interesting meeting, with good attendance. Dr. John Parmenter, of Buffalo, gave a paper. C. LOUISE WESTLAKE, Secretary.

Jefferson County Association.—At a meeting of the Jefferson County Medical Association, held at the office of Dr. C. C. Kimball, Wednesday evening, June 14th, the following committees were appointed by the president, Dr. A. J. Dick, to take action on the death of Mrs. Barnette.

Committee on Resolutions, B. C. Cheeseman, F. R. Calkins, W. D. Pinsoneault. Floral Committee, Dr. C. C. Kimball.

WHEREAS, The members of Jefferson County Medical Association have heard with profound sorrow of the sudden removal by death of Mrs. John A. Barnette;

WHEREAS, Mrs. John A. Barnette was a loving wife, a true friend and an esteemed member of society; therefore be it

Resolved, That the members of the Jefferson County Medical Association hereby express their grief at the removal of the esteemed wife of our colleague, Dr. J. A. Barnette, by death, and extend our sincere sympathy to the husband, relatives and friends of the deceased.

Resolved, That a copy of these resolutions be spread on the minutes of this Association, and a copy sent to the husband and family of the deceased.

(Signed) B. C. CHEESEMAN,
F. R. CALKINS,
W. D. PINSONEAULT.

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Orange County Association.—The regular summer outing of this Association took place on Wednesday, June 14th, when about forty people, members of the Orange County Medical Association, the Orange County Medical Society and the Historical Club, journeyed to Kerhonkson.

From Kerhonkson they were conveyed in carriages to the Wildmere House, at Lake Minnewaska. After a rest of twenty minutes they were driven about the picturesque grounds surrounding the mammoth hostelry, then over the famous Awosting drive, two miles through a pleasant wood, with occasional mountain views; thence one and one-half miles through Huntington Ravine, with its lofty cliffs and charming Rainbow Falls, consisting of a number of streamlets falling sixty to eighty feet upon fern-carpeted rocks and boulders; then four miles around Awosting Lake; thence under Battlement Terrace; thence returning to the Wildmere House, where dinner was served.

After dinner the Orange County Medical Association held a short business session and elected to membership Henry Lyle Winter, of Cornwall, N. Y.

Among those who were present at the outing were: Dr. Fancher and wife, Miss Katherine Fancher, Mrs. Sarah Davis, Dr. T. D. Mills and wife, J. W. Slauson and wife, Dr. C. I. Redfield and wife, Mrs. Charles J. Giering, Dr. M. A. Stivers and wife, Dr. H. J. Shelley and wife, Mesdames Geo. Dorrance, William Seeholzer, L.

Robertson and F. B. Hathaway, Frank Harding and wife, Dr. J. B. Hulett, Dr. W. E. Douglas and son, Stanley, William Snyder and wife and Dr. E. M. Schultz and wife, of Middletown; Dr. L. G. Distler and wife, of Westtown; Dr. E. Ross Elliott and wife and Dr. Robert Kerns and wife and Miss Lawson, of Montgomery; Dr. W. J. Carr and wife and Dr. J. T. Howell and wife, of Newburgh; Dr. G. W. Clanchard, of Highland Falls, and Dr. C. W. Dennis, of Goshen.

LAWRENCE G. DISTLER, Secretary.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Ippolito, Gennaro, New York City.
Kellogg, Edward Leland, New York City.
Lambert, Emerson B., Port Jervis, N. Y.
Pfeiffer, Felix, New York City.
Roberts, Percy Willard, New York City.
Sinnott, John Joseph, Mt. Vernon, N. Y.
Shrady, John Eliot, New York City.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

THIRD DISTRICT BRANCH.

Tompkins County—Abram Tucker Kerr, Ithaca.

FOURTH DISTRICT BRANCH.

Chautauqua County—Vernon Mark, Griswold; Albert Myers, Jamestown.

Erie County—Elizabeth Dort, Buffalo; J. A. Macleod, Buffalo.

Genesee County—William T. Smeltzer, Bergen.

Steuben County—Benjamin A. Barney, Hornellsville; Samuel Mitchell, Hornellsville; William Everett Palmer, Hornellsville; Bertis Rupert Wakeman, Hornellsville.

FIFTH DISTRICT BRANCH.

Orange County—Henry Lyle Winter, Cornwall.

Suffolk County—Arthur Hutchinson Terry, Patchogue.

OBITUARY.

Dr. John L. C. Whitcomb died at his home at Liberty, N. Y., May 21, 1905. He was a graduate of the New York University, New York, N. Y., class of 1890. He came to Liberty eleven years ago from New York, where he had practiced for three years.

Dr. Whitcomb was born in 1862 at North Norwich, N. Y. As the result of a competitive examination he received an appointment as physician in Bellevue Hospital, where he remained one year. For three years he practiced his profession in New York City, but failing health compelled him to leave the city and he located in Liberty in 1904.

He served as village health officer for eight years, and was President of the County Medical Association in 1893. He was a member of the Methodist Church.

In 1891 the deceased married Kate L. Pond, who survives him. He also leaves three children, and is survived by his father and mother, who reside at Roxboro, N. Y.

Among his greatest attainments was the perfection of the modification of the Brandt treatment of typhoid fever. In the use of this treatment he lost but two out of two hundred cases, and having brought the treatment to what would seem perfection, he treated one hundred and fifty cases of typhoid during the past eleven years without losing a single case.

The funeral services took place Tuesday morning. The interment was at Roxboro.

* * *

Dr. Benjamin F. Showerman, who recently died at his home in Batavia, N. Y., was a graduate of the New York University, Class of 1886. He was a member of the American Medical Association and The New York State Medical Association.

SECOND ANNUAL MEETING OF AMERICAN ASSOCIATION OF STATE MEDICAL JOURNALS.

Dr. Philip Mills Jones, San Francisco, Cal., president; Dr. James B. Bullitt, Louisville, Ky., secretary.

The American Association of State Medical Journals will meet in the parlor of Hotel Portland, Portland, Ore., on Tuesday afternoon, July 11th, at 4 o'clock. The following program is announced:

1. "An Outline of the Policy Controlling Medical Advertising in the *Journal of American Medical Association*," George H. Simmons, secretary of American Medical Association.
2. "The Aspects of Medical Advertising," Philip Mills Jones, secretary-editor California State Medical Association.
3. "Controlled and Ethical Advertising from the Standpoint of the Advertiser," E. Eliot Harris, M.D., chairman of Committee on Legislation The New York State Medical Association.
4. "The Function of the State Medical Association Journal," James B. Bullitt, secretary-editor Kentucky State Medical Association.
5. "The Possibilities from a Business Standpoint of Concerted Action on the Part of State Medical Journals." A general discussion of this subject by all those interested is invited.

The American Gynecological Society, at its thirteenth annual meeting, held at Niagara Falls the last week in May, elected the following officers for the ensuing year: President, Dr. R. B. Maury, Memphis, Tenn.; vice-presidents, Drs. Howard A. Kelly, Baltimore, and Reuben Peterson, Ann Arbor, Mich.; secretary, Dr. J. Riddle Goffe, New York City; treasurer, Dr. J. Montgomery Baldy, Philadelphia.

Hot Springs, Va., was selected as the place for holding the next meeting.

PERSONAL.

Dr. F. Park Lewis has been appointed a trustee of the New York State Institution for the Blind, Batavia.

Dr. John L. Archambault has been appointed health officer of Cohoes.

Dr. Albert H. Brundage, Brooklyn, has been appointed chairman and chief contributor for the department of toxicology and pharmacology of the Lewis and Clark Exposition.

Dr. and Mrs. Valentine Mott, of New York City, sailed on the *Barbarossa* June 8th.

Dr. Francis J. Quinlan, the president of the New York County Medical Association, has been elected president of the Catholic Club.

Dr. Newton M. Shaffer sailed for Switzerland on the 29th ult.

Dr. E. B. Lambert, of Port Jervis, has been appointed one of the Board of Managers of the State Hospital at Middletown, N. Y.

SOCIETY NOTES.

Brooklyn Gynecological Society.—At a meeting, held June 2d, Dr. Carroll Chase read a paper on "The Choice of Uterine Hoemattatic."

Buffalo Academy of Medicine.—At a meeting, held June 13th, the president, Dr. Arthur W. Hurd, gave an address on "The Uses of a Medical Society."

Elmira Academy of Medicine.—At a meeting, held June 7th, the following papers were read: "Erythro-Melalgia, with Report of a Case," by Dr. C. W. M. Brown; "Infection Through the Tonsils," by Dr. S. M. Seafuse; "The Diagnostic Value of Leulocyte Count in Appendicitis," by Dr. John A. Robinson.

Harlem Medical Association.—At a meeting, held June 7th, Dr. Henry S. Stark read a paper on "The Individual—Treatment of Diabetes" and Dr. E. L. Cocks on "The Treatment of Parasitic Skin Diseases."

Medical Association of Greater New York.—At a meeting, held June 12th, Dr. Parker Syms read a paper on "Perineal Prostatectomy by an Original Technique, with Illustrations."

Syracuse Academy of Medicine.—At a meeting, held June 6th, Dr. A. G. Doust read a paper on "Sequelæ of Diphtheria."

CORNELL'S EXERCISES

Cornell University Medical College's seventh annual commencement was held Wednesday afternoon, June 14th, in the main lecture hall of the college building, at First avenue and Twenty-eighth street. Dr. Jacob Gould Schurman, president of the university, presided, assisted by Dr. William M. Polk, dean of the college.

Dr. George P. Simmons made the only formal address. In discussing medical ethics he referred to a remark made by Longfellow, that laymen were not able to judge of the professional qualifications of a physician, but they were able to judge as to how a physician stands among his fellows, and it is therefore a matter of practical importance whether he shall abide by the code of ethics recognized by them.

A new society called the Harvey Society, consisting of laboratory workers in New York City, has recently been established under the patronage of the New York Academy of Medicine. Its purpose is the diffusion of scientific knowledge in selected chapters of anatomy, physiology, bacteriology, pathology, pharmacology and physiologic and pathologic chemistry, by the means of public lectures by men who are workers in the subjects presented. The fulfilment of the purposes of the society has been entrusted to the hands of the following committee: Dr. Graham Lusk, president; Dr. Simon Flexner, vice-president; Dr. George B. Wallace, secretary; Dr. Frederick S. Lee, treasurer, and Drs. Christian A. Herter, S. J. Meltzer and E. K. Dunham. The members of the society consist of two classes—active and associate. Active members are laboratory workers in the medical sciences residing in New York; associate members are such persons as may be in sympathy with the objects of the society and reside in New York. The first course of lectures will be given on Saturday evenings next Winter at the Academy of Medicine.

The directors of the Batavia Woman's Hospital have decided to accept the appropriation of \$1,500 made by the Legislature. The hospital will now come under the supervision of the State Board of Charities.

The criminal abortionist of to-day protects himself in his nefarious business by a close alliance with the minor politician. His opportunity for doing so is always at hand, and the reason therefor is obvious. Coroner Dugan, of Philadelphia, has shown during the past year what may be done in bringing criminal abortionists to the bar of justice by committing some twenty of these rascals to await the action of the Grand Jury.

The following is typical of the methods pursued by criminal abortionists: "Dr." A inserts in one of the Sunday papers an advertisement somewhat as follows:

LADIES IN TROUBLE desiring safe, sure and quick relief from suppressed or delayed periods consult me. Safe and skilful. We have no failures. Twenty years' experience. Cure guaranteed. No exorbitant fees. Call or write. Private home; skilful nursing for patients. Delays are dangerous. Ladies in trouble should not fail to call or write at once.

LADIES—Mrs. Dr. Smith's famous remedy has brought happiness to thousands of women by relieving the most obstinate cases of irregularities (from any cause); never had a failure; longest cases relieved in 2-5 days; no pain, danger, or interference with daily duties. A sure cure, or money refunded.

She has three sets of pills, of different strengths, and expensive in proportion to their strength. Her method, too, is one of obtaining money under false pretenses, for she trusts to luck either that something will happen to cause the expulsion of the foetus, in which case the pills get the credit, or that the patient may not be pregnant after all. At all events, the patient has been as clearly guilty of an illegal act in buying the pills for the avowed purpose as she has been in selling them, and at the worst the money only has to be refunded. The subsequent blackmail is, as Kipling says, another, but an old, old story.—*Medical Notes and Queries*, May, 1905.

THE ANTI-SPITTING CRUSADE.

New York has been having a very interesting crusade against spitting on the streets that has aroused widespread attention and has made the knowledge of the law in this matter very acute for a number of New York citizens. Now before a man dares to spit even into the gutter he looks up and down the block to be sure that there is no policeman in sight and even scans the faces of near-by passers in order to detect, if possible, the presence of a plain-clothes man. The Board of Health took the nuisance into its own hands and sent out men to arrest every one seen spitting on the streets in the most crowded portions of the city. Workmen, as a rule, were not bothered, but the better-dressed people were all arrested if caught expectorating. The fines were not heavy, but the lesson has been very thoroughly learned. In cases where the arrests were made at night some few had to spend the night in the station-house. This may seem a harsh and unnecessary enforcement of the sanitary regulation, but it has been necessitated by what is known of the prevalence of tuberculosis among the workmen of the Street Cleaning Department. Though these men spend all of their time out of doors, and though their work is not very hard, the mortality among them from tuberculosis has been nearly, if not quite, double that of the rest of the population, and it becomes necessary to do something to prevent the unfortunate sacrifice of life. At this season of the year particularly, when the dry, warm weather is likely to cause virulent sputum to be blown about as dust after its deposit on the streets, the enforcement of this regulation is especially opportune. Still more valuable, however, than the actual sanitary effect produced by the enforced cleanliness is the lesson that has been taught by the announcement of the results of the crusade in the daily press. While many a man insisted that it was impossible to spend the day without spitting, and there have been letters to that effect, there is now a very general agreement that under the circumstances the Board of Health could not consistently with our present knowledge of tuberculosis have done anything less than they did.—JAMES J. WALSH in *Medical Notes and Queries*.

The patent-medicine man has at last secured a place in the church in Manhattan, remunerative to both, although the former in the end gets the larger share. Permission to give a lecture to the ladies of the church is secured, and a date set. Of course, the lecture may be interesting, but when, at its close, literature of a patent medicine is passed among the audience and the speaker tells her hearers that Dr. ——— would be pleased to have a consultation with any one present at his office, the lecture loses its charms, and many of those present depart wondering how combination of church and patent medicine had its inception. But when it is afterward learned that the treasury of the church is enriched by 10 cents per head for each one present, paid by the good Dr. ———, the audience becomes more enlightened.—*New York Evening Post*.

DISTRUST OF DOCTORS.

Side by side with the immense development and authority of modern medicine, one encounters strange signs of revolt against its claims and its practices. The chief is, of course, the vast revival of superstition lurking behind the great vogue of Christian Science and "mental healing" of various kinds. At the very moment when the physician seems most absolute; when thousands of people in every city are all the while submitting to capital operations at the surgeon's word, and millions are guiding their daily lives, in sickness and in health, by doctors' advice; when the germ theory of disease and serum therapy and kindred discoveries and investigations are giving medicine more and more the air of an exact science—multitudes are found to reject it altogether. Many of them are, no doubt, a little queer in the head; others are carried away by enthusiasm or fanaticism. Yet their numbers are growing; and, whatever their minor differences or vagaries of belief, they are all agreed that the thing to do is to throw physicians to the dogs. The whole phenomenon is a suggestive reminder the the conquests of science are precarious. As the forest forever encroaches upon the clearer field, so do lingering savage beliefs tend to reassert themselves in the age that boasts itself most enlightened.

Such crude denial of fact and rejection of experience do not, however, make up the whole case of the distrust of doctors. Much skepticism about medicine goes only half-way; the general principle is accepted, but specific applications are called in question. Scientific niceties always find scant favor with the rule-of-thumb men, and nowhere are people more inclined to employ the rule of thumb than in the matters of health and disease. We know that a given water does not harm us, so what is the use of a doctor's telling us to boil it? Even health officers have been known to regard some of the finest demonstrations of medical science as pure whimsies. Recently in a large city of England the medical man in charge of public health was heard openly to sneer at the germ theory of disease as a mere fantasy of fussy microscopists. It was not for him to order precautions based upon absurd speculations about what he called "those pollywog things."

The distrust we speak of is usually more of the medical profession, impersonally, than of individual members of it. How grudgingly is medical inspection of schools provided for and paid for; what shabby treatment has been meted out to the profession in various ways in connection with the military service! These grasping fellows, the argument seems to run, are all the while making an outcry about unhygienic conditions in the public schools, and about the need of sanitation in the army, just to magnify their office and get themselves jobs. Yet this spirit goes hand in hand with the perception that the medical profession is the most ruthlessly exploited of all. No one thinks of going to a lawyer or engineer or architect without his fee; yet doctors are supposed to be under a moral obligation to give their services freely to the ill and injured. This they do, to their honor, relieving pain and suffering by the expenditure of their time and skill, often with no hope or possibility of payment. Yet their protests against perils to the general health are frequently resented, and treated as the selfishness of a profession aiming to thrust itself in everywhere. This is an attitude of mind really as bewildering as outright superstition. It is puzzling to find distrust provoked by what is really the crowning proof of disinterestedness; since, as it has been said, the devotion of the medical profession to the cause of public health is really a way of making its own extinction its final goal.—*The Evening Post*.

Book Reviews.

GYNECOLOGY: MEDICAL AND SURGICAL OUTLINES FOR STUDENTS AND PRACTITIONERS. By Henry J. Garrigues, A.M., M.D. With 343 illustrations. Philadelphia and London: J. B. Lippincott Company, 1905.

Dr. Garrigues is well known through his "Text-Book on Diseases of Women" and his "Text-Book on the Science and Art of Obstetrics." The present volume is an outline sketch of the salient features of gynecology as presented in his larger work. It is written more particularly as a text-book for students in medical colleges; at the same time an eye is kept on the requirements of the general practitioner, and the minor operations are described somewhat in detail. In the capital operations the chief features are set forth. The illustrations are abundant and the whole volume is embraced in about 450 pages.

ATLAS AND EPITOME OF OPERATIVE OPHTHALMOLOGY. By Dr. O. Haab, of Zurich. Edited, with additions, by George E. de Schweinitz, M.D., Professor of Ophthalmology in the University of Pennsylvania. With 30 colored lithographic plates, 154 text cuts and 377 pages of text. Philadelphia, New York and London: W. B. Saunders & Co., 1905. Cloth, \$3.50 net.

In concluding the series of atlases on the eye the editor has rendered a valuable service by many additions to the text; that the subjects are treated fairly, according to the original, the new matter has been placed in brackets. The importance of every detail in the operating room, sterilization, antisepsis and asepsis is emphasized; note the importance of wearing a mouth bandage when operating before students, and he wishes to make explanatory remarks. The chapters are divided into operations on the globe, operations outside of the eye-ball, operations on the lids and in the conjunctival sac and operations on the lacrimal organs. The 30 colored lithographic plates are excellent and reinforced in the 150 text illustrations. It is certainly the best work on operative ophthalmology published.

A PRACTICAL TREATISE ON NERVOUS EXHAUSTION, ITS SYMPTOMS, NATURE, SEQUENCES AND TREATMENT. By George M. Beard, A.M., M.D., Fellow of the New York Academy of Medicine, of the New York Academy of Sciences; vice-president of the American Academy of Medicine; Member of the American Neurological Association, of the American Medical Association, the New York Neurological Society, etc. Edited, with notes and additions, by A. D. Rockwell, A.M., M.D., Neurologist and Electro-Therapist in the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy; Member of the American Neurological Association, of the Neurological Society, etc. Fifth edition, enlarged. New York: E. B. Treat & Co., 241-243 West 23d street. Price, \$2.

The fifth edition of neurasthenia is fully justified in the interest of the profession. That the author has fully covered the subject is an undoubted fact. In this edition the author has added a chapter on the neuron theory in its relation to the treatment of neurasthenia. The book will be of interest and value to the profession and of practical value to the general practitioner of medicine.

A TEXT-BOOK OF PATHOLOGY. By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia. Philadelphia: W. B. Saunders & Co., 1904.

In this work the author has taken up many lines which are not usually found in works on pathology. We notice the discussion of the causes of diseases, and the clinical features are frequently mentioned. It has added to the value of the work, but decidedly increases the material and hence enlarges the size of the book, which, however, has been obviated to some extent by two sizes of type. The illustrations are of a high order and mate-

rially help in reading the text. It will be found very useful to the general practitioner.

THE INFLUENCE OF GROWTH ON CONGENITAL AND ACQUIRED DEFORMITIES. By Adoniram Brown Judson, A.M., M.D., Orthopædic Surgeon to the Out-Patient Department, New York Hospital, 1878-1903; formerly Chairman of the Orthopædic Section, New York Academy of Medicine; formerly President of the American Orthopædic Association; Member of the American Medical Association. Published, with many illustrations, by William Wood & Co., New York.

The subject is one which abounds in opportunities for the orthopædic surgeon to instruct his professional brothers, and, with an author of such rich experiences, we opened the book with great expectations of profit and enjoyment. In a great measure we were repaid, but the book, as a whole, is not what we hoped. We cannot expect 244 pages to exhaust such a subject. Undoubtedly Dr. Judson could write that number of pages on any one chapter with much more ease than he found in confining himself to 30 pages for a chapter. And for that very reason we believe greater care should have been exerted to eliminate extraneous matter and to enlarge upon valuable questions in diagnosis and treatment.

The subjects treated are: Congenital Club-Foot; Deformities Caused by Infantile Paralysis; Tuberculous Joint Disease; White Swelling of the Knee; Hip Disease (4 chapters, 102 pages); Pott's Disease of the Spine, and Lateral Curvature of the Spine.

There are a number of views as to etiological factors and as to therapeutic measures in which the author is at variance with the other teachers. It would be of no advantage to discuss them here. However, we will call attention to a mechanical matter, about which there should be but one opinion. We will quote from two eminent surgeons who are supposed to be students of mechanics as well. On page 50 Dr. Judson, under the Mechanics of Locomotion, says: "The common idea that the muscles push the body along is not in accordance with the facts. . . . The foot certainly spurns the ground in the wake of the runner in a very vigorous manner, but the recoil of this stroke simply propels the foot forward as it hastens to receive the weight of the falling body." On page 660, of Whitman's Orthopædic Surgery we find the following: "As has been stated, the foot is, in activity, a lever, by means of which the weight of the body is lifted and propelled."

Physicians who have not the time or inclination to read the larger works on this branch of surgery will find the book very valuable indeed. Too many are inclined to join the laity in their belief in that fetich, growth, un-directed or misdirected, as a cure of deformities and some diseases.

By carefully reading this little volume many physicians, and many surgeons, too, will be saved future censure for having allowed to progress a deformity which might easily have been cured had treatment been undertaken on the date of its discovery.

BOOKS RECEIVED.

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. Third edition, revised and enlarged. Illustrated with 12 plates, in colors and monochrome, and 118 engravings. Philadelphia and New York: Lea Bros. & Co., 1905.

MALARIA, INFLUENZA AND DENGUE. By Dr. Julius Mannaberg, Professor of Internal Medicine, University of Vienna; Dr. O. Lichtenstein, formerly of the University of Cologne. Edited, with additions, by Major Ronald Ross, F.R.C.S., F.R.S., C.B., Professor of Tropical Medicine, University of Liverpool, and Albert S. Grunbaum, M.D., F.R.C.P., Professor of Experimental Medicine, University of Liverpool. 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., 1905.

A TEXT-BOOK ON THE PRACTICE OF GYNECOLOGY FOR PRACTITIONERS AND STUDENTS. By William Easterly Ashton, M.D., LL.D., Fellow of the American Gynecological Society; Professor of Gynecology in the Medico-Chirurgical College, and Gynecologist to the Medico-Chirurgical Hospital, Philadelphia; formerly Lecturer on Gynecology in the Jefferson Medical College, Philadelphia; one of the founders of the Congres International de Gynecologie et d'Obstetrique; Member of the American Medical Association, etc. With 1,046 new line drawings, illustrating the text, by John V. Alteneeder. Philadelphia and London: W. B. Saunders & Co., 1905.

SAUNDERS' POCKET MEDICAL FORMULARY. With an Appendix, containing Posological Table; Formulæ and Doses for Hypodermic Medication; Poisons and Their Antidotes; Diameters of the Female Pelvis and Fœtal Head; Obstetrical Table; Diet List for Various Diseases; Materials and Drugs Used in Antiseptic Surgery; Treatment of Asphyxia from Drowning; Surgical Remembrancer; Tables of Incompatibles; Eruptive Fevers, Weights and Measures, etc. By William M. Powell, M. D., Author of "Essentials of Diseases of Children," Member of the Philadelphia Pathological Society, etc. Seventh edition, thoroughly revised and enlarged. Philadelphia and London: W. B. Saunders & Co., 1905.

REPORT OF THE COMMISSIONER OF EDUCATION FOR THE YEAR 1903. Vol. 2. Washington: Government Printing Office, 1905.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA. Fifty-first annual meeting, held at Raleigh, N. C., May 24, 25 and 26, 1904. President, Dr. Henry Bascom Weaver, Asheville, N. C.; Secretary, Dr. J. Howell Way, Waynesville, N. C. Raleigh: Presses of Edwards & Broughton, 1905.

TRANSACTIONS OF THE THIRTEENTH ANNUAL MEETING OF THE HAWAIIAN TERRITORIAL MEDICAL SOCIETY, held in Honolulu, November 19, 20 and 21, 1905. Honolulu, 1905.

TRANSACTIONS OF THE SOUTH DAKOTA STATE MEDICAL ASSOCIATION FOR THE YEARS 1903-1904. Published by the Association. William Edwards, Secretary; E. T. Ramsey and W. A. Kreisal, Committee on Publication. Aberdeen, S. D.: News Printing Company, 1904.

ATLAS AND TEXT-BOOK OF TOPOGRAPHIC AND APPLIED ANATOMY. By Oskar Schultze, Professor of Applied Anatomy in Wurzburg. Edited, with additions, by George D. Stewart, M.D., Professor of Anatomy and Clinical Surgery in the University and Bellevue Hospital Medical College, New York. With 25 colored illustrations on 22 lithographic plates and 89 text cuts, 60 in colors. Philadelphia and London: W. B. Saunders & Co., 1905.

NEW YORK CHARITIES DIRECTORY. A Classified and Descriptive Directory to the Philanthropic, Educational and Religious Resources of the City of New York, including the Boroughs of Manhattan, Bronx, Brooklyn, Queens and Richmond. Compiled by Mrs. Mary E. David. Fifteenth edition. Published by the Charity Organization Society of the City of New York, 105 East 22d street, 1905.

A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS. By Lewis A. Stimson, B.A., M.D., LL.D. (Yale), Professor of Surgery in Cornell University Medical College, New York; Surgeon to the New York and Hudson Street Hospitals; Consulting Surgeon to Bellevue, St. John's and Christ Hospitals; Corresponding Member of the Société de Chirurgie, of Paris. Fourth edition, revised and enlarged, with 331 illustrations and 46 plates in monoint. New York and Philadelphia: Lea Bros. & Co., 1905.

CLINICAL FEATURES OF THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Prof. D. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfurt a/M. Part VI, Drink Restriction (Thirst Cures), Particularly in Obesity, by Prof. Carl von Noorden and Dr. Hugo Salomon. New York: E. B. Treat & Co., 1905. Price, 75 cents.

Original Articles.

CEREBRO-SPINAL MENINGITIS.¹

BY HARLOW BROOKS, M.D.,
New York.

PRACTICALLY all forms of cerebral meningitis, certainly all suppurative types, are cerebro-spinal in character, the membranes of both brain and cord being affected, though often in relatively different degree. Tonight I shall limit my remarks entirely to the epidemic disease, commonly known as "spotted fever," and caused by the diplococcus of Weichselbaum, or the diplococcus intercellularis meningitidis. I make this definite statement for the reason that it has been shown that in certain epidemics of meningitis, the pneumococcus has been the unquestionable etiological factor, though it is true that this form has usually occurred in conjunction with, or as complicating, pneumonia.

It is manifestly impossible to consider the entire field of this disease in the time at our disposal this evening, hence I shall hurriedly pass over certain of its manifestations and shall devote the greater part of my time to the consideration of those points which are apt to be the least considered in the text-books.

I shall therefore omit the history of cerebro-spinal meningitis and refer you for data in this regard to the studies of Jager, Hirsch, Stille, Smith and Councilman. I shall also entirely limit my remarks to the disease as I have seen it in New York during the past ten years.

Cerebro-spinal meningitis is practically always present in New York City. There are more cases during the fall, winter and spring months and its curve of frequency, as stated by Councilman, corresponds rather closely to that of lobar pneumonia. It is more predominant some years than others. As you all know, it was particularly prevalent during the past fall, winter and spring. With this statement we must, however, remember that the great interest centered in the disease this year has probably caused nearly every case to be discovered and reported; this has hardly been probable at other times. In addition, I personally know that a good many cases have been reported this year as cerebro-spinal meningitis which in reality were nothing of the sort. Practically everything, from acute gastritis to the onset of pneumonia or measles, has been occasionally recorded this year as meningitis of the epidemic form.

The character of the epidemic, for it really amounts to an epidemic during the seasons mentioned, varies greatly. At times the disease, as a whole, seems to be very mild, and as high as 80 per cent. of recoveries are recorded; at other times it is extremely virulent and the cases are characterized by their rapidly fatal course. Again, the clinical manifestations vary consid-

erably; for example, in 1896 and 1897, when I first became acquainted with the disease, seeing it mostly in the wards and at the morgue of Bellevue Hospital, a considerable percentage of the cases presented the petechial spots and discolorations which gave rise to the name of spotted fever; this year, Huber, Manges and others, who have been in active touch with the greater number of cases which have occurred in the city, have remarked on the rarity with which this manifestation is evident, but herpetiform eruptions have this year been very frequent; formerly, in my experience, they were relatively rare.

The greater number of cases have come from the thickly settled portions of the city, particularly from those districts where sanitation is at its lowest and where overcrowding of illy ventilated, poorly lighted and actually filthy tenements exists. This, however, has not been the invariable case; sporadic instances have originated among the most sanitary and favorable conditions, but in no case has anything like a house or neighborhood epidemic developed outside of the unhealthy conditions, coupled, perhaps with poor and insufficient food, which characterize our city tenements of the cheaper class. I thoroughly believe that the most potent factor favoring the development of the disease is unhygienic surroundings. Furthermore, it has been noted and established beyond question that the disease is much more prevalent during cold seasons, when overcrowding and poor ventilation are at their maximum, and that a few days of good weather with a consequent opening of the windows, are followed by a decrease in the number of cases reported. Briefly, then, we are warranted in concluding that unhygienic conditions promote the spread and development of the disease and conversely that hygienic measures tend to dissipate it.

A question with which we have all been greatly concerned has been as to the possibility of the contagion being transmitted from case to case, let us say, in a hospital. Up to this year most of the city hospitals made little or no attempt at isolation, and cases were allowed to remain in the open ward. This winter close canvass of hospital statistics has demonstrated that beyond doubt the disease is sometimes, though rarely, transmitted in hospital and that new cases have unquestionably developed in the hospital as a result of infection carried from previous patients. This finding but bears out the experience of naval and hospital ship surgeons, facts to which the military history of even our own country brings abundant evidence. As a result, I believe now that none of the city hospitals place cerebro-spinal meningitis in general wards; most of them absolutely refuse the cases, sending them to special wards and pavilions at Bellevue, Gouverneur and Harlem, where they are received and treated as any other form of contagious disease. Personally I have as yet seen but one undoubted ward infection, and it is in my opinion very rare,

¹Read before the Ulster County Medical Association, May 15, 1905.

except where overcrowding and poor ventilation favor the transmission of the disease.

The prodromal stage is commonly short, and may last but a few hours before frank manifestations develop. The first symptom usually complained of is headache, followed in a day or so, if in rapid cases within a few hours, by severe backache, fever, rigidity of the neck and back muscles, mental disturbances and general hyperaesthesia. A chill with vomiting, often projectile, diarrhoea and the usual manifestations of any acute infection may be present. Delirium usually follows and is in turn succeeded by a more or less comatose state, which, in the severe cases, deepens as the disease progresses. The knee jerks are generally increased and Babinski reflex is present throughout. The pulse is rapid and often becomes soft, irregular and intermittent. Albumen, in greater or less quantity, generally appears in the urine, and, in some cases, casts and blood are also found. The blood usually presents a moderate polynuclear leucocytosis. Following the acute symptoms, contractures appear and opisthotonus of the most extreme degree may develop.

A petechial rash develops in a small number of cases, and, when present, justifies the name originally applied to the disease—that of spotted fever.

The symptoms may be briefly stated as those of an acute infection, plus those of cortical and ventricular pressure of the brain and spinal cord.

It hardly seems necessary to devote much time to the diagnosis of this disease, since the signs are those of any other type of meningitis of the suppurative form and not even the presence of spots or herpes is characteristic. The diagnosis rests, then, on the signs and symptoms of an ordinary meningitis, and the specification of epidemic form can only be made when the organism, believed to be responsible for the disease, is secured, either from the cerebro-spinal fluid by lumbar puncture or recovered from the blood. Agglutination of pure cultures of the meningococcus by the blood serum of suspected cases is not yet sufficiently certain. Let me state here that the finding of an intracellular diplococcus in smears from the nasal or other discharge and except from the cerebro-spinal fluid is worse than useless in the diagnosis of the disease. When discovered in the blood, it can only be absolutely identified by tedious and difficult cultural methods. Lumbar puncture should therefore always be resorted to for the purposes of diagnosis, but please understand that the fluid so obtained is not the exudate characteristic of the disease, but that it is but cerebro-spinal fluid, to which has been added a certain small amount of cells dislodged from the meningeal exudate; thus at times you may obtain it almost perfectly clear.

It seems best to introduce the question of the etiology of the disease by a brief consideration of the causative microorganism. This micrococcus was first described by Weichselbaum, who

asserted that it bore a direct etiological relationship to the development of certain, but not all, cases of epidemic cerebro-spinal meningitis. The organism is a large diplococcus, very much resembling the gonococcus in size, morphology, and in certain of its staining and biological characteristics. It is of distinct "biscuit" form, but is very prone to undergo involution, both on culture media and in the purulent exudate, in which it is found. In such instances, its staining characteristics (the organism is negative to Gram) become greatly modified, and it may resemble almost anything morphologically from a yeast cell to a sarcine or an ordinary staphylococcus. Like the gonococcus, it shows a particular affinity for the cytoplasm of pus cells, or leucocytes. From these few statements it must appear to you that this germ is distinguished with the greatest difficulty from certain other organisms, and particularly from the diplococcus catarrhalis, which is found very commonly in many catarrhal exudates. It is on account of its close resemblance to this particular organism that the finding of the germ in smears only from various discharges is utterly valueless since its distinction from the catarrhalis requires a very long and tedious bacteriological test; indeed, there are many careful observers who now assert that these two organisms are one and the same. Personally, I am only prepared to say that their distinction, morphologically and biologically, is most difficult, and, in many cases, impossible.

The organism grows very poorly on the usual culture media, and is successfully cultivated on special media only, the best of which seems to be human serum.

The production of the disease in experimental animals is a very difficult matter; practically the only absolutely conclusive experiments in the production of meningitis in the lower animals has been in the primates, and all members of the monkey group do not appear equally susceptible, as I have demonstrated by experiments of my own. The activity of the organism in its ability to cause death or typical lesions in even susceptible animals is very irregular and uncertain. The organism soon loses its pathogenic abilities when grown on artificial media or when transmitted from animal to animal. We have every reason to believe that its variation in activity in the human organism is just as fickle as in animal experimentation, thus accounting for the enormous disproportion in symptomology and in the lesion which we may almost say typifies the clinical disease.

Toxine production has never been satisfactorily demonstrated with this organism. The serum from infected cases gives a more or less definite agglutinative reaction, but this in itself is by no means absolutely indicative of toxine production, and the general clinical aspects of the disease tend to argue against this theory; hence the hopelessness of the attempts at the formation of an antitoxine for the treatment of the disease.

The normal habitat of the diplococcus intracellularis is not known, but it has been frequently found in the nasal and respiratory tubes; very possibly it is often confused in these localities with the diplococcus catarrhalis, but, as we have before stated, its entire differentiation from this organism is now by no means a matter of certainty.

There can be but little doubt but that it gains access to the cerebral meninges, through the cribriform plate of the ethmoid bone.

The mere presence of the organism in the cerebro-spinal fluid is not sufficient in itself to cause the production of the disease. It has been found in clinically normal cases, and statistics given by observers of unquestioned veracity and ability have shown a sufficient number of instances to make this statement a matter of certainty. There must, therefore, be some essential factor, as in most other infectious processes, which renders the individual liable to the infection, and which, for lack of a better name, we call susceptibility. Perhaps this factor is furnished by the unhygienic conditions which we have before mentioned. It is at least the most important one concerned in the prophylaxis of the disease, since it is unquestionable that we are all constantly more or less exposed to not only this but many primary infectious agents.

The meningococcus has also been found in the cerebro-spinal fluid of diseased cases in which postmortem we have been unable to demonstrate any changes definitely attributable to the organism. Thus during the past week it was isolated in pure culture from the cerebro-spinal fluid withdrawn by lumbar puncture from a case in which several days later the cerebral condition was found postmortem to be due to a simple acute hydrocephalus, without inflammatory manifestations.

The pathological anatomy of cerebro-spinal meningitis of the epidemic variety differs in typical cases, in so far as the lesions in the brain and cord are concerned, in no way from the lesions found in cerebro-spinal meningitis caused by certain other organisms, notably by the pneumococcus.

There are, however, certain points which it is very essential for us to discuss, in order that we may attain a sufficient understanding of the pathological anatomy to intelligently diagnose and treat the disease.

In the typical case, the surface of the brain is covered by an exudate of yellow or yellowish-green pus, which lies between the cortex and the pia-arachnoid; this is inseparably enmeshed in the spaces of the membranes. The amount of this exudate varies enormously; in some cases it is very thin and may be obvious to the unaided eye only as a narrow, yellowish strand on either side of the larger blood-vessels of the membranes. There is a general hyperæmia of the capillaries and of the smaller trunks, and rarely petechial hemorrhages are to be seen. As a rule, in cases

of this nature, the symptoms are comparatively mild; the case is of slow development and the contractures and other pressure symptoms are less marked, while, as a whole, the case is one in which a more favorable prognosis may be ventured. As a rule, however, the exudate is spread over all the convolutions, and not at all infrequently it is so extensive that all the sulci and grooves are filled out flat with a layer of pus, which, in some cases, reaches as much as one-fourth inch in thickness. Generally the amount of exudate is equally spread over the surface of the brain, but occasionally one finds it localized; for example, I have found instances in which it was very scanty except over the frontal lobes. Commonly, however, the pus is by far the most abundant over the vertex of the brain, a most significant finding, since it indicates that it is not dependent on the forces of gravity for its location. Occasionally one finds it most abundant over the base or along the sylvian fissures, as in tubercular meningitis, but this is the exception. Unquestionably, this tendency toward the active formation of pus over the vertex accounts to a considerable degree for the symptoms of acute cortical pressure which develop very early in the disease. The pus extends out along the nerve trunks, showing a particular tendency, in my experience, to attack the Gasserian ganglion and its trunks. In this manner the purulent exudate infiltrates into the nerve trunks, following the connective tissue tendrils of the endoneurium and causing pressure atrophy and degeneration of the nerve fibers. This finding, of course, accounts for the frequency with which degeneration of various nerve trunks takes place in the disease, notably in the optic, the auditory and the third cranial trunks. In the same manner the exudate penetrates into the brain tissue, usually passing in only along the connective tissue ingrowths of the membranes, and not by direct extension, as would be the case in the ordinary suppurative processes. Occasionally it is true, one finds, that there has been a direct extension into the brain tissue, or that pus cells have been taken up by the lymph or blood stream and have been swept into the lymph channels deep into the cerebral tissues, but one generally finds the exudate only about the blood-vessels and in the meshwork derived from the membranes proper.

It is curious to note the rapidity of formation of this exudate in some cases. In several instances where I have found the purulent deposit most extensive, the disease has been of very short duration, sometimes not more than from 24 to 72 hours.

One commonly finds the amount of cerebro-spinal fluid considerably increased and turbid with dislodged pus cells or occasionally clear. Maceration of the tissues of the cortex and pia-arachnoid are nevertheless rare, though usually present where the excessive amounts of this fluid are due to cerebral œdema, serous meningitis and other similar conditions. The ventricles of the

brain and the choroid plexus are more or less involved in the average case; this must be expected when one considers the direct communication of the ependyma, and the lymphatic supply of the ventricles with that of the pia-arachnoid. Generally the pus here is not so intimately adherent to the connective tissue framework, but is found diffusely scattered throughout the fluid. Postmortem one often finds the anterior portions of the ventricles filled with a perfectly clear, limpid fluid, while the posterior horns are filled with thick, slimy, greenish-yellow pus; apparently this finding is entirely due to the gravitation of the pus downward into the posterior horns as a result of the recumbent posture. The vessels of the choroid plexus are surrounded by the pus in exactly the same manner as those of the membranes at large, and often the amount of ventricular distention as a result of the hypersecretion of the cerebro-spinal fluid adds manifestly to the pressure to which the cortex is submitted. One often finds the cortical convolutions flattened out, as markedly as in hydrocephalus of long standing. In the case of the spinal cord the exudate is ordinarily not so diffuse, the compression, from the anatomical arrangement of the cord and its membranes, is less and the pus is generally arranged more in patches than in the diffuse manner seen over the brain. The nerve roots and the posterior root ganglia are infiltrated in the same manner as is the case with the cranial nerves.

In my experience there is very little difference as to the relative amount of the exudate found at various levels of the cord; sometimes, of course, the amount is greater above the cervical enlargement; at other times, let us say, in the dorsal or lumbar portions; but it is almost invariably abundant about the cauda equina, where the anatomical arrangement is such as to favor the formation. The membranes of the posterior aspect of the cord are occasionally somewhat more involved than the anterior, as some authors assert, but this, in my experience, is not constant, or even common.

The microscopic structure of the exudate varies even as much as the gross appearances. Generally the exudate is made up of many polynuclear neutrophilic leucocytes, or pus cells, bound together by a very tenacious network of fibrin. In a few instances the pus cells are very few in number, and the exudate consists chiefly of fibrin. In still more infrequent cases liquefaction of the exudate seems to have taken place with disintegration of the fibrin and the production of a liquid pus such as we ordinarily find in other locations; the exudate then, of course, loses its characteristic tenacity. As a rule, this tendency is seen only when mixed infection, as with a staphylococcus, is present. The highly fibrinous character of the pus is a most important factor, since, due to it, the hope of removing the pus by establishing drainage by surgery is defeated, for it is a very difficult matter, even at the autopsy

table, to remove the exudate without tearing off with it the superficial layers of the cortex.

The relative occurrence of the meningococcus in the exudate is very inconstant. In some cases it is extremely abundant, both in the cytoplasm of the pus cells and free in the fibrinous parts of the exudate; in other instances field after field may be searched without finding a single microorganism. Inoculation of large quantities of the exudate in such cases into appropriate culture media may then give absolutely no growth. Briefly, we may definitely state that the amount of exudate produced is in no way dependent on the number of microorganisms found postmortem. Neither does there appear to be any definite relationship between the rapidity of the disease and the number of organisms demonstrable in the exudate.

The changes in the brain and cord tissue in acute cases are often very slight, except for the extension of the process in from the tendrils of the pia-arachnoid, but in long-standing cases, and sometimes in more actively acute ones as well, degenerative lesions in the ganglion cells are demonstrable. These may vary from slight chromotolysis to an actual cytolysis, or, in the more chronic cases, atrophy with pigmentation of the ganglion cells is present. There is, however, nothing characteristic about these alterations, and they are less marked than in those infectious processes where the symptoms are more dependent upon toxæmia.

Naturally, in long-standing cases, more or less proliferation of the neuroglia takes place, particularly about the blood-vessels. This process is doubtless partly responsible, associated as it is with compression and atrophy of the parenchymatous portions of the tissues, for certain permanent defects which may follow the disease.

There are few diseases, indeed, which are more strictly localized to any one anatomical system than epidemic cerebro-spinal meningitis. In it we have one of the most straightforward and pure involvements of the central nervous system, but I am very sure that none of us begrudge the neurologists undisputed sway in the unsatisfactory management of these cases and their pitiable complications.

One of the most striking and significant facts in regard to the pathological anatomy of the disease is the great rarity with which metastatic abscesses arise even in the substance of the brain itself; this, even though septicæmia has been shown to be a common condition. The special affinity of the meningococcus for the neural membranes as a site for pyogenic processes is one of the most striking characteristics of the disease.

Clinically we find the complications arising from the general viscera, except as secondary to alterations in the nervous system, to be few and usually relatively inconsequential. Unlike in general infectious processes, or even most localized infections, the lymph nodes and the spleen are usually not enlarged. Universal hyperæmia is

ordinarily not present, and the general viscera are commonly found postmortem in a relatively normal condition, except that the kidneys often exhibit a mild grade of parenchymatous nephritis; otherwise general visceral disease is almost unknown in uncomplicated cerebro-spinal meningitis.

The entire course of cerebro-spinal meningitis may extend over but a few hours; cases of but twenty-four to seventy-two hours' duration from initial symptoms to death are by no means uncommon. The average case, however, lasts from a week to ten or twelve days. My experience has been mainly with adults, but I understand that with children the average course is often somewhat longer. As a chronic process it may last for months; the longest case with which I have personally dealt, in which active symptoms persisted throughout, had a duration of eighteen months.

Where healing takes place, the result which follows naturally is largely or entirely dependent on the amount of exudate present, its location and the manner with which it is absorbed. In case the exudate, for example, over the motor cortex, is abundant and absorption does not follow, more or less softening of the subjacent cortex must ensue and the result is naturally the more or less complete obliteration of the function of that area. As a rule, when life is sustained sufficiently long, absorption of the direct cerebral or cord exudate takes place fairly well, and the chief lesions of a permanent character are more apt to result from the invasion of the nerve trunks with the following interstitial and parenchymatous neuritis.

Compression of the spinal cord from replacement of the exudate by granulation tissue, originating from the membranes of the cord, may give rise to later spastic contractures with secondary ascending and descending degenerations in the spinal tracts; in short, any lesion or deformity which may arise from cortical destruction, from degeneration of the cranial or spinal nerves or ganglia, or from the compression of the cortex of the brain or cord may follow the disease. In fact, in a very considerable number of cases recovery with its attendant deformities and crippling is rather to be dreaded than hoped for.

Prognosis as to death or recovery is a difficult matter, since relapses with extension of the process are very prone to follow in any stage of the disease. Prognosis as to the amount of disability apt to follow healing is absolutely impossible in most cases, until recovery is well advanced; even then relapses with new outbreaks of inflammation, perhaps with a new mixed infection, are apt to entirely modify the ultimate result. The prognosis as to recovery should always then be extremely guarded, even in the most favorable cases, while absolutely no definite promises as to freedom from crippling or deformities should be made until the case is free from fever and indications of cortical pressure have entirely disappeared.

More and more attention is now being paid to the prophylaxis of the disease, and, thanks largely to the work of Dr. Darlington, of the New York City Board of Health, knowledge as to the necessary measures to prevent the inception and spread of the disease has become commonly disseminated throughout the city. Light, air and other ordinary hygienic measures undoubtedly go far toward preventing the development or dissemination of the disease. There can now be no question but that cases should be promptly and efficiently isolated, and from the frequency with which physicians, nurses and others in close contact with the sick have developed the disease, it becomes important to realize that those in charge of cases should have short hours, sufficient rest, and should spend at least a certain time each day in the open air and sunshine. In addition, it is now thought by many physicians that special attention to the nasal mucous membrane should be insisted upon, and for this reason various nasal sprays, douches and applications are advised, perhaps not so much with an idea of antiseptics as to the relief of mechanical inflammation and a simple cleansing of the nasal mucosa, through which we feel reasonably certain that primary infection occurs.

In considering the treatment of epidemic cerebro-spinal meningitis, I believe that it is well for us to admit at once that treatment is most unsatisfactory, and in my opinion most recoveries are due not so much to the efficiency of the measures employed as to the natural resistance of the particular person, and, most important of all, the low virulence of the infection, which characterized certain epidemics and cases.

As a rule, the patient does not come under the care of a physician, particularly in hospital cases, until the meningeal exudate is well formed. Any one familiar with the appearance of this exudate must indeed be of the most sanguine temperament, if he hope to always remove it through the agency of medicaments; nevertheless, cases are not uncommonly checked, held in abeyance, or actually cured in the early stages by efficient and prompt treatment. In regard to the measures to be employed in this stage of the disease, I do not think that anything compares with the early and continuous use of the ice bag, applied to both the head and to the spinal column. Ergot, on theoretical grounds, should also be efficient in this stage before the exudate has become developed, and several observers speak most favorably of it. Read in Uphams study, published in 1874, recommends it most highly, though I understand that it has been acclaimed as a recent therapeutic discovery. Of course, one must not be satisfied with those measures alone, and attention must particularly be paid to support of the circulation, nourishment and to the symptomatic treatment.

It is ordinarily necessary to employ sedatives, especially in the early stages, and bromides, chloral, phenacetine, codeine and morphia are

used for these purposes at least with comfort to the patient.

The use of diphtheria antitoxine has, I think, been pretty thoroughly discredited. Theoretically it has never had a leg to stand on, and since the more recent and careful clinical studies, particularly the convincing report of Holt, have been published, I think that it is now quite unnecessary for us to waste time in its consideration.

Hope as to the development of a specific antiserum has received but little encouragement, and though certain agglutinative bodies are formed in the blood of infected subjects, no definite toxine or antitoxine has yet been demonstrated, and it seems very doubtful if any such exists.

The great benefit derived, even though it be but temporary, from lumbar puncture and the removal of more or less cerebro-spinal fluid is one of the most startling chapters in the therapeutics of the disease. As a rule, the removal of fluid by this means gives more or less immediate symptomatic benefit. Somnolence, coma or delirium diminishes and may completely disappear, the contractures, opisthotonus and convulsions may clear up and the general appearance of the case markedly improve. Unfortunately, however, these improvements appear to be short-lived, and within a few hours, as a rule, the condition becomes as bad as before. A repetition of the operation usually again affords benefit, and this may be repeated indefinitely, but I have never yet seen a case in which I felt that the ultimate outcome was materially influenced by this treatment. We are, therefore, forced to conclude that in the ordinary case the relief furnished by lumbar puncture is but temporary, and that its benefits lie solely in the relief of pressure through diminution in the amount of cerebro-spinal fluid, and that no change is to be expected after its employment in the actual meningeal exudate. Just a word of caution in regard to lumbar puncture: In by far the larger number of cases even great amounts of fluid may be removed by this method without danger, and unless extreme carelessness be present, practically no injury to the cord or danger of mixed infection exists; nevertheless, if the fluid be allowed to escape too rapidly, or if large amounts be removed at one sitting, immediate collapse and death may follow, probably from sudden relief of medullary pressure. I have seen two cases in which this apparently took place, and I think that it should be generally known that the operation is not absolutely without danger.

The surgical relief of pressure by trephining the skull and by puncture and drainage of the ventricles has been attempted in some cases; naturally, the reports vary as to results, but in general I believe that they are not more favorable or unfavorable than in those cases which remain practically untreated. There can be no doubt but that this means furnishes a more permanent relief of pressure than lumbar puncture, but as to the hope of removal of the cortical purulent exudate by such means, I think that an inspection of the

character of the pus as we see it on the autopsy table will convince the most hopeful operator of the uselessness of such measures, particularly since the meningeal pus does not gravitate, but on account of its highly fibrinous nature, remains firmly attached to cortex and membrane, and, as stated, is usually found most abundant over the uppermost part of the brain. In chronic cases, particularly where a submeningeal abscess is suspected, the method is, of course, along lines of well-established surgical procedure.

In the general care of the patients, it should be remembered that as in other instances of pressure on the brain and cord and in degeneration of sensory fibers, that the skin is particularly prone to break down, and consequently hot-water bottles, rubbing and like measures should be carefully watched, for bad ulcers of the skin are very apt to follow even the application of moderate heat and the resulting lesion presents all the characteristics of the familiar bed sore of chronic cases of brain and cord disease.

In conclusion, it then seems that in the management of cerebro-spinal meningitis of the epidemic form our greatest hope lies in the limitation of the epidemic and in the treatment of the early prodromal stages. Our efforts must be directed toward the prevention of meningeal exudation, and when this has become well established, little beside general supportive measures are possible, except such purely symptomatic treatment as is afforded by lumbar puncture and the use of well-chosen hypnotics and stimulants.

In the chronic cases, or during recovery, our most reliable drug appears to be iodide of potassium, associated, of course, with proper dietetic and general measures. Massage, the use of electricity and the various measures of hydrotherapy sometimes relieve the deformities and crippling which follow in a very considerable number of cases.

ACUTE INTESTINAL INTUSSUSCEPTION.¹

BY DOUGLAS C. MORIARTA, M.D.,
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WHEN your president invited me to prepare a paper on some surgical subject for the meeting to-day, I was at a loss for a subject that I thought would be interesting and provoke discussion, and I still have my doubts concerning my choice. As my cases of intestinal intussusception have been unsatisfactory, I have decided to review the embarrassing phase of the subject—*i. e.*, the 100 per cent. fatality. I trust the conclusions drawn from this experience may invite discussion.

This condition has not been a common one in my practice. I have had only four cases in twenty years, and, unfortunately, four fatalities. In looking back to these cases I am sure that the outcome could not have been changed in three of them, as it was too late when they came under my

¹Read before the Saratoga County Medical Association, March 28, 1905.

observation. The fourth case, however, should have been saved, but was sacrificed because of my own indecision and the advice of eminent counsel.

If there ever was a fallacy or an ill-advised treatment for any disease, it is procrastination incident to following an expectant line of treatment in intestinal intussusception. Many general practitioners, particularly the older ones, are familiar with the teaching that this condition is relieved, either by the invagination slipping out, or by necrosis when the invaginated portion sloughs off, terminating in a cure. That either of these conditions could not occur I do not propose discussing. But I do maintain that no one familiar with aseptic surgery of the day should consider an expectant line of treatment for intestinal intussusception, and one can only think of those who advise such treatment as hold-overs from a preantiseptic period, which, after all, is not long ago.

In my judgment it is criminal for the surgeon who has diagnosed intestinal intussusception not to advise immediate operative procedures. At this time one can arrange for, and attempt, the reduction of the intussusception when the patient is under ether, by position or by filling the intestines with either water or gas. Of course, if the condition is not thus relieved, operate at once. This procedure has the same use and value in this disease that taxis has in hernia, and is only justifiable to the same extent, if the patient's life is to be saved. Surgeons who are familiar with the secondary septic condition of the peritoneum following this condition, when relieved, need no argument to convince them of the necessity of prompt surgical interference; but to those who are opposed to operative procedures I would appeal. This latter class of observers are optimistic, and believe Nature can care for herself, either by the invagination slipping out or by its sloughing after adhesions have occurred. While this is a possibility it is not a probability, and no practitioner should sit idly by and allow these patients to develop a secondary septic condition, which is certain to end in dissolution.

Intussusception in the intestine, commencing as a simple form, may become irreducible and yet remain pervious and continue for an indefinite period without developing alarming symptoms, as strangulation has not occurred.

The symptoms of intestinal intussusception are colicky pain in the abdomen, paroxysmal in character and of varying intensity. After inflammation and strangulation have occurred the pain is continuous. The abdomen, at first of natural fulness and soft, becomes distended and hard, while pressure is tolerated early in the disease. Later it becomes sensitive and painful,

due to the inflammation incident to the invagination, which is either localized to the region of the tumor or diffused over the abdomen. Vomiting is continuous, though at intervals, in the early hours of the disease. Later, if inflammatory trouble has developed, the vomiting becomes continuous and is often stercoraceous. The tumor is usually palpable through the abdominal walls; when it is not, a rectal examination should be made, as in this way a tumor low down is frequently made out. There is usually one or more evacuations after intussusception has occurred, which is from the lower bowel, after which constipation ensues, though there may be a small quantity of blood or bloody mucus discharged from the rectum following the tenesmus. Intestinal intussusception should be suspected, and the diagnosis made when the above symptoms are present, though with obstinate constipation, vomiting, paroxysmal pain, extreme tenesmus, accompanied by bloody mucous discharge from the rectum, the diagnosis is certain and calls for surgical interference, whether a tumor is made out in the abdomen or not.

The prognosis in these cases must depend absolutely upon an early diagnosis, followed by a prompt laparotomy. The point I would urge in the treatment of this condition is immediate operative procedures, and not until this is universally accepted will we have a lowered mortality in this disease. I do not care to discuss whether the invagination shall be reduced without intestinal resection, whether we shall do an end-to-end anastomosis, or whether we will have to make an artificial anus. Nor do I purpose taking up the different artificial suggestions for doing these anastomoses or discussing which is the best method of suturing at these times. But I do wish to urge that when in doubt concerning the diagnosis, an anesthetic or even an exploratory laparotomy is demanded and justified if necessary to make the diagnosis. The risk of an early laparotomy is not to be compared with the risk of an expectant line of treatment in this condition. If it needed anything more than your own judgment to decide this point, I would ask you to compare the statistics of these cases in the hands of our best men twenty-five years ago and the statistics of the ordinary men of today. Yet no less a text-book than that of Eichhorst, of the University of Zurich, published in 1901, on the practice of medicine, practically suggests opium, rest and an expectant line of treatment for intestinal intussusception, and mentions surgery as a secondary consideration. How unfortunate that medical authors should not be up to the times surgically!

In some of these cases the intussusception can be reduced, after the abdomen is opened, without resection. The number in which this can be done bears a direct relation to the period

during which this condition has existed, being markedly less successful after the first twenty-four hours. Many of these cases have a multiple intussusception, which should be borne in mind when operating. As I have mentioned, some of the cases of invagination have no strangulation or necrosis, but simply inflammation and adhesions, while others are congested, swollen, strangulated and necrotic, and later they become septic, and peritonitis, either local or general, develops.

The history of the one case that I would emphasize I recognize as incomplete, though characteristic:

J. M., male, aged about five years, a strong, healthy child—practically had never been sick since birth—was awakened Monday night about 10 o'clock with pain in the abdomen and vomiting. The mother knew the child had eaten some peanuts during the day, was not anxious and gave him a dose of oil and an enema to relieve the bowels. The next morning I saw the child about 10 o'clock, with the history as above. In addition there had been a result from the enema, an ordinary stool, with vomiting once or twice during the night. No temperature or apparent constitutional disturbance. I prescribed some tenth-grain calomel tablets, to be followed by citrate of magnesia, and saw the child again in about twelve hours. The next morning, Wednesday, there had been no movement of the bowels, and the child had a very little rise of temperature, had vomited once or twice since the last visit and there had been one small bloody mucous discharge, with some tenesmus.

I requested consultation, and Dr. Comstock saw the case with me and suggested, as I recall it, to repeat the citrate of magnesia. At this time, about forty-eight hours after the onset, the abdomen was soft, tympanitic, though not sensitive, and we could not make out a tumor. There was no result from our efforts, and on Thursday morning the family wanted Dr. Vanderveer to see the child, which he did the same afternoon. The child was not apparently in a critical condition. We were able to map out a tumor on the right side. He had a slight rise of temperature, pulse was accelerated; he had vomited more or less continuously since the onset, and now there was considerable colicky pain, with tenesmus and bloody stools. The doctor concurred in the diagnosis, but declined to operate and thought we should wait until the next day to see the result of our remedies. The next morning, Friday, I saw the little fellow and he was markedly worse, with symptoms of septic peritonitis. I informed the family if the child was to be saved it would be only by immediate operation, and that I thought even that would not be successful. I operated at once, nearly ninety-eight hours after the onset, and found that necrosis had occurred, and that general septic peritonitis was present. An anastomosis was done, but the little fellow only lived a few hours.

THE TREATMENT OF ACUTE OTITIS MEDIA.¹

BY CHARLES S. PAYNE, M.D.,
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THAT we must take care of a diseased organ is one truth, and that we must examine the organ in order to take care of it is another. These two affirmations depend upon good sense; unfortunately, when applied to the ear, good sense ceases to be synonymous with common sense.

In olden time the otitis was not treated. The ignorance of the physicians was in accord, at best, with the prejudices of the patients, so that they calmly waited for the humors of the ear to purify. The present method is different—the ear is cared for. It may be treated badly; dirty dressings of the auditory canal with soothing ointments, warm oils or laudanum are injurious things. Sometimes the progressive physician prescribes profuse injections of boric acid and carbolyzed glycerine into the suffering ear; however, the work is not so perfect but that it might be better.

"But what is it that causes so much anxiety?" some ask. Affections of the ear are, especially in children, only insignificant evils which care for themselves. Such at least is the feeling in certain quarters. What shall we answer? We may say, in the beginning, that it is irrational in our age of technique to treat organs by conjecture. Should a pneumonia be treated without auscultation?

Acute otitis media is too often subject to recurrence and full of danger in the future, like appendicitis. The discharge does not cease; slowly and insidiously it continues in its march to meningitis, which kills, and deafness, which cripples.

The time has come when the hope of treatment of acute otitis media seems to have been realized. Therefore, we undertake to show the necessity of treating acute otitis media. There are two things which demonstrate this necessity: the gravity of the otitis, whether it is untreated or badly treated, and, secondly, the benign character of otitis when properly treated. The benign character of acute otitis media which has been well treated is recognized by the usual absence of complications. Rapid death, indefinite chronicity and remote deafness almost never occur.

We will not take the time to report cases, numerous and easy to find, which support these two propositions. They are to be seen in the case-book of almost every physician.

A knowledge of the pathology of an affection alone can indicate the rational treatment. We know that acute otitis media almost always follows an ascending infection carried to the tympanum by the tube. Pathologic microbes, introduced into the nose by any contagion whatsoever or increased in situ by an attack of cold, spread and multiply in the epipharynx, pass into the tube by the assistance of a violent blowing of the nose, and arrive in the blind alley which

¹Read before the Sullivan County Medical Association, Liberty, N. Y., April 12, 1905.

forms the middle ear. Arrested here, they are installed, some in the tympanum, some in the mastoid antrum, chambers which communicate by a narrow passageway. Very soon they become numerous and attack the mucosa, which, however, has already prepared its defenses. It is congested, swollen and infiltrated with lymphocytes, and if this first reaction is not sufficient, it secretes mucus, and an effusion is established; the tube is closed somewhat later because its mucosa contained in an inextensible tube can only swell so far as its caliber allows. The middle ear then becomes a closed cavity, and retention takes place. On account of this there is pain from pressure on submucous nervous plexus, infection by resorption by the toxic-microbial products, secreted in a region where the tissues are eminently absorbent, and various complications, depending upon the place in which there is an injury to the walls of the middle ear subjected to the progressive pressure. Generally it is the membrana tympani which yields. The symptoms are lightened and the pus flows into the auditory canal, which more or less drains the ear. Nature thus decides to evacuate the exudate, inasmuch as, after some days of waiting, the physician has not decided to do so. But this perforation of the drum is only a fistula with all its complications. Nevertheless, things could happen differently. It might occur that spontaneous perforation of the drum does not take place, either because the exudate is small or because the tube is not so tightly closed that drainage is impossible. But the drum may not yield because it is too resistant, so that the pus must seek another outlet through the thin and often fissured cranial walls.

Text-books divide acute otitis media into (a) catarrhal; (b) exudate; (c) purulent; these are divided into intermediary forms; but we will treat it as a unit.

Since, therefore, knowledge of the pathogenesis of otitis dictates treatment, the danger is in the retention, the safety is in the drainage. The treatment of otitis has nothing in it that can be considered mysterious by the physician. It is expressed thus: *ubi pus, ibi evacua*.

Another thing is equally necessary to conduct the treatment of otitis: knowledge of the local anatomic characteristics.

Two points are to be considered in this regard:

(1) The different compartments of the middle ear, particularly the tympanum and the mastoid antrum, communicate largely with one another. Therefore, there is no means of isolating these chambers under normal conditions, and every microbial invasion in one necessarily affects all. The result is that acute otitis media is essentially formed by the association of an antritis and tympanitis; when there is pus in the anterior, it is also found in the posterior. From an anatomical standpoint, there is no otitis without mastoiditis, and if all the mastoids of those suffering from acute otitis media were trephined, pus might be found. This happens to some surgeons.

Whenever the suppuration is discharged easily into the tympanum by the way of the aditus, there is no mastoid reaction; and the experience of each day teaches that an early opening of the drum in the great majority of cases is sufficient to drain the mastoid.

Likewise it often happens that an opportune paracentesis will abort a mastoiditis of great menace which has already been manifested by external signs.

(2) The middle ear might be said to be only a diverticulum of the superior respiratory tract. An acute otitis media, therefore, is an affection of respiratory tract; and it is not astonishing, therefore, that otitis media should be accompanied by a salpingitis, a pharyngitis and epipharyngitis. We see, then, that it is an error to restrict the treatment especially to the ear. The disease is general and the therapy should be general, making it necessary to treat three different indications:

(1) To treat the ear.

(2) The nose, pharynx and epipharynx.

(3) The general condition.

The local treatment of acute otitis media may be stated as follows: Two indications. Seek to prevent (1) the immediate accidents resulting from exudate; means to employ, evacuation, drainage, imitating nature in this; (2) remote incidents of chronicity, resulting especially from secondary infections; means to employ, antiseptics or (better) strict asepsis, sterilization of the field of operation, instruments and dressings.

We should be radical upon the second point; no concession is possible. Let us remember that the middle ear has two entrances, two ducts, the canal and the tube giving access to the tympanum. Precaution at the tympanic entrance or canal will be of no avail if the tubal entrance is neglected. We should not forget to treat the ear and the epipharynx at the same time. The pivot about which our conduct in the treatment of acute otitis media revolves is the consideration as to the time when we are summoned to take care of the case. Very different will be our manner of treatment, according to whether or not we intervene before spontaneous perforation of the drum, and very different also will be the efficacy of our intervention in the two cases. We are called upon to consider the following: Before perforation we are still masters of the situation; we may by an active, energetic treatment arrest the affection in its course, sometimes even abort it. After perforation we can only submit to the course of events.

How much greater advantage it is for the ear which we treat at the proper time, in the beginning of the disease, than later, when the discharge is established. Therefore, the treatment of the preperforative phase and that of the postperforative phase is absolutely different.

In the preperforative phase the tympanum has not spontaneously perforated. Pain is the dominant symptom, and the primary indication is to

calm it. This pain may be due to a simple inflammation, or to the presence of an exudate with pressure. If the latter is constant it is necessary to incise the tympanic membrane so as to kill two birds with one stone; to relieve the tension in the tympanum, and to prevent the complications which may result from the burrowing of pus or from its continued sojourn in the ear. But otitis does not always present this condition of things. Very often there is only a predominant hyperemia, and opening the tympanum is then entirely useless. The problem to solve, then, is, is there or not an indication for performing a paracentesis of the tympanic membrane? Some otologists solve the question in a very simple manner: "Incise the tympanic membrane by all means. A paracentesis correctly and properly made is harmless. The worst that can happen is that it was unnecessary." There are then two cases to be considered—those in which paracentesis should not be performed and those in which it should be.

(1) Cases in which there is no indication for paracentesis.

When pain in the ear is not continuous, when the acuity of the diseased ear is not materially lessened, when the fever is slight, when cerebral reactions are absent, paracentesis of the tympanic membrane is not necessary, even when it is red and tense.

(a) The middle ear may be acted upon, through the auditory canal, in an immediate manner, and mediately through the periauricular region.

On the one hand the canal may be filled several times a day with warm carbolyzed glycerine, which has the double power of calming the pain and of disinfecting the external ear preparatory to future intervention. Without doubt carbolic acid has an abortive action on non-specific inflammations—for instance, its action on lymphangitis. Carbolic acid is, it is true, very irritant, but glycerine has the power of reducing its caustic action without modifying its qualities. A dilution of one to forty may be used.

On the other hand, an application may be made over the whole periauricular region of gauze compresses, dipped in boiled water and applied as hot as possible, and frequently changed.

(b) On the contrary, the canal should not be made unclean, the drum injured or the tympanum infected. Therefore, we should use no laudanum, no soothing balsams, no sweet oil or oil of sweet almonds in the auditory canal; no injections of boric acid, which, by striking the drum, opposes the general law that every diseased organ should be kept at rest. And we should not use air douches through the nose, which agitate the tympanum and its articulations and in addition force in germs from the epipharynx which could not penetrate for themselves. In the fortunate cases—and they are numerous—the resolution of the otitis is assisted by the application of this mild treatment; in fact, it is accelerated. The clinical sense teaches one when to discontinue this treat-

ment; the hot applications need only to be continued until the pain disappears.

If, on the contrary, these mild therapeutic measures fail, we may, if we have waited long, proceed as in the following without delay:

(2) Cases in which there is an indication for paracentesis of the tympanic membrane. These are divided into three classes:

(a) Pain, provided it is continuous, and, what is more positive, increasing. Thus attacks of transitory otalgia, such as the nocturnal ear cries of children, if they disappear quickly upon awakening the child, are not a formal indication for intervention.

(b) Deafness, provided it is recent and is very marked. An ear previously normal, which does not hear a low voice at a few centimeters' distance, is certainly filled with an abundant exudate, even if there is no pain. Immediate evacuation is called for in order to prevent ear troubles of lasting duration.

(c) It is necessary to intervene especially when there are cerebral symptoms, which occur so promptly in children.

The local indications furnished by the appearance of the drum, while they are certainly useful, are only of second rank in importance. However, a bulging drum, in connection with the preceding symptoms, can only add a new argument to the cause of intervention.

The instrument of choice is a lance-shaped knife, which cannot be too sharp.

The sterilization of the knife is indispensable, and too much precaution cannot be used. Disinfection not only of the canal but also of the vestibule of the ear is an obligatory precaution in order to prevent a secondary infection of the tympanum. The use of soap, washing with water, then alcohol, may easily be practiced in the canal by the aid of a cotton applicator, finally bathing the canal for a few minutes with a 1 to 2,000 solution of bichloride. Anæsthesia of the membrane should always be attempted, though it is not always successful. Nevertheless, the pain is of such a character that it is absolutely necessary to attempt to prevent it. The drum membrane should be thoroughly cleansed of the epithelial mass which covers it and perfectly dried, before the anæsthetic is applied. It is evident that in unmanageable children and in adults that are nervous the local anæsthesia is as painful nearly as the paracentesis itself. In these cases general anæsthesia should be used.

The incision should be made in the region of the drum that is always dependent, whether the patient be standing or lying down; that is to say, in the posterior-inferior quadrant, or the anterior-inferior quadrant. After thoroughly cleansing the canal of the pus and blood, a piece of sterilized gauze of fine mesh should be loosely applied through the length of the canal for drainage purposes without obstructing it, and a cotton compress should cover the auricle sufficiently thick to prevent the pus passing through it, and with

several turns of the bandage, fix the dressing around the head.

As an abscess is evacuated when it is well opened, so the middle ear should be emptied of pus, which is the case when a paracentesis is properly made. When the incision is once made, there is but one thing more to do—to provide for the drainage down from the tympanic orifice, but to provide for it in a proper way. However, such attention cannot be confided to the patient or his family. Those who, after the incision is made, prescribe instillations, douches and frequent injections, which by reason of repetition can only be given by unclean hands, are responsible for much damage to the tympanum, for it is repeatedly infected and thus prolongs the discharge until it becomes chronic.

Is it to be supposed that a surgeon, after having incised a phlegmon, would permit the husband or maid to introduce every two or three hours into the abscess cavity divers fluids differing chemically, but invariably septic? It would be better to make the dressings less often than to have the dressings dirty. On the other hand, the less one touches the wound the more rapidly will it be cured; the less one disturbs an ear upon which a paracentesis has been made, the quicker it will become dry. In the postperforative phase of this condition, we must put this question to ourselves: "Is the spontaneous perforation sufficient or not to drain the middle ear?"

(1) The signs that it is sufficient deal first of all with the general state. Absence of fever, cessation of malaise, the local condition, the permanent disappearance of the otalgia, all indicate that drainage is good.

(2) The signs of an insufficient perforation are simply the opposite of the above. If the spontaneous perforation is sufficient, and everything is getting along all right, it is sufficient to treat the ear exactly as after a paracentesis. If insufficient, it should at once be enlarged with a knife, or, if necessary, a curette is used to remove the endotympanic mass which acts as a plug.

In the treatment of the nose and pharynx, I would say that before, during, and especially after, acute otitis media, the tubal entrance to the middle ear should be protected from infection, even more than the tympanic entrance. The naso-pharyngeal treatment certainly acts more as a prophylaxis than as a cure of the otitis. Nevertheless, we often see suppurations of the ear stop from the time that the nose and naso-pharynx are cleansed, and infants who seem to have a discharge from the ears are frequently simply "blowing their noses" through the auditory meatus. Therefore, during the otitis, precautions should be taken to prevent ascending tubal infections. (a) Above all, compel the patient to blow his nose correctly, alternating through each nostril. (b) Assure relative asepsis by injecting into the patient's nose, with a medicine dropper, some sterilized mentholated liquid vaseline, or in adults a spray of mentholated water may be

used. (c) Maintain health of the mouth and pharynx by frequent cleansing with some mild antiseptic solution. Later, much later, after the acute symptoms have all subsided, prophylactic operations should be performed on the nasal and pharyngeal regions. In rare cases it may be necessary to perform an adenectomy during the otitis, in order to cut short a discharge kept up by the cavum.

Nevertheless, one cannot be too careful in this respect, so great is the risk of complication, hemorrhage and mixed infection following an intervention made during the acute stage on a cavum full of pus, and in a bad phagocytic condition.

As to the general treatment, in all cases of acute otitis media, however slight the symptoms, the patient should cease from his daily occupation and undergo severe hygiene. Every febrile inflammation of the air passages, acute otitis or bronchitis, demands rest at home, at least during the first few days. If the child has fever, it should be kept in bed. For cold of the ear there should be done what is done for colds of the lungs. Relative diet, movement of bowels, pleasant surroundings are routine prescriptions, but useful.

It is sometimes good to prescribe soothing medicines, which give sleep to the patient at night; antipyrin, and especially chloral, are advised, but not opium, which congests the head and causes a return of the pain on awakening. This must be done without interfering with the local treatment, which alone gives the true relief.

THE NEED OF SEXUAL EDUCATION.¹

BY EDWARD L. KEYES, JR., M.D.,
New York City.

A FEW weeks ago I had the pleasure of listening to a discussion of the ways and means of preventing certain diseases, and toward the end of the evening a clerical gentleman, the pastor of many souls, arose, and with every intention, I believe, of rendering the medical profession a sincere compliment, told us that if we would only busy ourselves about the prevention of other diseases as well as those under discussion, there would soon be no diseases left. He evidently thought that the idea of prevention of disease was then and there for the first time seeing the light, and he wished to hurry along and help warm the baby.

Such is the ignorance of enlightened men. Such, I venture to state, is the ignorance of you and me upon the present trend of theological opinion; but God forbid us the temerity to exhibit that ignorance in public.

But, on the other hand, you know a great deal about preventive medicine. Doubtless many of you can recite the names and deeds of the prophylactic hierarchy from Jenner down to Reed much better than I can. Yet I have come here to-night to enlighten some of you, to encourage all of

¹Read before the New York County Medical Association, New York, May 15, 1905.

you to lend a helping hand in the youngest branch of the young science of prophylaxis. I appeal for the prophylaxis of venereal disease.

Inasmuch as this subject must be entirely new to a great number among you, I take the liberty of treating the elements of the question, with due apology to those who already know.

In the first place, let me assure you of the importance of the venereal peril. On syphilis I need scarcely insist, for you surely appreciate not only the lesions of bone and brain produced by that disease, but also the tragic horror which so often afflicts the patient who is told—as he must be told—that he never can be absolutely and infallibly assured that his disease is ended. Yet the frequency of syphilis perhaps you do not all appreciate. What has impressed me most is, not the statistics that tell how one in ten New Yorkers, or one in four unmarried males aged 30 in Berlin, is syphilitic. Such estimates are large and vague and doubtless inaccurate; they do not grip one. But consider rather the fact that very many of our more aristocratic patients acquire their disease from what one might term an unimpeachable source. Tell them they have chancere, and they retort, "It is impossible." They do not deny sexual contact, but they do deny the possibility of contamination from so unsullied a source. They would deny that one who is kind to two may be generous to twenty; they maintain an exception to the law that "No woman, however beautiful, can give what she has not got."

Such fatuousness may make you smile, gentlemen; but 'tis no joke for a' that.

Another proof, perhaps even more forceful, of the frequency of syphilis has been often called to my attention by my associate, Dr. Chetwood. It is his custom to read the riot act to those casual youths who return again and again suffering from gonorrhoea, telling them: "Young man, if you keep on, in less than three years you will be back here with syphilis!" And, sure enough, in the great majority of cases, three years do not roll by ere they prove the prophecy correct.

From these facts one may conclude that illicit intercourse is never safe from the danger of syphilis, while promiscuity invites it almost to a certainty.

But gonorrhoea is the rock upon which we split. Its frequency we all admit, but its importance—its great importance—as a destroyer of health and home is not appreciated as it should be. But to discuss this subject, which has been often and ably discussed already, would lead us too far afield. Let us only paraphrase the saying of Ricord: "A clap begins and God only knows when and where it will end."

They wreck many lives, do these venereal diseases. Think of the tabetics in our streets, the paretics in our asylums, the dead or disfigured children; think of the laparotomies for pus tube that occur daily in our hospitals; think of the impotence, the sterility, the sexual neurasthenia that fill our offices with vagrants wandering from

physician to quack and back again in the vain hope of a cure!

Think of all this, and tell me why this suffering, why these loathsome diseases. The answer is easy: because of promiscuous sexual congress. And why promiscuous sexual congress? Listen well to the answer, for I expect many of you to disagree with me. I suppose many of you believe in your hearts that old, old fable about the adult male needing intercourse for his health. Indeed, I fear that many of you are listening with cynicism in your hearts; that you are thinking, "Oh, well, it's largely a matter of taste; some prefer one way and some another; those who don't have intercourse probably do worse." Well, gentlemen, that's true. It's perfectly true; but it ought not to be true. I wish you had heard all the discussion on the subject the other night. But since you have not, I commend to you for my present purpose a paper, entitled "The Sexual Necessity," which will soon appear in the *Medical News*.

But I haven't answered my own question yet. I haven't told you what I consider the reason for promiscuous sexual intercourse. It is habit; just the same sort of habit as smoking or drinking; a habit, tolerated if not encouraged; a habit, like smoking or drinking, though far easier to begin and far harder to break.

Just stop and ask yourselves what prompts a boy to his first illicit intercourse. Let us suppose, of course, that he has not grown up in the habit; that he has escaped seduction by nursemaids, and has not been taught to masturbate by his companions until, reaching the years of discretion, somewhere between the ages of 15 and 20, he "goes out with the boys." Why does he do it? Why does he take the first step in a habit which may last his whole life long? Often enough because he is just drunk enough to follow where others lead; oftener still because he is afraid to refuse, because he thinks it's manly, because he knows the other fellows do; rarely, very rarely, I believe, does a young man open his sexual life in this way solely under the impulse of his passions. The sexual impulse, be it ever so strong, is like the impulse of the drunkard—feeble enough so long as he has never touched his liquor; but let him once get the taste in his mouth, let him run his lips warm and wet along the edge of the glass, let him smell the aroma *after* he has acquired the taste—ah, there is passion full-blown, if you will!

And just here is where practice grapples theory. Can't we get at that young man to prevent his initial debauch? Perhaps yes; perhaps no. I am not at all sure but that, if every boy in this world were given the best possible chance of avoiding venereal disease, more than half of them might not go ahead and get infected anyhow. But the point is, they don't get the chance; your boys don't get the chance; you yourselves didn't get the chance when you were boys. Just hark back and call to mind how sexual matters were first

explained to you. For my part, I can well remember the pair of rabbits that constituted the physiologic clinic upon which my young instructors lectured.

And all those smutty tales, magnified by the groping imagination of youth! What a distorting, debasing influence they have! How they prepare the mind to take a low, vulgar, shameless view of the sexual life that is just dawning!

And to these influences we oppose what? Absolutely nothing. We read our boy the Ten Commandments, and he nudges his companion and chuckles as we reach the sixth—aye, even delves into the Bible for those passages, the memory of which is handed down among the boys from generation to generation. But we endeavor to forget the seriousness of these things when we grow up. We make no effort to keep our own boys out of the same old, muddy rut.

But, if you ask me to quit this theorizing, to come down to hard facts, to tell you how to approach the boy, how to get him into a clean way of thinking, I must confess I do not fully know. A lot of disconnected points I have picked up. I know that you can't teach a boy morals out of a book—he will take it into a corner and make fun of it with his friends; you can't teach him out of the mouth of a woman, his innate sense of decency rebels at that; you can't lie to him, he will find you out; you can't scare him much—he won't stay scared. On the other hand, there are a lot of things you can do. You can appeal to his manliness, to his inborn sense of decency; even, in some cases, to his sense of physical cleanliness or of religion. But the appeal must reach him with authority and with dignity. It must be directed, as much as possible, to that particular boy rather than to boys in general.

These are vague points that I allude to. In some of them I may be mistaken. Indeed, I am only the veriest student of these matters. I have been thinking them over seriously only since I became interested in the Society of Moral and Social Prophylaxis. And the more I study the matter, the more it appeals to me—the more real, practical good I can see will come out of it.

I have covered only one side of the vast subject which the Society of Moral and Social Prophylaxis aims to attack. Its object is to clear up ignorance of every shade, the ignorance of the prostitute who thinks the way to rid herself of venereal disease is by intercourse with a virgin, as well as the ignorance of the young lad who knows not how to interpret the first stirrings of sexual life; the ignorance of the man who thinks he can marry within one year of his chancre, as well as the ignorance of the boy who looks forward to his first gonorrhoea as the portal to true manhood.

The time is ripe for these things. Twenty years ago the discussion of matters sexual was too filthy for a medical society; to-day even the laity can take part in such discussions with an in-

telligent, clean interest; the clergy of every denomination are in sympathy with the movement. But it is for the medical profession to take the lead. Without you to keep the Society correct in its physiology and in its psychology, it could not discuss correctly the straight path of its best endeavor. That is why Dr. Morrow and I are here to-night, to enlighten you a little, to interest you much in a work rather moral than medical, in a work which, if energetically conducted, cannot fail to produce great good in the souls as well as the bodies of our fellow men.

Perhaps some of you are still skeptical. You think the old Adam will be too strong for us. Indeed, I confess to such skepticism, in some degree, myself. I have no idea that the Society of Social and Moral Prophylaxis, or any other society, will turn us out a race of passionless seraphs. But I do believe, with all my soul, that we are not giving our children or our fellows a fair share of the enlightenment which we possess, or ought to possess. They have a right to freedom and all means necessary to its attainment; they have a right to virtue and health and all means necessary to their attainment. The practical difficulties in the way of imparting this necessary knowledge in such a way as to produce a good moral effect are great, but not insuperable. And to present the evidence is about all we can do. Then, if the man wills with his eyes open to go the old evil way, he will, at least, have had an opportunity for enlightened choice not afforded by our present system.

The results of such a propaganda will be slow to show themselves; of that we may be sure. Perhaps the Society for Social and Moral Prophylaxis itself may wither under public indifference or contempt before its mission is fulfilled. But its spirit will not die. The rumor must spread; it must interest brother and son as well as mother and wife, prelate, and physician, and father of family. I cannot doubt that, in the end, it will produce a marvelous change in public spirit, that, as it was the triumph of the eighteenth century to make seduction unfashionable and of the nineteenth to make drunkenness unfashionable, so it may be the glory of the twentieth to make the law of public opinion the same for man as for woman.

I think that all of us laymen, men and women, have a peculiar appreciation of what a doctor means, for I do not suppose there is one of us who does not feel that the family doctor stands in a position of close intimacy, in a position of obligation under which one is happy to rest to an extent that hardly any one else can stand, and those of us—I think most of us—who are fortunate enough to have a family doctor who is a beloved and intimate friend, realize that there can be few closer ties of intimacy and affection in the world.

—THEODORE ROOSEVELT.

**A DISLOCATION OF THE FOOT BACKWARD,
WITHOUT FRACTURE OF THE BONES
OR RUPTURE OF THE LIGAMENTS,
WHICH IS IRREDUCIBLE.¹**

BY GUY CARLETON BAYLEY, M.D.,
Poughkeepsie, N. Y.

THE patient whose misfortune was my opportunity was Emil Holmes, aet. 30; native of Norway; a farm hand, strong and healthy. He was admitted to Vassar Hospital February 2, 1903. Diagnosis, dislocation of foot backward. History: On November 20, 1902, while attempting to separate two men who were fighting, one of them kicked him on the instep

placed under the leg. This was done to take the tension off the gastrocnemius and soleus muscles. Strong extension was made by two men with a strip of unbleached muslin around the heel and instep; reduction attempted, failed. February 10th, under ether, with Drs. Tuthill and Poucher in consultation, reduction attempted, failed. Dr. William T. Bull being the consulting surgeon of the staff residing in New York City, he was written to about the case, and asked to see the case in consultation. In his reply accepting he suggested that probably the only thing to do would be to open the joint and remove the head of the astragalus.



while his foot was suspended in the air. Two doctors had made various attempts to reduce the dislocation, but had failed.

Examination: Foot slightly everted, toe pointing downward; unable to get heel to the floor. No pain, except when weight of body is put on the toes, when pain is intense in the ankle. No heat or swelling. X-ray showed dislocation of the foot backward. February 3, 1903, patient taken to operating room, etherized fully, attempted reduction, while two men made extension and counter extension. Attempt failed.

February 7th, taken to operating room, etherized deeply, patient laid on the floor and a box

On February 23d Dr. Bull, in consultation, satisfied himself that the dislocation could not be reduced, and agreed with me that cutting the tendo Achillis and putting the foot in plaster, with the foot forcibly put at a right angle to the leg, might give a better result than the major operation of opening the joint, which could be done later if found necessary. I then cut the tendo Achillis subcutaneously, and applied a plaster dressing, the foot being held in place carefully until the plaster dried. On March 3d the patient was allowed to walk about the ward, the heel coming on the floor nicely and the patient having no pain. On April 2d the plaster was removed, and the man walked freely with no pain, and about as much disability as is ordinarily seen in a case where the arch of the instep has given way,

¹Read before the Fifth District Branch of The New York State Medical Association, at the Twenty-first Annual Meeting, at Poughkeepsie, N. Y., May 2, 1905.

and no more. The X-ray examination showed the dislocation unreduced.

The man has reported since that he is working as usual, perfectly satisfied with the condition of his ankle, which gives him no pain or inconvenience.

SECOND CASE.

Isabel Frazier (colored), aet. 65; native of U. S.; a heavy woman; general health good. On December 25, 1904, fell from the porch of her house, striking her foot. The foot shortened, the heel lengthened, much swelling, great tenderness, skin much blistered from tension.

X-ray shows complete dislocation of the foot backward, with fracture of tibia and rupture of ligaments. December 27th, under ether, the frac-

ary 10, 1905, fell from ladder, striking on his foot, and injured ankle. Examination: Heel raised, toe pointing downward, ankle swollen, tender and painful. X-ray examination showed dislocation backward, no fracture, probable rupture of ligaments, slight rotation of astragalus outward. January 12th, under ether, dislocation easily reduced, Day's splints applied, progress uneventful. February 2d, splints removed, ankle found strong, free from pain or swelling. February 6th, patient walking about ward with crutches. February 8th, walks without cane, and with no inconvenience. X-ray shows joint in normal condition.

Being baffled in my first effort to reduce the dislocation in Case 1, I turned to the books, and



ture and the dislocation were reduced easily. Day's splints were applied. X-ray taken December 29th shows fracture and joint in excellent position. Patient very restless, moving foot about continually in the bed. January 24, 1905, the splints were removed, union firm, ankle joint movable, blistered skin dressed with benzoated oxide of zinc. February 15th, patient walking about. February 25th, patient discharged; has no pain or swelling, with good motion in the ankle joint.

THIRD CASE.

George F. Skinner, aet. 75; Native of U. S.; remarkably well preserved and healthy. On Janu-

ary 10, 1905, fell from ladder, striking on his foot, and injured ankle. Examination: Heel raised, toe pointing downward, ankle swollen, tender and painful. X-ray examination showed dislocation backward, no fracture, probable rupture of ligaments, slight rotation of astragalus outward. January 12th, under ether, dislocation easily reduced, Day's splints applied, progress uneventful. February 2d, splints removed, ankle found strong, free from pain or swelling. February 6th, patient walking about ward with crutches. February 8th, walks without cane, and with no inconvenience. X-ray shows joint in normal condition.

Being baffled in my first effort to reduce the dislocation in Case 1, I turned to the books, and

was surprised to find how little was said about what seemed to be an important matter. The leading practitioners of surgery, the teachers, and even those who have made a specialty of fractures and dislocations, only mention the four dislocations in their direction—outward, inward, backward and forward—in all my search I found no account of a case similar to the first one mentioned. In fact, Gross, in his "System of Surgery," says: After a very careful examination of the records of surgery I find that the simple displacement of this bone in any direction is an occurrence of such extreme infrequency as hardly to deserve mention. He had evidently never

seen a case. Sir Astley Cooper had seen but one case of dislocation of the foot backward. Thomas Bryant, Mr. Cock, in Guy's Hospital Reports, had each seen but one case of the backward dislocation, and they mention their cases chiefly on account of the difficulty they experienced in keeping the parts in place after an easy reduction.

Edmund Andrews, in "Ashhurst's Encyclopædia of Surgery," devotes some space to the difficulty of retaining the parts in position. He quotes Professor Jarjavay, of Paris, who demonstrated that this difficulty of retention was caused by the fracture of the posterior rim of the articulation, leaving the lower end of the tibia a single inclined plane working on the smoothly rounded astragalus; the muscular action invariably causes recurrence of the displacement when extension is removed. He makes no mention of the uncomplicated cases of dislocation, or of the difficulties of reduction.

Stimson, the best of the later authorities on dislocations, says: In dislocation of the foot backward the astragalus, and with it the foot, is displaced backward to a variable distance, with rupture of the lateral ligaments and sometimes of other parts of the capsule, and sometimes with fracture of one or both malleoli and of the posterior edge of the lower articular surface of the tibia. Examples of pure primary dislocations are rare. Malgaigne could find only eighteen reported cases, but partial and perhaps complete dislocations occurring as a secondary result of rupture of the lateral ligaments or fracture of the fibula and internal malleolus, as in fracture by eversion of the ankle, are frequent. Reduction has always been easily obtained, etc. Hamilton, on "Fractures and Dislocations," gives the pathological anatomy of dislocations of the lower end of the tibia forward as follows: The displacement may be very slight, so that the end of the tibia is only a little advanced upon the astragalus; or it may be such that the tibia rests one-half upon the naviculare and one-half upon the astragalus, or it may even desert the astragalus entirely. The fibula may at the same time be broken at any point, but is generally broken two or three inches above its lower extremity. The malleolus internus is also sometimes broken, but more often the internal lateral ligament is torn. Still more rarely a fracture occurs through the posterior margin of the articular surface of the tibia.

W. F. Clark, in his "Manual of the Practice of Surgery," says: These injuries can hardly occur without fracture of one or both malleoli. Not infrequently it will be found impossible, after all, to bring the bone back to its place. In such a case the bone may be excised at once, or left to itself.

Erichsen, in his "Science and Art of Surgery," says: In the dislocation of the foot backward, the deltoid ligament is ruptured, the fibula broken in the usual place. In these cases traction on the foot in the proper direction will readily be attended by replacement of the bones. In this little country hospital in two years we have had three

cases of dislocation of the foot backward, and a fourth complicated by a rotation of the astragalus on its own axis. And yet some of the most prominent surgeons of their day have seen but one case of dislocation of the foot backward, in all their lifetime, and none have seen or described a case similar to the first detailed.

In backward dislocation of the foot I would note four conditions in the order of their frequency. A complete dislocation with fracture of bone and rupture of ligaments, easily reduced and kept in place.

Dislocation with fracture of posterior edge of articulating surface of the tibia, and rupture of ligaments, easily reduced and difficult to keep in place.

Dislocation without fracture, with rupture of ligaments, easily reduced and retained.

Dislocation without fracture or rupture, impossible of reduction.

In presenting these cases of the three conditions, I only regret that I could not report a case of the fourth, a fracture of the articulating surface of the tibia with difficulty of retention.

I believe that this difficulty could be overcome by the use of plaster, and we should not be placed in the position of Malgaigne, whose patient died of gangrene of the parts, caused by the means used to keep the dislocated joint in position.

UNILATERAL AND OTHER UNUSUAL FORMS OF NYSTAGMUS.*

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TRUE nystagmus is almost always a remarkably symmetrical affection, the vibratory movements being simultaneous, parallel, and equal in the two eyes. The following forms occur as rare exceptions:

1. *Disjunctive Nystagmus*.—The two eyes move, not in parallel directions, but alternately toward and away from each other. The movements are symmetrical and equal in the two eyes.

2. *Dissociated Nystagmus*.—The movements of the two eyes are unsymmetrical and unrelated, one either moving much faster and further than the other or moving in a totally different way.

3. *Unilateral Nystagmus*.—This is evidently only a variety of Form 2, into which, indeed, it often passes.

Mention may also be made of *circumduction nystagmus*, not so much because it is necessarily aberrant as because it is extremely rare.

CIRCUMDUCTION NYSTAGMUS.

In circumduction nystagmus the center of each cornea moves rapidly round and round in a circular or elliptical path. It obviously differs from a rotary nystagmus, in which the cornea rotates about its center, the latter remaining fixed.

Circumduction nystagmus is evidently a complex form of mixed nystagmus. In ordinary mixed nystagmus two kinds of oscillation occur

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simultaneously—*i. e.*, a horizontal vibration occurs simultaneously with a rotary one, a horizontal simultaneously with a vertical one, etc. In circumduction nystagmus, horizontal, vertical, and possibly also rotary, vibrations occur in rapid succession, causing the eye to describe a path which is at first horizontal, then oblique, then vertical, then horizontal again.

Circumduction nystagmus occurs in miners' nystagmus (Graefe⁴) and in spasmus nutans (Thompson⁹; in 1 case out of 20 noted by Spicer¹⁰). Thompson, indeed, thought that all rotary oscillations of the eyeball in spasmus nutans have the character of a circumduction nystagmus, but Spicer's statistics disprove this.

DISJUNCTIVE NYSTAGMUS.

In one form of disjunctive nystagmus the two eyeballs alternately and rhythmically converge and diverge. This occurs in spasmus nutans (in 2 out of 20 cases, according to Spicer¹⁰). Thompson,⁹ indeed, thought that this form of nystagmus, in which the eyes alternately approach and separate, is the only sort of lateral oscillation occurring in spasmus nutans, and that true horizontal nystagmus is not found in that disease. This, as Spicer shows, is an error. Spicer, in fact, found 6 cases of spasmus nutans with a pure horizontal nystagmus, and in the 2 which showed the disjunctive (converging) nystagmus there was also a horizontal nystagmus, the short, rapid oscillations of which were replaced from time to time by the slower, converging and diverging movements.

This form of disjunctive nystagmus, in which the eyes alternately and spasmodically converge and diverge, may also develop in adults in consequence of excessive eye-strain, as in a case observed by Eversbusch.¹⁷ It may be added that Uhthoff¹⁸ did not see a single instance of it in 150 cases of multiple sclerosis, 12 per cent. of which showed true nystagmus.

Very rarely a disjunctive nystagmus can be evoked in animals by electric stimulation of the brain (Topolanski⁴).

Circumduction nystagmus may be disjunctive, as in the case of miners' nystagmus reported by Graefe,⁸ in which the two eyes traveled in elliptical paths, but in opposite directions.

The other possible form of disjunctive movement is a convergent or divergent rotary nystagmus. The following case, in which the two eyes made turning movements toward each other ("bowing" movements), is an instance of the sort, and seems to be unique. In rotary nystagmus, as we ordinarily see it, both eyes simultaneously turn clockwise or both turn in the opposite way. In this case, while the right eye was turning clockwise, the left was turning in the reverse direction.

CASE 1. *Disjunctive (Convergent Rotary) Nystagmus.*

Alwin H., aged 5; right convergent squint of several lines: seems to fix imperfectly with the right eye. Intermittent rotary nystagmus of both eyes, the oscillations in both being

from the temples toward the nose (convergent rotation); makes more or less constant horizontal shaking movements of the head.

Under atropine shows: R + 1.75 + 0.75 cyl. 90°, L + 3.00 + 1.25 cyl. 75°.

Glasses were prescribed, and with the glasses nystagmus and shaking movements of the head were very much less than before, although squint was not lessened. Nystagmus, when present, always showed the same relations, *viz.*: a convergent rotary oscillation of both eyes. This was well demonstrated by holding a 20° prism with the base out, a little way in front of one of the patient's eyes, so as to nearly superimpose the images of the two corneæ, when the fact that the two eyes were rotating toward each other could be plainly made out.

DISSOCIATED NYSTAGMUS.

In dissociated nystagmus the tremulous movements in one eye differ from those of the other, so that the movements in the two eyes are unrelated, or, at least, unsymmetrical. Usually the difference is one simply of *rhythm and extent*, the movements in one eye being much smaller and sometimes also slower or quicker than in the other. This kind of asymmetry is most commonly met with in those cases of unilateral nystagmus which, as frequently happens, have become temporarily bilateral. Indeed, unilateral nystagmus itself is only such an asymmetry carried to its extreme. Hence these cases will be considered under caption of "Unilateral Nystagmus."

Occasionally, the difference in the movements of the two eyes is one of *direction*, the nystagmus being, for instance, horizontal in one eye and vertical or rotary in the other. This form, too, is seen in unilateral nystagmus which has become bilateral (Schapringer,⁸ Neustätter⁶), and likewise occurs in spasmus nutans (Thompson⁹). Frost² reports a case of acquired nystagmus in an adult, in which the oscillations were rotary and vertical in the right eye and horizontal in the left. Graefe's case of circumduction nystagmus, already cited, was also in part dissociated, since the elliptical movement in one eye was mainly horizontal, in the other mainly vertical. Graefe⁸ also says that Von Reuss and Van der Laan have described cases of dissociated nystagmus.* Lawford,¹ in a boy of 16 with congenital deficiency of upward and downward movement, found an irregular nystagmus which was different in the two eyes.

The following case occurred in my service in the Cornell University Medical Dispensary. (Cf. also Case 5 under Unilateral Nystagmus.)

CASE 2. *Convergent Squint; Dissociated Nystagmus (Movements much more marked in Squinting Eye).*

Gerald K., aged 5; marked convergent

*Not being able to examine the original records, I cannot say whether these were cases of dissociated nystagmus in the sense used here, or of disjunctive nystagmus.

squint, left eye. In left eye mixed nystagmus; oscillations mainly horizontal, but varying in character, and always very rapid and small in extent. In right eye, nystagmus either horizontal or rotary (clockwise), differing often in rhythm and direction from the nystagmus in the left eye, and being also always less pronounced. Sometimes, indeed, the oscillations in the right eye are nearly nil when those in the left eye are well marked.

The full correction (+ 5.00 \ominus + 2.00 cyl. ax. 90°) found under atropine was ordered. With this two weeks later showed no change in either the nystagmus or the squint.

Occasionally a nystagmus which seems to be dissociated is really not so. This is seen in the following:

CASE 3. *Paralysis, probably Congenital, of the External Rectus; Mixed Nystagmus becoming Vertical in One Position of the Gaze.*

Frieda G., aged 21; right eye cannot move out beyond the middle line; movement inward not excessive; other movements of each eye fairly normal.

-- In both eyes a mixed nystagmus, the movements being mainly horizontal but also slightly oblique (from the right and above down and to the left). These movements increase when the eyes are directed to the left and here they are mainly horizontal, and the excursions are large. When the eyes are directed to the right the nystagmus in the left eye is horizontal, whereas the right eye moves up and down.

In this case there was apparent dissociation of movement when the eyes were directed to the right, but what really took place was that the oblique movements in the right eye, composed of a large horizontal and slight vertical oscillation, were converted into a simple vertical movement, because the paralysis of its externus prevented the right eye from moving horizontally.

Possibly a similar explanation accounts for some of the other cases of dissociated nystagmus that have been reported.

UNILATERAL NYSTAGMUS.

As Neustätter,⁵ Schapringher^{8 11} and Spicer¹⁰ have observed, cases of unilateral nystagmus are often and perhaps usually bilateral, the oscillations in one eye escaping notice simply because they are so minute. Sometimes, as these authors have noted, an eye which seems to be free from nystagmus can be seen to oscillate if examined with the ophthalmoscope. When even by this evidence one eye is found to be perfectly steady, and the other alone shows nystagmus, it will still often happen that examination on another day shows a nystagmus in both eyes. It is evident, therefore, that no hard and fast line can be drawn between a nystagmus which is strictly unilateral and one

which is nearly so, the oscillations being present, although to a very unequal degree, in the two eyes.

My own experience with unilateral, or nearly unilateral, nystagmus comprises a case of one-sided vertical nystagmus that I reported⁷ in 1900, and the following:

CASE 4. *Left Convergent Squint; Unilateral Vertical Nystagmus of the Squinting Eye.*

Abraham N., aged 29; left varying convergent squint; in the left eye well-marked but inconstant vertical nystagmus, especially when the eyes are directed straight forward; nystagmus the same in binocular vision and when the right eye is covered.

R. V. 20/50, not improved by glasses.

L. V. 20/200, no improvement.

Under homatropine:

R. + 3.50 + 1.00c. 60° = 20/50

L. + 4.00 + 1.00c. 100° = 20/200

CASE 5. *Left Leucoma Adhærens and Left Strabismus Divergens and Sursumvergens (Paralysis of Left Inferior Rectus); Nystagmus usually Unilateral (Left) and Vertical, sometimes Bilateral (but slight in Right Eye) and Dissociated.*

Kate S., aged 11; central leucoma, left eye, from blennorrhœa neonatorum. Deviation of eye said to date from birth. In primary position left strabismus divergens and sursumvergens. Movement of left eye down and to left nil; movement down and to right normal, but eye diverges. Movement inward normal. In looking up, and also in looking horizontally to the left, the left eye shoots above the right. Movements of right eye normal. Left vertical nystagmus, increasing when the eyes are directed up or when they are directed to the left. At times, especially when the eyes are directed to the left, this is combined with a slight rotary nystagmus. In looking to the right, left eye shows a rotary nystagmus only. Right eye: In the primary position either no nystagmus or a very slight rotary nystagmus; rather more marked rotary nystagmus when the eyes are directed to the right or left.

CASE 6. *Unilateral Rotary Nystagmus.*

Mary W., aged 48; seen at Cornell Dispensary, February, 1904; referred from the Department for Nervous Diseases with the diagnosis of incipient general paresis. Has noticed tremor of objects looked at and sensation of trembling of the eyes, especially the left. A year ago had an attack of unconsciousness lasting three weeks, followed by delirium. After this, speech thick for two weeks; staggers in walking. Movements of the eyes normal, but slight diplopia in extreme terminal positions of the gaze. Left rotary nystagmus, the eyes making clockwise oscillations about 120 to the minute. Right

shows no nystagmus, although on second examination made one month later it exhibited at times very slight rotary (clockwise) nystagmus, but always much less than the left. Glasses were prescribed, and with these the tendency to nystagmus was slight.

CASE 7. *Nystagmus, at times Vertical and Unilateral; at times Bilateral and either Vertical or Horizontal.*

Miss M. E. P., aged 32; very marked left convergent squint with high degree of amblyopia. Hardly any movement of left eye outward. Marked quadrantal defect in left visual field downward and inward.

R. with + 0.75 + 0.50 cyl. 160° V. = 15/20. L. counts fingers in extreme temporal field; myopia of 14 D. or so; interior left eye shows sharply defined temporal crescent; no other abnormality.

Left, slow, not absolutely regular vertical nystagmus, oscillations of slight amplitude; seen particularly well by the ophthalmoscope. Right, no nystagmus.

Two months later irregular, rather slow bilateral nystagmus, the direction of the movement being up and a little to the right in both eyes.

Ten days later showed, when the eyes were directed straight forward, slight horizontal nystagmus; in looking up or up and to the right, an oblique, nearly vertical nystagmus in both eyes. In looking to the right, jerking bilateral oscillations (pseudo-nystagmus).

In unilateral nystagmus, as is well known, the direction of the oscillation is usually *vertical*. Thus it was so in 22 cases out of 25 collected by Neustätter⁵ and in one other that he observed himself, in 4 cases reported by Schapringer,^{6 8 11 13} 2 by Krauss,¹⁰ 1 case of Heimann's,¹⁴ one that I have elsewhere reported,⁷ and 3 cases given above.

The cases of *unilateral horizontal* nystagmus are those of Von Reuss,³ Eversbusch,⁸ Bouchaud,⁸ 2 reported by Norrie,^{8 5} and 1 each by R. Sachs,⁵ Neustätter,⁵ Nagel,¹² Oppenheimer,²⁰ and Schwarz.²¹ I had the opportunity of seeing one well-marked case in Dr. A. Knapp's clinic.

The cases of *unilateral rotary* nystagmus are those of Neustätter,⁵ Weber,⁵ Simon (2 cases),¹³ and mine (Case 6, above). Graefe also, it appears, saw similar cases.

Neustätter,⁵ has reported a case of *unilateral mixed* nystagmus (oscillations oblique) and Simon¹³ one in which the oscillations were vertical and rotary combined. This last case is very like my Case 5.

It would thus seem that out of 52 cases of unilateral nystagmus, here collected, 34 were vertical, 11 horizontal, 5 rotary, and 2 mixed. These figures, however, probably do not give a just idea of the preponderance of vertical nystagmus in these cases.

Unilateral nystagmus seems to be usually asso-

ciated with an *apparent movement of objects looked at*. This may be so even when the nystagmus is of infantile origin (Graefe⁹). On the other hand, bilateral infantile nystagmus, as is well known, hardly ever presents this symptom. In acquired unilateral nystagmus the apparent movement of objects is often very distressing, and may, even when the sight is otherwise good, incapacitate the patient from work. This was seen in Dr. Knapp's case, already cited, in which the vision was 20/30 or better, but the constant vibration of the letters prevented the patient from reading.

It would appear, in fact, that this apparent movement of objects looked at is more pronounced in unilateral than in bilateral nystagmus, and this indeed is what we should expect.

The *conditions under which a unilateral nystagmus develops* seem to be as follows:

(A) It occurs as an infantile affection in—

1. Spasmus nutans (Thompson,⁹ Spicer,¹⁰ Schapringer¹³). If we are to judge from Schapringer's case, the original condition here is a bilateral nystagmus, which becomes unilateral simply because in the course of the recovery, which always takes place, the tremor happens to disappear from one eye before it does from the other.

2. Unilateral opacity of the media (Simon,¹³ 2 cases; cf. also my Case 5).

(B) It occurs in later life from—

1. Unilateral amblyopia and squint (Heimann¹⁴; cf. also my Case 7).

2. Unilateral opacity of the media—*e. g.*, traumatic cataract (Krauss¹⁰).

3. Unilateral astigmatism (see my case already reported⁷).

4. Nervous disease, especially multiple sclerosis (Simon's Case 3¹³; Heimann¹⁴; cf. also my Case 6).

It may be noted that in Topolanski's experiments⁴ in no instance was a strictly unilateral nystagmus produced in rabbits by stimulation of the brain, although the nystagmus thus produced had something of a unilateral character in that it was of unequal rhythm in the two eyes.

In a large proportion (probably much more than half) of the cases, unilateral nystagmus is *associated with squint*. This usually affects the nystagmic eye, although Graefe reports a case in which the eye that did not oscillate squinted.

In other cases still, there are evident *anomalies (paresis, insufficiency) of some of the ocular muscles*. It is quite likely that these anomalies (squint, paresis), by producing a muscular weakness which is more marked in one eye than in the other, help to make the tremor also one-sided. In this connection it may be noted that in one of Neustätter's cases the nystagmus set in only when the eye that was affected began to diverge, and was cured by an operation that relieved the divergence.

As to the *ultimate cause* of unilateral (and dis-

sociated) nystagmus, various theories have been advanced. We probably, however, shall not know much about it until we know a good deal more about the causes of ordinary, bilateral and symmetrical nystagmus. Yet there are some facts from which we may draw conclusions.

For example, as already stated, a unilateral nystagmus often, perhaps usually, is or becomes in a measure bilateral. It may, indeed, become completely bilateral, as in Case 3 of Simon's and in Case 7 of mine.

Again, a nystagmus which at the outset is perfectly bilateral, may become unilateral, as in Schapring's case of spasmus nutans, already cited, and as in Case 2 of Simon's, in which a child with opacities of both corneae and bilateral rotary nystagmus lost the nystagmus in one eye as soon as the cornea in that eye cleared, and, ultimately, when the other cornea cleared, lost the nystagmus in that eye, too.

From these and other considerations it seems clear that *unilateral differs in no essential way from bilateral nystagmus*, but represents simply a form of the latter, modified by special conditions.

As Hering says, the marked symmetry of ordinary bilateral nystagmus proves that the condition consists in a perversion of the coordinate movements of the eyes; and, as Graefe very rightly adds, the occasional occurrence of unilateral and dissociated nystagmus cannot be held to invalidate this conclusion. Still more is this conclusion justified if we once admit—and the facts stated above seem to compel us to admit—the essential unity of bilateral and unilateral nystagmus.

Furthermore, it is evident not only that unilateral and bilateral nystagmus are alike due to a perverted action of the centers governing the coordinated eye movements, but also that the *primary causes producing this perverted action* are essentially the same in both. These primary causes are either—

(a) *Centripetal*—*i. e.*, consist in some condition (opacities of the media, high-grade astigmatism, albinism, defective illumination) producing blurred vision, particularly in infants (optical nystagmus).

(b) *Centrifugal*—*i. e.*, consisting of some brain disease, especially multiple sclerosis, which affects the coordinating centers themselves or the tracts connected with them.

In unilateral nystagmus either the conditions are such that these primary exciting causes (brain disease, on the one hand, defective sight, on the other) act predominantly on one eye; or else there is a contributing cause—a muscular anomaly—which, being mainly confined to one eye, makes that eye respond more readily than the other to the abnormal stimuli set up by the primary cause.

These considerations have some bearing on *prognosis and treatment*. If a unilateral nystagmus is determined in this way by the presence of

some cause (optical or muscular) which affects one eye and not the other, the removal of this cause ought to relieve the nystagmus. Judging from the scanty data that we have, this seems to be the case.

In general, unilateral nystagmus appears to be of better prognosis than bilateral nystagmus, and also more amenable to treatment—particularly treatment directed to the correction of refractive or muscular errors.

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THE SURGICAL TREATMENT OF GASTRIC ULCER.¹

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ONE cannot but be impressed with the importance of the surgical treatment of ulcer of the stomach after reading the discussion of the Mayos, Mayo Robson, Moynihan, etc., and to those surgeons we owe a great debt today for their brilliant expositions of their cases and results in this disease.

It is not advocated that surgical intervention is necessary in all ulcers of the stomach and duodenum, nor do I wish to convey the impression in this paper that many ulcers are not cured in time by medicinal and dietary means.

An ulcer that bleeds for the first time is not of necessity acute, as shown further on in this paper, neither is there proof that it is chronic; but these questions can be decided to a fair degree of certainty by developing a history with the utmost care in cross-examining the patient and relatives present, for previous digestive or stomachic symptoms. A single bleeding, as a symptom by itself, cannot be taken as a preliminary to a perforation and does not as a single symptom or sign demand operative treatment, but recurrent hemorrhages should place the patient in the surgical category.

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This argument was clearly demonstrated recently in the case of an 18-year-old girl whom I saw, with a history of some epigastric pain, one attack of rather profuse hemorrhage, followed while under the most careful medicinal, hygienic and dietary surroundings by another but most decidedly smaller bleeding. After two days' more observation, with no hemorrhagic history, but during which time positive pain evidences upon pressure and inquiry were elicited, she was submitted to a posterior gastro-enterostomy with entero-enterostomy. A careful search of the exposed stomach was made for evidences of the ulcer or ulcers by palpation, inspection and observation with transmitted light, all resulting negatively.

Upon opening the stomach to make the anastomosis, an ulcer about $\frac{3}{16}$ of an inch in diameter was seen in the posterior wall about 2 inches above the greater curvature; it was clean-cut and had gone completely through the mucosa; a cat-gut stitch was taken from side to side into the remaining coats of the wall of the stomach and the anastomosis completed by means of the Murphy button.

This patient was discharged in three weeks, free from all pain from the day of the operation, and no further bleeding. She had gained considerably in weight and color at the end of seven weeks when last seen by my staff.

The question of what benefits are to be obtained in operations upon non-perforated ulcer is answered by referring to the various results not infrequently obtained by all surgeons, in the following manner:

That, the various anastomotic and plastic operations give rest to the diseased area in two ways. When the ulcer is in the cardiac end or body of the stomach, more rapid emptying of the viscus takes place, thereby placing the stomach at rest for longer periods between ingestion of foods, and thus applying the principle of rest from irritation to the ulcer in the same manner as a splint or bandage to an ulcerated area in the external regions would.

When the ulcer is in the pylorus or duodenal portion of the stomach, motorial activity is diminished, in addition to diminution of irritation to the area by foodstuffs pouring out before this region is reached. Furthermore, two remote conditions are obviated to a marked degree:

(a) Pyloric stenosis, which is frequently a result of cicatricial contraction in this disease, with all its concomitant symptomatology.

(b) Malignancy, which has proved to be a frequent complication resulting from an area that is subjected, if not operated upon, to a constant source of irritation.

To the mind of every practitioner of medicine these two arguments should be productive of but one course in the treatment of this disease; that is, the surgical.

No diagnostic rule can be formulated as to the acuteness or chronicity of an ulcer that bleeds for

the first time, as numbers of cases have been seen where perforation has taken place, with no previous history of stomachic difficulty. I, personally, have operated upon eight or nine cases in each of which the above conditions were observed.

Recurring hemorrhages certainly are, in the eyes of the surgeon to-day, a positive indication to give rest either by pyloroplasty or an anastomosis. Furthermore, these recurring hemorrhages may come from malignancies that have been dormant as far as symptoms are concerned, and in just these cases the surgeon, by proper operative procedure, is in a position to extend the life of the patient, who otherwise would by protracted medical treatment, be carried along until motorial insufficiency and inefficiency, etc., would give the first clue to a malignancy, which in all probability at that time would be inoperable in the sense of removal of the diseased area.

The operative procedure in these cases resolves itself into either a pyloroplasty (that of Finney being preferable) or one of the various types of gastro-enterostomy with or without entero-enterostomy.

Perforated Ulcers.—Here the treatment is classically surgical, the only difference being one of opinion as to the procedure of closing with either excision or suture closure only, each with or without an additional gastro-enterostomy. When the ulcers are in the pylorus, difficulty as to time and procedure will arise if excision is undertaken, although instances are recorded (Blake) where excision was necessary. These ulcers in my series were usually within an inch of either side of the pyloric muscle, and on the ventrad, caudad and cephalad surfaces, in the order given; about $\frac{3}{16}$ to $\frac{1}{4}$ inch in diameter, and round as though cut with a punch.

When the ulcer is in the stomach wall, excision is more readily accomplished, although not necessary to recovery. Should the immediate surrounding area be thickened and indurated, excision, when possible, would be indicated. My custom, owing to conditions found, has been to surround the perforations with from two to three purse-string sutures and invert the edges, or to close with two or three rows of Lembert sutures.

Drainage has not been used except where food contents of the stomach were liberally found in the peritoneal cavity, or where exudate and adhesions existed in great quantity.

Washing or flushing by means of salt solution was done in those cases where large quantities of food contents soiled the peritoneum.

Shock is no contra-indication to operation, as it is only a progressive evidence of a serious lesion in all abdominal trauma.

DISCUSSION.

Dr. H. Grad.—The surgical treatment of gastric ulcer is in the stage of transition. Called upon to treat these cases, one is apt to waver, particularly in the presence of ill-defined symptoms, between the surgical and medical treatment, with

the tendency to lean towards those therapeutic measures that preclude surgical intervention. The transition stage, however, will not last long, because of the vast experience that is accumulating in gastric surgery, which will place the operative treatment of these affections on sound surgical principles. Experience has demonstrated over and over that most brilliant results can be expected from these operative measures in gastric ulcers. A vast army of gastric sufferers have been already relieved, comfort and happiness procured for them, by these not too complicated operations of gastro-enterostomy, excision and partial gastrectomy.

A gastric ulcer, even if definitely diagnosed, becomes a surgical disease when medicinal therapeutic measures fail to be curative. If this is admitted for the definitely diagnosed cases of gastric ulcers, then those cases that do not admit a definite diagnosis call most urgently for exploratory incisions. How dreadful are those calamities of gastric perforations, hurling the victim speedily into eternity! How awful to witness a case of death from hemorrhage of the stomach! What thoughts do not crowd into one's mind when called upon to treat these fatal perforations? These calamitous perforations would be largely eliminated if exploratory incisions for all the ill-defined cases were more frequently performed, and were the cases of gastric ulcers more often operated on. Only quite recently I had occasion to assist in a case of perforation of a gastric ulcer where pieces of beef-steak and potatoes in a state of decomposition were found in the abdominal cavity, the perforation having occurred soon after a hearty meal. Had her symptoms been heeded, for she certainly must have shown evidence of considerable gastric disturbance previous to the perforation, she might have been saved from perforation and speedy demise. It is estimated by competent observers that 3 per cent. of cases suffering with gastric ulcer die of hemorrhage. This is a very low estimate. Fenwick reports that out of a series of 112 fatal cases 16 per cent. died of hemorrhage. In another series of 298 fatal cases of gastric ulcer 9 per cent. of deaths were due to hemorrhage. Welch estimates that 3 to 5 per cent. of deaths in gastric ulcer are the result of hemorrhage. It has also been estimated that 6½ per cent. of gastric ulcers undergo perforation which result in a large percentage of deaths. Mortalities so heavy in any disease deserve consideration. We hardly appreciate the very serious condition of gastric ulcer in the present unstable condition of our knowledge of the affection. The symptoms in the vast number of these cases are so vague that it is refrained from advising operation. It will not be long before such advice will be given more often when symptoms do not disappear under medical treatment, and more frequent operations will be of much benefit to the patients.

It is not to be denied that a very large percentage of gastric ulcers heal spontaneously. This fact is, indeed, a strong argument in favor of medical treatment, but it must not be overlooked that as large as 8 per cent. of cases of hematomesis die of hemorrhage. There are three great dangers of gastric ulcer—hemorrhage, perforation and cancer; but what about the great army of sufferers whose lives are made a burden by the gastric disturbances incident to gastric ulcer? Are they not to be relieved of their suffering when a gastro-enterostomy or an excision will bring the desired relief? It is to be hoped that not only the dangerous gastric ulcers will be considered by the surgeon, but to relieve suffering in these cases will also fall under his domain.

In appendicitis, for example, we advise operation, not alone because of the frequent fatality of the disease, but because we want to anticipate these fatalities on the one hand and give relief and restore the sufferer to full integrity. A patient with even a slight peritoneal irritation is surely incapacitated. It is a question if a gastric ulcer causes less incapacity. Now, if advice to resort to operation in one case is sound, it must be so in the other.

In connection with this subject, I wish to show an instrument I devised about four years ago, for the purpose of facilitating the introduction of the McGraw elastic ligature, in gastro-enterostomy for gastric ulcer, for example. The instrument consists of two needles—each one can be made to disappear into its own cannula. The two parts of the instrument lock together like the blades of an obstetric forceps. When locked the needles are parallel to each other, and when in position bring the loops of intestine in opposition, thus favoring the rapid introduction of sutures.

The instrument is used in the following way: The operator having determined the site of the entero-enterostomy or gastro-enterostomy, the needle is introduced as shown in Fig. 1. Having entered the lumen of the bowel, the needle is made to disappear into its cannula. With the needle out of the way, the operator can now direct the cannula in any direction desired without fear of injuring the mucous membrane or any other part of the wall of the gut. The cannula is pushed on so as to pick up a sufficient amount of bowel wall, as shown in Fig. 3. The needle then emerges from the cannula and pierces the gut, as shown in Fig. 4. The same steps are now repeated with the fellow needle, and the parts to be anastomosed are thus brought into opposition, as shown in Fig. 5. In Fig. 6 the elastic ligature is shown, threaded, and the Lembert sutures of continuous catgut introduced. In Fig. 7 is shown the placing of the McGraw ligatures in position. The instrument greatly facilitates the introduction of the ligature and materially shortens the time of the operation.

THE SELECTION AND ADMINISTRATION OF THE ANESTHETIC.*

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IN the following paper my remarks will be confined principally to the four general anesthetics now in common use, administered with or without oxygen, and listed in the order of their comparative safety.

1. Nitrous oxide gas and oxygen.
2. Nitrous oxide gas and air.
3. Ethyl chloride and oxygen.
4. Ethyl chloride and air.
5. Ether and oxygen.
6. Chloroform and oxygen.
7. Ether and air.
8. Chloroform and ether and air (two parts chloroform, three of ether).
9. Chloroform and air.

The oxygen addition and classification is my own, based upon original experiments made in 1904.¹ I am inclined to believe that ethyl chloride and oxygen is safer than nitrous oxide and air and also that ether and oxygen is safer than ethyl chloride and air, but no experiments have been made to determine their comparative value as regards life.

While I do not intend going into the properties and physiology of the narcotics, still we must touch lightly upon their general peculiarities and behavior, if we are to make a wise selection. *The time is past when we can use one anesthetic as a routine for any and all cases.* The selection of a general anesthetic would depend first of all upon your geographical position, or, to state the truth in a different way, upon the barometric pressure and temperature of the locality. Richardson² proved this in 1894 by experimentally administering chloroform first at 40° and then at 80° F. In the first instance, vomiting, excitement and delayed anesthesia resulted, but with the higher temperature a featureless narcosis was rapidly induced. Chloroform is therefore given with less danger to life in the Southern States, Cuba and the Philippines and in all tropical countries, and this is why chloroform is generally preferred in the South. Surgeons in changing their locality should bear these facts in mind, and discard their preconceived ideas of the relative value of chloroform and ether. It is true that we strive to have the temperature of the operating room the same everywhere, but the fact remains as stated above. To illustrate the difference in tension of the same drug in different localities, I will state the following incident: On a recent visit to Norfolk, Va., I was surprised to find that it required from 1 1/3 to 1 1/2 bags of gas to produce the same results that we get from one bag of gas in New York City. I also used more ether than I customarily do here.

Statistics in different countries vary with the anesthetic, the method of administration, the ad-

ministrator, and the general truthfulness of the inhabitants.

A celebrated surgeon of this city says there is more lying about the statistics of anesthetics than about any other one thing in medicine. Without especially referring to this last-named factor, statistics in England would not apply to Germany or France, and statistics gathered in the northern part of the United States would not apply to the southern section, neither can we accept the word of any man who is especially interested in, or uses exclusively, some one drug or method, without the proverbial grain of salt. But a large number of cases collected from different sources would give us a consensus of opinion that would be invaluable and could not be disregarded by any thinking person. Hewitt³ has made such a combination of statistics.

1st. In over one million cases of chloroform and ether administrations, he makes the deduction that ether is, roughly speaking, more than five times as safe as chloroform.

2d. Waller⁴ has proved that one dram of chloroform is equal to one ounce of ether.

3d. Over 90 per cent. of the patients who have succumbed to chloroform have died within the first fifteen minutes.

4th. More than three times as many men have died as women.

5th. Many of the victims have been in robust health, requiring only a slight operation.

6th. Chloroform vapor is decomposed by contact with a naked flame, and should not be given in a room with gas jets. This decomposition causes smarting of the eyes, burning sensations about the upper air passages, etc.

7th. A 2 per cent. vapor or less is amply sufficient for all surgical operations. Over this amount is dangerous to life.

8th. The clinical feature of chloroform narcosis is depression.

Bearing the above facts in mind, if chloroform is the drug chosen, we can administer it with a degree of safety that approaches, if it does not equal, that of ether.

The first method advocated is to induce the narcosis with gas, continue with ether until relaxation occurs, then allow the reflexes to become active, and continue with chloroform by the drop method.

The second is to commence with gas, change to the vapor mask upon which 10 c. c. of ethyl chloride has been poured, and continue with chloroform vapor and air. After the operation has commenced, allow oxygen instead of air to flow through the chloroform.

The third way to increase the value of chloroform as regards life, and one that all can use, is to place the chloroform bottle in hot water about 100° F., thus raising the liquid to the temperature of the blood, and administer by the drop method. Continue the anesthetic by replacing the bottle from time to time in the hot water, or by

*Read before the East Side Physicians' Association of New York City, May 19, 1905.

wrapping a hot towel around the bottle. This warmed chloroform vapor is not only safer but more respirable, and is less often followed by nausea and vomiting. Comparatively speaking, chloroform and oxygen is safer than ether and air. If the oxygen is passed through chloroform raised to the temperature of the blood, it is still safer from every standpoint, and also more respirable.

I have stated that the clinical feature of chloroform narcosis is depression. This feature is conspicuously absent when administering oxygen with the chloroform. I know of no narcosis in which the pulse and respiration are so natural, and at the same time the anesthetic so manageable. Oxygen also makes a new anesthetic of both ethyl chloride and anesthesol (this latter having 17 per cent. of ethyl chloride). Both of these anesthetics, while ranking high as regards safety, are certainly depressant to the respiration. Oxygen supplies the element lacking in both of these drugs, and places them upon a firm basis as anesthetics.

Nitrous oxide gas is preferred to ethyl chloride as a preliminary to ether in England, where they have made a closer comparative study of anesthetics than we have.⁵ It is also preferred for short operations, as it is less likely to cause nausea and vomiting. From my own experience, I heartily indorse the above opinion. Ethyl chloride will, I believe, be used more and more in long operations instead of ether or chloroform; to be universally used, a method and technique must be worked out by which it can be more easily managed than at present. As now placed upon the market, its expense makes it prohibitive for routine general work. As compared with gas as a preliminary to ether, it costs three times as much.⁶

The clinical aspect of ether is stimulation. It is a stimulant to respiration, to circulation, and to every gland and organ in the body. This being so, it is the anesthetic to be used whenever shock is anticipated, or where the position of the patient is necessarily such that difficulty in respiration will result.

Nitrous oxide and oxygen (5 to 12 per cent. of the latter) is the safest anesthetic in the world. This has been proved both experimentally and clinically.⁷ But the cases must be selected, as surgeons demand relaxation with tranquillity and will be satisfied with nothing less. Nitrous oxide gas and air (not exceeding 30 per cent. of air) is perfectly safe for short operations. In administering with any of the ordinary gas inhalers, an even anesthesia may be obtained by giving every second to fifth inspiration fresh air—*i. e.*, two inspirations of nitrous oxide and one of fresh air, and so continue. Nitrous oxide and oxygen are most valuable for weak, anemic men and the majority of women. Ethyl chloride can be used when nitrous oxide is not available. With these preliminary considerations of the drugs, the selection of the anesthetic will further vary ac-

ording to the *surgeon*, the *operation*, and the *patient*.

The surgeon must be considered first of all. If he is accustomed to operating with chloroform, it is folly to expect him to be satisfied with gas, however skilfully administered. If ether is his routine anesthetic, the quiet breathing and pale face that accompany chloroform, as usually given without being warmed or without oxygen, may set his nerves on edge and prevent him from doing his best work.

The nature of the operation comes next. When the operation requires a sitting posture or anything approaching that position, or where the patient has to be carried up or down stairs or shock is anticipated, chloroform should be avoided. Gas or ether should be used in these operations. In all short operations, regardless of posture, gas or ethyl chloride should be used. Gas is considered the anesthetic the world over for the extraction of teeth.

In operations on the mouth, nose, larynx and pharynx, for an available anesthesia of one minute or less, nitrous oxide or nitrous oxide and oxygen should be used; if over one minute, ethyl chloride. If only from five to eight minutes is required, a single administration of ether pushed until the pupil is slightly dilated is perfectly safe and will usually suffice. For major operations lasting longer than this, where any kind of mask would be in the way, and the anesthetic is given through a tube, chloroform and oxygen is the ideal anesthetic. If during the operation surgical shock should arise, either from loss of blood or handling important vessels and nerves, ether should be mixed with the chloroform vapor and also alternated with it, besides the other usual procedures in such cases. It is really surprising how long a patient can be carried with an attenuated ether vapor in such cases, before you are compelled to use chloroform. In neck operations, the anesthetic should be so timed that the patient should show distinct signs of returning consciousness before the bandage is applied, otherwise recovery from both the anesthetic and the operation will be delayed. In abdominal operations the gas-ether sequence usually obtains in this city. If billowy breathing and turgescence are objectionable, oxygen and chloroform, by the vapor method, may be substituted. In genito-urinary, kidney and rectal operations, where the anesthetic must be pushed and all reflexes abolished, the stimulating anesthetic, ether, should be used. In obstetric practice, where natural labor is not to be interfered with, use chloroform or, preferably, chloroform and oxygen.

In ophthalmic practice, on account of the pupils not being available for observation, and where a deep anesthetic is required, use ether. In dislocations and operations upon the extremities, ether is the proper anesthetic.

The next consideration is the patient.

Providentially, those usually requiring an operation and who are reduced in health and strength

from any cause, take more kindly to the anesthetic and behave better than any other class of patients. Athletics, alcoholics, and those patients who are in comparatively robust health, are the ones that give the anesthetist the most trouble. This class of patients should have one-quarter of a grain of morphine before the operation, and the narcosis induced and maintained by the C. E. mixture. Chloroform (after surgical narcosis is reached) is more strongly indicated in the athletic-alcoholic than with any other class of patients. Here the drug reverses itself, and acts as ether does with ordinary cases.

For the extremes of life, it is the usual custom to give chloroform, but the C. E. mixture (two parts chloroform and three of ether) is a much safer and more satisfactory anesthetic. Chloroform is a protoplasmic poison, and should never be given by the drop method to babies. Ether is contra-indicated in atheromatous conditions of the aged, and also where cerebral hemorrhage from any cause is feared. In all valvular diseases and fatty or degenerative changes, *when compensation is present*, no anxiety need be felt.

When compensation is lacking, if a pulmonary anesthetic is given at all, nitrous oxide and oxygen, or the C. E. mixture, or chloroform and oxygen should be used and a light narcosis adhered to. Patients suffering from shock or collapse, as in perforative appendicitis, should have the gas-ether sequence.

Opinions of prominent men differ greatly as to the effect of anesthetics upon the kidneys, but the consensus of opinion seems to be that chloroform should be administered whenever possible in nephritic cases and a light anesthesia maintained. In bronchial, pulmonary and pleural diseases, the gas-ether sequence is contra-indicated. Oxygen and chloroform or the C. E. mixture is the anesthetic to be used in these cases. With the obese, any closed method is contra-indicated.

In diabetics, Dr. Pavy states that in cases in which sugar is either absent from the urine or present only to a slight extent, anesthesia is unattended by risk. But when the quantity is abnormally large, there is danger of diabetic coma.

Some patients cannot take a pulmonary anesthetic at all, but as there are no signs or symptoms that would indicate this, the fact is established only after exhaustive efforts with loss of reputation on the part of different anesthetists using different drugs and methods, the surgeon in the meantime being enveloped either in a sky-blue atmosphere or a profane silence that speaks for itself.

It was my misfortune to have such a patient a few weeks ago. He had been narcotized the previous year by a very prominent anesthetist who used the gas-ether method, but was unable to maintain a satisfactory narcosis. When told this, I determined to try the chloroform vapor method. The patient went under easily in five minutes, the operating table was wheeled in, and everything seemed favorable. But it was absolutely impos-

sible to produce a satisfactory narcosis; if I pushed the anesthetic so that the muscles were completely relaxed, the patient would choke up and stop breathing. If I tried to carry a light narcosis, the abdominal muscles became so hard that the surgeon could not operate. I tried earnestly to find the happy medium, but without success. The patient's lungs in the meantime became so edematous that there was danger of his being drowned in his own fluid. One-quarter of a grain of morphine was then given, and oxygen instead of air was used with the chloroform, when the operation was finished satisfactorily. The patient recovered with no bad after effects. I attributed the change for the better to the oxygen and morphine, but the surgeon would not allow me this consolation, saying that I simply wore my patient out and so he went to sleep. He may be right after all, but if I had the same patient again I would try oxygen and chloroform from the beginning of the operation, with a quarter of a grain of morphine before the operation commenced. With patients like this, cocaine locally, or spinal or rectal anesthesia would be the only alternative. Fortunately for the anesthetist, these cases are extremely rare.

In dealing with the subject of the ADMINISTRATION OF ANESTHETICS, I propose to go out somewhat from the beaten track and say a few things that should be said just at this time.

However trivial the operation, no anesthetic should be given without having everything ready that may be required in an emergency. This includes:

Wooden wedge for opening the mouth.

Mouth gag.

Tongue forceps.

Needle threaded with silk (sterilized).

Instruments for tracheotomy.

Towel, small basin.

Hypodermic strychnine, sulph. gr. 1-30.

Oxygen.

Normal saline solution, prepared and ready for instant use, and infusion apparatus.

Also drop bottles, of different shapes and sizes, to minimize the chances of a mistake, filled and marked:

1. Chloroform.

2. Ether.

3. Chloroform and ether.

Fatalities have unquestionably occurred by a persistence in some one anesthetic when a change was indicated. If the respiration, pulse and color are bad in giving chloroform (or any of its mixtures), change at once to ether; when the latter fails to relax (as it sometimes does with alcoholics) or the secretion is excessive, change to the C. E. mixture, or chloroform. On account of eroticism, always have a third person present when starting the anesthetic. Examine the mouth for loose or false teeth, chewing gum or tobacco. The physical examination should be made before the patient is placed upon the table. Remove all tight bandages or clothing around the

neck or waist. Having secured a satisfactory anesthesia, in order to maintain this level, we must be guided by the following:

Respiration.

Circulation.

Corneal, lid and swallowing reflexes.

Color.

Rigidity of the muscles.

Knowing the principal defects and dangers of chloroform, it is an easy matter so to administer it as to rob it of most of its dangers. For over fifty years attempts have been made to administer chloroform by some other way than the drop method with its irregular and unknown percentage of vapor inhaled. The Harcourt Inhaler is the latest English production. The principal feature of this inhaler is that it is impossible for the patient to inhale more than a 2 per cent. vapor, and it is so constructed that it can be regulated from this down to a vapor containing less than 1 per cent. of chloroform. It has been found that patients can be carried easily on a vapor of 1 per cent. or less. If those who administer chloroform by either the drop or vapor method will use oxygen and notice the difference in the color and respiration, it will not take a half-million cases to convince them which is the safest plan. The inaudible and almost imperceptible breathing that may result from a too sparing use of chloroform and air never occurs when oxygen is used. The element of fear can be in a great measure eliminated by giving the patient some of his favorite cologne until heart and respiration are normal. If this factor becomes conspicuous, chloroform should not be used at all.⁸ It may only need the depressing effect of the chloroform to terminate fatally a chain of symptoms over which the patient has no control. (The gas-ether sequence is the anesthetic of choice here.) The channel in which we must keep our patient is narrower than with any other anesthetic. Too little chloroform is almost as bad as too much. The thing to do is to steer straight ahead, neither too slowly nor too rapidly (*i. e.*, on an average about Mxxx every minute, or not over 1 dram every two minutes, in getting the patient under; after that, 1 dram every four or five minutes is sufficient) until surgical anesthesia is reached, and then to stay in the middle of the stream until the operation is completed.

Surgical anesthesia is indicated by quiet breathing with possibly a slight snore, fixed pupil, sluggishly responding to light, muscular relaxation, with conjunctival reflex nearly or quite abolished. In administering chloroform by itself, you must be sure the airway is open at all times. You may have *apparent* abdominal or thoracic breathing, the diaphragm moving regularly, and yet the upper air passage may be absolutely occluded. As the temperature is always reduced in the administration of chloroform, the patient should be amply protected during the operation, as well as afterwards.

As regards chloroform, my own preference is

to give it by the vapor method, for the reason that, after the patient is well under, you know absolutely what vapor strength your patient is getting (as far as the administrator is concerned) and the dangers from toxemia are eliminated.

In the administration of ether, the gas-ether sequence is decidedly the best routine procedure. It plunges the patient safely and rapidly into surgical anesthesia, and he does not become so saturated with the drug. It has been calculated that with this sequence from one-half to two-thirds less ether is required than with the open cone method. If for any reason whatever it is desirable for the patient to have as little ether as possible, and yet an ether narcosis is demanded, gas can be again used during the latter part of the operation.

When nitrous oxide is not obtainable, ethyl chloride is used as the preliminary anesthetic. Dr. Dawbarn states that since they have been using the closed method of etherization at the city hospital (*i. e.*, for the past eight or ten years) there has not been, to his knowledge, a single case of ether pneumonia following a surgical operation. He attributes this fact to the warmed-over ether fumes and the small amount of ether necessary to produce a satisfactory narcosis. He further states that the carbon dioxide necessary with the closed method is perfectly safe, and also desirable, as it makes the narcosis more like that of chloroform. In shock or collapse, oxygen passed through the ether works very successfully.

If the patient suffers from the limited air supply, as in the case of children or feeble subjects, ether dropped on an ordinary chloroform mask will remove this difficulty.

The drop method of giving ether is preferred by some anesthetists, and is used for the entire narcosis.⁹ My own preference is to use the gas-ether sequence for the first ten or fifteen minutes, and then change to an ordinary chloroform mask, upon which warmed ether is dropped, the ether bottle being treated as just mentioned for the chloroform bottle. There is no danger of an explosion, unless given in the presence of an open flame, or a match applied.

The barbarous so-called open method, of pouring an unknown quantity of ether in an open cone and slapping it over a patient's face while the orderlies engage in a catch-as-catch-can bout with the patient, still exists, like the horse-cars, in the byways of New York City. It is unnecessary to say anything of this last-named method. It speaks volumes for the safety of ether. If the open cone method is used, the narcosis should be as gradually induced as with the drop method of chloroform.

Surgical anesthesia is known to be present by the regular stertorous breathing, mobile pupil, quickly responding to light, and the full bounding pulse and muscular relaxation. The jaw must usually be held forward, and the head turned to one side (as it should be in all anesthetics), and an open airway maintained at all times. Panting or

rapid breathing calls for more air. With chloroform, and also with ether, a dilated pupil without a lid reflex means that you are on dangerous ground; a dilated pupil with an active lid reflex calls for more anesthetic. There is no anesthetic that is easier to give than ether, that fully meets all the requirements of the surgeon, and at the same time is so perfectly safe. The after effects have been reduced to a minimum by the gas or ethyl chloride preliminary.

The method of administering an attenuated ether vapor by the Braun,¹⁹ or my own modification of this method, is an ideal one, and still further reduces the after effects.

Braun's idea is to give an attenuated ether vapor and only add enough chloroform from time to time to abolish the reflexes, and so give smooth and even narcosis. My modification of this method is to give oxygen and chloroform (the latter heated to about 100° F.) whenever and as long as possible, and only give ether when a stimulating anesthetic is called for. It is ideal, for the reason that both pulse and respiration remain absolutely normal. It is physiological because the longer the operation, the more urgent becomes the call for oxygen by the blood, and with my new apparatus this demand can be accurately increased without at the same time increasing the anesthetic.

Paul Bert demonstrated that under chloroform less oxygen was absorbed and less carbonic acid exhaled, hence the necessity for an increased supply of oxygen as the operation proceeds. With this anesthetic it is rarely necessary to hold the jaw forward, the breathing is so natural and regular. While the channel is wider as regards safety with this combination than with chloroform or ether, yet we are able to steer a straighter course than with either of the others. You can keep your patient between a very light lid reflex or swallowing movement on the one hand, and a sluggish lid reflex on the other. The lid reflex, then, is the principal one to observe in giving oxygen and chloroform. The mucus r le is eliminated and a soft, natural breathing results.

The gas-ether combination is seldom used, and yet it produces a most satisfactory, slightly stimulating anesthetic. This can be used when a little heavier anesthetic than gas alone is demanded.

Rectal anesthesia will probably never become fashionable, but for certain cases it will prove a most valuable addition to our present methods, if the results of Cunningham and Lahey,²⁰ of Boston, are verified by others. In reporting forty-one successful cases they claim: Comparatively little ether used; no stage of excitement; vomiting rare; bronchial secretions absent, and a quick recovery.

The chloroform and ether mixture should be used oftener than it is. This is the old A. C. E. mixture with the alcohol left out. Hewitt states that it should be used in advanced cardiac disease and is particularly useful when mitral stenosis is present, also in the old or obese persons,

and in advanced emphysema and bronchitis, attended by fatty degeneration and dilatation of the heart. In administering, use the same precautions as when giving chloroform alone. This mixture is also an excellent one to administer as a preliminary to ether, and should always be used when neither gas nor ethyl chloride is available for this purpose.

In administering nitrous oxide, either alone or as a preliminary to ether, the surgeons and nurses should bear in mind the fact that hearing persists until surgical anesthesia is reached. All remarks should therefore be of a pleasant character. References to the anesthetic with the idea of quieting the patient's nerves, usually have the opposite effect. Remarks such as "Did you ever have a tooth pulled?" "Do you know what laughing gas is?" usually produce a laugh, and delay the anesthetic that much. Whenever possible the patient should be anesthetized on the operating table. There is no good reason why all operating tables should not be supplied with wheels. The patient could then be wheeled from the anesthetizing to the operating room, thus avoiding the lifting and jolting, and with no intermission as regards the anesthetic. If the patient is anesthetized in the operating room, every one should refrain from conversation until the patient is well under; neither should the patient be touched by any one until ready for the operation. Also the patient's room should be darkened, and quiet observed, after the operation. When the gas-ether sequence is used, surgeon, assistants and nurses should be ready before the anesthetic is started. Surgical anesthesia is usually reached in three or four minutes, and the operation should *begin at that time*. If not, a state of false anesthesia may arise (unless a very deep narcosis is maintained), and with the first incision it will be found that the patient is not under deeply enough. It is unfair to the patient to have surgical narcosis maintained for 25 minutes before the operation begins, as has been my experience on more than one occasion. In my humble opinion, students would be more impressed if he would commence operating immediately, and either lecture while he operates or make his remarks after the operation is completed.

In all operations around the head, and also wherever chloroform is used, the unsterilized nurse or an assistant should take the pulse every five minutes and report to the anesthetist, who should in turn report to the surgeon. In major operations, the anesthetist should be constantly on the lookout for any respiratory, circulatory or other signs of impending shock. If excessive hemorrhage from any cause occurs, ease up on the anesthetic at once: if an important vessel is cut, or shock asserts itself independently of hemorrhage, withdraw the anesthetic entirely. Shock may come on independently of either. The longer the operation the less anesthetic will be required. The anesthetist should devote himself exclusively to his patient and only take sufficient cognizance of the

operation to know when to ease up. The anesthetic should be so timed that the patient will show signs of returning consciousness as the bandages are being applied, or at least within five minutes after being put in bed. The anesthetist should also prevent the assistants from leaning too heavily upon the patient. This is no time for flirtations or side remarks. A motorman is not allowed to talk to passengers, and the anesthetist should remember that a human life is in his keeping until the curtain rolls up and consciousness returns.

In conclusion, I will state that if the anesthetist understands theoretically, as well as practically, all that appertains to the subject, the patient (as far as the anesthetic is concerned) is safer on the operating table than he would be on the streets of New York.

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THE DYNAMICS OF THE FEMALE PELVIS WITH SPECIAL REFERENCE TO MALPOSITIONS OF THE UTERUS AND THEIR TREATMENT.¹

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THERE has existed in the past, and there still exists at present, considerable difference of opinion regarding the normal position of the uterus and the means by which this position is maintained.

The uterus, more so than any other organ in the body, rests in a state of unstable equilibrium, and undergoes frequent changes in position consequent upon a shifting center of gravity and physiological changes in the adjacent viscera or within its own walls.

Being of small bulk, in weight less than three ounces, and suspended by highly elastic structures in a cavity large enough to admit of considerable latitude of movement, it can be readily understood how very slight a cause may often be sufficient to produce a displacement.

To understand how the normal balance is maintained, it will be necessary to turn for a moment to the anatomy of these parts. With the woman standing upon her feet the pelvis occupies an oblique position with regard to the trunk of the body, and is placed at an angle of 60° to 65° with the ground upon which she stands. Within the

pelvis lies the uterus, parallel, or nearly so, to the horizon, its fundus directed forward and resting by its anterior face on the posterior aspect of the bladder, to which it is united by a reflection of peritoneum. The cervix is directed backwards toward the hollow of the sacrum, perpendicular to the axis of the vagina, and nearly so to that of the pelvis. This relative position between uterus and pelvis remains pretty constant, though considerable variation within physiological limits may occur. For example, as the bladder fills with urine it rises up in the pelvis, carrying the fundus upward and backward and the cervix forward until the fundus approximates the promontory of the sacrum and the uterine axis is nearly parallel to that of the pelvis; then, as the bladder is emptied the uterus rises again to its former position. An overdistended rectum crowds the uterus well forward, even flexing the cervix upon the fundus, and at times raising the fundus well out of the pelvis. As the body is bent forward the uterus changes somewhat its position in the pelvis, which it tends to leave, approaching the abdominal cavity. In the dorsal posture the uterus sinks somewhat back toward the hollow of the sacrum, though normally this occurs only to a slight degree.

Now, the means by which this support, allowing as it does of such extensive change in position, is accomplished, is the same as all other organs of the body—namely, suspension by ligaments, for Nature makes no exceptions to her rules and takes no chances, and here on the cradle which she nurtures to fruition her greatest and most marvelous achievement she has been particularly lavish in this respect, as no other organ in the body compared in size has so many and so strong ligaments as the uterus.

That these ligaments are the sole support of the uterus is amply proven by investigation, and that the uterus derives its support from underlying structures is absolutely false, notwithstanding past, and even present, assertions to the contrary. That the perineum is not the support of the uterus, as was so long believed, is clearly demonstrated in cases of complete laceration when, though the integrity of the perineum is completely destroyed, the uterus still remains in place. The principal suspensory ligaments of the uterus are undoubtedly the uterosacral, two in number, passing from their origin at the third and fourth bones of the sacrum downward and forward to their insertion at the waist of the uterus. Composed largely of connective tissue, they are not as elastic as the other ligaments, and with the uterovesicle ligaments running forward to the bladder form a firm sling of tissue which holds the cervix in place. So long as they remain intact the cervix stays high up in the hollow of the sacrum and retrodisplacement, the first step of which is descent of the cervix, cannot occur. The uterovesicle ligaments together form a thick fibrous band, connecting the neck of the uterus to the posterior surface of the bladder, and control

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the antero-posterior and lateral motions of the uterus.

The broad ligaments are reflections of the peritoneum, passing from the lateral walls of the pelvis to the sides of the uterus. Their rôle is largely a passive one in relation to the uterus, in addition to aiding to the support of which their chief function seems to be the support of the uterine appendages and blood vessels going to the uterus.

The part played by the round ligaments is largely an accessory one and only at times are they called upon to actively enter into the support of the uterus. Attached to the fundus, they serve to guide and limit its excursions upward, and pulling away forward by virtue of their attachment to the external ring, it is easily seen how a tendency to retroversion is prevented so long as they maintain their normal tone. Largely muscular in structure, they possess, in common with other muscles, the power of undergoing hypertrophy and atrophy, which is well illustrated in pregnancy. Here they enlarge with the uterus, their chief function being to hold the fundus well forward as it rises in the abdominal cavity, thus keeping it in contact with the anterior abdominal wall and preventing injury to the intestines that might occur should they become anterior to the uterus and compressed between it and the abdominal wall.

After delivery involution takes place in the ligaments as well as in the uterus, and the subsiding fundus is held forward until it again reaches the pelvis in safety.

The malpositions most commonly met with and upon which our subject has the most direct bearing are the retrodeviations and procidentia. The former admit of two divisions, the versions and flexions, the difference between them being simply one of degree. We have seen how normally the uterus lies in the pelvis, supported by the broad ligaments on either side, and the firm sling of tissue composed of the uterosacral and uterovesicle ligaments holding the cervix well up in the hollow of the sacrum, the fundus being held forward, guided and limited in its excursions by the round ligaments. In this position the intra-abdominal pressure directed against its posterior surface helps also to keep the fundus forward. The first step in all retrodisplacements and procidentia is the sinking of the cervix, which results when the support of the uterosacral ligaments is lost. This brings the axis of the uterus more in line with the axis of the pelvis, changing its horizontal position, and admitting of a posterior recession of the fundus to the limits of control exerted by the round ligaments. This position is an extremely hazardous one for the uterus and one that cannot be maintained for any great length of time. Sooner or later the round ligaments, unable to stand the continuous strain put upon them, yield, either slowly, or suddenly, as in the traumatic displacements, thereby allowing the fundus to recede and the intra-abdominal pressure to act on its anterior face, forcing it back into the hol-

low of the sacrum. So long, then, as the cervix remains in place it is impossible for the retrodeviations and procidentia to develop, for the fundus and cervix cannot change their positions to any extent independently of each other. How, then, is this relaxation of the uterosacral ligaments, whereby the support of the cervix is lost, brought about? Probably the all-important mechanical factor in its causation is the constant traction downward exerted on the cervix by the posterior vaginal wall when a retrocele exists, for in complete laceration of the perineum, unaccompanied as it is by the formation of a retrocele, the cervix remains in place. Bearing these facts in mind helps greatly to an understanding of the process by which procidentia is brought about. Relaxation of all the uterine ligaments permits the sinking of the cervix, the swinging backward of the fundus and the descent of the uterus in the pelvis, when the downward pull of the retrocele and cystocele, plus the intra-abdominal pressure from above, do the rest.

This almost continuous tugging of the retrocele at the cervix is probably the all-important factor in causing its downfall, and explains the reason why many uncompleted retrodisplacements are permanently cured by replacing the uterus and operative correction of the retrocele, that invariably recurred under other forms of treatment.

In discussing the treatment of these malpositions, the retrodeviations and procidentia, I shall divide the former into two classes—the uncomplicated and the complicated—and the latter also into two—partial prolapse and complete prolapse.

That in individual cases the previously normal uterus can lie in a retroposed position without in any way affecting the general balance of health, is a well-known fact, but as the condition is a progressive one, proceeding from bad to worse, sooner or later indications for its correction arise. In uncomplicated cases, those free from adhesions and adnexial disease, and not congenital, where a retrocele does not exist, replacement of the uterus with the insertion and two to three months' use of a proper-fitting pessary is, as a rule, all that is indicated. The replacement may be effected in a number of ways. The one I prefer is downward traction with a tenaculum forceps on the posterior lip of the cervix, continued for a sufficient length of time to overcome the resistance offered by the patient, and to paralyze the uterine ligaments sufficiently to admit of the uterus being drawn fairly deeply down in the pelvis; the index finger of the free hand is then passed well up the rectum and with its tip firm pressure is made against the posterior face of the uterus above its waist. With this point as a fulcrum, the cervix is pushed backward into the hollow of the sacrum, when the fundus will swing forward into position. In dealing with large, subinvolved uteri it may be necessary to assist the fundus forward, and this can be accomplished by deep pressure on the abdomen, directed against the posterior surface of the fundus, or by placing

the patient in the knee-chest position to obtain the cooperation of gravity.

The uterus being replaced, a suitable-sized retroversion pessary should be introduced to retain it in place until involution is complete, and the ligaments have regained their normal tone and supporting power. This requires usually a period of two to three months, during which time the pessary should be occasionally removed and a smaller one substituted. The action of the pessary is not a support to the uterus in the sense of being placed under it to hold it up, as is so often believed, but by taking in the slack of the uterosacral ligaments, the cervix is kept up in place while they are regaining their normal tone.

It is in the retrodeviations developing shortly after a full-term delivery, or miscarriage in the latter months of pregnancy, that the pessary has its greatest field of usefulness and where it seldom fails to accomplish a cure if promptly used.

Where the displacement is accompanied by a rectocele, cystocele or lacerated perineum, they should be repaired. The treatment of the uncomplicated cases that do not yield to the pessary, and those complicated by adhesions, should be operative, for in the adherent retropositions, accompanying disease of the appendages is the rule to which there are few exceptions, and any efforts toward replacing the uterus without proper treatment of the appendages should not be attempted, for much harm is often done and time wasted in endeavoring to obtain an anatomical cure, which, however successful, will not result in a symptomatic one.

The methods of operative treatment in vogue at present are almost too numerous to mention, and I shall discuss only those designed to accomplish their result by acting directly on the supporting structures of the uterus, thereby utilizing the same means which Nature herself employs, as I consider that, except under extenuating circumstances, the creation of pathological ligaments, or adhesions, for this purpose is unscientific, unsurgical and highly dangerous to the future welfare of the patient.

We have seen how normally the position of the uterus is maintained by its ligaments, and that when these are relaxed to an extreme degree, the balance is destroyed and displacement occurs. The logical operative means, then, of reestablishing this balance is by shortening the relaxed ligaments, and this may be accomplished, as far as the uterosacral and round ligaments are concerned, by two methods of approach—the extra-peritoneal and the intra-peritoneal. The extra-peritoneal shortening of the uterosacral ligaments is performed through an incision in the posterior vaginal wall close to the cervix, and though at times extremely difficult of accomplishment, is highly efficacious. The round ligaments are reached by incision over the external ring, but this operation is open to the serious objection that it attacks the abdominal wall at its weakest points, where hernia is of most frequent occurrence.

These extra-peritoneal methods are only applicable to cases uncomplicated by adhesions and adnexial disease, so that their field of usefulness is necessarily limited.

In the cases complicated by adhesions and diseased appendages, composing the large majority of all retrodisplacements, access to the peritoneal cavity is necessary, in order that the adhesions may be separated and appropriate treatment of the appendages carried out. This demands an intra-peritoneal operation, and the pelvis may be reached in one of two ways—either through the abdomen or through the vagina. Each route has its advantages, but the vaginal is much to be preferred whenever practicable, as it is attended by less danger, immediate and remote, is followed by shorter and smoother convalescence and does not interfere with the integrity of the abdominal wall, which last, in view of the percentage of hernias developing after laparotomy, is an all-important consideration. The vaginal incision should be made through the anterior fornix, separating the bladder from the uterus, and entering the peritoneal cavity at the reflection of the peritoneum on the anterior face of the uterus. Having separated the adhesions and properly treated the appendages the round ligaments are then folded upon themselves and shortened to a degree sufficient to bring the fundus well forward into place. The incision is then closed and the uterosacral ligaments shortened extra-peritoneally through a posterior vaginal incision close to the cervix, any plastic work that may be indicated following. This operation restores as nearly as possible the normal integrity of the structures from which the uterus derives its support, and seems to me, based as it is upon sound anatomical principles, to offer the best solution of the problem at our command.

In dealing with complete procidentia we have to face one of the most difficult tasks known to surgery, and any operative measures except those which restore the integrity of the supporting ligaments will in the end prove futile. Repair of the rectocele, cystocele and perineum in cases of partial procidentia, with amputation of the cervix when elongated, will at times effect a cure by removing the mechanical cause and allowing the ligaments to regain their tone; but when the ligaments are greatly relaxed they should always be shortened as well. However firmly we may restore the integrity of the perineum below, or anchor the fundus above, the uterus, deprived of its normal powers of support, will tend to again prolapse, pushing through or dragging away from the artificial means by which we have endeavored to keep it in place.

The shortening of the uterosacral or round ligaments may be accomplished by either the vaginal or the abdominal route, but in the extreme degrees of procidentia it is necessary to shorten the broad ligaments as well, and this can only be done satisfactorily from above.

This brings me to a conclusion of the subject,

necessitated by the limited time at our disposal. I have purposely omitted reference to other forms of malposition, rare in their occurrence, or upon which our subject had not a direct bearing, nor have I described in detail the technique of the operations advised, which is readily accessible in the recent literature; but have endeavored to put before you briefly, to the best of my ability, the subject as I understand it, and to point out the lines along which, in my experience, any treatment hoping for permanent success should be conducted.

ABSTRACT FROM DR. WILLIAM B. PRITCHARD'S PAPER.

"Galvanism as a Curative Agent in Nervous Diseases; the Importance of Equipment and Technique."

Dr. Pritchard in part said, that medical electricity was not yet a science—that we had no knowledge of what electricity was, or its *modus operandi*. We had some knowledge of what it accomplished. Not all neurologists agreed as to its use or its scope. Some said that its field was very limited, all said that it had some use. The author thought, it had not more than a limited field, and was only to be used as an adjuvant in the treatment of disease. In the treatment of hemiplegias and kindred troubles it was not of much benefit. He had never seen it do much, if any, good in the treatment of *tabes dorsalis*. In inflammatory conditions it was contraindicated. It was of no use in poliomyelitis. In all forms of neuritis, paresthesias and fatigue psychosis there was a selective field for its use. There was no neurological disease in which its action was that of a specific. To get the best results, one must have a good equipment and one should not guess at the doses of galvanic electricity given. No expert knowledge or wonderful equipment was necessary in the employment of this form of electricity. The whole equipment could be obtained for the small sum of \$50. All that was necessary would be a meter, reostat, and a few carefully selected electrodes. The essayist showed his own form of electrodes, which consisted chiefly of burnished flexible metals, which as he explained were of especial benefit in that they would easily conform to the contour of the parts to which these electrodes might be applied. He said that the ordinary sponge-covered electrode was dirty and useless, furthermore, that it was nonhygienic. In applying his electrodes, he had made it a practice to first cover the part to which they were to be applied with a towel moistened in warm water, and upon this towel the electrodes

were placed. This was used to prevent local concentration of the current. Seances of less than twenty minutes' duration were useless, and in cases of sciatica an hour was often consumed in the application of the current. The author's electrodes were fixed with straps in order that the current might be applied continuously at the same rate and same pressure. This permitted the patient to move about and gave a better application than the unsteady hand of the administering physician.

The discussion was opened by Dr. J. J. MacPhee, who agreed with all Dr. Pritchard had said in favor of the use of galvanism in functional nervous troubles. He thought poliomyelitis might be included among the conditions directly benefited by its use, if given persistently and for sufficient time. It should not be used until about four weeks after the onset of the disease and should be continued while any response could be obtained in the paralyzed muscles. While he had not seen any direct good result from its use in other organic diseases, still he favored its use because of its indirect benefit. It enabled one to get better control of such cases and carry out a system of treatment with more advantage to the patient than could be obtained without it.

Dr. Milton Franklin remarked in discussing this paper, that medical electricity was far from being a science, but if there was one portion of medical electricity which had the rudiments of a science it was galvanic electricity. The current could be accurately and truly measured. It was acknowledged that the X-ray had some effect upon the tissues, but there was yet to be recorded a single case benefited from its use in any neurological condition. In "high-frequency currents" there was absolutely no known therapeutic use or benefit from it in internal conditions. He agreed with Dr. Pritchard in saying that the equipment should only consist of a meter, rheostat, and electrodes. The faradic current was practically useless in neurological conditions. If one told a man that he wanted electricity, it was the same as saying that he needed medicine. Prolonged application of the current was always necessary for the accomplishment of more than suggestive effect.

Dr. W. M. Leszynsky remarked that the patient's sensations were of importance in the regulation of the current as well as the strength of the current registered by the meter. Severe eschars would result from a defect in the covering of the electrodes. Dr. Pritchard, in closing, said that he had intended to say but little on the subject, as there was but little to be said with regard to the use of galvanism in neurology. In peripheral neuritis nothing could do more harm than the improper use of galvanism.

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STATE BOARDS OF MEDICAL EXAMINERS.

The action of the New Jersey Board of Medical Examiners in refusing to accept in the future, the license to practice medicine on the diploma granted by the University of the State of New York, once more brings before us the question of national control of this most important matter.

It is not to be wondered at that our New Jersey neighbors are a bit ruffled at the continued neglect with which our own State board has treated all their overtures for some sort of reciprocity. Their standards are practically those of our own State and they are as earnest in this matter as we are. It is more than likely that the step taken may prove to be a matter of no little inconvenience to those of the profession practicing in Greater New York, should the societies of our neighbors determine to wage an active war upon us. There are not a few of us who rely upon the Jersey practitioners for consultations, and should their societies so desire they might make it a bit embarrassing to these men when found within the confines of New Jersey.

Not alone are New York and New Jersey involved in the matter of non-reciprocal licensure, but all the States in the Union are bound to feel its weight. It is an obstacle to the progress of medical education in the whole country. New Jersey has no medical schools, but she has always been among the foremost in the upholding of standards of the highest sort in the licensure of practitioners. How can we of New York expect to help in the forward movement if we remain unwilling to meet the overtures of our sister State in the matter of reciprocal licensure? It is true that our requirements are high, but there are other States which require even more than do we,

and yet which do not refuse to recognize the value of our license.

What is the chief obstacle to the possibility of reciprocal licensure? It is nothing more or less than the old jealousy which has kept alive the desire to preserve intact, the so-called State rights. The Constitution of the United States was framed for the good of the greatest number and not for individual States or their inhabitants. Why, then, should it be regarded as unconstitutional for the Federal Government to take unto itself the right to regulate the practice of medicine in all of the States? But our legal brethren have decided that such is the case, and so we must be content to go on as before without a possibility of any final solution of this all-important Federal licensure.

But the question is not a hopeless one. The present generation may not solve the matter, but in this day, when the recent graduate realizes the large handicap the advanced methods of medical education have given him over his elder brothers, he will then gradually insist upon higher standards of license to practice medicine. In a comparatively short while the standard will have reached an equal point in all the States of the Union, and the result will be a uniform standard in the requirements of the separate States for the license of the practicing physician.

"NEWSPAPER DOCTORS."

The propriety of physicians granting interviews to the newspapers on medical topics is being discussed by the lay as well as the professional press.

Under the above caption *The Globe and Commercial Advertiser* of July 19th printed an editorial on the subject. After giving the physician's side of the question, it says, in part:

"From the layman's point of view this conservatism seems entirely unjustifiable. In the case of the illness of a great public man it claims the right to know what is the matter with him, and his chance of recovery.

"The practice of quoting as authoritative the opinions of unknown and hitherto unheard of phy-

sicians, which is unfortunately prevalent in certain newspapers, is reprehensible, not only because it readily degenerates into personal advertising, but even more, because it may deceive the lay reader into believing that Dr. So-and-So is qualified to speak with authority. There are a number of physicians in this city whose word on medical and sanitary subjects would frequently be of great immediate value to the public, but owing to their fear of getting the reputation of 'newspaper doctors,' as one of them puts it, they refuse to talk publicly on any medical subject. For many people the newspaper is the chief source of information on serious subjects, and the information which newspapers cannot get the public does not get."

The understanding by the public of matters relating to the medical sciences has progressed to such an extent that it demands a clear description and explanation of all things pertaining to health. It is quite true that the newspaper is the chief source of information for many people, and we believe the editor wants the best medical opinion—but, as *The Globe* points out, it is impossible to obtain an interview with physicians of standing.

The best solution of this question, thus far offered, is the appointment of a committee by the local medical society, which will hold itself ever ready to grant interviews and to give voluntary information on anything of public interest which involves professional opinions.

This is being tried in several of the smaller cities and is meeting with success. With the best men in all branches ready to help in this opportunity for education—with the newspapers asking for the truth and expert opinions, and with the public seeking information, are we not face to face with the best opportunity ever offered to rid our State of charlatans and quacks, and to break down the barriers which remain to the progress of the sanatory and medical sciences?

QUACK ADVERTISEMENTS.

The issue of *Collier's Weekly* for July 8th contains a very interesting and instructive article on the subject of quack advertisements, written by Norman Hapgood. Here it is shown how difficult is the problem of overcoming this ever increasing evil. "Is there any difference in the principle between the gold-brick doctor and the gold-brick medicine venders? No man is allowed to practice medicine without a license. . . . If, however, he puts up a certain amount of wood-alcohol and gives it an alluring name, he is allowed by our enlightened Government to prescribe it to people all over the country whom he has never seen. In this enterprise he is assisted by newspapers of every grade." How true is this statement: "The American public like to be fooled," said the late P. T. Barnum. And how well this fact was realized, the wealth that he left testifies. A story is told of a Massachusetts farmer that shows the ease

with which the credulous are beguiled by newspaper advertisements of "patent medicines." His daughter had been suffering with neurasthenia for some time and believed that she had an incurable female trouble, as the result of reading one of those "study-your-own-symptoms" pamphlets. So she ordered a dozen bottles of "Tell your troubles to a woman," and was fully restored to health, after she had consumed the first bottle. A few months later her father was taken ill, and as the local physician did not put him on his feet as rapidly as the old man wished, he called his daughter to his bedside and said: "Mary, where are the rest of those bottles that you got and were cured by? Waal now, I reckon as how, if that medicine cured you so fast it will fix me up too. Anyhow, I don't see no reason why it should be wasted."

The newspapers derive a large income from quack medicine advertisements and are naturally loath to stop them. Only the most stringent law will be able to control the evil, and as long as the newspapers have their hold on the legislatures of the country we cannot expect such laws to be made. The German Government has controlled the matter very well in compelling each and every manufacturer to publish in the papers an analysis of the preparation, signed by the Government chemist. In this way many of the quacks are kept out of the empire.

A very simple remedy to overcome this evil in this country would be to make a few slight changes in the "Copyright laws." If, for example, the manufacturers were compelled to register the formulæ of their preparations along with their labels or the names, which they so ingeniously devise, or if there were a law compelling the manufacturers to patent their nostrums, the public would be protected against such frauds. Attempts have been made to bring about such changes, but they have been frustrated.

A patent medicine is one the formula of which is on record in the Patent Office at Washington. The law requires that its contents shall be set forth and that the preparation shall always be constant in its constituent elements, so that at any time a chemist may extract from it the ingredients as set forth in the registered formula. As may naturally be expected, there are not two dozen "patent medicines" in existence.

Almost all of our States have passed very excellent laws prohibiting the unauthorized sale of opium and other poisonous drugs; yet the "habitué" of the proprietary cough medicine buys his "dope" at any corner drug store without hindrance. The "guide" in some of the Canadian provinces, and the workman of the "logging camps" of the regions, will almost to a man tell you that he prefers his "Perry Davis" to ordinary whisky.

State legislation can never overcome this evil; the only protection that will be furnished to the credulous public will have to originate in the Federal Government in Washington.

WORTHY OF ATTENTION.

In Mayor McClellan's address to the convention of the National Educational Association at Asbury Park on Tuesday, July 4th, are found two paragraphs worthy of attention.

How wholesome, for example, is this sentiment from the Mayor's address:

"The country needs men of thought and men of learning, and needs them badly. The man who thinks may be a greater patriot than the man who does. It has been said that no amount of sweetness and light will avail unless accompanied by action, which is the same as saying that the brain would be useless without the power of expression. We have deified action at the expense of thought. The good old motto, 'Act in haste, repent at leisure,' no longer stands at the top of our copybooks. We have so persistently preached the doctrine of action that we are almost convinced that any action is better than none. Not only have sweetness and light been discarded as effeminate fads, but thought and deliberation bid fair to follow them. 'If you can't act well, then act badly; but, for Heaven's sake, act,' threatens to become our guiding rule. When Samson pulled down the pillars of the temple he certainly performed a most vigorous action, and yet it may well be questioned whether a little more sweetness and light and a little less vigor might not have been as instructive and beneficial. Vigorous action is very admirable at times, but 'look before you leap' is a safe rule of life."

Then, too, how salutary is the lesson conveyed in these few lines of the Mayor's address:

"We suffer from the spirit of unrest which frequently prompts us to ill-considered, immatured and thoughtless action, often merely for the sake of doing something. We are inclined to applaud the man who does, not so much because he accomplishes anything useful as because he accomplishes something, be it good, bad or indifferent.

"This spirit of unrest permeates our whole national life, political, social, educational. Contentment bids fair to be banished from our existence. He who is content is sneered at as being without ambition, and yet ambition and hysterics are very different things. Contentment and happiness are synonymous, but we prefer to sacrifice both in a struggle for the unobtainable. Were our ambitions laudable our state of mind would be most commendable, but unfortunately we scarcely know what we are striving for. We have forgotten that deeds are merely a means to an end. Having no particular end in view, we treat the deeds themselves as the *summum bonum*, the ultimate object of attainment."

There is balmy truth enveloping these utterances of the Mayor's which should be taken home to every American heart. There are times when we should masticate crosscut saws, battle-axes and adzes, and assert that we are fond of the fodder, but for a steady diet aren't they rather trying?

AMERICAN MEDICAL ASSOCIATION SPECIAL.

On Saturday, June 24th, under the guidance of Dr. Wiggin, we were taken to the Pennsylvania depot, where we boarded the Lehigh Valley special train, consisting of five Pullman cars. At Bethlehem another car was added, which was filled with the Philadelphia guests. Sunday was spent at Niagara Falls, and we were taken over the Gorge route to the falls and rapids. Monday was spent in Chicago, and we visited the stock-

yards and hospitals and in the afternoon took an automobile ride through the residence and park districts.

Dr. Simmons met us and took us all over the buildings of the American Medical Association.

All of us came away satisfied that the Association has a complete, up-to-date plant, and one of which the members may well be proud. The next morning we arrived in Minneapolis. An enjoyable sail of twenty miles in Lake Minnetonka, visits to the Indian mounds, flour-mills, etc., took up the whole of the day. That night and the following day and night were spent in traversing the States of Minnesota, North Dakota and Montana. The Bad Lands of North Dakota, consisting of irregular elevations and depressions of gorgeously colored clay rocks, were sufficient recompense for the tediousness of the travel. Thursday we arrived at Gardiner, the end of the branch of the railroad leading to the Yellowstone Park. Here we were met by stages and taken to the Hot Springs Hotel. At this point began the most wonderful and enjoyable part of our trip. Each day the wonders increased until it would seem that all of the natural beauties of this planet were displayed here. The various geysers, hot wells, springs and paint pots, each somewhat different from the other, afforded an ever changing pleasure. The drive through the park covered more than 140 miles. The stages afford more easy riding than does a city buggy; the roads are smooth, and daily sprinkled, so that we had but little dust. Saturday was spent at "Old Faithful," so called on account of the geyser of that name which has spouted for years at hourly intervals. This building is one of the wonders of wonderland.

We are accustomed to look for masterpieces of woodworking and genius in architecture in the cities of the Old World and in ages gone by, in the same manner that we look upon the new world as the home of natural wonders, but here in this wilderness, a hundred miles from any civilization, and more than a thousand miles from any city of importance, is a building that architecture, woodworking and decorations of which will rank with any of the masterpieces of Europe.

Sunday was spent at Yellowstone Lake. This is the largest body of water in the world at this altitude, *i. e.*, about 1½ miles above the sea level. Many of the party went fishing, and there were few who did not closely approach the Government limitation of twenty trout per day—in fact, within a couple of hours the veriest tyro can secure that many of these beautiful fish. Monday and Tuesday were spent at the Grand Canyon of the Yellowstone. The colored pictures of this chasm that one sees at home are not exaggerations—in fact, it is well nigh impossible to re-

produce these colorings. On the evening of the Fourth of July a celebration was held by our party in the hotel parlors, the chief feature of which was the presentation of a testimonial to Dr. Frederick Holme Wiggin in consideration of his untiring efforts in getting up the party and the successful management of the trip. This testimonial took the shape of an album of views of the park, on each of which was the autograph of a member of the party. Speeches were made by Drs. Goffe, Campbell, Crosby, Kelly and Stevens. Dr. Mayer, of Hartford, contributed the following poem of dedication:

“What we would heartily express
 To one whose care has proved no less
 Than individual friendship given
 As free as dew from heaven,
 To one who led us from the East,
 To wonderland, to where the feast
 Of nature in her grandest mood
 To man untrammelled, unsubdued,
 Still heart and soul inspire,
 To one who saw all things were rightly done,
 That we were lodged, that we were fed,
 And watched o'er each distinctive head,
 To him would we express our thanks,
 And, though our warmly grateful ranks
 No gift of fitting worth can spend,
 Our sentiments must value lend,
 And may, when hours of future fall,
 Brightly this journey's joys recall.”

On the 6th we were entertained by the physicians of Butte, Mont. We were escorted about the mines, parks, etc., in a special car and souvenirs were distributed. It may be of interest to know that the fees here for an ordinary office visit are \$2.50; for outside calls, \$3; obstetric cases, from \$25 to \$50. A large amount of work is done on the contract basis at \$1 per month per man. Neither grass nor trees grow here, but saloons and copper flourish everywhere.

Friday we were entertained by the physicians of North Yakima, Wash. We were taken in carriages about the town and a reception and a lunch were supplied at the fair grounds; speeches were made by Drs. Wiggin, Frankhauser and Stevens. The physicians in this section, as well as every one else, are boomers, first, last and at all times.

Saturday was spent in Seattle, where a boat ride was given by the profession of this city to all who cared to take it. Most of the members preferred to explore this town, and all agreed that this was the first place that seemed like home since leaving New York. The place is well named, the “New York of the Pacific Coast.” The professional fees are about the same as in Baltimore. In the afternoon a trolley ride and reception were tendered to our party by the profession of Tacoma. We had an enjoyable time and were loath to leave these progressive cities.

Sunday we arrived in Portland, and for a few days discussions and papers took the place of sightseeing.

AN OLD DISEASE.

JULY 17, 1905.

C. E. DENISON, Editor, New York City.

Dear Doctor—Please find enclosed, herewith, a very old document, dating back to 1798. In settling up the estate of a very old lady here, “Katie Wager,” in 1903, Mr. Nathan Pulver, Justice of the Peace, found this paper and presented it to me.

It would seem interesting enough to be printed in the JOURNAL.

Yours truly,
 (Signed) J. J. MONTGOMERY.

Nicholas Wager, a farmer from the town of Troy, aged 56 years, after having been unwell several days with the complaint of the season, was brought from his lodgings near Coenties Slip to the hospital on the 25th of August, 1798. He had undergone some evacuations. At the time of his admission his tongue was dusky and pulse moderately full; he had a rendering pain across the forehead and great distress at the heart. By degrees, however, he fell into that heavy and torpid state which so often accompanies the distemper. A variety of food and drink of a nourishing kind had been prescribed for him. On the 28th he became disinclined to take them; the whole quantity allowed during the day amounting to no more than a few ounces of panacea; the aversion to fluids increased until the next morning. The following extract from the hospital records exhibits his situation a little before he died:

He has continued very much agitated during the night and an aversion to fluids came on. This is so remarkable as to be manifestly hydrophobic, for on offering him drink at this moment there was evidently an abhorrence of it, and on putting some lemonade with a spoon into his mouth the pharynx was convulsed and spasms extended along his arms; symptoms of opisthotonos took place immediately after, and on attempting to raise his body the whole muscles of the back were rigid; while raised up the spasms of the pharynx were renewed by attempting to give him some warm wine, which he was unable to swallow. His extremities were now cold, his pulse not perceptible at the wrist and he appears under the spasms and tremors of departing life. He soon after expired.

There are some members who have not returned the card acknowledging notice of the annual meeting of the State Association in October. It is earnestly requested that the members give this matter their earliest attention in order to save the expense of the personal service.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, and all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR AUGUST.

Onondaga County Association—Monday, August 21st.

Tompkins County Association—Tuesday, August 8th.

Ulster County Association—Monday, August 21st.

Third District Branch Association.—At the twenty-first annual meeting, held at Cortland, June 22d, Dr. E. Eliot Harris gave a history of some of the work in Albany in the interest of the public health, and then read the following resolutions, which he asked the meeting to consider:

WHEREAS, The number of bills introduced in the Legislature creating examining boards for some special department of medicine is increasing each year, and as the various bills provide a special examination which differs from the examination now required to obtain a license to practice medicine in this State, and in view of the fact that the medical profession is called upon to be active in Albany each year to protect the public health from such pernicious legislation. Be it

Resolved, That the Third District Branch believes that the time has arrived to create a sentiment in the medical profession as well as in the Legislature of this State in favor of one medical examining board instead of the three separate examining boards now provided in the law, and to counteract the growing tendency in the State Legislature to create special examining boards for some of the popular medical fads.

Resolved, That the Committee on Legislation of the Third District Branch Association shall cooperate with the Committee on Legislation of the State Medical Association, in preparing a bill to be introduced at the coming session of the Legislature embodying the recommendations contained in these resolutions.

Resolved, The Committee on Legislation shall be empowered to confer with other medical bodies in the preparation of the bill.

The resolutions were brought properly before the meeting on motion of Dr. George A. Edwards, of Syracuse. After discussion by Dr. E. D. Ferguson and others the resolutions were unanimously adopted.

FOURTH DISTRICT BRANCH MEDICAL ASSOCIATION.

The twenty-first annual meeting was held at the Genesee Valley Club, Rochester, on Tuesday, June 6, 1905.

The meeting was called to order at 10.30 A. M. by the president, Dr. J. W. Morris, of Jamestown. The minutes of the previous annual meeting were read and approved.

The secretary read the report of the Executive Committee.

The report of the treasurer was read and referred to an Auditing Committee for approval.

Dr. Wall made a motion that an assessment of 50 cents be levied upon the members present. Seconded and carried.

The Nominating Committee retired to nominate officers for the ensuing year.

Dr. Morris made the presidential address, emphasizing the importance of members taking an interest in their local organizations and attending meetings.

Dr. J. Riddle Goffe, of New York, president of the State Association, was introduced to the meeting. He stated that as far as the vote upon the question of the amalgamation of the two State organizations had been recorded, there was a large majority in its favor. Dr. Goffe corrected a number of misapprehensions which seemed to exist in regard to this matter and urged all those who had not recorded their vote to do so at once.

Dr. Rochester, of Buffalo, moved a vote of thanks to Dr. Morris for his address, and to Dr. Goffe for his explanation of the amalgamation question. Seconded and carried.

Mr. Henry W. Conklin, of Rochester, counselor at law, read a paper entitled "Introspection," which dealt in a good-natured way with certain foibles which the two associations had in common.

Dr. William H. Thornton, of Buffalo, moved a vote of thanks to Mr. Conklin for his interesting and instructive address.

Dr. George W. Goler, of Rochester, read a paper entitled "Some Problems in Tuberculosis." He emphasized the need of instruction in the matter of hygienic living in order to eradicate the disease.

Dr. Rochester led the discussion. He believed that isolation of ambulatory cases is the most important factor in stamping out tuberculosis.

The paper was also discussed by Dr. Home of Phelps. Dr. Goler closed the discussion.

The Committee on Nominations reported as follows:

For president, Dr. James C. Davis, Rochester; for vice-president, Dr. Herbert F. Gillette, Cuba; for secretary, Dr. William Irving Thornton, Buffalo; for treasurer, Dr. Charles O. Green, Hornellsville. Members State Nominating Committee: Dr. C. G. Bennett, Buffalo; Dr. Frank L. Stone, Leroy.

Dr. Wall moved that the name of Dr. Bernard Cohen be substituted for that of Dr. Davis. Dr. Rochester stated that where there was a contest in the election of one officer it was proper to ballot on the names of the two contestants and adopt the report of the balance of the ticket.

On motion this procedure was adopted.

By ballot Dr. Davis was elected, having received 22 votes; Dr. Cohen, 14.

The secretary was instructed to cast a ballot for the remaining ticket, and they were declared duly elected.

Dr. Davis reported for the Committee of Arrangements, and stated that dinner was ready to be served under the auspices of the Monroe County Medical Association.

The afternoon session was called to order at 2.25.

The Auditing Committee reported that the records of the treasurer were correct.

Dr. Goffe supplemented his remarks of the morning by designating certain members to canvass the different votes upon the amalgamation question.

The first paper of the afternoon was read by Dr. De Lancey Rochester, of Buffalo, entitled "The Prognosis and Treatment of Valvular Diseases of the Heart."

In general, aortic insufficiency is the most serious valvular lesion and mitral insufficiency the least serious. The prognosis of acute valvular disease is better than in the chronic forms, particularly in children under 5 years of age.

Dr. O'Hare expressed his appreciation and approval of the finished and scholarly address of Dr. Rochester.

Dr. J. Riddle Goffe, of New York, read a paper entitled "The Dynamics of the Female Pelvis in Relation to the Positions of the Uterus."

He explained the different planes and axes of the pelvis and the ligaments of the uterus and their relation to its position. The mechanism of retroincision was illustrated.

He believed that the best operation for this condition was shortening the utero-sacral ligaments.

The discussion was opened by Dr. C. C. Frederick, of Buffalo. It was also discussed by Dr. G. W. Goler, of Rochester.

Dr. C. N. Palmer, of Lockport, read a paper entitled "A Peep Into the Medical Horoscope." The paper was full of epigrammatic ideas and was well received.

It was discussed by Drs. Frederick and Goler.

Dr. Arthur G. Bennett, of Buffalo, gave a paper entitled "Some Peculiar Reflexes of Eye-Strain," reporting the following conditions, which were relieved by glasses: One of bradycardia; two of hiccough; one of sneezing; one of chronic pharyngitis.

The paper was discussed by Dr. N. B. McDowell, of Rochester.

Dr. Joseph R. Culkin, of Rochester, read a paper entitled "Pneumonia in Children." The three varieties, viz., broncho, tubercular and lobar, were discussed particularly as to their differential diagnosis.

The paper was discussed by Dr. De Witt H. Sherman, of Buffalo.

WILLIAM IRVING THORNTON, Secretary.

Dr. Thomas F. Reilly, of New York City, has been elected chairman of the Section on Pharmacology and Therapeutics of the American Medical Association.

AMERICAN MEDICAL ASSOCIATION.

The general meeting of the American Medical Association convened at Portland, Ore., with the opening of the House of Delegates on Monday, July 10th. There were on this day two sittings of the House. The address of the retiring President, Dr. John H. Musser, of Philadelphia, was delivered in a brief but most excellent manner. The secretary reported that there had been an increase of 3,951 members over the membership of the previous year. At the sitting of the House of Delegates, held on Tuesday afternoon, July 11th, the committee on the Senn prize essay awarded the prize to Dr. John L. Yates, of Chicago, the subject of the essay being Peritoneal Drainage. Dr. E. Eliot Harris, of New York, made a motion to the effect that the arrangements for the annual meetings be placed in the hands of the Board of Trustees, and the cost of the same be defrayed by the Association. The House of Delegates passed the resolution recommending the purchase of Engelhard's Standard Medical Directory, in order that the task of publishing the Association's directory might be more easily accomplished. The Chairman of the Board of Trustees, Dr. T. J. Happel, offered a resolution whereby the president of the Association be relieved from the duty of presiding over the House of Delegates, and that the House of Delegates should elect its chairman for the day's session.

The attendance at the present meeting of the American Medical Association has been much larger than was anticipated; up to the third day of the meeting between 1,700 and 1,800 members had registered at official headquarters. After quite a little argument and discussion it was voted to hold the next meeting of the association at Boston, Mass.

After the usual preliminaries, the following officers of the Association were elected for the ensuing year: President, Dr. William J. Mayo, Rochester, Minn.; first vice-president, Dr. Walter Wyman, United States Public and Marine Hospital Service; second vice-president, Dr. Kenneth A. MacKenzie, Portland, Ore.; third vice-president, Dr. Eugene S. Talbot, Chicago, Ill.; fourth vice-president, Dr. Edward Martin, Philadelphia, Pa.; secretary, Dr. George H. Simmons, Chicago, Ill.; treasurer, Dr. Frank Billings, Chicago, Ill.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

THIRD DISTRICT BRANCH.

Broome County—Andrew S. Fritts, Binghamton; Charles E. Thomson, Binghamton.

FOURTH DISTRICT BRANCH.

Monroe County—Nathan Davis McDowell, Rochester; Alvah C. Remington, Rochester.

Wyoming County—Charles Maynard Smith, Johnsonburg.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Doty, Alvah H., Quarantine, New York.
 Dugan, John A., Albion, N. Y.
 Gillette, Arthur A., Rome, N. Y.
 Hallock, Luther Reeve, New York City.
 Jarcho, Julius, New York City.
 Lesem, William W., New York City.
 Miglionico, Gabriele, New York City.
 Pearse, Richard M., Albany, N. Y.
 Pierce, Louis R., Newburgh, N. Y.
 Thompson, E. C., Newburgh, N. Y.
 Wakeman, Bertis Rupert, Hornellsville, N. Y.
 Williams, Henry T., Rochester, N. Y.

OBITUARY.

Dr. Augustus Palmer Dudley, of New York City, died in Liverpool, England, Saturday, July 15th. Dr. Dudley was born in Phippsburg, Me., in 1853. After attending the Portland Academy he went to the Dartmouth Medical School, from which place he graduated in 1877. After practicing in Portland for some years, he came to New York, where he has practiced ever since. Dr. Palmer was a member of the American Medical Association, The New York State Medical Association, American Gynecological Society, Medical Society of the State of New York, New York Academy of Medicine and the New York Obstetrical Society. He was Professor of Gynecology at the Post-Graduate Hospital and the Harlem Hospital and the Medical School of the University of Vermont, and Surgeon to the Harlem Hospital. He was at one time Chairman of the Section on Gynecology and Obstetrics of the American Medical Association. At the time of his death he was on his way as a delegate from the United States to the International Medical Congress, to be held in St. Petersburg in August.

* * *

Dr. William H. Vincent, president of the Cattaraugus County Medical Association, died at his home in Hinsdale, N. Y., on Wednesday, June 12th, after a long illness. Dr. Vincent was a graduate of the University of Buffalo, Class of 1881. He was a member of The New York State Medical Association and the Medical Society of the County of Cattaraugus.

* * *

Dr. Herman J. Schiff, of New York City, died very suddenly at Ogdensburg, N. Y., on Monday, July 24th. Dr. Schiff was a graduate of the College of Physicians and Surgeons, New York, Class of 1884. He was a member of The New York State Medical Association, the Medical Society of the County of New York, Alumni Association of Mt. Sinai Hospital. He was surgeon to St. Mark's Hospital and Mt. Sinai Dispensary.

COMMUNICATIONS.

LOCKPORT, N. Y., June 10, 1905.

CHARLES E. DENISON, M.D., Chairman Committee on Publication:

Dear Doctor—I enclose herewith my paper on "A Glance at the Horoscope of Medicine," as requested by you, for insertion in THE NEW YORK STATE JOURNAL OF MEDICINE. I shall be glad to distribute as many of the JOURNALS containing the article as you may send me, and I shall endeavor to send them to those who are not already receiving the JOURNAL. Hoping that it may stimulate the profession to further exertion in the line of prophylaxis, and thanking you for being honored with a place in our valuable JOURNAL, and trusting we may be able to continue its publication after the union of the societies, I am,

Very truly and fraternally yours,

C. N. PALMER.

_____, N. Y., June 10, 1905.

CHARLES E. DENISON, M.D., Chairman Committee on Publication:

My Dear Doctor—Several questions having occurred to me during the last few days and since sending my proxy, I have determined to write, asking you to answer them or publish my questions, so that others may answer.

If the two medical bodies in the State are combined, as proposed—

Will we have our JOURNAL, as heretofore?

Will we have our directory corrected annually and in as fine arrangement as now?

Will the malpractice defense feature continue?

Why was the old committee reappointed?

Why was there not a *new* committee appointed?

Last but not least—

Why is no proxy provided for "the other fellow," who *may* want to vote *against* the agreement?

These half-dozen problems having confronted me, I ask that you publish them, that I may find out if others have "seen visions."

Fraternally yours,

C. W.

This communication from C. W. in the July number of the JOURNAL contains questions, which we trust we shall answer satisfactorily. The first three questions can be answered together—whether the JOURNAL, directory and the malpractice defense will be continued by the Society after amalgamation. This decision will rest with the House of Delegates of the united body. Neither of the two medical bodies has at present the right to bind the united body to future actions in regard to these matters. The wisdom of the continuance of these three projects is clear beyond question to the members of the Association.

The next two questions of why the old committee was continued and why a new committee was not appointed, can be answered together. Few realize the enormous amount of detail and

tedious work which the committee performed in their endeavors to bring about the amalgamation. Most of this would have to be done over again with a new committee, and for that reason, it seemed wise to appoint the old committee. The appointment of the old committee meant an enormous saving of time in bringing about the already delayed amalgamation.

The last question concerns the proxies. The Association last year voted unanimously to amalgamate, the delay to amalgamation being due purely to legal complications. It did not seem, therefore, necessary to prepare proxies voting against the expressed will of the Association. It is the right and privilege of any member to come to the meeting and vote against anything and everything, as his judgment dictates. It is equally the right and privilege of any member to prepare a proxy for himself and endow some other member with the power to vote it at the meeting. The proxies were sent out by the unanimous vote of the Council in their endeavors to fulfil the legal technicalities necessary to carry out the expressed wish of the Association.

News Items.

Dr. S. T. Armstrong has been appointed Superintendent of Bellevue and the Allied Hospitals. After graduating from the St. Louis Medical College in 1879, Dr. Armstrong entered the Marine Hospital Service; later he was Visiting Surgeon to the Riverside Hospital, North Brothers Island, and the Willard Parker Hospital. From 1890 to 1900 he was in charge of the medical department of the army at Puerto Principe, Cuba, as a brigade surgeon, with the rank of Major. Later he held a similar position in the Philippine Islands.

STATE OF NEW JERSEY BOARD OF MEDICAL EXAMINERS.

At the annual meeting of the State Board of Medical Examiners of New Jersey, held at Long Branch, N. J., July 5th, the following resolution was adopted:

WHEREAS, The educational and examining standards for the medical license of New Jersey are at least equal in all respects to those of New York, and in some respects higher, and

WHEREAS, The degree of unreasonableness in the matter of interstate endorsement on the part of New York cannot further be ignored; therefore be it

Resolved, That on and after October 16th, the date of the next regular meeting of this Board, the endorsement of medical licenses issued by New York will be suspended until further notice.

E. L. B. GODFREY, M.D., Secretary.

SUMMER DOCTORS.

In all the sections of our common country in which the summer boarder or the summer cottager has struck his roots and come to be recognized as a factor in the economic life of the communities in which he æstivates, the question of medical attendance has become burning. The country doctor naturally assumed that he was to share in the prosperity of his neighbors and patients, the agriculturists, who "put" their products to the summer sojourner at prices from twice to ten times the local market. Visions of fees of \$1.50 per visit, instead of his customary 75 cents, began to flit alluringly before his eyes. But he forgot to allow for the fact that doctors as well as patients might æstivate. Not all city doctors go to Europe every summer. The baser sort go into the back districts of their own beloved land as cottagers, the refuse and offal even as boarders, and in their villeggiatura keep one eye open on the main chance. The urban patient prefers them to the rural practitioner. We will not undertake to say whether he is right, though on that point we entertain a decided opinion. At any rate the New Yorker, Bostonian, Philadelphian, in fact betrays in his rustication a preference for the urban practitioner. And the country doctor does not in fact partake the benefits of the urban Pactolus which irrigates the rural purveyor of milk, eggs, and "livery." Nay, more. The very country doctor's own rural patients in some cases exhibit a preference for the treatment of the visiting city practitioner. Not in many cases, and not in any case more than once, seeing that three visits from a fashionable New York specialist, at city prices, would suffice to darken with a mortgage any farm in New Jersey or New Hampshire. But, even without this aggravation, the lot of the country doctor in the face of the annual city influx is hard, harder than it was before.

The trodden medical worm will turn. The trodden medical worm has turned in New Jersey. He has also shown symptoms of turning in the rural regions of all the "Metropolitan States." He says in New Jersey, and more or less elsewhere, that the loafing city doctor who wishes to come to the assistance of suffering humanity during his vacation, when he ought to be playing golf, must take out a local license for the practice of medicine. The city doctor says that really no man after he has been out of a medical college for ten years can be expected to pass a technical professional examination, and insists upon being allowed to practice on the ground of interstate comity. But he is clearly, technically, in the wrong. Our own sympathies are distinctly with the country doctors, who are entitled to share the general perquisites of their neighbors, and against the city doctors, who ought to be improving their game of golf or imbibing the beauties of nature instead of healing the sick or burying the dead. Let the good work go on.—*New York Times*.

We have received the first number of *Surgery, Gynecology and Obstetrics*, a new monthly magazine, published in Chicago, Ill., under the management of Franklin H. Martin, M.D. Among those on the editorial staff are John B. Murphy, M.D.; J. C. Webster, M.D.; C. S. Bacon, M.D.; E. C. Dudley, M.D.; R. W. Holmes, M.D., and others.

The first issue contains articles by Drs. Nicholas B. Senn, E. G. Montgomery, J. Clarence Webster, Ed. P. Doris, J. Whitridge Williams, J. Clifton Edgar, H. D. Fry and others of equal prominence.

We wish the new enterprise every success.

PHARMACOLOGY.

Council of Pharmacy and Chemistry, American Medical Association.

OFFICIAL REPORT ON ACETANILID MIXTURES.

The following report has been approved by the Council:

To the Council on Pharmacy and Chemistry of the American Medical Association:

In response to the request of your chairman we have investigated the below-mentioned preparations and report as follows:

Specimens of the articles were bought in different cities in the open market, and in original, sealed packages, and were analyzed by some of us or under our direction. Each article was examined by at least two chemists, and some were subjected to several analyses. While certain of the preparations are represented as being chemical compounds, the specimens examined were all found to be mixtures, the principal ingredient being acetanilid. The percentage proportions of acetanilid given below are the minimum obtained by any of the analysts.

Soda and ammonia, combined with carbonic acid, are calculated and reported as sodium bicarbonate and as ammonium carbonate (U. S. P.), respectively. Salicylic acid is calculated and reported as sodium salicylate. Diluents and other constituents than those reported were not determined.

AMMONOL.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Sodium Carb.	Ammonium Carb.
50.	25.	20.

ANTI-KAMNIA.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Caffein.	Citric Acid.	Sodium Bicarb.
68.	20.	5.	5.

KOEHLER'S HEADACHE POWDERS.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Caffein.
76.	22.

ORANGEINE.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Sodium Bicarb.	Caffein.
43.	18.	10.

Other constituents said to be present were not determined.

PHENALGIN.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Sodium Bicarb.	Ammonium Carb.
57.	29.	10.

Certain packages of phenalgin were purchased which on analysis did not show ammonium carbonate.

SALACETIN.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid.	Sodium Bicarb.	Sodium Salicylate.
43.	21.	20.

We recommend that this report be printed in *The Journal of the American Medical Association.*

Respectfully submitted,

J. H. LONG, M.S., Sc.D.,
 W. A. PUCKNER, Ph.G.,
 S. P. SADTLER, Ph.D.,
 J. STIEGLITZ, Ph.D.,
 H. W. WILEY, M.D., Ph.D.

Committee on Chemistry, Council on Pharmacy and Chemistry of the A. M. A.

MEASUREMENTS OF THE PELVIS.

At the meeting of the American Gynecological Society held at Niagara Falls, May 25-27, 1905, a committee composed of Drs. A. F. A. King, William Williams, Edward P. Davis, reported that they were able to define a typical head and pelvis, giving measurements which should be standard for teaching purposes, as follows:

External measurements of the pelvis:

	Inches.
Iliac crests.....	11
Infraspinous.....	11½
External conjugate.....	8
External oblique.....	8¾
Bitrochanteric.....	13

Internal measurements of the pelvis:

	Inches.
Conjugata vera.....	4¼
Diagonal.....	5
Transverse.....	5½
Anteroposterior.....	3¾-4¼
Transverse.....	4½
Depth of pelvis at symphysis pubis.....	2
Depth of pelvis at tuberosities of ischia.....	5

Diameter of head:

	Inches.
Occipitontal.....	5¼
Occipitofrontal.....	4¾
Frontontal.....	3½
Biparietal.....	3¾
Trachelobrigmatic.....	3¼

ADVANTAGES OF A LOCAL MEDICAL CLUB OR SOCIETY.¹

Gentlemen—I have been asked to give a few of my ideas upon the question of the advantages of a local medical club or society. As stated in the announcement of this meeting, the subject of the possibility and practicability of such an organization of the local profession is open for discussion to all of those who desire to attend.

Personally I am extremely gratified to have so many of the profession here to-night. I think that the social spirit manifested by coming out to the little repast which has been furnished is a pretty good indication of the attitude of the members of the profession toward this question of organization.

It may seem to some that with the number of county and State medical bodies in existence a local society would be superfluous. It is necessary, however, only to inquire into the conditions

¹Read at the inauguration of the Medical Club of Middletown, N. Y., June 9, 1905.

present in other cities than our own to find that there does exist a very evident need of such local union among men working in the same profession.

Of course, cities of any considerable size have their academies of medicine, physicians' clubs, etc., but there are smaller cities which have some sort of local combination for mutual protection and scientific advancement.

Our sister city of Newburgh has long maintained a very excellent society of this kind, even in the presence of two county medical bodies.

It is an evident fact that no movement of this kind arises unless there exists an actual need for organization.

It has seemed apparent to some of us that the time is now ripe for some sort of a medical club or society in Middletown and vicinity.

I believe that the first mention of this matter was made while Dr. Stivers, Dr. Shelley and myself were en route to the annual meeting of the State Society on February 1, 1905. We all agreed that it would be an excellent plan for Middletown to have a local society. Dr. Shelley especially suggested "something to eat" as a means of promotion of good fellowship.

Since that time we have talked to a number of men, and all seemed to agree that some plan of organization would be a good thing.

Only recently the clergy of this city formed a ministerial association, and hold meetings at which a dinner is usually served, and personally I do not see any reason why the medical fraternity of this city cannot do likewise.

It remains for me to give you as briefly as I can a few ideas of the possible advantages which would be enjoyed if we had such an organization in this city, to suggest and elicit points for discussion, and, after all have expressed their opinions upon the subject, whether of a favorable or unfavorable character, to possibly obtain an expression as to whether we can organize the profession along the lines laid down in the discussion, and possibly to elect officers and a committee to draft a set of by-laws.

The evident advantages of a local society such as I have in mind are these:

First.—The advancement of scientific knowledge by frequent meetings, papers, cases, discussions, post-graduate instruction by members of other societies in other cities, either by clinics or papers, or demonstrations.

Second.—The promotion of good-fellowship, confidence and social spirit among the local members of the profession, and also among the families of those represented.

Third.—The education of the profession and laity in regard to what are the requirements of professional ethics by a more careful observance of its provisions among ourselves and proper instruction of the public by furnishing them with copies of the Principles of Ethics of the American Medical Association, as well as fre-

quent and pertinent articles in the daily press or by personal explanation of these requirements.

Fourth.—Prevention of the abuse of our hospital privileges by those perfectly able to pay for services.

Fifth.—Possible maintenance of a circulating library of medical books and magazines for the benefit of our members.

Sixth.—Prevention of counter-prescribing by the druggists of this city and the possible establishment of a stock company drug store by the physicians where prescriptions will not be substituted and strictly ethical drugs dispensed, patent and proprietary medicines to be excluded.

Seventh.—The establishment of a chemical and bacteriological laboratory for the rapid diagnosis of disease either at the hospital or elsewhere, to which all members of the profession could bring specimens for examination.

Eighth.—Education of the public as to all matters affecting the health of the city and cooperation with the local health authorities in these matters.

Ninth.—Supervision of the local press by a press committee as to the character of the advertising matter appearing therein, which, as is well understood, is often of very questionable nature; and also to suppress medical advertising through its pages.

Tenth.—Aiding in securing the passage of proper legislation for the medical profession in city, county and State affairs.

Eleventh.—Protection of the profession against the growing evil of contract practice, which has ruined the profession in many of the European countries, as well as the proper regulation of life-insurance fee.

Twelfth.—Protection of members from delinquent debtors by keeping a list of "dead beats," such list to be so collected as not to expose the physician who contributes the name of a debtor, and the publishing of a uniform fee-bill, containing in detail the proper charges for every branch of practice.

I have thus tried to give you an outline of some of the possible advantages of a local medical club, and trust that you will not hesitate to criticize and discuss the various points offered.

The topic of fee-bill and delinquent debtor list I wish to elaborate more fully and I cannot do better than read a few articles which I have collected from various sources which may give some idea as to what some local associations are doing along this line.

In closing, I wish to thank you for your presence and in giving attention to these suggestions. I trust that you will all feel free to express your views in this matter, and if we can succeed in making the burdens of our profession easier by any of the means suggested I shall feel amply repaid for any effort I may have made in this direction.

Book Reviews.

PROGRESSIVE MEDICINE, VOL. 11, JUNE, 1905. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and *Materia Medica* in the Jefferson Medical College of Philadelphia. 8vo., 346 pages, 48 illustrations. Per annum, in four cloth-bound volumes, \$9; in paper binding, \$6; carriage paid to any address. Philadelphia and New York: Lea Bros. & Co.

The second volume for 1905 of this most excellent review of the advances in medicine and surgery contains the following articles: *Hernia*, by Wm. B. Coley, M.D.; *Abdominal Surgery*, by E. M. Foote, M.D.; *The Year's New Work in Gynecology*, by John G. Clark, of Philadelphia; *hematology and the diseases of the ductless glands* have been supervised by Alfred Stengel, M.D., of the University of Pennsylvania; the compilation of the more recent studies in ophthalmology has been done by Edward Jackson, M.D., of Philadelphia.

The same method of presenting the material has been followed in this volume which have made the previous ones of such value to the busy practitioner who has not the time to spend hours of library research. The subject matter has been presented in a most clear and concise manner, giving in a few words the gist of the leading articles both in American and foreign literature.

A TREATISE ON HYGIENE AND SANITATION. For Students, Practitioners, Health Officers, etc. By Charles Harrington, M.D., Assistant Professor of Hygiene in Harvard University Medical School, Boston. New (third) edition, thoroughly revised. In one 8vo volume of 793 pages, with 118 engravings and 12 plates. Cloth, \$4.25 net. Philadelphia and New York: Lea Bros. & Co., 1905.

The third edition of Dr. Harrington's Practical Hygiene has been revised and enlarged, thus making this most popular text-book thoroughly up to date. The sections on malarial and yellow fever infections have been entirely rewritten. New statistics in regard to the prevalence of tetanus in toy-pistol wounds are given. A new section on uncinariasis disease in the Southern States has been added. A review of the epidemic of typhoid fever from polluted water supply in Butler, Pa., and Ithaca, N. Y., is of great value to health officers and others in charge of the water supply of cities. The epidemic of typhoid fever at Ogdensburg, N. Y., from polluted ice is accurately traced.

A new section on the destruction of algae in reservoirs used as a public water supply has been written. The value of copper sulphate is impartially discussed.

The sections on disinfectants has been rewritten and revised, especially in regard to surgical disinfection.

An entire new chapter on immunity has been added. This chapter discusses in detail Ehrlich's theory and Metschnikoff's theory. But most valuable of all is the section on the "Practical Application of Studies in Immunity," in which the various infectious diseases and the antitoxins so far produced are admirably explained, as well as the present limitations of antitoxins in general.

As a complete authoritative manual on all questions relating to public health, military and naval hygiene, and preventive medicine, this edition of Dr. Harrington's work can be heartily indorsed. It is at present the best text-book for students, and the general practitioner will find it of great value in every-day work.

TEXT-BOOK OF MATERIA MEDICA: INCLUDING LABORATORY EXERCISES. In the Histologic and Chemico Examinations of Drugs. For Pharmaceutic and Medical Schools, and for Home Study. By Robert A. Hatcher, Ph.G., M.D., Instructor in Pharmacology in Cornell University Medical School, of New York City; and Torald Sollmann, M.D., Assistant Professor in Pharmacology and *Materia Medica* in the Medical Depart-

ment of the Western Reserve University, of Cleveland. 12mo volume of about 400 pages, illustrated. Flexible leather, \$2 net. Philadelphia, New York, London: W. B. Saunders & Co., 1905.

Dr. Hatcher has treated this very dry subject in an unusually interesting manner, making it easier for the student to retain the subject matter. In this he has departed from the older methods.

The laboratory procedures in the study and classification of drugs is set forth in the macroscopic and microscopic description of most of the more common drugs.

We can heartily recommend this volume as a working text-book for students.

THE OPHTHALMIC YEAR-BOOK. A Digest of the Literature of Ophthalmology, with Index of Publications for the Year 1903. By Edward Jackson, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic; President of the American Academy of Ophthalmology and Oto-Laryngology; Ophthalmologist to the Denver County Hospital, St. Anthony's Hospital and Mercy Hospital, Denver, etc. With 45 illustrations. The Herrick Book and Stationery Company, Denver, Col., 1904.

This book is an excellent, systematic arrangement of the literature on ophthalmology for the year. The author has furnished a digest of the literature that is important; second, of the publications for 1903 the title of each book is given and date of publication. *The Journal* articles are arranged alphabetically, according to the authors' names.

CLINICAL FEATURES OF THE PATHOLOGY AND THERAPY OF DISORDERS OF METABOLISM AND NUTRITION. By Prof. D. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfurt a/M. Part VI, Drink Restriction (Thirst Cures), Particularly in Obesity, by Prof. Carl von Noorden and Dr. Hugo Salomon. Price, 75 cents. New York: E. B. Treat & Co., 1905.

An excellent monograph on thirst cures, giving a practical review of the therapeutic application in restriction of liquors. The evil effects of ingested liquids, due to the labor of the heart and kidneys, is forcibly put, and adds to our knowledge of how our patients are victims of dilated heart and dilated stomach. "In cases of nephritis the restriction of liquids is an important postulate of rational treatment, particularly in contracted kidney." For the benefit of obesity, we commend the reading of this work.

THE INTERNATIONAL MEDICAL ANNUAL. A Year-Book of Treatment and Practitioner's Index. 1905, twenty-third year. A résumé of the year's medical literature, by thirty-six department editors, with added articles by noted specialists. Price, \$3. New York: E. B. Treat & Co.

In this volume the publishers have improved the appearance and added greatly to the usefulness of this reference-book. The larger-size page gives better opportunity for illustrations and display text. As a reference-book it is the best for rapid work ever published. Many subjects are here treated which are not in the text-books. The contents are divided into three parts: First, the Dictionary of *Materia Medica* and Therapeutics; second, the Dictionary of Medicine and Surgery; third, Sanitation. The popularity of the work is ever growing, and it stands high as a ready book of reference to the general practitioner of medicine and surgery.

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. Collected and arranged with critical editorial comments. Under the general editorial charge of George M. Gould, M.D. Surgery and Medicine. Philadelphia and London: W. B. Saunders & Co., 1905.

This work, under the authorship of Dr. Gould, maintains the high position for conscientious thoroughness

which it has held so long. It is undoubtedly pre-eminent, the best of the published literature during the past year, and in a form to be readily accessible to the busy practitioner of medicine and surgery and of invaluable assistance in keeping in touch with the advances in the subjects treated. There are many excellent illustrations; also nine insert plates of practical value.

A REFERENCE HAND-BOOK FOR NURSES. By Amanda K. Beck, Graduate of the Illinois Training School for Nurses. Philadelphia and London: W. B. Saunders & Co., 1905.

This little book is designed for the beginner and the graduate as well. It contains a list of the more common drugs, with their doses and therapeutic uses. Many of the more common formulas are given, and a list of the receipts for the preparation of enemata and poultices is included. We have also placed before us the methods of preparing all sorts of food for the sickroom and for infants. All the various diseases with which the nurse has to do come in for their share of discussion and suggestion.

There is nothing in the book that can distinguish it from the raft of others of its kind that are now being offered to the student nurse.

MOSQUITOES OR CULICIDÆ OF THE STATE OF NEW YORK. New York State Museum, Ephraim Felt, State Entomologist, Bulletin 79, Entomology 22. New York State Education Department, Albany, 1904.

This monograph gives a complete list of all the known species of mosquitoes found in this State. Over fifty varieties are described in the text, and the drawings and illustrations of these are of the highest order.

The volume will prove to be a most desirable and useful reference hand-book in the library of any physician possessing a copy of it.

NOTHNAGEL'S ENCYCLOPEDIA OF PRACTICAL MEDICINE. American Edition. Malaria, Influenza, Dengue. By Drs. Julius Mannaberg, O. Leichtenstern. Edited, with additions by Maj. Ronald Ross, F.R.C.S., C.B.; J. W. W. Stephens, M.D., D.P.H., and Albert S. Grunbaum, M.D., F.R.C.P. Authorized translation from the German, under the editorial supervision of Alfred S. Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania. Philadelphia and London: W. B. Saunders & Co., 1905.

The general excellence of this system of medicine has been kept up in this volume, and it seems safe to say that all of them are just as good as this one. The chapter on malarial diseases is compiled by Dr. Mannaberg, while the other two are the work of Dr. Leichtenstern. On all subjects of a hematologic nature, the former is an authority of note and worth, and anything written by him is always of the best kind, showing deep study and discernment. The association of these two writers is a most happy one, and shows the keen insight of the editor.

The various old and new ideas of the methods of infection by the malarial organism are given in detail, and the means by which our present thoughts on these ideas were arrived at are exploited in the text. The work of Manson, Grazi and their contemporaries is taken up and most intelligently analyzed, and the best of each tabulated.

The chapter devoted to influenza is the most comprehensive of any so far published on the subject. Not only are the etiology, symptomatology and prognosis discussed at length, but the pathology and complications of the most common disease are dealt with.

There are but twenty pages devoted to the subject of dengue, and it would seem that the matter were thoroughly gone over. The micro-parasitic origin of the disease is insisted upon and direct contact is the method of transmission of the contagion herein held.

As in the other volumes of this encyclopedia, the work of the publisher has been most carefully and satisfactorily done.

NOTHNAGEL'S PRACTICE. DISEASES OF THE BLOOD. By Prof. Dr. P. Ehrlich, Prof. D. C. von Noorden, Dr.

A. Lazarus, Dr. F. Pinkus. Edited with illustrations by Alfred Stengel, 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., 1905.

In this day, when the science of hematology is really in its infancy, it is not an easy task to get together a volume on this subject which could in any manner be "up to date." Of course, many of the theories brought out in this book are already discarded as either erroneous or not proven, but on the whole, its text is such that we can say that we can accept the contents without more than the usual reservations of any new science.

Dr. Stengel, the editor, is keenly alive to all the most modern work on this subject, and has made corrections wherever the text is at fault or at variance with the newer thoughts.

Although the book contains 680 pages, the subjects under discussion are but those of anemia and its clinical features, chlorosis and the leukemias. By far the best of these chapters is that on chlorosis, which has been written by Dr. von Noorden. Here the etiology, general and special symptomatology and prognosis are most interestingly dealt with.

At the end of each chapter the literature of the subject treated is appended, and it is of the full German kind.

The theories of the morphology of the blood are those of Dr. Ehrlich, and are generally accepted by the medical profession to-day. Throughout the whole book the work and theories of the writer are most evident.

In every respect this is the best text-book on this subject that has so far been published.

BOOKS RECEIVED.

REPORT OF THE COMMISSIONER OF EDUCATION FOR THE YEAR 1903. Vol. I. Washington Government Printing Office, 1905.

A MANUAL OF ACUTE POISONING, giving classification, varieties and individual substances usually met with in emergency poisoning, with special symptoms, simple tests, chemical antidotes, physiologic antagonists and treatment. Together with methods for use in first aid to the injured. By John W. Wainwright, M.D., member of the American and New York State Medical Associations, the American Chemical Society, etc. New York: E. R. Pelton, 1905.

THE SURGICAL ASSISTANT. A Manual for Students, Practitioners, Hospital Internes and Nurses. By Walter M. Brickner, B.S., M.D., Assistant Surgeon Mt. Sinai Hospital, Out-Patient Department, etc. 360 pages, 123 original illustrations, and 116 illustrations of surgical instruments. New York: The International Journal of Surgery Co., 1905. Price, \$2 net.

THE PHARMACOPEIA OF THE UNITED STATES OF AMERICA, EIGHTH DECENNIAL REVISION. By the Authority of the United States Pharmacopœical Convention held at Washington, A.D., 1900. Revised by the Committee of Revision, and published by the Board of Trustees. Official from September 1, 1905. Philadelphia agents, P. Blakiston's Son & Co.; subagents, New York, E. R. Pelton, 19 East 16th street; Chicago, E. H. Colgrove Co., 65 Randolph street; St. Louis, C. V. Mosby, 2313 Washington avenue; San Francisco, Payot, Upham & Co., 100 Battery street.

GRAY'S ANATOMY.

Messrs. Lea Bros. & Co. have pleasure in announcing a new edition of "Gray's Anatomy," to be published about midsummer, and embodying nearly two years of labor on the part of the editor, J. Chalmers DaCosta, M.D., of Philadelphia, and a corps of special assistants.

Original Articles.

THERAPEUTIC VALUE OF ANTITOXIC SERA.¹

BY HARRY T. MARSHALL, M.D.,
Baltimore, Md.

IN selecting material to present before this meeting, it seemed to me unnecessary to give a complete review of the theoretical explanation of the action of the antitoxic sera, as the theory has been set forth so clearly and so often in the recent literature. On the other hand, a statistical review of the results obtained by the use of the various sera does not offer us any great return for our labor. Probably the best course to pursue is to review one or two works, which enable us to judge more correctly of the therapeutic value of these sera.

The antitoxin treatment of diphtheria is, of course, the best-known and most successful example of serum treatment which we have. The mathematical precision with which the serum acts if used properly; the importance of using the antitoxin at the earliest possible moment after infection; the advantages of employing even extremely large doses of the serum, especially if its use is begun after the disease is well established; the greater rapidity with which immunization can be effected by intravenous injection, and the consequent advantages of this method over subcutaneous injection; the harmlessness of the serum; the local use of antitoxin as a spray, both to neutralize the unabsorbed toxin and, as William R. Stokes pointed out, as a means of hastening the disappearance of the diphtheria bacilli from the throats of convalescent patients; these are matters which have been discussed fully in the recent literature.

Most of these actions of serum and diphtheria toxin can be clearly understood from our knowledge of the properties of the toxins and antitoxins. The diphtheria bacilli produce unstable poisonous bodies of complex but unknown chemical structure, called toxins. The toxins are readily soluble in the blood plasma, and are carried to the body cells for which they chance to have a chemical affinity. The toxin unites with the cells by means of the corresponding haptophorous, or binding, groups in the toxin and cell, and then, according to the virulence of the toxin and the vitality of the cell, either the cell is killed by the toxin or the cell reacts, throws off the toxin and a number of free haptophore groups—*i. e.*, side chains, or receptors of the kind which have chemical affinity for the toxin. These free receptors are the antitoxins. The antitoxins will unite with any free toxins that may be present in the circu-

lation, and even if the toxin is lightly bound to a cell, it may be dislodged if a great excess of antitoxin is brought to bear. Whether this phenomenon is due to dissociation is now a contested question, which is closely connected with the question of the complexity of the diphtheria virus. It is certain, however, that the toxin-cell, or toxin-antitoxin union cannot be disrupted after it has existed for some hours, and when once union between toxin and cell is firmly established, no amount of antitoxin will influence the action of the toxin on the cell.

In the case of diphtheria we have a soluble toxin conveyed in the circulation or in the tissues by the antitoxin. In the case of tetanus we are confronted with a different set of conditions. Since the work of Behring and Kitasata in 1890 we have known that animals can be made to produce an extremely potent serum against tetanus toxin, and in some experiments the value of this serum has been proven. However, neither in experiment nor in therapeutic use have the results been so clear and satisfactory as with diphtheria serum, although it appears that the serum has some protective value. We have now an explanation of some of the difficulties that are met with in the use of this serum. In 1903 (*Archiv. für exp. Pathologie, und Pharmakologie*, Bd. 49, p. 369), and in 1904 (*Proc. Royal Society*, Vol. 72, p. 26), Meyer and Ransom published the results of their work upon the action of tetanus toxin and antitoxin.

They could demonstrate the toxin in the motor axis cylinders after a subcutaneous injection of toxin; and they could prevent the toxin from reaching the cord by making an intraneural injection of antitoxin. A dose of tetanus toxin which was sublethal if injected subcutaneously, was fatal if injected into a motor nerve. After toxin was in a nerve tetanic symptoms could be prevented by cutting the nerve or cutting the cord. The intraneural injection of toxin was followed by tetanus, even though the blood contained a large amount of antitoxin.

Not only did they find that the tetanus toxin is carried to the central nervous system along the motor nerves, but they found also that the toxin gains entrance to the nerve through the motor end plates; that the toxin does not reach the central nervous system by any other route except along the nerves; that tetanic rigidity is altogether a result of central irritation, the peripheral nerves not being concerned, and that the latent period between the injection of toxin and the onset of tetanic symptoms is almost altogether due to the time required for the toxin to pass along the motor nerves to the cord or brain. They produced a local tetanus, and a general tetanus, in which toxin injected into the circulation was picked up by many motor end plates. They also produced a form of sensory tetanus, which they called "tetanus dolorosus," by injecting toxin into the posterior root or cord.

They found that the tetanus antitoxin is not

¹Read before the Medical Association of the Greater City of New York, April 10, 1905.

carried along the nerves, and has practically no action except upon that toxin which has not yet entered into the motor axis cylinders.

Some recent experiments of Wassermann in which adrenalin was used to produce a local constriction of the vessels, so as to prevent the action of injections of antitetanic serum upon the toxin also go to show that the toxin is absorbed only by the motor nerves, the antitoxin only by the circulation and lymph.

The importance of this work of Meyer and Ransom is great. It shows clearly that the tetanus toxin acts upon the nerve cells, and not upon the peripheral nerves, and that the motor nerve cells of the cord and brain are the selected cells, except under unusual circumstances, which may direct the toxin against the sensory nerve cells in the cord or posterior root ganglia. Their work also demonstrates an altogether new fact, namely, that the toxin is carried to the susceptible cells along the motor axis cylinders, a mode of transfer dependent in part upon a specific selective power of the end plates of the motor nerves. This peculiar mechanism brings the tetanus toxin in concentrated form upon the susceptible cells, and, furthermore, it places the toxin at an early period, and some time before the onset of symptoms, beyond the reach of the antitoxins, for, as we have seen, the toxin is within the axis cylinders and nerves; the antitoxin is in the circulating body fluids.

There are one or two practical lessons of importance to be learned from this work. In the first place, subcutaneous, intravenous and subdural injections of antitoxin are of no value as measures to relieve tetanus when the symptoms have appeared. In the second place, injections of antitoxin, especially near the infected wound, will effectually bind any toxin present in the tissue—*i. e.*, toxin before it has been picked up by the motor end plates. In the third place, it is probable that injections of antitoxin directly into a motor nerve leading from the infected wound, or even injections into the segment of the cord reached by this nerve, will have some influence upon the toxins. This procedure is suggested by Meyer and Ransom, though it cannot yet be said what value attaches to it.

Meyer and Ransom, and also Ritchie, think that the work just quoted affords evidence that the antitoxins of tetanus are not formed in the susceptible central nervous system cells, where Ehrlich supposed them to be found. For, on the one hand, the cells of an immunized animal are more susceptible to toxin than are those of unimmunized animals, and, on the other hand, there is apparently no antitoxin in the central nervous system.

This objection does not seem to be valid. The antitoxins, according to Ehrlich's theory, are to be looked upon as waste products of the cells producing them, as much as are any other products of cell metabolism which are thrown off from the cell, and, being waste products, they

should be removed rapidly from the neighborhood of the cells by the lymphatics and circulation. But the toxins are not, in this particular case, removed in the same way, but owing to their peculiar relation to the motor nerves, are kept separate from the circulation containing the antitoxins and brought directly to the susceptible cells. Now the antitoxins are looked upon as cell receptors, produced in excess and *thrown off from the cell*. If the receptors, or some of them, are *not thrown off*, the cell will have more opportunity of becoming anchored to the inflowing toxins—*i. e.*, the cell will be more susceptible. Of course, there must be more receptors in a cell forming antitoxins, according to the method of Ehrlich, for though part of the excess of receptors is thrown off, a new supply in excess will be formed, or in process of formation in the cell. This is just the condition that is found to exist. Ehrlich spoke of the receptors which were not thrown off from the cell as "sessile receptors," and called attention to the fact that they would increase the susceptibility of the particular cells to toxin. Another example of such a phenomenon is seen in the recent work of Jacobi, who found that the red blood corpuscles of rabbits after immunization with the hemolytic cell's serum are more susceptible to the serum and may bind greater amounts of it.

The study of diphtheria and tetanus shows that, however brilliant the results from the use of antitoxic sera may be in favorable cases, the antitoxin is not the only factor in the cure. Even though the toxin and antitoxin neutralize each other in the body with the regularity of acid and base, there are certain obscure phenomena in these infections which seem to depend upon the vital force of the animal. This is a factor upon which Weigert laid considerable emphasis.

It would carry us too far if we should undertake to discuss any others of the antitoxic sera, of which Wassermann lists about thirty and of which about ten may be used therapeutically.

The action of many protective sera is not at all clearly understood, and is probably due to combined properties, such as lytic and opsonic, opsonic and antitoxic, etc. In the last analysis the evil effects of all bacteria are due to chemical action of the bacteria or of bacteria products—*i. e.*, to a toxic action, using toxic in a general sense. The attempts to obtain the toxins and hence the antitoxins have been variable or unsatisfactory in most cases. The methods employed so far have not proved generally successful. It is still too early to pass judgment upon the attempts to obtain intracellular toxins by autolysis or of autolysis after growing the bacteria on special media, as Chantemesse has done with typhoid bacilli. However, one may safely say that the sera for hay fever (Dunbar), for typhoid (Chantemesse), and even the disputed serum for tuberculosis (Maragliano), have received such favorable reports that they are worthy of a careful trial.

SOME REASONS WHY WE SHOULD DISPENSE.¹

BY G. A. CHAPMAN, M.D.,
Glens Falls, N. Y.

OUR forefathers in the art of medicine were compelled to dispense their own drugs and to compound them as well. Later on, when the art of pharmacy became a known science and we began writing prescriptions, this fad became so popular that the up-to-date physician's armamentarium consisted chiefly of pads of prescription blanks and a fountain pen. Then Hahnemann and his followers, with their pleasant and perhaps harmless pellets, compelled us to contend for like conditions in order that the dignity of our profession might be sustained. So the pendulum swings back again towards dispensing. In this work we are ably assisted by the manufacturing chemist of to-day who comes forward with his palatable elixirs and syrups, compressed tablets and triturates in any desired formula. Is it not our duty to make use of these favorable conditions which are almost forced upon us?

Much has been said in the past regarding the adulteration of drugs and complaints have been made regarding substitution. You are all aware of the bill known as the Pure Food Bill, which considers the question of adulterated foods and drugs. It is in the adulteration of drugs that we as medical men are most earnestly interested. This is a question which has been confronting us for some time. What are we going to do about the matter? Have you always found upon investigating your prescriptions just the article you prescribe? Have you wondered why you did not get results expected? Have you ever had a tablet dispensed when you prescribed a powder? Do not misunderstand me; I do not wish to be disloyal to honest druggists. Perhaps these little changes in your prescription may have been just as well and no vital harm done to the patient. Yet do we care to have the druggist take this great responsibility of making the selection upon himself?

There is another evil with which we have to contend. That is the abominable habit of counter-prescribing. This is not usually done by reliable pharmacists, but the evil is none the less. A few days ago I was called to see a patient who was suffering from influenza. She informed me that she had taken "rhinitis half-strength" every half-hour for the past twenty-four hours and then actually questioned the cause of the intense nausea and the unbearable dryness in the throat. She wondered that she did not get the desired results when she had been so faithful in her treatment. Not long ago I saw in one of our principal drug stores a placard: "We guarantee to cure a cold for fifty cents." Is this loyalty to the medical profession? What if we should place a similar one in the window of our office to-morrow? Yet the druggists complain that we are not sending them the number of prescrip-

tions we did a few years ago. Is the fault with us or with them?

Another evil more difficult than any other to overcome is the repeated filling of prescriptions without our consent, and one in which the druggist is perhaps not wholly to blame. If the prescription has proved effective with one member of the family, it is at once adopted as a household "cure-all," regardless of the pathological conditions that may be present. And every spoonful of this remedy swallowed carries with it the reputation of the physician whose name appears upon the label of that bottle and for which he has labored hard and is justly proud. Possibly some of the blame rests upon our own shoulders. You will find in stock several prescriptions of our local physicians which can be had for the asking. When we prescribe a remedy that has its name beautifully blown into the glass of the bottle and all the patient has to do is to call for the remedy regardless of conditions, we are paving the way to this evil rather than eradicating it. If we prescribe such remedies at all, why should they not expect us to prescribe the same thing for almost any pathological condition? Or, to go further, why not prescribe "Paine's Celery Compound" for all affections of the nervous system, "Lydia Pinkham's Favorite Remedy" as our armamentarium in gynecology, "Kilmer's Swamp Root" in all disorders of the urinary apparatus, and "Dr. Hand's Save-the-Baby" for the croup? Do you wonder that it is sometimes difficult for the public to differentiate between members of the medical profession and detail men from the various drug firms? Look for one instant at the vast quantities of patent and proprietary medicines consumed by the American people alone each year. And yet if they did not have the semi-support of the medical profession, many of our patients would hesitate to use them. With these vast evils each year increasing upon us and upon the public whose interests at heart we must hold, is it any wonder that the pendulum is fast swinging towards dispensing, and is it not our duty to encourage the swinging on its way?

Then, as a remedy for these evils, let us, with a good pair of prescription scales, a quantity of standard drugs, elixirs and syrups, and a stock of reliable tablets, from a reliable firm, fill our own prescriptions. We are in a position to dispense almost any remedy that we are competent to prescribe; not only that, but by the constant handling of drugs we must of necessity become more familiar with their uses, so that the saying of Voltaire of two hundred years ago, when he said "The doctors poured drugs of which they knew little into human bodies of which they knew less," can at least be looked upon as a relic of the past.

To renumerate our advocacy for dispensing: First, by so doing we are better able to watch our patient, as he must return to us for medicine, and we are in a position to correct any errors in treatment, if any should exist.

¹Read before the Warren County Medical Association, at the Annual Meeting, Glens Falls, N. Y., January 11, 1905.

Second, we are in a position to prevent drug habit from being formed by the improper use of our prescriptions.

Third, by the constant handling of drugs we become familiar with their uses.

Fourth, we are able to stop substitution.

Fifth, by buying from a reliable firm we are able to prevent, to a certain extent, drug adulteration.

Sixth, we will be able to a certain extent to eliminate from the market the various compounds that are sold "On physician's prescription only," and whose samples have littered our ash-heaps, and are a menace to good morals and public health.

SOME GENERAL TUBERCULOSIS PROBLEMS.¹

BY GEORGE W. GOLER, M.D.,

Rochester, N. Y.

SOON as man passed from the life of a hunter to that of a herder, so soon as he deserted a roaming life for a communistic and stationary life, he began to contract tubercular disease. In the life of the early settled community, in crowded hut-like habitations, living over the same ground, fouling it with their wastes, and the wastes of their animals, the tubercle bacillus acquired more marked parasitic powers, and was thus enabled to find in man under such conditions an organism more and more vulnerable to its attacks.

Where these conditions of insanitary living continued, as the groups of men living in such communities grew ever wider and the population more dense, tuberculosis acquired new and more profound power over them. When after the lapse of centuries the descendants of these savage men began living together in old cities with narrow streets, little light, and all the unhygienic surroundings found in such cities, tuberculosis there attacked them as a plague. So it is to-day. The modern nomad is but little less tubercular than his ancient fellow, and he is more markedly susceptible to tubercular disease than his civilized brother. Let him sit down in a group of huts, even on the confines of civilization, and tuberculosis attacks him in much the same way as it did his ancestors. See what has happened to the American Indian, to the negro, to the Hawaiian Islander! What will happen to the Filipino? The white man has behind him a long line of ancestors who through centuries of warfare against tuberculosis has conferred a measure of immunity upon his descendants, and this immunity the modern savage does not have. But even this measure of immunity in the white man is an insufficient protection against the disease. Though much has been done to combat the disease in the last ten years, thousands of whites die every year of tuberculosis, and tens of thousands contract the disease and are restored to work and earning

power with damaged health. This is the tuberculosis situation to-day. What must be done to stop this unnecessary drain of death and disease? Erect sanatoria and cure the disease? I think not. If "cure," so called, in sanatoria is to be the principal measure of relief, these institutions will then be found insufficient to stop the widespread tubercular infection; but if we regard sanatoria for tuberculosis as educational institutions; as the chief means at our present disposal for spreading through the patients treated in them a knowledge of the mode of infection and means of preventing tuberculosis, then sanatoria will help much more through their educational influences than through the mere restoration to work and earning power of individual patients treated in them. The educational work of the sanatorium is its most valuable work. So far as sanatoria are able to influence the disease through restored patients alone, if every bed in every sanatorium were a separate institution in itself, equal in capacity and ability for work to the institution from which it came, there would not be sufficient accommodation to care for the patients now infected by the disease. The drain upon the populace by this disease must be really stopped by education, not by cures. The real solution of the tuberculosis problem is, therefore, beyond sanatoria, though I am not urging against the establishment of sanatoria, but for their multiplication. Nor is the tuberculosis problem to be solved by the use of drugs. Nor shall we find very material help in that protective inoculation for tuberculosis, upon the discovery of which we have almost arrived. The solution of the tuberculosis problem is mainly to be found through education; through the aid of those who shall teach people how to live; how to live the physical life right down here on top of this earth. Teachers are needed who shall be trained to teach the people how to live; to teach them about food, clothing, housing, sleep, rest and exercise; about personal hygiene and civic hygiene, and all the things that go to make up the fulness of physical life. It is only because these things are not taught as they should be taught that we have a tuberculosis problem as well as some other problems; and we shall have a tuberculosis problem, as well as these other problems, until we have teachers enough of the right sort. For several hundred, perhaps for several thousand, years we have been trying to teach people about the spiritual life; but, aside from the teaching of some of the older civilizations, there has been no great material aid which helped men to really learn how to lead a good physical life. For hundreds of years man has been taught to be spiritually good, while he has been housed and fed worse than the domestic animals. Let me try as briefly as possible to tell what I mean by the necessity for teaching people how to live in its relation to the tuberculosis problem. Every condition of life productive of poverty, dependence, intemperance, vice and crime is frequently a cause of tuberculosis. Whatever operates to reduce

¹Read before the Twenty-first Annual Meeting of the Fourth District Branch, Rochester, N. Y., June 6, 1906.

vital resistance helps to make soil where tubercle organisms may find lodgment and grow. As the vital resistance is lowered there is lessened ability to make the environment healthful, and in bad surroundings the tubercle bacillus finds it easier to grow and to multiply. In adult life tubercular disease obtains entrance into the body because of the lowered resistance that comes through bad housing and working environment. It also enters the body in early childhood through latent foci of tubercular disease along with, or following upon, measles, whooping cough, scarlet fever, diphtheria, tonsillar and cervical glandular affections, and also through mesenteric glandular infections resulting from dirty cows' milk or other foods. As doubtless many of these infections are acquired in early childhood, then here is a clue to the time at which the first step in the prevention of tuberculosis should be taken. That step is in training for right living. To begin early child training in the home presumes a teacher. This teacher should be the mother, and for her training she must look and has long looked to the physician for counsel and advice. Surely if the earliest training of the child is neglected through the inability of the parent to furnish rules for the orderly and reasonable living of the child; if air, food, clothing and housing are inadequate for its needs, and if in its earliest formative stage it contracts those diseases which then or later are to make it less resistant, the child must suffer the consequences, either surviving as a weakling, or becoming a victim of the universal disease.

The necessity for the training of the parent and the training of the child is not new; many of the great teachers in the past have earnestly striven for it. Of the later teachers, Herbert Spencer comments upon the lack of education for parenthood when he says: "If by some strange chance not a vestige of us descended to the remote future, save a pile of our school-books, or some college examination papers, we may imagine how puzzled an antiquary of the period would be in finding in them no indication that the learners were ever likely to be parents. We may fancy him concluding—'this must have been the curriculum for their celibates * * * for I find no reference whatever to the bringing up of children.'"

As a practical demonstration of what may be done in the training for parenthood, take the example of Krupp, the German gunmaker of Essen. Krupp saw the necessity for parental training when he established schools in connection with his works. He not only insured that his operatives should be trained in domestic science—cooking, household sanitation and domestic art—but he also provided that the girls in his schools should be taught how to rear and care for children, so that the potential mother might know how to care for children should she become a mother indeed.

How necessary such training has become in this country may be plainly seen when we observe the large number of children that apply for certificates to work, so soon as they become 14 years

of age. Nearly two-thirds of our children go to work in mercantile establishments and factories between 14 and 16 years of age. They thus must receive in the schools most of the training for living, for citizenship, for possible fatherhood and motherhood prior to their entrance to shop or factory life. How necessary is it then that these vast numbers of children, the future citizens, the potential fathers and mothers of the larger part of the race to be shall have a better knowledge of how to live other than the legends and superstitions of their grandparents before they enter upon the earning period of their lives.

The question just alluded to assumes a new and added importance when we see to-day vast aggregations of wealth owning and controlling land, foodstuffs, fuel, transit, light, and having within their grasp the destinies of men, women and children in this, as well as in other countries, and the effect which this control must have upon the lives of the people. Through the operation of a system known to be wholly conducted for purposes of private gain, and in many instances but slightly, if at all, under the control of popular government, human life is becoming more difficult of real living. The cost of living to-day is more, much more, than it was some years ago. Not only has the cost of living increased, but the desire for more things to live with has grown with the increase of wealth. The luxuries of yesterday are the necessities of to-day. The mode of life, too, has gone from the simple to the complex, and the example set by the rich in opulent splendor of living is aped by the poor, untrained in the art and science of physical life. Thus, in the endeavor of the wage-earner to follow the example set by the wealthy, gewgaws and furbelows are purchased, the real necessities are foregone, increased stress of life is endured that flashy house and personal adornment may be indulged in, and these are but too often purchased at high prices from monthly instalment houses on those *very easy payments*. To make these payments, the real necessities of life are often denied, the health fails, sickness interferes, and not infrequently tuberculosis as a direct or complicating disease closes the life scene. Then burial takes place, also at the highest cash prices, paid for out of the one or two hundred dollars insurance that has been carried at the highest possible premium.

But there are additional costs that come to the poor man and that make him more easily susceptible to tubercular disease. Chief of these added costs is rent.

The increased value of land, the higher prices of building material, together with the greed for gain at the cost of human life, have caused a considerable advance in rents. Separate houses with little lots and gardens have given place to flats with dark rooms, darker hallways, and this has resulted in the crowding together of many families under one roof. But, you may say, there are still the suburbs where a man and his family may live away from the flat and tenement. Yes,

but there must be a way provided to get to the suburbs, and with the way, for the poor man, must be reckoned the cost. For it is the cost that compels him to live near his place of employment in those congested quarters of the city where the congregation of many families in the smoke and dust area makes for intemperance, vice, crime and disease. Air to the poor man becomes a question of street-car service and street-car fare. The old saying, "free as air," is no longer true of the congested quarters of the city, for air in the city is no longer free. Life in the crowded quarters of the city in an atmosphere of dust in the shadow of coal smoke and soot from factory chimneys, in dark hallways and rooms, in houses where children play upon platforms projected from rear windows, or on the street pavements, and where they seldom see grass for bricks and pavements, or flowers, save in pots or boxes; where the park is a far-off fairyland to be bought only by car fare—this is the lot of too many of the poor in cities.

We know to-day that tuberculosis is a disease, due in the main to insanitary housing in an environment which has been already pointed out. In this environment, this insanitary housing, tubercular infection is spread through sputum and dust infection. The continuation of such housing and such life among the poor makes more tubercular diseases than all the sanatoria could successfully combat. Years ago, when the well-to-do lived under bad sanitary conditions, tubercular disease was almost as universal among them as it now is among the poor. To-day the wealthier classes do not suffer from the disease as they formerly did. It has been banished from among them by better housing and better sanitary conditions; and, by such means introduced among the poor may we hope to banish tuberculosis from among them.

But with these better housing conditions, we must also provide for better food, and first of all for better milk. We feed our children city milk—that opaque white mixture of hair, dirt and manure, teeming with millions of micro-organisms, and then too frequently administer bactericides in hope that that which should have been prevented may be cured. In the tenement and flat district the milkman frequently serves the dirtiest and most watered milk, and the little stores sell watered milk often richer in micro-organisms than sewage. The effect of such milk upon the child is that of insufficient food, and because of this it calls into play powers to resist milk and food poisons that should be used for growth and development. Then, too, the milk so distributed often comes from tubercular cattle, gaining its content of tubercular organisms, not from the milk apparatus of the cow, but through the manure which finds its way into the milk through careless handling. In the face of all this carelessness, the milkman will tell you that he Pasteurizes or sterilizes the mixture. One might as

well Pasteurize or sterilize sewage. In the ages at which children are fed upon milk, occur most frequently tubercular meningitis, tabes mesenterica and the more common forms of glandular tuberculosis. How much of this may be laid to bad milk?

In the districts inhabited by those most subject to tuberculosis the manner of housekeeping has undergone many changes. To say nothing of the trained housewife, what of the untrained housewife, who does what is known as "light housekeeping"? She buys bread and cake at the baker's, canned meat, fish and vegetables at the grocer's or at the corner shop, and often instead of having meals of home-cooked food, as becomes an American housewife, we find the table supplied with canned meats, beans with tomato sauce, pickles of forty-nine varieties, baker's bread and baker's cake. It is not, of course, by choice that many families are brought to flat life; domestic service has changed; girls who formerly went out to service are now found working in factories, driven by the lure of more apparent wages and sometimes by the ill-treatment of their former mistresses. With the growth of flat and tenement life and the crowding consequent upon this life, there has come a demand for cooked, baked and canned goods, so that now almost every little store, news shop, etc., is dealing in these things, the little dealers becoming the selling agents of the great packers and canners, helping to change the character of our American homes, running out the age of good American housewifery and substituting in its stead cooked and preserved, salicylated and borated, colored and formaldehyded fabrications for that food our mothers used to make. These little dealers, like the coal dealers, are becoming local selling agents for the vast canned goods combines, who through excessive charges for the sake of the dollar are putting undue stress into the life of the wage-earner, at the same time helping to squeeze the sweetness out of life, leaving little but bitter behind.

I have here presented some of the general problems which appear to be closely connected with the spread of the disease in cities. For the solution of these problems—and in their solution only may we hope for the first great step in preventing tuberculosis—I would begin the work, not in that direct order in which the work ought to proceed, but in the order in which the work seems to have already started.

The multiplication of sanatoria for tuberculosis must proceed until every city has its own sanatorium, until every hospital has its special educational and dispensary department for tuberculosis, until every State has a number of State sanatoria, and where every such institution depends for its real success, not upon the cured cases, but upon the hygienic education and training it is able to impart to its patients. This is the real test of the value of the sanatorium to the State, to the city and to the patient.

Then let us begin with the training and education of the child. To begin with the education of the child in the home, the mother must get from the physician more intelligent advice and training than she has had in the past. In the schools we ought to banish the present alcoholic physiology and substitute a decent kind of physiology, taught by demonstration with a ten-cent lens, if no better can be procured, for a small amount of biology taught the child at the right time is of more value than many hundred dollars' worth of reform school or of tuberculosis. In the higher schools enlarge upon that training in domestic science, which has already been begun, and if as yet it is impossible in this stage of our social evolution to impart to the child an elementary knowledge of sex in the higher forms of life, at least let it learn by actual demonstration that sex has a place in the flower and the frog. Along with this teaching there ought to be made known to the child the place that air and sunshine have as food and the value of air both day and night, in school, at home, in factory and shop.

Through the operation of medical school inspection, the medical school inspector may find opportunity for teaching in the schools a few elementary truths relating to the means for protecting from infectious diseases, and that part which housing, air, light, water, food and clothing play in promoting health and preventing disease.

The opportunities of the Church to do something for the physical life are many. Every year there go out from theological seminaries all over the land a host of young men whose power for good over the physical lives of the people in their churches can hardly be measured. Were it possible for these men to receive that elementary training that would enable them to teach people how to live the physical life, what a world of good might be accomplished through their offices in this direction. And the Church might do more to bring about better civics. When it teaches that to hold a block of badly cared-for tenements at a high rental, to squeeze long hours for little pay out of men and women, and in other ways that to take advantage of the people is not Christ-like, however much this gain is given to the Church, or however well man or woman doing these things performs his duty to the Church; when it teaches in substance, as Bernard Shaw has put it, that "a rich man without convictions is more dangerous to society than a poor woman without chastity," then the Church will be doing something to help solve the tuberculosis problem. When the Church teaches that neither the Church nor educational institutions may derive incomes from property holdings in the slums—and if it so taught, its teachings would be heeded—it would be going a long way toward aiding the solution of the tuberculosis problem. When industrial insurance societies return more than 66 per cent. of their income to the beneficiaries, and

more nearly ape the manner of the German State institutions, who return over 90 per cent. of their earnings; and when these great insurance corporations, industrial and otherwise, lessen their premiums, and make it cost less than 18 per cent. of their income to do business, then these institutions will be doing something for the suppression of tuberculosis. When the physician shall cease to be the unpaid agent of the great proprietary medicine houses for tablets, oils and fats, malts and tonics, so-called; when he shall stand more as teacher and counselor, and less as a prescriber, we shall have less tuberculosis. And when the physician in a united profession stands more in his relation to the community as one who protects health rather than one who cures diseases, we shall begin to approach the real solution of the general tuberculosis problem.

In closing this paper, I want to mention some of the work that has recently been begun in Rochester.

Through the cooperation of private philanthropy, with present city administration we have been able to establish a system of medical school inspection, a dispensary where eyes, nose, throat, and, best of all, the teeth, may receive treatment, and we have also been able to establish a splendid sanatorium in the suburbs of the city where cases of tuberculosis, incipient or advanced, may be cared for, and in this connection we have also been able to secure the services of a trained visiting nurse, who visits cases of tuberculosis in their homes, and also exercises a supervision over those cases that have been discharged from the sanatorium. Now we only await an expressed opinion by the people, the clergy and the physicians, so that all may cooperate in securing better housing conditions, more rapid and cheaper transit, the cleaning and disinfection of those houses where tubercular disease may be found, and, lastly, in securing an extension of that kind of work that shall, through the press, the people and the professions, teach that life is not to live, but to be well.

Three hospitals in this city are beneficiaries under the will of Margarette A. Jones, leaving to them almost a million dollars. These hospitals, which will share equally in the residuary estate, are St. Luke's, Presbyterian and the New York Post Graduate Medical School and Hospital.

That part which is to go to St. Luke's Hospital is to be known as the "Margarette Jones Fund," in memory of her mother, and to be invested for the support of free beds; the share for the Presbyterian Hospital is to be known as the "Margarette A. Jones Fund," and invested for a like purpose, and that for the Post Graduate Medical School and Hospital is to be known as the "David Jones Fund," in memory of her brother, to be used also for free beds.

FEEDING IN ACUTE DISEASES.¹

BY A. H. BAKER, M.D.,
Elmira, N. Y.

I THINK it is Osler who has said in substance, that in the treatment of pulmonary tuberculosis three things are to be considered, viz., air, rest and food, and the sooner the practitioner stops giving medicine for this disease the better it will be for the patients. If with food he includes water, this rule would apply, with very slight modifications, to all acute, self-limited diseases.

When, however, food is referred to in a general way, and the quality, quantity, digestibility, frequency of giving, etc., are indefinite and undecided, the subject is but imperfectly covered. As you are all well aware, the teachings in medicine, in the beginning, usually go to extremes. Almost every valuable measure we have has at first been given much more value than it deserved. If it has been a drug, it has been given in quantity and frequency far in excess of what it should have been. The reaction has always been excessive and the drug has fallen into a period of undeserved disuse, from which it only recovered after prolonged and careful examination to ascertain its exact value.

If it has been the application of water—hot or cold—electricity, locally or generally, it has, without exception, been carried to an extreme from which a reaction was not only inevitable, but highly necessary for the welfare of the public.

And the same with feeding in acute diseases: We have not to go back very far to find our honored predecessors refusing both food and drink to their patients suffering from acute, self-limited diseases. How many of us have listened to the story of the attack of measles, where for days the patient had been compelled to go without water, until about the only memory of the attack is the restless, delirious sleep in which dreams and visions of water were prominent features. The patients of those times who had typhoid fever will tell us of degrees of emaciation we almost never see now, simply because typhoid fever patients are allowed more food and drink. But following the period of no food and no water came, first the time when patients were allowed water in unlimited quantity, and then the period, reaching up to the present, when food was not only given when desired, but was forced upon the patient at regular intervals and in certain quantity, with no careful observation as to whether it was all properly digested, or whether the patient was more comfortable, less restless and apparently benefited. And it is to enter a protest against that method of feeding and to present the few observations I have made on this subject that this paper is presented this evening.

Many patients suffering with typhoid fever, pneumonia or rheumatism, if given four to six ounces of milk once in three or four hours, will in a

few days present a picture of distended abdomen, brown, dry tongue and mouth, sordes, high temperature and delirium. The bowels are either constipated or diarrhœa is present, and altogether the patient gives the impression of a most serious condition. And further, in many such cases it is most surprising and gratifying to note the change wrought by simply stopping the milk, clearing out the bowels, and when the bowels are cleaned out, and not before, substituting one of three or four foods that in my experience can usually take the place of milk with benefit to the patient.

If the physician will carefully observe the patient he will usually discover some article of diet specially adapted to the digestive powers of that patient. It may be milk, and in that case milk should be the staple article, modified and rendered more agreeable by the occasional substitution of some other food. But taking into consideration the changes which take place in milk during the process of digestion, the hard curd, etc., I consider it the food above all other liquid foods to be carefully watched, and capable of doing the most harm. When it disagrees the addition of lime water, peptonizing, etc., make very little improvement in it. The passage of curds in the stools of typhoid fever patients is almost invariably associated with a train of unpleasant symptoms, such as distention, high temperature, delirium and dry tongue, all of which will be modified and improved by withholding the milk and giving some form of broth or soup. Of those from which we may select, I will mention beef, mutton, chicken, oyster or clam broth, and pea or bean soup. It may be necessary to try all of these before the one best adapted to the needs of the particular patient is found, but when it is found and the patient is satisfied and we have the minimum amount of distention, pain, delirium and temperature, it is the staple article of diet for that patient, whether science tells us it is no better than salt and water or not. In some cases where the amount of light broth taken with comfort is excessively small a good beef extract or preserved blood may be given in small quantity in addition, always keeping within the point of tolerance and digestive powers of the patient. As I have intimated before, when the staple article of diet is found, it is well to find if possible one or two other articles which may be given the patient occasionally to relieve the monotony. Peas and beans are spoken of as albuminoid vegetables and a strong soup made by boiling small quantities of either until entirely broken up and softened, and seasoned to taste, makes a nourishing and satisfying article of food which in most cases surpasses milk.

Some parts of milk are sometimes better tolerated than the entire milk, whey or junket, or buttermilk representing the class. And when milk, or any part of it, disagrees and broth is beyond the digestive powers of the patient, egg albumen in water, or in orange or lemon juice

¹Read before the Elmira Academy of Medicine, March 1, 1905.

and water, will be sufficiently nourishing to tide over the period of greatest depression.

In some cases the distention and bad symptoms are due to the profound toxæmia, and careful watchfulness of the diet will have no influence; but always bear in mind that distention, sordes, dry, brown tongue, delirium, etc., whether due to improper feeding or toxæmia, mean arrest of digestion, and, if the diet has been liberal, it should at once be reduced. If it has been limited, it were much better to give a patient with the above condition no food than food which is not digested.

A scientific clause on the component parts of foods and their relative value would make an appropriate ending for this paper, but I will leave that for the pen of some member better informed; however, all I have said has been impressed upon me in a clinical way, and I submit it for what it is worth, feeling strongly the practical truth of it.

PELVIC INFECTION INCLUDING PYOSALPINX AND PELVIC ABSCESS.¹

BY JOHN F. MYERS, M.D.,
Sodus, N. Y.

BY pelvic infection we mean the entrance of a poison virus or germ with the power to multiply and increase its kind in the tissues, thus changing the normal into a pathological condition.

ETIOLOGY.

The causes of pelvic infection are few:

Traumatism.

Parturition.

Abortion or premature delivery.

Dirty instruments or foreign bodies.

Unlawful coition or prostitution.

More correctly speaking, the above so-called causes are conditions which favor the real causes.

My only reason for calling attention to this plague of womankind is the discovery I have made since beginning my hospital work that a vast number of women die with these infections, without a correct diagnosis being made and consequently nothing in the line of proper relief accomplished.

When the diagnosis is correctly made, most of the operations for relief are really quite simply either pelvic abscess or pyosalpinx. The point I wish to call attention to is the great necessity for more thorough study in diagnosing diseases by the average rural general practitioner. The skill most required is in the diagnostic power of the family physician.

Salpingitis may be either acute or chronic, or the inflammation may begin acutely and subside into a subacute or chronic condition.

In the acute form the membrane becomes more or less thickened, engorged, and may be smeared over with a mucus which may be either acid or neutral, or may be mucopus.

It may be smeared over with a lymph containing flattened epithelium from the lining, having undergone a granular degeneration. The plicæ in the tubes become obliterated by distension. The fimbriated ends of the tubes may be closed or obliterated by local peritonitis.

They are occasionally found open, in which case there may be a pelvic peritonitis, caused by the direct effect of germs in the escaping pus.

In case the tube is closed, it becomes greatly distended, and thinned so its walls may rupture, causing a local or general peritonitis.

In the chronic form we get the adhesions of the tubes to different organs, and bands formed by inflammatory products, which may cause strictures of the tubes at any point in the tube or the mesosalpinx may be shortened, drawing the fimbria down and away from the ovary.

Occasionally the tube or tubes may be so changed that there is a mere semblance of a tube left, several separate cysts having formed filled with lymph and debris. This is called hydro-salpinx.

Theoretically, traumatism from outside forces may be considered a factor in that it weakens the tissues and thus forms a fit pabulum for the real cause.

As we usually see these cases, there are two main causes: The gonococcus and the streptococcus.

The staphylococcus is so seldom a factor that it need hardly be considered.

With knowledge of the generally conceded fact that only one conception in twelve reaches its maturity, while the remaining eleven are aborted at some earlier period, we as physicians are forced to realize how frequent and fruitful a pabulum for the entrance and development of infecting germs is furnished by these abortions.

This taken with the fact that so many women are unknowingly and innocently carrying the gonococcus in their vaginæ explains one of the frequent causes.

The gonococcus usually enters the tube by the continuity of the mucosa.

The streptococcus may enter the tube after being introduced into the vagina by infected instruments, pessaries, etc., or it may set up an endometritis, a metritis and parametritis, thus emigrating through the uterine into the cellular tissues, causing the large pelvic abscesses which we usually find.

The acute form may follow abortions or confinements, and may or may not be the result of improper management on the part of the attending physician.

It is the firm belief of the writer, founded on observation, that many cases of pus tube, general peritonitis and death, result from germs having been unconsciously carried in the vagina for months and years, simply waiting for a chance to get in their hated work.

They may be so thoroughly distributed through the mucosa of the genital tract that the physician

¹Read by title at the Twenty-first Annual Meeting of The New York State Medical Association, New York, October 17-19, 1904.

may not be able to dislodge them. There is a continuity of a congenial pabulum from vagina to endometrium, from endometrium to the tube, and so on to the peritoneum, where their deadly results are accomplished.

DIAGNOSIS.

In many cases it is not difficult to diagnose an abscess of the cellular tissue or tubes. The history of the malady may often lead back to a septic confinement or abortion. The patient may date the beginning of her illness from the first week of marriage, when a severe leucorrhœa was experienced, since when, she has never been well.

The difference between the gonorrhœal and streptococcus infection is shown by Dr. Howard Kelly as follows:

1. Gonorrhœal infection is slow in its onset and is preceded by inflammation of the external genitals, while in streptococcus infection the onset is abrupt, and follows confinements, abortions or local treatments.

2. In gonorrhœal infection the pain is localized over the ovarian region, while with the streptococcus the pain is more general and severe over the lower abdomen.

3. There are no signs of general peritonitis in gonorrhœal, where there are usually signs of peritonitis in streptococcus infection.

4. The temperature runs from normal to about 102° in gonorrhœal, while with the streptococcus it runs from 101° to 103° F.

5. The gonorrhœal attack lasts from five to fifteen days, while the streptococcus infection lasts not less than a month, and often three or four months.

6. The gonorrhœal infection appears in good health, while in the streptococcus infection, the patient may be anæmic and weak.

7. The gonococcus is found in the discharges of gonorrhœa, while the streptococcus is found in the other streptococcus infections.

8. There is history of infection in the husband, while in the streptococcus infection he is sound.

In case the right tube is involved there may be some difficulty in distinguishing it from ovarian cyst or appendicitis.

By palpation we can usually discover the distended tube to be considerably lower in the pelvis than McBurney's point. We may find the long axis of the pus tube to be transverse to the perpendicular line of the body. These abscesses extend down to the uterus and are inseparable from it.

The appendicular abscess has its long axis parallel with the median line, and is nearly at right angles with the line drawn down from the extremity of one tube to the extremity of the other and is inseparable from the womb.

The exceptions to this are long-standing cases with rupture of tubes and large pelvic abscesses extending nearly to the umbilicus.

It is the opinion of the writer that if the family physician is properly skilled in diagnosis, he

will not permit his case to advance to such an extent without surgical interference and relief.

The treatment in the beginning of these inflammations is the same as in other inflammatory actions.

First clear out the alimentary canal and insist on perfect rest in bed with sufficient anodynes to control severe pain.

Opium in some form in peritonitis is usually used.

The writer is in the habit of using turpentine incorporated with some penetrating oil on the outside, and also incorporated with colon flushes, which are used frequently.

Sulphide of calcium in quarter-grain doses every two hours is one of the very best remedies to prevent suppuration, and the very best to promote absorption and desiccation where pus is already present.

The writer has seen certainly half a dozen cases where operation was refused where a considerable quantity of pus was present in the tube gradually subside and become desiccated and absorbed till apparently normal health was regained.

In some of the chronic gonorrhœal cases the operations necessary to relieve may be complicated and difficult to perform properly, but in most cases operations for relief are comparatively easy.

It is best to evacuate all abscesses that can be reached, through the vagina.

In case the pelvic organs are glued together in mass, the assistant may press down the mass through an opened abdomen so that operator reaches them from below.

There are many cases where a laparo-salpingotomy is necessary.

Laparotomy may be preferred by the operator, but the writer does many of these salpingotomies per vagina.

In cases with tubes moderately filled, where the muscular coats have not been destroyed, the tube may be opened on its dorsum, its contents milked out carefully, the tube washed out with a hot saline and returned to its place.

If the operator deem it necessary an iodoform gauze drain may be placed in the tube and drawn through Douglass's cul-de-sac for a short time.

CASE I.

Mrs. B., married and the mother of two children.

Three months before I saw her in consultation with Dr. D. she had suffered an abortion.

Soon after this she was taken with chills, a high fever and sweating profusely at night.

This condition had existed for nearly three months.

Palpation revealed a large tumor extending in Douglass's cul-de-sac.

Microscopic examination revealed a mixed infection with the streptococcus in excess.

The diagnosis was pelvic abscess.

She was brought to the hospital and put on the table, with a temperature of 103° F. and a pulse rate of 140 to the minute.

Etherization improved the pulse.

A vaginal puncture was made, and three pints of pus evacuated.

She was dismissed from the hospital in three weeks.

CASE II.

Mrs. C.; aet. 35; the mother of five children.

Four months previous to my visit she had conceived, and at the solicitations of a drunken husband she was persuaded to use the rib of an umbrella on herself for the purpose of producing abortion.

At the time I saw her she had been suffering for six weeks, and had mild symptoms of blood poisoning at the time.

I found a pyosalpinx of right side and the patient four months pregnant.

I made an incision over the tube, drew it up and stitched it to the parietal peritoneum, opened and evacuated its contents, washed it out with hot saline.

Recovery was complete, and at full term she bore a healthy eleven-pound baby.

CASE III.

Miss D., aged 19, came to me during the past month complaining of pain and tenderness in the right side.

At her first call she denied all previous disease or trouble.

At her second call she had a temperature of 101° F. and the pain in the side was no better.

By carefully interrogating her mother, I ascertained she had been suffering with what she called a leucorrhœa for more than three months.

With this history and a microscopical examination of discharges I found she had had a specific vaginitis.

As the tube remained large and the pain continued I did a laparo-salpingotomy with primary union and a speedy recovery.

CASE IV.

Miss E.; aet. 25; Holland descent, American born.

She was taken suddenly ill while working behind a counter.

The history of the case revealed the fact that she had been treated at a near city, for some local trouble, a large part of the previous year.

Her severe illness was ushered in with a chill and a temperature of 102° to 103° F.

There was pain, tenderness and tympanites over the whole abdomen.

She was treated six weeks for typhoid fever, when a second physician was called and she was treated two weeks more without a diagnosis being made.

When I was called to the case I found her so weak that I dared not operate, although I clearly

made the diagnosis of left salpingitis, with general septic peritonitis.

Her general symptoms finally improved, so I made a vaginal puncture and removed a half-pint of pus, after it could be palpated in the cul-de-sac.

The removal of this pus relieved her condition, and the temperature subsided.

Three or four days afterward she apparently took cold, and a new general peritonitis set in.

Her condition remained about the same for a month.

There was an evening temperature of 101° to 102° F. and profuse sweating.

An operation was refused till I called another physician in, who assured them an operation was necessary.

She entered my hospital and I did a laparotomy on her. I emptied the left tube and abdomen of about a pint of pus of decidedly fecal odor, and put a gauze drain down through the vagina.

There were adhesions everywhere and ulcers all over the peritoneal coat of the bowels, varying in size from a thirty-second part to a quarter of an inch in diameter.

I have never looked into the abdomen where the contents of the pelvis and abdomen were bound together in so solid a mass.

She was in my hospital service ten weeks and is not yet well. Will she ever enjoy good health?

I have had three other cases in the past month in which I did a laparo-salpingotomy in two and a vaginal salpingotomy in one.

A correct diagnosis had not been made in any of these four cases.

I discharged the three cases which I happened to receive early in the disease at the end of two weeks; I had primary union in ten days, while the incorrect diagnosis with procrastination makes the other a confined invalid.

The fact that I had four consecutive cases of pyosalpinx, in three of which no diagnosis had been made and in the fourth the wrong diagnosis had been made, impressed upon my mind the great necessity for the family physician to study diagnosis more carefully.

Any one can give drugs, but it requires knowledge with an educated touch to make a correct diagnosis.

ETIOLOGY AND PATHOLOGY OF ARTERIO-SCLEROSIS.¹

BY G. SCOTT TOWNE, M.D.,
Saratoga Springs, N. Y.

THERE is a tendency to atheroma in the arteries of the aged as an evolution process quite independently of exciting causes. In fact, longevity per se is purely a vascular question and has been very aptly and correctly expressed in the axiom, with which we are all familiar, that "a man is as old as his arteries."

The onset of what may be called physiological

¹Read before the Medical Society of Saratoga, Saratoga Springs, February 17, 1905.

arterio-sclerosis depends in the first place upon the quality of arterial tissue which the individual has inherited, and secondly upon the amount of wear and tear to which he has subjected it. The inherited arterio-sclerosis plays a very important rôle, and it is not rare to find individuals early in life with an arterial degeneration that would indicate advanced years. Entire families sometimes show this tendency to early arterio-sclerosis, a tendency, according to Osler, which cannot be explained in any other way than that, in the make-up of the machine, bad material was used for the tubing.

In the very recent past, students of vital statistics have noted with some apprehension an increase in the proportion of deaths caused by arterio-sclerosis and associated conditions, and explanations for the increase have been sought in the greater consumption of alcohol, etc., in more strenuous life, and similar cases. To a partial degree, at least, the explanation is simple. The arterio-sclerotic class of diseases, from which an increase of deaths has been noted, have been affections of old age; and the increase in this class shows that more persons are being saved from other disorders to live to, and die of, old age. So far as being a cause for alarm, this is really a testimony to the successful results of modern medical practice.

Osler says that the most potent etiological factor in the production of arterio-sclerosis results from the bad use of good blood-vessels and among the circumstances which tend to produce this condition he gives the following: The excessive use of alcohol, lead poisoning, gout and syphilis. These may act, according to Traube, by increasing the peripheral resistance in the smaller vessels and in this way raising the blood tension, or possibly, as Bright taught, they alter the quality of the blood and render more difficult its passage through the capillaries.

The poison of syphilis and of gout may act directly on the arteries, producing degenerative changes in the media and adventita.

Overeating and overdrinking are mentioned also as important factors, and particularly is this the case of very stout persons who take very little exercise.

Overwork of the muscles, also, which acts by increasing the peripheral resistance and by raising the blood pressure, tends to atheroma. Chronic Bright's disease is especially frequently succeeded by arterio-sclerosis, more rarely in acute articular rheumatism. In rheumatism the poison is probably the responsible agent, but in Bright's disease it is the retained excrementitious matter. Two classes of cases, according to Tyson, must be associated with Bright's disease, in one of which the arterio-sclerosis is general and primary, causing interstitial nephritis, and in the other it is secondary, the result of Bright's disease.

MORBID ANATOMY.

The atheromatous changes are most frequent in the aorta. Other arteries affected are the

coronary, the radial, the bronchial, the iliac, femoral and the arteries of the brain.

The internal surface of the affected vessels is irregularly thickened with either gelatinous and translucent, or dense and fibrous, or calcareous deposits and products. If the calcification is extensive the vessel is changed into a hard, stiff tube. Often the surface of the thickening or deposit is destroyed, presenting the so-called "atheromatous ulcers," which may be covered with masses of thrombus.

These changes are the result of inflammatory changes in the intima of the blood-vessel, which appears three or four times as thick as normal, due to the swelling of its elements, the new growth of connective tissue and the deposit of round cells. Fatty degeneration of the inflammatory products results.

The result of the changes in the arteries is a loss of their elasticity, thus hindering the propulsion of the blood current and raising the arterial tension, leading to the hypertrophy of the left ventricle. The changes affecting the coronary arteries lead to changes in the myocardium, resulting in disturbance of nutrition and a consequent degeneration and weakening of the heart muscle.

In the aged and prematurely aged there is a calcareous infiltration in the muscular coat without previous inflammation. This is found in arteries like the radial crural and temporal. Still another primary degeneration is the fatty erosion of Virchow extending through the intima and media as a transverse fissure, thought to be the starting point at times of dissecting aneurisms.

The effect of these changes is to produce rigidity and narrowing of the vessel, a loss of propulsive power residing in the elastic coat, a slowing of the current, and increased intravascular tension. These events tax the compensating power of the left ventricle, which, therefore, hypertrophies, and this hypertrophy continues as long as nutrition is maintained.

Localized softening of the brain also succeeds upon atheroma, but this condition is usually preceded by a thrombotic obstruction favored by sclerosis.

A more frequent accident to the brain is rupture of one of these atheromatous vessels, succeeded by the symptoms of apoplexy and hemiplegia. Such a rupture may be preceded by an aneurismal dilatation. Finally aneurism of the large vessels has for its almost indispensable condition, except in traumatic cases, atheroma from some cause of the dilated vessel. Both events, the primary atheroma and the subsequent dilatation, are favored by increased vascular tension.

Grateful acknowledgement is made of my indebtedness to the following authors, whose books were used for reference in writing this paper: Tyson's Practice of Med., Osler's Practice of Med., Hughes's Practice of Med., J. B. Nichols, M.D., in Internat. Clinic, and Ludvig Hektoen in Am. Ref. Hand-Book.

CONSERVATIVE SURGERY OF THE ABDOMEN.¹

BY D. C. MORIARTA, M.D.,
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CONSERVATIVE surgery I am sure is a synonym of the acme of surgical judgment, and I personally cannot conceive of a more flattering appellation for surgical skill than to be designated a conservative surgeon. Of necessity, conservative surgery varies from the most delicate dissection to the boldest procedure, a prompt appreciation of what not to do being quite as essential as to know what to do. If I were to attempt a definition of conservative surgery, I would say it is that surgery which, first, saves life, and then restores normal functions.

Your president has asked me to consider conservative surgery of the abdomen to-night, the principles of which, as applied to life, must be the same in all regions; though, of course, regional surgery must be governed by the accepted teachings of the day. You are all familiar with the views held by our gynecologists and surgeons, both past and present. Not many years ago practically every case of neurasthenia in the female, associated with ovarian irritation, would be unsexed; at that time men could count their cases of ovariectomy by the hundreds and some by thousands. Now the pendulum swings back, and at present a complete ovariectomy is the exception, unless the ovaries are hopelessly diseased; even then, many surgeons leave part of the diseased organ, and take a chance concerning the pathological outcome, trusting that there may be a fecundant possibility, though a second operation may be demanded later. No one would suggest that the multitude of ovaries sacrificed in years gone by was the result of surgical ambition for scalps, or the concomitant fees; or that the operator of to-day attempts to save a portion of an ovary that a second operation may follow. The careful operator and clinician will err, but, as has been said, it is the acme of skill to determine what to do with a given pathological condition; if the result is perfect—*i. e.*, life and function preserved—then the operator is conservative. Each case must be a law unto itself; age, resistance, general conditions, as well as local ones, have to be considered. To illustrate, a woman 30 years of age in a state of invalidism because of inflammatory pelvic trouble, associated with diseased ovaries and tubes, either or both more or less degenerated or perhaps practically destroyed. Yet we must try to save their function in part at least, even though time and money are sacrificed; we must, however, take no chance with the patient's life if we are to be conservatists. This same case at 40 years of age I am sure you would consider a pan-hysterectomy.

There are men in the profession who believe that they are conservative because they declaim that they do not believe in operations, and main-

tain that there is too much operating done, and that the operator is always anxious for an operation because of the fee. These men are a menace to public health and safety, and are a factor in the sacrifice of many lives. Of the same grade of intellect is the physician who says aseptic details are practiced to impress the lay mind of the greatness of surgery! Still others measure their conservatism by delays, postponing the necessary operative procedures as long as possible, which is often until all chance of recovery is wasted. Others measure their conservatism by the length of the incision!

The true conservative surgeon knows he must operate early, before irreparable damage has been done; that he must work expeditiously, understandingly, and be master of the situation; and that he should be ready to proceed as soon as the patient is anesthetized. I deem it pertinent to mention this feature, as I have often seen a surgeon delay the operation after the patient was anesthetized, while he was washing up or finishing a story, or listening to a colleague. The period of the anesthesia is a most important conservative factor, and if some one must wait, let it be the surgeon.

An operation is useless if the infection has passed beyond the field of operation; or, similarly, if a prostatectomy is deferred until after catheter life has been taken up and the bladder and kidneys irreparably damaged. Operations on the stomach, the biliary tract, the appendix, or for intestinal intussusception or strangulated hernia, must be early if conservative; and I would place myself on record as believing that an exploratory laparotomy is true conservatism when one is in doubt concerning the diagnosis. What is more distressing to a surgeon than, when a patient has been referred to him for uterine cancer, to find it inoperable? It is the universal expression of surgeons that these cases must be seen early if we are to save them. Thus the family physician more often becomes the conservative element, or the opposite, accordingly as he advises his patient to seek the skill of an operator, or tells him to wait and see what time will accomplish. There are many cases we meet in time, and can save, if we have the courage of our convictions, ignoring the possible criticism that the operation was not necessary. This feature we often have to contend with personally, as do all practitioners who have a limited field of practice. A surgeon must be willing to have errors of judgment charged against his skill, though he knows full well that the good features of his work are not to be amplified. And the public say "Send for Surgeon X and he will cut you—he needs the money"; while a jealous colleague echoes, "Sure thing."

While all must have experience before they are skilful surgeons, all are not surgeons who have had experience. The sacrifice of useful lives is the price that must be paid for educating surgeons. To see the bold novice attempting major work, indifferent to the life at stake, ap-

¹Read before the Saratoga Springs Medical Society, Friday, May 19, 1905.

parently believing he can do as well as others in the same line—is to hold one spellbound! Without rhyme or reason for these conclusions or actions, he proceeds in imitation of an experienced operator, and perhaps believes he is a conservative surgeon.

To enter into the details of conservatism in abdominal surgery, would, I am afraid, take us beyond the intent of our president when he outlined the papers for the evening. But, to generalize, what are the features that make up conservative surgery of the abdomen? Primarily, asepsis—though diagnostic skill, associated with judgment and dexterity, are prime factors. These latter, however, are of no value without a perfect aseptic technique. Asepsis has made so much possible in abdominal surgery in the past twenty years, that to the older men it hardly seems credible; while to the men of ten years' practice, it is accepted as a matter of fact, as if these features had always been possible. Yet I can recall when a successful laparotomy was the occasion for a national notice. Another recent measure is skidagraphy, useful in diseases of the kidney in locating stones; it has also some value in gunshot wounds.

I shall close with the mention of a few conservative features of abdominal surgery. Immediate laparotomy in stab wounds, gunshot wounds and severe traumatism of the abdomen, is a positive conservative surgical measure. The achievements of modern gynecologists in saving parts of ovaries and tubes, making reproduction possible, is surely wonderful. Formerly if an ovary was cystic, degenerated or septic, it was sacrificed; while to-day it is trimmed up, scrubbed up, sewed up, and often becomes a useful organ. So it may be with the fallopian tubes. Dudley has buried an ovary, or part of an ovary, in the coruna of the uterus, followed by a successful pregnancy. Equally conservative of life and function are myomectomy, hysterectomy without the ovaries, and ureteral exploration, followed by such surgery as may be demanded. A word of caution to the would-be conservative operator: When an old pyosalpinx is met, do not accept its contents as benign; it usually is, though not always. Be most careful of infecting the cavity.

Other conservative features of surgery are the Hunter-McGuire suprapubic opening of the bladder in the aged for drainage and stones; or prostatectomy, though to my mind the peritoneal route is the choice for prostatectomy. In either, the operation must be attempted before the patient is exhausted from the pain, fatigue, sleeplessness, sepsis, and the diseased kidneys, incident to catheter life. One not familiar with the ease, rapidity and small amount of shock which accompany this operation, might hesitate to advise his patients positively; and so they accept catheter life with its dangers and misery. Operative procedure is the conservative requirement.

I must say a word about appendicitis, though

I am sure I shall meet my Waterloo if I attempt to outline the conservative points or features in primary appendicitis:

1. I do not believe that pulse or temperature, per se, have any significant value.

2. I do not believe the period that the disease has existed is of diagnostic value.

3. I do believe that the area and amount of sensitiveness are of great value.

4. Rigidity of the abdominal muscles, associated with sensitiveness, is of much value, depending upon whether the condition is diminishing, stationary or progressive.

5. A conservative element enters into septic cases of appendicitis, as to whether we shall remove the appendix in all cases. My practice is not to try, when from the conditions present we will probably infect the cavity, if we attempt its removal; simply drain.

Statistics of disease of the stomach show conclusively that gastric ulcer is an etiological factor in malignancy. It is equally true that many cases of malignancy of the gall bladder are due to the irritation or ulceration of the bladder or ducts from the impacted stones. It is thus apparent that an early diagnosis, followed by operative procedures, in these conditions is imperative, if the patient's life is to be saved. The same is also true of acute inflammatory trouble with the gall ducts or bladder. Enterectomy, gastro-enterectomy, chloro-enterectomy, are most conservative measures.

The Murphy button is the one mechanical device that all appreciate, though its usefulness is a relative one when considered by all. The various methods of suturing, Halstead's inflated rubber bags, the various forceps, decalcified bone plates, plates of potato or apple, all have advocates; but the needle is continually becoming more useful and popular. Suture material, distance of sutures, and whether they can be passed through and through, will always be questions of judgment. The drainage of an abdominal wound, and how it shall be done, the closing of the abdominal wall, the position afterwards, and whether a patient shall be allowed to move, are all most important conservative features. As to drainage, when in doubt, use it; and the best is the cigarette drain covered with rubber tissue. Position depends upon the conditions present which one has to consider; if it is septic condition, elevate the head of the bed; if shock, elevate the foot. In the latter condition, saline solution, either in the veins or by hypodermoclysis, is of great conservative value. I believe a patient is better to move about in bed after abdominal operation where adhesions are likely to occur.

I think you will agree with me that the surgeon who is to undertake these operations early, will have to be a thoroughly capable diagnostician; honest, and true to his convictions; ready to stand public and professional criticism, because he believes and knows he is right.

No less brave and determined is the family

physician, who sees these cases first, if he hurries them to the surgeons. At this time they are prone to be skeptical and apt to turn to other professional men whose advice may not be in harmony with the views already expressed; delay is advised, and the family physician is in temporary disgrace.

In conclusion, conservative surgery depends upon an aseptic technique, diagnostic skill, accurate judgment, and an operator who has the courage of his convictions.

FADS IN SURGERY.¹

BY HOWARD LILIENTHAL, M.D.,
New York City.

ONE of the definitions of the word *Fad* given by the Century Dictionary is: "A matter of no importance or an important matter imperfectly understood, taken up and urged with more zeal than sense." The term, indeed, has been said to have been derived from the acrostical reading of the words *For a Day*, which happily expresses the evanescent quality characteristic of all fads.

The calling of the physician is a serious one. In the science and the art of Medicine, with its high aims and its life of altruism, it seems strange enough that anything like caprice should play a part. Yet the practice of our profession has been influenced in all ages by fads which have often been hard enough to shake off; which, indeed, have left permanent traces for evil and for good.

As the fruit of each new research makes its appearance, there are not wanting those who, failing to recognize its importance, set it down as a mere fad. And in truth it often requires keen insight and fine judgment to grasp in its incipency the true meaning of an epoch-marking discovery. When I first entered the medical school, only twenty-one years ago, some of our most respected teachers regarded the doctrine of microbic infection and of antiseptics in surgery as the whim of an hour. The black frock coat still formed the most striking feature of the operator's costume. Whole lectures were devoted to hospital gangrene. The theory of infection, however, had come to stay.

Not long after this, when the fear of invading the peritoneum had subsided, came the wholesale spaying of women. The ovaries were removed for what now would be called trivial reasons. I have seen the operation performed upon a young girl for the cure of hysterical attacks at menstruation, the patient being perfectly normal and well between times. The craze has fortunately passed, and few double oophorectomies are now performed, except for demonstrable organic disease. Yet even at the present day the ease and safety with which the uterus may be removed is responsible for hysterectomy in many a case in which the patient might have managed well

enough with local treatment and without the shock and risk of so grave a procedure. This criticism, naturally, does not hold when there is even a suspicion of malignant disease.

Again, referring to the improvement in technique, we have the spectacle of operators vying with each other as to who can remove the largest fibroid or myoma by way of the vagina—often enough with wounding of neighboring adherent viscera, an accident which would not have happened had the more surgical abdominal route been selected. In this day of keen competition among surgeons there is danger that the whim or fancy of the patient may be taken too seriously into consideration, so that the story of why Mrs. Dinah Washington recommended her doctor to her friend with the fibroid becomes more than possibility: "Doan you let 'em cut yore stummock," said she. "Go to Dr. Tompkins. He'll take it out troo de pajama." The artist in surgery will weigh each individual case and will plan his operation without being carried away by his desire to gratify the vanity of the patient as well as his own in avoiding an abdominal cicatrix.

Another modern fad is that of the man who cannot see—or palpate—a movable organ without an uncontrollable desire to anchor it, regardless of the fact that proof may be lacking that the said movable organ is to blame for the train of symptoms for which the patient seeks relief. The female right kidney is the greatest sufferer in this respect. And to this kind of surgeon it is certainly a remunerative organ, since the right kidney is movable in such an enormous percentage of cases that one may wonder whether a fixed right female kidney may not be the abnormality, not the movable one. I do not question that a wandering kidney may produce symptoms demanding operation. I merely believe that the presence of mobility should not be the only indication. Yet I see the published statistics of operators who anchor in the neighborhood of a hundred kidneys in a year. At Mount Sinai Hospital, which has a large general surgical and gynecological service, the operation is not done a dozen times a year. Evidently, doctors disagree.

Some years ago a lady called upon me for an opinion as to the advisability of anchoring her right kidney, this treatment having been deemed urgently necessary by another surgeon. The movable organ was certainly there, but the vomiting and emaciation which were to have been relieved by nephropexy were caused by an advanced gastric carcinoma, which has since terminated in death.

Within the last few years, following upon the work of Reginald Harrison and others in nephrotomy for the relief of anuria due to intracapsular tension came the proposition to submit patients with Bright's disease and other forms of nephritis rather indiscriminately to operations of various kinds. Nephrotomy, single and multiple splitting of the capsule and complete renal decapsulation have been urged upon the profes-

¹Read at the Annual Meeting of the New York County Medical Society, October 24, 1904.

sion with an enthusiasm which was not easy to withstand, even in the face of theoretical objections. Now, that good has been accomplished in certain cases by these operations it would be folly to deny. Passive congestion, with its albumin, casts and general symptoms may undoubtedly be benefited, or even cured, by capsulotomy or fixation. Also, some direct renal infections of a septic nature may be considered fit for surgery. To label this entire field of therapy as a fad would probably strike far from the truth. Every physician knows, however, that much can be accomplished by purely medical means in the amelioration of what may be called constitutional nephritis—the term is my own—even when the case looks most unfavorable. And that surgery might do more than this for those who suffer from a general disease of which the renal element is merely one expression is extremely doubtful. In the present light of our knowledge operation should be reserved for those unfortunate ones who are not helped by other treatment. Indiscriminate operation in all varieties of nephritis must be considered a dangerous fad.

It was my intention to say a few words on the fad which, with great show of mystery, would split off from general surgery the treatment and operations which might become necessary at the natural openings of the body. But this branch of so-called orificial surgery is such a patent absurdity that the time would be wasted. The only ones who seem to take it seriously are the orificial surgeons themselves.

And now we come to one more "important matter imperfectly understood, taken up and urged with more zeal than sense." I refer to radiotherapy when employed in cases of operable malignant growths, lying deeper than the skin. There is a time for the employment of radiotherapy, but it should be after the operation, not before it. I say this well knowing that the opposite has been held by some who have had greater experience in this branch than I. But I also know that men are more apt to be carried away by success than by failure and that radioactivity has been known to stimulate malignancy, and that it has even seemed to cause its development during the treatment of conditions supposed to be benign. No one would think for a moment of criticizing radiotherapy or, for that matter, anything scientific or unscientific, when the case is one of hopeless malignant disease. To be sure, the true physician will use every means which his science and skill can summon to relieve the wretched one, but when failure must be faced and despair seizes the sick man and those who love him, this same physician may view with sorrow, but hardly with blame, the forsaking of truth for error. And radiotherapy gives hope through science instead of through quackery.

There is one general rule for the employment of any new remedial agency, and that is: Use it only when old and tried methods fail to give sat-

isfaction. Gradually but surely the novelty will find its proper place with the minimum number of disappointments.

A young practitioner had purchased a large and gorgeous X-ray apparatus, which was duly installed in his office, to the envy of his less fortunate colleagues. One of his classmates from the country, happening to call upon him one day, was greatly impressed. "By Jove!" he exclaimed. "That's wonderful. What's it good for?" "Good for everything, till it's paid for" was the businesslike rejoinder.

There are, and there always will be, individuals in our profession who will fall over each other in their eagerness to try every new drug or every new instrument or operation as early as possible and upon as many patients as can be persuaded to submit. The very idea of novelty is, to them, attractive. Dr. Smith's *new* cystoscope must be better than Dr. Jones's old one. Yet their reasoning is false and humiliating failures often enough occur.

I would not be understood as decrying things which are new. On the contrary, all progress would cease if we were to rest satisfied with what we possess. It is merely the Fad—the taking up and urging "with more zeal than sense"—to which I would call a halt. Pope has most pithily put the whole matter—

"Be not the first by whom the new are tried
Nor yet the last to lay the old aside."

ACCIDENTS OF ANAESTHESIA.¹

BY S. ORMOND GOLDAN, M.D.,
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PREVENTION is better than cure applies with equal force to the accidents of anæsthesia as to disease in general. A proper consideration of this subject would entail covering almost the entire field of anæsthesia; I therefore purpose, treating of the most salient features of the subject. Properly considered, accidents of anæsthesia should be those arising only from unavoidable causes. To anticipate possible accidents presupposes a thorough knowledge of the physical, chemical, and especially the physiological, properties of anæsthetic agents—a knowledge of the peculiarities in types of patients—the proper selection and administration of anæsthetics; what to avoid and when.

Prophylaxis is as important in anæsthesia as in medicine generally; this is exemplified strikingly in the proper use of chloroform—for who having a correct knowledge of this substance would administer it in the sitting position? Yet this is frequently done in dental practice, and is one of the greatest causes of fatality from this improper practice. Knowing this, a prophylactic measure would prevent this most serious accident—invariably chloroform should be given with the patient in the fully recumbent posture.

¹Read before the East Side Physicians' Association of the City of New York, May 19, 1905.

Anæsthetics, like many drugs, possess the greatest power for good or harm, depending entirely upon the person using them. While my entire time is now given to general practice, still an extensive experience in the administration of various anæsthetics in general use at the present time leads me to state emphatically that no major anæsthetic (as chloroform) should be employed when a minor one (as nitrous oxide) will answer. All operative work should be done with rapidity sufficient to enable one to use a minor anæsthetic and thereby avoid not only the risk of the major one, but also the other considerable risk of keeping the patient an unnecessarily long time under the influence of the anæsthetic. Accidents may be classed as:

1. Avoidable (generally due to inexperience).
2. Unavoidable (where every possible precaution has been taken).

Causes of accidents in general may be stated as:

- Inexperience generally.
- Improper preparation of the patient.
- Improper position.
- Improper selection of the anæsthetic.
- Inattention.
- Undue exposure.
- Supersaturation with the anæsthetic.
- Asphyxial (mechanical causes) manifested by cyanosis due to:
 - Head too extended or depressed.
 - Relaxed tongue or jaw.
 - Saliva, mucus, blood.
 - Glottic and laryngeal spasm.
 - Spasmodic contraction of the chest muscles.
 - Contraction of the muscles of the lower jaw.
 - Absence of teeth (preventing breathing).
 - Short neck, combined with extreme obesity.
 - Nausea and vomiting.
 - Trendelenburg or prone position.
 - Foreign bodies.

- Fright.
- The anæsthetic, per se.
- Respiratory failure.
- Cardiac failure.
- Circulatory failure.
- Shock (vasomotor paralysis).
- Laryngitis, bronchitis, pneumonia.
- Nephritis.

Paralysis. } Central.
 } Peripheral.

Excessive nausea and vomiting.

Anæsthetics considered in connection with accidents:

1. Minor anæsthetics. By minor anæsthetics I mean those agents which produce their effects almost instantaneously and employed usually in operations of short duration. These are:

- Nitrous oxide and oxygen.
- Nitrous oxide and air (diluted oxygen).

Bichloride of methyl-ethylene (narcotile). Ethyl chloride. Ethyl bromide. Somnoforme. A mixture of Ethyl bromide. Ethyl chloride. Bichloride of methylene.	}	Hypervolatile anæsthetics.
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2. Major anæsthetics.

Ether, preceded by nitrous oxide, or one of the hypervolatile anæsthetics.

Ether alone.

Chloroform preceded by ether, or better, by nitrous oxide and ether.

Chloroform alone.

Conditions interfering with the free ingress of air will cause asphyxia, the symptoms of which are cyanosis of the skin and mucous membranes and undue venous condition of the blood.

The Tongue.—When anæsthesia is complete the relaxed condition of the muscles of the tongue permits it to fall backward upon the epiglottis, effectually closing the superior aperture of the larynx, preventing breathing. The simplest method of treating this, and which answers in most cases, is to extend the head and press the lower jaw forward at the angles. This tenses the muscles of the jaw connected with the tongue and hyoid bone, and also the ligaments of the epiglottis, drawing it forward and upward, while tongue forceps or tenaculum may occasionally become necessary. A better practice, and one I have never before seen mentioned, is to slightly depress the lower jaw, when the tongue will appear at the teeth. It can then be grasped with the finger and thumb and held between two layers of gauze, similar to the practice of the laryngologist when examining the throat. This will also permit the effectual swabbing out of the pharynx of mucus and saliva, which in themselves occasionally obstruct breathing. Regarding the passage of a silk thread through the tongue, it is permissible when the tongue repeatedly falls back, due to an abnormally large state of the organ. The thread should be passed a good distance from the tip, and directly through the center. It is sometimes necessary to forcibly separate the jaws before the tongue can be withdrawn. This is best accomplished with a periosteal elevator or wooden wedge, introduced at the site of the biscupids. The gag can then be easily introduced, and as far back as possible. The supports of the gag should always be protected with rubber, preventing the fracture of brittle teeth.

Various positions of the patient interfere with respiration. Trendelenburg's, which interferes with the action of the diaphragm and respiratory movements, sometimes causes cyanosis. The prone position, necessary to some operations, frequently occasions cyanosis, particularly in old subjects. The defects are obviated by resuming from time to time the horizontal in Trendelenburg's position, and turning the patient to one side when the prone posture is employed. Too

great flexion of the head can cause an obstruction to breathing, and too dependent position of the head causes a cyanosis, due to pressure on the great arterial trunks. Both these conditions are remedied by the head fairly extended, on a level with the body, and to one side; as before stated, this permits the mucus and saliva to flow from the mouth, and that in the pharynx to pass into the œsophagus instead of the trachea.

The lips, by their valve-like action, sometimes prevent respiration. This often occurs in old people as a result of atrophy of the alveoli of the jaws and of the muscles of the face. During inspiration the lips are drawn together and expiration does not effectually separate them, and cyanosis develops. The treatment here consists in separating the lips with the fingers. This condition may be overlooked if the inhaler is not at intervals removed from the patient's face.

Spasm of the Glottis, Spasm of the Chest Muscles, Spasm of the Lower Jaw.—These conditions are frequently associated, and occur at the beginning of the anæsthesia from a too concentrated vapor, and when the patient is regaining consciousness, due to the efforts at vomiting and swallowing when neither are accomplished. It also occurs during rather advanced narcosis from abnormal reflex action. The last is the most serious. As cyanosis develops the condition subsides, due to the stimulation of the respiratory center. If, after waiting a reasonable time, breathing does not commence, the jaws should be separated, traction on the tongue employed, and the epiglottis irritated with the fingers. Breathing will, in most cases, be resumed; if not, artificial respiration should be employed.

Vomiting.—This occurs most frequently after the patient is anæsthetized and allowed to return to a lesser depth of narcosis. It is usually preceded by spasmodic movements of the diaphragm, chest, and abdomen, gulping, contraction of the muscles of the lower jaw, grating of the teeth, dilatation of the pupils, and cyanosis. Vomiting is best avoided by deepening the narcosis rapidly with ether, gradually with chloroform. If vomiting occurs the head should be lowered, the patient turned to one side, and the mouth cleansed before recommencing the administration.

Foreign bodies, as loosened or artificial teeth, particles of vomited food, etc., are particularly dangerous, as laryngeal reflex is in abeyance. These objects may easily become impacted, resulting in respiratory obstruction and cyanosis, and, if not removed, will cause asphyxia. The removal of foreign bodies is usually accomplished with the fingers or forceps; if not successful, completely inverting the patient and vigorously slapping the back usually answers; if this does not dislodge the substance, immediate tracheotomy becomes necessary.

Insufflation of blood into the larynx can cause asphyxia. This is best avoided by proper prophylaxis about the mouth; operations, if prolonged,

are preferably preceded by preliminary tracheotomy, the pharynx being packed with sponges.

It will be seen that the emergencies mentioned are due to conditions with which the anæsthetic, in most instances, has nothing directly to do.

Dangerous symptoms resulting from the too sudden, prolonged, or excessive administration are most serious, and with ether are connected principally with the respiratory function, and are of an asphyxial nature. Collapse in most cases is gradual; for this reason prompt treatment rarely fails to afford relief. Direct paralysis of the respiratory center is rare with this anæsthetic. Depression of the circulatory apparatus, through either the vasomotor centers or the heart, though possible, is very rare, and occurs secondarily.

The factors in the causation of chloroform syncope are (1) depression and paralysis of the vasomotor centers, permitting a great fall in arterial blood pressure; (2) more rarely paralysis of the heart.

The respiratory center is secondarily involved as a result of the anæmia of the medulla, due to the great fall in arterial tension. Obviously, any condition interfering with the integrity of the circulatory apparatus must affect the respiration, and vice versa. Therefore, careful administrators watch unceasingly both the respiration and the pulse.

In collapse for hemorrhage, there is an anæmia of the medulla quite similar to depression by chloroform, but with hemorrhage treatment rarely fails to restore the patient. In surgical shock (vasomotor paralysis) there is a paralysis of the vital centers, not only from simple anæmia, but also from the anæsthetic, and treatment most frequently does no good whatever. Collapse from ether rarely occurs without warning, the symptoms being shallow, gasping, possibly high-pitched respiration, with or without cyanosis; the pulse at first will not be noticeably altered, but gradually becomes small, rapid and irregular.

With chloroform, the most frequent observable symptom of danger is an ashy pallor, with rapid failure of the pulse. It is said chloroform frequently gives no warning of approaching collapse. While possible at the commencement of anæsthesia (even then I think faulty administration the cause in most cases), during narcosis, after the operation is completed and the inhalation discontinued, pallor will frequently arise, with disappearance of the pulse, but prompt treatment usually restores the patient. During a large experience in chloroform administration in adults and children I have had cases, usually those with adenoids and large tonsils, which showed dangerous symptoms, not at the beginning or during the anæsthesia, but at the end of the operation, and after the anæsthetic had been discontinued for some minutes, and an exceedingly small quantity of the anæsthetic used, all the patients recovered. One of these patients was restored after the most persistent treatment of twenty minutes. The causes of these symptoms I have before men-

tioned, and they are undoubtedly due to the residual vapor in the air passages. Remembering this, it is always well to use alternate compression and relaxation of the chest with the patient upon the side and inverted—that is, treat the danger before it occurs.

Artificial Respiration.—By this it is endeavored to introduce fresh air into the lungs by artificial means, at the same time removing the anæsthetic-laden air from the blood. In order that artificial respiration may be effective, the air passages should be unobstructed, the patient's head extended and drawn to one side, the tongue drawn moderately out and allowed to fall to one side and to the dependent angle of the lips. If oxygen is to be employed, this is the time for it, as there can be introduced as much oxygen during one inspiration as during four inspirations with atmospheric air. Of course, if the patient will not breathe, all the oxygen obtainable will be of no avail. As to the method of artificial respiration, Sylvester's is to be preferred in most cases. In operations about the mouth, or where blood or vomited material has been insufflated, Sylvester's method is not the best, as, in drawing air, blood and other foreign material may be sucked into the larynx and trachea, and instead of relieving the condition it may be intensified. In these cases the patient should be turned to one side, when artificial respiration can be effectually performed, at the same time permitting the foreign material to gravitate to the hollow of the cheek and flow from the mouth.

Artificial respiration can be performed by forcibly introducing air into the lungs by means of a bellows or by the use of a catheter introduced into the larynx, the anæsthetist using his own lungs to inflate those of the patient. I have had two successful cases in children so treated.

Grasping the abdominal wall outward will cause a negative pressure in the lungs and lead to inspiratory efforts, not reflexly, as is usually said, but this condition will also increase vasomotor depression. If chloroform has been used the device should not be employed.

Inversion.—Hill has shown that in vasomotor paralysis the mechanism which compensates for the hydrostatic effects of gravity is abolished.

This permits a great fall in arterial tension, by which the blood is all located in the veins of the splanchnic area. By inverting the patient the blood is permitted to gravitate to a certain extent to the vital centers in the medulla, and directly to the heart, which stimulates it to increased action. It should be borne in mind that the heart may be overfull, when inversion, instead of correcting the evil, will increase it. Here the patient should be placed in the feet-down position for a moment or so, permitting the heart to empty itself, then again changing to the inverted posture.

By means of alternate compression and relaxation of the chest, both the circulation and respiration are affected. This is done very rapidly, or

at the normal respiration rate, by pressure upon the lateral portions of the chest, one hand causing pressure directly over the heart. This device mechanically influences the blood in the cavities of the heart and moves it onward, and at the same time permits of inflation of the lungs.

If dangerous symptoms occur in the earlier stages of anæsthesia, restoring the patient by means of reflex action may be of benefit, but in profound narcosis much good cannot be expected, though this means should, of course, be tried. The rhythmic traction of the tongue, about eighteen times a minute, is said to stimulate respiration reflexly. Laborde, who devised the method, used it in most cases in the earlier stages of anæsthesia, where the reflexes were not entirely abolished. Stretching the sphincter ani causes inspiration efforts, associated with the peculiar inspiratory stridor familiar to all. This is also of use during the earlier stages of narcosis, and has no influence during profound anæsthesia. Manipulations in Douglass's cul-de-sac act in the same way. Forcibly slapping the abdomen with hot wet towels has been found to be of some use, as well as ether or ice poured upon the abdomen. Applications of cloth wrung out of hot water and placed over the heart are said to stimulate it reflexly, and should be tried.

Regarding drugs, it may be said they will be found of little benefit if there is no circulation; further, when they are used, care is necessary that the dosage is not too great and too often repeated, for when the circulation becomes active the aggregate of the remedies used may act in an overwhelming dose, and in itself be the cause of collapse. If a fair-sized dose of any drug employed does no good, it is safe to say a large dose will not do so.

When drugs become necessary in anæsthetic emergencies there is usually, but not always, a condition of vasomotor depression in which the circulation is at a standstill. This is probably the reason the large doses of drugs we read about having been employed exerted no influence upon the patient. Drugs usually used for anæsthetic emergencies are whisky, ether, ammonia, strychnine, atropine, digitalis and amyl nitrate.

The instances in which I have seen whisky and ether employed have been with emergencies early in the narcosis, when anything used would probably restore the patient. Even in these cases, I have always felt that artificial respiration and inversion were the real causes of improvement. When syncope occurs early in the narcosis, or before little or any anæsthetic has been inhaled, whisky or ether will certainly stimulate the heart. During profound narcosis they should never be used, and Wood has justly condemned the practice of administering these drugs during anæsthesia.

Ammonia.—This is employed by inhalation to stimulate respiration or intravenously to stimulate the heart. It is capable of doing much harm to the respiratory apparatus if too strong. Some

good results from its use when introduced directly into the circulation if still fairly active.

Strychnine is, everything considered, the best circulatory and respiratory stimulant. If, after using a fair-sized dose, improvement does not result, no further dependence should be placed on it.

Atropine is a respiratory and vasomotor stimulant. It is also said to paralyze the cardio-inhibitory apparatus; to be effective, it should be given early, as soon as the patient shows the least sign of approaching collapse.

Atropine is slow in its action, and frequent fair-sized doses are to be preferred to one large dose.

Digitalis may be employed, but, as with other drugs, will be of little benefit if there is no circulation.

Regarding amyl nitrate, it may be said it increases vasomotor depression and does more harm than good; therefore, it should not be used if chloroform was administered; it is of use when nitrous oxide has been employed.

Saline infusion will be found of the very greatest benefit in the treatment of shock where more or less blood has been lost. In urgent cases the fluid may be introduced directly into the circulation, the temperature being 115° F.; in less urgent cases, by means of the colon. In surgical shock resulting from prolonged operations, and when the anæsthetic is also a factor, much good cannot be expected from saline infusion. Complete inversion of these patients with compression of the abdomen and the introduction of the saline solution directly into the colon, or hot coffee at the temperature of 120° F., with any drugs desirable, rarely fails to do good. While the introduction of the fluid into the colon is simple, few really know how to do it. A Wales's canalized bougie—in adults, size 7 will usually answer—is introduced, the fluid being pumped by means of a bulb syringe attached to the end. By this means the intestine is pushed away from the tube as it goes upward. Soft-rubber tubes should not be used; they rarely pass the sacral promontory and never pass through the sigmoid, whereas the Wales's tube will never fail to do so if properly used.

The introduction of hot fluid into the colon is not practiced to any extent. There is no better way of treating urinary suppression and shock from sepsis, and at the same time thirst may be allayed by it.

If patients were given a course of treatment by this means for, say, a week before any serious operation was to take place, surgical shock from prolonged operations would develop decidedly less frequently than it does. Even in emergency cases, it does not fail to do some good.

Laryngitis, bronchitis, pneumonia suppression of urine, nephritis, paralysis, occasionally occur subsequent to the narcosis. The anæsthetic is usually blamed—faulty administration and improper care of the patient are undoubtedly the real cause. Consider bronchitis and pneumonia, for instance; after the patient is removed to bed his chest is exposed; added to this, he is obliged to

lie upon the back continually. It is well known that patients who have been recumbent from illness and who had not taken an anæsthetic often develop a secondary pneumonia. This, I think, explains the cases of pneumonia developing days or weeks subsequent to the operation. Nephritis or suppression of urine, I do not doubt, can occur as a result of supersaturation with anæsthetics. I have seen it following not only ether and chloroform, but also where either no anæsthetic or local anæsthetic was used, particularly in operations upon the genito-urinary apparatus, and sometimes prolonged operations, as a result of surgical shock, where the quantity of anæsthetic used was remarkably small. Casts and albumen I have seen following both ether and chloroform narcosis, usually disappearing in a few days.

Paralysis may be: (1) Peripheral, due to faulty posture or apparatus for maintaining the position of the patient. It should be remembered that when a patient is anæsthetized the centers which control unconscious movements of the body, preventing injury, are in abeyance. A careful administrator will prevent pressure paralysis by slightly moving the patient from time to time and taking due care of the extremities, and thereby avoid pressure upon any part for too long a period.

(2) Central paralysis, due to a rupture of a blood-vessel, is, in my opinion, most frequently due to improper administration of the anæsthetic and occurs at the commencement of anæsthesia as follows: From a too great concentration of the vapor the patient takes a deep inspiration, holds his breath, tenses his muscular system, congests his venous system; as a consequence there occurs a great rise in blood pressure, and, as a result, rupture of the vessel.

SATISFACTORY ANAESTHESIAS OF SHORT DURATION

Effected by the Use of Laughing Gas and a Small Quantity of Ether.

BY PRESCOTT LE BRETON, M.D.,
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AMONG private patients of the better class there arise frequently surgical conditions in which the operation itself, although necessary, and requiring anæsthesia, is minor in its nature, while the choice of the anæsthetic and its method of administration are of chief importance. Especially is this true in the families of physicians or in the families of the wealthy, where the demand is that the safest anæsthetic shall be given and one which will cause a minimum of discomfort. For example, the case may be that of a child or a young woman who has already had to endure considerable pain or illness. Sometimes it is a person debilitated by age. Sometimes it is a case in which both heart and kidney lesions are present. Not infrequently the patient is a physician or a surgeon. The writer has been called upon often during the

past few years to use for such cases laughing gas from start to finish, adding a little ether from time to time to maintain relaxation. The kind of operations for which this combination has been used are the following: Incision of cellulitis or abscess, incision of bone abscess, breaking up of adhesions in joints, drilling of fibrous union after fracture of bone, refracture of bone after union with deformity, circumcision, herniæ, castration, operations for ingrowing toenail, skin grafting, removal of superficial tumors, hemorrhoids, dilatation of sphincter ani, etc.

In order to give gas and ether in the manner to be described, it is necessary for the administrator to be familiar with the use of laughing gas as it is ordinarily given to precede the use of ether. The writer uses the Goldan apparatus, in the cylinders of which a small hole has been drilled to allow the introduction of a few drops of ether by the nozzle of the ether bottle. This hole is kept closed nearly all the time. It is opened and shut by slightly twisting the cylinders. A nursing bottle with rubber cork and two small nozzles (as used for chloroform) forms a convenient ether holder, as it measures the quantity used and allows the ether to be added a few drops at a time.

The idea in this method of administration is to alternate and combine the gas and ether, interrupting the inhalation at times, as may be indicated, by one or two breaths of air. No oxygen is used. The ether is added to complete the relaxation and supplement the effect of the nitrous oxide. Consequently it is held in reserve as far as possible. The giving of the anæsthetic is preferably deferred until the patient is on the table, as it is somewhat awkward to start the anæsthetic in one room and shift the apparatus while giving gas. A hypodermic of morphine beforehand is of value, but is not a necessary adjunct. The gas is started in the usual way, and continued until beginning cyanosis appears. Before the blueness is marked and before respiration is impeded, the valve is shut and the face mask lifted until the patient has had one inspiration of air. Then the mask is returned and the valve opened and a little more gas sent into the rubber bag. One, or at the most two, inspirations of air will allow a marked change in the appearance of the patient. Any more allowance would mean loss of control of the anæsthesia. Very soon the typical condition will be evident where the face is dusky, the breathing rather snoring, the pupils contracted and the pulse firm and about 80 or 90 to the minute. Many cases will not remain perfectly quiet at first, and the administrator will have to pour into the cylinder about fifteen drops of ether to be inhaled with the gas. Cases vary considerably. In some ether is required at frequent intervals to prevent motion or crying out. In others gas alone may be used for the first ten minutes. A little experience enables one to perceive the indication for more gas or more ether or more air. The left hand is used to steady the

face mask. The right hand is used to turn on more gas, or to add ether, or to shut the valve and raise the face mask until a little air is inhaled. For a ten-minute narcosis, about twelve gallons of gas and half an ounce of ether should suffice; for a thirty-minute anæsthesia, about twenty gallons of gas and one ounce of ether.

It can readily be seen that this method is eminently safe because such a small amount of each agent is used. The patient, although anæsthetized, is always "on the edge," and is not saturated with the anæsthetic. Consciousness returns in a very few moments after removing the inhaler, and the discomfort is very slight unless some idiosyncrasy exists. Often a bad taste in the mouth, a chilly sensation from the increased perspiration, and a passing nausea will be the only complaint. The distress is usually directly proportionate to the length of the time of the anæsthesia. No pain is suffered during the operation, although sometimes the patient will have an indefinite recollection that something happened. It is not always possible to keep the patient absolutely quiet. Men, especially those who have been accustomed to one or two alcoholic drinks daily, are apt to talk, cry out or move the head occasionally until ether is pushed again. Ether is the necessary and valuable adjunct which makes it possible to continue the use of the gas. A little experience combined with consistent watchfulness insures a steady narcosis and a satisfied operator. As the Goldan apparatus has no expiratory valve, the patient must be allowed about once every second minute a full inspiration of pure air.

Although the writer has continued this combination for as long as an hour, it is more satisfactory to limit its use to the short cases. An operation requiring absolute relaxation or delicate dissection demands a different agent, because with a laughing gas narcosis some rigidity persists and the darker color of the blood may obscure an operative field. For the class of cases mentioned at the beginning of the paper it is very satisfactory and particularly grateful to the patient.

RESPIRATORY PROPHYLAXIS.¹

BY PAUL F. SONDERN, M.D.,
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AS the respiratory diseases are in the most part due to the primary "catching cold," our prevention of same, naturally, is in building up the body resistance to cold, and this further reduces itself to attention to the skin, as it is due to enlarged surface vessels and profuse perspiration, brought about by too heavy clothing, that the resistance to cold is lessened.

Damp clothing, as well as a damp skin, causes the body to be affected harmfully by the cold.

According to Pettenkofer, there is as much heat necessary to disperse an ounce and a half

¹Read before Section on Public Health, Rochester Academy of Medicine, February 22, 1905.

of water in wet stockings, as would melt half a pound of ice. Too warm clothing is doubly harmful in that it not only induces weakened resistance of surface vessels, but also causes extra perspiration.

It is surprising that, notwithstanding the fact so apparent of the immunity against respiratory troubles of those hardened against attacks of cold, so many continue to so clothe themselves and live as to weaken those resisting powers, but this is without doubt due to the fact that warmth is more agreeable until one has become accustomed to resistance to cold, after which the sensation of cold is not disagreeable.

It is, therefore, the duty of every physician to see that his patients are hardened in this respect. This is possible in every case under sixty years of age; above that age care must be exercised, except in cases of very recent development.

The process of hardening is in getting the skin accustomed to changes of temperature without effect on the general health.

This is not obtained through, say, the application of cold water alone, but other factors come into play.

Let me apologize in advance if I seem to enter into the method of cold application too minutely, but I have seen so many cases, where the patient has been simply told to take *cold* baths. ONE plunge in icy water proves *enough* for the person who has never tried it before.

The process is either prophylactic in the full sense of the word and must commence in early youth, or is commenced when the resisting power of the body against cold is already below par.

The first is undoubtedly the better, and can be commenced with the exceedingly young—beginning at the age of four weeks to rinse off with water of 85° after their bath, and then dry. As the child grows older, the temperature of this second sponging is reduced so that at the age of six months the water is about 75° to 70°. When the child is able to stand, let him do so, and pour water of temperature of room—about 67°—over him.

This is a more rapid reduction of temperature of water than is advised by some eminent authorities. Holt advises water not below 90° at end of first year. Jacobi, 90°, not much cooler for a number of months, and says cold baths 60° to 75° seldom, if ever, are appropriate for a body of less than eight months or a year. Keating, 90° at first, then, as child grows older, gradually reduce to 75° or cooler. Starr, first 2½ years 95°. In hot weather sponge at 90°. Cold sponge or cold plunge not admissible as daily routine until youth is well advanced. Rotch reduces to 75½ in three or four years, if possible.

This douche is also the most simple method for older persons, by means of shower or large sponge, after which the skin is dried with a rough towel, and then some gymnastic exercises performed. Younger and more robust people can bathe in a cold room, even in winter, but it is ad-

visible to then go into a warm room, or do some walking, either outside or about the room.

Parents should be instructed to see that the children continue these baths; they are generally neglected when the child is no longer in the nurse's hands, **often** being most religiously taken care of until the school age, when it is overlooked, to remain so until taken up of own accord, or not at all.

Those above 50 years of age should, as a rule, bathe in a heated room and not in water of below 60°, and those of very debilitated or anæmic constitution should be advised to use water somewhat warmer.

Perspiration is no contraindication, but exaggerated heart or lung action should be allowed to subside before the application of the cold water.

For a very old person or a very much weakened adult or child, it would be the greatest folly to commence the building up process by the immediate use of the cold baths. In these cases, it is best to start in by having the body rubbed for from two to three minutes, with a rough cloth, preferably in the hands of another person, the air of the room being warm.

After a very few days, the quickened reaction of the skin will be quite apparent, and then we can safely, after the dry rubbing, apply an alcoholic solution and follow with a short brisk rub of about a half minute.

In from six to eight weeks, according to degree of primary weakness, water can be substituted for the alcohol, first of the room temperature, and then colder day by day until after a further six weeks, we can generally start in with the baths.

Another method, when the facilities are at hand, is to have the patient commence by taking a full bath in water of 90° and follow this in five minutes by a shower or sponge five degrees colder, gradually reducing the temperature of both day by day, until 65° is reached; this method is especially practicable for children.

Those cases where a bath is out of the question, we must resort to first rubbing dry, and then sponging and immediately drying the different parts of the body.

Sea baths are of great benefit, but the mistake is generally made of remaining in the water too long—two or three minutes or until the first reaction is the proper length of time. Children should be simply dipped and then taken out. Wading in the salt water is good for children, besides the salt air is a good tonic for the respiratory apparatus, and in some forms of catarrhal troubles, a source of great comfort, notably in pharyngitis sicca, sufferers from which, who in the higher and dryer altitudes have very exaggerated symptoms, forget they have a throat when at the seashore.

One or even two years are necessary to build up a weakened body so as to offer full resistance to temperature changes.

As I have already stated, the cold baths are

not all that is necessary to put the body in proper condition, but exercise is also necessary; this can be of *any* kind that the heart can stand.

The clothing is a most important factor and the one where most mistakes are made, especially the wearing of woolen underwear. Wool causes profuse perspiration and should never be worn except as an outer garment, as in summer, when no coat or other shirt is worn over it. Chest protectors would be more properly styled "chest destroyers."

Mufflers are very harmful, especially in case of those addicted to throat inflammation, as they cause perspiration and prevent evaporation thereof. Fur is especially harmful in this respect, but I do not think the fashion could be successfully combated by the physician.

The wearing of heavy underwear in winter, especially by those who are confined to the home a great part of the time, is a custom to be decried, for we certainly do not need heavy clothing while in a temperature of 70°, besides the air is void of moisture, as it is in most houses. It is far more sensible to wear heavier outer clothing when venturing into the cold air.

Our great trouble in getting our patient into proper form, is the disposition to immediately put on heavier clothing on taking cold, not realizing that several attacks may have to be gone through before the resisting powers are normal. Sailors, I understand, usually go through a number of catarrhal attacks before being able to expose their throats and chests to the cold, as they do.

The cold-water cure and proper clothing will prove of no benefit if a person remains in a hot room; exercise in the open air is necessary.

Well-ventilated and cold sleeping-rooms should be insisted on, but avoidance of direct draughts. And the body should be well covered; heavier covering for the anæmic is necessary.

Foreign bodies, dust, etc., cause injury to the mucous membrane, thus forming a good bed for bacteria, as is seen so frequently in stone-cutters being affected by tuberculosis.

The indulgence in too hot or highly spiced foods or drink, also tobacco or spirits, causes a chronic inflammation of the mucous membrane which goes on to deeper-seated troubles.

Being in a smoky atmosphere is about as harmful as smoking, as is seen so frequently in waiters, and worst of all is the combination of smoke, spirits and use of the voice, singers in variety halls of the "smoking concert" class being almost impossible to relieve of respiratory difficulties, unless they abandon their line of work.

Other prophylaxis lies in the treatment of acute troubles or local conditions.

Any obstruction to free breathing through the nose must be removed, be it due to septal deflections or enchondroses, adenoids or hyperæmic conditions of the turbinate bodies or their mucous membrane covering.

Enlarged tonsils or those spongy or full of crypts, being a source of infection through the

lymphatic system, should receive our careful consideration. It should be remembered that it is not only the abnormally large tonsil that is a menace to the general health; a flat tonsil, if broken down, can be of far more danger, and should, in all cases, be gotten rid of, by whichever means most appeals to us.

ORIFICAL SURGERY—ITS ABSURDITIES, PHILOSOPHY AND MERITS.¹

BY HERMAN E. HAYD, M.D., M.R.C.S., ENG.,
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DURING the last decade the various orifices of the body have been carefully studied, and the part played by them in the production of disease and suffering has been intelligently interpreted, and certain definite and scientific procedures have been proposed and successfully applied for the relief and cure of many varied and complicated physical phenomena. Unfortunately this important field for medical and surgical usefulness—with a certain definite basis of absolute truth—has been appropriated and magnified by an ignorant class with quackish tendencies into a so-called specialty, and they have designated themselves orificialists or orificial surgeons, and maintain that all forms of chronic disease are due to a nerve waste occasioned by orificial irritation at the lower openings of the body. The principles of their practice assume first, that "the irritation of an organ begins at its mouth; that this mouth is guarded by sphincter muscles, and it will contract in response to any kind of irritation, be it a temporary one, as in the discharge of its natural function, when the contraction will be but temporary; and be it a continued irritation, the contraction will be continued and exhausting."

Pratt says that after a practice of many years, confined exclusively to the treatment of chronic diseases, he has yet to find an exception—that in all pathological conditions, surgical or medical, which linger persistently, in spite of all efforts at removal, from the delicate derangements of brain substance that induce insanity and the various forms of neurasthenia, to the great variety of morbid changes, repeatedly found in the coarser structures of the body, there will invariably be found more or less irritation of the rectum, or the orifices of the sexual system, or of both. In other words, there is one predisposing cause for all forms of chronic diseases, and that is, a nerve waste, occasioned by orificial irritation at the lower openings of the body. These irritations induce a rigidity of the sphincters guarding the parts, which either continues, sympathetically affecting the rest of the involuntary muscular system, and steadily draining the nervous power that supplies it, until the whole struggle terminates in rigor mortis; or, tiring out in the hopeless grip, it relaxes into the inertia of paralysis.

This philosophy is indeed interesting, to say the

¹Read before the Buffalo Academy of Medicine, April 4, 1905.

least, and demands from us more than mere skeptical notice. If the pathological conditions he claims exist—which I very much doubt—it still does not follow that all forms of chronic disease should be treated primarily from the lower orifices, or that every case of chronic illness from the insane to the consumptive, from the neurasthenic to the sufferer from organic liver, kidney and heart disease, from the subjects of simple anæmia to the incurable pernicious anæmias, etc., etc., is candidates for orificial surgery, unless the rectal or urethral orifices are clearly a source of pain and suffering as would be induced by easily recognizable pathology, as a protruding pile, a fissure, or a painful ulcer, etc., etc., and then the good which would result, would come not simply from the effect upon the circulation—by stretching the sphincter—by flushing the capillaries and stimulating the sympathetic system of nerves, as is claimed by the orificialist, but by removing a definite source of pain and suffering, as well as a common cause of peripheral irritation, which, by being left, produces ill-health, debility and perhaps exhaustion.

The nervous supply of the lower bowel and sexual apparatus of both sexes is very rich, and comes from the cerebro-spinal and sympathetic systems. The orifices are controlled by sphincters; the external muscle is supplied by the cerebro-spinal nerves, and the internal by the sympathetic system. All the vessels of the body, the heart and the internal viscera, are also supplied by the sympathetic. Therefore, it is reasonable for us to believe that irritations of the sympathetic at the internal sphincter may have a profound effect upon the whole system, and no doubt certain forms of disease are often cured or relieved by direct attention to these orifices, and perhaps not alone by relieving sources of reflex and peripheral irritation, but by profoundly impressing the great centers of the sympathetic, as is claimed by these specialists.

It may be true that the irritation of an organ begins at its mouth, and as a general proposition I can accept it, but when an inflammation has passed from the mouth into the deeper parts, surgical or medical attention directed to the mouth, I should say, would avail nothing, unless the mouth was pathological, because the orifice may be quite healthy, as is instanced by a stricture of the urethra, or by hyperæsthetic areas in the penis when the urethral meatus is of normal caliber.

Another axiom maintained by the orificial disciples is that where there is reflex irritation, there is always reflex congestion, and that the original site of congestion is transferred to the organ involved in the reflex process. For example, in an attack of mumps, the congestion and inflammation may leave the parotid gland and involve the ovaries or testicles, and yet there need be no trace of the original irritation in the parotid gland—the organ first affected. In like manner the uterus may be healthy, but the patient may

still be a sufferer from uterine headache, due to this transferred irritation. In this way, the field of orificial surgery is without limit; the blind, deaf and even the dumb, as well as all other chronic invalids and incurables, may seek hope through this subtle agency, because having been unrelieved by our usual, previously employed methods, they may still expect a reactive power to be awakened by dilatation of the sphincters. The orificialist also maintains that the upper passages are not so essential to the maintenance of the general health as those which open from below. The upper openings can be closed for repairs; the eye can be bandaged, and the nose can be stopped, but the sphincter-guarded orifices cannot, because the important functions of defecation and urination must be always carried on. The importance of this deduction is absurdly overestimated, because it is ridiculous to say that these openings do not get rest, as man is neither defecating nor urinating all the time. True, the anal sphincter may be in a condition of more or less contraction all the time, but this is but a physiological function, and is not extreme, excepting when Nature's demands are responded to. The heart pumps blood all the time, but it gets its rest by the changes in posture which man assumes, especially during our sleeping hours and hours of repose. The lower bowel is comparatively empty the greater part of the time, and this is equally true in reference to the urethra. An interesting clinical observation which demonstrates the excessive sensibility of the bowel opening is the behavior of a patient under narcosis. A hand or foot may be amputated, the pleural or peritoneal cavity can be opened; in fact, any of the ordinary major operations can be performed without materially affecting the depth of inspiration or the rapidity of the heart's action, but the dilatation of the internal sphincter will always produce an effect upon both, and often to an alarming degree. An experiment quoted by Pratt specially emphasizes this observation: "Let a patient be anesthetized, and then pass the two thumbs into the rectum only far enough to impinge against the external sphincter. If dilatation be practiced, even to an extreme degree, no more effect upon respiration would be produced than would be occasioned by pinching or otherwise injuring the integument of any other portion of the body supplied by the cerebro-spinal nerves. If, however, the thumbs or the speculum be inserted far enough to engage the internal sphincter, the effect upon the respiration is instantaneous and often profound, and the heart's action becomes slow and feeble, and in sensitive subjects the condition passes on to complete syncope. The capillaries of the system become universally flushed: hands and feet that have been cold get warm, and if the face has been pallid and sallow, it will glow with a new infusion of blood into their capillaries. If a carbuncle or boil exists in the skin, its color would probably change. No amount of dilatation of any other orifices in the

body, as the nose, the mouth, the nasal ducts, produces any appreciable effect upon respiration or the circulation, showing conclusively the intimate relationship which exists between the bowel opening and the entire body through the agency of the sympathetic system." Advantage is taken of this knowledge when operating upon other organs, when the signs of chloroform poisoning present themselves; the sphincter is at once dilated as a means to profoundly impress the heart and respiratory centers; in fact, is one of the recognized measures for resuscitation.

Again, during operations upon the rectum, when the pulse and respiration suggest danger, all manipulations should cease, the clamp perhaps should be removed; a tight ligature should be severed, and the internal sphincter should be again dilated, and when the signs of returning animation have declared themselves, we may perhaps proceed with safety.

There can be no question that a careful study of the orifices of the body and their influence upon morbid conditions must be borne in mind by every intelligent practitioner of medicine. Whether we accept these sweeping assumptions of the orificialists or not, we can profit by the fruits of their labor and the clinical evidences of such work when properly and intelligently performed, and without unduly exaggerating their importance, at the same time not losing sight of their possible usefulness, and without extravagantly including the whole list of diseases that flesh is heir to as within the domain for the application of orificial surgery. There is some good in all fads and schisms, even from the obscure and sacred tenets of the Christian Scientists, to the kinked and twisted spine with its prominent seventh cervical vertebra of the osteopath; from the absurd high potencies and similia similibus of the homœopath to the incantations and holy shrine of The Lourdes or The Mecca.

Whether we accept the philosophy of the orificialist or not, one thing is certain—that the orifices of the body should always be carefully examined, as great suffering, ill-health, and even death, can result from unrecognized diseased conditions about them, and the surprise is, that intelligent men and good practitioners in medicine have been so long ignorant in this field of pathology. In conditions of malnutrition, with their associated neurasthenias and hysterias in the male, the importance of a long foreskin with its shortened frenum must not be underrated; a contracted meatus, a stricture of the urethra with its hyperæsthetic areas along the urethral canal, and particularly at the bulb, as these conditions are capable of making a varied and complex class of distressing symptoms, and without local treatment, medicine will avail but little. Many cases of irritable bladder, nocturnal emissions, spermatorrhœa and atonic impotence, neurasthenia and even hypochondriasis and melancholia have been relieved by a circumcision or a simple meatotomy,

or an incision of the preputial hood. Chronic constipation in both sexes, pruritus ani, intestinal indigestion, various neuroses, due to intestinal toxæmias, have been relieved and cured by a simple dilatation of the sphincters, or by the excision of piles, and the tearing open and subsequent healing of a fissure and painful ulcer or fistula. Pockets within the sphincter grip and small hypertrophies of mucous membrane, papillæ and polyps must not be lost sight of, as their importance in producing an unduly tight sphincter with all its reflexes, should be recognized by all of us. In the female, from the little girl to the old maid, a tight preputial hood, with its enclosed and accumulated smegma, is a most frequent cause of nervous irritability, of fits, night screaming, wetting the bed and masturbation, as a similar condition in the male child results from its analogue—a long and tight prepuce. An irritable hymen, with its oversensitive carunculæ, and perhaps vaginismus, with all its train of painful symptoms; a contracted urethra, with its painful vegetations or caruncles; a swollen and hypertrophied mucous membrane, with irritable pockets behind it, are sources of much bladder distress and general irritability. A contracted os, with its excessively tender and sensitive mucous membrane at the internal os, are often responsible for the various neuralgic dysmenorrhœas of young women and their associated ill-health—insomnia and headaches and nervous breakdowns. Many facial blemishes result from reflex irritation from the pelvic and genital organs, and I have cured cases of acne and even eczema in young women by a dilatation of the cervix, curettage and packing the uterine cavity with iodoform gauze. Acne in young men has been relieved and cured by the passage of sounds and quieting hyperæsthetic areas, and other sources of genital irritation and sexual erithesism; dilating strictured areas, and by restoring the normal urethral caliber.

Lacerations of the cervix and irritable scar zones in the cicatrix are capable of producing a surprising amount of suffering, ill-health and chronic invalidism. So also with lacerations of the perineum, or even relaxed perinei, with their protruding cystoceles and rectoceles. The intimate relationship between the uterus and breast is of great importance, and often tumors and swellings in the breast disappear by removing sources of irritation in the pelvis; in fact, I read a valuable paper—I don't just call it to mind—in which a great many cases were cited where large swelling of the breast had been absorbed by various operative procedures about the uterus and its appendages. The effect of nursing in controlling hemorrhage after confinement is familiar to all of us. The importance of enlarged tonsils and nasal hypertrophies and adenoid growths must not be lost sight of, as well as the correction of various eye reflexes and phorias. Violent attacks of asthma have been cured by removing polyps from the nose and larynx, and even by

snipping off an elongated uvula, and many serious forms of indigestion have been cured by properly applied glasses. In fact, the field of reflex irritations and peripheral reflexes in general becomes larger the more carefully we study our cases, and so the field of orificial irritations and their rich reflexes becomes wider and more diversified the more we keep in mind the possible connection between these orifices and remote parts of the body.

So satisfactory and complete have been the cures in my hands of many of the conditions enumerated, that I am almost persuaded to believe that the rectum and sexual systems of men and women are responsible for more suffering, ill-health and chronic invalidism than all the other organs of the body put together, and that all kinds of symptoms and many different diseases can be simulated and masqueraded and even produced by irritations in and about these organs. Nor must we lose sight of the intimate connection which exists between the rectum and the genital organs of both sexes, because operations upon one organ often fail in bringing about a cure, because there also existed a source of irritation and disease in the other organ, which was overlooked or the importance of which was not considered by the surgeon. Again, the existence of a tight sphincter with or without other gross pathological changes in the rectum or genital organs, should be relieved because there is no doubt in my mind that much good will result from forcibly dilating the sphincters or subcutaneously dividing the fibers of the internal muscles in many chronic diseases.

We do not need to accept all the absurd theories and conclusions of the orificialists to be persuaded that important lessons are to be learned from attention to the orifices, and that much good will result from employing some of the principles and methods of their treatment of local and general diseases. Nor do we need to include in that scope of usefulness all the diseases that man is subject to, because we would then deservedly be as they are, an ignorant class of charlatans, who prey upon the weaknesses and credulities of a sick, dependent and impressionable people for selfish and commercial purposes.

HYDATID CYST.*

E. S. Age 49. Admitted March 6, 1905. To Bellevue. Born Switzerland. Length of residence in United States not known. Occupation, coal miner.

Family History.—One brother had tuberculosis, otherwise negative.

Habits.—Accustomed to taking five or six glasses of whiskey daily and several glasses of beer. Venereal taint denied.

Personal History.—Had none of the ordinary diseases of childhood. Pneumonia ten years ago,

does not remember on which side. Since has had a cough more or less troublesome. Eight years ago had an attack of rheumatism, the larger joints being involved. The attack was repeated one year later. For the past five months he has been coughing constantly with muco-purulent expectoration which has never been tinged with blood. He has had night sweats, loss of weight, strength and appetite. Three days before admission, during a severe coughing spell he had a sudden sharp pain in the right axillary region, since has had frequent chilly sensations, but no distinct chill.

Physical examination on admission to hospital showed a well-developed, fairly well-nourished man. Apex of the heart was in the fifth interspace, four inches from midsternal line. Action weak, no murmurs. The right chest showed well-marked signs of hydro-pneumo-thorax, the left chest of consolidation. Liver and spleen not palpable. Abdomen negative. The urine had a specific gravity of 1024 and was negative. The sputum contained many tubercle bacilli. The temperature on the first two days after admission ranged between 98 and 103 degrees F., on the following three days, which includes up to the date of death, the temperature ranged between 96 and 101 degrees F. The pulse varied from 96 to 140.

The following are the main points taken from the post-mortem findings:

The right pleural cavity contained about two litres of purulent fluid and air. The right lung was compressed to a mass about the size of one's hand. Parietal and pulmonary pleura covered by a very thick exudate of fibrin. Smears from the fibrin and fluid showed streptococci. The left lung was consolidated and contained many small tubercular cavities. There was general congestion through the abdominal organs.

The right lobe of the liver was slightly increased in size. Capsule smooth, no adhesions about it. The left lobe was represented by narrow margin of shriveled, yellowish-looking tissue which extended no more than 1½ inches to the left of the falciform ligament. Section through the transverse diameter showed the right lobe congested and abnormally fatty. The shriveled left lobe formed the fibrous covering of a cavity about 8 cm. in diameter. The cavity contains an echinococcus cyst, the diameter of which was many times that of the fibrous cavity in which it was contained. The cyst wall was folded upon itself to accommodate itself to the cavity. No fluid was present. There were no scoleces or hocklets found, but the membrane shows the outer stratified structure and the inner granular layer by which it was recognized as an echinococcus cyst.

Christian Science Mother—Eleanor, what is the matter?

Christian Science Child—Oh, mamma, I got a terrible error of the mind in my stomach. —*Massachusetts Medical Journal.*

*History presented to the Pathological Society, by Dr. J. E. Welch, April 12, 1905. Specimen shown.

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SECRET NOSTRUMS.

In the report of the Committee on Reports of Officers to the House of Delegates of the American Medical Association is the important action taken on the Council of Pharmacy and Chemistry, and resolutions on the use of secret nostrums:

Report of the Board of Trustees on the creation of the Council of Pharmacy and Chemistry is, in the opinion of your committee, the most important and effective measure ever undertaken by this Association to rid the profession of the abuse of the nostrum evil. The personnel of the council is of such a character as to create a feeling of confidence that the proposed work will be done thoroughly, conscientiously and justly. The publication of the results of the work of the council in book form, with annual editions, will afford a source of information of inestimable value to the profession.

Therefore, we recommend that the House of Delegates indorse the action of the Board of Trustees in the creation of the Council on Pharmacy and Chemistry; that the Trustees be requested to devise a plan through which the council may be made permanent, and that the Trustees request the Secretary of Agriculture of the U. S. Government to give the Council of Pharmacy and Chemistry recognition by authorizing the Bureau of Chemistry to cooperate with the council in its work.

We indorse the work already performed by the Council on Pharmacy and Chemistry in the formulation of rules governing the mode of selection of articles to be investigated and the publication of results already obtained.

We recommend the publication in book form of a list of the preparations not in the Pharmacopœia that are approved by the Council on Pharmacy and Chemistry.

We indorse the underlying sentiments of the preamble and resolutions presented by the committee of the State Medical Society of Missouri:

Resolved, That the three delegates of the Missouri State Medical Association to the American Medical Association be appointed a committee to prepare a resolution embodying the sentiments of a paper read by Dr. William G. Moore, of St. Louis, entitled "The Present Status of Therapeutics."

This paper dealt with the subject as its title signifies,

and drew attention to the fact that many of the remedies now used in the daily practice of the vast majority of the practitioners of this country, are of the so-called proprietary kind, the exact composition of which is unknown, save to the manufacturer of the remedy; and that the practitioner thus using such a remedy lowers the dignity of his profession.

Again, the responsibility of the profession is shown in the license allowed medical journals, which are absolutely their creatures and should be under their control, to advertise these remedies, not only in their advertising pages, but also by reading notices scattered throughout their columns.

Therefore, the delegates of the Missouri State Medical Association respectfully present the following:

WHEREAS, The majority of the so-called proprietary remedies are secret nostrums whose formulæ are unknown to the medical profession; and

WHEREAS, The use of such remedies stifles investigation of rational therapeutics and lowers the standard of our practice to mere empiricism; and

WHEREAS, The medical journals, the creatures of our profession, are filled with advertisements of these nostrums, enlisting the attention of the unwary practitioner and resulting in enriching the manufacturer and defrauding the unsuspecting patient; therefore, be it

Resolved, That it is the sense of this body that the use of these remedies by the members of the American Medical Association is reprehensible, and that these advertisements should not appear in reputable medical journals.

WALTER B. DORSETT,
A. R. KIEFFER.

Of those presented by the Section on Practice of Medicine:

WHEREAS, The medical profession of the United States has too long neglected to recognize the harm to the public, to the members of the profession, and to scientific medicine, from the nostrum evil; and

WHEREAS, The Board of Trustees of the American Medical Association has created a body, known as the Council on Pharmacy and Chemistry, to investigate and pass on the various non-official medicinal preparations placed on the market: therefore, be it

Resolved, That we, individually and collectively, heartily indorse the action of the Board of Trustees, and earnestly urge every physician to give this effort of reform his hearty support.

Resolved, That the Board of Trustees be requested to effect the removal of the remaining nostrum advertisements from the pages of *The Journal of the American Medical Association*.

Resolved, That the representatives of this section to the House of Delegates be instructed to present these preambles and resolutions to the House of Delegates, with the recommendation of this section for their in-

dorsement, and that a copy of the same be sent to the president and secretary of each constituent society of the American Medical Association.

And of the resolution presented by Dr. Jones, of California, that the House of Delegates instruct the Board of Trustees to abide by the rule which it adopted in 1895, and in 1900, to the effect that no advertisement of a remedy shall be printed in the pages of *The Journal* unless the formula, giving the quantities of the active ingredients of each dose, be stated, with each insertion of that advertisement.

We recommend the adoption of the following motions:

Resolved, That it is reprehensible for the members of this organization to prescribe or use nostrums, and that we request the Board of Trustees not to advertise any nostrum in the columns of *The Journal*.

Resolved, That we request the Board of Trustees hereafter to insert in *The Journal* with each advertisement the formulæ of remedies which may have been favorably passed on by the Council of Pharmacy and Chemistry for advertisement.

On motion, these recommendations of the committee were concurred in.

AMERICAN MEDICAL ASSOCIATION SPECIAL.

(Concluding.)

On our arrival at Portland the train was sidetracked and the party went to various hotels. The majority were quartered at the Portland Hotel, which was the headquarters of the A. M. A. The meeting-places of the sections were near one another, and for the most part were very satisfactory. The meetings were quite well attended. The majority of papers of interest were by Eastern men. The scientific part of the meeting was not on a par with that of former years, but the social side more than made up for any lapses in that respect. More than \$25,000 was raised for the entertainment of the members. A grand reception and entertainment at the exposition, with fireworks, boat rides, dancing, etc., took up one evening. On another night the prominent physicians and citizens entertained in the most lavish manner at their several residences. Thursday night a grand reception was given at Portland's Coney Island. The next day an excursion was taken up the Columbia River. In the meantime daily excursions, receptions, etc., were given to the wives of the physicians by the women of Portland. Such hospitality was quite refreshing, as it was unexpected. The exposition itself does not differ from any of the other expositions. It closely resembles the Buffalo Exposition. The United States Government exhibit is by far the most interesting and instructive feature. The general design of the building and grounds is very beautiful, but most of the exhibits have been shown at all previous fairs for the past ten years.

Friday we left Portland. The following day we stopped at Shasta Springs and had our first experience here of one of those thrilling rides in which the people of the West seem to delight. The car is pulled up an almost directly perpendicular road for a distance of 1,500 feet. The water of Shasta Springs contains iron and CO₂. It is much used as a table water along the coast.

Sunday morning we saw Sacramento by trolley. That afternoon we arrived in San Francisco. Trolley rides about the city, trips to Chinatown and the various parks quickly took up our three days in the metropolis of the Coast. While here we ascended Mt. Tamalpais, a distance of eight miles, yet the railroad makes 289 turns in this distance. The view from this point is one of the most extensive in this country. One can see more than 150 miles, and the ever-changing landscape makes a picture never to be forgotten. Wednesday we left San Francisco. That afternoon we arrived at Palo Alto. Carriages were taken to the Leland Stanford University. The buildings are constructed on the mission style of architecture and cover about 100 acres. They are for the most part but one story in height. The chapel is by far the most attractive building. A magnificent mosaic picture covers the whole front on the outside. Inside the mosaics, woodwork and sculpture strongly remind one of the famous churches of Europe, yet withal there is a freshness about it that is rather pleasing, and does not suggest imitation.

An organ recital was specially rendered for our party, and the musicians among us avowed that it was the most entrancing church organ music that they had ever heard.

The university has an endowment of \$30,000,000. There is no charge for tuition. There are about 3,000 students.

That same afternoon we visited the big trees—giants of wood, 300 feet or over, within the trunk of which more than thirty people can stand upright. That night we arrived at Monterey, and were quartered at the Hotel del Monte. This hotel, with its magnificent gardens, groves, lakes, etc., is a veritable fairyland. It is the most popular resort along the whole North American Riviera.

The old town of Monterey still retains its ancient quaintness, and it requires very little imagination to picture the adventurers of the Spanish main in their palmy days. The seventeen-mile drive along the coast was another enjoyable feature of our stay here. The next morning we were on our way again. A two hours' drive was taken about Santa Barbara. Magnificent gardens surround most of the houses and banks of flowers greet the eye everywhere. The famous mission of Santa Barbara, more than a hundred years old, is the Mecca for all students of Helen Jackson's Ramona. Our next stopping-place was San Pedro, whence we took passage by a steamer for Santa Catalina Island. This is a sail of more than four hours, and not a few of our party communicated with the old man of the sea. Any discomforts of the trip were more than repaid by this beautiful gem of the Western Sea. It resembles the Island of Capri in almost every particular. A trip in a glass-bottomed boat, through which the beauties of the fauna and flora of the Pacific may be viewed, is a marvelous revelation

to every one. Many of us thought this the most entrancing spot in California.

The next day was spent in a ride to the top of Mt. Lowe, followed by a trolley ride about Pasadena. Sunday was spent at Los Angeles. We saw the city in the morning. In the afternoon the ostrich farms were visited and some of our party took a dip in the Pacific in the evening. Los Angeles is thirty miles from the beach, but an excellent trolley service makes the distance in forty minutes.

The trolley systems in all of these California towns is far superior to anything that we have in the East; air-brakes are used entirely, and the cars ride much easier than they do here.

The next morning we saw Riverside. We were entertained at the beautiful Glenwood Hotel. In the afternoon we drove through Redlands. This is the resort of the tuberculous. Nine-tenths of the population have come here on account of phthisis either in themselves or in their families. Almost all of the physicians are Easterners, who came here seeking health. The cost of living is about the same as in a New York State town. All of the physicians seem to have enough to do and are prosperous. The fees are \$1.50 at office, \$2 for house visit, obstetric cases from \$20 up. There are thirty physicians in a population of 9,000 people. The climate here is superior to Los Angeles, because it is situated a little higher, and there is not so much dampness. The country hereabouts is given up exclusively to the orange and lemon. Gardens filled with all kinds of tropical plants are seen on every side.

The profession in California is naturally not overfond of having Eastern physicians come out here to settle, so they make the State Board examination quite severe. They say about six out of twenty applicants succeed in getting through. In managing tuberculosis they rely entirely on open-air treatment. They live on open porches, and here the patient sleeps the whole year.

A trip across the desert of Nevada with the thermometer at 100 was not as unpleasant as it might seem. The following day was spent at Salt Lake City. Here the novelty of floating on water with no effort was enjoyed by most of the party. An organ recital at the tabernacle and a trip through the city completed our day here. A dip in the waters of Glenwood Springs, a noted health resort of Colorado, and the Royal Gorge were the principal events of the next day.

On arriving in Denver we went over the Georgetown loop, one of those dizzy pieces of mountain engineering which delight the hearts of all true Westerners. The sight of hundreds of holes along the hillside telling the tale of lost hopes will doubtless be a valuable lesson to many of us when we receive the yellow literature next winter that tells of the rich mines of Colorado. Cripple Creek, Pike's Peak and Colorado Springs are household words in most homes and do not need mention. At Kansas City and St. Louis we were royally entertained.

We were very fortunate on the trip—there was but one rainy day and but one hot day. We had no accident in the course of more than 9,000 miles. According to railroad officials no entire train has ever gone this distance without change of cars. There was no serious sickness and no exhibition of bad temper, both of which facts are remarkable in a mixed party of eighty-six people.

The consensus of opinion was that Dr. Wiggin had planned and executed the best possible trip in the shortest possible time, and that the Kinports Company, through their agents, Messrs. McCann and King, did all in their power to make the trip pleasant. At every possible opportunity they made our comfort their chief aim. Almost every one of the party looks forward to another such trip at some future time—perhaps to one of the international congresses.

THOS. F. REILLY.

COMMUNICATIONS.

—, August 10, 1905.

Dear Doctor—In the May, 1901, number of our JOURNAL was published an article by Dr. A. A. Hubbell, of Buffalo, on "The Reason for the Existence of the New York State Medical Association," that serves to this day to point out the advantages of membership. In the same number is a stirring editorial; a few quotations will not be out of place at this time: "Study the Charter and the By-Laws, and realize what has been done, and is being done, to unite the medical profession along the lines of mutual improvement, advantage and public welfare. Spread the gospel of unity among the unbelievers, the hesitating, the timid; explain to them the democratic form of fraternalism, the unselfishness, the sociologic features of our organization."

"Do you realize that by standing shoulder to shoulder, with but one aim in view, we can exert an influence that will echo from one end of this broad land to the other? Do you know that individual effort and oneness of purpose will bowl down opposition and cavil, and bring us to the vantage ground that physicians, individually and collectively, have been denied during so many years, even, in fact, since the beginning? Think it over calmly, and without thought of personal prejudices. Work for the association, and you will work for the public, for a higher standard of medical practice, and, incidentally, for yourself."

I have not acknowledged acceptance of service of notice of proposed amalgamation because I am not in favor of it. Nothing is to be gained, and it is a great injustice to those noble men who have made the Association what it is and who have been the means of opening the eyes and "broadening the ideas" of the old State Society regarding eligibility to membership. There is nothing to hinder them joining the Association if they want and if they do not, they are not worthy of notice should they not unite with all others to further good medical legislation. I

shall be very much crestfallen if the Association goes out of existence and I shall consider that all is again under the control of the old Society bureauracy.

Very truly,
J. R.

The above letter undoubtedly voices the sentiments of the very small minority, who are not in favor of amalgamation. We publish it in order that both sides of the question may be placed before the members of the Association, and in order that we may not be accused of withholding the views of this aforesaid minority. We would like to say in reply, that the withholding of the acknowledgment of meeting, by the writer does not necessarily mean that he will not be served in one way or another. The Committee in charge of this matter is trying to carry out simply the ideas of the majority of the members of the Association. Therefore, it would facilitate matters a great deal if each member of the Association would acknowledge acceptance of service of notice, without causing undue trouble or annoyance. This refusal of acceptance of service by a member, simply means that the matter may be carried into the courts, and may bring about a large expense and litigation, which is absolutely unnecessary. Acceptance of service does not necessarily take from the individual his right to vote as he feels in the open meeting of the Association to be held in the coming October. We do not think that the idea of amalgamation means abolition of the ideas for which the Association was organized; we simply are striving for the unity of our medical brethren within the State of New York. Of course, the members of the Committee, it goes without saying, are not selling the birthright, which they have inherited from the State Association; were they so doing, they would consider themselves traitors to the organization which they hope they represent. The idea of the Committee is simply to prepare themselves beforehand to carry out those plans which were agreed to at the meeting of the Association in 1904, when the members present unanimously voted for amalgamation. It seems to us that the refusal of acceptance of service and notification is puerile and absolutely beyond the idea of what medical men should consider the true fraternal spirit. Therefore, we are sorry that our correspondent sees fit to take such a gloomy view of the earnest work of our Committee.

THE DIAGNOSIS AND TREATMENT OF ABDOMINAL PAIN.

In a very valuable article in the *Yale Medical Journal* are reviewed the more common causes of abdominal pain, the means of recognizing them and of avoiding the usual errors. The author, Dr. John B. Deaver, emphasizes these generalizations as the results of a long experience:

Pain is probably the most constant of all symp-

toms, no matter what the disease or where the pathological lesions are situated, and the abdomen is surgically the most important and the most extensive part of the human body. From the sudden stab of momentary indigestion to the chronic agony of cancerous disease, from the burning ache of gastric or intestinal perforation to the prostrating pain of ruptured extra-uterine pregnancy, through the whole gamut of abdominal disease, the surgeon's mind must run as he seeks here and there a note of hope from the discord of pain in the effort to snatch his suffering patient from the grave.

He insists upon the absolute necessity of attention to every detail, even the most trivial, before arriving at a conclusion, and condemns superficiality "of all other traits the one to be most avoided." Many surgeons are satisfied to arrive at one of two conclusions—*i. e.*, to operate or not to operate, leaving the determination of what the operation shall be until after the abdomen is opened; holding that "if we do not know what is inside, what is the harm of cutting a hole to look through?" The most appalling disasters are the result of such teaching. While not believing that the exploratory operation is never justifiable, as many conditions demand it, still he believes a surgeon should be able to say with reasonable certainty whether after the abdomen is opened anything further can be done to relieve the patient's condition. Of all things, delay is to be avoided.

His most emphatic warnings are against the promiscuous use of opiates. "Pain is Nature's signal light of intra-abdominal mischief, and it is criminal to shroud it over with the foggy mist of opiates." "Opium is the most valuable drug in the pharmacopeia, but the most outrageously abused." "A physician who makes a practice of administering a hypo to his patient who complains of abdominal pain before he makes a conscientious, systematic physical examination of the abdomen and arrives at a diagnosis at least tentatively correct, is not worthy of the name. Yet such physicians, I regret to say, have not entirely passed away, for all the fools are not dead yet."

The cause of pain in the abdomen is not always an easy matter to determine, and the surgeon who is widest in his experience and most painstaking and accurate in his examination and interpretation of the phenomena present will be least likely to err in his diagnosis, or, in case an error is made, will be less to blame than one who merely jumps at a conclusion without due reflection, or who confessedly makes habitual resort to an operation as a means of discovering the patient's ailment.

To call a patient a neuro who complains of pain in the abdomen, the cause of which is not easily to be discovered, is too often only a cloak for ignorance.

W.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, and all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR SEPTEMBER.

Wayne County Association.—Tuesday, September 5th.

Seneca County Association.—Thursday, September 7th.

Erie County Association.—Monday, September 11th.

Oneida County Association.—Tuesday, September 12th. (Annual.)

Orange County Association.—Wednesday, September 13th.

Cortland County Association.—Friday, September 15th.

Lewis County Association.—Tuesday, September 26th.

Westchester County Association.—Thursday, September 28th.

Broome County Association.—The quarterly meeting of this Association was held at the office of Dr. J. G. Orton, Binghamton, Tuesday afternoon, July 18th. In the absence of the president, Dr. L. H. Farnham, Dr. Orton presided. There were twelve members present.

Dr. Orton gave a full report of a meeting of the Third District Branch in Cortland, June 27th.

In the scientific session Dr. A. S. Fritts gave a carefully prepared paper on "Anesthesia." The paper was well discussed. Dr. George S. Lape gave an interesting paper on "One Thing That is Apt to Kill a Patient," which was discussed by those present.

CLARK W. GREENE,
Secretary.

* * *

Rockland County Association.—The regular meeting of this Association was held at the house of Dr. J. C. Dingman, Spring Valley, on Wednesday afternoon, July 26th. In the business session two new members were elected. In the scientific session Dr. C. D. Kline, of Nyack, read a paper on "Anatomy of the Gall Bladder," and Dr. John F. Erdmann, of New York, read a paper on "Surgery of the Gall Bladder." Both papers were discussed by the members present.

J. HOWARD CROSBY, Secretary.

* * *

Wyoming County Association.—The regular quarterly meeting of this Association was held at Castile on Tuesday, July 11th. In the absence of the president, Dr. Lusk, the vice-president, Dr. G. S. Skiff, presided. There was an excellent attendance of members and a number of visitors.

The scientific session opened with a "Symposium on Cholera Infantum," in which papers were read by Drs. W. B. Preston, L. C. Broughton, L. E. Stage, G. S. Skiff and P. S. Goodwin.

Dr. G. H. Peddle presented a very interesting paper on "Some Experience with Apomorphia."

A vote of thanks was extended to Dr. Greene for her kindness in entertaining the members of the Association and their wives.

The next meeting of the Association will be held at the Edwards House, Attica, N. Y., October 10th.

L. H. HUMPHREY, Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

FIRST DISTRICT BRANCH.

Oneida County.—Edwin C. Reames, Lee Center.

Oswego County.—Frank Edward Fox, Fulton.

THIRD DISTRICT BRANCH.

Broome County.—Joseph J. Kane, Binghamton.

FIFTH DISTRICT BRANCH.

Rockland County.—Daniel Burr Van Wageningen, Sloatsburg; Lee A. Whitney, West Haverstraw.

NEW MEMBERS IN THE AMERICAN MEDICAL ASSOCIATION.

Benedict, Arthur Judson, Newburgh, N. Y.
Berlin, Frederick Ferdinand Rudolph, New York City.

Cooke, Willis S., Otego, N. Y.

Conklin, Ray C., Batavia, N. Y.

Comfort, Clifford Vinal Craig, Rochester, N. Y.

Dort, Elizabeth, Buffalo, N. Y.

Duggan, John, Batavia, N. Y.

Fuller, Nathaniel Hall, Friendship, N. Y.

Friedman, Louis A., New York City.

Gross, Moritz, New York City.

Grady, James Joseph, New York City.

Glenny, W. Harry, Buffalo, N. Y.

Griggs, Elma, Ithaca, N. Y.

Herst, Samuel, New York City.

Hopkins, Frank Tucker, New York City.

Holland, Arthur L., New York City.

Jackson, Charles Ross, New York City.

Latham, Ora N., Bolivar, N. Y.

Liebermann, J. Monroe, New York City.

Lewson, Maximilian, New York City.

Lo Pinto, John, New York City.

Lytle, Claude C., Geneva, N. Y.

McBurney, Charles, New York City.

Meisburger, William, Buffalo, N. Y.

Moonzy, Louis Morgan, New York City.

Mac Coy, Cecil, Brooklyn, N. Y.

McFarlan, John P. A., New York City.

Neal, Benjamin Franklin, Ellenville, N. Y.

Nicolai, Curt E. H., New York City.

Preisch, Charles L., Lockport, N. Y.

Page, Charles Curtis, New York City.

Pattison, Warren E., Westport, N. Y.
 Potter, Irving W., Buffalo, N. Y.
 Remington, Alvah C., Rochester, N. Y.
 Rushmore, Edward C., Tuxedo Park, N. Y.
 Stewart, Edith W., Hume, N. Y.
 Stein, Sydney A., New York City.
 Winter, Henry Lyle, Cornwall, N. Y.
 Wheeler, David Everett, Buffalo, N. Y.

AMENDMENTS TO BY-LAWS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

These amendments were offered at the twenty-first annual meeting of The New York State Medical Association, held in New York City, October 18, 1904, and to be acted upon at the next annual meeting, October 16, 1905.

Amend Article II. *Duties of the Council*, by striking out Sec. 1 and substituting therefor the following:

Executive Board and Finance Committee.—Sec. 1. The Council in the interim between the annual meetings of The New York State Medical Association and the annual meetings of the Council and Fellows, shall be and is hereby constituted the Executive Board or Committee, both of The New York State Medical Association, and of the Council and Fellows, with full power and authority to put into effect the purposes of the Association as expressed in and limited by its charter, By-Laws and resolutions. The Council may select a Finance Committee from among its members, the sole power of which shall be to audit and authorize the payment of such bills as may have been theretofore incurred by order of the Council, or the Council and Fellows of The New York State Medical Association.

Amend Article II, Sec. 6. *Action under Medical Laws and Employment of Counsel*, by striking out Sec. 6 and substituting therefor the following:

Action under Medical Laws and Employment of Counsel.—Sec. 6. The Council may in the name of The New York State Medical Association, take action in any case of violation of the public-health law, subject, however, to the provisions of such law. The Council may in the name of The New York State Medical Association, employ an attorney at law to advise or act in any legal matter for The New York State Medical Association, upon such terms as the Council may determine.

Amend Article II, Sec. 7, by striking out Sec. 7 and substituting therefor the following:

Defense of Suits of Alleged Malpractice.—Sec. 7. Any active resident member of The New York State Medical Association may apply in writing for defense, and the Association shall, through its Council, furnish the legal services of a duly qualified attorney at law, in any alleged civil malpractice action brought against him, the alleged cause of action for which, occurred subsequent to the time when such applicant became a member of The New York State Medical Association,

provided, however, that said applicant shall not be in arrears in the payment of dues for a period of more than three months from the first day of January, and that said applicant shall agree in writing not to settle, compromise, adjust or discontinue such action without the consent of The New York State Medical Association or its attorney, and renouncing his own, shall vest in The New York State Medical Association or its Council sole authority to conduct the defense of said suit, or to settle or adjust the same with the consent of the applicant, but neither the Council nor its attorney, nor any other person shall obligate The New York State Medical Association to the payment of any money awarded by verdict, decree or court, upon compromise or otherwise.

Amend Article II. *Duties of the Council, Sec. 2, Meetings*, by striking out the period at the end of the section, and adding the following:

and notice of each special meeting of the Council specifying the time and place of the meeting, and the business to be transacted, shall be mailed in a securely sealed, post-paid wrapper, addressed to the last-given address of each and every member of the Council, at least five days before the date of meeting.

Amend Article III. *Duties of the Council and Fellows*, by striking out Sec. 1 and substituting therefor the following:

Duties of the Council and Fellows.—Sec. 1. Duties. The general supervision, business management and control, together with the financial interests of The New York State Medical Association and its membership, are vested in the body known and styled the Council and Fellows, as limited, qualified and authorized by Section 5 of Chapter 452 of the Laws of 1900.

Amend Article III, Secs. 1 and 2, by striking out Secs. 1 and 2 and substituting therefor the following:

Meetings.—Sec. 2. The Council and Fellows shall meet annually. The annual and all other meetings of the Council and Fellows of The New York State Medical Association, shall be held at its office or place of transacting its financial concerns in the City of New York, Borough of Manhattan. The annual meeting of the Council and Fellows shall be held on the third Monday in October in each year, beginning at 3 o'clock in the afternoon, and special meetings of the Council and Fellows shall be held at such other times, upon ten (10) days' notice thereof, as may be determined by the Council to be necessary or expedient, or upon the written request of twenty-five (25) members of the New York State Medical Association. One-half the membership of the Council and Fellows, shall constitute a quorum.

Amend Article IV, Sec. 5, by striking out Sec. 5 and substituting therefor the following:

Duties of Treasurer.—Sec. 5. The Treasurer shall receive and disburse all funds of The New York State Medical Association under the direction of the Council, or Council and Fellows, or

upon the audit of persons duly authorized by these By-Laws. He shall make a report at the annual meeting of the Council and Fellows upon the finances of the Association, and to the Council at such other times as the Council may require, and shall report upon the names of such members as may be delinquent in the payment of their dues. Any member who shall not have paid his dues on or before the first day of July in any year shall be considered a delinquent member, and a member not in good standing. The Treasurer shall collect the dues of non-resident members.

Amend Article V. Sec. 9, by striking out Sec. 9 and substituting therefor the following:

Committee on Nominations.—Sec. 9. The Committee on Nominations shall consist of a Chairman and ten members, two of which members shall be elected from the Fellows from each of the five District Branch Associations. It shall be the duty of this Committee to present to the Council and Fellows at its annual meeting a list of nominees for all elective offices of The New York State Medical Association, from which list the officers may be elected, unless otherwise ordered by a majority of the members present.

Amend Article VI. *Meetings of the Association*, by striking out Secs. 1, 2 and 3, and substituting therefor the following:

Annual.—Sec. 1. The New York State Medical Association shall hold a meeting annually to be called its Annual Meeting, in the City of New York and Borough of Manhattan, on the first Tuesday, following the third Monday in October in each year, at 9.30 o'clock in the forenoon, at its office or place of transacting its financial affairs, and the scientific or social sessions of such annual meeting shall be held at such place and hour as shall be selected by the Council and designated in the notice for such meeting, and The New York State Medical Association may hold special meetings at other times, places and hours in the City of New York and Borough of Manhattan. The notice for all meetings of The New York State Medical Association or the Council and Fellows shall be in writing, mailed in a securely sealed, post-paid wrapper, addressed to the last-given address of each and every member of The New York State Medical Association, which notice shall state the date, place and hour of such meeting. Notice of all special meetings shall be mailed to every member of the State Medical Association at least ten (10) days before such meeting, and shall state the date, place, hour and purpose of the meeting, and no other business at any special meeting shall be conducted except such as is stated in the call. The affidavit of mailing by the Secretary of The New York State Medical Association of such notice for the call of the meeting, shall be sufficient proof of the service of such notice upon each and every member, for any and all purposes.

Special Meetings.—Sec. 2. Special meetings shall be called by the President by order of the

Council or upon the written request of twenty-five (25) members of the Association.

Order of Business.—Sec. 3. The order of business at the annual meeting of The New York State Medical Association shall be as follows:

1. Calling the Association to order.
2. Reports of Special Committees.
3. Unfinished business.
4. New business.
5. Address of welcome by the Chairman of the Committee on Arrangements.
6. President's address.
7. Special addresses.
8. Reading and discussion of papers.
9. Installation of officers.
10. Adjournment.

To Article VI. *Meetings of the Association*, add Sec. 4, to read as follows:

One-third of the membership of The New York State Medical Association shall constitute a quorum, for the transaction of any and all business.

Amend Article VII. *Duties of Officers*, by striking out the present title, and substituting therefor the following:

ARTICLE VII.

The title preceding Sec. 5 should read: "Duties of District Branch Association Officers."

Amend Article VII, Sec. 7, by striking out Sec. 7 and substituting therefor the following:

Treasurer.—Sec. 7. The Treasurer shall receive and disburse all funds of the Branch Associations, as hereinafter prescribed under the laws regulating the distribution of dues.

Amend Article VIII. *County Medical Associations*, by inserting between Secs. 2 and 3 the title: "Duties of County Association Officers."

Amend Article VIII, Sec. 6, by striking out Sec. 6, and substituting therefor the following:

Treasurer.—Sec. 6. The Treasurer shall receive and disburse all funds of the County Association of the County in which he resides.

Amend Article II, Sec. 4, by striking out Sec. 4, and substituting therefor the following:

Privileges of Members.—Sec. 4. Active. Resident active members shall have all the rights and privileges conferred by their respective County and District Branch Association. 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 of the protection, benefits and support conferred by The New York State Medical Association except as herein qualified or limited, provided, however, that such active member's dues shall have been paid to the Treasurer of The New York State Medical Association on or before the first day of July in any year, and not otherwise. If at the time of the annual meeting of any County Association or District Branch Association a member shall not have paid his annual dues to such County or Branch Association, he shall not be counted as a basis of representation in The New York State Medical Association, nor shall he be

eligible for election as a Fellow, nor thereafter until he shall have discharged his indebtedness in full.

Amend Article IX. *Membership*, by striking out Sec. 5 and substituting therefor the following:

Privileges of Members, Non-Resident, Honorary and Corresponding.—Sec. 5. All members of The New York State Medical Association other than active resident members, shall *only* receive notice of all scientific meetings, and a copy of all publications of The New York State Medical Association.

Amend Article X. *Dues*. Sec. 3, by striking out Secs. 3, 4 and 6, and substituting therefor the following:

Payment of Dues.—Sec. 3. All dues shall be due The New York State Medical Association and payable on the first Monday of January in each year. Members resident in the State of New York shall transmit their dues to the Treasurer of the County Association in which they reside, or to the Treasurer of the District Branch Association if no County Association exists in the County wherein they reside. Non-resident members shall transmit their dues to the Treasurer of The New York State Medical Association.

Collection of Dues.—Sec. 4. On the first day of July in each year the names of all members who have failed to pay their indebtedness to The New York State Medical Association for the current year shall be omitted from all public accredited lists of members of The New York State Medical Association, and if at the close of the first day of the Annual Meeting of The New York State Medical Association such dues still remain unpaid and in arrears, the name of such delinquent member shall be dropped from the official roll of members, and he shall be notified of his suspension from membership in The New York State Medical Association as soon as conveniently possible thereafter.

Distribution of Dues.—Sec. 6. The Treasurer of each County Association or District Branch Association shall pay to the Treasurer of the State Association monthly, all dues or other funds in his hands received from members, which the Treasurer of The New York State Medical Association is entitled to receive.

Amend Article XV. *Amendments*, by striking out Sec. 1, and substituting therefor the following:

Amendments.—Sec. 1. Amendments to these By-Laws shall be made only upon the affirmative vote of a majority of those present and voting at a regular annual meeting of the Council and Fellows, or at a regular annual meeting of The New York State Medical Association, provided that notice of such amendment shall have been presented in writing at the previous annual meeting of the Council and Fellows, or at the previous annual meeting of The New York State Medical Association.

PRINCIPLES OF MEDICAL ETHICS.

The American Medical Association promulgated 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 counsels, 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 fellow-

ship, 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 so 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 confidence 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 advertisement or private cards inviting the attention of persons affected with particular diseases; to promise radical cures; to publish cases of 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 of 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 consultations, and this is generally practicable, for society has been so considerate as to allow the plea for 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; 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 are 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 disagree-

ment 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 upon 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 a conscientious regard for truth, and no hint or insinuation should be thrown out which would 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 range 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 or 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 probability; 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 or 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 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 the 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 physicians toward the public in regard to some professional questions, and as there exist many points in 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 arbitration 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.

News Items.

We regret that in the article published in last month's JOURNAL, on "Advantages of a Local Medical Club," the name of the author, Dr. Charles Ira Redfield, of Middletown, was omitted.

We are exceedingly sorry to learn of the accident to Dr. Henry D. Didama, of Syracuse, one of the oldest and stanchest members of the State Association, and we hope soon to hear that the doctor is out again.

By great good fortune, the Health Commissioner appointed by Mayor McClellan has proven a capable, loyal public servant.—*Evening Mail*.

The statistician should always remember that the question is not so much weight or value as adjusted equilibrium.

If the good old times came back, how many ideal reputations might be spoiled.

Desert-fenced Utopias is a suggestive phrase.

The plurality of personalities combined in one individual, according to Novalis, is genius.

The industrious apprentice squanders much time for a coming reputation, and rather than be idle amuses himself with gymnastics.

Dr. Charles I. Redfield, of Middletown, has been elected a member of the staff of Thrall Hospital, Middletown, N. Y.

That anger is temporary insanity, originally a maxim of one of the Seven Wise Men of Greece,

retains even yet its power in modern medical jurisprudence.

The members of the medical profession of Middletown, N. Y., held an informal meeting at the Old Orchard Club, June 9, 1905.

The following were present: Drs. Mills, Douglas, Hulett, Conner, Purdy, Fancher, Hammer, Redfield, Stivers, Hardenbergh, Preston, Schultz, Beers and Leemon, of this city, and Taylor, of Otisville.

Dr. Redfield was elected secretary pro tem.

The following officers were then unanimously chosen: President, Dr. W. I. Purdy; vice-president, Dr. T. D. Mills; secretary, Dr. J. L. Hammer; treasurer, Dr. J. B. Hulett.

The Committee on By-Laws is as follows: Drs. Stivers, Fancher and Preston.

The name of "The Medical Club of Middletown" was finally decided as most appropriate.

All legally licensed physicians of this city and vicinity are eligible to membership and are cordially invited to become members.

Much discussion of items of interest to the physicians of this city was then entered into, and it was not until the hands of the clock pointed well toward the hour of twelve that the gathering commenced to separate for their various homes.

Before adjournment, it was decided to hold monthly meetings at the homes of the members of the club.

INTERNATIONAL MEDICAL CONGRESS.

The next International Medical Congress will be held in Lisbon, April 19 to 26, 1906. It is expected that it will be one of unusual importance, for a meeting which will be held in what has always been considered as an out-of-the-way country. Already the titles of papers from some of the most distinguished men of the medical profession have been received. Some of the topics for discussion that have been selected by the Executive Committee are the following:

Section of Descriptive and Comparative Anatomy, Anthropology, Embryology and Histology.

Definition, structure and composition of protoplasm.

Origin, nature and classification of pigments.

Cellular changes in normal tissues.

Evolution and involution of the thymus gland.

Section of Physiology.

The role of leucocytes in nutrition.

The thyroid secretion.

Renal permeability.

The nutritive value of alcohol.

The physiology of the cytotoxins.

The blood ferments.

Section of General Pathology, Bacteriology and Pathological Anatomy.

What are the present scientific proofs of the parasitic nature of neoplasms, especially of cancer?

Preventive inoculations against bacterial diseases.

Preventive inoculations against protozoic diseases.

Preventive inoculations against diseases from an unknown specific agent.

The pancreas and fat necrosis.

Therapeutics and Pharmacology.

Local therapeutics in infectious diseases.

Separation, from a physiological and therapeutic point of view, of the different radiations produced in Crooke's tubes, and of those which are sent out by radioactive bodies.

The therapeutic value of bactericidal serums.

The relation between the molecular constitution of

organic bodies and their physiological and therapeutic action.

Section of Medicine.

- The pathogenesis of diabetes.
- The pathogenesis of arterial hypertension.
- The treatment of cirrhosis of the liver.
- Cerebrospinal meningitis.
- International defense against tuberculosis.
- Meningeal hemorrhages.

Section of Pediatrics.

- Spastic affections of infancy; classification and pathogenesis.
- Cerebrospinal meningitis; etiology and treatment.
- The social struggle against rickets.
- Orthopedic surgery in affections of nervous origin, spastic and paralytic.
- Congenital dislocation of the hip.

The treatment of abdominal tuberculosis (peritoneal).

Neurology, Psychiatry and Criminal Anthropology.

Penal reform from the anthropologic and psychiatric point of view.

- Forms and pathogenesis of dementia præcox.
- The relations of progressive muscular atrophy to Charcot's disease.

Cerebral localization in mental disease.

Education and crime.

Stigmata of degeneration and crime.

Section of Surgery.

Septic peritoneal infections; classification and treatment.

Gastrointestinal and intestinointestinal anastomoses.

Recent additions to arterial and venous surgery.

Section of Medicine and Surgery of the Urinary Organs.

Surgical intervention in Bright's disease.

Surgical treatment of prostato-vesical tuberculosis.

Progress of urology in the diagnosis of renal disease.

Painful cystides.

Section of Ophthalmology.

Blepharoplasty.

Serotherapy in ophthalmology.

Section of Laryngology, Rhinology, Otolaryngology and Stomatology.

Study of the epileptogenous action of foreign bodies in the ear, and of vegetations in the naso-pharynx.

The different forms of suppuration of the maxillary sinus.

Injections of paraffin in rhinology.

Differential diagnosis of tubercular, syphilitic and cancerous lesions of the larynx.

Choice of anesthesia in the extraction of teeth.

Treatment of alveolar suppuration.

Section of Obstetrics and Gynecology.

Conservative surgery of the ovaries.

Tuberculosis of the adnexa.

Symphiseotomy.

Pregnancy and cancer of the uterus.

Therapy of puerperal infections.

Section of Hygiene and Epidemiology.

The intermediary of yellow fever.

The cooperation of nations to prevent the importation of yellow fever and the pest.

Watering the streets as a means against tuberculosis.

Recent additions to the etiology and epidemiology of epidemic cerebrospinal meningitis.

Section of Military Medicine.

Portable ration of the soldier during campaign.

The purifying of the country water.

Emergency hospitals on the battlefield.

Section of Legal Medicine.

Signs of death from drowning.

Ecchymoses in legal medicine.

Epilepsy in legal medicine.

Organization of medico-legal services.

Section of Colonial and Naval Medicine.

Etiology and prophylaxis of beri-beri.

Etiology and prophylaxis of dysentery in hot countries.

Mental diseases in tropical countries.

Hospital ships and their function in time of war.

Tuberculosis in the navy and its prophylaxis.

RAMON GUIERAS, Secretary.

Book Reviews.

THE PHARMACOPEIA OF THE UNITED STATES OF AMERICA, EIGHTH DECENNIAL REVISION. By the Authority of the United States Pharmacopœial Convention held at Washington, A.D. 1900. Revised by the Committee of Revision, and published by the Board of Trustees. Official from September 1, 1905. Philadelphia agents, P. Blakiston's Son & Co.; subagents, New York, E. R. Pelton, 19 East 16th street; Chicago, E. H. Colgrove Co., 65 Randolph street; St. Louis, C. V. Mosby, 2313 Washington avenue; San Francisco, Payot, Upham & Co., 100 Battery street.

Under the new revision, many important changes have been made in the preparation of drugs most commonly used in prescriptions. All the tinctures are now of a uniform strength of 10 per cent. Tincture of aconite is now practically 10 per cent., instead of 35 per cent.; tincture of veratrum is 10 per cent., instead of 40 per cent., and many others have undergone a like change.

It has been deemed advisable to change the standard of all arsenical preparations to 1 per cent., and to standardize all fluid extracts so that 1 C.C. will equal 1 Gm. of drug. The antidiphtheric serum and thyroid and suprarenal extracts have been introduced as official. Among the other changes may be mentioned the dropping of the names "acid arsenosum" and "acid chromicum," "arseni trioxidum" and "chromii trioxidum," representing more nearly their chemical character. The name "acid carbolicum" has also been dropped, "phenol," the more correct chemical name, replacing it.

Throughout the whole the changes that have been made are for the better, and have simplified matters to a very great degree. As in the previous edition, the metric system has been retained, thereby making it possible to prepare our drugs in the same manner as that adopted by the International Committee. The medical profession owes a big debt of gratitude to the committee for the enormous amount of work that it has done in the preparation of the stupendous labor, which has been so very admirably performed in the revision of 1905.

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., Professor of Clinical Medicine in Jefferson Medical College; Physician to the Jefferson Medical College Hospital, and to the Philadelphia General, Jewish and Rush Hospitals, etc. Vol. XI, Serum-therapy. By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia. Organotherapy, by Oliver T. Osborne, M.A., M.D., Professor of Materia Medica and Therapeutics at Yale University. Radium, Thorium and Radioactivity, by Samuel G. Tracy, B.Sc., M.D., Radiologist, New York Skin and Cancer Hospital; Assistant Neurologist, Vanderbilt Clinic, Columbia University, New York City. Counter-Irritation, External Applications, Blood-Letting, by Frederick A. Packard, M.D., Late Physician to the Pennsylvania Hospital. An Outline of the Principles of Therapeutics, with Especial Reference to Physiologic Therapeutics, by the Editor, with addendum on X-Ray Therapy and an Index-Digest of the complete system of eleven volumes. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1905.

This is the last volume of the system on therapeutics, and contains articles on serumtherapy, organotherapy, a discussion on radium, thorium and radioactivity, and finally counter-irritation, external applications and blood-letting. Besides these subjects the editor has appended articles on the principles of therapeutics, with especial reference to physiologic therapeutics, and the latest knowledge of the therapeutics of the X-ray.

All that has been said in the reviews of the previous

volumes is true of the concluding. One could not at the present time conceive of a better method of treating this very complex subject, and the editor is to be most heartily congratulated for the results that this vast amount of work has accomplished.

A TEXT-BOOK OF MEDICAL CHEMISTRY AND TOXICOLOGY. By James W. Holland, M.D., Professor of Medical Chemistry and Toxicology, and Dean Jefferson Medical College, Philadelphia. 8vo volume of 600 pages. Fully illustrated, including 8 plates in colors. Philadelphia and London: W. B. Saunders & Co., 1905. Cloth, \$3 net.

It seems that we have at last had given us a text-book for medical students which will permit them to learn only that which is essential to the understanding of the complex subject of chemistry without compelling them to wade through masses of knowledge which they must acquire only to speedily forget when once the examination has been successfully passed. Only those subjects are treated of that are essential to the medical man in his preparation for future use in the actual practice of the art. The toxicology is given the prominence it deserves, and is made attractive and interesting.

There have been included chapters on milk, gastric contents, the chemical examination of urine, and one on water-supply and filtration. These are filled with information of a most practical value to both the graduate as well as the student, and render the book useful as a working laboratory guide.

NOTHNAGEL'S ENCYCLOPEDIA OF PRACTICAL MEDICINE.

Diseases of the Kidneys and of the Solen Hemorrhagic, by Dr. H. Senator, Professor of Internal Medicine, University of Berlin, and Dr. M. Litten, Professor of Internal Medicine, University of Berlin; edited with additions by James B. Herrick, M.D., Professor of Medicine, Rush Medical College, University of Chicago. 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., 1905.

Like the previous volumes of this most excellent system, this latest contribution to the series shows the high standard that its predecessors have manifested. The value of Dr. H. Senator's contributions on the knowledge of the kidney are too well acknowledged to require comment. His work is incorporated in the chapter devoted to the consideration of the kidney in this volume. It is all that one could desire for reference.

To Dr. M. Litten the task of the spleen and hemorrhagic diseases has been intrusted. And most ably has he done his work. It is most unfortunate that the average physician knows so little of the spleen, but the work of Dr. Litten is so clear and terse that it is within the reach of the student as well as the older and more learned physician.

The editors have added much to this part of the book that was not to be found in the original monograph by the author, thereby bringing the subject up to date.

We believe that this book, as well as the whole system, will prove a most valuable addition to the library of any doctor.

A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS.

By Lewis A. Stimson, B.A., M.D., LL.D. (Yale), Professor of Surgery in Cornell University Medical College, New York; Surgeon to the New York and Hudson Street Hospitals; Consulting Surgeon to Bellevue, St. John's and Christ Hospitals; Corresponding Member of the Société de Chirurgie, of Paris. Fourth edition, revised and enlarged, with 331 illustrations and 46 plates in monotyp. New York and Philadelphia: Lea Bros. & Co., 1905.

In this fourth edition the author has maintained the high character and authority of previous editions, by adding much new material, in the use of the X-ray for practical diagnosis. The illustrations are excellent, and particularly in the case of the smaller bones an accuracy of diagnosis is assured in otherwise obscure cases.

ACUTE CONTAGIOUS DISEASES. By William M. Welch, M.D., Diagnostician to the Bureau of Health and Consulting Physician to the Philadelphia Municipal Hospital for Contagious and Infectious Diseases; for thirty-three years Physician-in-Charge of the Municipal Hospital; Fellow of the College of Physicians of Philadelphia; and Jay F. Schamberg, A.B., M.D., Professor of Dermatology and of Infectious Eruptive Diseases, Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Diagnostician to the Bureau of Health, and Consulting Physician to the Municipal Hospital for Contagious and Infectious Diseases; Fellow of the College of Physicians of Philadelphia; Member of the American Dermatological Association. Illustrated with 109 engravings and 61 full-page plates. Philadelphia and New York: Lea Bros & Co., 1905.

The authors of this work are so well known as to be peculiarly well equipped to present this work on contagious diseases. From a long, practical experience in the Municipal Hospital of Philadelphia, where unlimited opportunities are offered for a personal study of many patients.

During the past thirty-five years, over 9,000 cases of small-pox and scarlet fever, and 10,000 cases of diphtheria. The diseases are limited to those met in the daily practice, such as small-pox, scarlet fever, diphtheria, chicken-pox, measles, rubella and typhus fever. The work is a practical guide to the general practitioner of medicine, and the high character of the authors gives it an undoubted authority, and it is complete in all details of synonyms, history, etiology, symptoms, complications, pathology, diagnosis, prognosis and treatment.

The illustrations are profuse and rare, showing the successive stages of the disease. The work cannot be too highly commended, and is undoubtedly of great practical value.

ATLAS AND EPITOME OF GENERAL PATHOLOGIC HISTOLOGY.

By Docent Dr. Hermann Dürk, of the Pathologic Institute, Munich. Authorized translation from the German. Edited by Ludvig Hektoen, M.D., Professor of Pathology in Rush Medical College, Chicago. With 176 colored illustrations on 80 lithographic plates and 36 figures in black and colors. Philadelphia, New York, London: W. B. Saunders & Co., 1904.

This new atlas in Saunders' Medical Hand-Atlases is indeed a worthy addition to the series. All the accepted views regarding the significance of pathologic processes have been concisely stated, conflicting theories having been wisely omitted. The illustrations are excellent, the care taken is shown in the remarkable reproductions, closely adhering to the original specimen, and are as near perfection as possible. In editing the volume, Dr. Hektoen has incorporated much useful matter. In our opinion, it will be found of unusual value to the medical profession generally.

THE SURGICAL ASSISTANT. A Manual for Students, Practitioners, Hospital Internes and Nurses. By Walter M. Brickner, B.S., M.D., Assistant Surgeon Mt. Sinai Hospital, Out-Patient Department, etc. 360 pages, 123 original illustrations, and 116 illustrations of surgical instruments. New York: The International Journal of Surgery Company, 1905. Price, \$2 net.

This work is to be commended for the minute details and the excellent care shown in describing the technical. Part I, on the surgical assistant, tells of the conduct and relation with the surgeon and patient. The preparation for an operation, the handling of instruments, and the anesthetist. Part II treats of the operation in detail; Part III on the after treatment, and preparation of surgical materials.

It will be a help to the student, nurse and general practitioner of surgery, and fills a gap which can be appreciated only by reading this excellent little volume.

A MANUAL AND ATLAS OF ORTHOPEDIC SURGERY. By James K. Young, M.D., Professor of Orthopedic Surgery, Philadelphia Polyclinic; Associate in Orthopedic Surgery, University of Pennsylvania, etc.

The advance sheets of this work have been received from the publishers, P. Blakiston's Son & Co. We are now impatient to see the completed book.

Few branches of medicine have progressed as rapidly as has orthopedic surgery, and such a complete consideration of the subject, as this promises to be, will find a welcome awaiting it from the entire profession.

The extensive clinical experience of the author, together with his knowledge of the literature on the subject, and his previous experience as a writer, fit him superbly for this task. It is to include the history, etiology, pathology, diagnosis, prognosis, prophylaxis and treatment of deformities, and will be illustrated with upward of 800 photographs and line drawings, mostly from original sources.

The publishers are presenting it printed on the best of paper, in a good, clear type. Doubtless the binding will be in keeping with the rest.

BOOKS RECEIVED.

THE TREATMENT OF FRACTURES, WITH NOTES UPON A FEW COMMON DISLOCATIONS. By Charles Locke Scudder, M.D., Surgeon to the Massachusetts General Hospital. Fifth edition, thoroughly revised, with 739 illustrations. Philadelphia and London: W. B. Saunders & Co., 1905.

PUBLIC HEALTH REPORTS (formerly Abstract of Sanitary Reports), issued by the Surgeon-General Public Health and Marine Hospital Service, under the Act of Congress granting additional quarantine powers and imposing additional duties upon the Marine Hospital Service, approved February 15, 1893. Vol XIX, Part 1, Nos. 1 to 26 inclusive; Part II, Nos. 27 to 53 inclusive. Washington: Government Printing Office, 1904.

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 Wm. Osler, M.D., Oxford; 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 II, Fifteenth Series, 1905. Philadelphia and London: J. B. Lippincott Company, 1905.

OPERATIVE SURGERY. By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospitals; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insane; former Surgeon-General of N.G.S.N.Y.; Fellow of the American Surgical Association; Member of the International Society of Surgeons, and of the American Medical Association; former President of the New York Academy of Medicine, and of the New York State Medical Association; President of the New York State Medical Society, etc. Volume I, General Principles, Anæsthetics, Antiseptics, Control of Hemorrhage and Shock, Treatment of Operation Wounds, Ligature of Arteries, Operations on Veins, Capillaries, Nervous Systems, Tendons, Ligaments, Fascæ, Muscles, Bursæ, and Bones, Amputations, Deformities, Plastic Surgery, Operations on Mouth, Pharynx, Nose, Œsophagus and Neck. Fourth edition, printed from new plates, entirely revised and largely rewritten. This volume contains 898 illustrations, 61 of which are colored. Volume II, Operations on the Viscera connected with the Peritonæum, the

Scrotum and Penis, and miscellaneous operations, including those for some deformities of the external ear. Fourth edition, printed from new plates, entirely revised and largely rewritten. This volume contains 895 illustrations, 39 of which are colored. New York and London: D. Appleton & Co., 1905.

HUMAN PHYSIOLOGY, prepared with special reference to students of medicine. By Joseph Howard Raymond, A.M., M.D., Professor of Physiology and Hygiene in the Long Island College Hospital, New York City. Third edition, thoroughly revised; 444 illustrations, some of them in colors, and 4 full-page lithographic plates. Philadelphia and London: W. B. Saunders & Co., 1905.

DIETETICS FOR NURSES. By Julius Friedenwald, M.D., Clinical Professor of Diseases of the Stomach, in the College of Physicians and Surgeons, Baltimore, and John Ruhrah, M.D., Clinical Professor of Diseases of Children, in the College of Physicians and Surgeons, Baltimore. Philadelphia and London: W. B. Saunders & Co., 1905.

ABSTRACT OF DR. GEORGE N. JACK'S PAPER, "PROGNOSIS OF ASTHMA FROM A DIGESTIVE, BLOOD AND METABOLIC STANDPOINT."¹

The author observed that he had demonstrated in previous papers that asthma was a digestive, blood metabolic disease, and not a narcotic, spasmodic or turgescient one, as heretofore maintained. He then quoted the discouraging prognosis of Stevens, Salter and other authorities, and remarked that such a prognosis is not surprising, owing to the mistaken conception of the nature of the disease. Jack claims that the prognosis of uncomplicated asthma when scientifically managed from a digestive, blood metabolic, etiologic standpoint is positively good.

Asthma is a disease with a functional pathology rather than a structural one. The only structural pathologic changes associated with asthma are the enlarged glands in the air-tubes and the sequelæ, as emphysema and a dilated right ventricle.

Having, then, the management of a disease with a functional pathology, and enough vital force back of its functional pathology to establish a hasty recuperation, then by removing the cause nature will rapidly and satisfactorily establish a harmony of function that will relieve all the distressing symptoms.

The vital adaptability and recuperative force of the asthmatic are very active, and they respond quickly to the proper stimuli. The prognosis of asthma when considered as above described can be simmered down to this conclusion: If an uncomplicated case of asthma has not its functional equilibrium permanently restored, or, in other words, is not completely cured in from one to three years' treatment, it is either the patient's or the physician's fault, which is to say that in all uncured cases of uncomplicated asthma that have been treated the physician did not understand the etiology and management of asthma or the patient did not live up to the directions.

¹Read before the Erie County Medical Association, June 12, 1905.

Original Articles.

A GLANCE AT THE HOROSCOPE OF MEDICINE.¹

BY C. N. PALMER, M.D.,
Lockport, N. Y.

SPECULATION is sometimes profitable as the parent of reform, and a man with a paramount idea, useful in raising the general average. Such is my reason for this brief creation. May it inspire in you a second thought or an abiding interest, not lost in the passing smile.

Words may be faint interpreters of fiction or of truth, But truth revealed, though half-concealed, blooms in perennial youth.

In casting the horoscope of medicine, we largely eliminate the checkered past, because understood. Her nativity was under a "variable" star, attaining, if ever, to the dignity of a star of the first magnitude, far in the future. If astrological observations are correct, medicine first saw the light through the most common form of pelvic presentation, hence missed her true mission, and followed the ravages of disease, instead of anticipating and preventing them. Medicine was never a weakling, and the energy exercised in her devious course has been striking, if sometimes appalling. Although lifting for three thousand years from the short end of the lever, she has notably gained strength from her heavy lifting. She has ever kept pace with the enlightenment of the age, and, be it said to her credit, has always accomplished more than was required of her by the intelligence of the people whose ills she has assuaged. She has harnessed the elements to her car of progress, and gathered material, and much that was immaterial, from the four corners of the globe. Nothing "curative" escaped her from mud to gold, from organic to inorganic, from hydropathy to desiccation. She sought out all mysteries, practiced incantations, introduced innovations and boldly utilized the products of all creation, until the twelve labors of Hercules were, by comparison, holiday pastimes.

In spite of all this, to-day typhoid fever still jogs along on its twenty-one-day trail, oftener stayed by the juggling of death than the jugulation of medicine, and this is but a type, in a sad world of sadder illustrations. There is a brighter side, however, to this picture. Our care, our toil, nay, even our medicines, bring reward day by day; the anxious tear is dried and thousands rise up from sickness and disease, to health and vigor, and call us blessed. Nor is this all. We are on the threshold of a revolution, which is the earnest of better days. Though we cannot change the leopard's spots, we are searching diligently for means whereby to make a leopardless world. Medicine has been baffled, humiliated, distraught, in all the days of her defenseless warfare, but the new field of discovery cheerfully invites. The

laboratory is disclosing the hidden mysteries of disease, the *causus morbi* of systemic infection, recognizing in minute nature, our enemies and our friends, and pitting them, the one against the other, to the destruction of our foes; ferreting out their haunts to raid them, their toxins to counteract them, their necessary pabulum to starve them, their limitations and environment to utterly annihilate them. In fact, medicine is establishing offensive for defensive warfare, a war of extermination with victories ahead—undreamed of in her philosophy.

With this glance at the past let us lay aside for a time the cares, burdens and perplexities of to-day, for a brief trip on the observation-car attached to the fleet-winged train of speculation, the only train that can successfully "run against time," and equipped on the horoscopic plan. Ours is the "limited" which stops only at special stations and at long intervals, and upon our journey, the present tense will represent the particular period of each halt, rather than the present day.

The first stop brings us abreast of the now well-established system of medical espionage. The people demanded protective medicine; the time was ripe and the material at hand for successful exploitation. Hence the establishment of a governmental, medical directorate, general and local, and the system everywhere prevails. The education of the masses to this end had been slow, even starting back in the nineteenth century, when the first object-lesson which "took" was cards on quarantined dwellings. The discovery of the means for the development of so great an undertaking, also, was in no way rapid. With the accomplishment, however, at hand, the results are even now wonderful and the end is not yet.

Already the white plague is fading away like dew before the morning sun, and communicative diseases are relegated to ancient history. The by-products incident to life are no longer floated away, as in other days—a menace to existence—but destroyed when produced, and all sewage systems, already partially bereft of their filth, are beginning to be looked upon with suspicion. Crematories have sprung up in every village, city and hamlet. Means for greater segregation in cities are being devised. The science of micro-organisms, essential, virulent and benign, affecting life, both animal and vegetable, has become an important branch in our schools and colleges. Much good has been accomplished by the climatic location of individuals and families, in accordance with their physical needs and predisposition. The hours of study in our educational institutions have been cut in twain, and mental, like physical, training is by new methods becoming a diversion. Other great advances throng upon our vision, but we are cut short by "All aboard!" and we are whirled away.

When we again pause, we observe that the improved methods of transportation, which almost

¹Read before the Fourth District Branch of The New York State Medical Association, at Rochester, June 6, 1905.

obliterate time and space, practically bring sanitary hospitals to our very doors, though located miles away amid rural scenes and ozonized zephyrs. Rapid-transit being solved, the metamorphosis of cities by segregation, approximately makes each house a sanitarium, by thus securing in abundance pure air, light, heat and space, which are God's medicines, vitalizing all. Sewers, from arteries of filth, have crystallized into limpid trout-streams, and water unable to bear the government test of purity finds no resting-place below or above ground. Even well water is becoming safely drinkable.

As a result of these advanced conditions, however, a new difficulty confronts us. It almost seems that prophylaxis may have its drawbacks. It has corrected dietetics and thus greatly economized food. It has also enhanced the value of human life, by increasing health and vigor. But valued more, the more sustained; hence suicide, intemperance and excesses cease. The marvelous extension of human longevity which leaves five or six generations upon the earth, added to the natural increase in population induced by these disease-preventing measures, has caused the earth to become densely populated. No virgin soil remains to be taxed, and yet, to sustain life, the people must eat. What shall be done for food for the billions? But, "All aboard" bars anticipation.

When the brakes have again ground us to a standstill, we are delighted to learn that supply and demand have embraced each other. Mouths may multiply indefinitely, but they are sustained, though the death-rate roll of generations decreases year by year. This time the farmer comes to the rescue in more ways than one. He, perforce, has called a halt to prodigality and wastefulness. Cremation has been too nearly destruction. "Return to me in palpable form my wheat and my corn, or retaining, for my own use, my minimized products, I alone shall survive. Utilize but do not destroy." His fiat goes forth, and through the chemistry of the farm the returns come; and the by-products of existence become converted into important articles of commerce. He accomplishes even more than this. Through his practical aid, plant life, germination, microbic inoculation and their interdependence, become matters of science. Under his magic wand thus reinforced, the energies of nature spring into new life, and even the desert places of the earth blossom into gardens of productiveness. Incidentally, as well, is removed the greatest nidus for disease germs—filth—putting thereby, upon prophylaxis, its seven-league boots. But time tarries not, and to outstrip him we must again away to stop at our culminative point.

Here we are rejoiced to find the doctor of medicine at last glorified. No longer, as of yore, does he follow in the wake of disease, anxiously striving to mend and restore to health the victims which this monster has ruthlessly cast down before him. He comes a conqueror, the exponent

of the "arm of precision," the savant who at last has builded of medicine a noble science, a perfect art; a structure so stable under the laws of cause and effect, as to consume, because of their ignorance, all quacks and pretenders. He has come to be recognized as the exponent of a science, which can throw such safeguards around the people that an individual illness becomes a personal sin; which has taught them greater care in the reproduction of the human species, than they had formerly exercised—God save the mark!—in the propagation of stock; which has doubled the years of human life and usefulness; and which has made life happy because vigorous, and death welcome because normal. He is recognized as the legitimate purveyor of the ripened fruit of prophylactic medicine, plucked from the tree of life for the healing of the nations; as the proud devotee of that exact art which by removing all stumbling-blocks in the way of health leaves man at his best, and the doctor the physical savior of his race.

Again the bell invites, but this time to return, lest we remain too long, gazing upon the seeming miracles of the future, which our horoscope reveals, and forget that *our* mission still lies in the realm of alleviative medicine. We must return to the precious lives entrusted to our care, administering to their necessities as best we may, boldly and hopefully carrying on the great work of amelioration and restoration, not forgetting the study and investigation necessary to the greater work of perfecting our weapons for the aggressive warfare, which is the "Open Sesame" to the true art and science of medicine, PROPHYLAXIS, which shall, in time, prevail.

ACETANILID POISONING.¹

BY E. B. PROBASCO, M.D.,
Glens Falls, N. Y.

ACETANILIDUM, or to use its registered name, "antifebrin," is the type of all the aniline antipyretics. Its chemical name is phenylacetamide, and it is an acetyl derived from aniline by heating with glacial acetic acid. It is purified by repeated crystallization from water.

It is soluble in 194 parts of water, in 5 of alcohol, and easily soluble in chloroform and ether. It is incompatible with chloroform and with sodium and potassium hydrate. It was discovered by Gerhard, and first used in medicine by Cohn and Hepp.

The following are some of the names by which acetanilid or its allied substances and compounds are known: "Acetanilid Compound," "Agathin," "Ammonol" (ammoniated phenylacetamide), "Analgen," "Analgesine," "Antikammnia," "Antikol," "Antinervin," "Caffacemon" and "Caffenol" (mixtures of acetanilid and caffeine), "Exodyne," "Exalgin" (methyl acetanilid), "Febrinol," "Migranin," "Phenatol," "Phenolid,"

¹Read before the Warren County Medical Association, at the Annual Meeting, Glens Falls, N. Y., January 11, 1905.

"Pyretine," "Salfene" and "Kaputin." Poisoning by this substance is not uncommon, though rarely reported.

Toxic Action.—Even small doses depress the heart by direct action upon the cardiac muscle. It decreases heat production by action upon the central nervous system. It also slightly increases heat dissipation. Toxic doses act as powerful sedatives upon the sensory portion of the nerves and spinal cord and finally upon the central nervous system, producing general anæsthesia with loss of reflexes and with sensory and finally motor paralysis; often preceded by convulsions. The blood pressure is lowered and there is cardiac and circulatory depression. Death results from respiratory failure, paralysis of the respiratory centers; the breathing first become rapid, then impaired and labored. This paralysis is brought about by the changes in the blood, which, influencing the oxygenation of the tissues, lead the respiratory centers to great effort, while they are, at the same time, directly depressed by the drug. The peripheral motor nerves may also be paralyzed, and so help on the failure of respiration. Long-continued use of even moderate doses has a hemolytic action upon the blood, disorganizing the red cells and decreasing the oxygen-carrying power of the blood, by forming methæmoglobin. Free hæmoglobin often appears in the urine, showing that destruction of the red corpuscles has occurred. There is congestion and later fatty degeneration of the liver, kidneys and spleen. If the dosage has been large, clots may be found in the cardiac cavities.

Symptoms of Poisoning.—These may come on suddenly. They are: Collapse with rapid and feeble respiration, becoming slow and shallow; skin is dusky or cyanotic; profuse sweating at first upon the face and spreading over the body; pupils usually dilated; great prostration, with expressionless or anxious face; there may be vomiting and convulsions. Untoward effects have occurred from doses of from 3 to 10 grains. Five grains has caused death.

Case I.—Mr. B.; age, 25 years. Patient had a commencing typhoid, mistaken during the first few days for influenza. Acetanilid in 5-grain doses was given for pain every three or four hours. He soon showed signs of the depressing effects of the drug, each dose being followed by profuse sweating, cyanosis and prostration with a rapid and very weak pulse. Recovery ensued after stopping the acetanilid and administering whisky, strychnin and atropin.

Case II.—Miss H.; age, 13 years. Grippal bronchitis. Acetanilid was given in 5-grain doses every three or four hours. This medication was followed by the same train of symptoms as in Case I. but they were, with the exception of the prostration, less marked. Sweating was slight and prostration intense. Recovery followed prompt stimulation with the usual drugs, together with external heat and friction of the extremities.

Case III.—Miss B.; age, 30 years. She was ordered by her physician to take, for headache, tablets, one every hour, each containing 5 grains of antikamnia and 1/12 grain of heroin. It was impossible to get a clear history, but she took from six to twelve doses in six hours. She had also taken, probably, some bromide tablets earlier in the day. She was found unable to attend to her duties, owing to faintness, and was put to bed and there took more of the antikamnia tablets, it is thought. She was found after a time in a state of collapse and partial stupor, exhibiting the symptoms of mixed acetanilid and opium (heroin) poisoning. She was very cyanotic; the pulse was weak, soft and slow, from 50 to 60; respiration 5 per minute; pupils contracted to pin point. She could be aroused by vigorous mauling and stimulation, but soon lapsed into stupor again. There was no sweating, probably due to the action of the heroin. Recovery followed the administration of whisky, strychnin and atropin, hypodermatically, and oxygen by inhalation. Convalescence was, however, protracted.

Case IV.—Mr. B.; age, 33 years; large, well-built, ruddy and strong. He had never employed a physician. One year ago while at table was taken with an epileptic seizure; did not regain consciousness after the attack and passed into a status epilepticus, convulsions following each other rapidly from 6 until 11 p. m., when, after the use of immense doses of chloral and bromide, per rectum, and repeated frequently, the convulsions ceased and a little later he became conscious and finally slept.

Subsequent history showed no physical deterioration, but he exhibited a mental dulness and depression, and at times irrational actions and frequent very severe headaches. He worked at his trade until May, when headaches became so severe he had to give it up. I was called to see him for the headache. He was irrational in his talk and suffered severely from the headache. He was ordered to his bed and given bromides. This was 9 a. m. Headache did not improve, whereupon a member of the family gave him some "Migrain tablets," which had been prescribed and dispensed by a physician who had given her about thirty for her own use. He took ten of these tablets, each containing 2½ grains of acetanilid, from 10 a. m. to 2 p. m. At 4 o'clock I saw him and found a typical picture of acetanilid poisoning. Patient was in beginning collapse, with cold skin; profuse sweating; temperature 97 degrees; partial stupor; intense prostration, and marked cyanosis. The radial pulse was very irregular and slow and barely perceptible. External heat was applied, and whisky, strychnin and atropin and other stimulants were administered in large doses hypodermatically, with no response. At 6 o'clock, during my momentary absence from his bed he had a brief convulsion and died. The cyanosis now was extreme, the face being nearly black. It is beyond doubt that the

25 grains of acetanilid taken within four hours was the cause of his death.

Cases I and II illustrate an idiosyncrasy, which we are liable to encounter in any patient, and where the incautious use of this drug may result seriously, if not fatally.

Cases III and IV illustrate the evil effects of prescribing and dispensing headache remedies in quantities beyond that intended for immediate use, and especially the proprietary remedies, the trade names of which patients readily learn and unscrupulous druggists sell unrestricted and in dangerous quantities.

Five grains of acetanilid unguarded by cardiac supporters is too large a dose to administer to an untried patient.

Chronic poisoning, the effects of long-continued taking of acetanilid and substances of similar nature, is due to the hemolytic action of the drug, and "fiends" addicted to their use are not uncommon. They exhibit the physical and mental characteristics of other drug "fiends." There is a rapid and weak heart action; severe anæmia and cyanosis, with marked changes in the blood and hæmoglobin and hæmatin in the urine.

I plead for a more scientific application of these drugs; for more caution in prescribing them; for avoidance of preparations which patients can obtain for themselves and practice self-dosing to their own injury and possible destruction; for greater care in administering them, always safeguarding the patient by giving small doses and adding sufficient cardiac and respiratory supports.

Physicians are responsible in a large measure for the evils and dangers attending the use of many drugs, by prescribing and encouraging the use of popular trade preparations.

Let us do what we can to remove this condition of things, especially discouraging our patients with regard to the pernicious and dangerous practice of using headache remedies purchasable at the stores.

TYPHOID FEVER.¹

BY S. J. SORNBARGER, M.D.,
Cortland, N. Y.

TYPHOID fever is an acute infectious disease caused by the bacillus of Eberth, and characterized pathologically by hyperplasia and sloughing of Peyer's patches and the solitary glands of the intestinal tract, swelling of the spleen, and clinically by its slow, insidious onset, peculiar and characteristic temperature curve and its sero-reaction, together with other inconstant and varying symptoms, such as epistaxis, a rose-colored eruption, diarrhœa, tympanites, hæmorrhage and perforation.

It was not until 1829 that the name typhoid was given to this disease. At that time the great work of Louis appeared, in which he pointed out the

clinical and pathological differences between typhus and what he then named typhoid fever.

However, as early as 1813, Pierre Bretonneau, of Tours, distinguished this as a separate disease.

Up to 1829, however, the intestinal lesions sometimes found associated with a continued fever were supposed by most observers to be simply accidental lesions in the course of ordinary typhus.

It was to a student of Louis, however, an American, Gerhard, of Philadelphia, that the honor belongs of first clearly defining the differences between the two diseases. His papers were the first in any language to give a full and satisfactory account of the clinical and pathological distinctions which we to-day recognize.

In 1833 James Jackson, Jr., returning from Paris, where he had learned from Louis the distinctions between the two fevers, demonstrated in the Massachusetts General Hospital, the identity of what had been called typhus in this country with the typhoid of Louis. As a result, two elaborate memoirs on typhoid fever were issued from the Massachusetts General Hospital by Drs. Jackson, Sr., and Enoch Hale. These, together with Gerhard's articles, brought it about that typhoid fever, as distinguished from typhus, was widely recognized by the profession in America long before these distinctions were generally recognized in Europe. It was not until 1851 that the distinctions between the two fevers were fully recognized in England.

The specific cause of typhoid fever is the bacillus of Eberth, found in the intestinal tract, the lymph glands, intestinal contents, spleen, liver, rose spots, bile, urine, sputa, vomitus and sweat. The bacilli cannot exist permanently outside the human body; they may, however, retain their vitality from seven to fourteen days in water, disappearing because of saprophytes. Thus an epidemic means continuous contamination. In the soil they may retain their vitality for months. Freezing does not kill them. They may multiply either in water or milk.

Typhoid fever may occur at any age, but is most frequent between the ages of 15 and 30. Rural population entering cities are predisposed to the disease. It may come at any season of the year, but widespread epidemics which cover a large area of country extending to the rural population are apt to come in summer or autumn, being distributed by flies.

Epidemics confined to cities and towns, however, may come at any season of the year, being caused by contamination of water, food or milk. Here also, if in summer, flies aid in spreading the contagion by carrying the infection from cesspools and closets to foods prepared for the table. During a dry season there are more or less sporadic cases. Often the excreta not disinfected are thrown into a cesspool or closet or out upon the surface. From the last the wind picks up

¹Read at the Twenty-first Annual Meeting of the Third District Branch of The New York State Medical Association, Cortland, N. Y., June 22, 1905.

the dust laden with germs, and it is inhaled and more sporadic cases occur; or, a large amount of rainfall following, the infection is washed into the soil and thence into the water of the wells, or into the streams furnishing water for cities and towns. Also during a long, cold winter, more or less infected excreta accumulate in vaults and on the frozen surface, which, during the first thaw, is washed into the water supply. Such was the case in the epidemic at Plymouth, Pa., in 1885, when a case of typhoid fever occurred during the winter near the banks of a small stream which flowed into the reservoir supplying the town. The excreta were thrown out upon the frozen ground. In the latter part of March there came a thaw which carried the excreta to the brook about sixty feet distant. The town had a population of 8,000. About April 10th typhoid broke out in the town, and for some time there were about fifty new cases daily. There were about 1,200 cases in all.

Infected milk is another source of epidemics—*c. g.*, the epidemic in Stamford, Conn., where there were several hundred cases. As most of these were the customers of one milk peddler, an investigation followed, and revealed the fact that there had been a case of typhoid at his house, and the well at which he was washing his milk cans had become infected from this case.

The writer personally believes that typhoid infection is more often carried by flies from excreta carelessly disposed of, to our tables spread for the meal. It was discovered during the Spanish-American war that officers whose mess-tents were protected by screens, suffered less from typhoid fever than did those whose mess-tents were not so protected. The inference was that flies carried the typhoid infection directly from the latrines or closets to the mess-tables.

Oysters fattened in waters which receive sewage have been the source of infection.

To recapitulate: The cause of the disease is the bacillus of Eberth, which must in some way gain entrance to the digestive tract. This entrance may be in contaminated food or water, or in dust inhaled. It may reach our food from hands or dishes soiled with excreta, from flies which carry it from excreta not properly disinfected, or from infected waters with which such foods as celery, lettuce, etc., which are eaten uncooked are washed. It may enter our drinking water from surface drainage into streams which supply reservoirs, or by leaking from vaults and cesspools, or leaking sewer-pipes. It may enter by means of dust, which may be from careless handling of soiled linen, or from street dust raised by the wind.

The period of incubation varies from ten days to three weeks, usually about fourteen days. During this time the patient complains of languor, anorexia, nausea, headache, pain in back and limbs, etc., although now and then a case seems to have no prodromal symptoms.

The course may be divided into three periods. First, the stage of development, lasting about a week, with chilliness and feverishness alternating with a rise of temperature of approximately 1° per day. Epistaxis occurs in about 75 per cent. of cases. There is a more or less profound angina, a hacking cough, headache, tongue coated, at first white and flabby, later becoming red at tip and edges with brownish middle. Pulse is usually slow, as compared with temperature. The abdomen is slightly tender. Second stage begins on about the fifth day, and usually lasts about two weeks. There is a daily or semi-daily remission of from 1° to $1\frac{1}{2}^{\circ}$ in temperature. Headache disappears and mental dulness increases. Usually delirium occurs. During this stage hæmorrhage or pneumonia may occur. Substultus tendinum is common. Third stage begins about the twenty-first day in most cases, when temperature begins to decline, becoming normal about twenty-eighth day if course is favorable. Perforation is liable to occur during this stage. Rarely the second stage consists of only one week. Diarrhœa and tympanites are not of as frequent occurrence as the books would seem to indicate, if the diet is properly controlled.

While in a general way typhoid symptoms are typical, yet the cases are not few which vary very widely from the typical. The temperature may be either "nil" or abnormally high— 106° or above. A case was reported last year in which temperature was normal throughout, yet the patient died from hæmorrhage, and an autopsy revealed the typical typhoid intestinal lesions. Again, instead of the usual gradual rise of temperature for four or five days, the patient is, without warning, taken with a violent rigor, followed by a sudden rise of temperature to the maximum, usually accompanied by catarrhal symptoms. Again, in the lightest forms, the fastigium may be absent, defervescence beginning about the end of first week. There is also a class of cases in which the temperature is intermittent, yet the blood shows no evidence of the plasmodium malarie.

It is now quite generally conceded that during the first stage Peyer's patches and the solitary glands, to a greater or less degree, are infiltrated and swollen from the presence in them of the typhoid bacillus; that during the second week more or less of these infiltrated glands slough out, causing hæmorrhage if a large blood-vessel happens to be opened; that after the second week ulceration ensues, making perforation a possible complication.

Of prophylaxis and treatment I will say but little, since knowing the sources of infection, the methods of prevention suggest themselves. I will say, however, that the best prophylaxis is good sanitation and a fine water supply, together with proper screens in summer and autumn for all residences, hotels and cafés, also with a proper disinfection during the course of the disease,

which should be: First, of the excreta; second, of the bed and coverings; third, of the patient and sickroom. Let all excreta (stools, urine, vomitus and sputum) be disinfected with chloride of lime solution, six ounces per gallon of water. Two or three pints of this solution should be thoroughly mixed with the excreta and allowed to stand three or four hours before being thrown out. A 5 per cent. carbolic solution is sometimes used, also a bichloride solution 1 to 500, but neither of these is as effective as chlorinated lime.

All bedding and clothing should be saturated with a 5 per cent. carbolic solution before being sent to the laundry. The dishes used by or for the patient should not be used by others. No flies should be allowed in the sickroom. The hands of the nurse should be carefully cleansed and disinfected after contact with the patient, or anything which has been in contact with him.

The treatment of typhoid fever should never be routine, but *always symptomatic* except in relation to diet. Few drugs should be given except as indications arise. *Never* give drugs to lower temperature. If temperature is abnormally high, reduce it by sponging with tepid water, with perhaps a little alcohol added to hasten evaporation. The diet is *the principal thing*. The writer, after trying many and various other foods which have had their advocates, has found only one thing that *never* does harm. Fresh egg-albumen, mixed with about five times its volume of water, and with lemon juice and sugar sufficient to make it palatable, I have never seen do harm. Most patients take it readily. Milk is *decidedly* harmful and should not be given. Better give no food at all than milk. Give all the water the patient can take. With no diet except egg-albumen there will rarely be tympanites, and hence much less danger of hæmorrhage or perforation. Should hæmorrhage occur, keep the patient perfectly flat in bed without pillow. Do not raise the foot of the bed, as is so often done, but rather raise the hips. Give oil of Erigeron, 3 to 5 drops, on sugar or in glycerine every half hour until hæmorrhage is checked. If the case is urgent, give 20 drops of ergot hypodermatically. Also give from 5 to 7 drops deodorized tincture of opium to check peristalsis. This may be repeated after three or four hours if needed. If meningitis develops use ice-coil on forehead and ice-bag at back of head and neck. Should hæmorrhage be rapid and alarming use from 1 to 6 pints of normal saline subcutaneously to make up for loss of blood and sustain the heart. The writer used in one case five quarts, injecting it into the cellular tissue beneath the breasts and in the loins. The patient made a good recovery.

It is my custom to have an enema of about one-half pint of sterile water given daily to cleanse the lower bowel and assist the escape of flatus.

In case of perforation, if sure of your diagnosis, open the abdomen at once, cleanse with

normal saline, and repair the perforation. Ninety-five per cent. of cases of perforation die if not operated upon. Of cases operated upon 22 72/100 per cent. recovered. Resection may be done, or, if the perforation is small, it may be closed by sutures. Healing usually follows as well as in cases not suffering from fever. Good drainage should always be supplied.

During convalescence solid food should be withheld until eight or ten days after temperature is normal.

How often we hear the remark, and by physicians, too, "You were threatened with typhoid fever and I broke it up." What nonsense! Can there be any honest physician who understands the nature and pathology of typhoid fever, who believes that it can be broken up?

THE EARLY CLINICAL DIAGNOSIS OF CANCER.¹

BY B. W. STEARNS, M.D.,
Binghamton, N. Y.

WITH all due regard for laboratory work, I emphasize the clinical consideration of the subject, for it is by an early diagnosis from clinical observation that the patient may be given the greatest assurance of cure. At the present time the public and many of the medical profession are greatly occupied over the subject of tuberculosis, and it is equally as important to frequently call the attention of the profession to that fully as frightful affliction, cancer, which is even more insidious in its inception and development, and, with our present meager knowledge of it, more to be dreaded. Ten years ago to make a diagnosis of consumption was to pronounce the doom of the patient, while to-day hope is held out on every hand.

But with cancer there is less hope offered the sufferer now than in previous years, except in the first stage, when diagnosis is uncertain. Even advertising impostors and charlatans fall to entrap and plunder many of the unfortunate sufferers, as in past years, and the medical profession will be again appealed to for relief.

Now that hope is offered the consumptive, what can we offer the cancer patient? If the case is in what may be termed the third stage, there is at present no hope of relief. If in the second stage, which is generally necessary to establish a laboratory diagnosis, we can hold out hope of cure in 20 per cent. of the cases; but to take ten cases and say which two can be cured by any particular line of treatment is practically impossible. But a diagnosis in the first or inceptive stage will offer a cure in 90 per cent. of the cases. Now this point has been attacked by the profession on the ground that many of these cases would never develop into cancers. And the patient, instead of being cured of cancer, had been flim-flammed out of a lot of money by the advertising charlatan. This no

¹Read at the Twenty-first Annual Meeting of the Third District Branch of The New York State Medical Association, Cortland, N. Y., June 22, 1905.

doubt is true, but the profession erred by making light of first manifestation of possible cancer. This view called attention to the unprincipled (or at least commercial) act of the charlatan, but has not reduced the mortality of the cancer. The public will again turn to the medical profession for relief from this terrible affliction, and I wish to remind you of your great duty in the matter—to be sure to recognize the first symptom of cancer—for therein is the only or greatest relief for the sufferer at the present time.

After six years of study of the subject and the experience of a very distressing case—and I am watching from day to day the slow but certain progress of the third stage of this case that I failed to recognize in the inception stage, twelve years ago, when it was an innocent-looking little nodule—I am determined not to allow another case, at least of external cancer, to develop under my observation unrecognized as long as I practice medicine. And that you all, and your patients as well, may avoid a similar experience, I hope you will keep a card in a conspicuous place in your office with the following reminder: Cancer suspected in (I) case of any small nodule or induration the size of a split pea to that of a chestnut, persisting for two months or more and free of pain, and capped with a cream-colored pearl, like a mustard seed under the outer layer of the skin; (II) suspected in case of repeated hemorrhage from any mucous surface of a person over 45 years of age; (III) in case of any nodule of the breast free from pain in the first stage; (IV) in case of any induration arising from a local irritation, as the sharp edge of a tooth scraping the tongue or cheek, absence of pain is the most insidious and at the same time distinguishing feature.

I might cite cases of each class that went on to full development and was the direct cause of death of the patient. I can also mention cases from my records that were detected in the first stage and cured. As regards the last statement, some of you may ask, how do I eliminate the possibility of error in diagnosis? My reply is that I eliminate the commercial factor, by treating the cases for the same fee as for dressing any ordinary case; second, by excluding the possibility of other conditions, and, finally, by arriving at a diagnosis based on the observation of a considerable number of cases.

To illustrate the subject of the paper, I will cite one or two cases from records:

Case 4.—Harry G.; age 28. Consulted me in March, 1903, regarding an enlargement the size of a large chestnut over the parotid gland, on the L side. There was at the time a protuberance the size of a pea on the temple one inch from the outer canthus of the eye. The protuberance had been noticed for two months or more, the enlargement near the ear about one month. The lesion on the temple had a crater-like center, with a small opening through the skin, showing a cheesy or pearly

formation under. The protuberance had been picked open with a needle and squeezed on several occasions by the patient and at no time gave any pain. In fact, the patient did not consider the temple lesion as of any importance, but was alarmed at the enlargement near the ear, and had applied iodine and other remedies to drive it away.

I at once recognized the nature of the lesion near the eye and applied a paste of the following:

R	Zinc chlorid.,	gr. xxx.
	Ac. arsen.,	“ xx.
	Insp. extr. oxal. acetæ,	“ xxx.
	Cocaine hydrochl.,	“ x.
	Po. gum acaciæ,	“ xxx.
	Glycerin q. s. ft. paste.	

This was applied for three successive days, when a mummified patch the size of a nickel became detached, leaving a granulating surface that healed over in ten days. The enlargement near the ear was then painted with:

R	Thiosinamin,	gr. xx.
	Pot. iod.,	“ xv.
	Alcohol dilut.,	ʒ i.

ʒt. solut. Sig.: apply 2 or 3 times a day.

In four weeks the parts assumed a normal appearance, and have since continued so.

Case 10.—Orrin W.; age, 32. Referred to me by Dr. J. G. Orton, November 4, 1903. There was a cyst about the size of a pea on the inside of the lower lip about the center. It was filled with a viscid mucus that had been opened and pressed out by the patient several times. I removed the cyst with the knife and the incision was entirely healed within a week. But on February 3, 1904, the patient appeared again with a dark-purple nodule the size of the original cyst. I then applied a paste of the above formula, covering it with a patch of muslin and collodion. This was kept on for three hours and was then removed by the patient, the pain becoming too severe to bear longer. On the third day a white mummified patch became detached, and in a week was healed over. I then noticed that the edges of the lower incisor teeth were very sharp, and were very likely the exciting cause of return. These were at once smoothed up and there has been no trouble with the lip since.

In comparison with this last case, I wish to call your attention to

Case 11.—J. G. S.; age 60. Consulted me May 6, 1904, for an affection of the right cheek. There was a marked thickening of the cheek with numerous small pearls showing under the epidermis. There was a discharging abrasion on the inside of the cheek opposite the second upper molar. The history of the case indicated its origin at the point of irritation by the tooth one year previous to my examination. At the time I saw the case the patient could not open the mouth enough to remove the tooth. In fact, extraction of the tooth then would have been of no avail, the

case was so far advanced. The patient died the first week in September, 1904.

In 1902 I reported a case of cancer of the tongue arising from the irritation of a jagged tooth.

On referring to the mortality statistics of New York State for the past five years, we find that there are 30 to 40 per cent. as many deaths from cancer as from tuberculosis. Basing an estimate on my own experience for the past five years, I believe it safe to say that with every practicing physician of the State alert in the diagnosis of cancer in the first stage, and by urging an immediate treatment of the suspicious cases, the mortality can be reduced 50 per cent. from the present rate. As regards treatment in the first stage, early diagnosis and excision has been urged by the surgeon for the past twenty years. It is equally as important in the treatment with a paste. And during the past year I have had some very satisfactory results from the use of a solution of the following ingredients:

Thiosinamin, adrenalin, F. E. Arbor vitæ, cocaine and atropin in dilute alcohol.

As to error in diagnosis, when the commercial factor is eliminated, no injustice will be done the patient. And when the medical profession awake to the urgency of the matter, the sufferers will be rescued from the clutches of the charlatan.

CARCINOMA OF THE BREAST.¹

BY E. C. THOMPSON, M.D.,
Newburgh, N. Y.

I HAVE announced the subject of my paper as "Tumors of the Breast." It is manifestly too comprehensive a subject to deal with in its entirety, and so I will confine myself to a discussion of carcinoma, speaking in particular of what is more pertinent to the practitioner—the *differential diagnosis* and *treatment*—and referring only to benign conditions as they interest us from the standpoint of diagnosis. In the beginning I would emphasize one pertinent fact—a fact which the practitioner should always bear in mind when a patient presents herself with a mass in the breast—that 79-83 per cent. of all mammary tumors are cancers, and that of the remaining benign tumors a proportion of the adenoma, and occasionally even a cyst, are destined to undergo malignant degeneration, if not removed. Bearing this fact in mind, the presence of a tumor of the breast is a significant thing, and an early diagnosis as to its exact nature pertinent to the interests of the patient.

Etiology.—The etiology of cancer of the breast interests us in the first place as to the local and general determining factors, which may cause the development of such an aberrant growth *in the breast*; in the second place as to what causes cancer to appear in any part of the body.

Cancer of the breast from the local predispos-

ing factors is usually the reflection of a degenerative process in a senescent organ. Thus it appears as a rule between the ages of 35 and 50, when the organ is undergoing those shape changes incident to its life's history. Again, it may be the reflection of a degenerative process in an already existing tumor, as an adenoma in a cyst. A pre-existing mastitis may be a predisposing cause, probably by causing nutritional changes in the cells. The question of heredity is always inquired into, but certainly the people who uphold the parasitic idea of the disease would say that a daughter contracted cancer not because her mother had the disease, but because she lived in the environments of the parasite. Trauma and other causes have seemed to me to be so correlated with coincident that it is impossible to fix their value as etiological factors.

Much attention has been attracted by the press by the reports coming from the Gratiwick Laboratory, of Buffalo, to the effect that cancer has been demonstrated to be a parasitic affection, and that a curative serum has been discovered (at least for mice). These findings have been in sharp contrast to the third report of the research committee of Harvard University, which holds a very negative view as to the parasitic origin of cancer and rather follows, it seems to me, the plausible pathological theory of Cohen Lewis, viz., that carcinoma is the result of misplaced embryonal cells, which later in life take on unusual activities. In passing, I would observe that it has seemed to me that if some of the pathologists would stop theorizing and attempt to unravel the many hidden mysteries which cell life contains, they would be the better able to interpret their findings, and the sooner, possibly, come to a solution of their problem.

Pathology.—Without entering into detail of morphological characteristics of carcinoma, I will enumerate in brief the different types.

By *scirrhous* carcinoma we mean that the proportion of connective tissue greatly exceeds that of the epithelial cells. About 30 per cent. are of this type.

By *medullary* carcinoma we mean that the epithelial cells are in the preponderance. About 40 per cent. are of this type, which is usually a rapidly growing tumor, and gives a small proportion of cures as the result of operative procedure. In about 25 per cent. of cases the two elements of cells and connective tissue are about even. Celloid carcinoma, adenoma carcinoma and Padgett's disease make up the remaining 5 per cent.

Differential Diagnosis.—The advanced case of carcinoma of the breast from the clinical standpoint offers no difficulty in diagnosis. The appearance and history of the growth are so uniformly classical as to need no analysis at this time. And so I have thought it would be more practical to confine myself for a few moments to the early differential diagnosis of breast tumors,

¹Read before the Orange County Medical Association, Newburgh, April 12, 1905.

reiterating and emphasizing the fact that without any known data we can assume that in any given tumor of the breast there is 79-83 per cent. of chance that it is malignant.

I am resolved that some of the pathological conditions which cause the most confusion and are hardest to differentiate from carcinoma of the breast are not tumors at all, but inflammatory conditions. Cirrhosis mammæ twenty years ago or more prevailed, and we have described cirrhosis mammæ. This is a chronic inflammatory condition of the breast comparable in its pathological significance to cirrhosis of the liver, and chronic interstitial nephritis. This diffuse mammitis bears a very close clinical resemblance to the atrophic withering form of scirrhus. Both are marked by a gradual shrinking of the breast, with depression of the nipple. In this form of cancer the glandular involvement is late, and the course of the disease may cover a good many years. The early differential diagnosis is very difficult. But later in scirrhus the glands may enlarge and the skin ulcerate. These are the main points in the differential diagnosis. If the condition is suspected a histological examination should be made, and if cancer is diagnosed the breast removed.

A Circumscribed Mastitis may simulate a rapidly growing carcinoma. At about the time of weaning, often as the result of some form of irritation, a nodule or patch of thickening may appear in the breast, the beginning of a more or less circumscribed mammitis. This tumor resembles cancer more or less in its early stages, both in the fact of its being badly limited, accompanied by glandular enlargement, and when it becomes attached to the skin by causing the so-called "pig-skin." But such an inflammatory nodule gives us the impression of being less definitely mapped out; of not quite the stony hardness; of being possibly more tender; of growing more rapidly; and when there is glandular involvement, the nodes enlarge more rapidly and are not as indurated as in the case of carcinoma. Here, again, if in doubt, a prompt exploration and histological examination are to be done.

Tubercular Mastitis.—Another chronic inflammatory condition, which I believe is occasionally mistaken for carcinoma, is tubercular mammitis. According to J. Collins Warren, tubercular disease of the breast is very rare. W. Watson Chayne, on the other hand, says that it is not nearly so uncommon as supposed. It has been my experience to see a mistaken diagnosis of this condition in at least two cases. It may occur either as a disseminated process secondary to enlargements of the glands in the axilla, or from some neighboring structure. The cases which cause confusion are where a nodule appears primarily in the breast, a single nodule at first, which finally goes on till it involves a lobule of the breast in a tuberculous mass. If the axillary glands are enlarged first, or if they enlarge very rapidly, tuberculosis must be thought of. The

tubercular is not as indurated, and grows more rapidly. The diagnosis is, of course, easily made later; but if in doubt in the early stages, again we must resort to our exploration incision and examinations.

A pus fibroma is a very rare condition of breast tumor. Occurring at an early age, usually near the periphery and well circumscribed, of slow growth and nodular in palpation, it can hardly afford any difficulty in diagnosis.

A fibro-adenoma occurs somewhat later than a pure fibroid, but earlier, as a rule, than cancer. It is one of the most common forms of benign growth of the breast. Here, too, the diagnosis is usually easy, and the tumor should be removed on account of the pressure of glandular tissue, which makes it prone to undergo malignant changes.

A Fibro Cyst Adenoma, or the so-called papillomatous cyst, or intercanicular cyst, ordinarily affords no difficulty in diagnosis from scirrhus. When occurring in its typical form it is tense and elastic in parts, possibly fluctuating, nodular in places, and usually near the nipple. A serous or sanguineous discharge from the nipple may take place. Occasionally such a tumor may become adherent to the skin; the skin reddens and breaks down, and a fungulore papillomatous mass be protruded. Such a condition may be mistaken for malignancy; the edges of the ulcer are clear-cut, never infiltrated, the pectoral fascia, and there is no glandular enlargement.

There is a different variety of cystic growth which may be mistaken for cancer. In a woman approaching the menopause the parenchyma undergoes atrophic changes. The tuber and ducts remain but become disturbed; a cystic condition supervenes. Occurring at the age when cancer is most likely to appear, such a tumor may excite alarm. A cystic growth of this nature is firm, usually nodular in some part of its circumference, with walls so tense that fluctuation can hardly be determined. On examining the breast minute nodules may be discovered on rolling the gland against the chest wall. Often both breasts are either simultaneously or finally affected. This condition of cystic degeneration of the breast is a very common condition—Warren says almost the rule at the time of the climacteria. If such a condition is found, a nodular tense tumor may be looked upon as a cyst; if in doubt, the aspirating needle will determine the diagnosis.

Sarcoma.—There is little resemblance between sarcoma and carcinoma. We have in a sarcoma a tumor appearing between the ages of 25 and 35, rapidly growing, nodular, heavy, elastic, mobile, non-adherent, and with no axillary involvement. If an ulcer appears it is due to pressure necrosis in the skin. In all these respects it differs from scirrhus. Chondroma, lipoma, myoma and galatocoele are conditions so rare that we will not take the time to consider them.

The one most pathognomonic symptom of cancer is its tendency to infiltrate the tissues; ad-

herence to the pectoral muscle and fascia or skin is the first thing to consider. The arms should be raised in examination for this symptom, the pectoral muscle put on the stretch, and if the tumor does not move in palpation parallel with its fibers we have the most positive indication of the infiltrating character of our tumor and of its probable malignancy.

Treatment.—Any treatment other than operative for cancer of the breast must be looked upon purely as a palliative. In making this statement I would include radium and X-ray treatment, and caustics, and exclude serumtherapy, because I know nothing about it.

The treatment of cancer by caustics is archaic. We have no agent of this class which has a selective influence in the cells. Of course, the vigorous use of a destructive agent may cause such an extensive necrosis of the tissues as to cure a breast cancer in its incipency; but weighing its advantages with its disadvantages, it can no longer be considered in the line of treatment by scientific men.

Radium.—Radium, in its effect upon living tissues and cancerous growths, is in kind very much the same as that of X-ray. Abbe, in summing up the effects of the radium, says that malignant cells which have escaped destruction or retrograde changes, show a striking quiescence which may mean death to the vital forces, which makes them malignant. This may seem to be quite a positive statement, but a careful analysis of it makes it quite a negative one, as far as radical treatment is concerned. I cannot find the report of any cases of carcinoma of the breast cured by the exhibition of radium. In the *Medical Record* Williams reports three cases of carcinoma of the breast improved; one unimproved. In the *Lancet*, 1904, we find a report of seventeen cases of well-advanced and secondary carcinoma treated without satisfactory results. I have seen one case of cancer of the breast treated by the Roentgen rays. A low vacuum tube was used with exposure of ten minutes every other day for two months. At the end of that time a radical operation was performed, and the histological report was rapidly growing medullary cancer, with active mitotic figures in the cancer cells. The X-ray in this instance seemed to have had no effect at all on the growth of the cancer cells. At the present time it would seem fair to place the X-ray and radium among our preventive measures in the treatment of cancer of the breast. I believe in time they will be used as an ameliorating and inhibiting agent for secondary and inoperable carcinoma; possibly after operation, with the view of preventing recurrence.

Operative Treatment.—It is not within the scope of this paper to discuss operative technique in detail; but rather in a few words I will consider the general indication for operation, the cardinal principles by which we should be guided in operating, and the comparison of the so-called newer or completed operation with the older

method. Operations should be performed in all cases where there is hope that the disease can be completely eradicated, provided the physical condition of the patient warrants it. In rare cases it should be performed solely for the purpose of euthanasia. The contraindications are cancer "en cuirasse," the involvement of this lymph nodes in the opposite axilla, metastasis in the external organs, and attachment to the chest wall; in other words, practically where there is no hope of eradicating the disease. Enlargement of the supraclavicular glands is not necessarily a contraindication.

A comprehensive knowledge of the rich lymphatic distribution of the mammæ is necessary for the surgeon who wishes to do breast surgery, if he is to get good results. This is essential, for a proper understanding of the completed operation and its effectual execution. The lymphatics of the breast for the most part enter into the axillary glands. The group of glands in the anterior axilla along the lower border of the pectoralis major, the pectoral group, are the first involved; from here the infection travels to the row of glands along the axillary veins, the axillary group. In the posterior axilla there is a group of glands not in intimate connection with the axillary group, but occasionally infected in cancer of the breast. From the axillary group the cancer cells travel beneath the clavicle to the deep cervical group in the posterior triangle of the neck, and so to the superficial cervical group. From the axilla the lymphatics accompany the vein up and inward to enter the R. lymphatic duct. It is along this entire route that the lymphatics of the two breast anastomose, and disease should be sought for in the opposite breast and axilla before undertaking operation. The very rich skin distribution of the lymphatics should teach the surgeon that a large area should be embraced about the nodule in the primary skin incision, and that any operation which aims at cosmetic effect rather than to the complete excision of possible sites of infection is out of date. A knowledge of the fact that some of the lymphatics pass directly through the chest teach him to make a systematic examination of the internal organs and the possibility of metastasis, which, if present, would indicate the futility of submitting a patient to a hopeless operation.

The newer radical or completed operation has now been in trial long enough to compare it with the older and even modern conservative operations, which are still practiced, unfortunately, even in our larger hospitals. The conservative operation aims to eradicate all the disease, not only in its apparent manifestation, but in its productive sites. The completed operation indicates the inclusion of a large skin in primary incision, and the careful dissection of this possible lymphatic extension of the disease as we have described it. It means the removal of the pectoralis major and probably the minor muscles, with their fascia, paying particular attention to the prolongation

of the pectoral fascia, which passes beneath the clavicle portion of the greater muscle, the portion usually left behind, to the prolongations of the fascia in front of and behind the axillary vessels, and to the fascia fat and glands in the posterior part of the axilla, and in some instances to the dissection of the posterior triangle of the neck. It emphasizes the fact that this entire area should be removed "en masse" by careful knife dissection, and not blunt dissections, avoiding at all times the possible infection of the field of operations by cutting possibly infected tissues. Operative procedure, governed by the broad indications, as conceived by Halstead and Warren, is giving about 40 per cent. of cure. Compared with the conservative plan of treatment, this is a gain of about 15 to 25 per cent. It would seem that the conservative operation has reached its limit of attainment as far as the percentage of radium cures which it gives is concerned. The prosecution of the completed operation seems to be justified by logic by what has already been found to be its improved degree of attainment, and has given to the surgeon renewed hope that with early diagnosis and operation he will be able to get a radical cure in about half of his patients who are suffering from a loathsome disease.

I will report in brief three cases, all interesting, and illustrating some of the points we have been over, which I have operated upon, in the service of Dr. Charles A. Gibson, of St. Luke's Hospital, New York, which I am permitted to report by his courtesy:

Case I.—Woman of 69; housewife. Two years before admission to hospital noticed a lump on upper and outer quadrant of breast size of a hazelnut. Tumor gradually enlarged, till on admission to hospital was about the size of an orange. Tumor hard, nodular, slightly elastic in one spot, attached to skin and fascia. No axillary enlargement. No apparent metastasis. Slight anemia.

Operation.—Simple amputation of breast, including fascia and a layer of the pectoral muscle. Time of operation, 14 minutes. No recurrence eight months afterward. Pathological report, scirrhous carcinoma.

Observation.—We have here an old woman, 69 years of age, with a tumor which in two years had apparently not involved the axillary nodes. On account of its apparently low grade of malignancy and the age of the woman, a simple amputation was performed. The case illustrates how slowly cancer in the old may advance.

Case II is a very interesting one. Patient a colored woman; age, 35. Two years before admission to hospital noticed a lump in the R. axilla. Some time later a lump appeared in the upper and outer quadrant of the breast. The mass in the breast had gradually increased in size, extending upward toward the axilla. Mass badly limited, hard, attached to the skin. Patient had a cough for six months with gradual loss of flesh and strength. Slight dulness over both apices, with

diminished breathing. Diagnosis, tubercular mastitis. The age of the patient, 33, when lump first appeared; the enlarged glands appearing first in the axilla; the race, cancers being very rare in the negro and tuberculosis common, and the cough, led to the mistaken diagnosis, for the case, on operation, proved to be scirrhous. The Halstead operation was performed. The patient died some time after operation before recurrence had time to occur, and so was no fair test of the operative technique.

Case III.—Patient 62. Noticed a lump size of a hazelnut in upper and outer quadrant of the breast three months before admission to hospital. Tumor slowly increased in size, and, on operation was found to be hard, slightly nodular, attached to the skin; movable on the muscle, with no apparent glandular involvement. No other symptoms subjective or objective. Physical examination negative, but for an irregular intermittent heart, with impure sounds at the apex.

Operation.—Completed operation. Time, 1 hour, 15 minutes. Patient made an uneventful recovery. Wound healed by primary union.

Pathological Report.—Carcinoma of breast, connective tissues in excess of cells, hyperplasia of the lymphatics, but no cancer infiltration. I recently heard from this patient, and she has now covered two years and eight months of the three years, at the end of which, with no recurrence, we consider the case a cure. The case is an illustration of what should be the aim of the practitioner—an early diagnosis, early operation, with about 40 to 50 per cent. of chance of radical cure.

URINE AND URINALYSIS.¹

BY MARY E. DUNNING, M.D.,
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FORMERLY the urine was thought to be secreted by osmotic action. More recent studies assign a selective or secretory office to the glomeruli of the kidneys, in accordance with which they permit certain materials to pass through and prevent others, among the latter albumin. They also indicate that even the passage of fluid through the glomeruli is not a mere exudation but a matter of selection as well, though it is greatly influenced by the rapidity of the flow of blood through them, which again depends on the general blood pressure and the resistance against which the blood is forced through the kidneys.

The urine in health is a straw-colored to amber-colored fluid, with a specific gravity of about 1020 and generally acid reaction. The amount passed in twenty-four hours is usually from forty to fifty ounces, but may fall to thirty or rise to seventy ounces without disease. Normally about six times more urine is passed in the daytime than at night. Women are supposed to pass five to ten ounces less than men, and it is usually of a lighter color. The volume

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is increased by inaction of the skin, cold, constipation, nervous excitement; diminished by free perspiration, diarrhoea, etc. Since we have so much variation in health, is it surprising that all constitutional diseases and many local ones cause more or less alterations in the renal secretion? The quantity may be increased, diminished or unaltered in disease. It is increased in diabetes mellitus and diabetes insipidus, and usually in the middle period of chronic Bright's, particularly in the interstitial form. It may be increased in hypertrophy of the left ventricle, which causes increased pressure in the renal arteries, and in cystic degeneration. All diseases which impair the force of the circulation lessen urinary secretion, therefore we find it diminished in myocarditis, in valvular diseases not fully compensated, in emphysema and in chronic bronchitis. It is also lessened in febrile diseases, in cirrhosis of the liver, in acute nephritis and sometimes in the middle period of chronic Bright's. We may have suppression of the urine or anuria in the last stages of all the organic affections of the kidneys. It may be caused by a mechanical block to the outflow of urine or from the secreting tissue being destroyed or its nerves or vascular supply being interfered with.

The color of the urine is due largely to urobilin, produced from the hæmatin of the blood; sometimes from a hyperabundance of hæmoglobin we see it red, or it is red from a hyperabundance of urobilin, as in scurvy or pernicious anæmia. It is red and clear when concentrated and full of urates. It is smoky, reddish brown or red in acute Bright's, due to blood. Then again it is red and yellow or golden red in many jaundice cases, also from the effect of santonine, picric acid, or rhubarb medication. Bile salts or indican may produce brownish or black urine, also the exhibition internally or externally of carbolic acid, creosote, tar. Senna, taken by the mouth, and victims of melanotic tumors may pass the brownish or black urine. Those living on diet without meat have proportionately lighter urine than meat-eaters. Pathologically light-colored urine may indicate diabetes, polyuria, chronic Bright's or a hysterical condition.

Healthy urine is acid, although about two hours after a meal of mixed food it may be alkaline. Our common, or the physician's ready test, is litmus paper. We find the acidity increased in gout, chronic Bright's, diabetes, acute rheumatism and the result of taking acids. The urine becomes alkaline from alkaline fermentation in cystitis, from blood or pus, from long immersion in a cold bath, sometimes in nervous dyspepsia, in debilitating diseases and as a result of taking alkalines.

The density is measured by the ureometer. Owing to the fact that urine passed at different times in the day varies as to density, a twenty-four hours' specimen should be used for the test. In health specific gravity varies from 1010 to

1025. The variation is wider in disease—from 1000-1005 in diabetes insipidus and some forms of Bright's to 1060 in diabetes mellitus. Usually, but not always, urines containing much albumin are of low specific gravity.

Sediments.—Upon standing, most normal urines throw down a white flocculent sediment composed of mucus and epithelium. The amorphous urates in excess give a dense deposit varying in color from brown sugar to pink or red; heat dissolves it. A white sediment with yellowish tinge may consist of pus with or without mucus. If the urine is alkaline it becomes a viscid mass, which can be drawn out into tough, stringy threads; if the urine is acid, however, this deposit is loose and free to move. Blood in quantity from the kidneys causes a chocolate-brown deposit, in a reddish, smoky urine. Clots of blood in the urine come from the bladder or urethra.

The odor of urine is characteristic. It becomes ammoniacal in cystitis and even putrid, after standing, if much pus is present. We all know the odors peculiar to certain foods and drugs and the sweetish odor of diabetes. Now let us turn our attention to a few of the chemical methods of examining urine. First there are some general points which I will enumerate briefly. Whenever possible, a specimen from the collected secretion of twenty-four hours should be examined. If twenty-four hours' sample cannot be obtained take from amount passed on rising and another passed about three hours after breakfast. Examine separately so as to obtain information as to effects of rest, fasting and taking food. If only one sample can be examined select the one passed three hours after breakfast, not the one passed on first rising, for albumin and sugar may be absent from the early morning one and be present later. Never put too much reliance on results obtained from one examination, because urine may be free from albumin at one time and it may be present at another. It is wise to warn the patient against spitting into the urine, as in testing for blood or albumin it may cause misleading results. In sending sample from a distance for examination send the bottle full, as this lessens the amount of disturbance by shaking and diminishes the risk of breaking up such objects as brittle tube casts, etc. Also add two drops of formalin for each ounce, as this will preserve the urine for several days even in warm weather. If examining specially for pus or gonorrhœal threads, examine specimen passed on rising, as they collect during sleep and are washed out in the morning. We will have time but to glance briefly at a few of the abnormal constituents of urine tests.

Urea results from the perfect decomposition of the nitrogenous elements of food and tissue. It is freely soluble in water, so *never* forms a sediment. Usually the sp. gr. of urine increases in proportion to the amount of urea it contains. About 500 grains is excreted daily by an average man

between 20 and 40 years of age. The amount varies within the limits of health just as the volume does. It is increased after eating, especially if the food be rich in nitrogen—after exertion, after drinking much liquids and by close atmosphere. It is diminished by starvation, free perspiration, a loose condition of the bowels and diet rich in vegetables and milk. Again age modifies—children excrete less than older people; also size is an important factor in determining amount excreted, a large body excreting more than a small one, and a large muscular man, more than a fat one of same height.

Pathologically urea is increased by fever and acute inflammatory processes, wasting diseases, anæmia, in diabetes and certain drugs, especially hepatic stimulants.

It is diminished in nephritis, in wasting diseases and anæmia, in leprosy, hysteria, cholera, melancholia, pemphigus, certain diseases of liver, etc.

For estimation of amount of urea excreted the Doremus ureometer is the most satisfactory apparatus for general use.

Albumin is perhaps the most important abnormal constituent of the urine. In testing for it filter the urine in every case before examining. This is necessary to remove mucus, blood cells, pus, etc.; take reaction if acid, proceed, if alkaline, acidulate with acetic acid, then use the heat test and the cold nitric acid test. If amount is small and still in doubt, use the picric acid test, which is a more delicate one than either of the above.

Sugar or glucose is, next to albumin, the most important abnormal constituent of the urine. While it is always present in normal urine it is in such small quantity that it cannot be detected by ordinary chemical tests. Fehlings and the fermentation tests are two of the standard methods for determining its presence.

I do not want to leave this subject without touching on another constituent of the urine—indican. It is found in small amounts in normal urine. When abundant it suggests that abnormal putrefactive changes are taking place in the intestinal tract or infection is occurring from suppurative processes in some part of the body. The test for it is so simple and satisfactory and its presence in any amount shows so clearly that the victim is suffering from one form of auto-intoxication, that its detection becomes a valuable aid to our diagnosis.

For the technique of carrying out these tests I would refer you to any of the text-books on urinalysis.

Microscopical examination of the urine, I think, few general practitioners take time for. But it is a most valuable supplement to the chemical examination and should not be neglected.

In closing I want to urge on each one of us the necessity of more careful and systematic examination of the urine, and the better knowledge and fuller appreciation of the condition of our

patients, which a little time spent in this direction gives, more than repay our labor.

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CATHETERISM OF THE URETERS.¹

BY WINFIELD AYRES, M.D.,
 New York.

CATHETERIZATION of ureters, especially in the male, has received marked impetus lately by modifications of the catheterizing cystoscope, so that the operation is much more easily performed and with much less discomfort to the patient than formerly. It is not unusual at the present day to find men who are perfectly capable of passing the ureteral catheter, yet only a few years ago a surgeon who claimed to be able to enter the ureters in nearly every case was looked upon with scepticism.

The choice of cystoscope is of considerable importance. The indirect-view catheterizing cystoscope has a few adherents, but by far the majority of surgeons, especially in this country, prefer the direct-view instrument. The reason for this lies in many facts: First, not so much experience in the use of the instrument is required in order that the surgeon may attain sufficient skill to catheterize ureters in the majority of cases; second, failures more rarely occur; third, there is less discomfort to the patient; fourth, there is less liability to cause traumatism to the ureters; fifth, the character of any obstruction encountered in the ureter is more accurately determined; sixth, the operation is much more quickly performed, saving time to the surgeon and discomfort to the patient; seventh (and this is a very important point), the cystoscope may be removed without disturbing the position of the catheters in the ureters. Surgeons have said quite recently that removal of the cystoscope is not necessary; that enough urine may be obtained for examination in a short time with the cystoscope in place. The statement is wrong, and, besides, I know of no patient who would not prefer to have the cystoscope removed, and it is a surgeon's duty to make his patients as comfortable as possible; eighth, it is often necessary before catheterizing the ureters to thoroughly inspect the bladder. A complete view of the bladder cannot be obtained by either form of instrument, but the straight or direct-view cystoscope has an additional telescope for indirect inspection of the bladder, and it is little trouble to introduce this indirect view through the sheath for examination of the fundus and sides of the bladder, before introducing the direct-view telescope for inspection of the back wall and catheterization of the ureters. Of the indirect view catheterizing

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cystoscopes, I consider the Bierhoff modification by far the most satisfactory. Of the direct-view instruments, it is natural that the author should consider his own modification the best. It possesses all the advantages and none of the disadvantages or dangers of other instruments of its kind, and in addition has several improvements over anything on the market. A full description of this cystoscope will be found in the June number of the *American Journal of Urology*.

The care of ureteral catheters is of utmost importance. After the catheters have been removed from the ureters they must be thoroughly washed inside and out, then perfectly dried before being subjected to sterilizing gases. My own preference is to place them in a jar containing chloride of calcium for forty-eight hours and to then force formaldehyde gas through them by means of an especially devised sterilizer (the author's). I then place them in glass jars containing a tablet which generates formaldehyde gas, and so keep them until required for use. If they are thoroughly dried they may be sterilized by bottling them for one week in glass jars with formaldehyde tablets. By this manner of sterilization three or four pairs of catheters are required for each patient. It is my custom to have individual glass jars for each patient. In addition, it is necessary to have a full supply of catheters, both blunt and olive pointed, of all sizes, thoroughly sterilized, for those patients who are sent in for diagnosis. Quick sterilization is not so reliable, but is sometimes necessary. For this I prefer the oxycyanide of mercury 1:500. Catheters are immersed in this for a few minutes and then used without rinsing. In addition, the fluids should be forced through the lumen of the catheter by a syringe. Catheters of the present day are so made that they may be boiled for a few minutes, but this method will not sterilize the lumen. All catheters should be tested with the hands to see that they are strong and unbrittle, as it would be exceedingly disagreeable to have one break in the ureter.

The cystoscope is best sterilized in the formaldehyde sterilizer; or, if it be not used often, by keeping it in glass jars with a formalin tablet. It may also be sterilized by immersion in oxycyanide of mercury or formalin. Five per cent. carbolic acid may be used, but it is more disagreeable than the other two.

The hands of the operator should be sterilized by washing and immersion in oxycyanide 1:500. Formalin may be used, but it is very irritating, and I have seen eczema of the hands directly traceable to its use. Oxycyanide is preferable to bichloride, in that it does not injure the instruments in the least.

The meatus urinarius must be sterilized by the use of some antiseptic before the cystoscope is passed. It is best not to irrigate the urethra, because it cannot be rendered sterile without injuring it, and the natural lubrication of the mucus

is then washed away, making the passage of the cystoscope much more difficult.

For dilatation of the bladder, water is to be preferred to air, as it is much less irritating and can be more easily controlled. Filtered or distilled water, to which formalin or oxycyanide of mercury has been added so as to make a solution of 1:4000, at a temperature of from 85 to 90 F., is best. If the urine be very purulent, it is necessary to wash out the bladder until the return flow is clear before passing the cystoscope, but if the urine be fairly clear, the cystoscope may be passed and the bladder filled through it, thus avoiding the passage of an extra instrument through the urethra, saving both time and discomfort to the patient. If the indirect view cystoscope be used, the bladder must be filled by the catheter before the cystoscope is introduced.

The cystoscope being in place, the orifices of the ureters are to be found, and when found the catheters must be passed slowly and gently up the ureters for a distance of from ten to fourteen inches, depending on the length of body of the patient. If it be desired that the eye of the catheter shall be in the renal pelvis, the flow of urine must be watched. While the eye of the catheter is in the ureter the urine will flow intermittently, but so soon as it reaches the pelvis the flow will be constant. There are exceptions to this rule. When the eye of the catheter passes an obstruction in the ureter the flow will be constant for quite some time, but the eye may still be in the ureter.

As described, the operation seems very easy, but I know of no act of surgery for which more training and constant practice are required; yet no surgeon of the present day should neglect this important branch. It is of invaluable aid to him in coming to a correct diagnosis. Before any operation on the kidney be decided upon, the absolute condition of both kidneys should be determined, and there is no method comparable to ureteral catheterization for accuracy. If the operator be unable to catheterize the ureters, he should have it done by one who has the skill. Less than two years ago one of the prominent operators in New York neglected to have the ureters catheterized, and his patient lost the only kidney he had ever had. The operation was exploratory, and a large tubercular kidney was found and removed. The patient died four days later, and necropsy disclosed the fact that there had never been a second kidney. A short time ago I was called to catheterize the ureters of a woman, and after about an hour's work was compelled to give up one side. I could find no left ureteral orifice, though the right was easily discovered and catheterized. Operation on the following day for floating kidney revealed an immense kidney on the right side. She probably had but one. Sometimes we have to deal with a suppurative pyelonephritis that has been recognized by general symptoms. It is absolutely essential that the con-

dition of the other kidney be known, otherwise an operation may prove rapidly fatal.

Catheterization of the ureters may be employed for diagnostic purposes; for treatment of various pathological conditions of the ureter, the renal pelvis and the kidney; and to act as a guide in avoiding the ureter when removing abdominal tumors in cases where extensive pelvic adhesions have occurred.

Not infrequently we are consulted by patients who give a history of persistently cloudy urine and complain of symptoms purely referable to the bladder. We may make a diagnosis of cystitis and give the patient appropriate treatment for that condition, but the urine may fail to clear and the symptoms disappear. If we investigate these cases more thoroughly, we may find the seat of trouble in the ureter or renal pelvis. Passing an observation cystoscope we may see a cloudy urinary jet from the ureteral orifice, after which we may be confident we are dealing with some inflammation of the ureter or renal pelvis, though there may be a chance of mistake; the urine may be phosphatic. I have seen urine quite cloudy from phosphates from one side while that from the other side was clear. If we pass the ureteral catheter and subsequently make a careful microscopic examination of the urine collected from the catheters, the condition of the ureters, of the renal pelvis and of the kidneys is determined.

The X-ray is of great aid in ascertaining the presence of renal or ureteral calculi, but sometimes fails to show a shadow when calculus is present. If a wax-tipped catheter be passed and scratched by a calculus, diagnosis is established. The X-ray will occasionally show shadows of objects not in the ureter; if a catheter containing a stylet be introduced and photographed, we may find the shadow far from the ureter. A new instrument has been devised by Cabot, of New York, which will prove of considerable service in detecting stone in the ureters and kidney. It consists of a bougie with a metal tip attached to a phoneidoscope. When the metal tip comes in contact with any hard substance the impact is distinctly heard. The use of this instrument is rather difficult, and cannot entirely displace the wax-tipped catheter.

Strictures of the ureter may be diagnosed and treated by the ureteral catheter. This condition often causes the patient considerable suffering. Not infrequently renal colic, simulating in every respect colic due to calculus, has as its cause stricture of the ureter.

Strictures and kinks of the ureter may cause hydronephrosis. If it be possible to pass a catheter by the obstruction, a large amount of urine will flow with the entire disappearance of the tumor, and so diagnosis is established. If the hydronephrosis be due to a kink of the ureter, palpation will show a floating kidney, which will have to be treated by operation, but if the kidney be found in place, the trouble is due to stricture, and may be cured by dilatation.

Various instruments have been devised to obtain separate urines from the kidneys, but no test is so accurate as that made by the urethral catheter. I should judge that in 2 per cent. of patients one ureter is situated so near the median line that it would be impossible to absolutely depend on obtaining separate urines by any other means than the catheter. The separator left in the bladder for any length of time causes great uneasiness to the patient, but catheters may remain in place for hours without the least inconvenience. They are also much better and more accurate when the working capacity of the kidneys is to be studied by the methylene blue or phlorizin test. When they are used sufficient urine for any test may be easily collected. And last, but not least, there is no more danger to the patient than in the employment of any of the separators.

Ureters have been cut in the removal of large abdominal tumors held down by many pelvic adhesions. Abdominal surgeons of the present day before operating pass the ureteral catheter, employing it as a guide so as to avoid the ureter. The catheter can easily be felt through the tissues.

At present much interest is felt in the treatment applied through the ureteral catheter. Ureteritis, catarrhal or purulent pyelitis and nephritis may be treated by medicated solutions injected through the ureteral catheters. We are able to dilate strictures of the ureters; to check hemorrhage from the ureters in some cases by the injection through the catheters of adrenalin; and we may facilitate the passage of a calculus by dilatation of the ureter and injection of sterilized oil about it. In fact, the field of the ureteral catheter is wide and not yet developed.

Though it is possible to fill the renal pelvis through a catheter inserted only a few inches, it is best in treating purulent ureteropyelitis to pass the catheter well up to the kidney, washing out the pelvis first, after which the wash should be repeated at intervals of six inches until the entire length of the ureter has been treated. By this method no pus is forced from the ureter into the pelvis. In dealing with this condition most benefit will be derived from the use of argyrol or strong solutions of silver nitrate.

Catarrhal pyelitis is sometimes cured by change of climate, diet and medication, but not infrequently local treatment is required. Severer cases are nearly always accompanied by involvement of the kidney, as shown by the presence in the urine of tubular epithelium, more or less albumin, and, in more advanced cases, casts. The symptoms accompanying this condition are pain in the back, along the course of the ureter, or in the testicle, and often abnormal urination. Under this head I shall include parenchymatous nephritis which has not reached the stage of contraction, as it, too, is to a certain extent amenable to the same treatment. For these conditions lavage of the renal pelvis with the nitrate of silver, protargol, or albargin accomplishes wonders.

Method of Lavage.—After the catheters have been passed well up to the kidneys; after the cystoscope has been withdrawn, leaving the catheters in place, and the urine has been collected for examination, the patient is ready for lavage. A half-ounce antitoxin syringe should be used, and an injection of about a dram given on each side, the solution being then allowed to drain out through the catheters. From four to eight ounces are required for thorough lavage by repeated injections. Most benefit may be derived from nitrate of silver 1:8000 and up; protargol one-half of 1 per cent. and albargin one-half of 1 per cent. From twenty to forty-five minutes are required for the administration of a proper lavage.

I have selected four cases as illustrative of the results of treatment:

Case I: Calculus Lodged in the Ureter.—Mr. J. C.; age, 49; janitor. Was referred to me by Dr. Henderson, of Brooklyn, February 14, 1905. He gave me the following history: He had never had a venereal disease. He had had six attacks of renal colic, the first occurring eighteen months previously. Each attack had been very severe, lasting from five to six hours, and had been followed by a hematuria lasting from three to six days. On two occasions he had noticed a little blood in the urine previous to colics. His last attack of colic, on February 7th, confined him to bed for four days, on account of weakness from loss of blood. The urine emitted voluntarily showed considerable blood, but that drawn by the ureteral catheters passed well up to the kidneys contained very little. Analysis of the urine collected from the catheters showed that he had interstitial nephritis with catarrhal pyelitis.

On February 21st, I passed wax-tipped catheters on the right side, and, encountering a slight obstruction at six inches, withdrew the catheter and found it to be scratched. A second catheter was also scratched at six inches. I then injected argyrol 50 per cent. about the stone and gave strict orders that he watch his urine carefully, but he was compelled to urinate before reaching home, and consequently could not investigate thoroughly. There was no obstruction to the passage of the catheter on his next visit, and I failed to get a scratch. I have inserted the wax-tipped catheter four times since, but have obtained no scratch. X-ray does not show stone in the ureter or renal pelvis. He probably passed the stone after the argyrol injection.

Case II: Purulent Ureteropyelitis.—Mr. L. M.; age, 24; salesman. Was referred to me by Dr. Schneider, October 26, 1904. He had had a gonorrhœa one year before coming to me, and had considered himself cured in six weeks. In February, 1904, he had noticed that there was some pain at head of the penis and that his urine was cloudy. At times there was slight frequency of urination, but he had no pains or symptoms referable to the kidney. He was well nourished and presented no evidence of septic absorption.

He had been treated from February until October by bladder lavage and the internal use of urotropin without benefit. Cystoscopic examination showed the bladder to be in a state of chronic inflammation, the trigone being thrown up into large knobs of inflamed mucous membrane. The right ureter was catheterized with difficulty, but the left could not be entered, though it was seen. Microscopic examination of the urine collected from the right kidney showed a mild catarrhal pyelonephritis. One week later I succeeded in passing a catheter into the left ureter. The urine therefrom was loaded with pus. I treated the patient by lavage of the left renal pelvis and ureter twelve times. At first I used silver, then protargol, without benefit, but his urine absolutely cleared under three washes with argyrol. The last time he called I catheterized both sides and found the right absolutely normal, while from the left I obtained only a few epithelial cells from the ureter. It is probable that the trouble on the right side was purely sympathetic and disappeared so soon as the inflammation on the other side was cured.

Case III: Catarrhal Pyelonephritis.—Physician; age, 30. Was referred to me as a case of seminal vesiculitis in March, 1904. He had had a urethritis two years before I saw him and had been unable to rid himself of discharge. He had been treated by urethral dilatation, massage of the prostate and vesicles and irrigations for eighteen months. The physician referring him to me did so because he thought his finger insufficiently long to massage the vesicles properly. Acting upon his diagnosis, I gave the patient massage for two months without improvement. His urine being then examined was found to contain a large number of cells from the renal pelvis and tubules, and a small amount of albumin. After the first treatment by lavage of the renal pelvis his discharge ceased, not to return until he contracted a second attack of urethritis some months later. He was treated eight times, and albumin, tubule and pelvic cells disappeared entirely. If the inflammation had been allowed to continue in the tubules of the kidney, he would probably have developed a typical case of interstitial or parenchymatous nephritis later in life.

Case IV: Well-Advanced Parenchymatous Nephritis.—This case will be reported in full in the *Medical News*. The following is a brief extract: Male; age, 32; occupation, clerk. I saw him for the first time June 20, 1904. He gave a history of nephritis, which had probably originated in about August, 1903, but was not recognized until an acute attack occurred in March, 1904. When I saw him he presented all outward signs of a well-advanced parenchymatous nephritis. There was a large amount of œdema to above the knees and an œdematous area over the sacrum. The heart was considerably hypertrophied; pulse 88, and somewhat increased in tension. Quantity of urine said to be fifty to sixty

ounces per day, sp. gr. 1020. Albumin was present in such a large amount that his urine solidified on boiling. Microscopic report showed a large number of granular and hyaline and a few blood and epithelial casts, besides pelvic and tubular epithelium. He was treated twice a week for six weeks, then once a week for six weeks. He showed distinct improvement from the beginning. When treatment was discontinued, the albumin was only 15 per cent. by bulk, or 2 gms. to the liter, instead of solid, or 8 gms. Casts had nearly all vanished. Epithelial cells had diminished in number and had become more healthy in appearance. Œdema had entirely disappeared. From March, 1904, until June he had been under treatment by the ordinary methods employed against this disease and had been slightly benefited, but one week before coming to me he had resumed work and had failed rapidly. From June until the present writing he has lost but six days from work, having been confined to the house twice with severe attacks of bronchitis. He could not possibly have continued work another week if his kidneys had not been lavaged. I doubt if he would have lived more than two months without such treatment. He still has nephritis, as albumin is always present, running from 5 to 15 per cent. by bulk; also granular casts in very small numbers are usually found in his urine, but he has been made comfortable and he has been enabled to work and provide for his family. His life has been prolonged many years. There can be no question that the improvement in this case was entirely due to lavage of the renal pelves.

In conclusion:

1. The immense importance of ureteral catheterization has only begun to be appreciated, though the operation has been performed since a few years.

2. The surgeon of to-day is negligent if he fails to avail himself of the use of the cystoscope in making a diagnosis of the pathological conditions of the bladder, the ureters and kidneys, for in no other way can an accurate diagnosis be made.

3. Many kidneys may be saved if diagnosis be arrived at early and lavage of the renal pelves be given. See Case II.

4. The histories of the two cases of Bright's disease (Cases III and IV) show to the general practitioner the importance of the subject in his line; for not only may the beginning cases of nephritis be cured, but selected cases of advanced nephritis be wonderfully benefited.

5. There is not the slightest danger in ureteral catheterization if the operation be properly performed.

The new National Standard Dispensary will be published by Lea Bros. & Co. about September 1st, when the U. S. Pharmacopœia goes into effect.

PUERPERAL SEPSIS.¹

BY J. C. TAYLOR, M.D.,
New York City.

THIS may be defined as a septic infection which takes place after childbirth or abortion, due to the virulent pyogenic cocci, staphylococci or streptococci—more frequently the latter. There are many causative factors which enter into the too frequent infections following childbirth. If we stop to consider that nearly 20 per cent. of the women in our large cities have about the external genitalia, vagina and cervix these germs present, though inactive, it will be seen how easily they make their way into the uterine cavity, and there produce dire results; hence the importance of sterile hands, douche tips, instruments, etc. It is not always the fault of the accoucheur, as some women prepare their own douches for cleanliness, against the instructions of the attendant. I do not think it wise to give a douche in any case where surgical interference has not been adopted, and then, not often; gauze is safer, as the ordinary family douche bag is reeking with germs of all descriptions.

Those who perform abortions (and I am sorry there are so many) are none too well educated in asepsis, which explains the frequent infections following their interference with Nature's greatest achievement. The infection may show itself as patches in the vagina or on the cervix, resembling very much a streptococcic patch on the tonsil. I have seen nearly the whole surface of the vagina and cervix covered by a membrane from which a pure culture of streptococci was made. If the disease was confined to this locality, the systematic effect would not be so marked, as the lymphatics are not so abundant here. The late Dr. Carmalt demonstrated, however, that the lymphatics about the vulva were directly continuous with those of the broad ligaments above, showing how easily a pelvic involvement may follow an infected laceration externally, be it ever so small. This should serve as a warning to the attendant to look after the surgical cleanliness of the pads used externally. The main focus of a septic infection, however, is within the uterine cavity, usually at the placental site. In some cases of abortion, brought about by instruments, a trauma may be inflicted at another point, and the infection take place there and spread.

Referring for a moment to the anatomy of a pregnant uterus or one recently delivered, we find the lymphatics are arranged in two layers, one beneath the mucous membrane and one in the muscular coat beneath the peritoneum. These are directly continuous with the lymphatics of the broad ligaments. Interspersed between these lymphatics are the venous sinuses in which are found infected in septic cases clots, from which there is an extension outward, into the body, causing what

¹Read before the Orange County Medical Association, Port Jervis, N. Y., March 8, 1905.

is known as a thrombo phlebitis. Small particles of infected materials may be caught up in the general circulation and distributed to most any part of the body, setting up a new focus. The most common sites are the lungs and pleura and endocardium. The joints are likewise frequently involved. The disease spreads very rapidly, sometimes through the lymphatics of the uterus out into the broad ligaments and the general peritoneum above, ending fatally unless arrested by surgical interference.

In a very few cases there may be only the focus on the surface of the uterine wall, which, if removed at once, will end well; but rapidly fatal cases have been seen from only this small amount of involvement—true cases of septicæmia. We expect in cases which have reached full term or abortion occurring at the third month or later, more severe types and rapid involvement, due to the enlarged lymphatics and venous sinuses, which keep pace with the growth of the uterus.

Symptoms.—The onset of the disease usually occurs from one to two days from the invasion of the causative germs. It may be ushered in by a chill, followed by a rapid rise of pulse-rate and a moderate rise in temperature; or it may be simply a general feeling of chilliness, with increasing prostration. In cases of abortion there may be marked pelvic pain, but not as a rule after full term. They complain chiefly of abdominal distention, even though the infection is confined to the pelvis. On examination, one detects usually pelvic tenderness, which is more marked in the uterus which has emptied itself after induced abortion than in the uterus which has emptied itself after normal labor. There is usually considerable fluid in the cul-de-sac, but seldom enough to cause bulging of the posterior fornix. The broad ligaments, if involved, give to the finger the sensation of a thickening, a fulness, not firmness, unless much engorged.

The discharge is thin, watery, and may be mingled with a little blood; no odor in the early stages, later pus, quite in contrast with a sapræmic condition, with which it is so easily confounded and frequently follows. In sapræmia we have a foul-smelling, profuse, dark, and often clotted, discharge. The chief points of differentiation from a clinical standpoint I will endeavor to describe.

Sepsis may be ushered in with a chill. If so, temperature is high at once. Usually there is a more gradual rise in temperature and increased prostration. Sapræmia is seldom accompanied by even a slight chill, but a high temperature at onset, which declines. Pulse, in septic cases, rises rapidly, seldom below 120, and thready; in sapræmia cases, rarely above 110, usually 90-100, full and bounding, more like a pneumonic pulse.

Facies in sepsis is drawn, pinched nostrils, pallor, anxious expression, severe prostration, later herpes labialis. In sapræmia, flushed cheeks, usually feels well, no anxiety. In sepsis, patches are

frequently present in vagina or on cervix, never sapræmia. Interior of uterus is smooth on examination in septic cases; a rough spot in sapræmic ones.

Blood Examination.—In septic cases, marked increase in leucocytosis, except in very rapidly fatal ones, where Nature has been overpowered in the beginning; in sapræmic cases, only a mild increase in leucocytes, if any. The microscope furnishes us the surest means of determining the exact condition, if we are fortunate enough to have one at hand, and a good bacteriologist to use it. The discharges should be taken from the interior uterus, and not mingled with contents in vagina. This is best accomplished by means of a Doderlein's tube; care being taken that the vaginal walls are well retracted from cervix, the tube is inserted into the uterine cavity and some of the fluid present sucked up, the whole being then sealed up in a large tube. If foreign material is encountered in the procedure, it is almost certain to be sapræmic.

If the lochia have been normal up to the onset of the infection, then diminish and become watery, it is almost sure to be a case of sepsis. In sapræmia, the discharge usually increases after the first sudden rise of temperature, if the uterus is able, unassisted, to free itself from the foreign substance in its interior.

The general course of the disease varies greatly. Some patients die within a few hours, if there has been no surgical intervention, while others live practically unattended, except symptomatic treatment, for weeks, and a small per cent. will recover, though they will always suffer to a greater or less extent from the morbidity caused by the invasion. The conditions we meet with usually depend upon two factors, namely, the virulence of the germs and the individual resistance of the patient. The activity of streptococci and staphylococci varies with different seasons, the same as pneumococci and other germs. I will endeavor to describe some of the types met with, not wishing to occupy your time with histories of cases. The most common form the infection assumes begins with a rapid rise of pulse-rate from the second to the fifth day after abortion or labor, in the latter often very much later accompanied by a rise in temperature not in proportion to the pulse-rate. A rise to 102 degrees or 103 degrees, with a pulse of 120 to 140, is usual. If the patient be strong enough to stand the toxæmia and there is no surgical procedure adopted, there may be a little higher rise in temperature at night, with a falling off in the morning, but the pulse never becomes very low, usually from 115 to 120, higher, small in volume. The toxins seem to affect the heart muscle almost from the beginning. In fatal cases an acute fatty degeneration of the heart muscle is found on autopsy. The organs which seem to suffer the most are the kidneys. Almost invariably we find an acute parenchymatous nephritis present with a falling off of the

amount of urine passed, sometimes nearly to the point of suppression. The function of these organs should be watched from the very beginning, keeping the urine as much diluted as possible. This will be again referred to under Treatment.

In the blood we find an increase of leucocytes (Nature's method of fighting the disease). If the resistance be strong enough and the toxins have not poisoned the emunctories, it may become confined to the lymphatics of the uterus and broad ligaments. On the other hand, the infection may spread rapidly through the lymphatics of the uterus and broad ligaments to the general peritoneum above, and produce a fatal ending in a short time. In nearly all these cases there is more or less free serous or sero-sanguinolent fluid in the cul-de-sac, with perhaps a venous involvement previously referred to. Toward the close, in these fatal cases, the temperature may go very high or it may become subnormal. The pulse, however, is the main guide. A small, thready pulse, ranging from 120 to 140 per minute is very pathognomonic. Given this with a thinnish discharge and a marked prostration, one cannot afford to delay long, even for a microscopical examination. Surgical interference should be adopted at once.

Another type of the disease, more frequently met with after abortion than labor, is slower in its onset and less virulent in nature, but steadily becoming more pronounced in symptoms, with a wavering temperature, highest at night. The lymphatics are less in evidence in the early part of pregnancy and the muscles firmer. Such cases may recover without interference, but if they do, there is left behind a soft, flabby uterus, with fatty degeneration of the uterine walls, thickened broad ligaments and adhesions. In cases after the puerperium, with slow progression, either the infection is of low type or Nature has limited the outward tendency. Here we are apt to find foci of pus in the broad ligaments, but very seldom free pus in the cul-de-sac, unless it be later mixed with a colon bacillus inflammation.

Treatment.—In cases where the diagnosis has been established clinically or positively by the microscope, the treatment should be the same as in similar infections on the extremities, viz., incision, drainage and the proper use of antiseptic agents. Of all these iodine seems to have more immediate effect on the cocci and the toxins which they produce. Various treatments have been employed, such as the expectant plan, the use of antistreptococcic serum, simple curettage, and others. The mortality from the use of the serum was very high—about 33 per cent.—somewhat above that of the expectant plan, which seldom ran higher than 25 per cent. Simple curettage, in real septic cases, in my opinion, does more harm than good, inasmuch as it removes whatever barrier Nature may have established in the first chain of lymphatics in the uterine wall and opens up the venous sinuses; in other words, has a tendency to spread the infective agents. The use of serum has to-

day been generally abolished, though much was hoped to come from it at one time. The enormous doses of quinine, strychnine and brandy and whisky advised by some do not, in my opinion, in any way check the advance of the disease, and only act as general agents.

From a surgical standpoint, one must keep before him the three factors named before, which insure success in purulent conditions. In addition, we are able to isolate the organs in the pelvis and prevent an upward tendency into the general peritoneal cavity. The uterus is first cleaned out by use of dull instruments, large curettes made after the manner of the old Sym's copper curette, or, better, modified Hunter forceps, as with these one is not so apt to do serious damage to the uterine wall or perforate the organ. In addition, the cavity should be well swabbed out with 5 per cent. iodoform gauze, and then packed with the same. The gauze will not only serve to drain the open lymph spaces and sinuses, but will serve as an antiseptic as well. Great care is required in the dilatation, lest the uterine muscle be torn through and serious damage inflicted. The muscle is soft, infiltrated and œdematous. The patient is then placed in the modified Trendelenberg position, in order that the intestines may roll upward, out of the field, as much as possible. An incision is then made with the curved, blunt-pointed scissors, through the mucous membrane, at the junction of the posterior fornix and the cervix, care being taken to keep between the attachments of the utero-sacral ligaments. The incision is then carried upward through the peritoneum. The forefingers with dorsal surfaces in apposition are inserted into the opening and spread outward, carrying the ligaments to either side on the palmar surfaces of the fingers, making a partial blunt dissection. The fore and middle fingers of the left hand are inserted through the opening, and the posterior surface of the uterus and broad ligaments are carefully dissected free from the intestines above, to which they are usually attached by plastic lymph.

If foci of pus be present within the broad ligaments, the surface can be easily penetrated by the finger, establishing drainage. One thing must always be borne in mind, and that is that the dissection must be carried out clear to the pelvic brim on either side. Merely opening the cul-de-sac and passing in a gauze drain will not suffice, as it will result in a high per cent. of mortality. Drainage and isolation must be complete. This is accompanied by means of packing with iodoform gauze, 5 per cent., clear across the pelvis, on a level with the upper surface of the uterus and broad ligaments, long, thin retractors being used for this purpose. The whole procedure should occupy about eight minutes, and can easily be done under primary anesthesia. The gauze is removed in six or seven days, and a much smaller amount inserted to keep up drainage. The infection, by this time, however, will be

passed. Cultures of streptococci can seldom be made after the first dressing. The dressings are changed every three or four days thereafter. When the pelvis is thoroughly drained out, the cervix is pressed back against the opening and allowed to heal, bringing the uterus into normal position.

Of over forty cases operated on by the late Dr. Pryor and myself, there have been no deaths from cases which had not previously been tampered with, and only two in the whole number. One had pneumonia and endocarditis when she entered the hospital, and the other had nephritis in its worst form. As I mentioned before, the kidneys are more affected by the toxins than any of the other organs. I nearly always infuse into the veins from iv vi 0 of saline solution at the time of operation, and repeat afterwards, if indicated, followed by saline enemata, and repeated every four hours, of from ̄ viii-̄ xii to keep the constituents of the urine diluted as much as possible, to prevent locking up.

Too many drugs should not be administered, and all drugs given very judiciously—usually strychnine, nitroglycerine, sometimes digitalis. Under no circumstances should any opiate be used, as this drug always tends to diminish the activity of the emunctories.

In cases where there has been a low form of infection, which are seen late, and when examination reveals a tubo-ovarian abscess on one or both sides, with the characteristic symptoms of pus, the above method is not advised, for fear of spreading the infection above the brim of the pelvis. Total vaginal ablation is the only method of safety to the patient.

A STUDY OF THE MILK SUPPLY IN NEW YORK.¹

BY S. W. S. TOMS, M.D.,
Nyack, N. Y.

THE milk resolution² introduced at our July meeting last year and adopted by the Rockland County Medical Association had for its object suggestions for a betterment of existing conditions as are believed to exist in some quarters. As the framer of the resolution, I believe the time has arrived for a food staple so important to the human race, especially infants, to be under regulations that will safeguard their lives and insure its purity at all seasons. The agitation by cities, States and the federal authorities for pure food laws at the present, as shown by the daily press, is evidence of the public sentiment of the abuses of adulteration, the low standards, and general menace to health from the daily consumption of what should be a healthy food product.

"Nearly one-third of all the milch cows in the United States are necessary to supply the people with milk in its natural state. The average quantity of milk consumed per capita in the United

States is over half a pint per diem, showing the universality of its use, and it ranks third as the most common article of food or drink—only being exceeded by bread and water.³ It is the most nutritious, economical and easily digested of all foods and one of the cheapest. Milk is usually used in the raw state, for much of its nutritive value is impaired by heat.

"Frequently cow's milk is the only nourishment taken by infants and invalids, and it is these who are least able to withstand the ill effects of impure foods. Vital statistics show that about one-third of all deaths are of infants, and that a very large percentage of these die from diseases of the digestive tract. These diseases are said to be due principally to impure food." The mortality of infancy and unwholesomeness of milk are inseparably connected. This I will show and refer to later in quotations from the health officer's statistics in Rochester, N. Y. Many outbreaks of infectious diseases have been traced to the milk supply, as all know, and there is little doubt but that tuberculosis, which kills 200,000 people annually in the United States, is also spread by infected milk. Dr. J. Finley Bell, of Englewood, N. J., tells me he traced an epidemic of summer diarrhoea in East Hampton and Sag Harbor, L. I., that resisted all treatment and caused the death of several children, to infected milk from a cow that had a sore udder from cow pox, which the farmer was not aware of. When the milk was discontinued the children improved, but when it was resumed they immediately became ill again. The separation of this cow from the herd and sterilizing of all milk utensils put a stop to the disease. He had cultures made from this cow's sores, and the bacteria were identical with those found in the stools of the infected children.

A most suggestive and important article has appeared in the *New York and Philadelphia Medical Journal*, since the preparation of this paper has been under way, by Dr. D. L. Edsall, a staff member of the Episcopal Hospital, Philadelphia, entitled, "The Influence of Infected Milk in the Diet of the Sick, etc."

Dr. Edsall found twenty-eight cases of typhoid in the men's wards on entering his service April 1st; sixteen cases were in the acute stage. Six of these had persistent diarrhoea and resisted ordinary treatment, while most of the others had "loose bowels." All had other abdominal symptoms, such as colicky pains, distention, nausea, etc. The character of the illness was more serious than is common in an equal series of cases, and the conspicuous features were the marked abdominal symptoms: four of the patients had dangerous hemorrhages and three others had moderate hemorrhage. The milk was suspected as a probable cause and a careful examination was made chemically and bacteriologically. The findings were fat and proteids up to the standard and free from preservatives. The bacteriologist re-

¹Read before the Rockland County Medical Association, April 19, 1905.

²See Oct., 1904, No. N. Y. STATE JOURNAL OF MEDICINE.

³17th An. Rept. Bur. Anim. Ind., 1900—R. A. Pearson.

ported the bacteria uncountable after twenty-four hours in a 1 to 10 dilution—"the number, therefore, being at least several millions to the c. c." The milk diet was stopped, the diarrhœa modifying at once, and subsequently only Pasteurized milk given. "In the three and one-half months after Pasteurization there were in ninety-two cases three severe hemorrhages and two mild ones * * * and abdominal symptoms seemed to have vanished.

"The darkest corner of the earlier picture is shown by the record of deaths. Among forty-six cases admitted to the men's wards previously there were three in which death was caused by exhaustion following severe diarrhœa, distention and other abdominal symptoms, that developed in the hospital. Among the ninety-two cases referred to there were no cases in which abdominal symptoms could be said to have been even important contributory causes of death.

"That such milk infection, even if mixed, is a serious matter when a grave disease is already present needs no demonstration."

These facts depend upon the results of accidental and preventable contamination, viz., that due to ignorance, carelessness or wilful negligence on the part of milker or dealer. (Read report from Rhode Island.)

The following cases, quoted from a paper read by a late New York State cattle inspector before the American Veterinary College a year or two ago, entitled "Tuberculosis—a Contagious Disease," show how diseased animals may infect human beings:

"Dr. Demme, of the Child's Hospital at Berne, records the case of four infants without any tubercular ancestry, that died of intestinal and mesenteric tuberculosis as a result of feeding on the unsterilized milk of tuberculous cows.

"Mr. Howe, of North Hadley, Mass., lost his only child, a strong, vigorous boy of one and one-half years, who paid a week's visit to his uncle, and fed on the milk of the cow which was shortly after condemned and killed with generalized tuberculosis. In six weeks from his return home the child was ailing, and in three months he died, a mere skeleton, with abdominal tuberculosis.

"Some year or two ago, Colonel Beecher, of Yonkers, lost his child from tubercular meningitis, and then found that the two family cows were the subject of advanced tuberculosis.

"On a farm in central New York during the past two years nineteen cows out of twenty-six were condemned as tuberculous; and it transpired that the farmer's wife and her father had both died of tuberculosis some time before, and two sisters and one brother of deceased wife had perished of this same disease—tuberculosis. Father and daughter both habitually attended to the cows.

"The Gromwal family, of Long Island, N. Y., suffered the loss of 139 cows with tuberculosis, a herd of swine, fowls, dogs and cats, of which

Dr. Faust made a post-mortem examination, and reported to the board of health; also, in his report he states the loss of a three-year-old child; and since the investigation two of the sons, grown up, have died of tuberculosis. No consumption was known in the family from either parent."

The quality of most foods can generally be judged by their appearance. This is not the case with milk. Some people think it a simple matter to judge the quality by its odor, color, taste, keeping properties and the (visible) sediment, but such is not the case, and milk of an actually dangerous character may not differ in appearance from the pure article. It may look the same whether it contains 200 or 200,000 bacteria to the c. c., and conform to the standards of fat and total solids required by law. It is impossible for the consumers of milk to personally inspect the source of supply. It is believed from experience that many milk producers and dealers would improve their methods if they appreciated the importance of so doing and were told just where and just how to make the necessary improvements. Many farmers and operators of some inferior dairies really do not know what is meant by a *clean* dairy.

Our water supply everywhere is safeguarded by most stringent laws which local and State boards of health enforce energetically. Public sentiment would not tolerate the public water supply being polluted by disease-bearing germs and disseminating typhoid and scarlet fevers, diphtheria, diarrhœal diseases and tuberculosis; yet milk, the most important of our foods in early life, is the dirtiest of all foods, and principally good for food purposes in the raw state.

Creameries and cheese manufacturers have standards which farmers have to comply with, but in the absence of the local or State regulations such milk as these men would reject as unfit for commercial purposes can be sold for home consumption without let or hindrance, carrying sickness, disease and often death to the innocent and defenseless children of our homes.

Bulletin No. 46 (1903) U. S. Dept. Ag. states there are laws governing the marketing of milk in thirty-five States; and in nine others there are pure-food laws bearing upon the milk supply. In twenty-six States there are officials whose special duty it is to enforce the laws. Almost every city and many towns and villages have ordinances or board of health regulations concerning the milk supply.

The solution of this problem lies in proper laws and public officers empowered and paid by the State to enforce these ordinances for pure milk and pure foods. Such a law as the State of Montana has affords the necessary protection to the public. There the whole matter is out of local influences, where personal equations cannot enter as political or other factors.

I wish to quote from a paper read before The New York State Medical Association meeting

of 1903, by Dr. George W. Goler, Health Officer of Rochester, N. Y., on "The Influence of the Municipal Milk Supply Upon the Deaths of Young Children":

"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 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 and those between 1 year and 5 years for the city of Rochester, N. Y., between 1891 and 1896 were as follows:

BEFORE MUNICIPAL REGULATION OF MILK SUPPLY.

Years.	Deaths Under 1 Year.	Deaths Under 5 Years.	Total.
1891	539	240	779
1892	589	374	963
1893	483	279	762
1894	391	241	632
1895	415	170	585
1896	462	192	654
Total	2,879	1,496	4,375

"The deaths in children under 1 year and those between 1 and 5 years between 1897 and 1902 were as follows:

AFTER MUNICIPAL REGULATION OF MILK SUPPLY.

Years.	Deaths Under 1 Year.	Deaths Under 5 Years.	Total.
1897	316	142	458
1898	354	128	482
1899	305	178	483
1900	333	165	498
1901	288	155	443
1902	291	108	399
Total	1,887	876	2,763

"In the last period of six years 992 fewer children died under 1 year, and 620 fewer children died between 1 year and 5 years. The diminution in mortality for the last period over the second period is 65 per cent. for children under 1 year, 58 per cent. for children between 1 year and 5 years.

"In the first period from all causes more than 28 per cent. of children died under 5 years; in the last period 19.5 per cent. of children died under 5 years.

"Milk, the chief, most necessary and most perfect food for children, is the dirtiest of all foods. After it becomes dirty, as it usually does, from barnyard filth, street dust, etc., no process of filtration, Pasteurization or sterilization can possibly make it a fit food for infants. For these reasons, milk, for infants at least, should be clean at its source."

I have been informed by gentlemen who are in the position to know whereof they speak, that tuberculosis in cattle comprising the dairy cows supplying milk dealers in Rockland County is quite prevalent. As you know, the law of State inspection was repealed some years ago—and perhaps rightly—owing to some of the abuses it gave rise to, and the hardships it imposed on others. It became known that certain unprincipled farmers deliberately bought tuberculous cattle for the purpose of having them condemned by a

State inspector and getting the allowance provided by law for their destruction. Then other men who had high-priced herds would have a lot of valuable animals destroyed because of slight reactions to the tuberculin tests, whose cattle had the "laboratory" disease but not the clinical entity—viz., a slight lymphatic gland involvement would give a tuberculin reaction, whereas no possible danger could accrue to others of the herd or to the tainting of the milk.

The justness of compensation to a farmer for destroying his infected cattle cannot be passed upon here, but strict equity as other parts of the public health law in maintaining quarantine for the protection of the public health in preventing the spread of contagious diseases seems as if some such provision should be made by the State. As it now stands no regular State inspections of cattle are made unless complaint is made of cases reported direct to the State. This allows of the diseased cattle remaining and infecting others until they get so emaciated from disease as to become unprofitable milk producers, when they are often disposed of for other purposes.

Years ago one of the sights of the city around the Grand Central Depot in the small hours of the early mornings when the milk trains on the Harlem road arrived were fights of the milkmen to get to the hydrants first. I have been informed recently that a gallon of milk is removed from the forty-quart cans and water substituted on some of the ferries in New York City to-day. These and other abuses have forced the authorities to enact laws that now give New York City the best milk any city in the world gets to-day. The fight recently that a gallon of milk is removed from the no railroad will accept milk for transportation from producers anywhere in the State unless the New York City regulations are complied with.

Health Officer Darlington and Chief Inspector Raynor have been through the State within a couple of weeks securing the cooperation of State and city health boards towards hunting down unsanitary dairies up the State and the clipping from the New York *Tribune* of April 12th tells the tale:

"Health Commissioner Darlington has entered into combination with Health Commissioner Greene, of Buffalo, and Commissioner Wheatling, of the State Agricultural Department, to reach all the milk dairies of the State. While Dr. Darlington has no real power outside of New York City, the authority of Commissioners Greene and Wheatling is aiding him materially through the State. Through these three men the disease-breeding milk dairies are rapidly being suppressed. Only a few cases need stringent measures, Dr. Darlington declares, as the dairy-men seem ready to remedy the defects as soon as they are pointed out.

"Our object is not to put men out of business," said Dr. Darlington yesterday. "A large

part of the trouble with the dairies arises from ignorance on the part of the owners and managers. There is now a bill before the Legislature providing that all superintendents of dairies must hold licenses. When they conduct their dairies in such a manner as to threaten the health of the consumers the measure will provide for the revocation of their licenses.'"

I wish to mention more specifically causes of milk becoming tainted and unwholesome, and suggest rational measures within the means and reason of all engaged in the production and marketing of milk.

First, What is the cause of bad milk? All will agree it is largely chemical changes. Why? These can only occur because the nature or character of the substance is possible for such to result, and the conditions favorable for such changes.

"The physical constitution of milk is well adapted to promote the active growth of many living organisms if they are once introduced, and the chemical composition of milk is also favorable to germ activity.

"All the surroundings of the animal are teeming with germ life. From the time of milking until it is removed from the barn it is continually exposed to conditions that permit of its being infected.

"A serious source of contamination of milk always comes from the animal herself. Drawn as milk usually is, in an open pail, the opportunity for entrance of loose hairs, particles of excreta, fine dust, epithelial scales and fodder particles could not well be improved. Every hair of the animal's coat is laden with dormant germ life. It may be thought that straining the milk removes this source of filth. So it does the *visible*, but not until the invisible living germs have been washed off into the fluid, there to set up the various fermentations that they are capable of producing. The kind of organisms that gain access to milk from this source is, generally speaking, thoroughly undesirable. They are largely fecal bacteria derived from decomposing animal excreta, which will produce diarrhœas in delicate infants and individuals. It will be seen dirty stables, un-groomed hides, unwashed udders, all contribute to the pollution and poisoning of what should be *good milk*.

"Cows wading in stagnant water in midsummer often cover their bags and flanks with slimy deposits that dry on, and in this condition particles of dust are readily dislodged.

"The custom of leaving the milk in the barn even during the milking is a practice that should be thoroughly condemned. It readily absorbs the odors and dust particles that contribute their quota of bacterial life. And dirty vessels are a most prolific source of trouble. Care should be exercised in selecting utensils with seams and joints that can be properly cleaned. The custom of returning in the cans the by-products of the

factory—garbage, etc.—is a source of much trouble. Not only washing thoroughly is insufficient, but sterilization with boiling water or steam is necessary to prevent polluting fresh milk.

"The proper treatment of milk does not stop with the securing of it in as near its original purity as possible, but it must be handled in such a way as to retard the development of bacteria that may find their way into it. As it comes from the animal, it has a high temperature—approximately blood heat. At this elevated temperature germ growth takes place with surprising rapidity, and unless the animal heat is artificially lowered and the milk kept chilled, various fermentations are rapidly set up in it as a result of different bacterial forms. The greatest danger that arises from a diseased milk supply comes from the poison-forming bacteria that get into it through improper handling. The cases of ice cream, cheese and milk poisoning, and the high mortality of bottle-fed infants, are in large part due to the poisons formed by putrefactive changes that take place in milks that are produced by careless and filthy methods of handling. The length of time required to produce these changes depends upon the temperature mainly at which the milk is kept."

REPORT.

Dairy No. 1.—Five cows; milk sold, eighteen quarts; stable very poorly lighted, and no ventilation excepting when door or windows are opened. Two horses are also kept in same barn alongside of cows, all very closely crowded together. Condition of stable exceedingly dirty and emits strong odors of animals. Manure allowed to accumulate on floor. Animals' flanks covered with dried excreta. Hides never groomed or udders cleaned before milking. Water for animals is obtained from a cistern in lower part of stable collected from roof of the barn. The yard is covered with manure and stagnant water close to the stable. The milk is not cooled at all, excepting in hot weather. Taken from the barn to the house, some distance away, it is strained and immediately delivered to customers in tin cans, retaining the animal heat. The utensils are taken care of by the housewife in as careful and cleanly manner as is necessary. Night milk is set in pans on a shelf in the cellar without being cooled, and is exposed to odors of vegetables and foods usually kept in a farmhouse where no refrigerator is used.

In summer the milk is cooled with pump water. This milk is sold to a number of select families, principally because it is considered "good farm milk fresh from the cow."

Dairy No. 2.—Cows in service, twenty to twenty-five; milk sold, ninety quarts daily. Cows look in poor condition; are found in a large stable yard completely filled by the winter's accumulation of manure, banked high around the sides of the stable, the basement of which is used for two rows of stalls, with a central passageway for feeding.

This stable has absolutely no light on three sides, or ventilation, and the roof, being the main barn floor, is but a few feet from the animals' backs, covered with dust and cobwebs. The barn floor where the animals are stalled is vilely dirty; the flanks and tails of the animals covered with masses of dried excreta; no grooming or cleaning of udders is ever done, and milkers do not wear protectors or wash their hands. Milk cooled in tub of water after being collected in the stable and strained, and can immersed in a well 200 feet from house. Milk utensils appeared to have been fairly well taken care of. Night and morning's milk sold to dealer, who takes every precaution after it reaches him by further cooling with ice, strained again, and bottled.

Dairy No. 3.—At present only two cows; selling ten quarts of milk, which is cooled in a stream of water, afterwards taken to the house, where it is kept in a cellar and sold from tin pails to customers some miles away. The animals are stabled in the basement of a barn, with horses, pigs and fowls, and a dirtier place could hardly be imagined. The stench from the mixture of odors from the combination was beyond endurance, yet the milking was done in this stable, where sunlight and air were almost strangers, and where the state of the animals was scarcely more inviting.

Dairy No. 4 comprises about fifteen well-kept cows, producing between eighty and ninety quarts of milk for sale, besides what was fed to calves and used in the household. The barn is new, built for the purpose, well lighted and ventilated. The cattle are well fed, and the manure pile is a respectable distance from the barn. The well is a reasonable distance from dangers of surface drainage. The milk is cooled immediately and placed in the well until taken to the dealer. Cans are properly cleaned. Only one thing was lacking to make this an up-to-date dairy, and that is keeping the cows' flanks and tails free from accumulated excreta and grooming the hides, cleaning off the udders and not allowing the animals to feed while being milked to raise unnecessary dust. The stalls might with reason be also a little better kept. Otherwise this man's herd was very good. He took me to see his horse stable in an adjoining building, where the animals were well groomed and the stalls and stable in splendid condition. I wondered if he would like to drive one of those manure-plastered cows to his well-kept carriage! Yet the care of his cattle's skins is infinitely more important than grooming his horses.

None of the cattle anywhere I have seen have been inspected for tuberculosis within the knowledge of the owners.

Through the courtesy of Mr. H. H. Law I was invited to visit and inspect a celebrated dairy farm where over 1,300 cows are kept for dairy purposes. The details of my visit, although interesting, would prolong this paper beyond a rea-

sonable length. Let me say, however, that nothing is done there that is not possible to carry out in well-kept dairies. The keynote is absolute cleanliness. The barns are kept clean, the cows curried, the udders wiped with a damp cloth before milking, the men put on overclothes and caps and wash their hands, which is repeated after every cow is milked. The cattle are not allowed any dry feed during milking, and no one is allowed inside the cow barns while milking is being done. This milk is strained after collected from each cow into a large can, which is immersed in ice-water. The strainer is several folded pieces of cheesecloth and absorbent cotton, which is washed and boiled and used but once. The milk is taken to the bottling house and there bottled under the strictest sanitary and sterile conditions. Each week a sample from each barn is examined by the chemist and bacteriologist of the New York City Milk Commission of the County Medical Society and, if more germs are found in it than are wholesome, and the superintendent is unable to eliminate the trouble in three weeks, he is dismissed as incompetent.

This milk brings 15 cents per quart on the New York City market, and the demand is greater than 1,300 cows can produce on 6,000 acres of land.

REPORT OF THE MILK COMMISSION.

NEW YORK, Feb. 27, 1905.

The counts of the milk sent by you last week for examination are as follows:

Herd	11,800 colonies per c. c.
" by collector.....	2,700 " "
Barn "B"	700 " "
Barn "D"	3,300 " "
Barn "E"	3,800 " "
Barn "F"	1,400 " "

NEW YORK, Nov. 28, 1904.

The counts of the milk sent by you last week for examination are as follows:

Herd	3,150 colonies per c. c.
" by collector.....	4,600 " "
Barn "B"	950 " "
Barn "C"	300 " "
Barn "E"	1,500 " "
Barn "F"	1,200 " "
East Side special sample.....	5,360,000 "

A test for butter fat gave as follows:

Herd	5.70 per cent.
East Side sample.....	4.20 "

I have communicated with the boards of health of Rochester, Buffalo, Syracuse, Oneonta, the State Department of Health, Albany; with practical men like Dr. E. F. Brush, the dairyman-farmer, physician and mayor of Mt. Vernon, N. Y., and Dr. Thomas Morgan Rotch, of Boston, for suggestions in this matter of our milk supply. The whole subject can be best explained by the Albany authorities, which I wish to read.

I have also consulted Chief Inspector Raynor, of the New York City Board of Health. I have examined chemically a number of samples of milk

gotten from the dealers selling it in Nyack, all of which I found conforming with the standards of fats, proteids and solids required by the State law.

APRIL 8, 1905.

No. 1.....1.032	50° F.	3.6	$\left\{ \begin{array}{l} 7.75=\frac{1}{4} \text{ sp. g.} \\ .72=\frac{1}{5} \text{ fat.} \\ \hline 8.49=\text{solids not fat.} \\ 3.60=\text{fat.} \\ \hline 12.09 \text{ total solids.} \end{array} \right.$
Corrected sp. g...1.031			
No. 2.....1.032	50° F.	3.6	$\left\{ \begin{array}{l} 12.09 \\ \text{Same as above.} \end{array} \right.$
Corrected sp. g...1.031			
No. 3.....1.0335	50° F.	fat 3.6	$\left\{ \begin{array}{l} 8.18=\frac{1}{4} \text{ sp. g.} \\ .72=\frac{1}{5} \text{ fat.} \\ \hline 8.85=\text{solids not fat.} \\ 3.60=\text{fat.} \\ \hline 12.45 \text{ total solids.} \end{array} \right.$
Corrected sp. g...1.0325			
No. 4.....1.034	56° F.	fat 3.8	$\left\{ \begin{array}{l} 8.40=\frac{1}{4} \text{ sp. g.} \\ .95=\frac{1}{6} \text{ fat.} \\ \hline 9.35=\text{solids not fat.} \\ 3.80=\text{fat.} \\ \hline 13.15 \text{ total solids.} \end{array} \right.$
Corrected sp. g...1.0336			

REGULATIONS AND RULES FOR THE PRODUCTION AND SALE OF MILK IN ROCKLAND COUNTY, NEW YORK.

1. No person shall sell or exchange, or offer or expose for sale or exchange, any unclean, impure, unhealthy, adulterated or unwholesome milk or cream, or any article of food made from such milk or cream.

The term "Adulterated Milk" shall be construed to cover milk containing more than eighty-eight per centum of water or fluids; or less than twelve per centum of milk solids; or less than three per centum of fats; or drawn from animals within fifteen days before or five days after parturition; or drawn from cows kept in a crowded or unhealthy condition; or milk which has been diluted with water or any other fluid; or to which has been added or into which has been introduced any foreign substance whatever; or milk that contains a higher bacterial count than 50,000 germs per cubic centimeter; or at a temperature above 55° F.

2. No person shall deliver, sell, offer for sale, or have in possession for the purposes of sale, any milk or cream in glass jars, unless said jars have been thoroughly washed and cleaned before being last filled; and no person shall keep milk or fill glass jars with milk in any barn or stable or on any public street or place.

3. No person shall keep milk in a living or sleeping room or in any room that is not kept clean at all times, or in which the plumbing is not constructed in accordance with the plumbing code of the municipality; or keep milk in any cans not made of well-tinned iron with inner surfaces smooth and free from rust; or fail to report to the health board any case of contagious diseases on the premises where milk is produced or sold; if the cellar is used for storage purposes that portion shall be partitioned off and used for no other purpose, and shall be properly ventilated, lighted and dry.

4. *Handling, Care and Marketing of the Milk.*—Remove the milk of each cow from the stable as soon as drawn, to a milk-room where the air is pure and sweet. Milk cans must not be filled in the stable or be there for any purpose. The milk must be strained through a metal gauze and flannel cloth or layer of cotton, as soon as drawn, aerated and cooled as soon as strained. Cool as rapidly as possible—at least within fifteen minutes after being drawn—to a temperature of fifty degrees or lower. In hot weather bottles should be packed in ice during delivery. Ice must not be placed in milk, and the milk should not be allowed to freeze. No preservative or other substance shall be added to milk for any purpose, and no part of the milk shall be removed. All utensils used for filling jars shall be scrupulously clean, and milk spilled in the process of filling shall not be put into them. No milk shall be sold which is more than twenty-four hours old. Delivery wagons shall be cleaned frequently, and during warm weather the inside shall be washed daily. No empty bottles, milk tickets or checks shall be taken from houses where any contagious disease is known to exist. After the removal of the quarantine the bottles and all tickets and checks in possession of the family or families shall be collected by some one other than the person delivering the milk to the families, and by vehicles not used for the purpose. All tickets in possession of the family shall be taken up and exchanged for new ones. Tickets taken from premises where contagious disease has existed must be burned and the bottles sterilized by boiling for 30 minutes, or steam before being put into service again. All tickets, checks and labels shall be new when delivered to customers, and none shall be used a second time.

5. *Care of Stables and Cows.*—The stables shall be well ventilated, lighted, drained and dry. They shall be whitewashed at least twice a year. The trenches shall be cleaned at least twice a day during the stabling season; the manure to be at once removed from the stable to a distance of at least one hundred and fifty feet.

The cows used for the production of milk shall not be housed in any barn or portion of a barn used by other animals, fowls, etc.

No hay or dusty forage or bedding to be shaken up,

Yet I am satisfied the conditions of dairies need radical changes to produce healthful milk, and I believe all those now engaged in the business can be enlisted in the good cause and depended upon for hearty cooperation if we submit our suggestions and have the different local health boards make such regulations that any common-sense farmer (who can be shown how to do it), to take the necessary care of his cattle, stables and milk, which will prevent these common contaminations I have brought to your notice here today. This must be done by licensing the vendors and having them sign a contract to see that their milk producers live up to the local board of health regulations governing the production and sale of milk. The dealers themselves should organize and not buy from farmers who refuse to comply with these ordinances, the same as the railroads of the State who now refuse all milk from a producer the New York Milk Inspection reports as unwholesome.

I recommend the regulations of Milk Commission of New York City, Rochester or any similar ordinances, or modifications of such, for adoption by our local health boards, and trust a resolution to this effect may meet the approbation of this Association to-day. If so, I will be well repaid for the efforts I have made in this direction; but whatever regulations are adopted by boards of health must be comprehensive, and first submitted to the State Department of Health at Albany to have the legal points passed upon that will prevent any effective legal opposition from interested parties or expense in defending the same.

In closing, I wish to acknowledge the assistance I have had from the gentlemen I have named, also to Mr. M. Deming, for assisting in testing the samples, and to the farmers' bulletins of Wisconsin and U. S. Dept. Agriculture, and H. A. Boyd, for valuable suggestions and assistance in framing the regulations.

fed, or distributed in the stable until after the cows are milked. The cows shall be supplied with plenty of pure, wholesome water, and their flanks and tails shall be kept free from all excreta. The udder shall be wiped off thoroughly with a damp cloth immediately before milking.

No milk shall be sold from a sick animal or from one suffering with a contagious or infectious disease. It shall be unlawful to buy or sell an animal for the production of milk who is suffering from a contagious or infectious disease.

6. *Permit to Sell.*—No person, persons or association shall sell, offer or have for sale any milk of any kind or description in any quantity whatsoever, within the limits of the county or municipalities without first obtaining a license from the local boards of health.

A license fee of two dollars shall be charged for each license issued.

Such licenses shall expire on the first day of May next after issue, but no such license shall be issued without the applicant having first obtained a permit from the Department of Health to engage in the milk business pursuant to the provisions of this ordinance.

This section shall not apply to storekeepers who do not peddle milk, but dispense the same solely upon their premises, provided such milk is obtained from a duly licensed milk dealer, and kept at a temperature of 50° F., and otherwise conform to requirements and regulations.

No licensed dealer shall furnish milk to be sold by any storekeeper unless said storekeeper complies with all the provisions of this chapter governing the sale and sanitary protection of milk, and such sale may be forbidden at any time by the health officer in the interest of the public health.

Each and every such license and permit shall expire on the first day of May next after its issue, and every violation of the provisions of this section shall subject the person, persons or association violating the same to pay a penalty of not less than ten nor more than fifty dollars.

7. Every dealer in milk who uses in his business a wagon, cart or other vehicle shall, during the months of May to September inclusive, have and keep upon said wagon, cart or other vehicle, a covering of canvas or other material so as to securely protect the contents from the rays of the sun, and every such dealer shall, during the months of June, July and August, carry in such vehicle a sufficient quantity of ice to prevent heating of the milk. Said covering shall be a clean tarpaulin, and not a blanket, etc.

Nor shall any dealer in milk or his agents serve milk in bottles to any dwelling that has in it any contagious disease, or that is placarded by the Department of Health for contagious diseases until said placard has been removed by the proper authorities.

Milkmen violating the ordinances governing the sale of milk shall forfeit their licenses.

All dairy utensils, pails, dippers, cans, bottles, everything in fact into which milk is put directly, shall be cleaned by first thoroughly rinsing them in warm water; then cleaning them inside and out with a brush or cloth and hot water in which some cleaning material has been dissolved, then rinse and sterilize with boiling water or steam. Use only pure water. After cleaning utensils keep them in a clean place away from dust and in the season of flies covered with mosquito-netting. Tin utensils in which parts of the tin are worn off should not be used. Sterilize brush and cloths used for cleaning by boiling daily, and oftener if necessary. Sponges for cleaning utensils must not be used.

Milk Inspectors.—The milk inspector's first duty after appointment shall be to visit each dairy, retailer, milk market, milk depot and all other places where milk is produced or handled for human consumption in Rockland County, and present to the owner or proprietor of such places a copy of the rules and regulations adopted by the different boards of health, also a blank application for license.

The inspector shall make note of any conditions which are not in accord with the standard requirements, and

transmit the same to the commission, together with any suggestions for their correction.

The inspector shall give every cow or other bovine animal over six months old, at each dairy visited, a physical examination, and if upon such examination he is suspicious of tuberculosis or any other infectious or contagious disease, general or local, being present, he will at once report the same, with the name and address of the owner, to this commission and to the Department of Agriculture at Albany.

The inspector shall keep in a book for the purpose a correct account of all animals examined for future reference.

Inspectors, before entering upon their duties, must be provided with a "Feser's lactoscope" or other suitable apparatus for making optical tests; these tests must be made at each dairy, and the inspector may take therefrom samples properly sealed and labeled for analysis.

In as far as possible, it is deemed advisable that the inspector will make his visits to the places requiring his attention without the knowledge of the owner that he is coming, and he shall be allowed access for this purpose at any time.

It shall be unlawful for any milk inspector, his servant or agent in the County of Rockland, to wilfully obstruct or assist in the violation of any rule or regulation adopted by the Rockland County Milk Commission or the Health Boards of the county. And whoever hinders, obstructs or interferes with any milk inspector or his servant or agent in the performance of his duty shall be guilty of a misdemeanor.

Inspectors are hereby empowered to enter any or all premises, vehicles of all kinds used for transporting milk, barns or stables used for housing bovine animals, milk houses, milk rooms or cellars used for keeping or storing milk, at any time for the purpose of examination of cows or other animals, sanitary conditions of buildings, feed, water, utensils used in handling milk, care of same while being drawn, stored or en route to wholesaler or consumers, to see that the rules and regulations of boards of health are being complied with.

All tuberculin tests shall be made under the supervision of an inspector, and the results reported at once to this commission or the Board of Health of the municipality.

Inspectors must familiarize themselves with the location of all dairies, milk markets, milk depots, or other places where milk is produced or handled for human consumption, and visit the same as often as required, at least twice in each year, to see that the rules and regulations of the Health Boards are complied with.

Inspectors are at all times responsible for their acts to this Commission and Health Boards who appoint him or them, and before entering upon their duties must file a satisfactory bond.

APPLICATION FOR LICENSE.

To the Board of Health of the village of.....
N. Y.

I herewith make application to your board for a certificate as provided for in the rules and regulations of the Board of Health of your village.

The conditions under which the milk is produced, cared for and marketed, and under which it is to be produced, cared for and marketed, are in strict compliance with the conditions required by your Board for the certificate and sale of milk in your village.

To the Commissioner of Agriculture:

I hereby apply for a license to act as agent or person in charge of a milk gathering station or establishment where milk is bought or received from dairymen for the purpose of selling the same for consumption or shipping the same for consumption as food. My name is.....
My post-office address is.....My residence is in the town of....., county of....., State of.....
The milk gathering station or establishment in which I desire or expect to work during the coming season

is the....., situate in the town of....., county of....., State of New York. My age is.....

The statements above set forth are in all respects true.
.....
(Signature of Applicant.)

State of.....
Town of..... } ss.
County of..... }

being duly sworn, deposes and says, that he is the person whose application is above set forth for a license to act as agent, and he will not, during the time he is acting as such agent or person in charge of any such establishment, adulterate or suffer or permit the adulteration of any milk or any product thereof which comes directly or indirectly under his control.

Subscribed and sworn to before me this..... day of190..
.....
(Signature of Affiant.)

This is to certify that..... above named is a person with whom I have been acquainted for..... years, and a man of veracity and good moral character.

PERSONS HAVING CHARGE OF MILK GATHERING STATIONS OR ESTABLISHMENTS, SANITARY CONDITIONS, ETC.

AN ACT

To amend the agricultural law, in relation to the licensing of persons by the commissioner of agriculture and the powers and duties of such commissioner. Became a law May 24.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section thirty-two of chapter thirty-three of the general laws, known as the agricultural law, as amended by chapter one hundred fifty-three of the laws of eighteen hundred ninety-eight and chapter one hundred and sixty-eight of the laws of nineteen hundred and four, is hereby amended to read as follows:

Sec. 32. Unclean receptacles and places for keeping milk; notice to violators of provisions. No person, firm, association or corporation, producing, buying or receiving milk for the purpose of selling the same for consumption as such, or for manufacturing the same into butter, cheese, condensed milk, or other human food, shall keep the same in utensils, cans, vessels, room or rooms, building or buildings that are unclean or have unsanitary surroundings or drainage, or in any condition whatsoever that would tend to produce or promote conditions favorable to unhealthfulness or disease. The commissioner of agriculture shall notify all persons, firms, associations or corporations, violating this section, to clean said utensils, cans, vessels, room or rooms, building or buildings, or to so improve the sanitary conditions that the law will not be violated, and if such notice is complied with in ten days' time, Sundays excepted, then no action shall lie for a violation of this section. Any person or persons having charge of any milk gathering station where milk is bought or received from the dairymen for the purpose of selling the same for consumption or shipping the same to market for consumption as human food before taking such charge or operating or working as such agent or person in charge shall apply to the commissioner of agriculture for a license to so work or operate or have charge, and shall at the time of making such application, file with the commissioner a statement under oath, setting forth the fact that he will not, while having charge of or operating any such milk gathering establishment or while employed therein adulterate or suffer or permit the adulteration of any such milk or any product thereof during the term for which he may be licensed. After the applicant shall have complied with the foregoing provisions of this section, the commissioner of agriculture upon being satisfied that the applicant is a person of good moral character and a qualified and proper person to so have charge of or operate any such milk gathering station or establishment shall issue to said applicant a

license which shall qualify him to have charge of any such milk gathering station or establishment for the period of two years from the date of such license. Any person or persons having charge of any milk gathering station or establishment as aforesaid, shall keep a true and correct daily record of the receipts of milk or other dairy products received at such station or establishment and a true and correct daily record of all sales or shipments of milk, cream and dairy products shipped or sold from such station or establishment. Which record shall be preserved at such station or establishment for at least two years after the same shall have been made and such records shall at all times be open to the inspection of the commissioner of agriculture or his assistants. If any such persons so duly licensed shall thereafter violate any of the provisions of the agricultural law relative to milk or the products thereof he shall forfeit his license and shall be disqualified for a period of five years from being again licensed by the commissioner of agriculture. The commissioner of agriculture shall have the power to issue subpoenas to be attested by him in his official capacity to any person or persons whom he may have reason to believe has knowledge of any alleged violation of the agricultural law, to appear before him or any of his assistant commissioners of agriculture for the purpose of investigating alleged violation of the agricultural law. Any person or persons who shall omit, neglect or refuse to obey subpoenas attested in the name of the commissioner of agriculture or who shall refuse to testify under oath before the commissioner of agriculture or his assistant commissioners of agriculture, is guilty of a misdemeanor. The commissioner of agriculture and his assistant commissioners of agriculture are hereby authorized and empowered to administer oaths and affirmations, in the usual appropriate forms, to any person or persons in any matter or proceedings authorized as aforesaid and in all matters pertaining or relating to the agricultural law and to take and administer oaths and affirmations, in the usual appropriate forms, in taking any affidavit or deposition which may be necessary or required by law or by any order, rule or regulation of the commissioner of agriculture for or in connection with the official purposes, affairs, powers, duties or proceedings of said commissioner of agriculture or his assistant commissioner of agriculture or any official purpose lawfully authorized by said commissioner of agriculture. The commissioner of agriculture or his assistant commissioners of agriculture shall have the power in proper cases to issue subpoenas duces tecum. Such subpoena or subpoena duces tecum may be served by any person over the age of twenty-one years. Any person who shall make any false statement under oath before the commissioner of agriculture or his assistant commissioners of agriculture is guilty of perjury.

Sec. 2. This act shall take effect immediately.

ALBANY, March 18, 1905.

S. W. S. TOMS, M.D., Nyack-on-Hudson, N. Y.

Dear Sir—I am in receipt of your communication of the 9th inst. referring to the action proposed to be taken by the County Medical Association in the matter of preventing the contamination, etc., of the milk supply, and requesting suggestions as to the powers of local boards of health in such matters.

It is suggested that one of the most valuable means of controlling a milk supply is for the Board of Health of a municipality to license the dealers in that commodity, the issuing of a license to be based upon the necessary proof furnished that the cows are in a healthy condition and are properly housed and fed; also that the utensils used are kept in a cleanly condition at all times.

Buffalo, Rochester, Utica, Syracuse, Oneonta and several other municipalities in the State have adopted regulations governing the milk supply of their various municipalities, and it might be well for your society, or the Board of Health of Nyack, to secure copies of regulations from the places named, from which, rules proper for Nyack could be formulated.

While the Board of Health of Nyack could not extend its powers beyond that municipality as to inspections of dairies, etc., this department will be pleased to designate one of the local officers a State inspector (without compensation from the State), which would enable each inspector to visit and inspect such dairies located outside of Nyack as are supplying milk to that village.

Very respectfully,

DANIEL LEWIS,
Commissioner of Health.
By T. A. STUART, Chief Clerk.

ALBANY, April 8, 1905.

S. W. S. TOMS, Health Officer, Nyack-on-Hudson, N. Y.

Dear Sir—I am in receipt of your communication of the 5th inst., and note your statement that rules and regulations are being formulated for the control of the milk supply of your village, and also note your request to be furnished with a copy of the Penal Code and of the health law.

In reply you are informed that this department has no copies of the Penal Code for distribution. We have, however, sent to you under a separate cover a copy of the Public Health Law.

As to enforcing compliance with such rules and regulations as your Board may adopt, you are referred to Section 21 of the Public Health Law, which authorizes a board of health to "prescribe and impose penalties for the violation of or failure to comply with any of its orders or regulations, not exceeding one hundred dollars for a single violation or a failure, to be sued for and recovered by it in the name and for the benefit of the municipality; and to maintain actions in any court of competent jurisdiction to restrain by injunction such violations, or otherwise to enforce such orders and regulations."

Under the section of law above referred to your Board could prescribe a penalty of a fixed sum for the violation of such rules as it may adopt, and it could further provide that licenses issued to milkmen would be revoked, based upon such milkmen violating the rules of the Board.

Very respectfully,

DANIEL LEWIS,
Commissioner of Health.
By T. A. STUART, Chief Clerk.

ALBANY, July 19, 1905.

S. W. S. TOMS, M.D., Nyack-on-Hudson, N. Y.

Dear Sir—I am in receipt of your communication of the 10th inst., enclosing a copy of proposed rules and regulations governing the production and sale of milk in Rockland County, and note your statement that it is proposed to have such rules and regulations adopted by the different boards of health in the county named.

In compliance with your request I enclose herewith a license blank, also a copy of the law referred to in the newspaper clipping which was attached to your communication.

Notwithstanding the requirements of the State Agricultural Department, covered by Section 32 of the Agricultural Law, it would seem proper for the boards of health of the different municipalities of the State to adopt and enforce compliance with such rules and regulations as in your judgment would be necessary in order to secure the sale of pure and wholesome milk in their respective municipalities.

Very respectfully,

EUGENE H. PORTER,
Commissioner of Health.
By T. A. STUART, Chief Clerk.

Milk Commission Meeting, June 15, 1905.

The object of this meeting was to suggest regulations for adoption by the various health boards of the county in accordance with a proposition of the State Commis-

sioner of Health, for the control of the milk supply sold to patrons in the county. These regulations should meet with the fullest discussion possible, and to further this the Rockland County Milk Commission was composed of representatives from the two medical bodies, the health officers, and invited representatives from the milk dealers and a veterinarian.

They should be adopted in such form as to be suitable for rational and easy executive methods, as the machinery for enforcing them is not that of a large force which cities of the first class can command. At the same time they should be comprehensive enough to attain the ends sought in producing and marketing good wholesome milk for public consumption. It is not the purpose to impose on any one irksome burdens or hardships; at the same time, manifest abuses in carelessness, unsanitary methods, or deliberate adulterations are evils the Milk Commission was formed to prevent and correct. Much contamination of milk is preventable, and to show producers and dealers how this can best be done must of necessity be incorporated into regulations for their guidance.

I have carefully and patiently examined the various regulations in force in such places as Oneida, Syracuse, Buffalo, Rochester, Utica, and New York City, and find the Buffalo (N. Y.) code, when modified to suit our rural conditions, will be most practicable and comprehensive.

NEW YORK STATE ASSOCIATION MEETING.

The twenty-second annual meeting of the New York State Medical Association will be held on Monday, Tuesday, Wednesday and Thursday, October 16, 17, 18 and 19, 1905, at the New York Academy of Medicine, 17 West 43d street, New York.

The railroad fares are reduced by the Trunk Line Association on the certificate plan—*i. e.*, full fare going and one-third fare returning to those who have paid 75 cents or over for their going journey, provided that at least one hundred persons shall have paid fares as above and hold certificates from ticket agents at starting point and shall be certified by the Association.

It is requested that members desiring to read papers on any subject shall send the title of the paper to the chairman of the Committee on Arrangements, Dr. Frederic W. Loughran, 742 Prospect avenue, New York City, at once.

Papers should not exceed fifteen minutes' length in reading.

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, Little Falls.
Vice-Presidents—Seymour S. Richards, Frankfort.
Secretary and Treasurer—Edgar H. Douglas, Little Falls.
Committee on Publication—Edgar H. Douglas, William P. Earl, John L. Crofts.
Committee on Public Health—William D. Garlock, A. B. Santry, Charles H. Glidden.

JEFFERSON COUNTY MEDICAL ASSOCIATION.

President—Andrew J. Dick, Watertown.
Vice-President—Michael J. Lawler, Carthage.
Secretary—W. D. Pinsonneault, Watertown.
Treasurer—Charles Campbell Kimball, Watertown.
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Committee on Public Health—Park Lewis, William H. Thornton, Jacob Otto.
Committee on Membership, Ethics and Discipline—Allen A. Jones, Charles G. Stockton, Grover Wende.

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Committee on Ethics and Discipline—C. D. Graney, R. C. Conklin, Sophie Page.
Committee on Public Health—F. A. Neal, A. F. Miller.

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Committee on Ethics and Discipline—S. Case Jones, Peter Stockschlaeder, James C. Davis.

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Secretary—John W. Atwood, Fishkill-on-Hudson.
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KINGS COUNTY MEDICAL ASSOCIATION.

Borough of Brooklyn.
 Meets second Tuesday in January, April and October.
President—Arthur Conklin Brush, 29 South Portland Avenue, Brooklyn.
Vice-President—James Cole Hancock, 43 Cambridge Place, Brooklyn.
Secretary and Treasurer—Louis Curtis Ager, 70th Street and Third Avenue.
Executive Committee—H. M. Smith (1 year), J. C. Bierwirth (3 years), W. H. Steers (4 years).

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First Vice-President—Henry A. Dodin, 1194 Washington Avenue.
Second Vice-President—S. Busby Allen, 63 East 86th Street.
Secretary—William Ridgely Stone, 66 West 49th Street.
Corresponding Secretary—John Joseph Nutt, 2020 Broadway.
Treasurer—Charles Ellery Denison, 68 West 71st Street.
Executive Committee—Parker Syms (1 year), Frederick P. Hammond (2 years), Alexander Lambert (3 years).
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Committee on Ethics and Discipline—D. Bryson Delavan, Chairman; George David Stewart, Daniel S. Dougherty, Joseph Ellis Messenger, Edward L. Keyes, Jr.
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Committee on Public Health—W. J. Carr, Chairman; A. W. Preston, D. H. Sprague.
Committee on Medical Charities—C. W. Dennis, Chairman; W. I. Purdy, E. A. Nugent.
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Committee on Legislation—C. E. Campbell, A. N. Moore, W. Q. Huggins.
Committee on Membership, Ethics and Discipline—E. O. Bingham, H. H. Mayne, N. W. Price.
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Committee on Legislation—Darwin Colvin, J. F. Myers, J. M. Turner.
Committee on Membership, Ethics and Discipline—G. D. Barrett, M. A. Brownell, A. F. Sheldon.
Committee on Public Health—A. Warnecke, T. H. Hallett.

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Committee on Public Health—L. E. Stage, George H. Peddle, Mary Slade.
Committee on Legislation—Zera J. Lusk, Zina G. Truesdell, George M. Palmer.

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The New York State Journal of Medicine.



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EDITORIAL COMMUNICATIONS.

Articles for publication under Editorial Communications must be accompanied by the name of the author. No name will be used in the publication unless requested by the writer. All such articles can be sent to Dr. C. E. Denison, 68 West 71st street, New York City.

ANNUAL MEETING.

The annual meeting of The New York State Medical Association will be held on Monday, Tuesday, Wednesday and Thursday, October 16, 17, 18 and 19, 1905. A full program of the scientific session is given in this number of the JOURNAL. The question of amalgamation of the Medical Society of the State of New York and The New York State Medical Association will be the principal and most important subject of the business session. Every member should take an active interest in this momentous question and try to be present.

MEDICAL DIRECTORY.

The *Medical Directory* of New York, New Jersey and Connecticut, Vol. VII, 1905, is being bound as we go to press, and will be issued and delivered about the 1st of October, containing a complete list of all registered physicians in the three States, with the name, address, telephone number, office hours, college and year of graduation. Membership is given in all societies having a recognized standing in the profession, hospital and dispensary appointments.

The endeavor to make this the best *Medical Directory* published can be furthered by the members notifying the Committee on Publication of errors and omissions, and by showing your friends a copy, pointing out the value it is to you, and the great usefulness it may be to others.

ANNUAL DINNER.

The annual dinner of the Association will be held at the Hotel Astor, 44th street and Broadway. Tickets may be obtained from the chairman of the Committee on Arrangements.

UNION.

The editors of this JOURNAL have received several letters during the past winter relative to the question of union. A few have been published; others were returned with request to modify their statements, or at least make them acceptable for publication. It does not simplify union by awakening antagonism that was long ago buried. The strongest argument is a "square deal."

That both may be heard, and a State journal cannot be the organ of a clique, all that is said should be heard, if respectful, both sides having the same privilege.

In this number will be found the letter from the president and a letter from the opposition to union. The members of the Association will have this question to decide at the next annual meeting—October 16, 1905.

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 "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.

THE CORONER AGAIN.

"In a few hours Coroner Scholer arrived, and after talking to the manager of the hotel, the hotel physician, and viewing the room where the tragedy occurred, announced that Mr. Thompson had died of apoplexy, that his wounds were the result of striking his head against the bookcase beside which he was found. Some hours later it was learned that Dr. Scholer had rendered his opinion without having seen the body."—*N. Y. Times*.

The Coroner acted as New Yorkers have learned to expect these useless officials to behave. He furnished another and convincing argument in favor of the abolition of the office he holds.—*N. Y. Sun*.

MEETING OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Committee on Arrangements.

FREDERIC WILLIAM LOUGHRAN, M.D., Chairman.
742 Prospect Avenue.

NEW YORK, Sept. 12, 1905.

Dear Doctor—Will you not aid the Committee on Arrangements by sending me \$6 as a contribution to the Entertainment Fund, to be used by the committee for defraying the necessary expenses of the three luncheons and the dinner in connection with the annual meeting of our Association, to be held at the New York Academy of Medicine, October 16-19, 1905?

This request is made necessary by the fact that the Council of the Association feels that money to be expended for such entertainment should be met by voluntary contributions, rather than drawn from the treasury of the Association.

Subscribers to this fund will, of course, be entitled, without further charge, to a ticket for the dinner, which will be held, as usual, on Wednesday evening (October 18th). Ladies' tickets will be furnished to subscribers at \$4 each additional. In other words, those subscribing \$10 to this fund will be given a gentleman's and lady's ticket.

As favorable terms with the caterer and the manager of the hotel can only be made by the guaranteeing of the attendance of 200 persons, or more, an early and favorable response to this letter will be of great assistance, and it is also

necessary that the committee have the money on hand before signing agreements of this sort.

Sincerely yours,

FREDERIC WILLIAM LOUGHRAN, Chairman.

Have you answered?

The following circular letter has been sent to all members of the Association:

THE NEW YORK STATE MEDICAL ASSOCIATION.

SEPTEMBER 12, 1905.

Dear Doctor—This is to remind you that the Twenty-second Annual Meeting of The New York State Medical Association will be held at the Academy of Medicine, New York City, October 16, 17, 18 and 19, 1905.

From the large and impressive majority in favor of amalgamation with the State Society, which has already been authorized by proxy vote, it is reasonable to infer that this meeting of the Association will probably be its last. This fact, for many of us, will doubtless tinge the meeting with many shades of sadness, but these will be readily dissipated by the thought that we are entering upon a larger field of usefulness and, with a bound, are carrying the valuable features of our Association into an organization that will embrace the entire profession of our Empire State.

An interesting and instructive program has been arranged; most attractive social features are provided for the doctor's wife as well as himself; this is the time for the renewal of acquaintances and the cementing of friendships. Let us demonstrate to the profession of the State that we are giving up our name, not on account of any symptom of dry rot, but because of an excess of vitality we are planning to extend the blessings of the good features of organization, which we enjoy, to the greatest possible number of our fellow practitioners. Come and bring your wife; we promise you both a good time. Automobile rides and an excursion about the harbor by boat, as well as conducted visits to Art, Historic and Natural History Museums, are being planned for the ladies.

The railroad fares are reduced by the Trunk Line Association on the certificate plan—*i. e.*, full fare going and one-third fare returning to those who have paid 75 cents or over for their going journey, provided that at least one hundred persons shall have paid fares above and hold certificates from ticket agents at starting-point which shall be certified by the Association. Tickets at full fare for the going journey must be secured between the dates of October 12th and 18th inclusive at starting-point. Certificates securing a reduction in return tickets must be procured at the same time. Return tickets are good to October 23d.

Every member who has not already returned his acknowledgment of notice of this meeting should do so at once, whether he intends coming or not. By returning the proxy also, signed and witnessed, you will insure your vote in favor of

amalgamation if you have not already done so. There is a strong and growing hope that this vote may be unanimous.

Kindly fill in the enclosed postal, stating whether or not you will attend the meeting and the dinner, and return promptly. This information will be of the greatest possible assistance to the Committee on Arrangements, to whom you should apply for all further information.

Faithfully yours,

J. RIDDLE GOFFE, President.

AMENDMENTS TO BY-LAWS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The following amendments to the By-Laws of The New York State Medical Association were offered at the last (twenty-first) annual meeting, 1904, and will be offered for action at the meeting to be held October 16, 1905:

Amend Article II. *Duties of the Council*, by striking out Sec. 1 and substituting therefor the following:

Executive Board and Finance Committee.—Sec. 1. The Council in the interim between the annual meetings of The New York State Medical Association and the annual meetings of the Council and Fellows, shall be and is hereby constituted the Executive Board or Committee, both of the The New York State Medical Association, and of the Council and Fellows, with full power and authority to put into effect the purposes of the Association as expressed in and limited by its charter, By-Laws and resolutions. The Council may elect a Finance Committee from among its members, the sole power of which shall be to audit and authorize the payment of such bills as may have been theretofore incurred by order of the Council, or the Council and Fellows of The New York State Medical Association.

Amend Article II, Sec. 6. *Action under Medical Laws and Employment of Counsel*, by striking out Sec. 6 and substituting therefor the following:

Action under Medical Laws and Employment of Counsel.—Sec. 6. The Council may in the name of The New York State Medical Association, take action in any case of violation of the public-health law, subject, however, to the provisions of such law. The Council may in the name of The New York State Medical Association, employ an attorney at law to advise or act in any legal matter for The New York State Medical Association, upon such terms as the Council may determine.

Amend Article II, Sec. 7, by striking out Sec. 7 and substituting therefor the following:

Defense of Suits of Alleged Malpractice.—Sec. 7. Any active resident member of The New York State Medical Association may apply in writing for defense, and the Association shall, through its Council, furnish the legal services of a duly qualified attorney at law, in any alleged civil malpractice action brought against him, the

alleged cause of action for which occurred subsequent to the time when such applicant became a member of The New York State Medical Association, provided, however, that said applicant shall not be in arrears in the payment of dues for a period of more than three months from the first day of January, and that said applicant shall agree in writing not to settle, compromise, adjust or discontinue such action without the consent of The New York State Medical Association or its attorney, and renouncing his own, shall vest in The New York State Medical Association or its Council sole authority to conduct the defense of said suit, or to settle or adjust the same with the consent of the applicant, but neither the Council nor its attorney, nor any other person shall obligate The New York State Medical Association to the payment of any money awarded by verdict, decree or court, upon compromise or otherwise.

Amend Article II. *Duties of the Council, Sec. 2, Meetings*, by striking out the period at the end of the section, and adding the following:

and notice of each special meeting of the Council specifying the time and place of the meeting, and the business to be transacted, shall be mailed in a securely sealed, post-paid wrapper, addressed to the last-given address of each and every member of the Council, at least five days before the date of meeting.

Amend Article III. *Duties of the Council and Fellows*, by striking out Sec. 1 and substituting therefor the following:

Duties of the Council and Fellows.—Sec. 1. Duties. The general supervision, business management and control, together with the financial interests of The New York State Medical Association and its membership, are vested in the body known and styled the Council and Fellows, as limited, qualified and authorized by Section 5 of Chapter 452 of the Laws of 1900.

Amend Article III, Secs. 1 and 2, by striking out Secs. 1 and 2 and substituting therefor the following:

Meetings.—Sec. 2. The Council and Fellows shall meet annually. The annual and all other meetings of the Council and Fellows of The New York State Medical Association, shall be held at its office or place of transacting its financial concerns in the City of New York, Borough of Manhattan. The annual meeting of the Council and Fellows shall be held on the third Monday in October in each year, beginning at 3 o'clock in the afternoon, and special meetings of the Council and Fellows shall be held at such other times, upon ten (10) days' notice thereof, as may be determined by the Council to be necessary or expedient, or upon the written request of twenty-five (25) members of The New York State Medical Association. One-half the membership of the Council and Fellows shall constitute a quorum.

Amend Article IV, Sec. 5, by striking out Sec. 5 and substituting therefor the following:

Duties of Treasurer.—Sec. 5. The Treasurer

shall receive and disburse all funds of The New York State Medical Association under the direction of the Council, or Council and Fellows, or upon the audit of persons duly authorized by these By-Laws. He shall make a report at the annual meeting of the Council and Fellows upon the finances of the Association, and to the Council at such other times as the Council may require, and shall report upon the names of such members as may be delinquent in the payment of their dues. Any member who shall not have paid his dues on or before the first day of July in any year shall be considered a delinquent member, and a member not in good standing. The Treasurer shall collect the dues of non-resident members.

Amend Article V, Sec. 9, by striking out Sec. 9 and substituting therefor the following:

Committee on Nominations.—Sec. 9. The Committee on Nominations shall consist of a Chairman and ten members, two of which members shall be elected from the Fellows from each of the five District Branch Associations. It shall be the duty of this Committee to present to the Council and Fellows at its annual meeting a list of nominees for all elective offices of The New York State Medical Association, from which list the officers may be elected, unless otherwise ordered by a majority of the members present.

Amend Article VI. *Meetings of the Association*, by striking out Secs. 1, 2 and 3, and substituting therefor the following:

Annual.—Sec. 1. The New York State Medical Association shall hold a meeting annually to be called its Annual Meeting, in the City of New York and Borough of Manhattan, on the first Tuesday, following the third Monday in October in each year, at 9.30 o'clock in the forenoon, at its office and place of transacting its financial affairs, and the scientific or social sessions of such annual meeting shall be held at such place and hour as shall be selected by the Council and designated in the notice for such meeting, and The New York State Medical Association may hold special meetings at other times, places and hours in the City of New York and Borough of Manhattan. The notice for all meetings of The New York State Medical Association or the Council and Fellows shall be in writing, mailed in a securely sealed, post-paid wrapper, addressed to the last-given address of each and every member of The New York State Medical Association, which notice shall state the date, place and hour of such meeting. Notice of all special meetings shall be mailed to every member of the State Medical Association at least ten (10) days before such meeting, and shall state the date, place, hour and purpose of the meeting, and no other business at any special meeting shall be conducted except such as is stated in the call. The affidavit of mailing by the Secretary of The New York State Medical Association of such notice for the call of the meeting, shall be suffi-

cient proof of the service of such notice upon each and every member, for any and all purposes.

Special Meetings.—Sec. 2. Special meetings shall be called by the President by order of the Council or upon the written request of twenty-five (25) members of the Association.

Order of Business.—Sec. 3. The order of business at the annual meeting of The New York State Medical Association shall be as follows:

1. Calling the Association to order.
2. Reports of Special Committees.
3. Unfinished business.
4. New business.
5. Address of welcome by the Chairman of the Committee on Arrangements.
6. President's address.
7. Special addresses.
8. Reading and discussion of papers.
9. Installation of officers.
10. Adjournment.

To Article VI, *Meetings of the Association*, add Sec. 4, to read as follows:

One-third of the membership of The New York State Medical Association shall constitute a quorum, for the transaction of any and all business.

Amend Article VII, *Duties of Officers*, by striking out the present title, and substituting therefor the following:

ARTICLE VII.

The title preceding Sec. 5 should read: "Duties of District Branch Association Officers."

Amend Article VII, Sec. 7, by striking out Sec. 7 and substituting therefor the following:

Treasurer.—Sec. 7. The Treasurer shall receive and disburse all funds of the Branch Associations, as hereinafter prescribed under the laws regulating the distribution of dues.

Amend Article VIII, *County Medical Associations*, by inserting between Secs. 2 and 3 the title: "Duties of County Association Officers."

Amend Article VIII, Sec. 6, by striking out Sec. 6, and substituting therefor the following:

Treasurer.—Sec. 6. The Treasurer shall receive and disburse all funds of the County Association of the County in which he resides.

Amend Article II, Sec. 4, by striking out Sec. 4, and substituting therefor the following:

Privileges of Members.—Sec. 4. Active. Resident active members shall have all the rights and privileges conferred by their respective County and District Branch Association. 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 of the protection, benefits and support conferred by The New York State Medical Association except as herein qualified and limited, provided, however, that such active member's dues shall have been paid to the Treasurer of The New York State Medical Association on or before the first day of July in any year, and not otherwise. If at the time of the annual meeting of any County Asso-

ciation or District Branch Association a member shall not have paid his annual dues to such County or Branch Association, he shall not be counted as a basis of representation in The New York State Medical Association, nor shall he be eligible for election as a Fellow, nor thereafter until he shall have discharged his indebtedness in full.

Amend Article IX. *Membership*, by striking out Sec. 5 and substituting therefor the following:

Privileges of Members, Non-Resident, Honorary and Corresponding.—Sec. 5. All members of The New York State Medical Association other than active resident members, shall *only* receive notice of all scientific meetings, and a copy of all publications of The New York State Medical Association.

Amend Article X. *Dues*. Sec 3, by striking out Secs. 3, 4 and 6, and substituting therefor the following:

Payment of Dues.—Sec. 3. All dues shall be due The New York State Medical Association and payable on the first Monday of January in each year. Members resident in the State of New York shall transmit their dues to the Treasurer of the County Association in which they reside, or to the Treasurer of the District Branch Association if no County Association exists in the County wherein they reside. Non-resident members shall transmit their dues to the Treasurer of The New York State Medical Association.

Collection of Dues.—Sec. 4. On the first day of July in each year the names of all members who have failed to pay their indebtedness to The New York State Medical Association for the current year shall be omitted from all public accredited list of members of The New York State Medical Association, and if at the close of the first day of the Annual Meeting of The New York State Medical Association such dues still remain unpaid and in arrears, the name of such delinquent member shall be dropped from the official roll of members, and he shall be notified of his suspension from membership in The New York State Medical Association as soon as conveniently possible thereafter.

Distribution of Dues.—Sec. 6. The Treasurer of each County Association or District Branch Association shall pay to the Treasurer of the State Association monthly, all dues or other funds in his hands received from members, which the Treasurer of The New York State Medical Association is entitled to receive.

Amend Article XV. *Amendments*, by striking out Sec. 1, and substituting therefor the following:

Amendments.—Sec. 1. Amendments to these By-Laws shall be made only upon the affirmative vote of a majority of those present and voting at a regular annual meeting of the Council and Fellows, or at a regular annual meeting of The New York State Medical Association, provided

that notice of such amendment shall have been presented in writing at the previous annual meeting of the Council and Fellows, or at the previous annual meeting of The New York State Medical Association.

MEMORANDA.

1. All papers announced in the program take precedence over those offered at the beginning of a session.
2. It is required that the order in which papers appear on the program should be maintained.
3. To insure promptness in the publication in THE NEW YORK STATE JOURNAL OF MEDICINE, the author of each paper is requested to hand a true copy to the Secretary when read.

Papers may be read either entire, by abstract, or by title only, as may be determined by the Council.

The reading of a paper shall not occupy more than twenty minutes, except by permission of the Association.

No person shall speak more than once, and then not longer than five minutes, in the discussion of any paper, except by permission of the Association.

No voluntary communication shall exceed fifteen minutes in length, except by permission of the Association.

THE PRINCIPLES OF MEDICAL ETHICS.

One section of the agreement of the Joint Committee on Conference provides that, as soon as practicable after the entry by the court of an order for the consolidation of the two State medical organizations, there shall be submitted for vote, to all members in good standing of the consolidated body, the question as to whether or not they will adopt the Principles of Medical Ethics of the American Medical Association as the *guide* of members in their relations to each other and to the public.

In order that these members may act with full knowledge of what this document, called the Principles of Medical Ethics, is and what it imports, it has been thought wise by both Dr. Bryant and Dr. Goffe that every voter should have in his possession a copy of the Principles of Ethics for perusal and consideration long enough in advance of the proposed ballot for him to become familiar with them. Accordingly, about the first of October, a copy of the Principles of Ethics will be sent to each member of the Society by Dr. Bryant, with a letter explaining why it is sent, and a similar copy and letter to each member of the Association by our president, Dr. Goffe. It is hoped that this opportunity of becoming familiar with the Principles of Ethics will be improved by the members of both organizations.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, and all items of interest, such as deaths, marriages and personals of the members.

NEW YORK STATE MEDICAL ASSOCIATION.

Annual meeting will be held in New York City, October 16, 17, 18 and 19, 1905.

COUNTY ASSOCIATION MEETINGS FOR OCTOBER.

Cattaraugus County, Tuesday, October 3d.
 Rensselaer County, Tuesday, October 3d.
 Tompkins County, Tuesday, October 10th.
 New York County, Monday, October 16th.
 Lewis County, Tuesday, October 24th.
 Monroe County, Tuesday, October 24th.

Orange County Association.—The first meeting of the Orange County Medical Association following the vacation period of the months of June, July and August, was held at the Russell House, Wednesday afternoon, September 13th, at 2 P. M.

There was a good attendance. The meeting was called to order by the president, Dr. E. D. Woodhull, of Monroe.

At the scientific session, under report of presentation of cases, Dr. Dennis, of Unionville, and Drs. Mills, Redfield and Fancher, of this city, reported some very interesting and instructive cases. Dr. Woodhull, of Monroe, reported two rare cases of chorea and hysterical hemiplegia.

The speaker from New York who was to be present was unavoidably detained.

At the business session the following resolution was duly presented, seconded and carried:

Resolved, That the chair appoint a committee of three to investigate and report in writing at the next meeting any violation upon the part of any member or members of the resolution adopted at the February meeting regarding contract, lodge or club practice.

The chair made such appointments, and the names are withheld from publication for various reasons.

Other important matters were discussed, at the conclusion of which it was decided to hold the next meeting at Goshen, Wednesday, October 11, 1905.

(Signed) L. G. DISTLER, Secretary.

Members and delegates are requested to register immediately on their arrival, and to deposit with the Chairman of the Committee on Arrangements THEIR RAILROAD CERTIFICATES, that they may be properly endorsed by the Secretary and the Agent of the Trunk Line Association.

PROGRAM.

The New York State Medical Association.

THE TWENTY-SECOND ANNUAL MEETING

WILL BE HELD ON

MONDAY, TUESDAY, WEDNESDAY AND THURSDAY,
 OCTOBER 16, 17, 18 and 19, 1905.

In Hosack Hall, New York Academy of Medicine,
 17 West 43d Street, New York City.

First Day, Monday, October 16th.

Meeting of Nominating Committee, 12.30 P. M.
 Meeting of the Council, 1 P. M.
 Meeting of the Council and Fellows, 2.30 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.

Tickets for the Annual Dinner at the Hotel Astor, 44th Street and Broadway, can be obtained from the Chairman or the Secretary of the Committee on Arrangements.

Second Day, Tuesday, October 17th.

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.
 Report of Committees.
 New business.
 Unfinished business.
 Reception of Delegates from other associations.

LUNCHEON AT 1 P. M.

Second Day, Tuesday, October 17th.

AFTERNOON SESSION AT 2 P. M.

1. "Lumbago, Sciatica, Pseudo-Rheumatism." By DR. JAMES J. WALSH, New York City.
 2. "Some Experience with Apomorphia." By DR. GEORGE H. PEDDLE, Perry, N. Y.
 3. "The Significance of Dysmenorrhœa at Puberty and Its Relation to Uterine Tumors." By DR. FRANK DEWITT REESE, Cortland, N. Y.
- Discussion opened by DR. MARY GAGE-DAY, HENRY C. COE and others.

4. "The Abrupt Onset of Typhoid Fever." By DR. MORRIS MANGES, New York City.

Discussion opened by ALBERT KOHN, New York.

5. "Typhoid Fever in Children." By DR. LOUIS CURTIS AGER, Brooklyn, N. Y.

Discussion.

6. "What Organized Malpractice Defense Does for the Profession and the Public." By MR. JAMES TAYLOR LEWIS, New York City.

Third Day, Wednesday, October 18th.

MORNING SESSION, 9.30 A. M.

SYMPOSIUM ON HYGIENE AND PREVENTIVE MEDICINE.

a. "Protection of the Water Supply."

1. DR. THOMAS DARLINGTON, New York.
2. DR. ERNST J. LEDERLE, New York.
3. MR. HENRY HOPKINS ADAMS, New York.

b. "Protection of the Milk Supply."

1. DR. WALTER BENSEL, New York.
2. DR. EDWARD F. BRUSH, Mt. Vernon.
3. DR. S. W. S. TOMS, Nyack.

The President's address.

LUNCHEON AT 1 P. M.

Third Day, Wednesday, October 18th.

AFTERNOON SESSION, 2 P. M.

SYMPOSIUM ON THE TOXÆMIA OF PREGNANCY.

1. "The Acid Toxæmia of Pregnancy." By DR. HENRY McMAHON PAINTER, New York City.

2. "The Pathology of Eclampsia." By DR. JAMES EWING, New York City. (Illustrated by lantern slides.)

3. "Hyperemesis Gravidarum." By DR. WILLIAM S. STONE, New York City.

4. "The Treatment of Eclampsia." By DR. BERNARD COHEN, Buffalo, N. Y.

5. "Vaginal Cæsarian Section in Eclampsia." By DR. M. STAMM, Fremont, O.

Discussion of the entire subject by DRs. J. WHITRIDGE WILLIAMS, of Baltimore; J. CLIFTON EDGAR, of New York; HENRY D. FRY, of Washington; JOSEPH BROWN COOKE, of New York, and others.

6. "Resection of the Bladder." By DR. HOWARD KELLY, Baltimore, Md.

Wednesday Evening.

The Annual Dinner of the Association will be held at the Hotel Astor, 44th Street and Broadway.

Tickets may be obtained from the Committee on Arrangements.

Fourth Day, Thursday, October 19th.

MORNING SESSION, 9.30 A. M.

SYMPOSIUM ON CARCINOMA—NON-SURGICAL TREATMENT.

1. "Mediastinal Tumors." By DR. WILLIAM FRANCIS CAMPBELL, Brooklyn.

2. "Spontaneous Cure in Cancer; Its Significance in Relation to the Ultimate Solution of the Problem of the Cure of Cancer." By DR. HARVEY R. GAYLORD, Buffalo, N. Y.

Discussion opened by DR. A. R. ROBINSON.

3. "Therapy of Carcinoma." By DR. SAMUEL LLOYD, New York.

Discussion opened by DR. WILLIAM E. COLEY.

4. Title supplied later. By DR. WILLIAM FRANCIS CAMPBELL, Brooklyn.

5. "The Sanatorium for Tuberculous Patients and Its Medical and Social Mission." By DR. S. A. KNOPF, New York City.

LUNCHEON, 12 NOON.

Fourth Day, Thursday, October 19th.

AFTERNOON SESSION, 1 P. M.

SYMPOSIUM ON CANCER—SURGICAL TREATMENT.

1. "Carcinoma of Stomach." By DR. WILLIAM J. MAYO, Rochester, Minn.

Discussion opened by DR. JOHN B. DEEVER, Philadelphia, Pa.

2. "Carcinoma of Intestinal Tract." By DR. JAMES P. TUTTLE, New York.

Discussion opened by DR. ARPAD G. GERSTER.

3. "Carcinoma of the Uterus." By DR. GEORGE BEN. JOHNSTON, Richmond, Va.

Discussion opened by DR. CHARLES P. NOBLE, Philadelphia, Pa.

4. "Carcinoma of the Larynx." By DR. JOHN N. MACKENZIE, Baltimore, Md.

Discussion opened by DR. D. BRYSON DELAVAN.

MEMBERS OF THE COUNCIL.

- J. RIDDLE GOFFE, New York City.
 ALLEN ARTHUR JONES, Buffalo.
 J. ORLEY STRANAHAN, Rome.
 EVERARD D. FERGUSON, Troy.
 CLARK W. GREENE, Binghamton.
 JAMES CLEMENT DAVIS, Rochester.
 IRVING D. LE ROY, Pleasant Valley.
 CHARLES IRA REDFIELD, Middletown.
 FREDERICK A. BALDWIN, New York City.
 FREDERIC WILLIAM LOUGHRAN, New York City.
 E. ELIOT HARRIS, New York City.
 ALEXANDER LAMBERT, New York City.
 LOUIS CURTIS AGER, Brooklyn.
 CHARLES E. DENISON, New York City.
 WISNER R. TOWNSEND, New York City.

FELLOWS AND ALTERNATES OF THE NEW YORK STATE MEDICAL ASSOCIATION FOR 1905.

First District Branch.

- | <i>Fellows.</i> | <i>Alternates.</i> |
|---------------------------------------|-----------------------|
| HERKIMER COUNTY MEDICAL ASSOCIATION. | |
| Charles H. Glidden. | Seymour S. Richards. |
| JEFFERSON COUNTY MEDICAL ASSOCIATION. | |
| Byron C. Cheeseman. | Henry G. Dawson. |
| Charles C. Kimball. | Frederick R. Calkins. |
| LEWIS COUNTY MEDICAL ASSOCIATION. | |
| Ira D. Spencer. | Alexander H. Crosby. |
| ONEIDA COUNTY MEDICAL ASSOCIATION. | |
| Fred. J. Douglas. | Frederick M. Miller. |

Fellows.

Alternates.

Second District Branch.

ALBANY COUNTY MEDICAL ASSOCIATION.	
John U. Haynes.	William E. Lothridge.
COLUMBIA COUNTY MEDICAL ASSOCIATION.	
T. Floyd Woodworth.	Henry W. Johnson.
ESSEX COUNTY MEDICAL ASSOCIATION.	
George Hall Beers.	William T. Sherman.
RENSSELAER COUNTY MEDICAL ASSOCIATION.	
Everard D. Ferguson.	Thomas C. Church.
William Finder, Jr.	James P. Marsh.
John B. Harvie.	John T. Cahill.
William L. Hogeboom.	George L. Meredith.
SARATOGA COUNTY MEDICAL ASSOCIATION.	
Douglas C. Moriarta.	
Frank J. Sherman.	
George F. Comstock.	
Dudley R. Kathan.	
Frank A. Palmer.	
WARREN COUNTY MEDICAL ASSOCIATION.	
William J. Hunt.	Edgar P. Probasco.
George A. Chapman.	Annetta E. Barber.

Third District Branch.

BROOME COUNTY MEDICAL ASSOCIATION.	
John G. Orton.	Benjamin W. Stearns.
Clark W. Greene.	Lester H. Quackenbush.
CORTLAND COUNTY MEDICAL ASSOCIATION.	
Charles D. Ver Noov.	Emory A. Didania.
ONONDAGA COUNTY MEDICAL ASSOCIATION.	
Franklin J. Kaufmann.	Amos S. Edwards.
OTSEGO COUNTY MEDICAL ASSOCIATION.	
Daniel Luce.	Marshall Latcher.
SENECA COUNTY MEDICAL ASSOCIATION.	
John W. Russell.	Frederick W. Lester.
TOMPKINS COUNTY MEDICAL ASSOCIATION.	
Eugene Baker.	Edward Meany.
John S. Kirkendall.	Elijah Osterhout.
Marcus M. Dumond.	Royden M. Vose.

Fourth District Branch.

ALLEGANY COUNTY MEDICAL ASSOCIATION.	
Charles M. Post.	Francis E. Comstock.
Nathaniel H. Fuller.	Emerson W. Ayers.
CATTARAUGUS COUNTY MEDICAL ASSOCIATION.	
Orrin A. Tompkins.	Charles P. Knowles.
CHAUTAUQUA COUNTY MEDICAL ASSOCIATION.	
William M. Bemus.	Walter Stuart.
George F. Smith.	Charles S. Cleland.
John A. Weidman.	Thomas D. Strong.
ERIE COUNTY MEDICAL ASSOCIATION.	
Alvin A. Hubbell.	William Scott Renner.
Wm. Harvey Thornton.	Lorenzo Burrows, Jr.
Charles G. Stockton.	Henry C. Buswell.
DeLancey Rochester.	Elmer G. Starr.
Bernard Cohen.	Thomas G. Allen.
Julius Ullman.	Marcell Hartwig.
F. Park Lewis.	Alfred E. Diehl.
Charles A. Wall.	Edward L. Frost.
George F. Cott.	Prescott Le Breton.
Grover W. Wende.	Albert E. Woehnert.
Arthur G. Bennett.	William C. Phelps.
Marshall Clinton.	Ray H. Johnson.
Earl P. Lothrop.	Carlton C. Frederick.
Howard L. Hunt.	Jacob S. Otto.

Fellows.

Alternates.

GENESEE COUNTY MEDICAL ASSOCIATION.	
Frank L. Stone.	Augustus F. Miller.
MONROE COUNTY MEDICAL ASSOCIATION.	
Richard Mott Moore.	S. Case Jones.
Thomas A. O'Hare.	James Clement Davis.
NIAGARA COUNTY MEDICAL ASSOCIATION.	
Allan N. Moore.	Charles N. Palmer.
Frank Guillemont.	Wm. Quincy Huggins.
Flavius J. Baker.	Alva Le Roy Chapin.
ORLEANS COUNTY MEDICAL ASSOCIATION.	
Edward Munson.	John H. Taylor.
STEBEN COUNTY MEDICAL ASSOCIATION.	
Charles O. Green.	John G. Kelly.
WAYNE COUNTY MEDICAL ASSOCIATION.	
Newell E. Landon.	Gard Foster.
WYOMING COUNTY MEDICAL ASSOCIATION.	
Philip S. Goodwin.	Zina G. Truesdell.
George S. Skiff.	L. E. Stage.

Fifth District Branch.

DUTCHESS COUNTY MEDICAL ASSOCIATION.	
John W. Atwood.	Irving D. Le Roy.
NEW YORK COUNTY MEDICAL ASSOCIATION.	
Robert Abbe.	Edward Ayme.
David P. Austin.	S. J. Baker.
Richard T. Bang.	George E. Barnes.
Bennett S. Beach.	Charles C. Barrows.
Charles S. Benedict.	Thomas L. Bennett.
Hermann M. Biggs.	Henry W. Berg.
Joseph B. Bissell.	Herman J. Boldt.
John A. Bodine.	Joseph A. Blake.
John W. Brannan.	Nathan G. Bozeman.
Nathaniel E. Brill.	John W. Brennan.
Joseph D. Bryant.	Abram Brothers.
James H. Burtenshaw.	George A. Cherry.
Charles H. Chetwood.	Robert J. Carlisle.
William B. Coley.	Charles G. Child, Jr.
D. Bryson Delavan.	Edmund L. Cocks.
Thomas Darlington.	George W. Collins.
Daniel S. Dougherty.	Joseph B. Cooke.
Chas. Ellery Denison.	Francis W. Davis.
Ellery Denison.	Edward B. Dench.
Henry A. Dodin.	
John F. Erdmann.	Edward C. Ehlers.
Henry H. Forbes.	Frank J. Eversfield.
John A. Fordyce.	Joseph O. Farrington.
W. Travis Gibb.	A. M. Fernandez-Ybarra.
John W. S. Goutley.	Frank S. Fielder.
J. Riddle Goffe.	Louis Fischer.
Ramon Guiteras.	Edward J. Gallagher.
E. Eliot Harris.	A. Ernest Gallant.
Frank Hartley.	S. Ormond Goldan.
Frederick P. Hammond.	William S. Gottheil.
George T. Harrison.	Edward J. Graff, Jr.
Irving S. Haynes.	F. Spencer Halsey.
Isaac M. Heller.	Wm. H. Hemmingway.
William P. Herrick.	Neil J. Hepburn.
Lucius W. Hotchkiss.	George B. Hope.
Monta W. Jamison.	Carlyle H. Howell.
Smith Ely Jelliffe.	Edward F. Hurd.
Charles G. Kirchhof.	Herman Jarecky.
Samuel J. Kopetzky.	Mary B. Jewett.
Richard Kalish.	Frederick C. Keller.

Fellows.

Edward L. Keyes, Jr.
 Alexander Lambert.
 Charles A. Leale.
 Wm. G. Le Boutillier.
 Egbert Le Fevre.
 Johanna B. Leo.
 William M. Leszynsky.
 Samuel Lewengood.
 Guy D. Lombard.
 Frederic W. Loughran.
 George B. McAuliffe.
 Constantine J. McGuire.
 J. W. Draper Maury.
 Emil Mayer.
 Joseph E. Messenger.
 Francis W. Murray.
 John J. Nutt.
 Michael G. O'Brien.
 Harry R. Purdy.
 Charles E. Quimby.
 Francis J. Quinlan.
 Thomas F. Reilly.
 Henry Roth.
 Reginald H. Sayre.
 Harry H. Seabrook.
 John Shrady.
 Stephen Smith.
 George D. Stewart.
 William R. Stone.
 Parker Syms.
 Wisner R. Townsend.
 James P. Tuttle.
 James J. Walsh.
 Fred'k Holme Wiggin.
 John A. Wyeth.

Alternates.

Theron W. Kilmer.
 Justin de Lisle.
 Frank H. Loucks.
 Anna Lukens.
 William McChristie.
 James F. McKernon.
 James C. Mackenzie.
 C. Carrington Minor.
 Forde Morgan.
 Alvah M. Newman.
 Henry S. Oppenheimer.
 John Parsons.
 Bruce G. Phillips.
 Adolph Rupp.
 Gertrude Rochester.
 John Rogers, Jr.
 John C. Schminke.
 Walter M. Seward.
 Lewis M. Silver.
 A. Alexander Smith.
 William E. Swan.
 William S. Terriberry.
 Jacob Teschner.
 Alfred B. Tucker.
 Fred. C. Valentine.
 John W. Wainwright.
 Simon J. Walsh.
 John E. Weeks.
 William A. White.
 Isaac M. Wilzin.
 Herbert W. Wootton.
 Jonathan Wright.
 Julius W. Woodward.
 Sidney Yankauer.
 Bernard Zweighaft.

ORANGE COUNTY MEDICAL ASSOCIATION.

Henry E. Wise. Edward C. Rushmore.
 Joseph B. Hulett. Emerson B. Lambert.
 Frank D. Myers. Alpheus E. Adams.

ROCKLAND COUNTY MEDICAL ASSOCIATION.

Charles D. Kline. John C. Dingman.

SULLIVAN COUNTY MEDICAL ASSOCIATION.

Frank W. Laidlaw. Charles E. McDonald.

ULSTER COUNTY MEDICAL ASSOCIATION.

Albert H. Palmer. Elijah Osterhout.

WESTCHESTER COUNTY MEDICAL ASSOCIATION.

William J. Meyer. H. Eugene Smith.
 Norton J. Sands. George C. Weiss.

COUNCIL MEETING.

A special meeting of the Council of The New York State Medical Association was held at the Business Office, 64 Madison avenue, New York City, on Monday, September 11, 1905, at 4.15 p. m. The meeting was called to order by the president, Dr. J. R. Goffe.

The secretary reported that the appointment of the following delegates to other State Medical Associations had been made by the president:

New Jersey State Society—Dr. J. A. Wyeth, Dr. William Leszynsky and Dr. C. I. Redfield.

Pennsylvania State Society—Dr. R. M. Gibbons.

American Medical Association—Dr. George F. Cott, of Buffalo, has been elected as a delegate to fill the vacancy in place of Dr. J. W. Grosvenor, resigned.

The secretary reported that acknowledgment of service of notice of time of the annual meeting had been received from 1,622 of the members, and that these had also been accompanied by signed proxies to vote in favor of the three questions stated upon the cards sent with the notice of meeting. There remained 168 members who had not returned any word whatsoever.

Under the head of unfinished business Dr. Townsend offered the following resolution:

"That the contract made with Dr. Gnichtel as official stenographer for the annual meeting in October by the secretary be ratified by the Council, and the treasurer be authorized to pay the bill for the same when certified to as correct by the secretary." Seconded by Dr. Ager. Carried.

Dr. Goffe stated that under the head of unfinished business was the matter of the service of notice of the annual meeting upon the delinquents who had as yet returned no acknowledgment of such service of notice.

After some discussion as to the best method to pursue, Dr. Ager offered the following resolution:

"That the-counsel for the Association cause to be served legal notices of the annual meeting upon those members of the State Association who have not already acknowledged receipt of such notice." Seconded by Dr. Le Roy. Carried with secretary voting nay.

Dr. Townsend then spoke at some length upon the new *National Directory* to be published under the direction of the American Medical Association, and gave an interesting account of an interview with the secretary of the American Medical Association as to the best method for collecting data for said *Directory*. It was his opinion that each State should provide data for the *National Directory* as published by the American Medical Association. Some discussion was then entered into as to the cost of collecting data for New York State, comparing the estimated cost with the actual expense of such data as incurred in compiling each edition of the *Directory* of New York, New Jersey and Connecticut and published by this Association.

Dr. Townsend made the following motion:

"That a committee of three be appointed by the president to confer with the secretary of the American Medical Association in regard to the furnishing of data for the new *National Directory* to be issued by the American Medical Association, and that the chairman of the Publication Committee be a member of such committee." Seconded and carried.

Dr. Goffe appointed as such committee Dr. Townsend, chairman; Dr. Denison and Dr. Lambert.

There being no further business, the Council adjourned. C. I. REDFIELD, Secretary.

GARNISHMENT LAW.

To the Editor—It may be of interest for some of the doctors to know that the Garnishment Law has been amended so that now, for necessities sold, it is possible to compel persons owing judgment debtors to turn a fund over to the creditor. The question of whether or not doctors' bills would come under the heading of necessities sold is still undetermined by the Courts of this State so far as the reports show, but there have decisions been rendered which I believe soon will cover the question of doctors' bills in favor of the doctor.

There has been for a number of years in the State of Maine a similar law. In that State physicians have succeeded in enforcing payment of their bills against delinquent debtors, and I have no doubt that the same rule may be eventually be adopted in this State.

Any person earning more than \$12.00 a week is liable to have his wages intercepted.

It would be of interest to the rest of the profession if physicians in the interior of the State would report the finding of any court on this subject in their locality, so that physicians all over the State might have the benefit of the ruling of the judge, as otherwise it is impossible to keep in touch with these decisions until they reach the higher courts, which on account of the amount of the claim might never be carried that far.

I should consider it a favor if any of the physicians in the interior counties would take the trouble to notify me of any successful operations in this direction.

Very truly yours,

JAMES TAYLOR LEWIS,
Counsel to the Association.

News Items.

DR. BALDWIN.

We regret to announce the death of Dr. Frederick A. Baldwin, one of the most widely known in the medical bodies of the State, as well as of the National Association. His loss is most deeply deplored, as one not to be excelled in social qualities or general attainments. He certainly had a symmetrical make-up, conjoined with a singular modesty, which seemed to be straining after ideals that could satisfy his ambition for absolute perfection. As ever working, he spared no time for exhibition or proclamation. His enjoyments, far from trivial, satisfied his optimistic disposition, so that the most of our regrets are for our own disappointments.

* * *

NEEDS LEGAL REMEDY.

"I am slightly in doubt," said the physician to a lawyer who was ill, "as to whether yours is a constitutional disease or not." Whereupon the patient exclaimed:

"For heaven's sake, doctor, have I to go to the

expense of appealing to the United States Supreme Court to find out whether it is or not?"—*N. Y. Press.*

* * *

In the treadmill of opinion many move only to divide the responsibility of every component part.

* * *

After all, do the young earn so very much by dispensing with old experiences?

* * *

"The history of civilization," said Lord Beaconsfield, "only proves the struggles of the West for the spices of the East."

* * *

A review of the money market in a leading daily paper maintains that cheap money has had its day. "Easy comes—easy goes" is a terser expression.

* * *

According to Novalis, a Prussian romanticist of the eighteenth century, genius is the plurality of personalities combined in one individual. Perhaps the better description is that of the Saxon, to wit: "The good all-round man."

* * *

"Anger is temporary insanity" was a psychological phrase of one of the seven wise men of ancient Greece.

* * *

A hasty judgment may doom even the mosquito. The suspect from a headquarters camp might be a spy or only a scout. It is hard to discriminate in a hostile country. To grade down the waste meadows and unclassifiable reservoirs seems the reasonable policy at present.

"It is incompatible with honorable standing in the profession to resort to public advertisement or private cards inviting the attention of persons affected with particular diseases; to promise radical cures; to publish cases of 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 aduce certificates of skill and success, or to employ any of the other methods of charlatans."

Some members of the profession are inclined to criticize a directory published by the County Medical Society, in which the names of all physicians belonging to the organization are in black-faced type, while light-faced letters are used for those who have no such connection. The defenders of this plan maintain, however, that as the book is published by the society primarily for the information of its own members, no invidious distinction is intended. A similar directory published by the Medical Association in this county, however, does not typographically indicate the association members.

The time is passing, and should be entirely past, when the "boosting" of proprietaries, the publishing of "clinical reports" or other write-ups in the reading matter will be tolerated by the profession. The reading matter of a legitimate medical publication belongs solely to the subscribers who pay for it; and it should be devoted wholly and solely to them and their interests. It is bad faith toward subscribers to allow any other interest to encroach upon the part of a magazine which belongs to them.—*Medical World.*

INTESTINAL PERFORATION IN TYPHOID FEVER.

The author shows that more than 50,000 people die annually in this country from typhoid fever alone. Assuming that 3 per cent. of typhoid patients die from intestinal perforation, we have more than 15,000 deaths from typhoid perforation every year. He calls attention to the contrast between this large number of cases occurring annually in the United States, which should be operated upon, and the small number of operated cases which Frank was able to collect in 1903 from all over the world. He is optimistic to an extreme as to the value of operation in typhoid perforation, not so much from his own experience, but from a study of the opinions and results secured by others. He had seven operations for complete perforation of the lower portion of the ileum, with but one recovery. This he attributes to late diagnosis, the cases not being sent to him until they were almost moribund. In all but two of the cases the first twenty-four hours were over and general peritonitis was conspicuously present. The author then undertakes to show what surgery has accomplished in typhoid perforation. After a consideration of recent statistics he confidently predicts that early diagnosis and operation will save 50 per cent. or more. The most important phase of the subject is early diagnosis and the author urges cooperative study, in all suspicious cases, by the general practitioner and surgeon. He believes that adhesions may form in the preperforative stage and that this possibly saves many lives. It is important to take into consideration the occurrence of appendicitis, acute cholecystitis, and the infection, suppuration and discharge of the mesenteric and other intraperitoneal glands and also the possible thrombosis of intraperitoneal blood vessels. He has never seen perforated peritonitis during typhoid fever due to any cause except typhoid perforation. The most important feature in the diagnosis is the sudden transition from the quiescent condition to one evincing acute intraperitoneal invasion, characterized by acute, lasting pain and tenderness with muscular rigidity. There may or may not be symptoms of shock. All other possible symptoms are mentioned. The author quotes Osler, Cushing, Richardson and Greig Smith, all of whom advocate *early* operation, which lessens the amount of surgery necessary to save life. He believes in getting into the abdomen early and out of it just as quickly as is consistent with complete work. He pleads for early diagnosis and early operations. He urges operation in all cases and states that even the general practitioner can perform the operation advocated by Escher, which saves 50 per cent. of the cases operated upon. Escher contents himself with simply finding the perforation and suturing the torn segment of the bowel into the abdominal incision, leaving a fistula.—*Hugh M. Taylor, Southern Medicine, December, 1904.*

SOME MEDICINES ARE LIQUORS.

Those Whose Chief Ingredient Is Spirits Will Be Subject to Special Liquor Tax.

WASHINGTON, Sept. 14.—Under a decision rendered by the Commissioner of Internal Revenue every druggist who after December 1st of this year may sell certain so-called patent medicines having whisky or other distilled spirits as the chief ingredient will be obliged to pay a special tax to the Government as a liquor dealer. The manufacturers of these medicines will be required to pay the special tax imposed upon rectifiers and liquor dealers.

The subject of placing certain patent medicines in their proper classification has been under consideration by the internal revenue authorities for some time. In 1901 the matter was considered by the Commissioner of Internal Revenue, but it was decided at that time that if the preparations in question "are composed of spirits in combination with drugs, herbs, roots, etc., and are held out as remedies for diseases stated in labels on the bottles, they are to be regarded as medicines until the facts ascertained as to the purpose for which they are usually sold or used show them to be beverages, and until such facts are obtained druggists and merchants who sell these compounds in good faith as medicines only are not to be called upon to pay special tax as liquor dealers on account of such sales."

This decision, according to the announcement to-day, is now revoked.

Commissioner Yerkes, who promulgated the decision after conference with Secretary of the Treasury Shaw, is convinced that several so-called medicines widely advertised and extensively sold are really not medicinal in their character beyond the inherent medicinal quality which may be possessed by the alcohol or other distilled spirits which forms their chief ingredient. In his order imposing the special liquor tax on dealers handling those so-called medicines Commissioner Yerkes says:

"The fact that these compounds during the existence of the statute imposing a tax on proprietary medicines were, without the necessity of investigation into their medicinal character, by the terms of the law made subject to that tax because they were held out to the public as medicines, does not afford ground for relieving the manufacturers from special tax as liquor dealers under the provisions of section 3244, revised statutes and amendments. It is held that the statute requires the exaction of this special tax from the manufacturer of every compound composed of distilled spirits, even though drugs are declared to have been added thereto, when their presence is not discoverable by chemical analysis, or it is found that the quantity of drugs in the preparation is so small as to have no appreciable effect on the alcoholic liquor of which the compound is mainly or largely composed.

"The same ruling applies to every alcoholic compound labeled as a remedy for diseases and contagion containing, in addition to distilled spirits, only substances or ingredients which, however large their quantity, are not of a character to impart any medicinal quality to the compound: but where substances undoubtedly medicinal in character are contained with whisky or other alcoholic liquor and are used in sufficient quantities to give a medicinal quality to the liquor other than that which it may inherently possess, such compound is, of course, not to be included in this ruling. The question in each case arising under the terms of this circular will be determined by this office, not merely upon examination of the formula submitted by the manufacturer of the compound, but upon the result of the analysis made in the chemical laboratory here of samples obtained in the open market and sent in by the local internal revenue officers and agents."

In order to relieve druggists and other dealers from loss, the ruling will not go into effect until December 1st next.—*New York Sun.*

Letters.

NEW YORK CITY, Sept. 8, 1905.

DR. CHARLES E. DENISON.

My Dear Doctor—I wish to present the following matter for such action as the Association may decide proper:

On August 26th I was called to attend a young lady who was injured while alighting from a trolley car. She was contused and suffering from shock. She was extremely nervous, so I instructed her to remain in bed for a few days. Two days following an adjuster for the railroad called and requested to see the patient. The mother informed him that the girl was in my charge, and if he called on me I would give him full particulars; this he refused to do, stating he would have the doctor call on me.

On August 30th the physician for the railroad called at the patient's house and stated to the mother that he had communicated with me, and that we agreed to see the case together that evening, and if I did not keep the appointment he was to examine the patient alone, which he did. All the statements made by him were absolutely false. He made no effort to see me, and we had made no appointment.

I consider his conduct decidedly unprofessional, unethical and discourteous and ungentlemanly, and I feel that the Association should take action in such a matter. If required I would be able to obtain sworn statements covering all the facts.

Yours truly,

(Signed) _____

CHARLES E. DENISON, M.D., Chairman Committee on Publication, 64 Madison Avenue.

Dear Doctor—For some time past, the JOURNAL has published letters relative to the question of amalgamation and asking questions as to what will become of the State Association after amalgamation has taken place. Some of us firmly believe now that amalgamation will not take place if the members of the Association understood what amalgamation means. At the last meeting of State Association the matter of amalgamation was laid upon the table for a year by the unanimous vote of the Association. Since the proxies were sent out and signed by the members of the Association, we have thought over this question—Are the best interests of the medical profession conserved by a union on the present terms? We might inquire—Can anybody possibly understand why the committee is so diligent in its desire and work for amalgamation? What possible benefit would accrue to the members of the State Association by the amalgamation? Does not the State Association in amalgamating with the State Society give up every single point and principle for which it was instituted twenty years ago? Do we in the amalgamation go over in a body to the

State Society, to serve under their officers—in the County or State—or will there be an election for officers by the new formed amalgamated Society? It should be understood by every member of the Association that it is perfectly possible to withdraw the proxy he has signed. All that is necessary would be to send a postal card to the secretary of the State Association, with these simple words upon it: "I hereby recall all proxies which I have given, granting to another the voting right on the subject of amalgamation." Therefore, each member has it in his power to recall his proxy if he wishes to do so.

Fraternally yours,

ANTITUBERCULOSIS WORK IN THE UNITED STATES.

S. A. Knopf, New York City (*Journal A. M. A.*, February 11th), reports progress in the organization of the medical profession and the public against tuberculosis in the last few years, including a list of the special sanatoria for patients suffering from this disease in the United States and Canada. These appear under various names—hospital, sanatorium, sanitarium, home, etc. The proper designation, he holds, is sanatorium, derived from the Latin word *sanare*, "to heal," while sanitarium evidently comes from the Latin word *sanitas*, "health," and is usually employed to designate some specially healthful locality suitable for convalescent patients or an institution for the care of nervous and mental diseases. That this is coming to be the general understanding of the term is shown by the adoption of the word sanatorium by all the more recent establishments and some of the old ones. The term "home" suggests an asylum, a place which the patient will enter and never leave, and from his observation he does not think that these institutions, as a rule, are as well equipped for curative purposes as are the regular sanatoria. One institution on his list is a seaside sanatorium for tuberculous children, an institution of special value for this class of cases. Multiple institutions for scrofulous children will be required in the fight against consumption. He speaks highly of special tuberculosis dispensaries, a number of which have been established in the large cities, and he thinks that special wards in general hospitals for this class of cases are next best, though not equal to special institutions. Isolation of consumptives in asylums and prisons is desirable, and Dr. Knopf commends the Agricultural Colony connected with the Texas prison as a worthy example. He holds also that such establishments would be of great advantage to indigent convalescents discharged from sanatoria, especially those who had formally followed unhealthy occupations. He pleads for the cooperation of the various boards throughout the country in combating the ravages of tuberculosis.

Book Reviews.

INTERNATIONAL CLINICS, a quarterly of especially prepared original articles and illustrated clinical lectures 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, M.D., Philadelphia. Vol. I, fifteenth series. Philadelphia and London: J. B. Lippincott Company, 1905.

This volume opens with an interesting clinical lecture on the Treatment of Cardiac Asthma, by Merklen, of Paris, and is followed by the report of a clinic on Cirrhosis of the Liver, Unusual Syphilis, Tuberculosis, Suffocating Catarrh, and Mucomembranous Enterocolitis, by Robin, also of Paris. Chauffard, of Paris, contributes a paper on Therapeutic Indications in Infected Cholelithiasis, which is a valuable addition to the literature on this much discussed subject. The Carbohydrates of Human Urine in Health and Disease, is by Douglas, of Glasgow, and the Eye and Hand in the Diagnosis of Heart Disease, by Walsh, of New York. The latter is extremely well written and instructive. The Early Diagnosis of Heart Disease in Children, is by Parkinson, of London. Manges, of New York, writes on Aortic Stenosis, Adherent Pericardium, and Benedict, of Buffalo, on Intestinal Adhesions, and the report of a Case Illustrating Elasticity of the Hepatic Support. Skin-Grafting in the Late Treatment of Severe Burns Involving Extensive Areas of Skin, is by Young, of Glasgow. It is to be regretted that lack of space forbids extensive notice of this paper. It is one of the most valuable on this topic that has come under the notice of the present reviewer.

Dawbarn, of New York, contributes a paper on the Starvation of Malignant Growths by Depriving Them of Blood-Supply, and Durante, of Rome, Italy, one on A New Operative Method for Total Extirpation of the Larynx. The Treatment of Knee-Joint Disease, is by Hibbs, of New York, and the Treatment of Glenard's Disease, by Gallant, of New York.

The opening paper under the head of Neurology, is by Mills, of Philadelphia, and is entitled Morphinomania, Cocomania and General Narcomania, and Some of Their Legal Consequences, and is followed by a Case of Cerebellar Tumor, by Carr, of London. Bramwell, of London, reports Two Cases of Ocular Palsy. Under Obstetrics, Jardine, of Glasgow, contributes a paper on Anterior and Posterior Parietal Presentations of the Head in Slightly Flattened Pelves.

Stevens, of Philadelphia, reviews in detail the Progress of Medicine During the Year 1904. That portion relating to typhoid fever is especially interesting and instructive. The practice at Johns Hopkins, of administering large quantities of water during the progress of the disease, the minimum being three liters a day, would appear to be at variance with the views held by certain practitioners, who claim that altogether too much fluid is given under these circumstances, resulting in overdistension of the blood vessels and increased strain on the heart. Edsall and Stanton, of Philadelphia, present a review of Medicine, and one of Surgery, by Bloodgood, of Baltimore, closes the volume.

VOLUME II.—FIFTEENTH SERIES.

Morse, of Boston, contributes the opening paper of this volume, writing on the subject of the Treatment of Acute Nephritis in Childhood. This paper is followed by one from the pen of Hayem, of Paris, on the Therapeutic Indications of Kephir. For the information of those who are not thoroughly abreast of the times in their knowledge of dietetics, it is well to state that "Kephir is cow's milk that has undergone a special mode of fermentation through the action of a mushroom, called kephir seed." Hayem's article is interesting and valu-

able. Some Observations on the Treatment of Pulmonary Hemorrhage by Adrenalin Chlorid, is by King, of London, and Suggestions Regarding the Treatment of Neurasthenia, by Edes, of Boston. X-Ray Treatment of Tinea Tonsurans, by Sabouraud and Noire, of Paris, gives hope that the ordinary baldheaded individual may, in time, grow a luxuriant thatch if he possesses sufficient patience.

The Diagnosis of Incipient Thoracic Tuberculosis, is by Willson, of Philadelphia. Just why "thoracic" should have been used instead of "pulmonary," the reviewer does not know. The paper, also, is altogether too long; Kelly should have used his blue pencil. Uremic Psychosis; Multiple Gastric Ulceration; Diabetes Mellitus, is a clinical lecture by S. Solis Cohen, of Philadelphia; Galloping Typhoid Fever, is by Roger, of Paris, and an interesting paper on Plague, is by Williamson, presumably of Bombay, India. Benedict, of Buffalo, writes entertainingly on Seasickness, with Special Reference to Its Pathology. Strange as it may appear to the uninitiated, he states that "the essential cause of seasickness is the motion of the boat." We had supposed it was more commonly due to the table-stake games going on in the smoking-room. But the paper is interesting, and the easy flow of words shows Benedict at his best.

The Pathology and Treatment of the Hernias of Children, and Their Relation to Similar Conditions in the Adult, is by Corner, of London, and Injuries of the Prostate Gland, by Lydston, of Chicago. Eisendrath, of Chicago, writes on Enlargements of the Testis and Epididymis, and Lermoyez and Bellin, of Paris, on Acute Purulent Generalized Meningitis. Clinical Notes on Intracapsular Fractures and Dislocations at the Hip-Joint, is by Manley, of New York; Traumatism as an Etiologic Factor in Infectious Diseases of the Bones and Joints, by Cumston, of Boston; Sarcoma of the Gluteal Region, Epithelioma of the Leg, Angioma of the Lower Lip, a clinical lecture, by Sherrill, of Louisville, and the Use of Scopolamin as a General Anesthetic in Surgery, by Terrier, of Paris.

Palmer, of Cincinnati, writes on the Rational Therapy of Uterine Displacements. The present reviewer regrets exceedingly that existing conditions preclude him from expressing an opinion in detail of certain statements contained in this paper, as, for instance, "A pure displacement of the uterus always means some hernia of the pelvic floor." If gynecologists would disregard some of the autocratic dicta promulgated by men of their ilk in a bygone age, and accepted by the present generation as something little less than holy because of the reputation of the teacher, the understanding of gynecology and the proper treatment of pelvic conditions would be more in accord with the rules of common sense. Ten years ago a uterus which could be easily palpated from cervix to fundus, through the anterior vaginal wall and bladder without the necessity of pressure on the anterior abdominal wall, was considered so abnormally placed that operative interference was indicated, in spite of absence of pathological symptoms. Who would advise operation in such a case to-day? And there exist at the present time about as many ridiculous notions concerning a retrodisplaced organ. It is sincerely to be hoped, for the sake of our women patients, that a clearer understanding of these conditions will soon be on the way. In the name of Allah let us have fewer handed-down, half-baked theories and more real knowledge of pelvic anatomy and dynamics! But Palmer's paper contains much good, solid meat, and one sentence contained in it should be blazoned on the walls: "Neither an Alexander-Adams nor a hysterorrhaphy will relieve the symptoms of any displacement unless the pelvic circulation is bettered." The bettering of this same pelvic circulation should be at the root of all treatment of uterine displacements, and the sooner specialists realize the fact the better it will be for everybody concerned.

The Clinical Significance of Exophthalmos, is by Mary Buchanan, of Philadelphia. Mary writes well, but her paper savors of the pedantic. Pierce, of Chicago, writes on the Symptoms and Diagnosis of the Suppurative Diseases of the Accessory Sinuses of the Nose; Hem-

meter, of Baltimore, on Some Physiologic Aspects of Erlich's Side-Chain Theory, and Its Application to the Physiology of Digestion, and Wiesel, of Vienna, on the Anatomy, Physiology and Pathology of the Chromaffin System, with special reference to Addison's Disease and Status Thymicus.

These two volumes of *International Clinics* are up to the average, which, as all know, is high, but the editor, now that he is home from his summer vacation, and is strong and healthy, should use his blue pencil more strenuously. Many of the papers are too long, and the good King's English in several instances is woefully emasculated, and by some of his own townsmen at that. It is not often, either, that a publisher knows just what variety of subjects in a work of this kind will most appeal to his clientele, but an editor should be thoroughly conversant with this detail of his work, and should be guided accordingly, which same would result in a greater degree of satisfaction on the part of his readers. Advice is free, and we tender it absolutely without regard for the pain it causes us.

The Lippincott Company desires us to draw particular attention to the fact that the price of each volume of *International Clinics* is but \$2. We do this with much pleasure, and add, on our own account, that each would be cheap at double the price asked.

THE TREATMENT OF FRACTURES, WITH NOTES UPON A FEW COMMON DISLOCATIONS. By Charles Locke Scudder, M.D., Surgeon to the Massachusetts General Hospital. Fifth edition, thoroughly revised, with 739 illustrations. Philadelphia and London: W. B. Saunders & Co., 1905.

In this edition the author has added to his popularity and general acceptance, as the best textbook on fractures, both general and special. It has been necessary to issue a new edition each year, and with each issue new material and the latest methods of treatment. In the present number particular attention has been given to the use of X-rays in diagnosis. Of the fifty new illustrations, many are of the X-ray, and it becomes essential to use this method of diagnosis to secure accuracy. The evidence of careful revision of the text is shown throughout the book. The author is particular in the important changes given to the new method of treatment for fractures of the neck of the femur. Of sixteen cases treated at the Massachusetts General Hospital by traction, thirteen have impaired functional use of the leg. The old-time method of treatment of fracture of the neck of the femur did not produce satisfactory results.

The illustrations are numerous, clear, and very satisfactory. It is a book worth having, and very useful to the general practitioner of medicine and surgery.

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 City Hospitals, Randall's Island, New York; Consulting Ophthalmologist to the French Hospital and to the Red Cross Hospital, New York; Adjunct Ophthalmic Surgeon to Mt. Sinai Hospital, New York, etc. Fourth edition, revised. With 360 original illustrations, including 21 plates, with 60 colored figures. New York: William Wood & Company, 1905.

CURRENTS OF HIGH POTENTIAL OF HIGH AND OTHER FREQUENCIES. By William Benham Snow, M.D., Author of "A Manual of Electro-Static Modes of Applications, Therapeutics, Radiography and Radiotherapy," Professor of Electro-Therapeutics and Radiotherapy in the New York School of Physical Therapeutics, Editor of the *Journal of Advanced Therapeutics*, and Late Instructor in Electro-Therapeutics in the New York Post-Graduate School, etc. New York: Scientific Authors Publishing Company, 1905.

PATHOLOGICAL AND MORBID ANATOMY. By T. Henry Green, M.D., F.R.C.P., Consulting Physician and Emeritus Lecturer on Clinical Medicine at Charing Cross

Hospital, London, and Consulting Physician to the Brompton Hospital for Consumption and Diseases of the Chest. Tenth American, revised from the tenth English edition. Revised and enlarged by W. Cecil Bosanquet, M.A., M.D. Oxon., F.R.C.P., London, Assistant Physician (Late Pathologist) to Charing Cross Hospital, London, and to the Brompton Hospital for Consumption and Diseases of the Chest; formerly Fellow of the New York College, Oxford. With a colored plate and 348 illustrations in the text. Philadelphia and New York: Lea Brothers & Co., 1905.

THE READY REFERENCE HANDBOOK OF THE DISEASES OF THE SKIN. By George Thomas Jackson, M.D., Chief of Clinic and Instructor in Dermatology, College of Physicians and Surgeons, New York; Consulting Dermatologist to the Presbyterian Hospital, New York, and to the New York Infirmary for Women and Children; member of the American Dermatological Association, and of the New York Dermatological Society. With 91 illustrations and 3 plates; fifth edition, thoroughly revised. New York and Philadelphia: Lea Brothers & Co., 1905.

THERAPEUTICS: ITS PRINCIPLES AND PRACTICE. By Horatio C. Wood, M.D., LL.D. (Lafayette, Yale, Pennsylvania), Professor of Materia Medica and Therapeutics in the University of Pennsylvania; member of the National Academy of Science. Twelfth edition. Thoroughly revised and adapted to the eighth (1905) edition of the *United States Pharmacopœia*, by Horatio C. Wood and Horatio C. Wood, Jr., Demonstrator of Pharmacodynamics in the University of Pennsylvania. Philadelphia and London: J. B. Lippincott Company, 1905.

A TEXTBOOK OF CLINICAL DIAGNOSIS BY LABORATORY METHODS, for the use of students, practitioners and laboratory workers. By L. Napoleon Boston, A.M., M.D., Associate in Medicine and Director of the Clinical Laboratories, Medico-Chirurgical College, Philadelphia; formerly Bacteriologist at the Philadelphia Hospital and at the Ayer Clinical Laboratory of the Pennsylvania Hospital. Second edition, revised and enlarged, with 330 illustrations. Philadelphia and London: W. P. Saunders & Co., 1905.

A TEXTBOOK 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. Second edition, rewritten and enlarged, with 701 illustrations, many of them in colors. Philadelphia and London: W. B. Saunders & Co., 1905.

LECTURES UPON THE PRINCIPLES OF SURGERY, delivered at the University of Michigan. By Chas. B. Nancrede, A.M., M.D., LL.D., Professor of Surgery and of Clinical Surgery in the University of Michigan, Professor of Surgery in Dartmouth Medical College, Emeritus Professor of General and Orthopedic Surgery, Philadelphia Polyclinic; Late Senior Vice-President of the American Surgical Association; Corresponding Member of the Royal Academy of Medicine, of Rome; Member of the Société Internationale de Chirurgie; Member of the American Academy of Medicine, Member of the American Medical Association, Late Major and Chief Surgeon, U.S.V., etc. With an appendix containing a résumé of the principal views held concerning inflammation, by Wm. A. Spitzley, A.B., M.D., Late Senior Assistant in Surgery, University of Michigan. Second edition, thoroughly revised. Philadelphia and London: W. B. Saunders & Co., 1905.

THE PRINCIPLES AND PRACTICE OF MEDICINE, designed for the use of practitioners and students of medicine. By William Osler, M.D., Fellow of the Royal Society, Fellow of the Royal College of Physicians, London; Regius Professor of Medicine, Oxford University; Honorary Professor of Medicine, Johns Hopkins University, Baltimore; formerly Professor of the Institutes of Medicine, McGill University, Montreal, and Professor of Clinical Medicine in the University of Pennsylvania, Philadelphia. Sixth edition, thoroughly revised, from new plates. New York and London: D. Appleton & Co., 1905.

Original Articles.

DIAGNOSIS AND TREATMENT OF GASTRIC ULCER.¹

BY WILLIAM VAN V. HAYES, Ph.B., M.D.,
New York City.

THE diagnosis of gastric ulcer, "peptic ulcer" or "round ulcer," is frequently easy, but it may be difficult or impossible for the reason that the symptoms are indefinite or wholly absent. Like many other gastric disorders, ulcer may exist for a long time without causing distress and may even eat its way through a large blood-vessel, producing fatal hemorrhage, or perforate the gastric wall without previously causing sufficient annoyance to lead its victim to seek medical aid.

However, the typical picture of gastric ulcer is unmistakable. There is pain coming on a short period after eating, sometimes before the patient has left the table; vomiting of food at the height of the pain, when the mechanical rubbing of the food alone or with associated commencing free acidity proves a sufficient irritant; and the vomiting of bright red or purplish-brown blood in considerable quantity, or in small quantity blended with the food. The stools after a considerable hemorrhage have the well-known tarry appearance. At some point in the gastric area there is distinctly localized and very marked tenderness, and corresponding tenderness, though less exquisite, behind, just to the left of the tenth, eleventh or twelfth dorsal vertebrae. The patient is almost immediately distressed by taking any coarse or highly seasoned food and by ice-cold, very hot or alcoholic drinks. Frequently certain positions cause pain, especially as Leube states so emphatically, lying on the right side. One of my own patients recently gave interesting corroboration of this point. Up to the time of his gastric hemorrhage he was accustomed to sleep on his right side, and preferred to do so. After the hemorrhage he could no longer rest comfortably in this position.

Often, however, the characteristic symptoms are absent, and it is necessary to weigh with special care all the evidence. One should note the character of the pain—which may be burning, stinging, gnawing or may simply give a sense of soreness—its time of occurrence and its location. Pain due to the ulceration of the cardiac orifice is felt as the food, especially solid food, enters the stomach; whereas the pyloric ulceration commonly causes pain one to three hours after the meal. Ulceration between these points usually produces pain a short period after food has been taken.

Having noted carefully the position of the stomach, a painstaking examination must be made to locate any epigastric and dorsal points of tenderness and to find by inspection and palpa-

tion, if there be evidence of thickening of the gastric wall at the tender spot. Some of the best authorities claim that it is almost impossible to locate an ulcer which is not situated at one of the openings of the stomach, but I am convinced that it is often possible to do so if sufficient time and pains are taken.

If there has been no recent hemorrhage and the symptoms described above are not marked, it is safe to give a test meal, provided the following suggestions are observed. Paint the throat with 4 per cent. cocaine solution and use a soft velvet-eyed tube with side openings; be careful not to carry the tube far into the stomach, usually not more than 20 or 21 inches from the teeth; instantly withdraw it if the patient has a tendency to violent straining. The contents taken one hour after the test breakfast will usually show a total acidity exceeding 60 and a free HCl content exceeding 20 or 30. This I believe to be true, in spite of the fact that Dr. Campbell Howard, of Johns Hopkins, found hyperacidity in only 27 per cent. of 82 cases recently reported by him. Van Valzah and Nisbet state that hyperacidity exists in 70 per cent. of the cases. Not only is hyperchlorhydria found, but often there is evidence of a well-marked hypersthenic gastritis.

Both the gastric contents vomited—or obtained through the tube if this can be done with safety—and the stools should be carefully studied for blood pigment. It is well to be certain that no rare meat or fish has been eaten two or three days before the stools are examined.

To test the gastric contents for blood Weber's method is most convenient. To 10 c. c. of the contents in a test tube add 3 c. c. of glacial acetic acid and shake well. Ether (5 to 10 c. c.) is now added and the tube again well shaken. The ether separates in a layer after standing a little while and usually has a brownish color if blood be present. The ether extract is now decanted or drawn off, and to it is added 10 drops of fresh tincture of guaiac (made each time by chipping a little resin of guaiac into alcohol) and then 20 to 30 drops of ozonized turpentine (ordinary spirits of turpentine allowed to stand two or three days in an open dish). After a few moments a blue color appears if blood is present. Van Valzah and Nisbet recommend substituting for the turpentine a small amount (6 or 8 drops) of hydrogen peroxide, which is more convenient and satisfactory.

The feces should be softened with water and shaken with pure ether to remove the fat, after which the test for blood may be made, as in the case of the gastric contents.

Further, in arriving at a diagnosis in doubtful cases, probable causative and predisposing factors should be considered—*i. e.*, malnutrition and anæmic states, as well as previous gastric superacidity.

A history of traumatism, external blows, reckless use of stomach tubes, the use of an improperly constructed tube, injury due to thermal or chemical irritation, all render more likely the

¹Read at the Twenty-first Annual Meeting of the Fifth District Branch of The New York State Medical Association, at Poughkeepsie, N. Y., May 2, 1905.

diagnosis of ulcer. The fact that a patient is under 40 and a woman increases somewhat the probability of ulcer.

To summarize, the characteristic symptoms and signs are: The peculiar pain, and the distress caused by a certain position, commonly lying on the right side; the vomiting; the hematemesis; the tender points, epigastric and dorsal; the melæna or small amounts of blood in the stools as shown by chemical tests, and the symptoms due to the hyperchlorhydria or hypersthenic gastritis.

Differential Diagnosis.—The conditions most frequently mistaken for gastric ulcer are duodenal ulcer, hyperchlorhydria and hypersthenic gastritis, gastric carcinoma, gastralgia and chololithiasis. In duodenal ulcer the pain is delayed, occurring when the stomach is empty; it is located more to the right; there is little tendency to vomiting; the blood, if hemorrhage exists, regularly escapes by the bowel and is rarely vomited. In hyperchlorhydria and hypersthenic gastritis the pain usually comes somewhat later, and is relieved more completely by alkaline medication; there is little vomiting as a rule; the tenderness, if present, is diffused over the stomach. In gastric carcinoma the pain comes on irregularly; it is not directly related to the taking of food, but may be due to its retention with the formation of organic acids. There is vomiting when obstruction exists. If blood is expelled, it is almost invariably of the familiar "coffee-ground" variety. In gastralgia the pain is inconstant; it is not directly related to the taking of food, and is helped by pressure or electric current. Other neurasthenic symptoms are to be found as a rule. With chololithiasis the pain is more to the right, radiating to right chest and shoulder; the dorsal tender point, if present, is to the right of the spine; the gall bladder may be distended and sensitive; the liver is congested and tender; there may be jaundice; gall stones may be found in the feces, and there may be rigidity of right costal arch. (Eliot.)

The most frequent complications are (1) hypersthenic gastritis; (2) anæmia and inanition; (3) perforation with associated pain, shock, abdominal rigidity, diminished or absent liver dullness; (4) perigastritis; (5) abscess formation; (6) deformities; pyloric obstruction, cardiac obstruction and distortion of body of stomach; (7) engrafted carcinoma.

Treatment of Gastric Ulcer.—Where there is repeated severe hemorrhage, perforation with its various sequelæ, cicatricial obstruction, engrafted carcinoma, or, where the case is intractable after a reasonable length of time, a competent surgeon should be consulted.

Essentials of Medical Treatment.—(1) Rest in bed, ordinarily four or five weeks—*i. e.*, a week or two if possible after abnormal signs and symptoms are controlled. The rest during the first few weeks should be complete, the patient not being allowed to sit up for any purpose.

(2) Proper alimentation. This includes the selection of a suitable diet and feeding by rectum in the more severe cases.

The importance of proper alimentation cannot be overestimated. It is necessary to vary the food according to the need of each particular case, but the following will serve to illustrate the general plan employed:

Milk, if it agrees, may be given, one-half to one glass every two hours. It should not be very hot or ice cold, and may be combined with two ounces of vichy or lime water. If taken plain, it should be slowly sipped and insalivated. If milk is not well tolerated, the whites of two eggs beaten up with water and two ounces of beef juice may be given alternately every two hours. This should be continued for a period of about ten days, until the symptoms are well controlled, when there may be added strained gruels, thickened soups, flaked rice, the fine wheat cereals or tapioca cooked until thoroughly done, chicken or pigeon stewed and minced, fish with a tender white meat, baked or broiled, soft-boiled or lightly poached eggs, bread—a day or two old, free from crust—butter and cream. After a few weeks the patient may be allowed a general diet, but should be warned to abstain from all seedy fruits or vegetables of coarse texture and with tough hulls. The latter when served should be made into a fine purée.

Rectal feeding should be employed for four to fourteen days in hemorrhagic and severe cases. The following suggestions may prove helpful:

Give cleansing enema one hour before nutrient enema.

Nutrient enema to be given through long tube (with side openings, velvet eyes), patient's hips being raised on pillow. Towel held against anus twenty minutes. Patient to retain position on pillow one-half to one hour.

Enemata to be given three times daily.

Formula:

- | | |
|-------------------------|----------------------------------|
| a. Milk, peptonized.... | 5 ounces. |
| Yolk of egg..... | 1 |
| Claret | 1 tablespoonful. |
| Prepared cereal food. | 1 tablespoonful. |
| Salt..... | $\frac{1}{4}$ level teaspoonful. |
| b. Milk..... | 4 ounces. |
| Water | 1 ounce. |
| Eggs | 2 |
| Salt..... | $\frac{1}{4}$ level teaspoonful. |

The milk and egg in this preparation may be predigested with pancreatine 5 grains and bicarbonate of soda 15 grains. Place receptacle containing this mixture in wooden bucket of water as hot as can be borne by hand and allow to remain one hour. One tablespoonful of arrowroot made into paste may be added before predigesting.

- | | |
|--|----------------------------------|
| c. Some standard preparation of peptones | 1 ounce. |
| Water or peptonized milk | 5 ounces. |
| Salt..... | $\frac{1}{4}$ level teaspoonful. |

Alcohol may be driven off peptone solution by using boiling water in making dilution or allowing to simmer a short time on stove.

Add 3 to 5 minims tincture of opium to each enema if bowel is irritable.

(3) Suitable medication. Drugs to control bleeding, if present, hyperacidity, if present, to protect ulcer and to stimulate healing, to control anæmia and to regulate the bowels.

Warm compress over stomach if comfortable to patient.

The remedies commonly employed with benefit are nitrate of silver, which should be given in solution, one-fourth grain in a half-ounce of water undiluted every morning when patient awakes, for a period of about ten days. After stopping this it is helpful to give bismuth subnitrate in dram doses at bedtime, which may be continued for weeks if need be.

If an alkali has not been combined with the liquid nourishment a powder made up as follows may be given fifteen minutes after the food is taken:

Bismuth sub. carb.	gr. iii.
Sodii bicarb.	
Magnesia carb. levis a	gr. v.

In case the bowels are relaxed, prepared chalk should be substituted for the magnesia in the above powder.

Extract of belladonna, in doses of 1/50 to 1/25 grain three times daily with meals, often increases the comfort of the patient and helps in the cure.

After the first ten days Carlsbad sprudel salts powder, one-half to 2 teaspoonfuls dissolved in a half-pint of warm water, should be given in the morning a full hour or more before food is taken. If necessary the bowels may be moved by an enema of warm water at any stage of the treatment.

For Hæmorrhage.—If there be hæmorrhage the essentials of the treatment are:

Absolute quiet.
Hypodermic injection: Morphine sulphate, gr. 1/4.

Atropine sulphate, gr. 1/150.
Adrenalin chloride (1-1000) 30 drops well diluted, by mouth.

Ice bag or cool compress to epigastrium.
If necessary, one pint warm normal saline solution by hypodermoclysis, by rectum or by intravenous injection.

Nutrient enemata after twenty-four hours.
For Anæmia.—Iron, preferably a liquid preparation, as tinct. of the chloride of iron, 10 to 15 drops, in egg albumen water taken through a tube three times daily. (Ewald.)

Feiner's method, which is of unquestioned value, in suitable cases, is employed as follows:

Lavage till clear fluid returns, after which bismuth subnitrate, 2½ to 5 drams, in a glass of warm water, is allowed to flow into stomach. The tube is then compressed and the patient occupies a posi-

tion favoring deposit of bismuth on ulcer. After five or ten minutes the water is withdrawn through tube, leaving a healing protecting coating of bismuth.

Van Valzah and Nisbet think it wiser to omit use of tube and to administer one glass of Carlsbad water to cleanse stomach and then one hour later to give 2 drams of bismuth in one-half glass of water once daily for seven to ten days.

Riegel advises the administration of bismuth in all cases of ulcer. He gives 150 grains suspended in water, having the patient drink this some time during the forenoon.

THE SYSTEMATIC EXAMINATION OF SCHOOL CHILDREN'S EYES.¹

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ACCORDING to the Census Bureau statistics, there are in the United States 15,000,000 children of school age. One million two hundred thousand of these school children are residents of New York State, and 25,000 of them live in Rochester. These figures show the magnitude of the State's responsibility in preparing this vast multitude for future citizenship.

The State has for some time recognized the importance of surrounding its school children with the best hygienic conditions, realizing that a little store of knowledge or a little culture will not be of much avail if they come out of the ordeal with broken health or with physical degeneration. In the main, public education is intended to equip the youth of our land for the struggle of life which is before them. The State defeats its avowed purpose when it sends them forth with constitutions less able to resist disease than before or suffering from ill health—the direct result of the confinement and strain incident to school life. Herbert Spencer taught that vigorous health and the high spirits accompanying it constitute the largest elements of happiness. We probably all accept the threadbare adage: "Mens sana in corpore sano." Yet, in our public life, while we have dealt liberally with the training and developing of the mind, proportionately little has been done towards caring for and strengthening the body.

It is not the purpose of this paper to take up the subject of general hygiene, but to confine it to a consideration of the effects of school life on the eyes of school children. Much work has already been done in gathering statistics on this subject, and much study has been given to the facts established thereby. Among these workers the names of Cohn, in Germany; Ware, in London; Szokalski, in Paris; Jaeger, in Vienna; Erisman, in St. Petersburg, and Risley, in Philadelphia, stand out prominently. There are published records of over 200,000 examinations of the eyes of school children, undertaken to determine the relative frequency of normal and ab-

¹Read before the Rochester Academy of Medicine, March 29, 1905, and the Rochester Pathological Society, April 13, 1905.

normal eyes, and the presence or absence of disease. A brief résumé of these statistics shows the following fundamental facts:

First.—That at the beginning of school life the number of hypermetropic eyes (the short, undeveloped eye) greatly exceeds the number of emmetropic (the normal eye) and myopic eyes (the long, stretched-out eye).

Second.—That the myopic eye—very seldom congenital—is rarely seen at the beginning of school life.

Third.—That the percentage of normal eyes remains the same throughout the school period.

Fourth.—That corresponding with the pupil's advance in the school grades the percentage of myopic eyes greatly increases, while the percentage of hypermetropic eyes proportionately falls.

Fifth.—That not only does the percentage of myopic eyes increase with the progress of the pupils, but the degree of myopia also increases.

Cohn's statistics in the following table show very conclusively the advance of myopia with the advance of school life:

	Percentage of Myopia.
Five village schools.....	1.4
Twenty elementary schools.....	6.7
Two higher girls' schools.....	7.7
Two intermediate schools.....	10.3
Two realschulen.....	19.7
Two gymnasias.....	26.2
Among university students.....	59.5

All authorities agree that the number of short-sighted pupils is in direct proportion to the length of time devoted to school life. In our country the percentages are not so high as those found in the German schools. The following table, compiled from the statistics of twelve American investigators, gives the average percentage of myopic eyes found in the different grades of our schools:

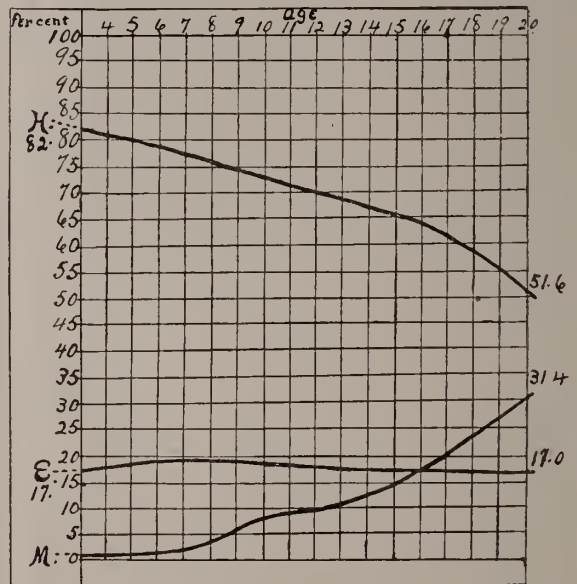
	Percentage of Myopia.
Primary (1, 2, 3 grades).....	3.3
Average age of pupils, 6, 7, 8 years.	
Intermediate (4, 5, 6 grades).....	8.5
Average age of pupils, 9, 10, 11 years.	
Grammar (7, 8 grades).....	11.0
Average age of pupils, 12, 13 years.	
High school (4 years).....	17.5
Average age of pupils, 14, 15, 16, 17 years.	
College students.....	31.4

It is a well-established fact that myopia is rarely found among the uncivilized races, and among those whose eyes have not been required to perform continuous near work. This question naturally arises then: What significance should be placed on these facts? Is the myopic eye simply a physiological adaptation to the conditions required in making close use of the eyes,

or are these changes pathological? Erisman states that in 1,200 myopes examined by him he found that 95 per cent. had some pathological lesion of the choroid. Cohn (*Hygiene des Auges*) states that in 800 myopes Horner found that 47 per cent. showed some pathological condition—9 per cent. showing disease of the vitreous; 11 per cent., disease of the choroid; 4 per cent., detached retina, and 23 per cent., some form of cataract. Riseley found, as the result of his extensive examination of the school children in Philadelphia, that among the myopic eyes, 87 per cent. exhibited some form of choroidal disease. Between 5 and 6 per cent. of all blindness is due to myopia. This array of evidence, I am sure, will be sufficiently ample to convince any one not only that near-sight is a disease, but also that it is a serious disease.

Ophthalmologists since Donders have regarded the myopic eye as a sick eye, and the problem of preventing myopia and of checking its progress vexes the profession even to-day.

During the past decade much attention has been given in our own country and in Germany also, to the proper ventilating, lighting and furnishing of school houses, according to scientific principles; and much care has been exercised in selecting the proper type and printing for school books, and in seeing that pupils assume correct



H. = hypermetropia
 E. = emmetropia
 M. = myopia

positions while studying. All these most desirable reforms, although carried out now for a number of years, have been a disappointment to the hope that they would materially decrease the number of near-sighted pupils. Wherein, then, does prevention lie?

The diagram shows that while the percentage of normal eyes remains practically stationary throughout life, the percentage of myopic eyes increases with school progress, and the percentage of hypermetropic eyes proportionately falls. Therefore, the myopic eyes must be recruited from the hypermetropic. And, further, cases under direct observation have been found to pass from hypermetropia into myopia. This is the common experience of every ophthalmologist. Dr. Norris² and Dr. Risley³ have given us the detailed reports of several such cases which have come under their observation. Dr. Risley holds that hypermetropic astigmatism plays the all-important rôle in producing myopia. He says: "My own cases, without exception, passed from the hypermetropic ball over into near-sight through the turnstile of astigmatism." We have learned—at least the concensus of competent opinion teaches—that myopia, except for a very few congenital cases, is derived from hypermetropia; and, moreover, hypermetropia, especially hypermetropic astigmatism, is the principal underlying causal factor in the production of near-sight.

In order to determine what effect, if any, the correction of errors of refraction might have on the prevention of myopia, Dr. Risley made a study of his own private cases and also of the prescriptions of two optical companies. These prescriptions covered a period of twenty years—1874-1894—during which time the oculists of Philadelphia have very generally corrected all refractive errors. These studies considered the correcting glasses for nearly 200,000 eyes. They show that the proportion of myopia at the beginning of this period (1874-1880) was 26.9 per cent.; for the end of the period (1890-1893) it had fallen to 16 per cent. They also show that the degree of myopia had fallen as well. These facts are very good evidence in favor of the utility of glasses in preventing myopia.

The development of myopia is but one—the most dreaded to be sure—of the evil results which the close application of school life may produce in a defective eye.

Much work in gathering statistics has been done in different parts of the world to learn what proportion of school children has defective eyes. The percentage given by different authors varies widely. Dr. Risley found that among the school children of Philadelphia the percentage was as high as 88; Truc, of Montpelier, France, among the school children of that city, found it was 24; Uribe-Troncoso, in the City of Mexico, found it was 42.3. In Columbus, O., the percentage of pupils of the high school found to have defective eyes was 56; in London, among the pupils of the seventh grade, the percentage was 20. The above differences of percentage can be accounted for largely on the ground of the personal equation, for each man has his own opinion as to what constitutes a normal eye.

In a large majority of cases a child with defective eyes will have defective vision, but this is not always the case. When the vision falls much below normal, the child is proportionately handicapped in pursuing his studies or is prevented almost entirely from acquiring knowledge by means of sight. You will readily admit, I am sure, that vision is all-important to a child in pursuing his course of study in our public schools. Yet there are many pupils there to-day with defective vision, some having only one-half normal vision or even less, and many of these could be given perfect eyesight. By way of illustration, the history of the following case is interesting: On February 9, 1905, Robert Pearl, an intelligent boy, 16 years of age, came to my office for examination of the eyes, presenting this condition; Vision of right eye, fingers only; vision of the left, 10/200. His right eye is practically blind. The left, his better eye, had only 1/20 of normal vision. He said that he always had had very bad vision, but that he never had had his eyes examined except once when he was about 4 years old. At that time his mother took him to the City Hospital, but nothing was done for him. He never had glasses at any time. My examination showed that his eyes were shallow and undeveloped, but with the correcting glass, a +10 spherical, his distant vision was improved from 10/200 to 20/30, which is within one line of perfect vision; and whereas without glasses he could read only the largest type in the headlines of a daily paper, with them he could read easily the small and crowded type. This boy has struggled all through his school life attempting to do the impossible, whereas during all this time he could have been enabled to see quite as well as his companions. By this unpardonable neglect he was left needlessly hampered; and it was a most pathetic tale that he told of his struggle in attempting to do his daily school tasks. He had been scolded and abused by both parents and teachers when he continually failed to "get the lessons." On two occasions, he remembered, he had been sent home because he had said that he could not see. Nevertheless he had been kept in school more or less of the time for the past ten years; but he had acquired the little knowledge he possessed in the way James Whitcomb Riley says most of us get it—on the way to and from school—for the large print of the bill-boards and the bright signs of the theater opposite his home taught him to read. Not until both parents were dead did he have the good fortune to fall into the hands of some one of sufficient intelligence to have his eyes examined. After the glasses were put on, the delight with which he read the paper for the first time in his life was worth seeing. What a travesty on the educational system which attempts to teach a boy who can see only 1/20 of the normal amount! And how pathetic when we realize that good vision was within his grasp all the time; and that the ten most valuable years of his educational

²Transactions of Am. Oph. Society, Vol. IV, p. 369.

³Transactions of Am. Oph. Society, Vol. IV, p. 520.

period were unnecessarily wasted! You may say that this is an exceptional case. It is in degree, but it is typical of a large class of such cases among school children.

Besides this class of defective eyes which have defective vision, there is also a large number of defective eyes which have perfectly sharp, normal vision. For the most part, these are hypermetropic eyes in which there is sufficient power of accommodation to overcome the error of refraction, but perfect vision is obtained at the expense of an abnormal amount of ciliary muscle work—commonly called eye-strain. In these eyes there is likely to develop a peculiar group of symptoms—headache, ocular pains, early fatigue, watery eyes, eyes sensitive to light, etc. These pupils are called asthenopic, weak-eyed, since they are not able to use their eyes long without suffering from some or all of these symptoms.

What effect do these various conditions, depending on, and resulting from defective eyes, have on the child's progress and on his morals? In order to answer this very question the Health Board of New York City instituted an investigation, making a systematic examination of the eyes of all children in one school. It was found that those pupils who had the more marked defects of ametropia were older than the normal children of that grade, and that such pupils became discouraged, depressed and indifferent, and finally dropped out of school, half-educated. Dr. Evans, of the University of Pennsylvania says: "Eighty per cent. of the truants from school are suffering from defective eyesight." Children with defective brains and consequent defective morals, probably have defective eyes as a part of their generally deficient make-up. However, it is the consequential and natural evolution of the defective child to acquire a hatred for school when he finds his more fortunate companions easily outstripping him. When there is hatred for school there is laid the foundation for ignorance, and with ignorance are sown the seeds of idleness, shiftlessness and crime. Dr. Allport, of Chicago, says: "If the direct cause of criminality and pauperism could be accurately ascertained, I venture the opinion that the prevailing etiological factors would be physical defectiveness and social surroundings." New York State has recognized the relation between defective eyes and young criminals, and has provided its penal institutions for young offenders in Rochester, Elmira and on Randalls Island, with ophthalmologists to care for the eyes of the inmates of these institutions. If there is any ground for the belief that such physical defectiveness is a factor in making truants or criminals, would it not be wiser to apply the prophylactic before this class of youth becomes criminal?

Germany became deeply and vitally interested in the prevention of near-sight in the schools of that country because, in view of the fact that near-sighted youth do not make good soldiers, a large percentage had to be lost to the service of the

army—a serious matter there. We should have our interest excited on higher grounds than service in the army, for it is our desire to make good citizens rather than good soldiers. It is not only the State's duty to give every child an equal opportunity to acquire an education, but it is every citizen's inalienable right to have it—to be placed on an equal footing with his fellows to acquire an education. In order that a child may have the advantages which the State offers, so far as it is possible to mitigate or to remove any physical hindrance to his acquiring an education, it would seem to be the economic and moral duty of the State to mitigate or remove such hindrances.

The importance of preventing, or at least of checking, the development of myopia has been recognized for years by physicians and publicists. In Europe, especially in Germany and Italy, largely for economic reasons, the State has long ago assumed the responsibility of caring for the eyes of its school children and students; so that in these countries public inspection and supervision of schools by regularly appointed ophthalmologists is no novelty. In our country, although the subject has received considerable attention, the State has been reluctant to assume any degree of responsibility. Examinations of school children's eyes have been made spasmodically, and for the most part they have been undertaken with the object of gathering scientific data, but without any idea of attempting to relieve directly or to improve the evil conditions found. However, during the past few years, public opinion has been enlightened and public interest aroused to activity, so that to-day in a large number of our cities good and practical work is being done. In New York City the whole subject of physical defectiveness is being considered, and all backward pupils have not only their eyes examined, but also their ears, teeth and throats, and evidence of any other bodily deformity or physical weakness is carefully investigated. Mental capacity is also considered. This work is done by physicians connected with the Health Bureau and with the Board of Education.

Realizing the value and importance of the early detection and correction of ocular defects, and believing that the State should assume the responsibility of supervision at least, Dr. Allport started a movement that has been almost national in extent. Largely through his efforts, at the meeting of the American Medical Association in New Orleans, May, 1903, the following resolution was adopted both by the Ophthalmological Section and by the House of Delegates:

"WHEREAS, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of these 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, when possible, legislation be se-

cured looking to the examination of the eyes and ears of all school children, that disease in its incipency may be discovered and corrected."

Similar resolutions have been adopted since by the State medical societies of nearly every State in the Union, and by many State boards of education. Similar resolutions were also adopted in 1903 by the State and Provincial Boards of Health of North America and by the American Public Health Association. Encouraged by these actions of the national associations, State and municipal public health associations and boards of health throughout the country have taken up the work, and these bodies have pushed it forward in a practical way.

The State of Connecticut was the first to place a law among its statutes making it obligatory on the school authorities of the State to examine regularly the eyes and ears of all public school children. Vermont's Legislature has recently passed a similar law, the essential features of which I quote to you:

AN ACT PROVIDING FOR THE BETTER CARE OF THE HEALTH OF PUPILS IN PUBLIC SCHOOLS.

It is hereby enacted by the General Assembly of the State of Vermont:

Section 1. The State Board of Health and the superintendent of education shall prepare or cause to be prepared suitable test cards, blanks, record books and other needful appliances to be used in testing the sight and hearing of pupils in public schools and necessary instructions for their use; and the superintendent of education shall furnish the same, free of expense, to every school in the State. The superintendent, principal or teacher, in every school, during the month of September in each year, shall test the sight and hearing of all pupils under his charge and keep a record of such examinations according to the instructions furnished; and shall notify in writing the parent or guardian of every pupil who shall be found to have any defect of vision or hearing, or diseases of eyes or ears, with a brief statement of such defect or disease; and shall make written report of all such examinations to the superintendent of education as he may require.

These resolutions and this legislation have resulted in the systematic examination of school children's eyes in a number of our States and in many of the larger cities. Minneapolis and St. Paul, in 1895, were the first cities to adopt a method of having these examinations performed by the teachers. And now similar systems are being successfully used in many parts of the country, and have met with the approval of physicians, educators and people alike.

In our own State, while the Health Department does not require that these examinations be performed, not having the legal authority to do so, it is urging on the various health boards and school authorities of the State the importance of such work. The necessary funds have been placed at its disposal, so that this board will now

furnish free, to the proper authorities, the test-types, instructions for using the same, blanks for reports, etc.

The system of inspection which has proved most successful is the one, with modifications, which Dr. Allport first devised. Its principal features are these:

(a) That, either with or without the supervision of an ophthalmologist, the eyes of the pupils are annually examined by their teachers.

(b) That these teachers are given test-letters with instructions how to use them and how to record the findings.

(c) That cards with a few simple questions on them which are to be answered by the teachers are used as records.

(d) That from these tests and answers, when the record-card shows apparently some defect or disease, a note of warning is sent to the parent or guardian requesting that the child have his eyes examined.

By this simple method nothing obligatory is imposed on the parents; and neither the school authorities nor Health Bureau in any way undertakes either to make a diagnosis of disease or to offer any treatment. Simply stated, the system is this: Under the supervision of the Board of Education or the Health Bureau, these tests are made and the parents are warned of any defect which interferes with the child's school progress, and they are requested to arrange with their physician for the proper care.

These simple tests, although they are by no means perfect or accurate, will detect a very large percentage of eye defects. And when parents are notified in this way it has been found that they will heed the warning.

In this paper I have called your attention to these facts:

(a) That myopia is a serious disease in itself and in its sequelæ.

(b) That it develops during school life.

(c) That myopia, for the most part, is engrafted on a defective oversighted eye as the result of close application.

(d) That when such oversighted eyes are rendered functionally normal by correcting their errors of refraction, myopia is much less likely to develop.

(e) That children with defective eyes, in which myopia does not develop, are likely to have either defective vision or they are subjects of a group of annoying symptoms.

(f) That such defective vision or such symptoms very materially interfere with a child's progress.

(g) That defective eyes are often the underlying cause for truancy; or at least children with such eyes are soon discouraged and fall hopelessly behind or leave school without acquiring even the rudiments of an education.

I have shown, briefly, that the medical societies,

boards of education, and public health associations throughout the country are putting forth efforts to arouse public interest in the necessity for, and the utility of, some form of ocular inspection and systematic examination of school children's eyes; that successful systems are now in use in many cities, and in a few States these examinations are required by law; that in our own State the Health Commission is urging "the great importance" of such work.

A simple form of systematic examination and inspection by the early detection of ocular disease and defects would, undoubtedly, not only prevent and check many diseases, but it would also put a large number of defective children on an equal footing with their more fortunate companions in acquiring knowledge, and thus give them a more nearly equal opportunity in the struggle of life.

In conclusion, I wish to say that here, as in other fields of medicine, "Prevention is better than cure." And not only is prevention better than cure, but in the words of Dr. Allport, "Prevention is possible a thousand times, while cure is possible but once."

Printed Forms for Eye Work in Schools.

INSTRUCTIONS FOR THE USE OF TEACHERS.

(After the method of Dr. Allport.)

Do not expose the card except when in use, as familiarity with its face leads children to learn the letters "by heart."

First grade children need not be examined. The examinations should be made privately and singly.

Children already wearing glasses should be tested with such glasses properly adjusted on the face.

Place the "Vision Chart for Schools" (Snellen's) on the wall in a good light; do not allow the face of the card to be covered with glass.

The line marked XX (20) should be seen at 20 feet, therefore place the pupil 20 feet from the card.

Each eye should be examined separately.

Hold a card over one eye while the other is being examined. Do not press upon the covered eye, as the pressure might induce an incorrect examination.

Have the pupil begin at the top of the test-card and read aloud down as far as he can, first with one eye and then with the other.

FACTS TO BE ASCERTAINED.

1. Does the pupil habitually suffer from inflamed lids or eyes?
2. Does the pupil fail to read a majority of the letters in the number XX (20) lines of the Snellen's Test Types, with either eye?
3. Do the eyes and head habitually grow weary and painful after study?
4. Does the pupil appear to be "cross-eyed"?

NOTE OF WARNING TO BE SENT TO PARENT.

(Form used by the New York State Department of Health.)

Public School No. —.

Mr.

The examination of your (son's), daughter's (ward's) eyes, as required by the State Department of Health, shows them to be defective, and not up to the standard necessary for satisfactory performance of school work.

You should advise with your family physician, as to the choice of an eye doctor, whom you are to consult in the matter. Respectfully,

.....
Principal.

A CASE OF MULTIPLE NEURITIS AND DIABETES MELLITUS.¹

BY W. T. SHERMAN, M.D.,
Crown Point Centre, N. Y.

THIS case was of more than ordinary interest to me on account of its being my first experience with multiple neuritis, the protracted period of treatment and the results.

Family History.—Father living at age of 94 years and quite active. Mother died at age of 72 years from heart disease. Three brothers and one sister living and in good health.

Personal History.—Patient male, 62 years old; height, 5 feet 8 inches; usual weight, 170 lbs; merchant. Had diseases of childhood. Severe attack of la grippe in 1889. Severe attack of dermatitis herpetiformis of both legs, beginning in spring of 1900 and continuing for eighteen months.

Habits.—Inveterate cigar smoker. Takes usually 2 to 4 ounces whisky on retiring. Rarely any exercise out of doors. Denies any specific infection. Does bookkeeping and correspondence after closing store at night, rarely retiring before 2 A. M., and often 4 to 6 A. M. Remains in bed until noon. Breakfasts at noon. Lunch at 6 P. M. Supper at 11 or 12 midnight. This has been mode of life for twenty years. Is patent medicine fiend. Has had numerous attacks of rheumatism and treated himself with various patent cures. For six months before I was consulted patient had sciatic rheumatism of left leg and lumbago and had been treating himself.

Patient's statement to me in spring of 1903 as follows: In past four weeks had lost thirty pounds in weight; poor appetite; always constipated. Had taken a daily dose of sodium phosphate for past year, sufficient for relief. Very nervous and getting feeble and unsteady. Slept very little on account of sciatic pain. Urine scanty, at times high-colored, and again clear as spring water. Was getting forgetful. Irritable, and at times abusive over trivial things. Depressed about fate of business and his rapid loss of flesh and strength.

¹Paper read before the Essex County Medical Society, at the Annual Meeting, April 18, 1905, at Port Henry, N. Y.

PHYSICAL EXAMINATION.

Heart.—Apex and area of dulness normal, irregular, rapid and feeble. Rate, 80 to 100 normally; as low as 45 after taking phenyo-caffeine pills for pain. No murmur, dilatation or hypertrophy. Has dyspnoea. No oedema or cyanosis. Arteries not atheromatous.

Lungs.—Normal.

Liver.—Dulness extends two inches below costal margin. Skin clear.

Spleen.—Not enlarged.

Muscular System.—Muscles generally soft and flabby. General muscular tremor most pronounced on left side. Wasting of muscles of left hip, thigh and leg more than right side. Has left foot drop. Left patellar reflex absent; right feeble. No scars except on legs, from dermatitis herpetiformis. Painful points throughout course of left great sciatic nerve. Tremor of tongue, and when excited speech is defective.

Tongue.—Furred. No elevation of temperature. No thirst, drinks very little water; tea or coffee with meals.

Character of pain was as if bones were breaking in legs and arms.

URINARY EXAMINATION.

Amount, twenty-four hours, 16 ounces; color, light amber. Specific gravity, 1035; slightly acid. Abundance of sugar by Tehling's and Haines' tests. No albumin or sediment.

Diagnosis.—Sciatic neuritis with diabetes mellitus.

Prognosis.—Guarded, but favorable.

Treatment.—Strict diabetic diet after thorough purging with calomel. Followed diet strictly for three weeks, with exception of usual nightly dose of whisky, which patient was bound to have. No change in amount of sugar in urine. Patient lost ten pounds in weight, and strength accordingly. Neuritis had appeared in left upper extremity and cervico-occipital region. Pain of tearing or breaking character. Many coal-tar anti-neuralgics and analgesics tried, and effectual for few doses. Patient would not consent to morphine hypodermically. Electricity of no benefit. Bromides and chloral effective for few nights. Sulphonal and trional of no value. Tried salol and oil gaultheria in capsules for pain. Neuritis appeared in right half of body, leg, thigh, hip and, lastly, right upper extremity. After all this experimenting, I told patient he might eat anything that he thought he wanted, and I would now take care of his pain and the diabetes by other means. Put patient on codeine— $\frac{1}{4}$ -grain doses every two hours, gradually increased—to give relief of pain. Required $\frac{1}{4}$ -grain to 1-grain doses every two hours. After taking codeine for a week urine showed only trace of sugar. Appetite returning. First meal to relish was buckwheat cakes with maple syrup. Constipation corrected by nightly dose of cholagogue cathartic. No mild laxative effective. Could not take whisky while taking codeine. Sure to have nausea and vomiting if he did.

Mucous colitis was a distressing complication for a period of two months. No special treatment given for it. Neuritis ran typical course, until patient was unable to walk alone. Would sit up every day. Had foot drop of both lower extremities and wrist drop of both upper extremities. Weight, 115 pounds.

Patient was drinking lithia water freely every day. Urine increased in amount and free from sugar after three weeks' use of codeine. Appetite improved, neuritis subsiding. In April, 1904, pain was so slight I determined to stop codeine. Told patient what he might expect from abrupt withdrawal of drug. Gave hyoscine hydrobromide— $\frac{1}{50}$ grain every two or three hours, as necessary—after stopping codeine. This was very satisfactory, and after twenty-seven days I was able to withdraw hyoscine and substitute milder sedatives.

Various tonic combinations and food products were used throughout this long treatment. Appetite was now improving under use of simple bitters and mineral acids, with cholagogue every night. This restorative treatment was continued until July 11, 1904, when patient had gained fifteen pounds in weight and was gradually recovering nerve and muscle tone. Urine was normal in amount and free of sugar. Sleeping four to six hours. Mucous colitis cured as improvement continued. To-day patient is practically well, and has been attending to business for past six months. Weight nearly normal, and has entirely recovered use of hands and feet.

POINTS OF INTEREST IN CONCLUSION.

Probable length of time glycosuria had been in progress, six months, while patient was treating rheumatism.

Absence of unusual thirst and fever.

The typical progression of the neuritis.

The immediate value of codeine with cholagogue cathartic in this case.

The intolerance of whisky while taking codeine.

The hyoscine treatment of the codeine habit with no bad effects.

The gradual return of liver to normal size.

The return to practically normal state of muscles and nerves affected by neuritis.

I gratefully acknowledge assistance of Dr. J. J. Montgomery, of Luzerne, N. Y., and Dr. C. B. Warner, of Port Henry, N. Y., who saw this case with me.

CHRONIC GASTRIC CATARRH, ITS SYMPTOMS AND TREATMENT.¹

BY V. A. MARSHALL, M.D.,
Moriah, N. Y.

OF all diseases which come to our notice, I believe chronic catarrh of the stomach to be the most frequent, and, I may say, the most obstinate of treatment, hence the mutual disgust on the part of the patient and physician. The patient, as a rule, is glad to try the new doc-

¹Read before the Essex County Medical Association, Port Henry, N. Y., April 18, 1905.

tor, and his family physician is glad to have him.

In the course of time chronic gastritis has received a variety of names, as chronic catarrh of the stomach, habitual dyspepsia, chronic indigestion, atony of the stomach, bradypepsia, etc. But I agree with Monges that a disturbance of digestion ought not to be considered as a separate disease. As the majority of cases present themselves to us, it is difficult to separate the catarrhal inflammatory condition of the glandular coat of the stomach from the nervous affections of the same, in all cases, as there is more or less nervous phenomena. The inflammatory processes are always attended by a lessening of the glandular secretion—*i. e.*, of *h. cl.* and pepsin. The secretion of mucus may be very abundant and yet the gastric juice absolutely wanting. The portion of the stomach usually involved is the pylorus, but it may extend to the fundus, and even the entire mucous membrane. Ewald says: "There is a mucoid degeneration of the protoplasm of the cells deep down into the fundus of the gland." As the disease advances it finally causes retrogressive changes in nutrition, which are at first manifested in a progressive fatty degeneration of the glandular cells, and finally causes complete atrophy of the mucous membrane in many cases, when we have a hopeless case, especially if a large area be involved, as it would lead to a total destruction of the secreting parenchyma, with all its consequences, which condition, I believe, an autopsy on several cases of death from supposed marasmus in the aged would reveal.

The causes may be dietetic, as in the use of unsuitable or improperly prepared food, the persistent use of certain articles of diet, as fats or foods containing too much carbohydrates, eating too rapidly and at irregular hours, imperfect mastication, drinking too freely of ice-water during meals. Also putrefaction in the mouth from carious teeth or inflamed gums; these putrid products are swallowed and may cause inflammation either directly or indirectly. In the male, tobacco, especially in the form of chewing, and concentrated alcoholic beverages. Constitutional causes, as anemia, chlorosis, chronic tuberculosis, diabetes, Bright's disease, rheumatism, uterine diseases, pregnancy, etc. The numerous cases which have come under my notice at the menopause leads me to consider the changes undergone by the whole economy at that time as a causative factor.

Local conditions of the stomach, as cancer, ulcer, dilation. Conditions of the portal circulation, causing chronic heart disease and chronic lung affections. Chronic constipation, which produces products of intestinal putrefaction. The disease presents itself in two clinical forms—"chronic simple gastritis" and "chronic mucous gastritis." The differentiation depends upon a chemical analysis of the stomach contents. To us, as physicians, seeking to remove the cause and alleviate the sufferer, I think we may consider the second classification as an advanced

stage of the first. The affection, as the name implies, persists for an indefinite period, and, as in case of other chronic diseases, changes from time to time. The appetite is variable, sometimes wanting, at others abnormally good. Early in the disease there is occasional distress, or oppression after eating, the frequency of which increases, and finally becomes more or less constant and may be aggravated and amount to actual pain. The pain differs in different cases, and may be trifling or of extreme severity. Cardialgia is a common symptom. There is usually diffuse pain, but not very severe, on pressure over the epigastric region. The tongue is furred, especially in the morning, and there is a bad-tasting mouth and foul breath. Belching is very frequent. The gas may be odorless, but frequently has an offensive, sour smell. Regurgitated masses of food in a fermentative state, imparting a sour, disagreeable taste, and a burning sensation along the œsophagus. Vomiting is a very irregular occurrence. Trismus and nausea usually precede it. It usually occurs within one or two hours after eating and consists of digestive and putrefactive products, and usually considerable stringy mucous. The pain in the stomach is often temporarily relieved by taking food. True gastralgia does not belong to the ordinary symptoms, and if it occurs we should be on the lookout for other lesions. Patients frequently complain that the food lies in the stomach, abnormally long after eating, which condition actually exists due to the weakness of the gastric muscular wall; as a result decomposition takes place, carbohydrates ferment, albuminoids putrefy; this distends the stomach with gas, which in turn may paralyze the muscular fibers, and these conditions may ultimately lead to dilation. Constipation is the rule, although there may be an irritative diarrhea caused by undigested particles of food. Urine is scanty and loaded with urates. Emaciation is early and constant. Among the general symptoms are headache, a morose, irritable disposition. Sleep is profound and longer than usual, but is not refreshing. Diminution of mental activity, disinclination to bodily exertion. Irregular heart action, especially after the indigestion of food. Vertigo is a common symptom and may be of a very severe character. So far as treatment is concerned, the only essential point of diagnosis is from gastric neurosis, malignancy and ulcers. This diagnosis can be made by an analysis of the stomach contents after a test breakfast. Neurosis usually occurs in middle-aged or young, and the course is irregular, while this disease seldom occurs under the age of 40. The prognosis should not be considered too slightly, especially as in prolonged cases atrophy, an incurable and fatal lesion, may develop.

Treatment should consist in removing the cause, if possible, restoring the stomach to something like its normal condition, and relieving the patient of mental and physical distress. First, I

attempt to correct the constipation. I usually find copious enemata, in conjunction with the internal administration of some preparation of cascara, effective. Do not use vegetable oils, as they irritate the stomach. Prohibit condiments, alcohol, fats in excess, limit the use of tobacco. Impress the importance of perfect mastication of food, taking at least an hour to eat each meal. Advise patient to drink nothing during the meal. Cleanse the mouth and teeth after each meal, and eat at regular hours, and finish their meal while still having the desire to eat more. As to articles of diet, each case must be governed by itself, according to circumstances and general conditions. Many cases will do well on strictly milk diet, with a pinch of salt added to each glass of milk. Of drugs, h. cl. is superior to all others. I give from thirty (30) to forty (40) gtt. of dilute in water, fifteen (15) minutes after meals.

Nitrate of silver, grain one-fourth, with ext. hyoscyamin, grain one-half, one hour before meals. Some authorities claim that bitters have a good effect upon the secretive and digestive powers of the stomach when taken some time before a meal. I think I have had some good results in some mild cases with a combination of tr. nux, minims ten, and fl. ext. candurango, minims forty (40), with simple elix., one-half hour before meals. Cases with heavy, slimy, furred tongue, nausea, flatulence and anorexia, sometimes improve on creosote, minims five, duotol, grains ten, one-half hour after meals. Cases with severe pains at the pylorus one-half hour to an hour after meals are relieved by the use of cerium oxilate, grains five, bis. sub. gal., grains ten, calcin magnesia, grains twenty, mx. and sig., one-half hour before meals. I find relief for the vertigo of these cases in antifermentatives, such as resorcin, grains five to ten, well diluted in water, or chloroform, two or three drops, in a teaspoonful of claret.

In cases of gastritis, associated with pulmonary tuberculosis, I have had excellent results with bismuth, sub. nitrate and beta-naphthol, of each grains ten after meals. Cardalgia is often relieved by ext. canuobis indica, grains one-half to one; better codeine sulphate, grains two.

But as most cases who come to me have been under treatment a long time and received various medical attention, I usually assume they have received treatment according to the above, and I have now ceased to prescribe medicines to such cases to any extent, but employ the use of gastric lavage and gastric electrification. In general practice I use about a 3 per cent. solution of boric acid for irrigating the stomach. As to the amount of water, I use the irrigation until the water returns from the stomach clean and free from mucous. I advise this treatment to be done in the morning before taking any food. I have used in some cases a 2 per cent. solution of nitrate of silver, and in some cases a dram to the pint of na. cl., but I prefer the boric acid. It is remark-

able to see the improvement that takes place in some cases under this treatment. I usually repeat the lavage every third day.

For the past two years I have used gastric electrification in cases of obstinate character, and especially such cases as had considerable pain after meals. At the same time I employ the lavage if there is an excessive mucous secretion. So far I have had no experience with the galvanic current, having used the faradic in all my cases. I have followed Einhorn's methods of using intragastric faradism, but I use Dr. G. G. Marshall's electrode, as it is easier for the patient. In preparing a patient for treatment, they should be given a glass of water on an empty stomach, the large sponge or plate electrode and battery being in readiness, so that as soon as the electrode is introduced into the stomach the connection can be instantly made and the current established, thus avoiding the needless delay and annoying the patient, and furthermore the inclination to retch is not so great when the current is on. Einhorn's method is as follows: "At first large electrode at the gastric and epigastric region for five minutes. If there is constipation the electrode is passed over the ascending, transverse and descending colon, beginning at the left iliac region; duration two minutes, always beginning at the right iliac region and ending at the left iliac region. Thereafter proceed from the gastric region, from the right to the left, to the back, and remain at the left side of the seventh dorsal vertebra for one minute. Then return to the front, moving the electrode gently up and down over the gastric region for two minutes, gradually reducing the current and thus ending the sitting."

Frequently I place the electrode over the front and sides of the neck in the course of the pneumogastric nerves. At other times I place the electrode over the fifth and sixth cervical vertebrae instead of the seventh dorsal. I have often seen positive and decided benefit by the electric treatment in chronic gastritis. I have one case under my treatment now who has gained over twenty pounds in weight, and her general strength has improved in proportion. I have used gastric faradism experimentally in a case of cancer of the liver in the manner above described, where the pain was very intense in the epigastric region, with absolute relief from pain for eight to ten hours. From my experience I believe it acts as both a sedative and stimulant to the gastric mucosa. Under its use in many cases the pain is relieved, the appetite improved and digestion enhanced. During the application of the current the salivary secretions are greatly increased. The patient expresses a sense of warmth and comfort in the stomach after the treatment. If the electrode is not in the stomach cavity, but lodged in the orifice of the œsophagus, the patient will be seized with a paroxysm of coughing when the current is turned on. As to the experimental

studies of the movements produced in the stomach and bowels by electricity, I would refer you to the *Medical Record*, January 7, 1905. I do not believe it necessary or wise to use a current of sufficient strength to produce a contraction of the abdominal muscles.

As to the *modus operandi* of gastric faradism, I can only accept Charles D. Stocton's statement in the *American Journal of the Medical Sciences*, 1880, p. 20. He says:

"Exactly what rôle is played by faradism I am unable to state: Whether it is gastric sedative or gastric stimulant, I do not know. My efforts were in the direction of study, and the results were so favorable that I applied faradism to cases seemingly contradictory in character, and I have concluded that the great variety of gastric neurosis depends upon a common cause, or imperfect innervation of the stomach; that electricity improves this innervation, then, by relieving the cause, and so the conditions which at first thought are so contradictory." But be the explanation what it may, certainly the therapeutic results reported by Einhorn and others are worthy of attention.

RESUME OF THE RECENT LITERATURE ON PNEUMONIA.¹

BY JULIAN C. SMITH, M.D.,
Oneonta, N. Y.

THE purpose of this short paper is not to present a complete new story of the subject of pneumonia, but rather to review some of the recent observations, and, if possible, separate the generally accepted resources of value from the theoretical, visionary, one-man ideas so numerous always in conditions for which we have no specific.

First, a word as to the cause; it does not seem just clear yet as to whether the infection is admitted to the general circulation in various ways, and the pulmonary condition is simply the local manifestation, or the invasion takes place in the lung and the constitutional symptoms follow; whichever the way of development the pneumococcus seems to be the responsible microorganism. True, it is associated with the streptococcus, staphylococcus, Friedlander's pneumobacillus and other members of the bacterial union, but to the pneumococcus is given the credit for the resulting complex of symptoms which we call pneumonia. All persons are, of course, subject to the visitation of these microorganisms, but only those whose resisting power is less than the invading power of the organisms will develop symptoms.

In this disease more than any of the other acute infections, do we see the marked early evidence of poisoning on the entire system, but more particularly in the vasomotor nerves. These poisonous products, which the French call ectosins, produce a vasomotor paresis, which is really the

most dangerous feature of the disease. This accounts for the very low arterial tension which is present in these cases; also in the cases where heart failure seems to be the cause of death. Such is not the real cause, for the fatal cases are those that have not been ill long enough to get a badly degenerated myocardium, and furthermore, in the cases where we have a completely hepatized lung with all the other symptoms of a very serious condition terminating by crisis, the heart action at once comes down to nearly normal rate and improved strength, but the lung is still solid and our mechanical obstruction is still present, showing that the real cause of death is the poisoning which paralyzes the vasomotor nervous system. This statement, of course, applies to cases of uncomplicated pneumonia.

Within the memory of every one present here to-day the classification of pneumonia has gradually been modified so much that one is apt to overlook the underlying causative element in trying to find under which one of the numerous subdivisions or atypical forms our particular case comes. It seems to me that the two clinical divisions of croupous and broncho pneumonia are practically sufficient, and further subdivisions unnecessary and misleading. The question as to whether the patient is young or old, alcoholic in habits, just recovering from or in the midst of other infections, as influenza, measles, pertussis, etc., is one which influences principally the prognosis and not materially the treatment.

I think that all who have practiced any length of time will agree with me that we see now fewer cases of typical croupous pneumonia, but more of the lobular type.

The diagnosis of either variety in typical cases is easily made. The only caution necessary is to make careful examinations often in all cases of acute trouble, whether accompanied by cough or not. When the pneumonia supervenes on some other condition, the so-called terminal pneumonia, the diagnosis is more difficult, and very often impracticable, from a clinical standpoint. Here the detection of the pneumococcus would be of aid, but it can be only rarely used. The blood examination is of no value, as the leucocytosis which occurs in pneumonia also occurs in the conditions, from which we wish to differentiate.

The prognosis in pneumonia is, as we all know, a very serious question, and we can preserve our respect and confidence best with the friends of the patient by being not oversanguine in the early course of the disease.

Treatment.—Occasionally a man comes forward with the statement "fifty cases of pneumonia without a death," as in a recent paper by Dr. Galbraith, of Mexico, where he describes the use of quinine in enormous doses and fairly good doses of iron. His cases seem to have tolerated the large doses well, but I should hesitate to give same amounts here. In spite of these occasional outbursts of brilliant results, the majority of the

¹Read before the Otsego County Medical Association at the Annual Meeting, Oneonta, N. Y., April 25, 1905.

best observers say that no remedy is known that is antidotal to or that limits the course of a pneumonia, but the proper management of the patient tends to a more favorable termination even though he takes no drugs. The first important thing to do is to secure a good nurse, one having plenty of common sense. This having been done, the patient should have absolute quiet in bed in well-ventilated room, not to be raised for any purpose, no one admitted to the room outside of the attendants, careful feeding, fluid diet, nutritious and easily digested, plenty of water taken at regular intervals, together with a cathartic in the beginning, will be all that is needed in the milder cases. When pain is severe the application of dry cups seems to relieve the congestion and also the pain, but in some cases a little Dover's powder may be necessary; after the cupping heat or cold may be applied, according to preference. No expectorants will be necessary as a rule, unless there is considerable bronchitis present, always using care to save the stomach all unnecessary medication. If the temperature runs up toward 105 and the patient is restless, sponging is of value, beginning at 90 and reducing to 65, using plenty of friction. In the alcoholic cases or other drug users, the hypodermic use of ergot for first twenty-four to forty-eight hours seems of service. I think that the majority of thinking men see no effect on the pneumonia itself of external applications, although, as stated above, for the pleuritic pain which is present in some cases, the external application of heat or cold does relieve, but should be discontinued as soon as pain is relieved. If there are any gentlemen present who have any question in mind as to the value of the celebrated "clay mixtures" I will refer them to a recent paper by Dr. Roth, of Ann Arbor, for further scientific proof of their inefficiency.

As the vasomotor disturbance increases, tympanites is apt to be a troublesome symptom, for which saline irrigation of the lower bowel and sometimes the ice-bag does good.

Of the so-called cardiac stimulants, strychnine in moderate doses is probably best for the vasomotor symptoms, but should be used only when occasion demands it, and not with the idea of early administration to prevent heart failure. Digitalis also is of service in the low arterial tension, unless the temperature is above 103, when it does not show its usual effect. Nitro-glycerine for the failing right heart seems to do best, and alcohol may also be used, as their action is very similar on the arterial system.

From the observations of many of the best men of the present day we must appreciate that in dealing with pneumonia as yet there is no best treatment established, and while we are waiting for some one to find the special serum or other drug that will show some specific influence over the condition, we must proceed along the lines of common sense in the light of the clinical history of the disease.

REPORT OF A CASE OF MYXŒDEMA, WITH REMARKS ON THYROID FEEDING.¹

BY ROSS G. LOOP, M.D.,
Elmira, N. Y.

CASE.—D. W. was admitted to my service at the Arnot-Ogden Memorial Hospital, November 21, 1904, the following history being obtained: His father had always been in good health, and died from accidental causes at the age of 73 years. His mother is alive and well at the age of 84 years. His only brother is 56 years old and has always been in good health. He has no sisters. One cousin on his paternal side has a simple goiter, which causes her very little trouble.

The patient himself has had the ordinary diseases of childhood, facial erysipelas in boyhood, and gonorrhœa at 22 years of age. No other diseases. He was an excessive consumer of alcohol up to 25 years of age, but has been a total abstainer since then. As a boy he was active and a good student. He had followed his trade of gas-fitting successfully, until compelled by failing health to abandon it.

His weight had ranged from 170 to 180 since early manhood, which is about normal for a man of his height, 5 feet 9 inches. About four years ago he began to take on flesh, and his weight gradually ran up to 250 pounds. This increase was particularly marked about the face, neck, upper thorax and hands. He thinks that his waist measurement has increased little, if at all, but whereas a 15½ shirtband and collar formerly fitted him, he now requires an 18 band and collars of the narrowest style are uncomfortable to him. He also requires a glove two sizes larger than four years ago. He suffered no inconvenience from his adiposis until about one year ago, when dyspnœa became evident, and has greatly increased. Coincidentally he has noticed a diminution of the perspiration and an increasing coldness of the skin and sensibility to cold. He has had no more than the natural falling of the hair, but has noticed that the hair was becoming stiff, dry and unmanageable, and that the nails were brittle and stunted.

About three months before admission to the hospital vertigo developed, and its increase, together with dyspnœa, muscular weakness and anorexia, compelled him to give up work six weeks before admission. His wife reported that she had noticed an increasing cyanosis of his face and neck and a change in his voice for over a year previous. After giving up his work there was a rapid aggravation of all the symptoms. Cyanosis increased, until it seemed, as his wife said, "that the blood would burst through." His breathing became very labored and noisy. His weakness would hardly allow him to raise from his bed, and a delirium, most marked during the night, developed. His speech became like the grunt of a swine, it being almost impossible to

¹Read before the Elmira Academy of Medicine, May 3, 1905.

understand what he said, and deglutation became extremely difficult.

When admitted to the hospital his temperature was 97 degrees; pulse 70, weak and irregular; respirations about 30, stertorous and labored. The cutaneous surfaces were cold, almost cadaveric. He appeared to be slightly above the average in fat over the whole body, but more noticeably about the head, neck and hands, and the skin over these regions was dry, cyanosed and of coarse texture. The superficial blood-vessels in these places were distended, and what appeared to be true varicosities were found over the manubrium. Examination of the heart, lungs and abdominal viscera was negative. Tendon reflexes and cutaneous sensation were normal. The mucous membrane of the pharynx was congested, but not swollen to any extent. There was no enlargement of the tongue, but it seemed stiff and difficult to protrude. The pupils reacted normally to light and distance, but the conjunctivæ were injected. The muscular sense was unimpaired, as was shown by good coordination. The urine was also normal.

The face and hands, presenting the most conspicuous symptoms, were next examined. The hands and fingers were very much cyanosed and puffy. The fingers were extended and clumsy in action. The bones did not show any enlargement, nor was the hand lengthened appreciably. It seemed to be only a cool, awkward and very fat hand. The deposit of soft tissue did not pit on pressure, and gave a brawny, elastic feel. The deposit about the hands disappeared quite abruptly above the wrist into a fat arm, but fat of an altogether different feel from that on the hand. The nails were stunted, dry and brittle.

The face, neck and upper thorax presented the same cyanotic fulness. The forehead and temples were rounding; the upper eyelids were puffed over the ball. The nose was broadened and clubbed. The lips and cheeks, while somewhat thickened, were not so noticeably affected as the parts above mentioned, but from the lower border of the inferior maxilla, extending downward to the manubrium and clavicles in front, and backward to meet behind, was a thickened mass of tissue in the shape of a collarette. This condition, in all these locations, presented the same characteristics. The skin was rough, coarse and dry, of a reddish-purple color, cool, and was adherent to the subcutaneous tissue. There was but slight pitting on pressure, there being a feeling of elastic resistance. The superficial blood-vessels were distended, and there were well-marked varicosities over the upper end of the sternum. A careful examination failed to reveal even the presence of the thyroid gland. The bony prominences of the face could be distinctly made out, and showed no enlargement. The chin, while round and thick, was not protruding.

His breathing was very noisy, especially during sleep; his speech was thick and guttural, articulation being very indistinct. His mental

processes were slow and he seemed to have difficulty in expressing ideas. There was no delirium during his stay at the hospital. The lines of expression were mostly obliterated, and as he would sit indolently in an attitude of apathy, with his noisy breathing and grunting voice and distended face, one would be reminded of a well-fed swine.

The diagnosis of myxœdema was abundantly verified by the result of thyroid feeding. The subnormal temperature reached normal in about one week; the dyspnoea also showed marked improvement by that time; speech improved rapidly and was apparently natural within one month; the patient's mental condition brightened and he soon became a great reader; the subcutaneous deposits disappeared rapidly, and, upon leaving the hospital, six weeks after admission, were hardly noticeable. His weight had also declined to 214 pounds, as against 250 upon admission. Treatment was continued after his discharge, and an examination one month later, or about ten weeks after admission, showed an almost total disappearance of all symptoms. There still remained some muscular weakness. The weight had declined to about 200 pounds, and patient stated that he felt well.

My object in thus presenting at length my observation of this case is, first, to call attention to the fact that such cases are occasionally encountered in our community, and that the brilliant results of thyroid feeding make their recognition imperative; and, second, to briefly present my views of thyroid therapy, formed from observation and reading.

The physiology of the thyroid gland and its modus operandi when administered are still subjects for investigation. The theory of an internal secretion seems to be generally accepted, although Munk, of Berlin, concluded from his experiments on animals that the thyroid gland is not extremely important to life. However, his views are far outweighed by an indisputable mass of evidence to the contrary.

The main question now is whether this internal secretion acts directly as a food for the organism, or indirectly as a stimulant or regulator of certain organs or functions. It is evident from the wonderful changes in nutrition produced by thyroid feeding that we have to do with a powerful agent for good or harm, according as its use is indicated or contraindicated. It has been applied to the treatment of the greatest latitude of morbid conditions, and, of course, with greatly varied results. It is naturally in those conditions in which there is demonstrable absence or perversion of the thyroid gland, such as congenital, infantile or adult myxœdema, and cacexia strumaprevia, in which it is most commonly and rationally applied. Early in cretinism it will usually effect a complete cure.

Even after adolescence, remarkable results are reported. Thus Clark (*Jour. A. M. A.*, March 19, 1904) reported a case in which treatment

was begun in a typical case at the age of 20 years and 4 months. Eighteen months' treatment effected a gain of $13\frac{1}{2}$ pounds in weight, $5\frac{3}{4}$ inches in height, and a marked improvement in the mental condition. Many similar cases could be enumerated.

In selected cases of epilepsy and insanity, particularly catalepsy, there has been a marked response to thyroid treatment. R. Hessler (*Jour. A. M. A.*, March, 1897) reported several cases of catalepsy so treated in the Northern Indiana Hospital for the insane. One case had been immovable in bed for more than three years, with absence of sensory or motor activities. Feeding was by means of a nose-tube. Increasing doses of thyroids brought about a marked improvement of both speech and motion. Toxic symptoms, tachycardia, dyspnoea, twitchings, etc., from overdosing necessitated a withdrawal of the drug and was followed by relapse. More moderate doses later brought about a cure.

A Russian writer (Baldowski, *St. Petersburg Gazette*) has reported a case of eclampsia in which two 5-grain doses of thyroïdin caused a complete relief from convulsions, an increase of urine, and a marked diminution of albumin therein in six hours, the improvement being permanent. In this case narcotics were used in combination; but even so, what narcotic will produce like results in the same length of time?

It would seem, if our knowledge of the pathology of exophthalmic and simple goiter be correct, that thyroid feeding would be contra-indicated, and so it is in the majority of cases, but we find many cases of marked improvement or cure by thyroids.

In obesity thyroid feeding has proved itself one of the most reliable remedies; particularly in certain obese females, almost numerous enough to constitute a type, hypochondriacs usually, with dysmenorrhœa, bearing-down pains, and constant turgescence of the visible pelvic mucous membranes, but with slight or no organic changes, I have found thyroid feeding very useful. This list could be further extended by mention of the thyroid type of diabetes, certain skin diseases, some infectious diseases, and many other diseases.

The administration of thyroids in most of these conditions is largely empiric. It would seem that the normal secretion of the thyroid, which in health tends to prevent their evolution, must be in some manner perverted, and that artificially supplying the organism with it removes their cause or causes.

In this connection, it seems to me that the theory advanced by Sajous ("Internal Secretion and Principles of Medicine," Vol. 1) is a most satisfactory one. He believes that the perversion of the thyroid secretion is not, per se, the cause of the disturbances usually attributed to it, but that the thyroid secretion is one of the regulators of the adrenals, and that it is their disturbed functions, due to absence or abnormality of their

normal stimulant, that causes the various symptoms amenable to thyroid feeding.

According to his theory, the symptoms of exophthalmic goiter are due primarily to overactivity of the adrenals from various causes, and in this stage thyroid feeding would be adding fuel to the flame. But later the adrenals become overstimulated, their function exhausted, resulting in deficient oxidation, and the disease continues either by reason of toxins allowed to accumulate because of adrenal insufficiency, or else changes into myxœdematous condition. In this stage thyroid treatment may be beneficial by reason of its stimulating effect upon the adrenals. It is improbable that many cases of exophthalmic goiter ever reach this second stage, and, therefore, few cases improve or even tolerate thyroid feeding.

This hypothesis is in no way antagonistic to the various results reported from thyroid feeding. On the other hand, it gives a logical explanation of the action of thyroid in all the diseases in which it has proved most useful. In obesity and myxœdema, including cretinism in particular, the increased oxidation from adrenal stimulation is the most rational explanation of the marked benefits obtained. Would not also an assumed degeneration of the adrenals explain many cases of this character in which treatment failed? The following case appeals to me in this way:

Dr. J. Ramsay Hunt (*American Jour. of Medicine Sciences*, April, 1905) reports in detail a case of myxœdema of four years' standing, with death from putrid bronchitis and broncho-pneumonia, in which, in addition to characteristic changes in the thyroid—namely, sclerotic changes, with disappearance of the colloid contents of the acini—there was tubercular involvement of four-fifths of each suprarenal capsule. This would seem to explain the apparent failure of thyroid feeding in this case. There was not sufficient of secreting adrenal substance to supply the organism, even when stimulated by thyroids.

BRONCHO-PNEUMONIA.¹

BY CHARLES E. DARROW, M.D.,
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BRONCHO-PNEUMONIA, as it occurs in infants and young children, is either a secondary or a primary disease. In infants under 2 years of age it is more commonly primary, while in children more than that age it is usually secondary to bronchitis, to some one of the infective fevers (such as measles, pertussis, diphtheria or tuberculosis) or else to some gastro-intestinal trouble.

Whether primary or secondary, it represents a large proportion of the morbidity occurring at these ages, and therefore its recognition and treatment become matters of prime importance. The question of the degree of contagiousness of this disease is undetermined, although the oc-

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casual occurrence of a large number of cases, in some institution, would lead to the conclusion that there may be, at least, a possibility of the transmission of broncho-pneumonia from the sick to the well.

In these cases a large number of different kinds of bacteria have been found in the lungs, and in the mucus—the pneumococcus, the streptococcus, the staphylococcus, the Kleb-Loeffler bacillus, etc. In time some relation may be discovered between the particular germs found, and the varying symptoms of the differing cases of broncho-pneumonia, but at present no such relationship has been proved.

The pathology of this disease differs from that of lobar pneumonia in the distribution of its lesions, and in the nature of the product of its inflammation. Its lesions are always found about terminal bronchi, and are therefore disseminated, and not massed as in lobar pneumonia. The tissues and the caliber of the bronchi and air cells are invaded by material largely consisting of cellular elements, such as connective tissue corpuscles, red and white blood cells, and pus, but with little or no fibrin, while in lobar pneumonia the disease product consists largely of fibrin, with a few red and white blood cells.

The onset of broncho-pneumonia, as a primary disease, is usually abrupt; as a secondary condition it is marked by an increase of temperature and rate of respiration. Some cases begin so suddenly and progress with such rapidity to a fatal termination, that no diagnosis is arrived at during life, twelve hours even marking the span from the beginning of any symptom to the moment of death. Some cases terminate by a crisis after from two to four days, but the great majority of cases run from one to several weeks before either recovery or death occurs. Relapses also often prolong cases.

The winter months present the larger number of cases of broncho-pneumonia, but no season is entirely exempt from the disease.

The diagnosis of broncho-pneumonia must often depend upon the perverted ratio existing between the pulse-rate, the temperature and the rate of respirations, and not upon auscultation or percussion findings. Although some cases have areas of dulness on percussion, and bronchial, or at least broncho-vesicular breathing, and while most cases have a cough, and many have fine, moist râles, yet there are times when the percussion note is tympanitic rather than dull, owing to an accompanying emphysema, and when the breathing is not at all bronchial in character, and all the usual signs of consolidation are absent; yet despite these facts the patient has broncho-pneumonia, and may die of the disease without the advent of any complication whatsoever. Because this is so, great stress must be laid upon the peculiar alteration existing between the ratios of respiration, temperature and pulse. If the respiration is rapid out of proportion to the eleva-

tion of the temperature, and further, if it be increased to such a degree that it bears the proportion of one respiratory act to every three heartbeats, instead of the normal proportion of one to every four, then a tentative diagnosis of broncho-pneumonia may be made, without the presence of any physical signs in the chest. If added to the symptoms given above, fine, moist râles are heard, the diagnosis must be regarded as positive. The bronchial breathing, and the dulness on percussion are only to be regarded as confirmatory signs, and never as essential conditions.

The above is meant only for a cursory and quite incomplete outline of the natural history of this disease, to be regarded merely as an introduction to a few remarks upon a line of treatment that has proved quite successful.

All cases were treated upon the same general plan—the use of nuclein solution, combined with strychnia sulphate, and the inhalation of creosote carbonate. No alcohol was used, and no inhalations of oxygen. The general plan was only varied in regard to the size of the doses, adapting them to the age of the patient. Cases that presented marked tympanites and distention of the abdomen were given in addition calomel and castor oil. As soon as a case was suspected of being one of broncho-pneumonia, the following treatment was begun, and continued without interruption until the temperature became normal: The nuclein solution prepared by the Abbott Alkaloidal Company and styled "Auld's Nuclein," was given in doses varying from 2 to 5 minims, once every hour or once every two hours, according to the age of the patient. For example, a child 6 weeks old received 2 minims every two hours, while one 5 years old received 5 minims every hour night and day.

The strychnia sulphate was given in doses of from 1/1000 of a grain to 1/200 of a grain every two to four hours, according to the age of the patient, and to the degree of prostration shown. This was also given day and night. These doses were given with the corresponding doses of nuclein so as to avoid unnecessarily frequent disturbance of the patient, and the times of feeding were so arranged as to fall at the second or third time of giving the medicine, so as to allow as long an interval of uninterrupted repose as the necessity for frequent medication would permit.

The inhalation of creosote carbonate was given for one hour out of every three hours, and in doses of from 5 minims to 15 minims, according to the age of the patient. The creosotal was placed upon a bit of absorbent cotton, on the grating of what is called the "Simplex Steam Atomizer." When the boiler of this apparatus is filled two-thirds full of water and the lamp is well filled with alcohol, it will generate steam for a full hour without requiring any attention. It is then placed about two feet from the patient at such a height as to bring the spout on a level with the patient's face and a sheet is fastened

over the crib or bed, so that the moist vapor of the creosotal is kept fairly close to the child. As these inhalations involve no disturbance to the patient, no attempt is made to have them fall at the time of giving medicine and food.

Twenty cases form the basis of my conclusions as to the success of this treatment. Eight were treated in the children's pavilion of the Rochester City Hospital, and twelve occurred in private practice—all during the months of February and March of this year. The ages of the patients varied from 6 weeks to 5 years. Sixteen of the cases were primary and four were secondary. Of the latter, one followed a double otitis media and accidental burns, another followed an ileocolitis, while the other two followed measles.

Of these twenty cases, two died—one a primary and one a secondary. The secondary case was that of ileocolitis, which became further complicated by meningitis, and the primary case was one that was received into the hospital late in the disease.

The mortality in the series was exactly 10 per cent., though Holt, in his last edition of "Diseases of Children," gives a mortality varying from 30 per cent. to 65 per cent. The showing, therefore, of these cases suggests that the treatment itself was rather successful.

The average length of time elapsing before a normal temperature was reached and maintained was ten days, the shortest being two and the longest twenty-eight days.

The results are only fair samples of a much larger series of cases treated in the same way, and they seem to justify the conclusion that this line of treatment is an improvement upon the course usually recommended in broncho-pneumonia.

SCARLATINAL NEPHRITIS.¹

BY CHARLES O. BOSWELL, M.D.,
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THE insidiousness and destructiveness of this, the most common and yet often unheralded complication of so widespread a disease as scarlet fever, are the reasons for my offering tonight, by the invitation of your chairman, this paper.

There is an old saying of frontier life: "If you see signs of Indians, be careful; if you see no signs, be more careful still." That may well apply to this condition.

This form of nephritis is rather a sequela of scarlet fever than a complication, for I have not in mind the almost universal catarrhal or desquamative type of pathological change of the kidneys which occurs during the height of the fever, not alone in scarlatina, but in the other acute infections as well. The changes in this condition are embraced in a mild involvement of the glomerular tufts in the capsule of Bowman, which show desquamation of the endothelial cells of the

capillaries and of the lining membrane of the tuft itself, and tend to a prompt and permanent recovery.

A better understanding of the pathological changes in both these mild and severe types of nephritis is to be had, if we remember that there are really two glandular portions of a kidney, or, in other words, both the capillary bundles which form the malpighian bodies in the cortex and the descending tubules leading from these bundles, have secretory functions. The blood circulating in the capillary tufts holds in solution certain substances which in health transude through the vessel walls in the malpighian bodies and to less extent through the walls of the descending uriniferous tubules, without in any way injuring these delicate structures. Now let the blood stream, as it comes into the kidney, carry along with it the products of an infectious organism; then these minute walls no longer retain their healthy state. The power not only to secrete a normal amount of urine is changed, but the urine itself will show the presence of certain foreign materials, as albumin or blood, or molds of detached cells of these tubules—that is, casts.

The first portion of the kidney to meet this unusual work is the capillary bundles—*i. e.*, the malpighian tufts. Here are seen the first pathological changes. The vitiated blood causes the endothelial cells of these capillaries to swell, serum albumin leaks through, and the cells become swollen and granular. This is known as cloudy swelling. The urine contains albumin and fine granular casts, composed of the desquamated cells.

Owing to the increased body temperature and increased absorption of fluids, there is an impaired secretory power of the kidney, this being dependent on the integrity of the epithelial and endothelial cells. The quantity of urine is lessened, the fever metabolism produces an increased oxidation; thus uric acid and acid urates are increased, and are no longer soluble in the reduced volume of urine. Thus we find the lessened quantity of urine with high specific gravity and greater amount of solids.

So far we have spoken of no change not common to all infectious fevers. Should the child die during the course of the fever the death must in the vast majority of cases be laid to the intensity of the toxins, as would be evidenced by the extent and severity of the angina, the cardiac phenomena, myocarditis, endocarditis, or rarely a pericarditis. In fact, any of the serous surfaces may be hopelessly involved.

Leube, in his text-book, "Special Medical Diagnosis," claims that this type of nephritis can be distinguished from the later type—a diffuse nephritis—because in the simple glomerulo-nephritis the casts are never cylindrical rows of epithelial cells. That is, the absence of epithelial casts indicates that the disease has not yet invaded the uriniferous tubules, which are lined with epithelial

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cells whose desquamation would be evident in the form of epithelial casts.

So far we have considered a transitory mild condition, dependent on the presence in the body of a toxin which is being eliminated by the kidneys especially.

The treatment demanded in this state is only that of ordinary caution—rest in bed between woolen blankets. Woolen "combination" night clothes, free movements of the bowels to aid in relieving the work of the kidneys, stimulating the activity of the skin by means of mild diaphoretics and plenty of good water within and without are usually all that is required.

The next type of nephritis—the typical scarlatinal nephritis—is, however, an entirely different story. No exact statistics are available as to its frequency, but it is a matter of common consent that its frequency varies so that at times it almost constitutes an epidemic in itself. Moreover, it is often extremely fatal or may be the starting-point of a subsequent chronic nephritis and so cause early death of the child.

This sequela usually occurs about the end of the third week of the disease, but may postpone its arrival until the sixth week. A most unpleasant feature is that profound changes in the kidney have been known to take place before any clinical symptoms have made their appearance.

Reichel, in a recent number of *Die Zeitschrift für Heilkunde*, gives his results of a study of 58 cases of scarlatinal nephritis, as they came to the autopsy table. In 23 of these 58 cases the clinical diagnosis of nephritis had been made; a few more cases had albumin in the urine, but were not considered cases of nephritis. Some of the kidneys showing pathological changes had given no clinical evidences of the same.

The findings are in accord with Cabot's article in two recent numbers of the *Journal of the American Medical Association*, in which he contends that our present methods of urinary examinations are not definite enough to enable us to make an accurate diagnosis of nephritis in many cases.

Reichel distinguishes two independent inflammatory conditions of the kidneys as subsequent to scarlet fever—an interstitial and a glomerular type.

The interstitial type seems to be especially connected with the more septic forms, although the extent of its changes does not necessarily correspond to the severity of the symptoms. The glomeruli are not affected.

The typical post-scarlatinal nephritis occurs, as said, usually at the end of the third week of the disease, but the pathological changes may have been going on for some time previously. The most common anatomical changes are as follows: Thickening of the walls of the glomeruli, proliferation of the nuclei of the capillary endothelial cells, showing at times leucocytes and fibrin formation. The epithelium lining, Bowman's cap-

sule, shows degenerative changes and desquamates so that the blood current may stagnate.

Stengel claims that there are similar changes in the uriniferous tubules and that there is usually an extension of the inflammatory phenomena into the parenchyma in more acute cases, so that a diffuse acute nephritis may result.

Such kidneys may undergo restitution or fibrous changes may result in the destruction of the glomeruli.

According to Reichel all these changes are due to a chemic irritation.

The "American Text-Book of Pathology" speaks of two types of pathological kidney change, which, while in no way characteristic of scarlet fever, yet may at times be observed. The first is an acute non-suppurative interstitial nephritis. This may correspond to the first of Reichel's types. It may be found in various infectious diseases of childhood. Councilman has found it in 5 cases of scarlet fever, also in measles and diphtheria.

No definite bacilli seem to be concerned. The kidney is enlarged. The cut surface is pale, shows irregular hyperæmic areas. The contrast between medulla and cortex is lost, the cortex is increased, the glomeruli visible with difficulty. The changes are most marked about the bases of the pyramids.

Microscopically the principal changes are seen in the interstitial stroma. There is an intense infiltration of small round cells and leucocytes, often hyaline change of the epithelium of the tubules.

The other type is a septic nephritis, accompanying the strongly septic cases. Here the renal manifestations may be overcast by the septicæmia.

The kidney changes are embolic, and present small yellow foci of suppuration. Microscopically there is an intense infiltration of small round cells, blood cells and pus cells.

So much for the pathology. Can we in any way lessen the tendency to this dangerous condition?

Albuminuria is to be expected during the height of the disease. It usually appears about the seventh day and lasts about nine or ten days; that is, until desquamation is established. A decided diminution in the quantity of the urine with a persistence of the albuminuria beyond the limit mentioned above should put us on our guard. If to this be added marked thirst, return of vomiting, a rise of temperature not otherwise accounted for, rarely a feeling of distress in the loins, an œdema of the upper eyelids or in the ankle joints usually, but which may appear or disappear without seeming reason, we can be fairly certain that we have to do with a nephritis. To this picture may be ultimately added the symptom complex of uræmia, headache, persistent vomiting, slow pulse, irregular muscle twitchings, a dry, brown tongue and stupor.

The usual urine of a scarlatinal nephritis is reduced to as low as six ounces, or even less, in

twenty-four hours, dark-colored, high specific gravity, large amount of albumin and an abundant sediment, showing granular and epithelial casts, often fatty degenerated epithelial cells and red blood cells, but there is no definite ratio between the number of the latter and the amount of albumin.

The quantitative estimation of urea is of little value, since the amount of this product excreted by the kidneys is influenced by the ingestion and absorption of nitrogenous foods and the amount of urea excreted by the feces as well.

Are we unable in any way to avoid this dangerous complication?

It seems to me that there are many means that it is our duty to undertake.

While pathologists may deny the causal relation of cold to nephritis, nevertheless the child should be clothed in flannel combination suits and kept between blankets until the end of the fourth week. A couple of tepid baths daily maintain the activity of the skin and so relieve the kidneys of part of their work. Especially are these baths needed if the skin is kept greased, which process, by closing over the pores, tends to the retaining of excrementitious products.

Keep the bowels freely open to the extent of two to three liquid movements daily. This also aids to relieve the kidneys. I am in the habit of giving a daily grain of calomel in divided doses, usually 1/10 grain, followed every morning by a couple of ounces of solution of magnesium citrate or a high enema if needed.

Should the urine become scanty, high enemas of two or three ounces of normal salt solution may be given as often as every four hours if retained.

The old preparation, Basham's mixture, given every six hours in water in doses proportionate to the child's age, should be a routine treatment. It is both diuretic and diaphoretic, and has valuable tonic properties.

A free use of drinking water should be carried out.

Diet.—Insist on a milk diet for at least three weeks. If unpalatable a little soda water or vichy may be added, or buttermilk or koumyss may be given.

Personally, during this time I want to give no nitrogenous foods, so avoid broths, not giving any meat foods until the fever has been normal several days, the symptoms abated, and no danger signs in the urine.

Plain vanilla ice cream is extremely valuable. It is nourishing, palatable, easily digested and its coolness often aids in soothing the sore throat; moreover, it is a powerful inducement to the child to endure the tediousness of a strict diet.

An interesting statement from *Progressive Medicine* is regarding the use of urotropin as a prophylactic of nephritis. Widowitz followed 102 cases of scarlet fever. He gave the drug in five-grain doses for three days, both at the beginning of the disease and at the end of the third

week, and in none of the cases did he encounter any evidences of nephritis.

No explanation of the results is given, but there is too much uniformity to regard them as merely chance results.

The treatment of uræmia and convalescence does not belong to this paper, except to urge careful oversight of the patient's urine and avoidance of exposure to cold until at least six weeks after the onset of the disease.

THE NON-OPERATIVE TREATMENT OF HEMORRHOIDS.¹

BY ALFRED JOHN WESTLAKE, M.D.,
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THIS paper is not presented with the view of advocating non-operative treatment of hemorrhoids, for it is conceded that radical operation is the best method of dealing with this common affliction; but is simply a review of some of the methods used when patients refuse surgical operation.

In all cases attention should be paid to the diet. The use of highly seasoned foods, cheese, cabbage, beans and coarse bread; stimulants such as tobacco, whisky, wines and beer, should be discontinued, and a simple diet consisting of fat meats and food leaving large residue, with plenty of fruit, substituted. Bowels kept open by Hunyadi, vichy and other mineral waters or saline laxatives. If symptoms of congested liver are apparent, 1/10 grain calomel triturates or blue pill properly administered will prove beneficial. Frequent bathing should be practiced, and the anus washed with castile soap and cold water after every movement of the bowels. Injections of cold water add to the comfort of the patient. If the piles are of the thrombotic variety, the old-time valuable lead and opium wash, applied either hot or cold, affords great relief. If cold fails to relieve, hot poultices of any kind, if applied constantly, will prove valuable in relief of pain and reduction of inflammation. The many ointments recommended by the various authors applied in the form of suppositories or on a tampon of cotton are used with benefit. Among the suppositories should be mentioned one called "Anusol." This will relieve pain better than any other in use to-day. It is put up by a German firm, and is composed of bismuth, iodo-resorcinsulfon, zinc oxide and balsam peru, with the excipient.

This paper does not take up the operative measures, and, as I do not classify the injection method under that head, a few words on that much abused subject would be entirely permissible. Personally I have a very warm spot in my heart for the injection treatment, as, when a youngster, I suffered greatly with an aggravated case of hemorrhoids. After trying all other known palliative measures, my father used the carbolic acid formula for injecting (given later in this paper) with immediate relief and no bad

¹Read before the Elmira Academy of Medicine, February 8, 1905.

results. Much has been said against this plan of treatment as unsurgical, but I am positive that, if the pile is not of the external or the mixed type, it is perfectly safe to use, provided that the proper technique is followed. This method appeals to the laity because no knife is used. It is almost painless, and does not necessarily detain them from business. This is true when a perfect result is obtained. On the other hand, when extensive sloughing and inflammation occur, they will suffer more and be detained longer than if radical operation had been made.

It certainly is not the best method of treating hemorrhoids, but where the tumors are small, distinct, pendulous, and situated above the grasp of the sphincter muscle, it is applicable with a minimum of danger.

Piles should not be injected when inflamed, strangulated, large or external. The preparations are the same as for rectal operation. In applying this method, surgical cleanliness should be observed both as to instruments and the patient. Be careful that air is excluded from the syringe and needle before injecting. Two to five drops is sufficient in small tumors and five to ten in larger ones. The physician should be careful to inject into the pile only, and not the base, as extensive sloughing will positively occur if this rule is not observed. Fresh solutions should be used, and only one or two piles injected each time.

Patient should remain in recumbent position for a half hour after the injection is made. Two or three treatments may be necessary to effect a cure. Carbolic acid, twelve grains, glycerine and water, of each a dram, make the best solution I have ever used. This formula, in my hands, has been used many times, with uniform good results, despite adverse criticism of the injection method.

When patients have absolutely refused surgical procedures, other solutions, such as normal salt or plain boiling water, have been recommended and used with good success, but I have had no experience with them. When a pile bleeds after injection, torching it with the caustic pencil is sufficient. If patients can keep off their feet for three or four days after the above method, recovery will be more rapid, but they need not necessarily be detained from business.

CONSERVATIVE SURGERY OF EXTREMITIES.¹

BY GEORGE HAUGHTON FISIL, M.D.,
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THE importance of conservative surgery of the extremities cannot be overestimated. Many useful limbs have been saved when it seemed folly to try to save them, simply by the patient's flatly refusing amputation. These cases, which are well known, showing us, as they do, that many times the best surgical judgment is in error, should teach us to always favor the utmost conservatism in removal of tissue in cases which can be closely watched and kept under our observation. There are, in my judgment, but three

classes of cases which should be exceptions to this rule: 1st, cases of injury, in which the shock is profound and in which it is aggravated and kept up by the presence of the bruised and mangled nerve trunks; 2d, cases of injury in the aged where the circulation is poor and does not warrant the belief that the injured member can live; 3d, cases of gangrene, in which any attempt at conservatism is, I believe, an error, and will only lead to secondary operation or perhaps loss of patient.

In advocating such radical conservatism in the removal of any tissues from the extremities, I realize fully the dangers usually present from sepsis or gangrene, and that, undoubtedly, many lives have been lost by attempts on the part of the surgeon to save a member in cases of extensive injuries with open fracture of the bone, instead of amputating promptly, but I believe the loss of life in many of these cases to be due not to the desire toward conservatism, but to the failure of the surgeon to inspect the injured extremity daily. These cases require the most careful and frequent observation, and when we find that sepsis is developing acutely, secondary amputation should be promptly done.

The main safeguard against a disastrous outcome in our attempts to save the injured or diseased member is constant vigilance for the symptoms of sepsis and frequent inspections of the parts. We must not be satisfied after reducing a compound fracture and cleaning the parts as thoroughly as possible to leave the fracture in the original dressings without inspection for a week or ten days. If this is done, pus may form and burrow up and down the limb, destroying periosteum and causing loss of the limb and perhaps the patient's life, and this may all occur without severe local symptoms. The dressings of the injured limb must be removed sufficiently *daily* to enable the surgeon to be sure that no septic changes are taking place, and that the condition of the parts is satisfactory.

Among our best aids in preventing and combating sepsis are the time-honored bichloride pack and complete immersion of the limb in alkaline or antiseptic bath.

The advantage of conservative surgery of the extremities is that many limbs, or their members, are saved, which, it seems at the time of accident, must surely be lost. Even in cases in which extensive destruction of tissue, with some necrosis of bone, has already taken place, the necrosed bone may be removed and many times the extremity saved, perhaps, it is true, with shortening or contracture, but still a living, useful extremity, much more to be desired than an artificial one.

In cases of injury referred to above, when shock is profound and fracture and laceration extensive, amputation should be done promptly to relieve the continuance of shock caused by the afferent sensory impulses transmitted from the bruised nerve trunks: shock in these cases may be greatly lessened by "blocking" the nerve impulses with cocaine after method of Crile.

¹Read before the Saratoga Springs Medical Society, at the Annual Meeting, May 19, 1905.

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EDITORIAL COMMUNICATIONS.

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ANNUAL MEETING.

The twenty-second annual meeting of The New York State Medical Association, held October 16-19, 1905, was most successful from every standpoint. No better scientific program was ever presented, as men recognized as authorities in different lines of work were present not only from New York, but from other States, to take part in symposia on hygiene and preventive medicine, on the toxæmia of pregnancy, and on cancer. The attendance was large and the discussion most interesting.

The meeting of Tuesday, October 17th, was devoted to the question of the amalgamation of the State Association with the State Society. The resolutions approving the agreement made by the Joint Committee of Conference and heretofore approved by the Medical Society of the State of New York at its annual meeting, January 31, 1905, were carried by the decisive vote of 1,517 ayes, 2 noes, 295 not voting. The reappointment of the old Committee of Conference of the Association was carried by the same vote.

The large majority in favor of amalgamation clearly shows the desire on the part of the members of the Association to carry out the agreement and foreshadows a united profession after the Court has ordered that the State Association and State Society shall no longer be separate organizations but one body, enjoying "all the powers, rights and privileges possessed by either corporation at or immediately prior to the consolidation."

The new Society is thus strengthened, and the Medical Society of the State of New York will become more powerful and the profession and public thereby benefited.

It now behooves all members of the Associa-

tion to work faithfully for the best interests of the Association until amalgamation is accomplished and then continue with equal faithfulness to work for the reorganized Society. Osler has well said that the master word in medicine is "Work," and the reason the Association has attained a commanding position among medical organizations is because its members have worked and loyally supported their officers, and it is a pleasure to know that while the aim and object of its members were to make the Association great it will now be their aim and object to make the Society still greater.

Differences of opinion over small and unimportant matters will always arise among large bodies of men, but where all are working for such common causes as the advancement of the science of medicine and the relief of human suffering and the upholding of the honor of the Medical Society of the State of New York, such differences can never be of great importance. There is no doubt that great good can be accomplished by the consolidated Medical Society of the State of New York, as in union there is strength.

CENTENNIAL CELEBRATION OF A UNITED PROFESSION IN NEW YORK.

As will be noted in our news department, The New York State Medical Association, at its annual meeting this week, again endorsed the report of the Committee on Amalgamation with the Medical Society of the State of New York. As will be remembered, a year ago the report of the Committee was adopted but it was afterward discovered that certain legal formalities had to be gone through before The New York State Medical Association could give up its existence and merge into the Society. The legal difficulties involved notifying every member of the Association and giving him the right to vote on the proposition. The result, judging from a telegram received as we go to press, shows that the vote in favor of amalgamation was almost unanimous. The other legal formalities, as we under-

stand it, will necessitate but little time, and it is now hoped that the next annual meeting of the Medical Society of the State of New York, to be held in Albany next January—which will be its hundredth meeting—will be a grand centennial celebration of a united profession of the Empire State. The congratulations of the physicians of the entire country are extended, we are sure, to the members of the Association and of the Society who have worked so diligently to bring about this union.—*American Medical Association Journal*, October 21, 1905.

THE NEW YORK STATE MEDICAL ASSOCIATION.

By the action taken on Tuesday this Association elected to merge itself in the Medical Society of the State of New York. The unanimity of the vote shows that many men who have dearly cherished the desire to perpetuate the Association's separate existence have yielded to the will of the majority gracefully. In its twenty-two years of life the Association has done admirable work, and it cannot be doubted that its independent achievements will stimulate the consolidated organization to higher work than it would have aimed at but for the example of its younger constituent.—*New York and Philadelphia Medical Journal*, October 21, 1905.

THE ANNUAL DINNER.

The dinner of the Association this year was one of the most enjoyable that has ever been held. The enthusiasm awakened by the general meeting and the success of the amalgamation proceedings was prolonged into this function, and a feeling of general exhilaration was apparent in the demeanor of every one present. The presence of the ladies, who were out in greater numbers than ever before, also lent a most agreeable charm to the occasion. A toast was drunk in silence to President Roosevelt, followed by one to the ladies.

Dr. Mayo, who was present in his official capacity as president of the American Medical Association, gave an interesting account of the influence of the New York profession in that organization, the unfortunate consequences that supervened upon the isolation of New York State from affiliation with that body, and the impulse that will undoubtedly come with the renewed acquisition of the entire profession of the State. He also emphasized the importance of the crusade now waged against patent and proprietary medicines. Mr. Samuel Hopkins Adams, who is writing the series of articles in *Collier's Weekly*, exposing the felonious character of the proprietary medicine abuse, who was present by invitation, continued the latter theme in an interesting and amusing vein. In the course of his remarks, he insisted that the so-called religious press was the greatest of all offenders in the character and multiplicity of their quack advertisements. This aroused the attention and interest of the Rev.

Dr. Vander Water, who was the next speaker, and responded with vigor to the accusations made. Following the reverend gentleman came Mr. Littleton, the president of the Borough of Brooklyn, who entertained the audience vociferously with a series of delightful and well-told tales. Mr. Bomeisler and Dr. Joseph D. Bryant completed the list of speakers. General I. J. Suzuki, the Surgeon-General of the Japanese Navy, who was with Togo at the battle of the Sea of Japan, was present and lent no little interest to the occasion. In all its features the dinner proved a most enjoyable occasion.

LADIES' COMMITTEE.

It may be well right here to recognize the debt of gratitude due the ladies of New York City and vicinity for the efficient and attractive manner in which they assisted in the entertainment of the visiting ladies. The businesslike way in which they organized a working committee, under the chairmanship of Mrs. J. Riddle Goffe, with Mrs. Frederic W. Loughran as secretary, insured effective work. The 4 o'clock reception and tea on Monday afternoon enabled all to become acquainted and initiated delightfully the succeeding functions. It was and is the universal conviction that every doctors' meeting should be enlivened by features of this character. The ladies are indispensable.

OBITUARY.

Henry Darwin Didama, M.D., LL.D., dean emeritus of the Syracuse University Medical College, died at Syracuse, N. Y., on October 4, 1905. Dr. Didama was born at Perryville, Madison County, N. Y., June 17, 1823. He was the son of a prominent physician in New Jersey and graduated from the Albany Medical College, class of 1846. He was president of the Medical Society of the State of New York in 1879, and of The New York State Medical Association in 1883. He was always prominent in the Association affairs until a few years ago, when, on account of age, he ceased to take an active part in them. Dr. Didama was a member of the American Medical Association, The New York State Medical Association, American Academy of Medicine, American Climatological Association, Medical Society of the County of Onondaga and the Syracuse Academy of Medicine. He was also chief of staff of St. Joseph's Hospital and consulting physician of the House of the Good Shepherd.

CORRECTION.

Dear Doctor Denison—Let me express to you my appreciation of the attractive way in which the article on "Diagnosis and Treatment of Gastric Ulcer" was printed. One error crept into the article, due probably to an oversight on the part of the typesetter, which I would be much obliged if you would correct in the next number of the *NEW YORK STATE JOURNAL*. On page 362, first column, eighteenth line, in place of *empty* should be the word *emptying*. The statement as printed is not true, or at any rate is not what I meant to say. Very truly yours,

WM. VAN V. HAYES.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, and all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR NOVEMBER.

Orange County.—Wednesday, November 8th.
 Otsego County.—Tuesday, November 14th.
 Cortland County.—Friday, November 17th.
 New York County.—Monday, November 20th.
 Onondaga County.—Monday, November 20th.
 Ulster County.—Monday, November 20th.
 Lewis County.—Tuesday, November 28th.
 Monroe County.—Tuesday, November 28th.
 Westchester County.—Thursday, November 23d.

Eric County Association.—The regular September meeting of this Association was held at the University Club, Buffalo, N. Y., on October 9, 1905. There was a good attendance, 47 members being present.

In the business session, the Hon. Adelbert Moot addressed the Association on "The Need of an Art Department for the University of Buffalo." On motion of Dr. A. A. Hubbell, the Association voted itself unanimously in favor of an art department for the University of Buffalo.

In the scientific session, the following papers were read: "Suicide," by Dr. James W. Putnam; "Dacryocystitis Neonatorum," by Dr. E. E. Blaauw.

The next meeting will be held December 11, 1905.

(Signed) DAVID E. WHEELER, Secretary.

* * *

New York County Association.—The stated meeting of this Association for October, was held at the Academy of Medicine, 17 West 43d street, Monday, October 16, 1905. The president, Francis J. Quinlan, in the chair. The Association went into executive session at 8.20 p. m., and twelve new members were elected.

Dr. E. E. Harris made a motion to the effect that the Association express its approval of the resolution passed by the State Association to continue with the work for the abolition of the office of Coroner in the city of New York. This motion was carried by a unanimous vote. At the scientific session of the meeting the following papers were presented to the Association for discussion: The History of the Dispensary Law, by E. E. Harris, M.D.; Dispensary Rules Adopted by the State Board of Charities and the Policy of the Board in the Enforcement of the Dispensary Law, by Stephen Smith, M.D.; The Practical Application of the Law to the Dispensaries, by Mr. W. N. Buck, Chief Inspector New York State Board of Charities; The Experience of the Special Inspec-

tion of the New York State Board of Charities, by Mr. John R. Prest; The Practical Value of the Investigation of the Dispensary Cases, by Prof. E. T. Devine, Columbia University; The Question of Medical Ethics in the Relation to the Dispensary Law, by John A. Wyeth, M.D. In the general discussion of these papers the following members took part: Drs. J. D. Bryant, Frederick Sturges, Egbert La Fevre, Messrs. Robt. Erbard and G. N. Gay. The Association adjourned at 11.45. (Signed) WILLIAM RIDGELY STONE, Secretary.

* * *

Orange County Association.—The regular monthly meeting of the Orange County Medical Association was held at Goshen, Wednesday, October 11, 1905, at 2 p. m. There was a good attendance.

The meeting was called to order by the president, Dr. E. D. Woodhull, of Monroe. At the scientific session under report and presentation of cases, Dr. Charles I. Redfield, of Middletown, reported a case of typhoid fever in a child 10 years of age. He stated that the eruption was particularly well marked, that persistent vomiting was a prominent symptom, as is quite usual in children, and that the blood test was characteristic, 1-30, instead of 1-19, being about double the usual amount, making the diagnosis an established fact. Dr. William J. Carr, of Newburgh, read a very interesting paper on Abdominal Injuries and Treatment. The subject was treated in a very concise and able manner which reflected great credit upon the writer. The whole ground was thoroughly gone over and a complete résumé of the subject given. The paper was discussed by Drs. Dennis, Hulett, Redfield, Thompson and Distler. At the conclusion of the discussions, Dr. Carr was extended a hearty vote of thanks for his excellent paper.

At the business session Dr. J. B. Peters, of Walden, and Dr. E. Ross Elliott, of Montgomery, were elected to membership. Dr. Distler called attention to the meeting of The New York State Medical Association, October 16th to 19th, inclusive, and earnestly requested as many as could to attend this important meeting.

Owing to the compliance with the resolution regarding contract lodge practice by a suspected member, the special committee appointed to investigate were discharged with thanks.

There being no further business before the Association the meeting adjourned to Wednesday, November 8th, to be held at the Russell House, Middletown, N. Y.

(Signed) LAWRENCE G. DISTLER, Secretary.

* * *

Sullivan County Association.—Semi-annual meeting of this Association held at Liberty House, Liberty, N. Y., Wednesday, October 11, 1905, called to order 2.30 p. m. H. P. Deady, president, in the chair. There were present:

Drs. Paul, H. P. Deady, S. W. Wells, H. M. King, A. B. Neagle, of Liberty; Drs. J. A. Miller and S. D. Maynard, of Roscoe; Dr. Wm. Racoonin, of Centerville Station; Dr. O. N. Meyer, of Monticello; Dr. Frank W. Laidlaw, of Hurleyville; T. M. Millspaugh, druggist of Liberty.

The Chair appointed Drs. S. W. Wells and L. C. Payne a committee to draft resolutions on the death of Dr. J. L. C. Whitcomb.

At the last meeting it was suggested that the scientific session of this meeting be devoted entirely to the discussion of the general topic, "Typhoid Fever."

The consideration of "Etiology and Symptomatology" was assigned to Dr. A. B. Neagle, of Loomis Sanitarium, who read a very able and carefully prepared paper, the discussion of which was opened by Dr. H. M. King.

"Modern Treatment" was presented in a very able and instructive paper by Dr. O. N. Mayer, of Monticello. Discussion opened by Dr. S. D. Maynard, of Roscoe.

"Bacteriological Aspect" was presented in a complete and masterly manner by Dr. H. M. King, who demonstrated the practical working of the Widal reaction.

The meeting was by far the most practical and satisfactory one the Sullivan County Association has held.

The subject, "Pneumonia," was selected as the general topic for the next session.

(Signed) FRANK W. LAIDLAW,
Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

THIRD DISTRICT BRANCH.

Cortland County.—Harry S. Braman, Homer; Paul Higgins.

FOURTH DISTRICT BRANCH.

Chautauqua County.—Arthur C. Christie, Clymer; Laban Hazeltine, Jamestown; Frederick H. Nichols, Jamestown; Perry J. Payne, Jamestown; Fred C. Purcell, Ellington.

Erie County.—Henry J. Mulford, Buffalo.

New York County.—Salvatore Brancato, New York; Arthur Richard Braunlich, New York; Dillon Brown, New York; Samuel Albertus Brown, New York; Warren B. Chapin, New York; Walter J. Clarke, New York; Maximilian Davidoff, New York; John E. L. Davis, New York; John Ernest Gignoux, New York; Julius Halpern, New York; Henry B. Henson, New York; Thomas J. Hillis, New York; William E. Howley, New York; Lee M. Hurd, New York; Augustine T. Kingston, New York; Jacob Lewengood, New York; Archibald Lybolt, New York; Albertus Adair Moore, New York; William T. Moynan, New York; Louis C. Pettit, Ward's Island; John B. Shotwell, New York; John Gorse Simmons, New York; John Joseph Slevin, New York; George Fremont Straub, New York; Ed-

win E. Swift, New York; William J. Tierney, New York; Benjamin F. Vosburgh, New York; Henry Weil, New York; Charles Mallory Williams, New York.

Orange County.—E. Ross Elliott, Montgomery; Jacob B. Peters, Walden.

Richmond County.—Newton D. Chapman, Port Richmond.

LEGAL NOTES.

The development of the Garnishment Law and its application to physicians' bills are a matter of great interest to the profession of the State, and the counsel can report that during the past month there have been decisions which bring within the definition of a "necessary" the attendance of physicians and the furnishing of medicines. Any person (who is in receipt of a salary in excess of \$12 per week) now owing a doctor can be examined under an order of the Court, and when the amount of such salary is disclosed the employer can be compelled to turn over a portion of the weekly stipend to apply on the doctor's bill.

These decisions have not been made in the Supreme Court, but in the County Court of Erie and Niagara Counties, and the counsel is awaiting with interest to hear and report the decision of a Supreme Court Justice upon this subject. The opinion of the County Judges, while not at hand, will doubtless have weight with the higher courts on these questions.

* * *

There has come to the attention of the profession an attack recently made upon one of our reputable Italian physicians by a patient, and the attack can only be explained upon the theory that the woman is insane and should not be allowed to be at large.

An action was brought by this woman against the doctor for \$2,000 for an alleged assault, and subsequently the case was dismissed. Thereupon the husband called, with the patient, at the District Attorney's office, and there undertook to bring to bear the power of the District Attorney's office to not only ruin the reputation of the doctor, but doubtless to get him to make some settlement by reason of their blackmailing attacks.

Through the careful investigation in that office the doctor was wholly exonerated, and another attempt at blackmail through criminal prosecution was thwarted.

The physician was told that the woman had threatened his life and that she would shoot him on sight.

This is only an illustration of what dangers physicians are subjected to, and it also shows how important it is that physicians should not allow themselves to be made the prey of scoundrels of this variety by meekly submitting.

THE ANNUAL MEETING OF THE COUNCIL AND FELLOWS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

The annual meeting of the Council and Fellows of The New York State Medical Association was held at the Academy of Medicine, 17 West 43d street, New York City, on Monday, October 16, 1905.

The President, Dr. J. Riddle Goffe, in the chair.

The meeting was called to order at 2.45 P. M.

The following Members of the Council, Fellows and Alternates answered to the roll-call: Byron C. Cheeseman, T. Floyd Woodworth, Douglas C. Moriarta, George F. Comstock, Dudley R. Kathan, George A. Chapman, Clark W. Greene, Franklin J. Kaufmann, Eugene Baker, John S. Kirkendall, William M. Bemus, George F. Smith, John A. Weidman, Alvin A. Hubbell, William Harvey Thornton, Charles G. Stockton, DeLancey Rochester, Bernard Cohen, George F. Cott, Grover W. Wende, Arthur G. Bennett, Edward Munson, Charles O. Green, George S. Skiff, Irving D. LeRoy, David P. Austin, Hermann M. Biggs, Joseph B. Bissell, John A. Bodine, Nathan E. Brill, Joseph D. Bryant, Charles H. Chetwood, William B. Coley, Daniel S. Dougherty, Charles Ellery Denison, Ellery Denison, Henry A. Dodin, John A. Fordyce, W. Travis Gibb, Henry W. Berg, A. M. Fernandez-Ybarra, J. Riddle Goffe, E. Eliot Harris, Frederick P. Hammond, William P. Herrick, Lucius W. Hotchkiss, Monta W. Jamison, Samuel J. Kopetzky, Richard Kalish, Edward L. Keyes, Jr.; William G. LeBoutillier, Egbert LeFevre, Johanna B. Leo, Samuel Lewengood, Guy D. Lombard, Frederic W. Loughran, J. W. Draper Maury, Emil Mayer, Harry R. Purdy, Francis J. Quinlan, Thomas F. Reilly, Henry Roth, Reginald H. Sayre, Harry H. Seabrook, George D. Stewart, William R. Stone, Wisner R. Townsend, James P. Tuttle, Gertrude Rochester, A. Alexander Smith, John W. Wainwright, Sidney Yankauer, Joseph B. Hulett, Charles D. Kline, William J. Meyer, Allen A. Jones, L. C. Ayer, C. I. Redfield.

The President declared that as a quorum was present, the meeting was now open for the transaction of business.

Dr. Louis C. Ager, of Brooklyn, said that as the former by-laws of the Kings County Medical Association did not conform to those of the State Association, there had been some delay in electing Fellows, and he asked for a ruling from the Chair as to whether those Fellows who were elected at a meeting held on the 10th of last May would be permitted to serve.

The Chair asked Dr. Ager whether the Fellows who were elected last May were duly qualified.

Dr. Ager replied that they were not.

The President ruled that they would not be permitted to serve, and that the Fellows elected two years ago still held their positions.

Dr. Ager appealed from the decision of the Chair. The question was thereupon put to a vote, and the decision of the Chair was sustained.

Dr. Arthur G. Bennett said that as president of the Erie County Medical Association he had been authorized that in case the Fellows or their Alternates from Erie County were unable to be present at this meeting to appoint others to take their place. He asked whether such appointments would be in accordance with the by-laws?

The President stated that he found no provision for such action, and he would have to rule against it.

Dr. Bennett said that such a course had been allowed on a previous occasion.

The President said the ruling of the Chair would stand.

President's report on the Needs of the Association was read by Dr. J. Riddle Goffe, President. See page 394.

Annual report of the Council was read by the Secretary. Moved and seconded that the report of council be accepted. Carried. See page 396.

Annual report of the Treasurer was read by the Treasurer. Moved and seconded that the report be accepted. Carried. See page 400.

Reports of Standing Committees:

Committee on Public Health. Dr. Louis C. Ager, the chairman of the Committee on Public Health, presented the report of this committee. It was moved and seconded that the report be accepted and placed on file. Carried. See page 398.

Committee on Publication. Dr. Charles E. Denison, the chairman of the Committee on Publication, presented the annual report of this committee. Moved and seconded that the report be accepted. Carried. See page 399.

Committee on Arrangements. Dr. F. W. Loughran, chairman, presented the report. Moved and seconded that the report be accepted. Carried. See page 402.

Committee on Legislation. Dr. E. Eliot Harris, the chairman of the Committee on Legislation, presented the annual report of this committee. It was moved and seconded that the report be accepted. Carried. See page 402.

Dr. Harris, the chairman of the Committee on Legislation, submitted the following resolutions:

WHEREAS, The number of bills introduced in the Legislature creating examining boards for some special department of medicine is increasing each year, and as the various bills provide a special examination which differs from the examination now required to obtain a license to practice medicine in this State, and in view of the fact that the medical profession is called upon to be active in Albany each year to protect the public health from such pernicious legislation; Be it

Resolved, That The New York State Medical Association believes that the time has arrived to create a sentiment in the medical profession as well as in the Legislature of this State in favor of one medical examining board instead of the

three separate examining boards now provided in the law, and to counteract the growing tendency in the State Legislature to create special examining boards for some of the popular medical fads.

Resolved, That the Committee on Legislation of The New York State Medical Association be empowered to confer with other medical bodies in preparing a bill to be introduced at the coming session of the Legislature embodying the recommendations contained in these resolutions.

AND WHEREAS, The New York State Medical Association believes that the Coroner's system in this State, and especially in the city of New York, is antiquated and should be replaced by one more modern than the system which now prevails. Therefore, be it

Resolved, That the Committee on Legislation be instructed to investigate the question embodied in these resolutions, and embody the result of its work in the form of a bill to be introduced in the Legislature of 1906.

Resolved, That the Committees on Legislation of the district branches and county associations are requested to cooperate with the Committee on Legislation of this Association in carrying out the recommendations contained in these resolutions.

It was moved and seconded that the above set of resolutions be adopted. Carried.

Committee on Library. In the absence of the chairman of this committee, Dr. Alexander Lambert, the report of the committee was accepted and placed on file. See page 399.

Dr. Wisner R. Townsend said that certain amendments to the by-laws were offered at the last annual meeting of the Council and Fellows, and were printed in the October (1905) issue of THE NEW YORK STATE JOURNAL OF MEDICINE. In that report were several typographical errors, to which he desired to call attention. With these corrections, he moved that the amendments be adopted as printed.

Dr. DeLancey Rochester moved that the proposed amendments be read. Carried.

Dr. Townsend thereupon read all the amendments in their corrected form.

It was moved and seconded that the amendments to the by-laws as read, be adopted. Carried.

For By-Laws, see page 409.

Dr. William R. Stone moved that these by-laws, as amended, go into effect at once.

The President ruled that as the by-laws had been adopted, Dr. Stone's motion was unnecessary and out of order.

Dr. Wisner R. Townsend moved the adoption of the following resolution:

Resolved, That the Secretary of The New York State Medical Association notify the Treasurers of the various county medical associations that in accepting dues for the year 1906, from members or candidates for membership, that such dues shall be returned in case an order for the amalgamation of The New York State Medical Association and the Medical Society of

the State of New York shall be entered on or before January 1, 1906.

Seconded.

Dr. Denison said he did not think such a resolution was constitutional. He thought it was unnecessary and would have no force on the county associations.

Dr. Rochester also opposed the resolution. Even if the legal obstacles to the amalgamation were removed, he questioned whether the reorganization could be completed before January, 1907, because of the lack of organization in the various county societies.

The President stated that the moment the court entered the order, the amalgamation was an established fact. The dues paid by members of the Association were higher than those required by the Society, and if the amalgamation occurred before 1906, it was only fair that dues paid by members of the Association for that year should be returned to them.

Dr. Frederick P. Hammond thought the resolution might lead to a legal complication in case of its adoption. By returning a member's dues, it practically threw him out.

After some further discussion, Dr. Wisner R. Townsend's resolution was adopted as read.

Report of the Counsel of the Association, James Taylor Lewis, Esq., was then read. See page 402.

Dr. A. A. Hubbell moved that the services of Mr. Lewis be retained for another year, if the Association lived for that length of time.

Dr. Douglas C. Moriarta moved that the services of Mr. Lewis be retained during the continuance of the cases now on the calendar.

The President suggested that the question be left for the Council to decide.

Dr. Nathan E. Brill moved that Mr. Lewis' report be placed on file. Carried.

Dr. Wisner R. Townsend, chairman for the Nominating Committee, reported as follows:

For president, Dr. Allen A. Jones, of Buffalo.
First vice-president, Dr. H. Ernest Schmid, of White Plains.

Treasurer, Dr. Wm. G. LeBoutillier, of New York City.

Secretary, Dr. Charles I. Redfield, of Middletown, N. Y.

Chairman of the Committee on Arrangements, Dr. Frederic W. Loughran, of New York City.

Chairman of Committee on Legislation, Dr. E. Eliot Harris, of New York City.

Chairman of the Committee on Library, Dr. Alexander Lambert, of New York City.

Chairman of the Committee on Public Health, Dr. A. A. Hubbell, of Buffalo.

Chairman of the Committee on Publication, Dr. Robert J. Carlisle, of New York City.

Chairman of the Committee on Nominations, Dr. Wisner R. Townsend, of New York City.

Delegates to the annual meeting of the American Medical Association, Dr. E. Eliot Harris, of New York City, and Dr. J. W. Grosvenor, of

Buffalo. Alternates to the annual meeting of the American Medical Association, Dr. Charles G. Stockton, of Buffalo; Dr. Frank D. Reese, of Cortland; Dr. John A. Fordyce, of New York City, and Dr. Wm. C. LeBoutillier, of New York.

Dr. DeLancey Rochester moved that the report of the Nominating Committee be accepted, and that the Secretary be instructed to cast a ballot for each gentleman for the office for which he had been named. Seconded.

Dr. William R. Stone said he understood nominations from the floor were in order, and if so, he wished to avail himself of that privilege.

Dr. Ellery Denison said he wished to amend Dr. Rochester's motion so that each candidate could be voted for separately.

The President stated that as an objection had been raised to Dr. Rochester's motion, it would be necessary to vote for each candidate separately.

Dr. Rochester said he would withdraw his motion.

Dr. E. Eliot Harris moved that the Secretary be instructed to cast a ballot for Dr. Allen A. Jones for president of The New York State Medical Association. Seconded by Dr. Green. Carried. The Secretary thereupon cast the ballot as instructed, and Dr. Jones was declared elected.

Dr. Harris then moved that the Secretary be instructed to cast a ballot for Dr. H. Ernest Schmid for vice-president. Seconded. Carried. The ballot was cast, and Dr. Schmid was declared elected.

Dr. Harris then moved that the Secretary be instructed to cast a ballot for Dr. Wm. G. LeBoutillier for treasurer. Seconded. Carried. The ballot was cast, and Dr. LeBoutillier was declared elected.

Dr. Harris then moved that the President be instructed to cast a ballot for Dr. Charles I. Redfield for secretary. Seconded. Carried. The ballot was cast, and Dr. Redfield was declared elected.

Dr. Nathan E. Brill then moved that the Secretary be instructed to cast a ballot for Dr. Frederic W. Loughran for chairman of the Committee on Arrangements. Seconded. Carried. The ballot was cast, and Dr. Loughran was declared elected.

Dr. Brill then moved that the Secretary be instructed to cast a ballot for Dr. A. A. Hubbell, for chairman of the Committee on Public Health. Seconded. Carried. The ballot was cast, and Dr. Hubbell was declared elected.

Dr. Bernard Cohen moved that the Secretary be instructed to cast a ballot for Dr. E. Eliot Harris for chairman of the Committee on Legislation. Seconded. Carried. The ballot was cast, and Dr. Harris was declared elected.

Dr. Cohen moved that the Secretary be instructed to cast a ballot for Dr. Alexander Lambert for chairman of the Committee on Library. Seconded. Carried. The ballot was cast, and Dr. Lambert was declared elected.

Dr. Brill moved that the Secretary be instruct-

ed to cast a ballot for Dr. R. J. Carlisle for chairman of the Committee on Publication.

Dr. William R. Stone objected to this motion and proposed the name of Dr. Charles E. Denison, of New York City.

A formal ballot was thereupon ordered, with the following result:

Dr. Carlisle, 42 votes; Dr. Denison, 31 votes.

Dr. Carlisle was thereupon declared to be elected.

Dr. C. E. Denison moved that the election of Dr. Carlisle be declared unanimous. Seconded, and carried.

Dr. Brill moved that the Secretary be instructed to cast a ballot for Dr. Wisner R. Townsend for chairman of the Committee on Nominations. Seconded. Carried. The ballot was cast, and Dr. Townsend was declared to be elected.

Dr. Townsend moved that the Secretary be instructed to cast a ballot for Drs. Harris and Grosvenor as delegates to the American Medical Association. Seconded. Carried. The ballot was cast and Drs. Harris and Grosvenor were declared elected.

Dr. Townsend moved that the Secretary be instructed to cast a ballot for Dr. Charles G. Stockton, F. D. Reese, John A. Fordyce and Wm. G. LeBoutillier as Alternates to the meeting of the American Medical Association. Seconded. Carried. The ballot was cast, and Drs. Stockton, Reese, Fordyce and LeBoutillier were declared elected.

Dr. Townsend said he was certain the members of the Association would be pained to learn that their colleague and ex-President, Dr. Ferguson, was so ill that it was impossible for him to attend the meeting of the Association. He moved that the Association instruct the President to send a telegram to Dr. Ferguson, expressing the sympathy of the Association for his illness and their best wishes for his speedy recovery.

Dr. Joseph D. Bryant said he hastened to second Dr. Townsend's motion, with which he was in hearty sympathy. In a recent interview Dr. Ferguson had assured him that if he was alive and well he intended to be present at this meeting and use what influence he had for uniting the two State societies.

Reading of the minutes and action thereon. The Secretary read an abstract of the minutes of the present meeting.

Dr. Moriarta said he did not think any action could be taken on these minutes, as no quorum was present.

Upon Dr. Townsend's motion, the meeting adjourned.

REGISTRATION.

The number of members registered at the annual meeting of the Association, October 16-19, 1905, was 317. This is the largest registration recorded during the last five years, and compares with 214 registered in 1904. The interest in the meeting was great and the members were full of enthusiasm.

**TWENTY-SECOND ANNUAL MEETING OF THE
NEW YORK STATE MEDICAL ASSOCIATION.**

Held at the New York Academy of Medicine, 17 West 43d Street, New York City, Tuesday, October 17, 1905.

The President, Dr. Goffe, called the meeting to order at 10 A. M., and, having announced that all members had been personally served with a notice of the meeting, and there being a quorum present, declared the meeting open for the transaction of business.

The President stated that in the transactions of the day's business he would follow the order outlined in the amended by-laws, which differed from that printed on the official program of the meeting.

The Secretary then began reading the minutes of the twenty-first annual meeting of the Council and Fellows.

Dr. Wisner R. Townsend declared that the reading of these minutes was out of order. He stated that the only minutes that were in order at a general meeting were those of the Association.

The Secretary thereupon read the minutes of the business meeting of the Association at the twenty-first annual session.

Dr. Emil Mayer moved that the reading of the scientific portion of the minutes be dispensed with.

Seconded. Carried.

Dr. Townsend moved that the minutes of the twenty-first annual meeting of the Association be adopted.

Seconded. Carried.

Dr. Townsend stated that at the last annual meeting of the Association a series of amendments to the by-laws were offered and laid on the table to be acted on at this meeting. He moved that the consideration of these amended by-laws be now taken up.

Seconded. Carried.

Dr. Townsend then read the proposed amendments to the by-laws.

Dr. DeLancey Rochester called attention to the fact that Section 4, Article VI of the proposed amended by-laws gave one-third of the entire membership as constituting a quorum. This would mean about 600, which he thought was a rather large quorum.

Dr. Townsend explained that this large quorum was necessary in order to comply with the corporation law of the State of New York. He stated that at these meetings members could be present by proxy.

Dr. A. A. Hubbell stated that that fact might be made clear by adding the words "present either in person or by proxy," and he moved that those words be inserted.

Seconded.

Mr. James Taylor Lewis, the counsel of the Association, said they had no right to qualify the

paragraph. In its wording it was simply complying with the corporation law.

Dr. Hubbell thereupon withdrew his motion.

Each of the by-laws, as amended, was then adopted separately by the Association, and finally the entire series, as amended, was adopted as a whole.

The amendments were all adopted as read. The new by-laws are the same as those adopted by the Council and Fellows October 16, 1905, with the exception of Article VI, Section 1, and Article X, Section 4, which were amended by the Association to read as follows:

Annual.—Sec. 1. The New York State Medical Association shall hold a meeting annually, to be called its annual meeting, in the city of New York, and Borough of Manhattan, on the first Tuesday following the third Monday in October, in each year, at 9.30 o'clock in the forenoon, at its office or place of transacting its financial affairs, or elsewhere in the city of New York, and the scientific or social sessions of such annual meeting shall be held at such place and hour as shall be selected by the Council and designated in the notice of such meeting, and The New York State Medical Association may hold special meetings at other times, places and hours in the city of New York and Borough of Manhattan. The notice for all meetings of The New York State Medical Association or the Council and Fellows shall be in writing, mailed in a securely post-paid wrapper, addressed to the last given address of each and every member of The New York State Medical Association, which notice shall state the date, place and hour of such meeting. Notice of all special meetings shall be mailed to every member of the State Medical Association at least ten (10) days before such meeting, and shall state the date, hour and purpose of the meeting, and no other business at any special meeting shall be conducted except such as is stated in the call. The affidavit of mailing by the Secretary of The New York State Medical Association of such notice for the call of the meeting, shall be sufficient proof of the service of such notice upon each and every member, for any and all purposes.

And Article X, Sec. 4, reads:

Collection of Dues.—Sec. 4. On the first day of July in each year, the names of all members who have failed to pay their indebtedness to The New York State Medical Association for the current year shall be omitted from all public accredited lists of members of The New York State Medical Association, and if at the close of the last day of the annual meeting of The New York State Medical Association such dues still remain unpaid and in arrears, the name of such delinquent member shall be dropped from membership in The New York State Medical Association as soon as conveniently possible thereafter.

Dr. Townsend presented the following resolution:

Resolved, That The New York State Medical Association hereby approves and adopts the agreement of consolidation prepared by the Joint Committee of Conference appointed by the New York State Medical Association and the Medical Society of the State of New York, dated January 23, 1904, and heretofore adopted at the regular annual meeting of the Medical Society of the State of New York, held in Albany, January 31, 1905, and at a special meeting, held in Albany, February 2, 1905, as follows:

For agreement see JOURNAL, New York State Medical Association, February, 1904.

Dr. Emil Mayer said that as copies of this agreement had already been printed and dis-

tributed to the members of the Association, the reading of it be dispensed with.

Seconded. Carried.

Dr. Townsend then presented the remainder of the resolution, as follows:

And be it further

Resolved, That a committee, consisting of E. Eliot Harris, Julius C. Bierwirth, Alexander Lambert, Parker Syms and Wisner R. Townsend, is hereby appointed, or, in case of the disability of any of them, then of such other persons as the President may appoint in his or their place and stead, to carry out the purposes of said agreement and with full and absolute power to take any and all legal steps necessary in the premises, in the place of the said The New York State Medical Association, as may be necessary, to complete the consolidation of The New York State Medical Association and the Medical Society of the State of New York.

Dr. Townsend: I move that the Association approve and adopt these resolutions, and that a full copy of the resolutions, agreement, act of the Legislature, Constitution and By-Laws, etc., be spread on the official minutes of the meeting.

Seconded by Dr. Harris.

Dr. Amos S. Edwards said that if it was in order, he wished to offer the following amendment to the resolution introduced by Dr. Townsend:

Resolved, That after the word "that" in Section 7 of the agreement of the Joint Committee of Conference, the following words be stricken out, viz., "As soon as possible after the entry of an order for the consolidation of the corporations, the following proposition shall be submitted by referendum to the vote of the members of the Society, namely."

Seconded by Dr. Kaufmann. Discussed by Drs. Harris, of New York; Howe, of Buffalo, and Kaufmann, of Syracuse.

Dr. Edwards said he would withdraw his proposed amendment to the resolution.

Dr. Joseph D. Bryant said that as President of the Medical Society of the State of New York, he wished to assure the members of The New York State Medical Association that he would make every effort to secure the object they were working for to-day. He had sent a copy of the principles of ethics to each member of the State Society, and he was receiving assurances daily that many were warmly in favor of its adoption, and he had no doubt it would be adopted.

Dr. Harris said that under the corporation law of the State of New York a roll call was necessary for the adoption of the resolutions.

Dr. Emil Mayer moved that three inspectors of election be appointed by the Chair. Seconded. Carried.

The Chair appointed as inspectors of election, Emil Mayer, Henry A. Dodin and Daniel S. Dougherty.

The Chair stated that the result would be announced at the opening of the afternoon session.

The afternoon session was called to order by the President at 2.30 P. M.

Dr. Emil Mayer, the chairman of the inspectors of election, reported as follows:

NEW YORK, October 17, 1905.

Dr. J. Riddle Goffe, *President*,

New York State Medical Association:

The undersigned, inspectors of election appointed under resolution of The New York State Medical Association, at its meeting held October 17, 1905, to receive and record the ballots of its members on the question of the amalgamation of The New York State Medical Association with the Medical Society of the State of New York, and the appointment of the Joint Committee of Conference as per resolutions introduced by Dr. Wisner R. Townsend, and seconded by Dr. E. Eliot Harris, beg leave to report as follows:

Ayes, 1,517; noes, 2; not voting, 295; the latter includes twelve newly elected members in New York County. Total, 1,814.

Respectfully submitted,
EMIL MAYER, M.D., Chairman;
HENRY A. DODIN,
D. S. DOUGHERTY.

The President, after announcing the result of the vote, decided the resolutions adopted.

Dr. Townsend moved that the sincere thanks of the Association be extended to the inspectors of election for their faithful and arduous work. Seconded. Carried.

The President announced that he had just received the following telegram from Dr. Ferguson: "Several weeks of illness prevents my attendance. I trust all will be done wisely and well."

Dr. Denison, the chairman of the Committee on Publication, said he had just received a letter from Dr. Simmons, in regard to the supervision of medical nostrums and pure food legislation, as follows:

*Dr C. E. Denison, *Chairman*,

Committee on Publication, New York, N. Y.:

My Dear Doctor—I find that I failed to officially call your attention to a resolution which was unanimously adopted at the last meeting of the House of Delegates of the American Medical Association. The resolution referred to was introduced by Dr. E. Eliot Harris, of New York City, and is as follows:

Resolved, That the Committee on Publication of the journals of medicine published by the State Medical Associations affiliated with this body be asked to assist the Board of Trustees in their efforts to suppress the advertisement of medical nostrums, and to cooperate in the work of securing pure food and pure drug laws in the United States.

Respectfully yours,
GEORGE A. SIMMONS,
General Secretary.

Dr. Frederic W. Loughran, the chairman of the Committee on Arrangements, announced that the

*Received the day after the meeting of the Council and Fellows, hence no action taken.

annual dinner of the Association would be held at the Hotel Astor on Wednesday evening, October 18th, and that tickets might be obtained from the Committee at \$5 each. Among the guests who had been invited to attend the dinner were Governor Higgins, Dr. William J. Mayo, of Rochester, Minn., and Surgeon-General Suzuki, of the Japanese Navy.

Dr. John Shradly presented a brief memorial address of the late treasurer of the Association, Dr. Frederick A. Baldwin, of New York.

Dr. Gibbons, who had been appointed as delegate to the recent meeting of the Pennsylvania State Medical Association, made the following report. See page 414.

Dr. John A. Wyeth presented report as delegate to New Jersey State Medical Society. See page 402.

Dr. Emil Mayer presented Surgeon-General Suzuki, of the Japanese Navy, who thanked the members for their kind reception.

Major Louis L. Seaman, U. S. V. E., presented the two following resolutions, which were unanimously adopted:

Resolved, That The New York State Medical Association, now assembled, respectfully petition Congress at its next session to reorganize the medical departments of the United States Army and Navy on a broad basis, similar to that of the countries most advanced in military sanitation, giving to its army department an independent transport system and advisory authority over the commissary department, and to its officers equivalent rank, dignity and power to enforce sanitary measures, and to their personnel, ample measures for the proper care of the ill and injured in the service. Also

Resolved, That it petition Congress to direct that a graded course of study in sanitation and hygiene be added to the regular curriculum at the Military Academy at West Point, and at the Naval Academy at Annapolis, and that examinations in this course shall count equally with other studies in establishing the final standing of the graduate.

The following delegates from other State Associations were present at the meeting:

Dr. William J. Chandler, from New Jersey, Drs. A. M. McDonnell and A. R. Diefendorfer, from Connecticut, Dr. C. E. Chandler as substitute delegate from Vermont, Dr. Charles A. Stearns from Rhode Island, and Drs. William H. Hartzell and David I. Giarth from Pennsylvania.

SCIENTIFIC SESSION.

The President's address, by Dr. J. Riddle Goffe. See page 403.

The Abrupt Onset of Typhoid Fever, Dr. Morris Manges, New York City.

Discussed by Drs. Albert Kohn, New York City; Charles G. Stockton, Buffalo; Douglas C. Moriarta, Saratoga Springs. Discussion closed by Dr. Manges.

Lumbago, Sciatica, Pseudo-rheumatism, Dr.

James J. Walsh, New York City. Discussed by Dr. Richard H. Gibbons, New York City. Discussion closed by Dr. Walsh.

Some Experience with Apomorphia, Dr. George H. Peddle, Perry. Discussed by Dr. Sidney A. Dunham, Buffalo; Dr. Giarth, of Kittanning, Pa. Discussion closed by Dr. Peddle.

The Significance of Dysmenorrhœa at Puberty and Its Relation to Uterine Tumors, Dr. Frank DeWitt Reese, Cortland. Discussed by Dr. Mary Gage-Day, Kingston; Dr. Robert T. Morris, New York City. Discussion closed by Dr. Reese.

Typhoid Fever in Children, Dr. Louis Curtis Ager, Brooklyn. Discussed by Dr. L. E. LaFetra, New York City; Dr. Frank D. Reese, Cortland. Discussion closed by Dr. Ager.

THIRD DAY, WEDNESDAY, OCTOBER 18TH. MORNING SESSION, 9.30 A. M.

The President announced that he would reappoint Dr. E. Eliot Harris, of New York City, as delegate to the National Legislative Council.

"Test Feces; Their Value in the Recognition of Intestinal Disturbances Taking Their Origin in Other Parts of the Digestive Tract," Dr. Heinrich Stern, New York City.

What Organized Malpractice Defense Does for the Profession and the Public, Mr. James Taylor Lewis, New York City.

Symposium on Hygiene and Preventive Medicine. (a) Protection of the Water Supply, Dr. Thomas Darlington, New York City; Ernest J. Lederle, Ph.D., New York City; Mr. Samuel Hopkins Adams, New York City. (b) Protection of the Milk Supply. Dr. Walter Benschel, New York City.

AFTERNOON SESSION.

Symposium on the Toxæmia of Pregnancy.

The Acid Toxæmia of Pregnancy, Dr. Henry McMahon Painter, New York City.

The Pathology of Eclampsia, Dr. James Ewing, New York City.

Hyperemesis Gravidarum, Dr. William S. Stone, of New York City.

The Treatment of Eclampsia, Dr. Bernard Cohen, of Buffalo.

Vaginal Cæsarian Section in Eclampsia, Dr. M. Stamm, of Fremont, O.

Discussion of the entire subject by Drs. J. Whitridge Williams, Baltimore; J. Clifton Edgar, New York City; Joseph Brown Cooke, New York City; David P. Austin, New York City, and James J. Walsh, New York City. Discussion closed by Drs. Ewing, Stone and Cohen.

The President moved that a vote of thanks be extended to the readers of the papers and those who had taken part in the discussion, as many of them were present at the meeting at considerable personal inconvenience. Seconded. Unanimously carried.

Resection of the Bladder, Dr. Howard Kelly, Baltimore, Md. Discussed by Dr. Hiram N. Vineberg, New York City; Dr. Herman J. Boldt, New York City; Dr. A. Ernest Gallant, New York City. Discussion closed by Dr. Kelly.

Upon motion of Dr. Boldt, a unanimous vote of thanks was extended to Dr. Kelly for his paper.

FOURTH DAY, THURSDAY, OCTOBER 19TH.
MORNING SESSION.

Symposium on Carcinoma—Non-Surgical Treatment.

Spontaneous Cure in Cancer; Its Significance in Relation to the Ultimate Solution of the Problem of the Cure of Cancer, Dr. Hervey R. Gaylord, Buffalo. Discussed by Drs. William B. Coley, New York City; Carlton C. Frederick, Buffalo; Mary E. Dunning, Newburgh; Charles P. Noble, Philadelphia. Discussion closed by Dr. Gaylord.

Therapy of Carcinoma, Dr. Samuel Lloyd, New York City. Discussed by Dr. William B. Coley, New York City; Harvey R. Gaylord, Buffalo; James J. Walsh, New York City. Discussion closed by Dr. Lloyd.

Mediastinal Tumors, Dr. William Francis Campbell, Brooklyn.

The Sanatorium for Tuberculous Patients, and Its Medical and Social Mission, Dr. S. A. Knopf, New York City.

At the conclusion of his paper, Dr. Knopf announced that the International Congress of Tuberculosis would meet in Washington, D. C., in 1908.

AFTERNOON SESSION.

Symposium on Cancer—Surgical Treatment.

Carcinoma of Stomach, Dr. William J. Mayo, Rochester, Minn.

Discussed by Dr. John B. Deaver, Philadelphia; Dr. Willy Meyer, New York City. Discussion closed by Dr. Mayo.

Carcinoma of Intestinal Tract, Dr. James P. Tuttle, New York City.

Discussed by Dr. Arpad G. Gerster, New York City. Discussion closed by Dr. Tuttle.

A New Aid in the Treatment of Malignant Tumors. Dr. C. G. Ende, New York City.

Carcinoma of the Uterus, Dr. Charles P. Noble, Philadelphia. Discussed by Dr. Carlton C. Frederick, Buffalo; Dr. Hiram N. Vineberg, New York City. Discussion closed by Dr. Noble.

Carcinoma of the Larynx, Dr. John N. Mackenzie, Baltimore. Discussed by Dr. D. Bryson Delevan, New York City; Dr. Emil Mayer, New York City; Dr. Robert C. Myles, New York City. Discussion closed by Dr. Mackenzie.

Installation of New Officers.—Dr. Goffe, the retiring President of the Association, welcomed his successor in office, and said it was hardly necessary to recall to him the striking contrast that was presented by the conditions confronting the Association to-day, and that of a year ago. At that time they were in the throes of a struggle to amalgamate the two State Societies, a task which then seemed almost insurmountable. In addition to that, there were internal discords in their own ranks amounting almost to a revolution. Since that time the scene had completely changed. All the requirements of the law had been complied

with, the resolution had been passed carrying them into the arms of the State Society, and the prospects were that there would soon be a reunited medical profession in New York State. In the vote on the question on Tuesday, there were only two dissenters, so that it was almost unanimous. The Association was now in a condition of unity, peace and concord, and he felt that its interests would be safe in the hands of Dr. Jones.

Dr. Allen Arthur Jones, of Buffalo, the newly elected President, said it gave him great pleasure to assume the office to which he had been elected, and after such a graceful introduction on the part of his efficient predecessor, nor was he unmindful of the honor that had been conferred upon him. Dr. Goffe had spoken of the difference in the condition of the Association a year ago and what it was to-day, and the speaker said he could not do better than to emphasize those words. The difference was certainly enormous. He then paid a tribute to the efficiency of the retiring President, to whom he thought the Association owed a deeper debt of gratitude than it was possible to express. With the help of his efficient coworkers, and by tireless efforts, endless detail, by personal sacrifice and unremitting hard work, Dr. Goffe deserved no small share of the credit for bringing about the amalgamation between the two State medical bodies. He would speak also of the services rendered by the efficient secretary, Dr. Redfield, whose labors during the year had been enormous, nor should we forget the persuasive, ever-ready, Dr. Townsend, whose untiring enthusiasm had been such a factor in the great work just consummated. Nor would he forget Dr. Harris, the able parliamentarian, who had done so much to remove the legal objections to the consolidation, and in that work Mr. Lewis, the Association counsel, had also been most efficient and successful.

In assuming this office at this time, he would have a comparatively easy task, as the hard work had been done by those who preceded him. The future of this great amalgamated body was worthy of some thought. In this State, with its over-seven millions of inhabitants, we would soon have a medical Society of enormous size, and he expressed the belief that it would be great not only in numbers but also in the character of its scientific achievements. It might become necessary, in the scientific work of this body, to divide it into sections, perhaps beginning with medicine and surgery, and gradually adding others as the necessity for them arose. Personally, he was in favor of having certain of the specialties discussed at all of the general meetings.

Dr. Emil Mayer moved that the thanks of the Association be extended to all the retiring officers for their most efficient services. Unanimously carried, and it was ordered spread upon the minutes of the Association.

Dr. H. Ernest Schmid, of White Plains, the newly elected vice-president, thanked the Association for the honor that had been conferred upon

him, and referred to himself as one of the post-humous children of the Association.

Dr. C. G. Am Ende moved that the thanks of the Association be extended to the visitors who had read papers and taken part in the discussion. Unanimously carried.

Dr. Goffe moved that a special vote of thanks be tendered Dr. Frederic W. Loughran, for his efficient work as chairman of the Committee on Arrangements. Unanimously carried.

The twenty-second annual meeting of the Association was then declared adjourned.

ADDRESS OF WELCOME TO THE COUNCIL AND FELLOWS.¹

By J. Riddle Goffe, President of the New York State Medical Association.

A noted statesman in battling in debate for a principle that he deemed of the greatest importance, although warned that his action was destructive to his political ambitions, made the familiar declaration that he would rather be right than be president. During the trials and the work that have attended my brief term of presidency, I have with difficulty restrained the thought that there are many other things I would rather be than be president. Still, I was not unmindful at the time of my election, as I am sure you were not, of the difficulties that confronted the Association, the uncertainty of its position on the amalgamation question, and the time and work involved in bringing order out of the seeming chaos and carrying forward the wishes of the majority with dignity and determination. This condition of affairs made the selection of any one of your number as president a signal expression of your confidence, and rendered the recipient of your suffrages acutely, though humbly, conscious of the great honor conferred. It is becoming that at this time I express to you members of the Council and Fellows of The New York State Medical Association, and through you to all the members of the Association, my warm appreciation of the honor I have received at your hands. You have my sincere and heartfelt thanks.

In this connection I hasten to express my especial thanks to the Council and its individual members for their suggestions, advice and assistance in the management of the affairs of the Association. They have proved a tower of strength at all times. Thanks are also due the various committees and many individual unofficial members for the prompt response they have given to every call made upon them for assistance, and the work they have done to advance the interests of the Association.

From every point of view the result of the year's work is a subject for congratulation and encouragement. It is a source of no little pride that in the face of the troublous times that have

beset us we have not only been able to stand pat in our membership, but have actually increased it. Many of our members are also members of the County and State Medical Society. To many of these it seemed needless expense to continue the payment of dues in both, as membership in either would assure position in the united society of next year, and yet, of these, only a few have failed to pay their dues and continue their membership.

The status of our membership is as follows:

October 1, 1904, we had on our rolls 1,772 active members. During the year we have lost by delinquency in payment of dues, removals, deaths and resignation 167, but we have received 195 new members, bringing our membership up to 1,800, an increase of 28.

The great leveler, death, has been very active in our midst during the past year. Twenty-three have left us. It is truly said that

"With his sickle keen

He reaps the gilded grain at a breath
And the flowers that grow between."

I will simply recall the fact that those who have thus fallen embrace many noble workers from Dr. Didima, one of the patriarchs of the profession, who had worked steadily in harness for well nigh threescore years and always stood for that which was best whether in science or personal conduct, to Dr. Churchill Carmalt, a young man of sterling worth and great promise. The sudden death of our treasurer, Dr. Frederick A. Baldwin, came as a great shock to all of us. His many excellent qualities of head and heart and his faithful performance of his official duties commanded the respect, admiration and love of all who knew him.

At a special meeting of the Association, held at the New York Academy of Medicine, March, 1904, the following resolutions, on motion of Dr. Joseph D. Bryant, were unanimously adopted:

Resolved, That the report of the Joint Committee on Conference be accepted and that the proposed agreement for the consolidation of the Medical Society of the State of New York and The New York Medical Association be, and the same is hereby approved and the President of the Association is hereby authorized and directed to execute the same in the name and behalf of the Association, and the Secretary is hereby authorized and directed to affix the corporate seal thereto, and be it further

Resolved, That the Committee of the Association heretofore appointed for the purpose of bringing about the consolidation be and they are hereby continued as such Committee with full power and authority to do whatever may be necessary to carry the agreement into effect.

At the last meeting the following resolution was unanimously endorsed:

Resolved, That it is the unalterable desire of The New York State Medical Association that har-

¹Delivered at the Twenty-second Annual Meeting, held at New York City, October 16, 1905.

mony and good-fellowship should prevail throughout the entire profession of the State and to that end this Association pledges itself to use its best endeavors to secure the union of the two State organizations until that much-desired end shall have been accomplished.

In my remarks made upon accepting the office, I said: We have pledged ourselves to-day in a formal resolution to continue our efforts and use our best endeavors during the coming year to consummate the union between the two State medical organizations, so that with the expiration of this year of grace and patient waiting the medical men of the Empire State will become one united and harmonious profession. *Una fides altare commune.* That has been the keynote of my administration, and has been the consuming interest of the year's work. How successfully it has been carried forward is for you to judge. The plan of campaign has been along two distinct and different lines. Knowing, as I did, the generous and altruistic spirit that animated our Association, and how completely the members were imbued with the conviction, that in thorough and complete organization of the profession resides increased power for ennobling the profession, strengthening its dignity and influence, protecting it against its enemies and advancing it to a higher plane of usefulness; realizing these conditions, I say, I was convinced that any latent or active opposition must lie in a misconception of the conditions of the amalgamation agreement and the practical working of the newly constituted Society. To overcome these seeming misconceptions, among the indifferent and actively opposed, there was opened and conducted a wide and vigorous correspondence with the hope of setting forth these apparently objectionable points in a more favorable light. This correspondence supplemented by conferences at the district branch meetings has fortunately been successful in allaying the apprehensions of many and arousing some to enthusiastic advocacy of amalgamation.

The failure of our previous efforts was due to the fact that the meeting at which the amalgamation resolution was adopted was, as decided by the court, not a legal meeting for the transaction of such important business. The question therefore arose, what constitutes a legal meeting and how can it be obtained? By the provisions of our charter the business management of the Association is vested exclusively in a house of delegates, known as the Council and Fellows. The Association itself had no by-laws except those prescribed by the Council and Fellows, and no stipulation as to what constituted a quorum. The court held that under such circumstances the State law regarding corporations must obtain. This law stipulates that a quorum must consist of at least a majority of the corporate members. Provision, however, is made against the difficulty, and in most instances the absolute impossibility, of securing the bodily presence of such a large proportion of the members by a system of proxies,

through the working of which they may be recorded as constructively present and voting. We are all more or less familiar with this custom in the management of all the great corporations at their annual meetings. As the Association had no special method of legally notifying the members of a legal meeting, it was necessary to invoke the State law again and this stipulates that when no method is provided in the by-laws, nothing short of a *personal notice* meets the requirements. This, however, may be waived by the members accepting and acknowledging notice through the mails.

After careful and prolonged consideration of the subject by members of the Council, it seemed wise to that body to make a supreme effort to place all the acts of the Association directed toward amalgamation on a strictly legal basis, and so compass the entire subject that the expressed wishes of the Association should be carried through to completion, and amalgamation secured. To this end the Council at its appointed meeting in February, instructed your President to secure the best available legal talent in New York as associate counsel to our legal adviser, Mr. Lewis, and obtain from this combined talent a mode of procedure that would embrace all the requirements of the law and avoid any violence to vested rights. As you know, the eminent counsel selected was Mr. Chas. F. Brown, Ex-Judge of the Supreme Court. It seemed wise to him and Mr. Lewis that the final action upon amalgamation be taken at the regular annual meeting. They outlined a scheme for accomplishing this end, securing as far as possible the vote of every member of the Association either personally or by proxy. This commended itself to the Council and at its regular meeting, April 29th, the President was empowered to carry it into effect. Accordingly an official notice of the meeting, stating time, place and object, was mailed to every member, accompanied by a card acknowledging the receipt of the notice, and a second card instructing certain named proxies to vote in favor of amalgamation, the reappointment of the Joint Committee of Conference as formerly constituted, and the proposed amendments to the constitution. In the same envelope was a copy of the amalgamation document and a circular letter explaining the purpose of this action on the part of the President and the Council.

A large majority of the members acknowledged receipt of notice through the mails, and others responded to the personal solicitation of their fellows, but a few through carelessness or general opposition to the scheme, though warned that failure to respond would necessitate additional expense on the part of the Association, have compelled a resort to court officers. This, however, has been done and every individual member has been notified, thus giving us a legal meeting. But it has been a gigantic task.

Proxies instructing the parties named to vote in favor of amalgamation have been received from 1,497 members. This insures a large majority

in favor of the adoption of the report of the Joint Committee, and the consummation of union with our sister Society. It only remains for the formality of the vote to be taken at the general meeting to-morrow to make this an accomplished fact. Thus, I am able to assure you in advance, that our pledges to use our best endeavor to consummate union has resulted in its successful accomplishment. It only remains for the Association to-morrow to receive this vote and instruct executive officers to legally execute this resolution, and action in the process of amalgamation will have been completed.

I need not assure you with what satisfaction I make this announcement. Satisfaction to myself because it means the consummation of an impassioned desire in my own heart that has burned steadily throughout the year, but satisfaction because I know that most of you, too, have waited just as impatiently for this happy moment and hail it with glad and welcome hearts.

Even now, at the last moment, although there have been some mutterings of opposition, I cannot repress the hope that this vote in favor of amalgamation may be a unanimous one; that with our flags joyfully flying at the masthead and ourselves buoyant with the thought that with whatever self-sacrifice may be necessary, and we know there is much on the part of many, we are keeping step with the march of progress and promoting the best interests of our beloved profession.

ABSTRACT OF THE ANNUAL REPORT OF THE COUNCIL OF THE NEW YORK STATE MEDICAL ASSOCIATION.

Mr. President, Council and Fellows:

In view of the fact, that an unusual amount of business has been transacted by the Council during the past year, and that the volume of business before the meeting of Council and Fellows would preclude all possibility of reading the entire detailed report of the Council, I have been requested by the President to give an abstract of the principal facts in relation to the work of the year. The full account of the Council proceedings will be printed in the JOURNAL, subsequent to the meeting, but if, during the reading of this abstract, any one wishes more explicit information, I shall be pleased to read in detail from the full report, a copy of which is at hand.

The Council has held six meetings during the year, as follows:

On October 19, 1904, at which most of the members of Council were present. The principal business transacted was the appointment of committees for the coming year by the Chairmen. The appointment of a special committee on Finance by the President, consisting of Drs. Goffe, Denison and Baldwin, and the election of Dr. C. E. Denison as acting assistant secretary. The Secretary desires to publicly acknowledge the very efficient aid which Dr. Denison has given him in the discharge of his duties during the year.

The meeting of the Council on January 5, 1905,

consisted of: Report of two polls of the Council, one in favor of the defense of Dr. G., of New York, for malpractice and the other in favor of a resolution introduced by Dr. E. E. Harris, seconded by Dr. Ferguson, authorizing the purchase and distribution of copies of medical ethics to the profession of the State. Some discussion was had upon the advisability of excluding certain objectionable advertisements from the JOURNAL on the ground that they were unethical. A resolution was made that the Publication Committee take measures to cancel any contract with an unethical advertiser.

Dr. Lambert reported that the plan of a circulating library for the use of the members was not practical in view of the fact that many of the books were now obsolete and it would not pay to catalogue them.

A resolution was adopted requiring the counsel for the Association to render a report of the disposition of all malpractice cases during each year.

Also a resolution authorizing the Finance Committee to make a new contract with the counsel, and, if possible, increase his salary.

Two new members of the Finance Committee were appointed, namely, Drs. Lambert and Townsend.

A resolution was passed requiring a statement of the finances of the Association by the Finance Committee at the end of the year.

Dr. White resigned from the Committee on Arrangements and Dr. Kopetzky was appointed in his place.

Dr. Quinlan resigned from the Publication Committee and Dr. William R. Stone was appointed in his place.

At the meeting of the Council on February 25, 1905, the Secretary reported having sent letters to the members of the Senate Judiciary and Judiciary Committee of the House of Representatives of the United States, asking them to vote in favor of the Bill for National Incorporation of the American Medical Association. A number of replies had been received and a resolution was made to have copies of these replies sent to Dr. Joseph D. Bryant, chairman of the Committee on Incorporation of the American Medical Association.

The Secretary reported that a poll of the Council had been taken upon the defense of Dr. R., of New York, and had resulted in favor of such defense.

A resolution authorizing the publication of the 1905-1906 Directory was passed.

Dr. Harris, chairman of the Committee on Legislation, read an extract from an argument he had prepared in opposition to the Osteopathic Bill, and a resolution was passed to authorize the expense of the printing and distribution of copies of his argument.

A resolution authorizing the President to employ associate counsel in the amalgamation proceedings was passed, as was also a resolution that the President was to incur no expense in this con-

nection unless the consent and approval of the Finance Committee was first secured.

At the meeting of Council, April 29, 1905, the Secretary reported that two polls of the Council had been taken in two suits for malpractice and that each applicant had received thirteen votes in favor of defense by the Association.

The President gave a detailed account of the opinion of the counsel and associate counsel for the Association upon the matter of securing a legal meeting in October, also as to how to obtain a vote on the three questions: 1st, the revision of the By-Laws as proposed at the last annual meeting; 2d, as to the continuance of the Committee on Conference; 3d, as to ratifying the agreement between The New York State Medical Association and the Medical Society of the State of New York.

The President stated the expense of the associate counsel and requested the Council to express an opinion in the matter.

Dr. Ferguson made a motion that the President's action be approved and that the expense of special legal advice and the printing and mailing of notices be authorized, which was unanimously carried.

A loan of \$425 which was made by the New York County Medical Association on February 6, 1903, to the State Association, was ordered returned to the County Association.

The Secretary was instructed to employ an official stenographer for the annual meeting in October.

A meeting of the Council was held on September 11, 1905.

The Secretary reported that since the last meeting Dr. J. W. Grosvenor, of Buffalo, had resigned as delegate to the American Medical Association, and by a poll of the Council, Dr. George F. Cott, of Buffalo, had been elected to fill out his unexpired term.

According to instructions, the Secretary had secured the services of Dr. A. L. Gnichtel as official stenographer and his action was approved, and the expense thereof authorized by the Council.

The Secretary reported that there were still 168 members who had not returned acknowledgment of notice of the annual meeting, and the Council accordingly passed a resolution empowering the counsel, Mr. Lewis, to cause legal notice to be served upon the delinquents.

The Treasurer was requested to confer with the Trustees of Mott Library in regard to the lease of the business office for the ensuing year.

A committee of three, namely, Drs. Townsend, Lambert and Denison, was appointed to confer with the Secretary of the American Medical Association with reference to this Association furnishing data for the new National Directory, to be published by the American Medical Association.

A meeting of the Council of The New York State Medical Association was held at the

Academy of Medicine, on Monday, October 16, 1905. The Secretary reported that since the meeting of the Council on September 11, 1905, the Association had suffered a great loss in the sudden death of our late treasurer, Dr. F. A. Baldwin, which occurred on September 21st. A poll of the Council had been taken and Dr. William G. LeBoutillier, of New York, had been elected to fill out the unexpired term of the late treasurer.

There had been a second poll of the Council taken upon the application of Dr. G., of New York, for defense in a malpractice suit recently brought against him. The poll had resulted in the Council voting to take up his defense.

A letter from the secretary of the Board of Trustees of the Mott Library Building, relative to a new lease on the rooms used as a business office, was read. The matter was referred to the new Council.

The secretary reported that all the members of the Association had returned notice of the annual meeting or had been served by our counsel.

The annual report of the Council was read and ordered placed on file.

The Secretary reported that a circular letter and a copy of the principles of ethics had been sent to every member of the Association according to the resolution passed by a poll of the Council in November, 1904.

The chairmen of the various committees presented their reports. They were ordered received and placed on file.

The Special Committee appointed to confer with Dr. Simmons reported progress.

A committee consisting of Drs. Townsend, Harris and Denison was appointed to draw up resolutions on the death of Dr. Baldwin, and the Secretary was instructed to communicate with the widow, informing her that the accounts of Dr. Baldwin had been found absolutely correct by the public accountant engaged to examine the accounts of our late Treasurer.

The Finance Committee presented the Auditor's report as the report for the year.

This comprises in as brief a manner as possible the principal business of the Council during the past year.

The reports from the district branches are as follows:

The First District held no meeting and the same officers hold over.

The Second District held a very enthusiastic meeting at Saratoga Springs. Dr. E. D. Ferguson was reelected president, and Dr. William Hogeboom, secretary.

The Third District held a large meeting at Cortland, at which resolutions on the death of Dr. Higgins were presented by Dr. Sornberger. Dr. Harris, of New York, was present and explained some of the legal difficulties of the amalgamation, and also introduced a resolution favoring the establishment of one medical examining board for State license to practice medicine, instead of three

boards as at present, which was unanimously carried. The officers elected were: President, C. W. Greene; vice-president, S. J. Sornberger; secretary, Julian C. Smith; treasurer, Frank Kenyon.

The Fourth District held a large meeting at Rochester. Dr. Goffe, president of the State Association, was present and gave a résumé of the amalgamation question. Very valuable scientific papers were read. The officers elected were: President, James C. Davis; vice-president, Herbert F. Gillette; secretary, William I. Thornton.

The Fifth District held two meetings of great interest—one at Newburgh, and the annual meeting at Poughkeepsie. At the special meeting at Newburgh, scientific papers were read and a resolution was passed endorsing the bill for national incorporation of the American Medical Association. At the annual meeting papers of great value were presented.

Notwithstanding that the principal theme of Association work this year had been the union of the medical profession of the State, and how to legally accomplish the same, the Association has had time to increase its membership, which is as follows:

Total number of members, October 1, 1904.....	1,772	
Total new and reinstated members, October 1, 1904, to October 7, 1905	195	
	<hr/>	1,967
Number of deaths, October 1, 1904, to October 7, 1905.....	23	
Number of removals.....	14	
Number of resignations.....	10	
	<hr/>	47
		<hr/>
		1,920
Total number of delinquents dropped, October, 1904.....		120
		<hr/>
Total membership, October 7, 1904.....		1,800

This record shows that in spite of the fact that we have lost through death and other causes 167 members there has been an accession of 195 members, an actual increase in membership of 28.

The following is a list of those who have died during the year, from October 1, 1904, to October 7, 1905, among whom I would especially call attention to the deaths of Dr. Baldwin and Dr. Didama.

- Asch, Jacob H., New York.
- Baldwin, Frederick A., New York.
- Brownell, Mary Alice, Newark, N. Y.
- Carmalt, Churchill, New York.
- Crisfield, James E., Dansville, N. Y.
- Didama, Henry Darwin, Syracuse, N. Y.
- Dingman, James Alva, Spring Valley, N. Y.
- Dudley, A. Palmer, New York.
- Elebash, Clarence S., New York.
- Greene, Cordelia A., Castile, N. Y.

- Hoople, Heber N., Brooklyn, N. Y.
- Hunter, George Tremont, New York.
- Keifer, Charles W., Mechanicsville, N. Y.
- Lynch, Patrick Joseph, New York.
- Maduro, Montefiore Levy, New York.
- North, Nelson L., Brooklyn, N. Y.
- Palmer, George Miles, Warsaw, N. Y.
- Plasse, Louis P. J., New York.
- Schiff, Herman J., New York.
- Seymour, William Wotkyns, Troy, N. Y.
- Showerman, Benjamin F., Batavia, N. Y.
- Vincent, William H., Hinsdale, N. Y.
- Whitcomb, John L. C., Liberty, N. Y.
- Total, 23.

RECORD OF RECEIPTS AND EXPENSES, OCTOBER 1, 1904, TO OCTOBER 1, 1905.

In accordance with the By-Laws, I submit to you at this time the record of the receipts and expenses for the year, 1904-1905, as taken from the figures in the Treasurer's books, as follows:

Receipts from advertisements, dues, sales of Directories, etc., October 1, 1904, to October 1, 1905.....	\$13,644.41
Balance on hand, October 1, 1904.....	4,073.16
	<hr/>
	\$17,717.57
Expenses, October 1, 1904, to October 1, 1905.....	13,081.12
	<hr/>
Balance on hand, October 1, 1905....	4,636.45
Investments on bond and mortgage..	3,250.00
	<hr/>

Balance on hand, including investments \$7,886.45

Respectfully submitted,
(Signed) CHARLES I. REDFIELD,
Secretary.

REPORT OF CHAIRMAN COMMITTEE ON PUBLIC HEALTH.

The Committee on Public Health has very little to report as the result of its year's work. In the early part of the year another determined effort was made to secure the passage of what is known as the Coroner's Bill, but the attempt was again unsuccessful. The greater part of this work was done by the member from New York County, who deserves great credit for his persistence in this aim.

According to the constitution of the Association, the Committee on Public Health should present to the Council and Fellows recommendations for action in regard to matters of public health. Under existing circumstances there does not seem to be any occasion for such recommendations, but if there are any subjects which the Association desires the committee to take charge of it will be glad to be so employed.

Respectfully submitted,
(Signed) LOUIS C. AGER,
Chairman.

REPORT OF THE COMMITTEE ON PUBLICATION.

The JOURNAL of the Association at the beginning of its fifth volume was facing a serious problem. The number of papers furnished by the members at the annual meeting was small, due to a short program, and it became necessary to secure papers that would be satisfactory to the members. Your committee therefore sought the best papers read at the meetings of the district branches, county meetings and the numerous societies throughout the State. We were thus able to publish a larger number of valuable papers, and we are pleased to know this has met with your approval.

The reports from the secretaries of the district branches and county associations have been received and published promptly; it is a pleasure to acknowledge the evident interest of the members in these reports, which indicates the value of the JOURNAL to the profession. Many letters have been published on subjects of current interest; we have rejected some that were not acceptable for publication, but believing that a State journal is open to all members, we have endeavored to be fair to all, showing no favor or partiality. Many letters received were in relation to amalgamation, both for and against. Acting on the wishes and advice of the officers and certain members of the Council, we have purposely withheld some of these latter from publication.

The cost of publication—that is, the expense of printing, postage and wrapping and addressing—amounts to \$2,654.42; to this must be added rent, stationery, commissions on advertisements and salaries of \$821.78, making a total expenditure of \$3,476.20. The receipts from advertisements were \$2,889.69; sales, \$4.75, a total of \$2,894.44. Thus the actual cost to the Association was \$581.78, and the cost per member for twelve numbers is 32 1-3 cents.

The Medical Directory has met with the usual satisfaction of the members; the list of registered physicians is increasing every year, and to keep the volume within reasonable size it has been necessary to limit the data therein. The same plan as adopted in the last volume has been carried out in Volume VII, and has met with universal approval.

The expenses of the 1905 Directory are: For stationery and sending out cards for data, \$690.66; rent and salaries, \$734.02; for printing, 1904 Directory, about \$2,839.18; for delivering the 1904 Directories and commissions on advertisements, \$350.42; the total expense being \$4,614.68; the receipts for advertising, \$667.50; sales of Directories, \$1,216. Total receipts, \$1,883.50. Cost to the Association, \$2,730.78, making the cost per volume about \$1.84.

The Business Office.—The amount of work in this business office has increased very materially in the past year. The necessary work of the President, Secretary and Treasurer has been enlarged by the labor bestowed on the members to

bring to a successful conclusion the amalgamation of the State Association with the Society. The expense of the Business Office has, consequently, been greater, about \$1,500 having been spent for amalgamation, which includes printing, postage, legal fees and serving of notices of the meeting on the members.

I have not attempted to give in detail all the expenses and receipts of the JOURNAL, Directory and Business Office, as that will be included in the report of the Treasurer. C. E. DENISON,
Chairman of Committee on Publication.

REPORT OF COMMITTEE ON LIBRARY.

The two chief objects of a medical association, from the standpoint of pure medicine, are to afford opportunities for the exchange of knowledge and also means for the ready dissemination of knowledge. The first object is obtained by the exchange of views among members and guests at the stated meetings of the county and district branch associations, and the annual meetings of the Association as a whole. The second object is obtained in some measure by the maintenance of a journal, but cannot be completely fulfilled without an active library. In the city of New York, the library of the Academy of Medicine and the library of the Medical Society of the County of Kings, and the Buffalo Medical Library fulfil all needs for reference and for the current literature. But this is but a small area compared to the rest of the State which is thus reached. The library of The New York State Medical Association is at present in a crystallized condition, and will soon become fossilized unless some active measures are undertaken to render it more accessible to the members of the Association. It contains many valuable and interesting books of the past, some still unsurpassed by books of the present, and which are valuable as reference books. But the need of this Association, in order to reach each and all members alike, is to possess a circulating library on the plan of one of the modern circulating libraries for current literature. This plan is feasible with the present library for a nucleus. Such a plan has been considered during the past year, but it was not considered wise by the Library Committee, nor by the Council, to endeavor at that time to develop fully such a plan. Whether, during the coming year, it will seem wise to develop such a circulating library must remain for a time undecided; but the convenience of such a plan to the physician and surgeon living away from the large libraries is self-evident, and the advantage of having for a nominal annual fee the opportunity to read at home and at leisure the standard, current medical literature, is too evident to need discussion. Such a library is sure to come in the future, and The New York State Medical Association possesses the opportunity to add to the practical benefits which a membership in the Association confers.

(Signed) ALEXANDER LAMBERT,
Chairman, Library Committee.

THE NEW YORK STATE MEDICAL ASSOCIATION

In Account with F. A. Baldwin, M.D., Treasurer, for the Year Ending September 30, 1905.

<p>1904. DR. Oct. 1—To Balance on hand, per last report of Treasurer \$4,073 16</p> <p>1905. Sept. 30—To Receipts for year ended this day, de- tails as per Schedule "A" hereof..... 13,644 41</p> <hr/> <p style="text-align: right;">\$17,717 57</p>	<p>1905. CR. Sept. 30—By Payments, for year, as shown in Sched- ule "B" hereof..... \$13,081 12</p> <p>" " —By Balance on hand.. 4,636 45</p> <hr/> <p style="text-align: right;">\$17,717 57</p>
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Schedule "A"—Receipts, \$13,644 41.

Arrears and Dues collected	\$8,531 00	
Interest:		
On Building Fund Mort- gage, \$3,250 @ 4½%..	\$146 24	
At Lincoln Trust Co., for half year to Sept. 30, 1904	57 49	
March 31, 1905	52 06	255 79
Commission received for obtaining new members, American Medi- cal Association	8 00	
Clerical work, Business Office...	42 62	
N. Y. Department of Excise, for reprints	15 75	
Telephone rebate, for 1904	13 33	
Journal:		
Advertisements	2,889 67	
Sale of Journals	4 75	
Directory, 1904 Edition:		
Advertisements	427 50	
Sales of Directories ..	291 00	
1905 Edition:		
Advertisements	240 00	
Sales of Directories ..	925 00	
		\$13,644 41

Schedule "B"—Payments, \$13,081 12.

AS SHOWN IN SUBSCHEDULE.	
(a) Council Expenditures:	
Council	\$1,321 37
Secretary	140 70
President	47 86
Fifth District Branch	89 60
	\$1,599 53
(b) Treasurer's Office Expenses.	288 42
(c) Legal Department	1,898 61
Committee Expenditures, viz.:	
(d) Committee on Arrangements.	\$114 65
(e) Committee on Conference ..	583 33
(f) Committee on Legislation...	228 85
(g) Committee on Library.....	268 00
(h) Committee on Public Health	9 25
	1,204 08
(i) Journal Account	\$3,476 20
(j) Directory Account	4,614 28
	8,090 48
	\$13,081 12

Subschedules—Payments.

(a)			
Expenses of the Council		\$1,599 53	
Rent of rooms	\$84 00		
Telephone service	84 90		
Printing and Stationery	413 38		
Miscellaneous, petty cash	176 99		
Insurance	20 00		
Committee on Conference postage	19 25		
Printing and Stationery:			
For the Secretary	36 55		
For the President	12 19		
For the Fifth District Branch..	54 60		
Luncheon at special meeting of Fifth District Branch	30 00		
Special car, I. D. Leroy, Pres. of Fifth District Branch	5 00		
Salaries:			
General Office	522 85		
Secretary's Office	104 15		
President's Office	35 67		
		1,599 53	
		=====	
(b)			
Expenses of the Treasurer's Office.		\$288 42	
Direct working office expenses..	\$26 81		
County dues refunded	3 00		
County entrance fees refunded..	10 00		
State Association dues refunded..	4 00		
Commission paid for securing 40 new members	40 00		
Office salaries	204 61		
		288 42	
(c)			
Legal Department Expenses		\$1,898 61	
Fees for legal services	\$1,454 46		
N. Y. County, legal services	425 00		
Stationery	19 15		
		1,898 61	
		=====	
(d)			
Expenses, Committee on Arrange- ment		\$114 65	
On account expenses of Annual Meeting for 1904 (previously paid on this account \$60.80)...	79 65		
On account of expenses of An- nual Meeting for 1905	35 00		
		114 65	
		=====	
(e)			
Expenses, Committee on Public Health		\$9 25	
Stationery	\$9 25		
		9 25	
		=====	
(f)			
Expenses, Committee on Confer- ence		\$583 33	
H. Van Sinderin, legal fees	\$583 33		
		583 33	

(g)	
Expenses, Committee on Legisla- tion	\$228 85
E. E. Harris, Albany	\$16 00
E. C. Cuyler, services 1905 ses- sion	35 00
Clerical work	66 00
Stationery	111 85
	228 85
(h)	
Expenses, Committee on Library..	\$268 00
Rent of rooms	\$248 00
Fire insurance	20 00
	268 00
(i)	
Journal Account, Expenditures...	\$3,476 20
Publication, viz.:	
Printing	\$2,322 11
Bulk postage	64 79
City and foreign postage	182 54
Wrappers	54 00
Addressing	30 98
	\$2,654 42
Rent of rooms	84 00
Printing and Stationery, inci- dentals	166 62
Commissions on advertisements ..	362 44
Office salaries	208 72
	3,476 20

MEMORANDUM.	
Total Expenses, Journal	\$3,476 20
Total Receipts, Journal	2,894 42
	\$581 78
(j)	
Directory Expenses	\$4,614 28
On account of publication of Di- rectory	\$2,837 18
Rent of rooms	84 00
Telephone service	3 22
Returns of sales	2 00
Commissions on advertisements...	43 00
Delivery, 1904 issue	496 96
Printing and Stationery	497 90
Addressing	34 40
Office salaries	615 62
	4,614 28

MEMORANDUM.	
Total Expenses, Directory	\$4,614 28
Total Receipts, Directory	1,883 50
	\$2,730 78

Memorandum of Unpaid Bills, October 1, 1905.	
Hackett & Williams	\$1 50
A. T. & T. F. Saunders	1 00
John Hogan	10 00
E. J. Tallman	7 86
Chas. M. Villone	36 65
Geo. P. Decker	1 00
Joel C. Fisk	8 00
David Clark	3 20
D. Van Hyning	2 60
O. T. Wilson	1 00
O. H. & W. E. Hopkins	3 00
Whitney Safford	1 00
Grant Curry (Sheriff)	10 38
W. H. Weeks	2 00
George C. Andrews	2 00
Wertime and O'Brien	1 00
N. Y. Herald	3 20
Library Bureau	1 50
Styles & Cash (Stationers)	240 55
Federal Printing Co	283 01
Wallace & Co.	2 64
Dr. C. I. Redfield, Secretary	4 34
J. Taylor Lewis, Counsel	140 41
New York Telephone Co	7 75
Lincoln Trust Co., exchange	40
	\$775 99

Supplementary Statement of Receipts and Payments.	
1905.	
Oct. 1—Balance on hand, as per Treasurer's Statement.....	\$4,636 45
“ 1-14—Receipts, amount de- posited to date	205 59
	\$4,842 04
“ 1-14—Payments, bills listed as unpaid, in Treas- urer's Statement, with further October items, received since report, in all	1,308 35
“ 14—Balance on hand, per checkbook	3,533 69
	4,842 04
Oct. 14—Bills remaining unpaid:	
Federal Printing Co. (October ac- count)	\$280 44
Dr. Goffe (just received).....	41 91
Empire Paper Box & Tube Co (just received)	21 25
Trow Directory, Printing and Book- binding Co. (received in response to request for same, desired for in- formation; bill not due, goods not yet received)	3,127 04
	Total of unpaid bills at date
	\$3,470 64

Of the foregoing, bills or items, amounting to \$62.28, are dated in October, 1905, but the expenditure appears applicable to the term just ended.

W. G. LeBOUTILLIER,
Treasurer.

CERTIFICATE.

I have examined the foregoing Statement and its and accounts of the Treasurer, and have examined and therefor, and have verified the balance stated to be on

schedules, and have compared the same with the books verified the disbursements stated with the vouchers hand; and I find the same correct.

Dated; New York City, October 10, 1905.

FRANK N. DODD,
Certified Public Accountant, State of New York.

REPORT OF COMMITTEE ON LEGISLATION.

The items constituting the report of the Committee on Legislation have been published from time to time, and now occupy the space of 12 pages of the JOURNAL of the Association. The Committee believes it will economize your time and considerable JOURNAL space by referring to it by the number of the pages in JOURNAL instead of reproducing it in, and then reprinting as a part of, this report. The detail of the work performed by your committee will be found on pages 33, 34, 35, 64, 65, 66, 100, 101, 102, 136, 137, 138 of the 1905 JOURNAL.

Respectfully submitted,
(Signed) E. ELIOT HARRIS,
Chairman.

REPORT OF COMMITTEE ON ARRANGEMENTS.

The programs for the meeting represent the work done by the Committee on Arrangements. The Chairman trusts that not only the scientific but the social features may be approved by the members. He desires on this occasion to personally express his thanks to the members of the Committee, and to the officers of the Association for the valuable assistance rendered, and to those gentlemen who have so promptly responded when requests were made upon them for papers.

(Signed) FREDERIC WILLIAM LOUGHRAN,
Chairman, Committee on Arrangements.

REPORT OF DELEGATES TO THE NEW JERSEY STATE MEDICAL SOCIETY.

As a delegate from The New York State Medical Association to the 139th annual meeting of the Medical Society of New Jersey, which was convened in the music hall of the Hollywood Hotel, West End, N. J., on June 20, 1905, I beg to report the following proceedings under the presidency of Dr. Walter B. Johnson.

The officers of the meeting were: Walter B. Johnson, president; Alexander Marcy, Jr., second vice-president; Edward J. Ill, third vice-president; E. W. Hedges, corresponding secretary; William J. Chandler, recording secretary; Archibald Mercer, treasurer.

The recording secretary reported a membership of the Society of 1,213, a gain of 55 persons since the last meeting.

The annual address of the President, Dr. Walter B. Johnson, was on the subject of "The Proof of the Existence of Amblyopia Exanopsia in Strabismus." Dr. C. J. Kipp moved a vote of thanks for the president's able address and requested that it be printed in the transactions, which was unanimously carried. A very interesting paper was read by Dr. Edward J. Ill, of Newark, on "The Trained Nurse and the Doctor—Their Mutual Relation and Responsibilities." Dr. Frank D. Gray delivered The Oration in Surgery, upon "Surgical Diagnosis," which was followed by an address on the "Difficulties in the Diagnosis

of Abdominal Conditions," by Dr. Richard P. Francis, of Montclair. The following papers were read on Wednesday, June 21st:

"The Surgical Treatment of Bright's Disease, from the Viewpoint of the General Practitioner," by Dr. Alexander Marcy, Jr., of Riverton. "Ectopic Gestation," by Dr. Edward Staehlin, of Newark. "Prophylaxis in Gynecology," Dr. G. H. Balleray, of Paterson. "Uræmic Surprises," by Dr. J. T. Wrightson, of Newark. A paper on "Weaning," by Dr. Floyd McEwen, of Newark. Following this was a Symposium on Tuberculosis, with papers by Dr. S. A. Knopf, of New York; Dr. C. J. Kipp, of Newark; Dr. T. W. Harvey, of Orange; Dr. I. H. Hance, of Lakewood; Dr. Theodore Senseman, of Atlantic City. This was followed by The Oration in Medicine, subject, "Modern Neurology," by Dr. R. C. Newton, of Montclair, and "Is the Mosquito the Only Etiological Factor in Malaria?" by Dr. J. T. Wyckoff, of Leonia.

On the third day, Thursday, June 22d, at the general session, Dr. McAlister, of Camden, read a paper on the "Essentials in Diuretic Treatment," and Dr. E. Marvel, of Atlantic City, read a paper on the "Application of Adrenalin in the Peritoneal Cavity." Dr. Philip Marvel, of Atlantic City, read a paper on "The Demands of the Osteopaths—How Shall We Meet Them?" "The Treatment of Convergent Squint in Young Children," by Dr. Linn Emerson, of Orange.

All the papers read were instructive and the discussion showed deep interest taken in the welfare and high standing of the Society.

JOHN A. WYETH.

REPORT OF COUNSEL FOR THE ASSOCIATION.

NEW YORK, October 5, 1905.

The New York State Medical Association, Council and Fellows:

Gentlemen—I beg leave to report the following with reference to the malpractice defense conducted under my supervision on behalf of the members of The New York State Medical Association:

From the date of the beginning of this work up to the present time twenty-seven cases have been disposed of where alleged malpractice has been interposed in one way or another against members of the State Medical Association. It might be well to add right here that as a result I have had the misfortune to lose one case, in which a verdict of \$1,900 was secured against Dr. D., of Boonville, and was a case tried before Mr. Justice Maurice L. Wright and a jury in the city of Utica, N. Y. The trial of the case lasted nine full days, and counsel was assisted by Thomas S. Jones, Esq., of Utica, N. Y., as associate counsel.

The members are aware that on December 31, 1905, next, my contract to defend members of the Association will expire, and unless some provision is made by the Council and Fellows im-

mediately, after that date members of the Association will be unprotected so far as malpractice defense is concerned. If the members shall decide in favor of amalgamation and if the new organization shall determine to take up this matter of defense the members of the Association will be in the same favorable situation as they now are, but if, on the contrary, there is amalgamation of the two organizations and the new organization fails to adopt the defense for any reason, on December 31, 1905, this defense will terminate.

During the past year of 1904-1905 actions have been begun as follows: Ella H. Brown, Supreme Court, New York County, Brown & Patterson, attorneys, against Dr. G. for \$25,000, alleging improper operation for prolapsed uterus. Ralph Breskey, by guardian, Supreme Court, Sullivan County, Frank S. Anderson, attorney, against Dr. G., for \$10,000, alleging improper operation for a fracture of the right femur. Kate F. Ray, New York Supreme Court, action brought by Edwin D. Webb, attorney, against Dr. G., for \$10,000, for improper care of dislocated elbow. Spiro Coundouris, New York Supreme Court, against Dr. R., action brought by Ignatius Weltner, of 135 Broadway, N. Y., attorney, for \$25,000, for an X-ray burn.

There are pending all of the above actions, and in addition thereto is the action brought by Malcolm Sommerville against Dr. V., for \$2,000, in the City Court of the city of New York, by Flynn & Cohen, of 150 Nassau street, New York, attorneys, and also an action against the same physician arising out of the same case, for \$10,000, in the Supreme Court. One is for loss of services of the wife and the other for the injury itself. Maurice S. Casey, against Dr. S., brought by P. Gearson Oppenheim, in the Supreme Court, New York County, for \$10,000 for operation on infant, and the case of Philip Kronenburger, against Dr. McC., in the Supreme Court, New York County, brought by Robert Kuehnert, attorney, for \$5,000.

In addition to these is the case of Capron, against Dr. Douglass, in which a verdict was rendered against the doctor, and which I have now appealed to the Appellate Division of the State of New York, from the verdict of the jury.

It is unsafe and improper not to notify the defendants in these various actions that the defense may not be continued after December 31, 1905, in order that they may be given an opportunity of securing an attorney to conduct their cases who will be able to familiarize himself with the details in time to properly defend them. The probabilities are that none of these actions, with one exception, will be reached before December 31, 1905, the time when my contract with the Association terminates, and if any action is to be taken it must be taken immediately.

I beg leave to thank the Council, Fellows and members for their considerate cooperation and earnest endeavors in behalf of the various mem-

bers, and in their support of my efforts in the defense of malpractice suits.

Respectfully yours,

(Signed) JAMES TAYLOR LEWIS,

Counsel, The New York State Medical Association.

THE PRESIDENT'S ADDRESS.¹

"Organization the Watchword of Creation."

By J. RIDDLE GOFFE,
New York.

The dominant note of the present day in every department of human endeavor is organization. This obtains and is apparent in all the activities of life. It is a basic principle of all progress and had its early inception or practical human application in the idea of the division of labor. In a wider sense it has its foundation in the very elements of Nature itself and may be said to be the Watchword of Creation. Organization implies thought, foresight, and under its dominating influence order is brought out of chaos; the stars by their mutual dependence swing smoothly in their orbits and the universe moves to the harmonious music of the spheres.

Human endeavors are subject to the same law, and the vast combinations and organizations which we have witnessed in the last quarter century represent simply one stage in the evolution of progress that redounds to the benefit of the human race. In the luxuriance of their growth, many of these may have become exuberant and need pruning. But the fact remains that this is simply the latest phase of commercial, political, financial and social evolution.

Our great scientist and statesman, Benjamin Franklin, recognized the importance of organization when amid the discords of Colonial days, he unfurled to the wind his famous flag bearing a serpent cut into several sections and the motto, "Unite or die." The organization of the individual States made of those discordant elements a Nation, and the sentiment of national unity that has since grown, has made it possible for this country to cast its influence into the world's scale of justice to succor the down-trodden and oppressed, and finally to halt two of the largest armies that ever faced each other in deadly combat and bring about an honorable and lasting peace.

The organization of the Rhine bund and the petty German States into the great German Empire at the close of the Franco-Prussian War is a striking illustration of the benefits of organization. Instead of numerous little communities hedged about by restrictive tariffs and import duties between each other, and each one governed by an hereditary prince whose principal motive was to aggrandize himself at the expense of his subjects, where narrowness, ignorance and poverty prevailed, there sprang up an organized centralized government which improved commercial re-

¹Delivered at the Twenty-second Annual Meeting of The New York State Medical Association, October 17, 1905.

lations between the petty States and between them and outside nations and suppressed the parasitic functions of the petty sovereigns. No one doubts the vastly improved condition of these people today.

See what organization has done for the struggling millions in the trades and laboring classes throughout the world. Within the lifetime of most of us here, by organization they have raised themselves from a condition bordering closely on serfdom to a position in which they can secure better homes, better living, better clothes, better education for their children, and enough comforts, recreation and opportunities for self-improvement to make life worth the living. The world at large has not suffered thereby. The rich have grown richer just as fast, and the great middle class has suffered no degradation.

In all this great movement which has embraced every activity that has any vitality, the medical profession has been a laggard. But we are waking up from our Rip Van Winkle stupor. A new light has come to us and organization in our ranks is the demand of the hour. As William Morris says: "To cease to fear our fellows and learn to depend on them, to do away with competition and build up cooperation is our one necessity."

In the old constitution-making days of the Colonial time, medical societies were organized in the various communities, and, imbued as the profession was in those days with the statesmanlike ideas of the lawmakers, they adopted a plan of organization along the same lines as that of the National Government, viz., county, district and State bodies, each one dependent for its composition upon an assemblage of the next lower grade. Conspicuous in this movement were the medical societies of Connecticut, Massachusetts and Alabama. In these States the scheme worked smoothly and successfully, but in comparative obscurity. The New York State Medical Association has the distinction of having rediscovered this quiet little scheme as worked out in the State of Connecticut, and in the reorganization of The New York State Medical Association at the time of its incorporation, this plan was elaborated in its completeness and adopted. Here it has had its fullest and truest application and has been an object lesson not only to our sister States, but also to the American Medical Association itself.

It has worked admirably, and since the American Medical Association has put its approval upon it, it has been adopted by most of the State medical organizations of the country. As you know, the distinguishing features of this organization are that the County Association is the unit; that membership in this carries with it membership in the District Branch and State Associations, and, through the latter, and only in that way, to the national body.

Society throughout the world in its political, moral and social organization recognizes the family as the unit. The family is the foundation

of the whole structure. From the family organization and the family relations emanate the virtues, the morals, the character that make our modern civilization possible. Upon the family as the unit the whole superstructure depends. So in our medical organization the home society, the county organization, is the unit upon which its superstructure rests. When the County Association languishes, the District Branch and the State body languish, and when the County Society flourishes the impulse there engendered spreads throughout the entire system.

The intimate relations of the family circle cultivate forbearance, self-restraint, self-sacrifice, love and charity, as well as an intimate knowledge of each other's character, and these in turn beget unity, peace and concord. It has been truly said that in the struggles, the misunderstandings, the reconciliations, the parental discipline of a large family of children are evolved the finest characters in the world. Selfishness, untruthfulness, cunning and deceit are worked out of each other by the ferment of justice and right; another's privileges are respected and the rights of all are on a common plane.

Members of the County Association are but children of a larger growth where the same homely virtues need to be practiced and cultivated. The County Association exists primarily for the cultivation and dissemination of medical science and art, but the value of experiences there recorded depends largely upon the careful estimate of the narrator's powers of observation, the accuracy with which he records what he sees, and his natural bias or personal equation. This can only come from a personal, intimate acquaintance obtained by more or less familiar intercourse. The members must know each other, not as bowing acquaintances, but in that intimate way that comes from association when they are off their guard in affairs of mutual interest, in recreations and social functions. The program of the monthly meeting should always include a definite time for social intercourse. This has usually been recognized and generally recorded in the preamble to constitutions of medical associations. I quote from one of the oldest County Societies in the country: "This Society is framed on the most liberal and generous principles and is designed first to lay a foundation for that unanimity and friendship which is essential to the dignity and usefulness of the profession." As Osler has said, "The practice of medicine is not a business and can never be one, therefore, the education of the heart—the moral side of the man—must keep pace with the education of the head." In this respect membership in the County Society becomes a post-family education while the intellectual feature continues as post-graduate instruction.

To know the pitfalls and errors that mar the successful making of a local society and prevent it from attaining the highest fulfilment of its mission is of inestimable value. Osler has presented

such a graphic picture of these in his characteristic way that I cannot refrain from presenting it here—indeed, I think it should be constantly kept before the mind of every one of us. He says: "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, there 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, 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-essentials, 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."

In one particular I think Osler's picture just a little unfair, for the fault frequently lies with the young man quite as much as with the elder. Fresh from hospital experience and the laboratory he is very much inclined to look upon the elder man in the community in which he may settle as a "hold over" from the previous generation, and an out-of-date product, and worse still, he is very apt to say so.

Dr. Conan Doyle, in one of his stories ("Behind the Times," in "Round the Red Lamp," A. Conan Doyle) brings out strikingly the fact that there is more in the practice of medicine than the young enthusiast is apt to understand in spite of his acute diagnostic skill, his up-to-date instruments and his knowledge of the latest alkaloids. He and his medical college chum named Patterson—both of them young, energetic and up to date, decided to locate in the district in which he had been born and reared. It was a retired part of the country, where the doctors all belonged to a former generation and these young doctors

entered upon their work with the idea that they were going to sweep all before them. Still practicing in the town was the kindly old doctor that had officiated at his birth. He describes his first interview with the old doctor as a very dramatic one. "It occurred at 2 in the morning, in the bedroom of an old country house. I kicked him twice on the white waistcoat and knocked off his gold spectacles, while he with the aid of a female accomplice stifled my angry cries in a flannel petticoat and thrust me into a warm bath." From that time onward the epochs of his life were the periodic assaults that Dr. Winter made upon him. He vaccinated him, he cut him for an abscess, he blistered him for mumps. "It was a world of peace, and *he* the one dark cloud that threatened." But at last there came a time of real illness, a time when he lay for months together inside his basket bed, and then it was that he learned that that hard face could relax, that those country-made creaking boots could steal very gently to a bedside and that rough voice could thin into a whisper when it spoke to a sick child.

Now, as he returned to his native place the old doctor was still there, going the rounds of his daily calls just the same as ever, the brindle hair a trifle whiter and the huge shoulders a little more bowed. That big back of his had curved itself over sick beds until it had set in that shape. His face was of a walnut brown and told of long winter drives over bleak country roads with the wind and rain in his teeth, and his face was shot with innumerable fine wrinkles like a last year's apple.

These young men looked upon him as a survival of a past generation and spoke of him as having learned his medicine under that obsolete system by which a youth was apprenticed to a surgeon. They laughed at him for regarding chloroform as a dangerous innovation, and for calling the stethoscope a "new-fangled French toy." They said he carried one in his hat out of deference to the expectations of his patients but he was so hard of hearing it made little difference whether he used it or not. The germ theory of disease he regarded as a great joke and in the sick room he would chuckle and say: "Shut the door or the germs will be getting in."

But he had a fine surgical hand and had learned to trust more to his fingers and the sense of touch than to instrumentation. On one occasion the young doctor secured a patient in no less a personage than a member of Parliament, and had cut him for stone, but were unable to find the stone. It was a horrible moment. Both their careers were at stake. Then it was that Dr. Winter, whom they had asked out of courtesy to be present and witness their important operation, passed his fingers into the wound and slyly hooked out a stone, saying with a chuckle: "It is always well to bring one in your waistcoat pocket."

Out of gratitude they made him president of their branch of the British Medical Association, but he resigned after the first meeting. "The

young men are too much for me," he said, "I don't understand what they are talking about." But the old doctor's patients, in spite of all this, seemed to prefer him to the advanced science of the young men. He seemed to have the healing touch, and his patients did very well. His mere presence left the patient with more hopefulness and vitality.

In commenting on this, Patterson said: "It's all very well for the poorer people, but the educated classes have a right to demand that their medical attendant shall know the difference between a mitral murmur and a bronchitic râle. It is the judicial frame of mind, not the sympathetic, which is the essential thing." Both were agreed as to that.

It so happened shortly after this that an epidemic of influenza broke out and the doctors were all worked to death. Doyle met Patterson one morning on his rounds and found him looking pale and fagged out. Patterson made the same remark about his friend. In fact, he was completely done out and lay all that afternoon on the lounge with a splitting headache and pains in every joint. Towards evening he felt convinced that the scourge was upon him and he should have medical advice. Of course, his thoughts first turned to Patterson, but somehow the idea of him became repugnant to him. He thought of his cold, critical attitude, his endless questions, his tests, and his tappings. He longed for something more soothing, something more genial. Calling his attendant he said: "Please run around to old Dr. Winter and ask him if he won't be good enough to come and see me." He was back with the answer promptly: "Dr. Winter will come round in an hour or so, sir; but he has just been called in to attend Dr. Patterson."

The scientific handling of disease is not the whole thing by any means, and the young man will find much to learn from the old doctor in the sympathetic handling of the patient while at the same time he fights the disease.

I would not be understood as maintaining that the local society exists solely for the cultivation of the urbanities of life and the study of moral character. The scientific work, the papers and the discussion fix the intellectual status of the members. From the discussions it quickly develops who has the observant eye, the keen ear, the delicate fingers and the educated touch. To quote Osler again: "The well-conducted medical society represents a clearing house in which every physician of the district receives his intellectual rating, and in which he finds out his professional assets and liabilities."

On the educational value of the local medical society we need not dwell. That is appreciated by all. The aim in each county should be, moreover, to see to it that every respectable practitioner is a member of the local society, and that every practitioner who is not respectable is bounced out of the profession. Let us not deceive ourselves, however, with the idea that the country society

may become such a post-graduate school of instruction that it will make finished scholars out of all its members. But its influence is always for the good. As George Horace Lorimer says in his letter to his son at Harvard: "College doesn't make bright men, it develops them; it doesn't make fools, it develops them. A fool will turn out a fool whether he goes to college or not, though he will probably turn out a different sort of a fool."

But the homely virtues are not all. The stay-at-home man may cultivate and possess the elemental qualities that, as we have said, are essential to the foundation stones of our superstructure, but the man with the broader outlook must go afield to the neighboring societies and the State organization for congenial spirits and higher mental stimulus. Then it becomes necessary to know "who is who" and have means of exchanging ideas and securing a rating of the man in the medical centers and the distant parts of the State. Nothing meets these requirements so completely as a State medical directory, and a State medical journal. Through their instrumentality the Association is made compact, the mutual interests and dependence of the constituent societies are kept alive and responsive, and the organization as a whole becomes a ready instrument for defensive or aggressive action.

The Directory is of service and value in many ways. It is a record of accurate information regarding every member of the profession. It exposes fraud in our midst. In the gathering of information it has been discovered that many men are in the habit of habitually appending to their names distinguished titles to which they have no just claim. These are used for advertising purposes to give a false impression as to their standing in the profession. In the "proving-up" process which naturally attends a carefully confirmed card catalogue these are exposed and the false assumptions brushed away. In the large cities the Directory is indispensable for the identification and location of men, and in the small towns and country districts it keeps before the mind and gives a feeling of acquaintanceship with fellow practitioners both in the neighboring counties and the remoter towns. A large national directory is too clumsy and unmanageable for constant use in daily work. A directory compiled in a distant State from records gathered once a year cannot be as accurate as one compiled on the ground in a constantly inquisitive office with a card catalogue undergoing daily revision from the beginning of the year to the end, especially in a community where changes are as frequent as in New York. The importance of this will become instantly apparent in the new amalgamated Society with a membership of 7,000 to 8,000 men. With such a large clientèle the advertising pages, *when kept strictly within the most severely ethical lines*, will readily meet the expense of publication. It is sincerely to be hoped that the newly constituted Society will be wise enough to see the advisability

of continuing the Directory. As Dr. Thornton declared in his address of last year: "To say that one has no use for a directory is practically to admit that his work is confined to his immediate neighborhood and that he has little or no interest beyond the limits of his own drive."

The *Journal of the American Medical Association* has made our National organization what it is to-day. Likewise, THE NEW YORK STATE MEDICAL JOURNAL has been a most potent factor in building up, welding together and maintaining the solidarity of our State Association. The reports of the various county meetings have stimulated commendable rivalry in the excellence of their programs and the quality of the reports. Facts of local and immediate interest, personal news and legislative matters of medical importance and import, the progress of the Association affairs as recorded in the meetings of the Council, all of this means much in the maintenance of *esprit de corps*.

The superiority of a journal as a substitute for the traditional bound volume of transactions would seem to need no argument. It comes with freshness every month. It is quite apt to bring to the notice of many a busy man at least one article discussing a condition that is just at that time absorbing his attention and actively present in a case under his care. The bound volume, to be sure, would contain the same article, but it is up on the shelf and the thought of it has passed out of mind long ago. We must look at the conditions as they are. In the experience of the vast majority of doctors the bound volume of transactions, containing as it does, a collection of articles that have appeared long ago in the medical journals, as soon as it comes is added to the row of previous volumes on the shelf, is out of sight and out of mind, like its fellows becomes gradually covered with dust, and is rarely taken down except, perhaps, at annual house-cleaning or perennial moving. The journal comes fresh every month, is removed from its wrapper and at least glanced through, with the news items to attract attention and the probability that at least one article may be apropos of a case in hand and studied carefully; the affairs of the Association are there to awaken interest and the various reform movements to enlist his sympathy and cooperation. Just at the present time there is an active movement afoot of vast portent to the public and the medical profession. I refer to the effort that is being made to expose the evils of so-called proprietary tonics, drugs and medicines, and the insinuating debauching methods that are pursued to make the medical profession a *particeps criminis* in foisting them upon the public. I think I am not overstating the situation when I say that from the standpoint of the health of the community and the dignity and welfare of the profession the exploitation of quack nostrums and proprietary medicines is the greatest abuse of the present time. There has been a struggle going on for many years to free the advertising pages

of our medical journals from their advertisements. But great difficulty has been experienced in determining just where to draw the line between what is ethical and what is non-ethical. The simplest dictates of common sense would seem to compel the necessity of a physician knowing before he prescribes it just what the ingredients of a preparation are, and the amounts of each. The best of our medical journals, notably the *Journal of the American Medical Association*, and some of the official State journals have prescribed for themselves that no advertisement of a medicinal agent will be accepted unless it contains a statement of the active ingredients and the amount of each. This seemed to be a desirable move for both the doctors who made use of such articles and the proprietors of them. But the suspicion arose that perhaps the proprietors were not quite honest in giving the formulæ of their preparations and careful analysis of some of them which were submitted to scientific laboratory experts confirmed the suspicion. This has led to the establishment, by the Trustees and Directors of the American Medical Association, of a Council of Pharmacy whose duties are to prove up or disprove the given formulæ of patent and proprietary medicines. It is hoped by these restrictions on advertisements and unlicensed statements to keep this business within reasonable bounds. Thus much is the profession contributing to the restraint of this abuse. To carry it on successfully it is necessary to have the support of a united profession, and this can only come from widespread information. Right here is where a State medical journal finds its mission, and is a potent argument for its existence. Our reconstituted Society, consisting as it will of 7,000 to 8,000 members, will afford ample subscription list for a good, live monthly or even weekly journal, and the journal in turn will maintain the *esprit de corps* and the solidarity of its organization; indeed, it is absolutely essential.

The running of a journal involves an immense amount of work. It is unreasonable to expect a committee of busy men or the chairman of a committee to give the time and labor necessary to its successful accomplishment. It requires a properly selected editor, with a reasonably remunerative salary. By combining the two offices of editor and secretary in the hands of a paid official, the work of both will be efficiently performed and no imposition practiced upon any one. The secretaryship of a large organization involves more work than should be expected gratuitously. The combination suggested, as has been demonstrated in the American Medical Association, solves the problem.

Apropos of the effort on the part of the profession to restrain the proprietary and quack medicine abuse it is highly satisfactory to note that a wave of moral rectitude has struck some of the lay press, notably, the *Ladies' Home Journal* and *Collier's Weekly*. The latter publication is now presenting a series of articles by Samuel

Hopkins Adams, the most scathing arraignment of a public abuse, I was about to say crime, that has ever been presented. He attributes the source of its present flourishing condition to advertising, and says: "Should the newspapers, the magazines and the medical journals refuse their pages to this class of advertisements, the patent-medicine business in five years would be as scandalously historic as the South Sea Bubble; and the nation would be the richer not only in lives and money, but in the drunkards and drug fiends saved. Gullible America will spend this year in the purchase of patent medicines, \$75,000,000. In consideration of this sum it will swallow huge quantities of alcohol, an appalling amount of opiates and narcotics, and a wide assortment of varied drugs ranging from powerful and dangerous heart depressant to insidious liver stimulants. In speaking of the exploitation of Peruna in alliance with the New Orleans *Times Democrat* in connection with the yellow-fever epidemic, *Collier's* says, that this sheet (the *Times Democrat*) has accomplished a feat of prostitution which, considering its pretense to respectability, probably sets the record. While the South is struggling to check a peril of the direst magnitude, this newspaper publishes an interview with "Dr. Hartman," with the familiar allegation that he "said in part," and all other devices to make it look like an important piece of news. Its headlines are: "How to Avoid Yellow Peril. An Interview with Dr. Hartman Concerning the Yellow Plague." To the reader this is the genuine opinion of a physician. He cannot know that Dr. Hartman is the head of the Peruna Company, and that the *Times Democrat*, in whom the reader presumably has some trust, is selling itself and the safety of its constituents for a bag of gold. "A summary of this interview," the *Times Democrat* informs us, "is being spread broadcast over the United States for the benefit of yellow-fever sufferers." The gist of it is that, while screens and other precautions are advisable, Peruna should be taken at once and continued during the whole course of the epidemic. Is there anything to which men cannot be led by money? To own a newspaper and hire it out to perilous fraud in an emergency like the yellow-fever danger almost surpasses one's belief in human greed. No more disheartening proof of the need of the crusade which we have begun could possibly have been offered."

Speaking of Peruna recalls the story which appeared recently in the *Journal of the American Medical Association*:

The following is a true tale of a recent happening in an American city. A respected clergyman fell ill, and the family physician was called. After examining the patient carefully, the doctor asked for a private interview with the patient's adult son. "Harry," said the doctor, "do you know what is the matter with your father?" "No. We sent for you to tell us that." "Well," the physician said, "I am sorry to tell you that your father undoubtedly is suffering from chronic

alcoholism." "Chronic alcoholism! Why that's ridiculous! Father never drank a drop of liquor in his life, and we know all there is to know about his habits." "Well, my boy, it's chronic alcoholism, nevertheless, and at the present moment your father is drunk. How has his health been recently? Has he been taking any medicine?" "Why, for some time, six months I should say, father has often complained of feeling unusually tired. A few months ago a friend of his recommended Peruna to him, assuring him that it would build him up. Since then he has taken many bottles of it, and I am quite sure that he has taken nothing else."

I speak of this in this connection to emphasize the fact that the time is ripe for the profession, which is now organized as never before, to join in a crushing crusade against this gigantic evil, viz., the proprietary medicine and quack nostrum octopus. There are now sixteen State medical societies which have official journals. By forming a combination against the advertisements of secret or proprietary medicines what a power for good could be exerted! And among these, New York State should take the lead.

A satisfactory rule of practice was announced by the Committee on Proprietary Medicines in its report at the meeting of the American Medical Association, 1904. The following principles were proposed to govern the rejection of advertisements in medical journals: 1, medicinal articles of secret composition; 2, articles for internal medicinal use, advertised or in any manner exploited as remedies or cures to the laity; 3, medical articles of known composition whose formulæ do not give the exact quantity of the active medicinal agents and their names in recognized scientific terms; 4, articles with trade names, without the true, scientific chemical name, or of mixtures of pharmaceutical preparations, without a pharmaceutical title which describes its pharmaceutical character and the principal active ingredients.

Malpractice defense is a pertinent feature of a State medical society, and in our organization it has worked most satisfactorily, as shown by the report of our counsel, Mr. Lewis. The work of the insurance companies that have undertaken such work is worse than useless. They are working on a strictly business basis for the benefit of their own pockets. It is cheaper, as a rule, to compromise than it is to fight. The ease with which litigants thus obtain compensation for simple or fancied mishaps encourages the practice of suing for damages and the doctor becomes a marked object for blackmail on the slightest provocation. The number of suits for malpractice is rapidly on the increase. Dr. Maurice Richardson in his address as chairman of the Surgical Section at the recent meeting of the American Medical Association, said: "With the great increase in the number of surgical operations, the discontented are beginning to bring actions against physicians for bad results in fields of surgery other than that of fractures. Hence, al-

though malpractice suits are, as I say, not common, yet the number of complaints is greater every year. I have known suits to be brought for various reasons—for alleged negligence in leaving gauze in the wound, for operation without the patient's understanding or consent, for abdominal fistulæ, for burns, for post-operative hernias and the like. In one instance a surgeon was actually sued because he advised against the removal of a uterine fibroid; in another case damages were claimed because a surgeon overlooked a splinter of wood in a boy's neck; in still another, because amputation was performed on a minor without the consent of the father. Suit was brought in one case for pressure sores following the application of plaster of paris.

"The cases that come to trial are the ones that we hear of; doubtless many claims for damages are settled out of court. Whether the recent introduction of insurance against claims for damages will increase the number of suits or not, is thus far a matter of opinion. When it becomes generally known that corporations stand by physicians, malpractice suits will, I think, increase, especially if the insurance companies make settlements favorable to themselves, without the consent of the physician. On the other hand, a determined and obstinate defense seems a real protection."

The three features, viz., a directory, a journal and malpractice defense, involve expense. That is true, but every good thing in this world involves expense. Doctors are as ready to pay for such things as any other body of men. They may grumble at large annual dues when they see no benefit except that which comes to a ring of politicians who perpetuate themselves in office and enjoy the honors and the spoils. But the directory, the journal and malpractice defense are tangible benefits and are felt to be such by every man in the ranks; they come to him personally. The larger the society the less the per capita expense. If our Association, with a membership of 1,800 members, has maintained these features without feeling them a burden how much more lightly would they rest on the shoulders, or the pockets, of a society of 7,000 or 8,000 members!

Of the Principles of Ethics, I have little to say. They need no advocate. They stand as a masterpiece of diction, Chesterfieldian in their maxims of conduct, a model for every man in the profession to emulate. No man can read them and familiarize himself with them without being a better man thereby, and a more thorough professional gentleman.

The *Journal of the American Medical Association* in commenting last year on the union of the two New York State Medical organizations said: "The name of The New York State Medical Association on the terms of the agreement ceases, and its separate existence ends, but in a far broader and more practical sense it now enters into a new life. The Association has an enviable history of over twenty years, which requires no

apology. It now steps out into a wider field and represents the whole profession. The spirit of loyalty and of sacrifice shown by the members of the Association is one of the grandest legacies which they can bequeath to the new organization."

There was a time in the history of Egypt when the twin kingdoms of Palestine and Phenicia gave conquerors and rulers and laws to Egypt under her shepherd kings. But Egypt waxed strong and prosperous and threw off the yoke of her conquerors. Phenicia, however, never forgot the days of her prosperity or the glory of her reign in Egypt, and continued to pride herself on the fact that Egypt owed much of her greatness to the Phenician influence, and was wont to say: "Phenicia is not dead while Egypt lives."

So the State Association, looking forward to future years of prosperity, of greatness and of power in the reconstituted medical organization, may say with pride: "The Association is not dead while the State Society lives."

THE AMENDED BY-LAWS.

Presented at the October Meeting, 1904, and Approved as Amended, at the Meeting of the Council and Fellows, Held October 16, 1905.

BY-LAWS.

(As amended October 16, 1905.)

ARTICLE I.—ORGANIZATION.

Composition.—Section 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 their 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-officiis, 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 and Finance Committee.—Sec. 1. The Council in the interim between the annual meetings of The New York State Medical Association and the annual meetings of the Council and Fellows, shall be and is hereby constituted the Executive Board or Committee, both of the New York State Medical Association, and of the Council and Fellows, with full power and authority to put into effect the purposes of the Association as expressed in and limited by its charter, by-laws and resolutions. The Council may elect a Finance Committee from among its members, the sole power of

which shall be to audit and authorize the payment of such bills as may have been theretofore incurred by order of the Council, or the Council and Fellows of The New York State Medical Association.

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, and notice of each special meeting of the Council specifying the time and place of the meeting, and the business to be transacted, shall be mailed in a securely sealed post-paid wrapper, addressed to the last given address of each and every member of the Council, at least five days before the date of meeting.

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 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.

Action Under Medical Laws and Employment of Counsel.—Sec. 6. The Council may, in the name The New York State Medical Association, take action in any case of violation of the public health laws, subject, however, to the provisions of such laws. The Council may, in the name of The New York State Medical Association, employ an attorney at law to advise or act in any legal matter for The New York State Medical Association, upon such terms as the Council may determine.

Defense of Suits of Alleged Malpractice.—Sec. 7. Any active resident member of The New York State Medical Association may apply in writing for defense, and the Association shall, through its Council, furnish the legal services of a duly qualified attorney at law, in any alleged civil malpractice action brought against him, the alleged cause of action for which occurred subsequent to the time when such applicant became a member of The New York State Medical Association, provided, however, that said applicant shall not be in arrears in the payment of dues for a period of more than three months from the first day of January, and that said applicant shall agree in writing not to settle, compromise, adjust or discontinue such action without the consent of The New York State Medical Association or its attorney, and renouncing his own, shall vest in The New York State Medical Association or its Council sole authority to conduct the defense of said suit, or to settle or adjust the same with the consent of the applicant, but neither the Council nor its attorney, nor any other person shall obligate The New York State Medical Association to the payment of any money awarded by verdict, decree or court, upon compromise or otherwise.

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 re-

ceived 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.

Duties.—Sec. 1. The general supervision, business management and control, together with the financial interests of The New York State Medical Association and its membership, are vested in the body known and styled the Council and Fellows, as limited, qualified, and authorized by Section 5 of Chapter 452 of the laws of 1900.

Meetings.—Sec. 2. The Council and Fellows shall meet annually. The annual and all other meetings of the Council and Fellows of The New York State Medical Association, shall be held at its office or place of transacting its financial concerns in the city of New York, Borough of Manhattan. The annual meeting of the Council and Fellows shall be held on the third Monday in October in each year, beginning at 3 o'clock in the afternoon, and special meetings of the Council and Fellows shall be held at such other times, upon ten (10) days' notice thereof, as may be determined by the Council to be necessary or expedient, or upon the written request of twenty-five (25) members of The New York State Medical Association. One-half the membership of the Council and Fellows, shall constitute a quorum.

Rules of Procedure.—Sec. 2. 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 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 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 meetings 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-Officio.—Sec. 3. In the absence or disability of the Vice-President, the Vice-Presidents Ex-Officio 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 writ-

ten 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.

Duties of Treasurer.—Sec. 5. The Treasurer shall receive and disburse all funds of The New York State Medical Association under the direction of the Council, or Council and Fellows, or upon the audit of persons duly authorized by these by-laws. He shall make a report at the annual meeting of the Council and Fellows upon the finances of the Association, and to the Council at such other times as the Council may require, and shall report upon the names of such members as may be delinquent in the payment of their dues. Any member who shall not have paid his dues on or before the first day of July in any year shall be considered a delinquent member, and a member not in good standing. The Treasurer 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-officio.

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 legislative 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 ten members, two of which members shall be elected from the Fellows from each of the five District Branch Associations. It shall be the duty of this committee to present to the Council and Fellows at its annual meeting a list of nominees for all elective offices of The New York State Medical Association, from which list the officers may be elected, unless otherwise ordered by a majority of the members present.

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 New York State Medical Association shall hold a meeting annually, to be called its annual meeting, in the city of New York, and Borough of Manhattan, on the first Tuesday following the third Monday in October, in each year, at 9.30 o'clock in the forenoon, at its office or place of transacting its financial affairs, and the scientific or social sessions of such annual meeting shall be held at such place and hour as shall be selected by the Council and designated in the notice of such meeting, and The New York State Medical Association may hold special meetings at other times, places and hours in the city of New York and Borough of Manhattan. The notice for all meetings of The New York State Medical Association or the Council and Fellows shall be in writing, mailed in a securely sealed post-paid wrapper, addressed to the last given address of each and every member of The New York State Medical Association, which notice shall state the date, place and hour of such meeting. Notice of all special meetings shall be mailed to every member of the State Medical Association at least ten (10) days before such meeting, and shall state the date, place, hour and purpose of the meeting, and no other business at any special meeting shall be conducted except such as is stated in the call. The affidavit of mailing by the Secretary of The New York State Medical Association of such notice for the call of the meeting, shall be sufficient proof of the service of such notice upon each and every member, for any and all purposes.

Special Meetings.—Sec. 2. Special meetings shall be called by the President by order of the Council, or upon the written request of twenty-five (25) members of the Association.

Order of Business.—Sec. 3. The order of business at the annual meeting of The New York State Medical Association shall be as follows:

1. Calling the Association to order.
2. Reports of Special Committees.
3. Unfinished business.
4. New business.
5. Address of welcome by the Chairman of the Committee on Arrangements.
6. President's address.
7. Special addresses.
8. Reading and discussion of papers.
9. Installation of Officers.
10. Adjournment.

Sec. 4. One-third of the membership of The New York State Medical Association shall constitute a quorum, for the transaction of any and all business.

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 or Southern District shall embrace the counties of Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, 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 DISTRICT BRANCH ASSOCIATION 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 stated visitations to such County Associations during the year, shall make himself familiar with the character and quantity 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 all funds of the Branch Associations, 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.

Committees 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 the 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.

DUTIES OF COUNTY ASSOCIATION OFFICERS.

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 and 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 all funds of the County Association of the County in which he resides.

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. Active resident members shall have all the rights and privileges conferred by their respective County and District Branch Association. 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 of the protection, benefits and support conferred by The New York State Medical Association except as herein qualified or limited, provided, however, that such active member's dues shall have been paid to the Treasurer of The New York State Medical Association on or before the first day of July in any year, and not otherwise. If at the time of the annual meeting of any County Association or District Branch Association, a member shall not have paid his annual dues to such County Branch Association, he shall not be counted as a basis of representation in The New York State Medical Association, nor shall he be eligible for election as a Fellow, nor thereafter until he shall have discharged his indebtedness in full.

Privileges of Members, Non-Resident, Honorary and Corresponding.—Sec. 5. All members of The New York State Medical Association other than active resident members, shall receive only the notice of all scientific meetings, and a copy of all publications of The New York State Medical 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.

Application 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 due The New York State Medical Association and payable on the first Monday of January in each year. Members resident in the State of New York shall transmit their dues to the Treasurer of the County Association in which they reside, or to the Treasurer of the District Branch Association if no County Association exists in the county wherein they reside. Non-resident members shall transmit their dues to the Treasurer of The New York State Medical Association.

Collection of Dues.—Sec. 4. On the first day of July in each year the names of all members who have failed to pay their indebtedness to The New York State Medical Association for the current year shall be omitted from all public accredited lists of members of The New York State Medical Association, and if at the close of the first day of the annual meeting of The New York State Medical Association such dues still remain unpaid

and in arrears, the name of such delinquent member shall be dropped from the official roll of members, and he shall be notified of his suspension from membership in The New York State Medical Association as soon as conveniently possible thereafter.

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 or District Branch Association shall pay to the Treasurer of the State Association monthly, all dues or other funds in his hands received from members, which the Treasurer of The New York State Medical Association is entitled to receive.

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 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 Associations.—

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 shall be made only upon the affirmative vote of a majority of those present and voting at a regular annual meeting of the Council and Fellows, or at a regular annual meeting of The New York State Medical Association, provided that notice of such amendment shall have been presented in writing at the previous annual meeting of The New York State Medical Association.

Suspension of By-Laws.—Sec. 2. Section 4 of Article III and Section 3 of Article VI of these by-laws may be suspended by unanimous consent at any meeting of the Council and Fellows during such session only.

REPORT OF DR. RICHARD H. GIBBONS, DELEGATE TO THE PENNSYLVANIA STATE MEDICAL SOCIETY.

Mr. President, Ladies and Gentlemen—The meeting of the Medical Association of the State of Pennsylvania, held recently in Scranton, Pa., which I had the honor of attending as a delegate from this Association, was largely attended, every county throughout that great State having been represented by its delegates.

The social features of the meeting were many and well attended. The ladies of Scranton contributed largely to the pleasure of the wives and other relatives of the visiting physicians. A theater party was one of the social features provided for by the Committee of Arrangements, and the magnificent theater, the Lyceum, was filled on this occasion by the visiting doctors, their wives and friends. President Foster, of the Scranton International Correspondence Schools, provided a big fête in the way of a conversazione, and in various parts of one of their magnificent buildings lectures were given on different interesting and scientific subjects. A fine supper and dancing were additional features of this social entertainment which were also greatly enjoyed by the visiting doctors and their friends.

The scientific program of this meeting was most interesting. Unfortunately it was not fully carried out. The absence of Price, Deaver, Murphy and Harry Beyea was disappointing in the extreme. Dr. Hartley, of this city, was also greatly missed.

The papers that most appealed to me, inasmuch as I attended only the surgical section of the meeting, were those of Mills, on general brain topography, and Frazier's classical paper on surgical intervention in tumors of the cerebrum, Crile, of Cleveland, also read a magnificent paper, the discussion of which was opened and carried out in the truly scientific way in which the discussor, Dr. Dawbarn, of this city, carries on his discussions. He did not agree entirely as to the technique of Crile, upon whom we are apt to look as a wizard in this line of surgery. Among other points brought out by Dr. Dawbarn was the fact that much of the surgery in the class of cases under discussion was made possible by the orig-

inal work of Dr. John A. Wyeth, of this city. This was particularly pleasing to me from the very fact that few authorities nowadays appear to even know of, much less to have a desire to give to him, that due which so justly belongs to Wyeth as the first to carry out the dissections which showed the possibilities of dealing surgically with the external carotid and its branches.

Dr. Curtis, of this place, also had a very interesting paper.

A most extraordinary paper was one by Dr. Thomas, of the University of Pennsylvania. It related to fractures of the head of the radius. He gave quite a number of cases that came under his own observation, besides quoting Stimson and others and their views concerning this fracture. He did not agree with any of them, however; on the contrary, his own observations furnish reasons for disagreeing with other authorities. His reasoning was definite and there is no doubt that his ideas relative to this fracture will be sustained by further observation. He is a studious and painstaking surgeon and much will be heard from him that will be of the greatest value to surgery.

The old-time howl of how to deal with pus cases in the pelvis and abdomen was amusingly dealt with. It seems strange that pus should be found or pus doctors needed nowadays, when medical men, *internists* in particular, lay claim to medicine having advanced to such a high state of perfection.

What was more pleasing to me personally, relative to my attendance upon this meeting, was that it gave me an opportunity again to meet the Pennsylvania doctors, the best lot of fellows on earth. It was especially gratifying to have the opportunity of again greeting such distinguished men as Professor Tyson, that erudite scholar and famous teacher, and Roland G. Curtin, the distinguished diagnostician and teacher of diagnosis. These two men have contributed very largely indeed to the knowledge of medicine and have done an immense amount for the education of young physicians. Indeed, they have shared with the Hodges, the Penroses, Alfred Stille, Joseph Leidy, Joseph Carson, Francis Gurney Smith, D. Hays Agnew, William Pepper, Wier Mitchell, William Goodell, H. C. Wood, Theodore G. Wormley, J. William White, John B. Deaver, Edward Martin and Gwilym Davis, the glory of the past and present standing of the medical department of the University of Pennsylvania, that famous institution of medical learning. Tyson has always stood for and has always taught the very best that was in medicine. His innate modesty has kept him from getting even a tithe of that which belongs to him, while Curtin has received but little recognition for his great ability, unless it be that he is acknowledged to be the most popular consultant in all Pennsylvania.

It was delightful, too, to again meet John G. Clark, John B. Roberts and others of Philadelphia, Koenig, of Pittsburg, the president of the Association, and that slave to the Association and

editor of its paper, Cyrus L. Stevens. The president-elect of the Association, Dr. William H. Hartzeli, was the same happy-going individual of old. He is not only a physician, he is a gentleman. Beates, the president of the Examining Board of Pennsylvania and the president of the interstate collegiate system, was there in all his glory. He is the one strong enemy of fakes and fakery, of quacks and quackery, and has done more toward elevating the standards for both entrance and examination than all others.

It was also pleasing indeed to have the opportunity of again meeting Halberstadt, of Pottsville; McCormack, of Williamsport, and Bishop, of Harrisburg. Bishop can say more and say it more to the point when in debate than any other medical man.

I think the method of The New York State Medical Association in holding its sectional meetings at different points throughout the State and then the annual meeting here in the city, is far in advance of the itinerant way in which the Pennsylvania Association conducts its annual meetings. It seems to me that its annual meeting should be held in Philadelphia, and then throughout the year let the various districts hold meetings at varying times. It is said that State meetings held in the large cities, as New York, Philadelphia, etc., have detractions by way of clinical and other sorts of interferences with the scientific meetings. This is probably true, but, on the other hand, see all the other advantages that are offered by an annual visit to the large cities. And if clinical advantages detract from the scientific meetings of the Association, why not add another day to the meeting and make it clinic day, having the various men in their respective lines make appointments for their operations, etc., at such times during that day as will allow of the members being able to attend the clinics of their choice?

I thank you, Mr. President, and you, Mr. Secretary, for my privilege of joining in reunion with the friends of the best years of my life.

MEDICAL DIRECTORY, 1905.

The seventh volume of the Medical Directory of New York, New Jersey and Connecticut, issued by The New York State Medical Association, was distributed to the members early in October.

In compiling the list of physicians, every possible effort has been made to prevent errors, but in a State like New York, where physicians move so frequently and change office hours and telephone call numbers, in some cases several times during a year, absolute accuracy is impossible. It is believed, however, that this is the most complete and accurate list of the physicians of New York, Connecticut and New Jersey ever published.

Book Reviews.

A TEXTBOOK ON THE DISEASES OF WOMEN. By Barton Cooke Hirst. 742 pages; 701 illustrations; second edition. Saunders & Co.

In preparing this work the author has followed out the same method of presentation that has made his *Obstetrics* so successful. The language is simple and direct and makes the reader feel that it is the personal experience of the author that is presented. Hirst does not believe that all cases of retroversion of the uterus with adhesions are necessarily operative. In many of these cases with the patient in the knee-chest position he makes a firm vaginal tamponade both anterior and posterior to the cervix. The tampons are dry and dusted with boric acid. They are removed at the end of 48 hours and repeated. In ten or twelve weeks there is often astonishing improvement. Large, distended tubes may become practically normal and the uterus may become freely movable. He is a firm believer in the use of the pessary in cases of simple retroversion. A chapter on the minute details of Gynecic Surgery adds greatly to the value of the work. *Coccydynia* is the title of a very interesting chapter. He says that so-called rheumatic *coccydynia* is always due to injury of the joint. Three-fourths of these cases are the result of injuries occurring in labor. If there is no union in the parts within six months, he advises the removal of the *coccyx*. He advocates the use of a silver filigree in abdominal herniæ. No mention is made of the fact that this was first suggested by the late Dr. A. M. Phelps, of this city. The illustrations are profuse, are appropriate and are well done. The typographical part of the work is done in the same clear type that has characterized the work of this well-known firm. The book is up to date in every respect.

HUMAN PHYSIOLOGY. By Howard Raymond.

Though this volume is not as widely known as some others, the rapidity with which it has gone through a third edition shows that it is being more and more appreciated by both teachers and students. In this third edition many changes have been introduced which add not a little to its value, and the subject-matter has been thereby brought thoroughly up to date.

The important additions are the subjects of hemolysis and bacteriolysis. There has also been incorporated in the text the latest contributions to the literature on the subject of alcohol in its relation to uric acid elimination. In fact, we find here a very careful compilation of all the work of modern physiologists which may be useful in the teaching of the subject.

The illustrations have been most carefully selected and arranged and unlike those of most textbooks do not add difficulty in the proper understanding of the text they are supposed to elucidate.

ATLAS AND TEXTBOOK OF TOPOGRAPHIC AND APPLIED ANATOMY. By Oskar Schultze, Professor of Applied Anatomy in Würzburg. Edited, with additions, by George D. Stewart, M.D., Professor of Anatomy and Clinical Surgery in the University and Bellevue Hospital Medical College, New York. W. B. Saunders & Co., 1905.

The combination of a textbook and atlas necessarily means a condensation of both and the omission of many details. This has its advantages and disadvantages, but a careful perusal of this book shows that nothing of importance has been omitted, and the names of the authors render it certain that it will meet with a favorable reception by the profession. The arrangement is excellent, and the artistic work done by the illustrators shows a distinct advance over much that is found in many more pretentious works. It will be found a valuable aid to all classes of physicians, as a knowledge of anatomy and especially of topographical anatomy is essential to all.

BOOKS RECEIVED.

METHODS OF ORGANIC ANALYSIS. By Henry C. Sherman, Ph.D., Adjunct Professor of Analytical Chemistry in Columbia University. New York: The Macmillan Company; London: Macmillan & Co., Ltd., 1905. All rights reserved. Price of book is \$1.75.

MEDICAL AND SURGICAL REPORT OF BELLEVUE AND ALLIED HOSPITALS IN THE CITY OF NEW YORK. Volume I. 1904. Edited by Alexander Lambert, M.D., Chairman. W. K. Draper, M.D., B. Farquar Curtis, M.D., George Woolsey, M.D.

REPORTS OF THE TRUSTEES OF BELLEVUE AND ALLIED HOSPITALS, for three months ending December 31, 1904.

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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 Wm. Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; Jas. Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; Thos. 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. Fifteenth series. 1905. Philadelphia and London: J. B. Lippincott Company, 1905.

MANUAL OF DISEASES OF NOSE AND THROAT. By Cornelius Godfrey Coakley, A.M., M.D., Professor of Laryngology in the University and Bellevue Hospital Medical College, New York City; Laryngologist to Columbus Hospital, the University and Bellevue Hospital Medical College Clinic; Consulting Laryngologist to the New York Board of Health; member of the New York Academy of Medicine, Society of the Alumni of Bellevue Hospital, Medical Society of the County of New York, Medical Society of the State of New York, American Laryngological, Rhinological and Otological Society, etc., etc. Third edition, revised and enlarged; illustrated with 118 engravings and 5 colored plates. New York and Philadelphia: Lea Brothers & Co., 1905.

A TREATISE ON DIAGNOSTIC METHODS OF EXAMINATION. By Prof. Dr. Hermann Sahli, Director of the Medical Clinic, University of Bern. Edited, with additions, by Francis P. Kinnicut, M.D., Professor of Clinical Medicine at Columbia University (College of Physicians and Surgeons), New York; Physician to the Presbyterian Hospital; and Nath'l Bowditch Potter, M.D., Visiting Physician to the City Hospital and to the French Hospital, New York. Authorized Translation from the fourth revised and enlarged German edition. Philadelphia and London: W. B. Saunders & Co., 1905.

THE NATIONAL STANDARD DISPENSATORY, containing the natural history, chemistry, pharmacy, actions and uses of medicines. Including those recognized in the pharmacopœias of the United States, Great Britain and Germany, with numerous references to other pharmacopœias. In accordance with the eighth decennial revision of the United States Pharmacopœia, 1905. By Hobart Amory Hare, B.Sc., M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Member of the Committee of Revision of the United States Pharmacopœia. Eighth Decennial Revision, 1905; Charles Caspari, Jr., Ph.G.,

Phar.D., Professor of Theoretical and Applied Pharmacy in the Maryland College of Pharmacy (Department of Pharmacy of the University of Maryland), Baltimore; General Secretary of the American Pharmaceutical Association; Member of the Committee of Revision of the United States Pharmacopœia, Eighth Decennial Revision, 1905; Henry H. Rusby, M.D., Professor of Botany and Materia Medica in the College of Pharmacy of the City of New York (Columbia University); Member of the Committee of Revision of the United States Pharmacopœia, Eighth Decennial Revision, 1905; Joseph F. Geisler, Ph.C., Chemist, New York State Department of Agriculture; Edward Kremers, Ph.D., Professor of Chemistry, University of Wisconsin; and Daniel Base, Ph.D., Professor of Inorganic and Analytical Chemistry, University of Maryland. Philadelphia and New York: Lea Brothers & Co., 1905.

THE DIAGNOSTICS OF INTERNAL MEDICINE, a clinical treatise upon the recognized principles of medical diagnosis, prepared for the use of students and practitioners of medicine. By Glentworth Reeve Butler, Sc. D., M.D., Chief of the Second Medical Division, Methodist Episcopal Hospital; Attending Physician to the Brooklyn Hospital; Consulting Physician to the Bushwick Central Hospital; formerly Associate Physician, Department of Diseases of the Chest and Diseases of Children, St. Mary's Hospital, Brooklyn, N. Y.; Fellow of the New York Academy of Medicine; Member of the Medical Society of the County of Kings; Fellow of the Society of Science, Letters and Art (Lond.), etc. With 5 colored plates and 288 illustrations and charts in the text. Second revised edition. New York and London: D. Appleton & Co., 1905.

ATLAS AND EPITOME OF DISEASES OF THE SKIN. By Dr. Franz Marcek, Professor of Dermatology in the University of Vienna, Authorized Translation from the German. Second edition, revised and enlarged, edited by Henry W. Stelwagon, M.D., Ph.D., Professor of Dermatology, Jefferson Medical College, Philadelphia; Physician to the Department of Skin Diseases, Howard Hospital; Dermatologist to the Philadelphia Hospital, etc. With 77 colored plates by the artists J. Fink and A. Schmiton, and 50 half-tone illustrations. Philadelphia and London: W. B. Saunders & Co., 1905.

A TEXTBOOK OF THE PRACTICE OF MEDICINE. By James M. Anders, M.D., Ph.D., LL.D., Professor of Medicine and Clinical Medicine at the Medico-Chirurgical College; Physician to the Medico-Chirurgical Hospital; formerly Physician to the Philadelphia and to the Protestant Episcopal Hospitals, Philadelphia; Fellow of the College of Physicians, Member of the Academy of Natural Sciences, Philadelphia, etc. Illustrated. Seventh edition, thoroughly revised. Philadelphia and London: W. B. Saunders & Co., 1905.

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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 to St. Agnes' Hospital, Fellow of the College of Physicians of Philadelphia, etc. Seventh edition, revised, illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

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PROPRIETARY MEDICINES, PATENT MEDICINES, NOSTRUMS, AND SECRET SYNTHETICS.

We must call attention to the confusion of terms so generally used in the literature upon the subject of proprietary remedies, patent medicines and nostrums. There is great need for clearness in the selection of terms which will definitely convey the intended meaning of those who speak or write upon this question, which has become such a live one to the general public as well as to the medical profession. The authority for the proper use of the words hereinafter defined is based upon the definitions given in the dictionary, and the United States patent law. A proprietary medicine is an article which any person or firm has the exclusive right to manufacture or sell; which definition includes a medicine of known formula or published process of manufacture, as well as a medicine of unknown formula or secret process of manufacture. The word proprietary should only be used generically, and should never be limited in its application as a synonym of the word nostrum. Proprietary medicines include: I. Patent medicines, all of which are of known process of manufacture; II. Pharmaceutical mixtures of known quantity and quality of ingredients; III. Nostrums, such as secret pharmaceutical mixtures, and the so-called synthetics, of secret formulæ protected by a trademark.

A patent medicine is a new and useful definite chemical compound of known formula, the process of manufacture is made public in the patent papers issued by the Government; therefore, all patent medicines are ethical. A nostrum is a medicine, the composition of which is secret, a quack medicine, or any recipe of charlatan character.

The trademark protects a class of secret synthetics which are nostrums, they being secret mixtures of some coal-tar product, advertised with a formula such as C_1 , H_2 , N_3 , O_4 . They are not patented, because they cannot conform to the patent law which demands that they shall be new and useful, definite chemical compounds.

The public and the profession have a right to be protected from the fraud practiced by the exploiters of nostrums which represent the only class of medicines offered to the medical profession which should be condemned as an insult to its intelligence and honesty. Any internal or external medicine, the formula of which does not state the quantity of its ingredients, and in the case of a synthetic, which does not state the process of its manufacture, is a nostrum or secret proprietary medicine. All nostrums thrive on false statements as to their therapeutic value. And it is the nostrum or secret proprietary vendors who have profited by the confusion of terms used in articles written by the authorities in medicine, who should know better than to play into the hands of the nostrum people, who must be considered as parasites on individual and public health.

Within two years articles have appeared by able teachers of scientific medicine, which illustrate the confusion of terms referred to. Transactions of State medical societies and medical journals contain the articles from which the following quotations are made:

I. "The wide use of many proprietary pills or mixtures is distinct evidence of the great power of foolishness and fraud even when directly opposed to honesty and instructed wisdom."

II. "There are no hard and fast lines which separate patent from proprietary remedies. In their secrecy of composition and method of exploitation they are comparable."

III. "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."

IV. "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 physiology and clinical therapeutics, or to his inertia."

V. "The difference between a proprietary and a patent medicine is more apparent than real. There is no good excuse for using these preparations."

These are fair extracts from the articles which do more harm than good, as many of the most valuable remedies used by physicians are proprietary medicines, and should not be condemned as nostrums. Many writers have strongly condemned the use of patent medicines in the face of the fact that all medicines now protected by a patent granted by our Government are ethical because the process of their manufacture is known. Recently an editorial and article have been published which distinguishes between a patent and a patented medicine; such a distinction is of recent origin, and if not killed in its infancy will surely lead to greater confusion than that which now exists in the minds of the profession and of the public.

The old prejudice against a patent medicine dates from the time when a prescription of a simple or compound mixture could be patented, but such mixtures have not been patented in many years, so that the patent medicines of to-day represent only new and useful definite chemical compounds, the patent covering the process of manufacture, and any competent pharmaceutical chemist, by following the process described in the patent, can reproduce the identical preparation found upon the market; but the patent protects against a commercial use of such published process, which in being made public meets every condition necessary to make a patent medicine ethical.

The subject of monopoly in drugs and other therapeutic agents is a sociological one, and not essentially a medical question. To use the word "patent" as the synonym, and the word "patented" as the antonym of nostrum, as is being done by some of the workers in this field, is to increase rather than to clear up the fog which surrounds this important subject. The literature is full of such tautology as secret nostrums; the word "nostrum" means secret remedy, which makes qualifying it by the word "secret" equivalent to saying that *one should heed the voice of the vox populi*. The reader often leaves the several articles in the medical journals upon the question of proprietary remedies, patent medicines and nostrums, and the discussion of the subject as reported in the transactions of the several State medical societies, in a condition of mind best described as confusion worse confounded; which is largely due to the careless use of terms, and the questionable remedies suggested, for this evil.

It is not unusual to read in many of the discussions before medical societies, which have been reported within the past five years, such advice as: Why not limit the prescribing of physicians to the articles mentioned in the pharmacopœia? Or should not the profession agree not to use any patent medicine; or that all proprietary medicines should be excluded from the advertising pages of medical journals, and should not be used by physicians? It is such advice which supplies the nostrum journals with the telling arguments in opposition to this great work, which is so often made ridiculous through misstatement and misunderstanding. The medical profession should be in possession of a criterion which should help it to decide which of the many samples of medicines left in a physician's office should find their way to the trash-basket. Samples of secret mixtures, protected by trademark, but not patented, which are exploited as definite chemical compounds—or coal-tar synthetics—should be considered as an insult to the intelligence of every physician receiving them. The information about such articles, so often limited to the statement that they do not depress the heart, at once suggests that they are more or less dangerous mixtures of acetanilid exploited as definite chemical compounds with popular names valuable only as commercial assets. Often the workmen in nostrum manufactories who know the secret of some special mixture will exploit such mixture under new, popular names, furnishing formulas such as C₅, H₁₀, O₂₀, N₃₀, and then circularize and sample the medical profession, expecting physicians to accept such samples, and prescribe such nostrums or secret proprietary medicines, to their patients, which represent, as all nostrums do, fraud as to their composition, and false statements as to their therapeutic value.

To sum up: I. Proprietary remedies include ethical preparations and nostrums.

II. All medicines protected by a patent are ethical.

III. Nostrums include secret proprietary mixtures and secret synthetics protected by the trademark law.

All samples of secret medicines should be deposited in the trash-basket, as every scientific physician should know the quantity of the ingredients in the mixture or mixtures which he uses, and should beware of secret synthetics.

The Council of Pharmacy of the American Medical Association has the courage of its conviction and is doing splendid work in educating the medical profession along the lines of scientific medicine, and away from the nostrum evil, and, with the cooperation of the *Ladies' Home Journal*, *Everybody's Magazine* and *Collier's Weekly*, the same thing is being done for the general public. By the study of pharmacology the United States Pharmacopœia will come into more general use and scientific medication will be correspondingly advanced throughout the United States

E. ELIOT HARRIS, M.D.

Association News.

The secretaries of the county and district branch organizations are requested to furnish the business office a program of the meetings to be held, and after the meeting a full report of the proceedings, and all items of interest, such as deaths, marriages and personals of the members.

COUNTY ASSOCIATION MEETINGS FOR DECEMBER.

Wayne County.—Tuesday, December 5th.
 Erie County.—Monday, December 11th.
 Tompkins County.—Tuesday, December 12th.
 Orange County.—Wednesday, December 13th.
 Cortland County.—Friday, December 15th.
 New York County.—Monday, December 18th.
 Monroe County.—Tuesday, December 26th.

Broome County Association.—The quarterly meeting of this Association was held at Dr. Orton's office, Tuesday, October 10, 1905, at 10.30 A. M.

The president, Dr. Farnham, being absent, the meeting was called to order by the vice-president, Dr. Martin.

The secretary read the minutes of the previous meeting, which were approved. Members present: Drs. Orton, Farrington, Martin, Lappeus, Knapp, Stearns, Stevens, Walker, Cannon, Longstreet, Allen, Fritts, Quackenbush, Michael, Lape and Greene. Dr. C. S. Payne, of Liberty, N. Y., was present and was invited to take part in the discussions.

Dr. H. T. Cannon presented an excellent paper on "Therapeutic Use of Calomel." The paper was discussed by Drs. Orton, Farrington, Greene, Longstreet, Walker, Quackenbush, Michael and Payne.

Dr. F. L. Allen gave an interesting paper on "Importance of Early Diagnosis of Adenoids." The paper was discussed by several of the members.

Dr. Farrington offered the following resolution: That a vote of thanks be given to Dr. Orton for the use of his office to the County Medical Association since its organization. Carried unanimously.

The name of Dr. L. D. Fosburgh, of Endicott, was presented for membership.

Meeting adjourned.

(Signed) C. W. GREENE, Secretary.

* * *

New York County Association.—The regular meeting of this Association was held Monday evening, November 20, 1905, at the Academy of Medicine, 17 West 43d street, at 8.30 P. M. The president, Dr. Francis J. Quinlan, presided. Fifteen new members were elected by the Asso-

ciation. At the scientific session of the meeting, the first paper of the evening was read by Isaac Adler, M.D., entitled, "General Infections Through the Tonsils." This paper was most interestingly discussed by Drs. Alexander Lambert, Emil Mayer, Wm. K. Simpson, Morris Manges and Wolf Friedenthal. The second and final paper on "Diarrhoea and Its Diagnostic Significance," was read by James P. Tuttle, M.D. In the discussion of this essay the following members took part: Drs. Samuel G. Gant, Max Einhorn and William Lusk. This closed the business for the evening and the meeting adjourned at 10.45 P. M. (Signed) WILLIAM RIDGELY STONE, Secretary.

* * *

Onondaga County Association.—A regular meeting of this Association was held at Syracuse, on Monday evening, November 20, 1905.

In the business session a resolution favoring the amalgamation of The New York State Medical Association and the Medical Society of the State of New York was adopted.

(Signed) THOMAS B. DWYER,
 Secretary.

* * *

Orange County Association.—The regular monthly meeting of the Orange County Medical Association was held at the Russell House, Middletown, N. Y., Wednesday, November 8, 1905, at 2 P. M. The following gentlemen were present: Drs. Connor, Purdy, Redfield, Preston, Shultz, Fancher and Leemon, of Middletown; Dr. F. W. Dennis, of Unionville; Dr. E. D. Woodhull, of Monroe; Dr. A. D. Davidson, of Florida, and Dr. L. G. Distler, of Westtown.

The meeting was called in scientific session by the President, Dr. E. D. Woodhull, of Munroe. Under report and presentation of cases, Dr. Fancher presented a puzzling case which elicited a great deal of discussion of particular interest to those present. The opinion was divided whether the case was one of aneurism of the anterior jugular vein or whether it was emphysematous.

Drs. Connor, Purdy and Woodhull also reported interesting cases.

Dr. F. W. Dennis, of Unionville, read an able and learned paper entitled, "To Better the Race." Dr. Dennis suggested that there be a Secretary of Health in the President's Cabinet, whose duty it should be to look after the health of the nation. He also stated as a suggestion that persons suffering or afflicted with epilepsy, syphilis, insanity, tuberculosis or alcoholism be prohibited from marrying unless they be provided with a clean bill of health issued by a physician.

Many other good suggestions were made by the doctor regarding the prevention and cure of these diseases. At the conclusion of the paper a general discussion was had and many points of value were brought out. Dr. Dennis was given a hearty vote of thanks for his earnest and interesting effort. At the business session nothing of

importance was transacted. The meeting then adjourned to Wednesday, December 13, 1905, to be held at the Palantine Hotel, Newburgh, N. Y.

(Signed) L. G. DISTLER, Secretary.

* * *

Wyoming County Association.—The regular quarterly meeting of this Association was held at the Edward House, Attica, N. Y., on Tuesday, October 10, 1905. In the business session the name of Dr. Wallace J. French was proposed for membership.

In the scientific session papers on pneumonia were read by Drs. Lester B. Lougee and M. E. Martin. The next meeting of this Association will be held at Warsaw, January 9, 1906.

(Signed) L. H. HUMPHREY, Secretary.

ADDITIONAL LIST OF MEMBERS OF THE NEW YORK STATE MEDICAL ASSOCIATION.

SECOND DISTRICT BRANCH.

Essex County.—Melvin H. Turner, Ticonderoga.

FOURTH DISTRICT BRANCH.

Erie County.—Joseph Burke, Buffalo; Jacob S. Otto, Buffalo; John V. Woodruff, Buffalo.

FIFTH DISTRICT BRANCH.

New York County.—Winfield Ayres, New York; Harry B. Breckwedel, New York; Frank Churchill, New York; Annie Sturges Daniel, New York; Alfred Waldemar Herzog, New York; Harry Dash Johnson, New York; Jacob Kaufmann, New York; George Edward Maurer, New York; Maurice Packard, New York; Abraham Roginsky, New York; Frederick Schmidt, New York; Samuel Schneider, New York; Richard John E. Scott, New York; Alexander Strong, New York; Faneuil Suydam Weisse, New York; Jacob Lewis Wollheim, New York; Jacques Ephraim Zipser, New York.

Sullivan County.—Frank P. Howser, Bloomingburg; Herbert Maxon King, Liberty; Oscar Northway Meyer, Monticello.

The Committee appointed by the Council to prepare resolutions on the death of the late treasurer, Dr. F. A. Baldwin, beg leave to present the following:

Resolved, That we have heard with deep regret of the death of Dr. F. A. Baldwin, late treasurer of The New York State Medical Association.

As a member of the Council, he was most faithful in the discharge of his official duties. As a member of the Association, he was devoted to its interests and proud of its success. As a member of the profession, he was an earnest and conscientious worker and beloved by his patients.

Resolved, That to all those intimately concerned in and afflicted by this dispensation of Providence, we offer our deep and heartfelt appreciation of the great sorrow and loss that has befallen them.

Resolved, That on behalf of the Council, a copy

of these resolutions be sent to the family and that they be spread in full on the minutes.

(Signed) WISNER R. TOWNSEND,

E. ELIOT HARRIS,

CHARLES ELLERY DENISON,

Committee.

IN MEMORIAM.¹

Dr. Frederick Augustus Baldwin was born January 7, 1846, in the Bloomingdale section of "Old New York." His father was Abner Wade Baldwin, who married Mary Ann Mode. His ancestry was English and emblazoned with prominent names. Among these was Deacon Henry Baldwin, who emigrated to Massachusetts in 1630, probably with Winthrop's colony. The nearest forbears of our colleague settled in Connecticut during Colonial times and thence removed to New Jersey. Others of the kin drifted to Pennsylvania, the frontier settlement of Virginia, Delaware and the Huguenot hamlets of South Carolina. They were people of the best repute, and, according to church records, at peace with God and man.

Dr. Baldwin married Mary Elizabeth, daughter of Stillman A. Field and Lydia Lansing. The Lansings were originally from Holland, well known in the manors north of New Amsterdam, the chief city of the State.

Previous to his graduation in 1881 from the Bellevue Hospital Medical College, Dr. Baldwin's life was not punctuated by any unusual incidents. A high-school preparation with a five years' training in business methods made him exact and analytical. His study of human nature in an East Side dispensary, together with his hospital experience gave him many side views of human nature; if naught else it kept him alert and practical. He aimed to be a general practitioner and to deprive not even the most abject of his efforts to save.

The State Association knew him well as treasurer of the Mott Memorial Library, an office which was a heritage from his devoted friendship to the Mott family. This jealously accurate treasurer, whose name yet adorns without an asterisk the program of the twenty-second annual meeting, had mailed notices two days before his death of a trustees' meeting at the Mott Memorial Library. He died September 21, 1905. Such was the pathetic ending of a noble life warding its eyes against the enchantments of its distant hopes.

(Signed) JOHN SHRADY.

ERRATUM.

On page 399 of the November issue of THE JOURNAL, the cost per volume of the Directory in the Report of the Committee on Publication, was placed at \$1.84; it should have been \$1.08.

¹Read at the Twenty-second Annual Meeting of The New York State Medical Association, October 17, 1905.

Original Articles.

HISTORY OF THE DISPENSARY LAW.¹

BY E. ELIOT HARRIS, M.D.,
New York.

Mr. President, Ladies and Gentlemen:

On account of the number of papers to be presented this evening, in addition to the general discussion of the Dispensary Law, I shall limit myself to a brief presentation of salient facts connected with the history of its enactment. A learned economist has said that all civilized communities have enacted laws having for their object the enforcement of certain restraints upon the appetites, and he states that the so-called benevolent impulses of our nature which move us to give relief to those who may appear to be in distress may often be the cause which creates a new lot of beggars. And he advises that these impulses which may lead to injury, when not guided by reason, should be restrained as well as the appetites. The Dispensary Law, which requires all dispensaries to obtain a license, was enacted to restrain such impulses on the part of those who are largely responsible for the abuse of medical charity through the multiplication of dispensaries, and to act as a deterrent to the fraud so easily practiced on this form of medical charity.

Many persons take their first lesson in the successful practice of the fraud because it is so easy to deceive the individual who admits them for treatment. The scientific workers in the field of charity have educated the press and the public to the full danger of such moral degradation, and to the full value of efficiency when associated with self-respect. The latter is the goal to which all social workers aim to lead their charges. When the first dispensary bill was introduced into the Legislature in 1897 the committees representing the medical societies found the press and public alive to the question at issue and ready to actively cooperate to secure the enactment of the Dispensary Law. As evidence of such cooperation, I quote from a few of the leading newspapers published in 1897.

In the *New York Herald* of June 19, 1897, we find an article describing a visit of a reporter to one of our well-equipped dispensaries. In it he says: "It is difficult to resist the conclusion that not more than one in twenty-five—the pen is tempted to write one in fifty—of the applicants treated at the clinic yesterday afternoon was a legitimate patient." Making due allowance for the reporter's enthusiasm, the proportion would still be very high.

In the *Mail and Express* of May 20, 1897, we read: "The indiscriminate medical charity is but one phase of the morbid philanthropy which seeks to be doing something which appears to

be good—a philanthropy which has done much to degrade men."

In the *Evening Post* an article states that "the free dispensaries which are such worthy charities in theory have through several causes become dangerous menaces to society in general; they absolutely encourage begging and dependence on charity; persons who can well afford to pay for their treatment, and for medicines, have become so hardened, that they will stand on a line, waiting their turn to receive their drugs for nothing."

The *Tribune*, of the same date, says: "The financing of many medical charities gives the impression that it is proper for the citizen to receive something for nothing."

To quote from an editorial in the *Sun*, of May 26, 1897: "Many hospitals and dispensaries intended for the relief of the poor are supported by public money and by private gifts which should not be devoted to those who can afford to pay for medical advice. To permit knowingly such an abuse is entirely indefensible, and is in the nature of a breach of trust, and it is, besides, an encouragement to fraud."

Notwithstanding such general support from the press, the Dispensary Bill was vetoed by Governor Black in 1897; and in 1898 the bill was again defeated, although supported by a joint committee representing thirteen medical societies. When the joint committee of 1898 disbanded it placed the fate of the Dispensary Bill in the hands of the Committee on Legislation of the New York State Medical Association, which committee started an immediate investigation into the causes which led to the defeat of the bill in the previous years. The then Governor Black in an interview kindly restated his reasons for vetoing the bill; and to meet his views, and at the same time to lessen some of the opposition to the bill, certain changes were made, to which I will ask your attention.

The Governor when reviewing his veto stated that every person had a right to establish a dispensary as long as he used his own money in maintaining it, but if he used any money other than his own in maintaining such dispensary, then he could properly be subjected to State supervision. The following extract from the Dispensary Law, as it now appears on the statute book, shows what was added to meet the Governor's views. Section 19 of the law says: "However, that the moneys used by and for the purposes of said dispensary shall be derived wholly or in part from trust funds, public moneys, or sources other than the individuals constituting said dispensary, and the persons actually engaged in the distribution of charities of said dispensary."

The Governor made no objection to Section 23, although it always seemed to me to invalidate the words expressed in Section 19, which I just read. That section permits any person to carry on a dispensary, provided he uses his own money; but what privilege is gained, when Section 23 deprives the individual of the use of the word dispensary

¹Read before the New York County Medical Association, New York, October 16, 1905.

or any of its synonyms? Section 23 of the law reads as follows: "Nor shall any person, corporation, institution, society, association, or agent thereof, except a duly licensed dispensary, display or cause to be displayed a sign or other thing which could directly or indirectly or by suggestion indicate the existence of the equivalent, in purpose and effect, of a dispensary."

Certain unincorporated institutions, such as medical clinics, connected with medical schools, and the dispensaries connected with hospitals, had to be cared for in the bill to avoid their opposition. This explanation will aid you to perceive the meaning of the following from Section 20 of the law: "A license shall be issued on application to all dispensaries legally incorporated, and to unincorporated dispensaries conducted in connection with incorporated institutions at the time of the passage of this Act."

The fears of some of the schools of medicine were quieted with this provision of Section 21 of the law: "The State Board of Charities shall make rules and regulations, and alter and amend the same, in accordance with which all dispensaries shall furnish, and applicants obtain, medical and surgical relief, advice or treatment, medicine or apparatus. But such rules and regulations shall not in any case specify the particular school of medicine in accordance with which a dispensary shall manage or conduct its work or determine the kind of medical or surgical treatment to be provided by any dispensary." The Governor had very decided views upon the subject of giving power to the State Board of Charities to revoke the license of incorporated dispensaries for disobedience of its rules. He said that many of the dispensaries were incorporated long before the creation of the State Board of Charities and he believed that the State Board should not possess such judicial powers. To meet the views of the Governor the following was added to Section 22 of the bill which is now the law: "The said Board is hereby directed to apply to the Supreme Court to revoke the license and annul the incorporation of any dispensary legally incorporated or conducted in connection with an incorporated institution at the time of the passage of this Act for wilful violation of the rules and regulations made by said Board."

The Dispensary Bill was introduced in the Legislature on February 24, 1899, and was signed by Governor Theodore Roosevelt on April 18, 1899.

DISPENSARY RULES

Adopted by the State Board of Charities, and the Policy of the Board in the Enforcement of the Dispensary Law.

Dr. Stephen Smith reviewed Chapter 368 of the Laws of 1899, which was "An Act to Amend the State Charities Law, relating to the Licensing and Regulation of Dispensaries, by the State Board of Charities." This law went into effect

on October 1, 1899. He also presented the report of the Board's special committee on the rules and regulations for dispensaries; together with the rules and regulations, the form of application for a license, and the form of license adopted by the Board, pursuant to the provisions of Chapter 368, Laws of 1899. In this report it was stated that the form and manner of application for a license of a dispensary consisted of issuing to parties desirous of a license a circular, which Dr. Smith submitted in full, which was designed to secure, in writing, such information in regard to the institution as would enable the Board to form a correct judgment as to the propriety of issuing its license. The form of the license issued was that usually employed by the State authorities, which granted license. In preparing the rules and regulations a circular of inquiry was first sent to the managers of all the dispensaries in the State, and to persons known to be interested in their reform, requesting opinions and suggestions as to the rules and regulations best adapted to the objects contemplated by the law. A large number of replies were received, containing many suggestions which were useful to the committee. The committee endeavored to create as little embarrassment as possible in the management of existing dispensaries and yet secure the needed reforms. Rule I required that each dispensary should post a notice conspicuously in the waiting-room, announcing the fact that the dispensary had been licensed by the State Board of Charities to furnish medical and surgical relief to the sick poor who were unable to pay for the same. Added to this notice was the penalty for false representations by applicants in their efforts to obtain medical or surgical relief. This penalty stated that any person who obtained medical or surgical treatment on false representations should be guilty of a misdemeanor, and on conviction thereof should be punished by a fine of not less than \$10 and not more than \$250. Rule II created the "Registrar," a new office in the dispensary, or, rather, a new title to the officer known as the "House Physician." The advantage in this provision would appear in the appointment of a competent person to have charge of the daily management of routine duties, keeping records, etc. Rule III was the most important, because it aimed directly to control the alleged abuse of the indiscriminate treatment of applicants. It prescribed the rules governing the admission of individual applicants. Two classes were to be admitted at once, emergency cases and those evidently poor and needy. Those about whom there was doubt were to be given one treatment and then investigated. The results of investigation had to be filed in the dispensary. Any who refused to sign the card of admission were rejected. On the admission card was printed the representations to which the applicant subscribed

and which covered those subjects most liable to conceal the frauds hitherto practiced upon the dispensaries. The committee regarded this card as the most important of the rules, as it brought directly to the applicant the responsibility which he incurred in signing the card containing his representations. Rule IV provided for a matron, who, in addition to her general duties, should attend women who had to submit to gynecological examinations and operations. Rule V gave force and effect to existing rules of most dispensaries against the treatment of contagious diseases in these institutions. The enforcement of the rule had, however, been so lax that dispensaries had come to be regarded as prolific means of spreading diseases. Rule VI governed the utilization of the dispensary for purposes of instruction and was designed to prevent the use of harsh and compulsory methods of compelling reluctant patients to submit to examinations and operations. Rule VII would eliminate from dispensaries druggists who had had no training for their responsible duties, and would prevent the dispensary being the medium for the refuse stock of wholesale dealers. Rule VIII insured periodical sanitary inspection by the local health boards and immediate compliance with their orders. Rule IX was designed to prevent an inadequate number of seats in the waiting-room, the indiscriminate mingling of the sexes. The committee suggested, in conclusion, that there should be at least two women in the Board of Managers of all dispensaries operating under their own charter and which received and treated women and children. It also suggested that there should be two classes of physicians and surgeons, visiting and assistants. The term of service was limited to three years in a division. The members of both classes should be elected annually by the Board of Managers. Physicians and surgeons should be held more rigidly responsible for the proper treatment of the patients of the classes to which they were respectively assigned. After the rules were prepared a public hearing was given, to which all the managers of dispensaries in the State were invited. On October 10, 1900, these rules and regulations were amended. One of the amendments provided that the "Registrar might select a deputy to perform his duties or to assist him"; instead of "every applicant," the phrase, "or parent or guardian of such applicant," was inserted. Several other minor changes were also made. A special report of the Committee on Dispensaries, in relation to the enforcement of the Rules and Regulations of the Board, was made in April, 1901, after the amended rules had been in operation for five months. In the opinion of the Board the time had arrived when action should be taken to secure compliance with the rules. At this time tables were presented, showing the results of the inspection of the dispensaries of the State and how far the Rules and Regulations of the State Board of Charities were complied with.

THE PRACTICAL APPLICATION OF THE LAW TO THE DISPENSARIES.¹

BY WILLIAM B. BUCK,

Superintendent of Inspection, New York State Board of Charities.

IN the year 1899 as a result of the efforts on the part of the medical profession and others, covering a period of several years, the present dispensary law placing the licensing and supervision of dispensaries in the hands of the State Board of Charities was enacted, after two unsuccessful attempts to secure similar legislation. Rules governing the management of dispensaries were adopted by that Board almost immediately, and a year later a special inspector was assigned to visit and report upon their general management, but particularly as to their observance of the rules.

It is unnecessary to discuss here the history and scope of these measures or their more important provisions, as these have been fully set forth in the papers to which you have just listened and will also appear in subsequent portions of this paper. Suffice it to say that the objects of this legislation were threefold: First, *to limit the number of dispensaries to the real need of the community*; second, *to confine their work to the actually poor*—that is, to persons unable to pay a physician a moderate fee for medical services; and third, *to improve their physical condition and management*. In a word, the law was designed primarily to remove the so-called "dispensary evil," which was commonly held to be the unrestricted multiplication of dispensaries, and the indiscriminate bestowal of medical charity alike upon the well-to-do, the self-supporting and the indigent; and as a secondary but not unimportant consideration, so far as possible, to do away with the unwholesome physical conditions and improper professional practices which in certain instances attended the management of dispensaries.

The question has recently been raised whether the dispensary law has not been a failure. Many interested observers of dispensary matters have felt that the law was not securing any tangible benefits and some have given expression to this feeling either in public or private. One of the students in the New York School of Philanthropy recently undertook to prepare a paper which would show the results of the dispensary law, and gave up the enterprise largely because, after a somewhat cursory examination of the field, she felt, rightly or wrongly, that she could not point out a sufficiently marked difference between conditions as they existed prior to the enactment of the dispensary law and those of the present time. Just here lies the crux of the matter. Is there an appreciable difference between dispensary conditions to-day and those which obtained in 1899, and if so, is this difference sufficiently great to have made this legislation worth while, or must the law be placed in the category of the abortive and the futile? It

¹Read before the New York County Medical Association, New York, October 16, 1905.

seems desirable, accordingly, to inquire briefly into the present conditions as compared with those of 1899 and previously, so as to throw light on these questions, and also on the further question whether or not there are points wherein observance of the law may be extended with good results.

Considerable information as to prior conditions is found in the thorough-going report of the special committee of the State Board of Charities, consisting of Commissioners Smith, Stoddard and Bergen, which appears as an appended paper in the annual report of that body for the year 1899, and the current publications of the same year. As to present conditions the records of the Board, the annual reports of the Committee on Dispensaries, and a special inquiry during the past year made by the Board's Inspector of Dispensaries, Mr. John B. Prest, in reference to the extent of compliance with the Dispensary law, are illuminating. For convenience in comparison these two sets of ascertained facts past and present are set forth side by side.

*Conditions in 1899,
before the Dispensary law
was passed.*

1. A policy of *laissez faire* on the part of the State toward dispensaries in marked contrast to its attitude toward other charities, which resulted in the establishment of large numbers of these institutions, some of them for insufficient or improper reasons, and in a low standard of management after they were established. Anybody, in any place, and at any time, might establish a dispensary and operate the same in the most inefficient manner without the State taking cognizance of the matter.

2. *Dispensaries were located without regard to the needs of the community.*

As suggested above, a dispensary might be set down in any community or in any part of the community which the projectors fancied. Four dispensaries might be placed in a single city block; rival dispensaries were established on opposite corners. Dispensaries were often located far away from the poor districts, and sometimes grouped in a district where there were very few if any sick poor.

3. *Dispensaries were opened in improper and unsuitable buildings, such*

*Conditions at the present
time.*

1. *The former absence of control has been replaced by a system of supervision and inspection by the proper State Department, in accordance with a specific statute.*

No dispensary can now be established without a license from the State Board of Charities, and when established is subject to inspection by the Board, and to rules governing its management. The Board may also recall a license for cause, and has done so when necessary.

2. *The location of dispensaries is now restricted in important particulars.*

No license is now granted by the State Board of Charities unless the applicants for such license are able to show conclusively that a dispensary is needed in the particular locality where it is proposed to establish the same, and that when established it will be properly maintained. The records of the Board show that a large number of applications for dispensary licenses have been acted upon unfavorably for the above reasons, particularly during the last two years.

3. *Suitable buildings, furniture, and other equipment must now be provided,*

as tenements and drug stores, and without adequate or proper equipment.

The abuse known as "the drug store dispensary" is discussed forcefully in the *New York Times* of September 14, 1899.

The report of the special committee before referred to contains the following statement:

"Some of the new dispensaries have still more approved buildings, but considered in the light of modern medical science, it is scarcely possible to find a dispensary building fully answering the requirements which it demands.

"There are dispensaries in full operation in tenement houses, in drug stores, and in dilapidated old buildings and shanties. A dispensary that reports treating 48,000 patients annually, is conducted in a wooden structure 20x12 feet, and 8 feet high. A visitor to that dispensary on a day of average attendance of patients will not be able to enter the building, so great and persistent is the crowd. There are seats for not more than ten of the fifty or more waiting.

"Few dispensaries are properly provided with necessary furniture. The sittings for patients are rude benches, and rarely in sufficient numbers to meet the wants of the crowds attending at the sessions of the largest classes. The apparatus and appliances are of poor construction, and not kept in proper repair nor with aseptic cleanliness."

The following is an extract from a report of inspection made immediately after the enactment of the law:

"Water for use of doctor and patients was carried in a galvanized bucket from the next building. Did not see any basins or other vessels to hold water, other than the bucket. The whole place is about as desolate, cold and dirty as it was possible to be."

4. *Supervision of the work of dispensaries by their board of managers was lax, in many instances.*

Although the majority of dispensaries had responsible boards of managers, some were under the control of a single indi-

ed, together with seats for all applicants.

The Dispensary law prohibits the opening of a dispensary in a tenement-house or drug store, and the State Board of Charities issues no license except upon a report of its inspector, showing that the premises in which it is proposed to locate the dispensary are suitable for the purpose. A recent inquiry by the Board's inspector shows that in 109 out of 119 dispensaries suitable equipment and supplies are furnished; seats for all applicants are provided at all times in 107 out of 119 dispensaries, and in most of the remaining 12 the overcrowding is only occasional, and due to special circumstances. Under a rule of the Board cleanliness and order must be maintained, and the inspector's recent investigation showed that such cleanliness and order were maintained in 115 cases.

4. *The responsibility of the managers of a dispensary for the work done is now constantly emphasized.*

The inspector's reports upon dispensaries visited are now invariably forwarded to the managers for their information or

vidual, and those dispensaries which had boards of managers were not always carefully supervised. In one case the managers visited annually, and in another five times since 1869; in one instance they had never visited. There was no stated way of bringing home to a board of managers its responsibility for the dispensary under its control.

5. *In a number of dispensaries gynecological examinations were made and treatments given by male physicians without a nurse or woman attendant being present.*

6. *The records kept in dispensaries were often unsystematic, inaccurate and incomplete.*

The report of the Board's committee in 1899 showed that in 21 dispensaries no record whatever was kept, and that in 17 others the records were very brief, while in the greater number of dispensaries that reported keeping records, an examination showed them to be worthless for any practical purposes. Four dispensaries kept no financial accounts whatever.

7. *There was no standard of fitness for apothecaries in dispensaries.*

The report of the special committee before referred to contains the following statement:

"While most of the old dispensaries exercise proper care in the selection of their dispensers, many of the new dispensaries have as druggists men whose only qualification is that they have served a term, long or short, in a drug store. In a dispensary which treats 52,000 patients annually, and issued prescriptions for the same number, there were three persons acting as druggists, not one of whom was a graduate of a college of pharmacy. In an-

other dispensary reporting 12,000 patients treated in the year 1895, and prescriptions prepared, the druggist, a man of very limited education, had only served in a subordinate capacity in a drug department of a hospital."

5. *Under a rule of the Board the matron or a female nurse must be present at all gynecological examinations and treatments.*

The inspector's recent inquiry showed that in but 3 dispensaries out of 119 are such treatments given without a woman being present.

6. *As a rule, fairly complete, systematic and accurate records are now kept.*

Each dispensary is required to have a registrar, one of whose duties it is to make and preserve all records. There is still some lack of uniformity in these records, but the statistics required for the annual report to the State Board and those requested by the inspector upon his visits may, as a rule, be obtained from the books of any dispensary. A uniform system of records, combining simplicity and elasticity, would be exceedingly desirable, and an outline for such a system is now in preparation.

7. *By a rule of the Board apothecaries in dispensaries must now be licensed pharmacists or medical graduates.*

In only 3 cases out of 119 is this rule not followed, and in these cases simple prescriptions only are compounded in the dispensary.

8. *The medical service in dispensaries was sometimes inefficient and irregular.*

From the report of the special committee the following statement is quoted:

"It has long been an opinion current in the medical profession that the treatment of patients is very inefficient in the dispensaries. This fact is better known to physicians connected with the hospitals where the results of treatment at the dispensaries come under their special notice through the patients who come from the latter to the former."

The report then goes on to say that it is not surprising that even the best physician in a dispensary fails frequently in his diagnosis when the conditions under which he performs his duties are considered. These conditions were, in brief, the lack of seclusion and quiet, the large number of patients to be treated in a given time, and the absence of proper facilities. The following is an excerpt from an inspector's report made in 1899, which indicates lack of faithfulness on the part of the medical staff connected with the dispensary:

"Called January 2d at the hour of opening, as indicated by the printed card, viz., 2 o'clock; place was closed; waited until 3.30, and no one appearing, retired."

"January 4th, visited the place again; found it open at 2 o'clock, and three women awaiting the arrival of the doctor, who did not appear until 3.30."

9. *Lack of care in the handling of contagious diseases and in the separation of the sexes was common.*

8. *Considerable improvement in the faithfulness and efficiency of medical service in dispensaries is noted.*

With very rare exceptions dispensaries are open during the advertised hours, and physicians perform their duties with care and interest. Any neglect on their part is brought to the attention of the managers. In a few dispensaries, which are fortunately the exception—chiefly the small dispensaries connected with struggling churches—the medical staff is sometimes less punctual and faithful than is to be desired.

9. *Persons suffering from contagious diseases are now excluded from dispensaries, and where such persons apply for treatment they are immediately isolated, and the matter reported to the Board of Health.*

The report of the special committee referred to

Each dispensary is required by a rule of the

above contains the following statement:

"Too often the waiting-room receives every class, men, women, children and infants, all suffering from some form of disease. It is no uncommon occurrence to find among the waiting crowd, infants suffering from diphtheria, children in the early stages of scarlet fever or measles, adults in the later stages of consumption. Here this motley gathering of persons suffering from all forms of contagious and infectious diseases, mingle together for hours without any attempt at separation or isolation of classes of cases. When dispensary hours are over, there is no adequate airing and ventilation of rooms, and the following day a new crowd of susceptible people fill the rooms again from morning to night. It is quite impossible to devise a more ingenious method of propagating all our domestic pestilences than that furnished by the dispensaries."

10. *There was an almost universal lack of sufficient care in the admission of applicants, and almost no investigation as to their ability to pay.*

As to this matter, the report of the special committee states:

"An examination of applicants to determine whether they are of the poor and needy class, entitled to gratuitous treatment, is very imperfectly practiced in a number of the dispensaries. In many the only method pursued is to ask some very pertinent questions about income and cost of living of each patient, the purpose of which they immediately apprehend, and for the most part answer accordingly. A large number of institutions make return that the method of determining the ability of the patient to pay is by their personal appearance. Five dispensaries frankly admit that no question is asked, and no attempt is made to discover the applicant's worthiness.

"As no effort is made to investigate the homes and determine the character and financial circumstances of each patient, any one can visit different dispensaries without detection."

State Board of Charities, and a similar ordinance of the New York City Board of Health, to isolate applicants found to be suffering from a contagious disease. Observance of this rule and of the ordinances of the Board of Health is reported as complete in all of the dispensaries of the State. The present tendency to provide a number of separate clinic rooms in each dispensary makes possible the separate treatment of diseases which were formerly treated in the same room.

Another rule requires the separation of the sexes, excepting family groups, in both waiting and treatment rooms.

10. *As a rule care is now used in the admission of applicants to the dispensaries of the State.*

The dispensary rules require the appointment of a registrar, whose chief duties are those of an admitting officer. He is required to receive and examine all applicants and to determine the question of their admission. His discretion in the matter is further limited by rules requiring that all emergency and needy cases shall be admitted promptly, that persons able to pay for treatment shall be excluded, and that those in regard to whose ability to pay the registrar is in doubt shall be admitted to a first treatment only on signing a representation card. The examination on the part of the registrar is reported as being thorough in 54 cases, as being fairly thorough in 31 more, and as superficial in 34 instances.

The rules also require that a subsequent investigation be made in the cases of persons who sign representation cards. Although this is the rule at present the least well observed of any (41 out of 119 dispen-

saries), yet its enactment has set up a standard to aim toward, and the number of dispensaries complying with the rule has increased steadily from year to year. The number of investigations has also increased in the same manner. It is apparent, however, that much is still to be desired in this particular.

The foregoing statement of conditions shows that there has been a marked improvement in certain features of the dispensary situation as a result of the enactment of the dispensary law and its administration up to the present time. A condition of anarchy has been replaced by one of law and order; dispensaries have been driven from drug stores and tenement houses and their location restricted by law and the requirements of the State Board. Dispensary buildings are now usually suitable, clean and in good order, and their equipment adequate. The responsibility of dispensary managers has been consistently emphasized. Women patients are no longer examined or treated alone but in the presence of a matron or female nurse. Instead of incomplete and inaccurate records an officer is provided to make and preserve suitable and accurate accounts of the work done and statistics are collected yearly in regard to this work. The apothecaries are no longer "drug clerks," but licensed pharmacists. Instead of frequent cases of negligent medical service such service is now, as a rule, prompt, faithful and thorough. Persons suffering from contagious diseases are immediately isolated and reported to the Board of Health, where they were formerly permitted to mingle with other patients. In a majority of dispensaries care is taken in the admission of applicants.

The system of regulation provided in the dispensary legislation of 1899 has also resulted in a diminution in the number of dispensaries from 136 in 1899 to 119 in 1904, and that in spite of the marked increase in population. The population of New York City alone has increased 150,000 annually in that time. The number of beneficiaries has increased only slightly in that period (from 932,672 to 1,009,334, or about 77,000), while the number of treatments given has grown from 2,196,723 to 2,825,649, an increase of more than 800,000. This would seem to indicate that the number of persons receiving charity in dispensaries is not increasing in proportion to the increase in population and that more attention is given the individual patient than formerly.

The statement shows, however, that much remains to be done. A uniform system of keeping records and accounts of dispensaries should be adopted and more care in the admission of applicants and in the subsequent investigation of doubtful cases is imperatively needed. Inquiry at the office of the Charity Organization Society develops the fact that doubtful cases are often not

reported by the dispensaries until several days or even weeks after the application is made. These investigations are not always made by the Society until after more pressing cases are disposed of and, consequently, the reports reach the dispensary too late to be of much value. Considerable progress must be made in these matters before satisfactory conditions are obtained.

The facts stated do not answer the query raised at the outset completely or finally, but they show a degree of progress that is most encouraging when the complexity and the difficulty of the situation which the law was designed to meet are duly considered. Further progress is apparently both possible and desirable, but it cannot be secured by the State Board of Charities or by the Medical Association alone. The interest and co-operation of dispensary officers, physicians and managers in this State are essential if genuine and lasting progress is to continue. The fact must be thoroughly appreciated by all parties concerned in this matter that the Dispensary Law is not a creation of the State Board of Charities or of a few physicians, or of any group of people, but is the expression of the serious purpose of the community as a whole to safeguard its social interests in two ways, first by restricting the bestowal of medical charity to persons unable to pay for the services of a physician, and second, and at the same time by insuring to the actually poor prompt, careful and considerate treatment.

THE EXPERIENCE OF THE SPECIAL INSPECTOR OF DISPENSARIES.¹

BY JOHN B. PREST,

Inspector New York State Board of Charities.

I HAVE been asked to address you, giving the experience of the special Inspector of Dispensaries of the New York State Board of Charities. My qualifications to speak upon this subject consist of about five years' service for the State, during which time I have visited every dispensary from New York to Buffalo, from five to upwards of twenty times; have investigated on behalf of the State a considerable number of unlicensed dispensaries, medical companies, medical institutes and money-making schemes; I have examined new dispensary organizations and studied their growth and operations from many points of view.

In addition to reading much that has been written upon the question of dispensary abuse, at home and abroad, I have inspected the casualty and out-patient departments connected with several of the large hospitals in London and I have gained by personal observation some impressions relating to dispensaries in other localities.

During the first year of operation of the New York Dispensary Law, the Board had no special

inspector to visit these important charities, but assigned one of its women inspectors. She was able to give the work only that fraction of her time which could be spared from other duties. The next year the Legislature provided the salary for a man inspector and I was chosen. Since December, 1900, practically my entire time has been devoted to dispensaries.

Prior to the commencement of my duties with the State Board of Charities, about 125 licenses had been granted to dispensaries in various parts of the State; the rules and regulations in accordance with which dispensaries were to give medical and surgical advice and treatment had been given a year's trial, and the original rules which had proven rather too drastic had been modified by amendment.

When I first commenced to go to the dispensaries, some of which had never been visited by a State inspector before, considerable hostility was shown. Some of the persons in charge of administration appeared surprised to see me and others questioned my authority to inquire into the methods and the every-day workings of the dispensary. In several instances it was made clear that as an inspector, I was unwelcome. A few seemed interested to know what advantage there was in answering all sorts of questions put to them by a stranger. Opinions were expressed that the dispensary law was a failure.

In some places, more particularly outside of New York and Brooklyn, where inspections were infrequent and where hospital internes conducted the dispensary service, ignorance of the law was encountered. On two occasions in different cities of the State where I had gone to inspect the dispensaries, the superintendent informed me that their medical internes had declared that there was no State supervision of dispensaries and that the dispensary inspector was a myth. In each case the superintendent summoned the internes and showed apparent delight at the discomfiture of the young physicians on being confronted with the inspector.

Opposition made itself apparent in other ways. Licenses were lost and few seemed to care whether they had a license or not. At many of the institutions the licenses were not framed. At other institutions some of the doctors seemed to think the licenses might be carried around in the pocket of the physician, and with the license in his possession, it would be legal for him to open a new dispensary anywhere and at any time. An instance of this was discovered when I went to inspect a dispensary in Harlem and found the building vacant. A merchant doing business next door to where the dispensary was formerly located, informed me that the dispensary closed a few months before, but he had since heard that it was started again about three or four blocks down the street. Following the directions given, I found, sure enough, the dispensary had opened up again and this time in a twenty-family tenement house. The facts were reported. That

¹Read before the New York County Medical Association, New York, October 16, 1905.

dispensary-is not doing business to-day. Its license has been canceled.

As is well known, the regulations provide that a public notice shall be posted in the reception room for applicants, calling attention to the fact that the dispensary is for the poor only and quoting a section of the law. Instead of posting a notice that could be seen across the room by newcomers, a typewritten notice was posted in an obscure corner in several of the dispensaries. In other institutions the required public notices were written with ink and a fine-pointed pen in letters hardly legible at short range. One institution was found where the registrar had a notice two by three inches in size fastened upon the wall with a pin.

Six years ago little was known as to the number of cases treated at the various dispensaries. Some figures had been compiled which seemed to indicate that half of the population of the City of New York was treated at dispensaries each year. This statement, however, was disputed. When I first visited the dispensaries and inquired as to the number of cases, in many instances I found that no record had been kept. On further inquiry as to the basis for the figures given in previous annual reports made to the State Board of Charities, I found that the number of cases reported had been estimated.

Such were some of the conditions which confronted the inspector in the early days of his work. The attitude of the managers and those members of the medical profession whom the inspector met at the dispensaries gradually changed. On successive visits I found that many of the physicians had become interested in the work and seemed to realize that some good might come out of it.

At first this interest in many cases was prompted by mere curiosity or impelled by a desire to know more of the affairs of a rival dispensary. There was a peculiar and almost amusing attitude noticed which, if I may be permitted, I will mention here. The physicians were always interested in the affairs of other institutions of a similar kind, especially those in the same locality. Often when I inquired about the use of the representation cards which are, as you know, designed to restrict the use of dispensaries to the poor, the physician in charge would remark that in *his* dispensary they were hardly necessary, saying, "Our dispensary treats only the very, very poor and needy patients," while "the dispensary across the street treats many rich patients and does not discriminate at all."

But in general it has been very apparent to me that while the law some years ago was little thought of by the medical men in charge of dispensaries, now to a very large extent the same persons look upon the law with favor. At that time they seemed to care nothing at all for the State license and considered the formalities necessary to acquire one an unnecessary bother. Many of them now look upon the license as a valuable

asset and they indicate clearly that they believe applications for new licenses should be closely scrutinized and issued only in most urgent and desirable cases.

The records kept at most of the dispensaries are now very complete, showing the total number of treatments and also the number of new cases; whereas, prior to the time when dispensaries were regularly inspected under the supervision of the State Board of Charities, the statistics were incomplete and were kept on a yearly basis. They are now compiled each month. This enables a more frequent comparison of results, stimulates interest and insures greater accuracy. This has been accomplished by frequent inspections at which the number of cases treated month by month was asked for. When such figures could not be furnished that fact would appear in the report of the inspector sent to the institution, and by this means conditions have been greatly improved.

The statistics now gathered by the State in regard to the volume of relief given at the dispensaries are precise, and trustworthy figures can be given to prove that one-half of the population is not treated at dispensaries as formerly reported.

Of all the regulations governing dispensaries the one calling for use of the representation cards, which, as I have said, are designed to restrict the dispensary privilege to the needy poor, and the requirement that doubtful cases be investigated, has caused the most opposition and brought forth the loudest protest. The managers seem to want to make a record showing a large number of cases treated, influenced somewhat no doubt by the increased revenue resulting from a large number of ten-cent fees received from patients.

Hospital superintendents also tell me that if their dispensary registrars should restrict the cases admitted to those applicants who are clearly too poor to pay a physician, the clinics would be so reduced that it would be impossible to retain the most experienced specialists on their respective medical staffs.

I observe that the physicians are inclined to treat all who apply and in so doing they no doubt meet a greater number of interesting cases which, as they receive no pay, are their only compensation.

My impression is that where the registrar has exercised extraordinary diligence in questioning applicants as to their ability to pay for treatment, such practice has met with disapproval and discouragement from the doctors.

However, even this much-abused regulation is now more generally observed than formerly—in some cases grudgingly, it is true, but it *is* being observed. An instance came to my attention in one of the up-State cities. In New York, as you are aware, doubtful cases are investigated by the Charity Organization Society, but in the city in question—there being no such organization—the superintendent of the hospital sent some of the

representation cards to the chief of police with the request to investigate the cases. A sergeant of police was detailed and he called at the addresses given on the cards. I am told that when the police officer in full uniform visited some of the addresses shown on the representation cards consternation reigned in those families, and it is needless to say that those persons did not try to get free medical treatment at the dispensary thereafter. The method pursued in this instance was, no doubt, too drastic, but it showed that the hospital authorities sought to comply with the spirit of the regulations, using such means as were at hand.

This incident stands out in pleasing contrast with the instance where the registrar of a dispensary informed me that he had been instructed to fill out just three cards each month in order to satisfy the State inspector.

All the important dispensaries have a pharmacy or drug department of their own. Such pharmacies are useful in supplying quickly and economically such medicines as the various physicians prescribe, and generally the pharmacy is a source of considerable profit to the institution.

In several instances I have found that these pharmacies do not hold a certificate of registration, as is required by the State Pharmacy Law, and also that they are not being regularly inspected by the inspectors of the State Board of Pharmacy. As is natural under the circumstances, the standard of such pharmacies has not been kept up.

Recently I have been looking into the source of the supply of dispensary bottles. The general practice is for the patient to bring a bottle, but as this is not always done, it is necessary for the dispensaries to supply some bottles. I have found that some of the New York dispensaries purchase from time to time, from second-hand dealers, a cheap assortment of bottles gathered from nobody knows where. In one dispensary the other day I found a meal sack filled with second-hand bottles purchased at 90 cents a gross. The drug clerk volunteered the information that the institution could not afford to buy new bottles and give them away filled with medicine for ten cents.

Some of the largest and finest dispensaries in New York exchange the bottles brought in by patients, giving out to different patients to-morrow such bottles as were received from the patients who came to-day. Unsuitable bottles are destroyed. Where competent pharmacists are employed and proper bottle-washing facilities are provided, this practice is both economical and satisfactory.

Some other dispensaries do not supply any bottles. This is the case at a certain dispensary near the seashore. The patients are instructed to bring a bottle. When I inquired what was done when the patient was unable to procure a bottle the resourceful interne at the dispensary responded quickly, that such patients were advised to go out on the beach, as a bottle could always be found there.

Ordinarily dispensaries are supposed to be charitable institutions, but like things American, they are to a considerable extent becoming infused with the commercial spirit. I refer to the payment of small fees by dispensary patients. These fees amount in the aggregate to considerable sums of money. In a number of instances the revenue nearly equals the operating expenses, and in other dispensaries a surplus has been created.

Coupled with the fee system has been the acceptance of public appropriations from the municipal authorities, though the custom of giving municipal appropriations to dispensaries is gradually being curtailed in New York.

To show to what extent this money-making practice has been carried, and the original, primary, charitable function of the dispensary lost sight of, I wish to call attention to an extreme case. An instance which is within my experience as an inspector arose in a dispensary in this borough situated in a densely populated locality. It had a popular medical staff which attracted numerous patients and the fees received from them together with the proceeds from the sale of medicines, amounted to a considerable sum. This dispensary also accepted an appropriation each year from the City of New York and soon a considerable surplus was accumulated. The governing board held a meeting and voted to divide up the surplus among themselves. This plan was actually carried into effect and the sum of \$1,500 was divided among the trustees of the dispensary.

Another phase of the commercial spirit and its effect was illustrated at a large dispensary recently where a workingman without hat or coat came with a lacerated hand. The registrar demanded ten cents before the sufferer could see the surgeon. The man, his one hand dripping with blood, produced with the other a bill of generous denomination and the registrar made the change. The man was then treated.

The price paid at the dispensary was much cheaper than that of any private physician and the workingman, as in the case of most people who have paid the entrance fee charged at a dispensary, departed, with the impression no doubt that he had paid in full for the services received.

Now, in conclusion, we realize that dispensaries are a necessity in all large cities. Their uses and abuses form a complex problem which has everywhere received much attention and is being more and more considered. I believe, however, that in the State of New York where the regulation of dispensaries by statute has been tried for six years, that the problem is nearer solution than in any other place.

First: The dispensary law has resulted, in my opinion, in placing a permanent and desirable check upon the indiscriminate establishment of dispensaries throughout the State of New York.

Second: It has, to a large extent, weeded out the institutions not possessing real merit.

Third: It has secured the adoption of more uniform methods of administration.

Fourth: It has greatly improved the record systems at the several institutions, resulting in more trustworthy statistics.

Fifth: It has established better cooperation between dispensary officers and charitable societies.

Sixth: It has strengthened the institutions now existing and closed the less desirable ones.

On the other hand, the law has failed to effect a permanent check upon the total volume of medical and surgical relief given at the dispensaries. In my opinion, this is not the fault of the law, or the rules and regulations, or the methods of enforcing the law by the State Board of Charities, but is due largely to other causes, viz.:

First: The growing competition for cases fostered by the medical schools, both primary and post-graduate, and the operation of dispensaries as feeders for hospitals.

Second: The commercializing of the dispensaries to make them self-sustaining.

Third: The subsidizing of the dispensaries by the public authorities.

THE PRACTICAL VALUE OF THE INVESTIGATION OF DISPENSARY CASES.¹

BY EDWARD T. DEVINE,
New York.

I AM asked by the committee to state from my experience with the Charity Organization Society what is the immediate, practical, direct effect of the investigation of dispensary cases, and all that I can say is that, judging from the total number of cases sent by the dispensaries to the Society for investigation, and by the results of these reports in influencing the action of the dispensaries the effect is very slight indeed. Altogether about 34 of the dispensaries in the city, out of a total of 119 in the State—most of them in the city—in other words, about one-third of the city dispensaries, have referred any cases for examination. Some other dispensaries have employed a visitor to investigate their own cases, but the number doing this is very small. During the last year these 34 dispensaries reported altogether 1,500 cases, or about 1 in 700 of the cases reported in the State as a whole. Nearly a million of the individuals treated were in New York City, but not more than 1 in 600 of these were reported for investigation. It is understood, of course, that the registrars shall report the suspicious cases only—those which in their judgment seem to call for payment of the private physician. All I can say is that there must be a great many registrars who are not very suspicious by nature.

I am far from being pessimistic about the operation of the dispensary law, and I think that the showing made by Mr. Buck and Mr. Prest is a very good one on the whole. There is no doubt of the excellent effects that have followed the

enactment of the law, the limitation of the number of dispensaries and their proper geographical distribution, the improved methods of operation and sanitation, the separation of the sexes, etc. All of these have been exceedingly desirable results, but I would have you note that it has been practically admitted in the discussion that the fundamental purpose for which the dispensary law was enacted—the restriction of free charitable treatment to the sick poor—has not yet been accomplished.

If it be the primary object of the dispensary law to limit free medical treatment to the sick poor, it is clear that the more drastic measures to which the chairman of the committee referred will have to be employed. It would be a comparatively easy matter for the dispensaries on a large scale and in perfect good faith to cooperate with the State Board in a literal and complete enforcement of the law. To investigate these 1,500 cases sent in by 34 dispensaries during the past year, it has cost the Society about \$200.00, if we consider the service only, or about \$300.00 including carfares, etc. Thus far the Society has borne this expense, and it is willing to do so on the present scale. If this service should be extended it might be greater than the Society could bear; but if this expense were distributed among the dispensaries it would not be large on a pro rata basis—something like fifteen or twenty cents for each investigation. A considerable number of the cases referred to us are not found at all at the addresses given, and this, of course, reduces the average expense of the inquiries.

Aside from the small number of cases reported for investigation, what are the reasons for the actual effect of the investigations being so slight? In the first place, because the cases are not apt to come in promptly. After the treatment which the patient has desired is finished, it is no more a matter of concern to him whether he is accepted free or not. The figures represent two and a half times as many treatments as patients, indicating that only two or three calls are made by each patient. Consequently, the inquiry must be prompt if it is to have any effect on the patient. Again, many of the dispensaries send in an inquiry a second or a third time for the same patient, indicating that the records are not kept properly. We do not complain of that, as it is a very easy matter for us to see that such a report was made two or three months ago, and to repeat the information. It is true that of these 1,500 cases only a small proportion are people who would be entirely unable to pay, and some of these tell us that they have gone to a dispensary at the suggestion of a physician. Within a few days such a case has come to my notice—a fireman, whose salary begins at something over \$100. He was a married man with no children. He expressed great surprise when he was interviewed by our visitor, and said that he had gone to a physician connected with

¹Read before the New York County Medical Association, New York, October 18, 1906.

that particular dispensary, and the physician had asked him why he did not see him in his dispensary hour when the treatment would cost him nothing. It was rather awkward for us, but we are accustomed to awkward situations, and our visitor backed out as gracefully as possible.

After all, the case is not so simple as some of these things which I have myself said, and which others are accustomed to saying, would indicate. The difficulty lies in the fact that with the best intentions to agree about this matter and to restrict free medical treatment to people who ought not to be asked to pay, we have not been able to agree as to who ought to pay. We are not at all clear in our own minds about our standards. I am not even sure that every fireman getting \$100 or more should be asked to pay for every form of medical or surgical treatment he may require. I am not sure that we take into consideration the enormous cost of living in New York City in deciding whether such people are or are not fit subjects for treatment; and, from the public point of view, I am not sure whether people should not be encouraged to come for free treatment instead of being checked. If you think for a moment of the great number of tuberculous, venereal, and other infectious diseases from which the public should be protected, it might be thought best to adopt a more liberal standard and provide free treatment for many who are not now receiving the treatment which they should have.

THE QUESTION OF MEDICAL CLINICS IN RELATION TO THE DISPENSARY LAW.¹

BY JOHN A. WYETH, M.D.,
New York.

I HAVE always held the opinion that the framers of the act known as the Dispensary Bill were guided by the highest and best motives for the welfare of both the public and the profession, and that in no sense was it intended that it should be prejudicial to the interests of the medical clinics in connection with recognized medical institutions of New York City. Holding this view of the bill, the medical staff of the New York Polyclinic Medical School and Hospital added their influence to secure its passage. It was our policy even before the bill was introduced to be guided by a proper conception of the relation of our faculty to the profession of the city as well as the social body, regardless of any law, and since its passage to cooperate with the Charity Board in stamping out those institutions which formerly were so closely allied to charlatanism and quackery.

Since October, 1882, when we opened our public clinic in 34th street, it has been the established custom of the medical staff to discourage attendance at these clinics of persons seemingly able to pay even a moderate fee for necessary professional services at their homes.

There is no doubt that no matter how vigilant the public clinician may be he is not infrequently deceived as to the financial condition of an applicant for free treatment; but by practicing proper scrutiny and insisting that the members of his staff who come more immediately in contact with the overflow shall do the same it soon becomes known that at the clinics of a dispensary managed in this fashion those who are not really worthy need not apply. I have observed that while such cases were quite frequent in the earlier years of our institution, in later days it is very exceptional when a patient of this character is encountered.

I cannot doubt that the medical profession at large in New York City, certainly the better element of the profession, is heartily in sympathy with those who are connected not only with the graduate but with the post-graduate medical schools in the effort to make of this metropolis the medical as well as the financial center of our continent. They know full well that one great reason for our not yet having achieved this success is the lack of money from city and State appropriations, such as, for instance, are allotted to the medical schools of Philadelphia.

To be successful and to attract the outside profession to these schools there is needed a large clinical material, which requires the maintenance not only of a dispensary but of a hospital, and a consequent entailment of great expense. Speaking with knowledge and authority for one of the two post-graduate medical schools, and being closely enough in touch with its friendly rival to know something of its affairs, I can assert what I believe is already generally known, that there are no emoluments, financial or otherwise, equal to the expenditure of private means and of time devoted to this work which otherwise employed would mean a larger financial return.

We are simply working with the high aim of improving the condition of our profession and of remedying, as far as laboratory and clinical post-graduate work may remedy, the deficiencies of much of the under-graduate methods which prevail in the United States.

The purposes of the bill, as I interpret it, were: To restrict the abuse of medical charity by a certain class of persons who, notwithstanding their ability to pay for professional care at their homes, take advantage of the free treatment offered at these public institutions: and the protection of those who are entitled by reason of their poverty to free treatment from certain professionally incompetent and morally deficient persons who take advantage of the dispensary method of advertising to secure small fees for the sale of drugs and for services.

The results of the passage of this bill, so far as I am able to judge, have been satisfactory, and great credit is due to the State Board of Charities, which was empowered by the act not only to issue licenses but to apply to the Supreme Court to revoke those already in existence when, in

¹Read before the New York County Medical Association, New York, October 16, 1905.

their opinion, the institutions holding them were not properly managed.

DISCUSSION.

The general discussion which followed was opened by Dr. Joseph D. Bryant.

Mr. President, Ladies and Gentlemen:

My qualifications for speaking upon this subject do not relate to modern methods of practice in dispensaries, but my qualifications for speaking of the earlier treatment of patients in dispensaries are ample, and without multiplying words, I can confirm in every instance the experience of those who have criticized them—no separation of the sexes; no records of cases, except those scribbled down in the most hurried manner, and these when kept were written in the promptest possible manner.

Since that time, however, a great improvement has taken place. My later experience relates to the appointment of the attending staff, and the young men who are appointed for the purposes of attending patients in the dispensaries are, as a rule, first-class, able, competent young men with an experience which warrants their appointment, the majority of whom have already served in hospitals. Whether or not these young men attend properly to the patients, whether or not they are constant at the hour allotted to duty, I am not certain. Probably many of them are late, many are detained, many do not come at all, or at least come irregularly. The picture drawn of waiting patients in a dispensary is not a new one. It is a common occurrence, but I am not disposed to blame the attending physicians or surgeons of a dispensary as much as I do those who are over him, because if an attendant be held strictly to an account in the care of patients, and promptly dismissed if not efficient, improvement in the service will follow.

I am aware, too, of the fact that many patients that visit dispensaries are unworthy of the opportunity offered for their relief. I do not care to deal in traditions, but there are many who will recall the fact of wealthy patients who have attended dispensaries and claimed the right of treatment because they were taxpayers.

Another feature, which has been ably and emphatically presented by Professor Divine, should be taken into consideration. Not all patients who come to the dispensaries dressed well are able to pay. You may think them able, but look around, and you will meet men in all walks of life from whom one cannot collect an honest debt of smallest dimension. They spend all they have either on themselves, or in themselves; yet when ailing they are entitled to treatment at a dispensary, as it seems to me.

The question raised by Professor Divine as to where the line should be drawn is one of the most important that can be raised. Living, comfort, capacity to enjoy one's self, are always comparative. That which satisfies me, according to my means, might not satisfy some one else of equal or larger means. A person with a large family

may find it impossible to suitably recompense a physician. Shall this family be excluded from the dispensaries? If not, under what circumstances should they be? I think, so far as this question is concerned, the method of living, the place where one lives, the food one takes, the number in the family, etc., are matters which, although they cannot be determined accurately, should, nevertheless, receive careful consideration, because we cannot say to the people with whom we deal in this regard that such and such shall be your food, and such the clothes you shall wear, etc., before being entitled to dispensary attention.

One may claim that if any unworthy patient who is ill visits a dispensary and receives a prescription, in other words, keeps what he has and gets what he can, he is debased. Perhaps he is, but what would be the effect if he were to receive from the manager of a theater a free ticket? They both belong to the same category—"getting what one can for nothing," or "keeping what one has and getting what one can." So, after all, as it appears to me, the manifestations noted in the dispensaries are simply the manifestation of a common practice which extends "higher up" into the activities of life. Still we must not be discouraged.

As far as I am concerned, I believe in the Dispensary Law and in the *practical* rules which have been established by the Commission, and I believe that they should be reasonably enforced. I cannot see why my distinguished friend, Dr. Smith, should feel, as his words would seem to indicate, discouraged, for the reports of those following his own seem to mark great improvement and furnish a strong incentive to continue the work. Any influence which I may be able to exercise toward carrying out *proper* rules in this respect will be freely, cheerfully and promptly given.

George W. Gay, M.D., of Boston, said:

Massachusetts has no dispensary law. That she needs one or needs some sort of regulation of the present unjust and unwarrantable abuse of her medical charities is shown by the fact that the number of persons who receive annually free treatment in the 75 hospitals and dispensaries in the City of Boston is equal to one-half of its entire population. After making due allowance for the "repeaters and rounders," and for the out-of-town patients, it would be safe to say that at least one-fourth of these people are able to pay for the necessary services, and are, therefore, unworthy of the charity which they receive.

In Philadelphia, with its 60 hospitals and as many dispensaries, more than one-fifth of the population are annually treated as charity patients. In this great City of New York, with about 90 hospitals and nearly as many dispensaries, approximately one-fourth of the people receive free medical and surgical treatment every year. Sir Henry C. Burdett is authority for the statement that one third of the inhabitants of London depend upon charity for medical services. Boston would thus

seem to hold the unenviable position of having the largest number of mendicants in proportion to her population of any of the cities under consideration. As she is said to be one of the richest cities, per capita, in the country, how can this peculiar condition of things be explained except upon the supposition that a considerable proportion of these people are able to pay for what they need, and hence abuse their privileges?

Over 300,000 persons receive practically free treatment in the hospitals and dispensaries of Boston every year. The number of surgical operations performed upon them must approximate 25,000 annually. A pretty conservative estimate of the commercial value of this enormous amount of work foots up to about ten millions of dollars annually.

For doing this great service the physicians and surgeons receive no direct compensation whatever in the way of salary or fees. The experience and reputation gained thereby are valuable, but in the opinion of most well-balanced minds they do not justify this wholesale, promiscuous, unrestricted and unwise dispensation of medical charity. The custom at present in vogue in our State ignores justice to our profession, without whose services there could be no medical charity; it ignores common business principles, as well as the plainest rules of common sense; it tends to demoralize the individual, and encourages laziness, deceit and pauperism.

That the profession are alive to these facts was made evident recently in the following manner: The reader sent a series of questions to over 400 physicians in our vicinity of all grades and schools, and in all social and professional circles. The first question was this: In your opinion is medical charity abused in the hospitals and dispensaries of Boston and vicinity?

One gentleman, a noted pathologist not in active practice, answered in the negative; two replied "not much," and 302 replied in the affirmative.

Another query of the series: Do you think that patients who are able to pay for a private room in a hospital should, as a rule, pay the physician who takes care of them? Eighteen said no; four were doubtful, and 295 said yes.

Again: Do you think that physicians who give their services to the poor should be required to treat the rich and well-to-do patients in our hospitals and dispensaries for nothing? Ten said yes; two were doubtful; 310 said no, and most of them said it in italics.

While there is no concerted action among the hospitals and dispensaries in Boston looking to an abatement of the evil under consideration, yet considerable is being done by certain institutions in this direction with excellent results. The rule in most of our hospitals is to require all who are able, to pay something for their board and nursing. Members of the staff in most of them can have private patients in the private rooms upon the same terms as in their own home or elsewhere. The Massachusetts General Hospital is the only

large general hospital that forbids fees to members of the staff under all circumstances. This hospital, however, has an excellent system of inspection in its out-patient department, thereby protecting its staff and the profession. About a hundred are refused treatment every month by reason of ability to pay for the necessary service.

The Boston City Hospital receives over 9,000 house patients and more than 60,000 out-patients annually, and has no system of exclusion whatever on the above grounds. The physicians and surgeons are allowed to collect fees from their own private patients occupying private rooms, but cannot charge those who were admitted directly from the superintendent's office. This hospital is supported by the city, and the probability of our obtaining much relief may be inferred from the fact that last summer the city government passed an order requesting the trustees of the institution to keep the out-patient departments open from 9 to 2 and from 6 to 7 in the evening. Thus far the request has not been complied with.

The Massachusetts Charitable Eye and Ear Infirmary, under the admirable management of Dr. Farrar Cobb, has instituted a most efficient method of inspection, which accomplishes the desired object to a most satisfactory degree. During the three months that it has been in operation over a thousand patients have been directed elsewhere as not being worthy recipients of the charity. No patients are received who can pay over \$6.00 a week, as the institution is designed for the poor only.

The Massachusetts Homœopathic Hospital is managed upon strict business principles, the physicians sharing with the hospital in whatever the patients are able to pay. All patients occupying private rooms and paying \$15.00 or over per week for board must pay the attending physician a reasonable fee, which is agreed upon in writing before entrance, or upon the first visit, and filed with the superintendent. Furthermore, any member of the staff may take a private patient to that hospital, and if he pays \$7.00 per week for board, the physician may charge a fee for his professional services, but it is to be paid only after the hospital charges have been settled. The Homœopathic Dispensary, a separate institution, has no system of inspection.

The Boston Dispensary, our oldest charitable institution of its kind, has over 40,000 patients annually. The doors are wide open, and there is no exclusion for any reason. The abuse of this charity is said to be moderate in degree, not flagrant, as in some of the other clinics. The objection to an inspection is the expense.

With the exception of the Children's Hospital no other outdoor clinic in Boston, so far as known to the writer, has any system of inspection or exclusion. That the matter is an important one is plainly evident from the fact that physicians living in the vicinity of some of the dispensaries say that they have no office practice, that the people in the neighborhood all flock to

the hospital. The temptation to get something for nothing is too strong to be withstood by the ordinary individual without a little help from some sort of a barrier.

For more than a quarter of a century a portion of the profession for various motives has been educating the public to the idea that the hospital is the best and cheapest place to obtain advice and treatment in time of accident or sickness. The public are apt scholars when their pockets are involved, and they have learned their lesson but too well. The trend of the people towards the free clinics was never so universal as at the present day. As the profession has been largely instrumental in bringing about this unfortunate state of affairs, it devolves upon us to correct it as far as we can.

Dr. John M. Peters, the able superintendent of the Rhode Island Hospital, has solved the question admirably so far as his institution is concerned. Whether the same results can be obtained in the large hospitals in the larger cities remains to be seen. The writer believes that a concerted system of inspection of all applicants offers the best prospect for a reform. It would seem that a judicious dispensary law must have some influence for good, but just how much we in Massachusetts are interested to learn from your experience. Our State is not an ideal place in which to procure this sort of legislation. She has the reputation of being the abiding place of more fads and isms than any other State in the Union, and the moment a move is made for justice and common sense in the matter in hand, all the cranks and jingoes in New England will begin to howl about interference with personal liberty, grinding the poor for the benefit of the doctors, and all that sort of nonsense. But a fight of some sort has got to be made, or this great wrong will never be corrected.

The public must be educated to the fact that medical services have a real value, and are as worthy of recompense as is any common commodity; that the doctors are willing and glad to take care of the worthy poor without pay, but that is no reason why they should be called upon to serve the well-to-do upon the same conditions. Moral suasion may do something in correcting the evil, but that measure is not depended upon to prevent the obtaining of other goods under false pretenses, and it will not suffice in the present instance. Common sense and common honesty are the requisites needed, and it is our duty to insist upon their ruling the management of our charitable medical institutions.

Dr. Frederick R. Sturgis said:

I shall not hold up for your admiration

"The good old rule, the simple plan,

That they should take who have the power,
And they should keep who can."

Nor shall I apologize for dispensary abuses; but

I shall ask you to see where the fault lies, and shall try to suggest a remedy.

A number of years ago at a meeting of the Medical Society of the State of New York, I called the attention of the medical profession to the relations then existing between the dispensaries and the profession, and I stated my belief that unless steps were taken by the profession to check the abuse the dispensaries would soon control the profession. This statement apparently made some impression, for the Society referred the matter to its constituent County Societies for consideration, with orders to print the paper; but after this was done nothing more was heard of the subject. I suppose the dispensaries did not hurt the profession sufficiently to make the doctors pay attention to the question.

In order to study this question of dispensary abuse at short range, I then applied for the position of house surgeon in one of the largest and best-known dispensaries in the city. At that time the dispensary was in financial straits, and it was a question whether it would not have to close its doors unless something were done. From my investigation I was satisfied that 94 per cent. of the patients attending the dispensary were able to pay something, even if it were only a small fee for medicines, and I suggested to the trustees of the dispensary that such a small fee should be charged. That was in the days when dispensary charity really meant something, and I will say to the credit of the members of this dispensary board that they were very loath to make a business out of the charity, saying that it would no longer be a charity but a business enterprise. To that I agreed, but I stated that it was a condition and not a theory that confronted them, and that if they did not wish to shut their doors they would have to get the money out of the patients. The board finally agreed to charge a fee of 10 cents, and in nine months after that time the dispensary had over \$3,000 to its credit from this source.

Gradually, as you know, all the other dispensaries in the city adopted this plan, and it worked very well so far as the business part of it was concerned. The charity side was a different matter. The clinics attached to the schools of medicine then followed suit, and now, so far as I know, there is not a single clinic that does not charge the patients something for medicines.

The charity abuse went on from bad to worse, and it was clearly shown that a large number of patients resorted to the clinics and dispensaries for gratuitous treatment who were amply able to pay a physician a good fee, and it was in consequence of the protests raised due to this condition of affairs that the Dispensary Bill was passed in the face of extreme opposition; and you have heard that in the five years' time that it has been in operation it has worked fairly well in most respects, except as regards the elimination of unworthy objects of medical charity.

And here we might as well acknowledge that the fault lies largely at the door of the doctors,

and no where else. The medical men do not take these positions in the dispensaries or clinics simply for charity, but for the opportunity to see cases. They furthermore wish to be known as having large clinics, and if an interesting case comes the doctor is oftentimes inclined to be blind to the fact that the patients are not worthy objects of charity and to take them either as dispensary cases or send them to his private office, as I have been told has not infrequently been the case. In this connection, and as proof thereof, let me call your attention to the case already mentioned by one of the previous speakers—the dispensary on the East Side which was managed by a number of physicians, where they took in \$3,000 a year and divided it among themselves. That might have gone on indefinitely but for the fact that they quarreled among themselves as to how the money should be divided. The attention of the Comptroller of the City of New York was attracted to this peculiar charity (?), and it was found that it was obtaining appropriations from the city under a false name—drawing the money from the city under the name by which it was first known and not under its new name, which had been adopted after it was taken over by the new management. This led to the Comptroller's refusing to give them any appropriation and the matter was referred to the State Board of Charities, which investigated the case and revoked the license of the dispensary. Thus this was an instance where the plea of charity was made a cloak for a business enterprise.

Another instance also has come to my personal knowledge, and that was in the early days of the dispensary where I was house surgeon and where \$1,200 had been collected from small fees. This lesson was apparently not lost on some of the medical attendants at the dispensary, for they started a private office of their own not far from the dispensary which they fed from the dispensary by sending to it patients who could afford to pay \$1.00 or more. They did a good business, not infrequently taking in \$100.00 a month. For this they furnished the medicines.

It would seem, therefore, that not infrequently medical men can "turn an honest penny" while at the same time seeming to do charitable work; and I am inclined to believe that the same little game goes on even nowadays. I have lately been very much struck with the number of physicians who have been applying to the State Board of Charities for dispensary charters, urging that the neighborhoods where they propose to found these dispensaries are poor ones, and that it would be a great charity to these poor people to have gratuitous medical service at that particular place. I have often wondered why they were so anxious, and the suspicion has more than once crossed my mind that they were pleading for that kind of charity which is said to begin at home, and that the enterprise which they had in mind was more of a business than a benevolent one. If they could attract a large number of patients, the small

fee system—even as low as 10 cents—would amply repay them for the two or three hours a day which they would give to the work, if we can take the case of this East Side dispensary as a criterion, and this view of the case would have a very decided bearing upon the difficulty of eliminating paying patients from dispensary benches.

Now, as to the remedy. In the first place, I would suggest that no charitable institution, dispensary, or clinic, shall be allowed to charge anything, not even for medicine. It may be urged that many patients who could afford to pay 10 cents for medicine could not afford to pay even 50 cents as a fee. I hold, on the other hand, that if that be so, it is brutal to take that 10 cents. The dispensary or clinic should be a charity, and there should be a limit placed below which no charge should be made of any kind; above that limit—make it any you please—the patient should be excluded from the dispensary; and it should be a rule that no physician attending the dispensary should refer to his office any patient who can afford to pay and is excluded from the dispensary. The objection may be raised that it is very hard to catch a doctor at this little trick, but if the dispensary officials keep their eyes open it would not, in my belief, be difficult. More than that: If the State Board of Charities hold the dispensary to a strict account in that matter, the dispensary itself would see that the doctors obeyed the rule, and the dispensaries could be held to accountability in this regard by withdrawing their licenses for the infraction of the rule.

Then the next point that I would suggest would be that if the State Board of Charities were to have it distinctly understood by the dispensaries that their licenses would be revoked if they did not comply with the rule excluding improper subjects from the benefits of the dispensary and taking the necessary steps to see that this rule was enforced, the dispensaries would very quickly bestir themselves and insist that their subordinates comply with the rule, and that improper subjects should not be received.

At first I felt a great deal of sympathy for the doctors, but upon more careful study of the subject I confess that this sympathy is very much diminished, for the simple reason that I believe that if the doctors chose to exercise proper discrimination and care they could, in a great measure, check this dispensary abuse, and at the same time protect themselves from imposition. But whatever the cause may be, they appear to be absolutely apathetic and are either incapable of helping themselves or are unwilling to do so, for, after all, the gods themselves cannot help those who are not willing to help themselves.

Dr. Egbert LeFevre said:

This question of dispensary abuses has been one of great interest to me during my entire career. For over twenty years I have been con-

nected with dispensaries, and can bear testimony to the efficiency of the present State law in many respects. It has improved many abuses of administration.

The statement has been made to-night that it has not cut down the number of patients attending the dispensaries and that there is as much abuse in this direction as before. Attention has also been called to the difficulty of deciding between the worthy and the unworthy. I would like to relate my experience on this subject.

At the time of the putting in effect of the present rules of the State Board of Charities the question of inspection and investigation of patients coming to the college clinic came up for consideration, and those attending the different classes were asked to send the names and addresses of those they thought should be investigated. The Charity Organization offered to investigate these cases for us, but it was thought that their investigators might have a different point of view from the physician as to what would constitute medical charity. The names of thirty-five patients were submitted to me as probably the most unworthy of medical charity and who, in all probabilities, were able to pay. They were all well-dressed and seemed to be intelligent. In every case they proved to be worthy objects of charity. They came to the dispensary because they had paid their physicians all they could afford to pay. They required long courses of treatment, and felt that they could not ask their physicians to take the mere pittance that they could offer, and they were compelled to seek relief at the dispensary. Who are the unworthy is the most difficult problem that confronts us. Those who are dead-beats will come and there is no method of detecting them; they will clothe themselves so as to deceive in order to obtain treatment for their maladies, and if they wear better clothing they will tell a story that would melt the hardest heart. On the other hand, patients who present a better appearance are often misjudged.

On their limited means they are just able to clothe themselves decently and live respectably, and when sickness comes their resources are readily exhausted and they become worthy objects of charity. To this class sickness is more of a hardship than to the very poor, and their very intelligence causes them to seek the very best medical and surgical relief. The very poor have no hesitancy in going from physician to physician, often not having any one physician called more than once or twice and very rarely, if ever, having any intention of paying him. The other class, on the other hand, know that they are unable to pay the regular fee of the physician. Many of them pay as long as they are able and when their means are exhausted they have no place to turn except to the free dispensaries, or if there is a dispensary in their neighborhood where they can pay a small amount they feel that they are not in a true sense charity patients.

It should be said to the credit of the profession

that many of them continue to treat patients and families whom they know cannot any longer afford to pay; but there are others who, after the patients' resources are exhausted, refer them to the dispensary for treatment. This latter class of physicians have had not a little influence in educating the public to seek relief at the free dispensaries. They have not been willing to modify their fees to meet the circumstances of the case, nor do they consider that, having once taken charge of the case, their duty as a physician should cause them to continue in attendance.

Many physicians advise patients to go to dispensaries because conditions have arisen which demand special treatment. The physician is not able to give the treatment required and he knows that the patients' circumstances are such that they are not able to go to those that are able to give them proper advice and pay for it. The physician does not feel like asking of the specialist to make a reduction in his fees, as too often when such a favor is asked the family physician is told that if his charity patients want to see him they must come to the dispensary or the hospital. A large percentage of the patients who come to the dispensaries, especially those connected with the colleges, have been referred by physicians who know that they are worthy. To all appearances they are able to pay, but when investigated they prove to be thoroughly worthy.

Another question has been raised to-night. Some of the readers of the papers have said directly, and others have inferred, that a great deal of the abuse of medical charity is due to the dispensaries connected with medical colleges and that the desire to have interesting cases in their dispensary is a fruitful source of abuse. Those who are connected with medical colleges see the other side of the question. The medical profession has demanded that the standard of medical education be raised and that a certain curriculum be carried out; that students not only be taught the science of medicine, but should be given an opportunity to acquire the art. There is not a single medical man here to-night who would vote that the instruction given in the college should return to that given even a decade ago. Those who were graduated before that period know how eager they were for clinical instruction.

To give the instruction demanded by the profession a well-organized dispensary is as necessary a part of the medical schools to-day as is the anatomical-room or the laboratories. They cannot be conducted without it. There is no medical school in this city but what is safeguarding the profession as far as possible. The desire to have the necessary amount of clinical material does not cause them to treat unworthy cases.

Patients coming to the dispensaries connected with the teaching institutions stand in a different light to the profession than those coming to a dispensary where teaching is not conducted; they know that when they come they may be asked to appear before the classes so as to afford the

students an opportunity to acquire medical knowledge. While they may not be able to pay in money for their treatment they are willing to give through their infirmity an opportunity for clinical instruction. They are not being pauperized in the broad sense of the word.

For this reason, I want to say an emphatic word in the behalf of dispensaries connected with teaching institutions. Most of these institutions do not charge anything, either for medicine or attendance. Patients are not forced to appear at the clinics. Those who object are excused, but no treatment is refused, and they can return to be treated just as if they had not refused. This question of the abuse of free treatment comes back to the physician. Who is to treat these people when they are poor? How many of us are willing or able to burden our general practice with charity cases that would come to us? The dispensaries, like the poor, will always be with us. I think many are overestimating the abuse of medical charity. The complaint that the rules of the State Board of Charities have not limited the number of patients bears this out to a certain degree. I do not consider that those who formulated the rules had any wish that those who were worthy would be refused treatment. The fact that the number of patients has not been cut down cannot be laid entirely to the faulty application of the rules by those who are in charge of the dispensaries.

I am not here to defend the abuse of medical charity. I have no excuse for institutions or patients who abuse it, but I think we should deal with all who seek relief with that charity which covers a multitude of sins—sins in many cases more apparent than real.

TYPHOID FEVER IN CHILDREN.¹

BY LOUIS CURTIS AGER, M.D.,
Brooklyn.

IT would be useless on an occasion of this kind to make any attempt to cover in a systematic way the subject suggested by the title of this paper. It might better be entitled, "A Few Notes on Typhoid in Children." The conclusions presented are drawn from personal experience, and are, therefore, chiefly valuable as an object for criticism and comparison with the experiences of others.

During the past two years, a great deal has been written upon the subject of typhoid in children, chiefly by men of wide experience. Nevertheless, there are great differences of opinion among the writers upon many important phases of the question.

During the recent prevalence of typhoid in some sections of Brooklyn, I had under treatment at the same time five cases of typhoid in children under 6 years of age. As the source of infection

was undoubtedly the same in all cases, and conditions were similar in other ways, some comparison may be of interest.

The cases were briefly as follows:

Case 1. H. B., vigorous male, age 3 years and 4 months. No previous illness. I was first called at 11 P. M., and found the boy in a state of violent delirium—fever and tympanites marked—no rose spots. The child had been under the treatment of another physician for a week. He had taken the temperature once on the first visit, and diagnosed malaria, which was quite reasonable at the time. Quinine had been given for a few days, and the patient had grown worse. The child was rather spoiled, and the attending physician had lost patience, and told the parents that there was nothing the matter with the boy except temper. I made a diagnosis of typhoid, which was confirmed by a very marked diazo the next day, and a positive Widal reaction two days later.

This case ran a moderately severe course, the temperature touching 105 once, and reaching a normal morning temperature 9 days later, having had as nearly as I could determine, a period of pyrexia of about 20 days.

Case 2. E. S., female, aged 4 years; previous health good. A mild case with sudden onset; the highest temperature 104 2-5; normal morning temperature on the tenth day; a slight relapse or at least a return of the fever one week later and lasting four days.

Diazo present on the sixth day; Widal negative on the fourth day, and not taken again on account of the nervous effect on the patient.

Case 3. F. H., male; strong child; previous health good except for pneumonia two years previous; aged 5 years. This was a mild case. The temperature reached normal in the morning on the tenth day after my visit. It was not possible to determine the exact period of pyrexia in this case. The mother thought he had had a fever for a day or two before I saw him, but the diazo was positive on the day of my first visit, and the Widal five days later (the first examination). This child, by the way, contracted pertussis during convalescence, from which he has not yet entirely recovered.

Case 4. W. M., male; strong, healthy boy; no previous illness; aged 4 years. Insidious onset; malarial type of disease; a few full doses of quinine given without effect on the course of the disease; diazo positive on the third visit; Widal on the sixth visit (the first examination); evening temperature on the first visit 102; normal morning temperature on the tenth day after the first visit. This is another case in which the exact period of pyrexia cannot be stated.

Case 5. H. G., female, aged 2½ years; strong, sturdy child; no previous illness, except some digestive disturbance during the summer. This was another case of insidious onset. The child had several slight diarrhoeal attacks during the summer, and the typhoid came on in the same way. The temperature at my first visit was 102, and it did

¹Read before The New York State Medical Association, at the Twenty-second Annual Meeting, New York, October 16-19, 1905.

not reach normal in the morning until 16 days later; diazo reaction positive on the third visit; Widal positive the next day; period of pyrexia apparently about 21 days.

This case differed in almost every particular from the others. Although the child was not naturally of a nervous temperament, the nervous manifestations were marked from the outset. This, in my experience, is always a sign to put the physician on his guard, whether the patient be old or young. The heart action also was poor from the first, the pulse varying ten or more beats from minute to minute, without any apparent cause. On the sixth day—counting from my first visit—the nurse telephoned about half an hour after my morning visit that the temperature had suddenly dropped to normal. I was only a block away, at Case No. 4, and got back in five minutes. The pulse had run up to 170 as the temperature fell to normal. The respirations were not particularly disturbed, and the general appearance of the patient had not changed much, color no worse than before—it was bad much of the time—tympanites the same degree, feet rather cold. The child was conscious, but a cautious abdominal examination did not elicit any signs of pain or muscular rigidity. The patient revived in a few hours. The diagnosis was, of course, hemorrhage, which was confirmed the next day by the passage of a large number of small blood clots. Three days later, a small amount of quite fresh blood was passed without much constitutional disturbance. The most trying features of this case were the very poor heart action and the insomnia. Fortunately, the parents could do everything necessary, and we were blessed with a nurse of exceptional skill and judgment. Before convalescence set in, emaciation was extreme; there was a slight bed-sore on the back; there were several hemorrhagic spots on the ears and the extremities, and the loss of muscular power in the legs was so great as to give the impression of paralysis.

The first point of interest that these cases have in common is the apparently early presence of the diazo and the Widal reactions. On this point Hollopeter, of Philadelphia, says (*Journal A. M. A.*, Sept. 2, 1905): "The Widal test and the diazo reaction are of very little value prior to the beginning of the second week. At this time we have additional symptoms to confirm the diagnosis, thus reducing the value of the test. Undoubtedly, most cases of chronic fever in children are diagnosed by a process of exclusion, and not usually before the tenth day, the only exception being where we have an overwhelming toxemia with few complications. Many cases of typhoid brought under my notice had been previously treated for pneumonia, and many cases were classified as typhoid which were chronic food poisoning."

I quote thus at length because the statements are so largely at variance with my own small experience. And furthermore, they seem to be some-

what contradictory. If there are so many mistakes made in diagnosis in Philadelphia, the logical conclusion is that the Widal and diazo reactions ought to be of great value as a corrective. I have myself found these tests the first positive diagnostic point in at least half the cases of typhoid that I have seen in children. Furthermore, as a matter of prudence, the diagnosis, even if positive in our minds, should be confirmed by these positive tests. By no means have all the members of the medical profession yet divested their minds of the old fallacy that typhoid is a very rare condition in young children, and among the laity you will meet many a busybody anxious to persuade the parents after your patient has recovered that a child that was sick less than two weeks could not possibly have had typhoid fever, when everybody knows that typhoid takes weeks to run.

It is in the younger children, however, that these tests are of the greatest value. When we remember that in bottle babies there is really nothing in the green stools, mild pyrexia, listlessness and moderate tympanites of typhoid to distinguish the typhoid from a simple enteritis, we can fully appreciate the value of a positive diagnostic method. I shall refer again to this resemblance to gastroenteritis in speaking of feeding.

On the other hand, I would not lay too much stress on the diazo test, as it is of course found in other diseases. A peculiar example of this came under my notice while the typhoid patients were under my care. L. T., female, aged 8 years, became suddenly ill on a Wednesday, while in the country, with chills, headache and nausea. The next day she had five chills, followed each time by high fever. These symptoms continued with severe diarrhoea and vomiting until Sunday, when I saw her for the first time. At that time, she had a typical typhoid tongue and typhoid headache. The throat was a dark red, and the tonsils were swollen. She did not complain of sore throat. The nausea and vomiting were severe. There had appeared that morning all over her arms and legs a bright red erythematous eruption, like a scarlatina rash. The face and body were entirely clear. The child had had scarlatina three years previously. I could get nothing in the history to account for a toxemia. The urine showed a brilliant diazo reaction. The ice cap gave relief from the headache, the rash cleared up rapidly, and the temperature dropped from 103 to normal in the next three days. By the middle of the week the child was entirely well.

Another class of cases in which tests are of great value is exemplified in Case No. 4. This is what might be called the malarial type, although there is no malarial infection. I regret that there was no examination for the plasmodium in this case, but quinine was prescribed at the first visit without waiting for a blood examination. As full doses had no effect on the course of the disease, it is safe to suppose that it was a simple typhoid.

On the other hand, bearing in mind the fact that the patient was in fairly good condition each morning and became worse at night, would you not be likely to diagnose malaria? Do we not all hear of cases of "stubborn malaria" in children, that the physician was unable to break up for nearly two weeks? Is not this one of them?

The first essential, then, in the care of these cases is to make the diagnosis. After that, we must decide on the treatment. Here again there is a diversity of opinion. The subtitle of Hollopeter's article quoted is, "A plea for Enteroclysis." In discussing this paper, Morse, of Boston, cautioned against the too free use of enteroclysis. He pointed out the fact that the vasomotor system is relaxed, and that there is danger of overdilating the blood vessels and thus throwing an extra burden on an already weakened heart. To this I would add that there is also grave danger of paralyzing or at least weakening the muscular coats of the intestine by the use of large amounts of water. If the water is not freely and easily expelled soon after its introduction, it should be used very cautiously and in small amounts. A marked degree of tympanites is often aggravated, in children, by the introduction of a large volume of water; and dangerous embarrassment of the heart and lungs may result. This, of course, does not mean that small high enemas of saline solution or soapsuds, with or without glycerine, turpentine, etc., are never to be used. But they are not to be used except as definitely indicated.

Practically all the treatment should be symptomatic, with a careful consideration of the fact that typhoid in children is usually a mild disease and may be greatly aggravated by improper treatment. As Morse puts it, "the tendency in all these cases is to get well no matter what the treatment, unless it be absolutely bad." There are, however, exceptions to this rule, and it is these exceptions that we should be on the watch for. Among these exceptions may be classed Case No. 5, reviewed before. Even in that case, in reviewing it in my own mind, certain questions arise as to the cause of the bad symptoms, and it is these questions that may be particularly worthy of discussion.

This patient No. 5 had the most sturdy normal physique and the most sanitary and intelligent environment of the five. In contradistinction to the other four, she was a very docile, obedient child, and as a result, my directions were carried out with great precision. Moreover, this patient was fond of milk, and was accustomed to a milk diet, while the others did not like milk. For some years I have used much less milk in typhoid than most physicians, and I never use it unpeptonized. Nevertheless, as this child was accustomed to a milk diet, she was given from ten to sixteen ounces of peptonized milk during the twenty-four hours for the first week, whereas the other children had practically no milk during their illness, but were fed on the proprietary

foods, meat broths and grain gruels. In fact, they took as a rule a startlingly small amount of nourishment of any kind.

Again, in Case No. 5, rectal irrigation was resorted to at regular intervals, but in the other cases, or more particularly in three who were taken care of by the mothers, there were almost no high enemas given. I am thus led to the conclusion that patient No. 5 was overfed during the first week. Although there were indications that her infection was more virulent from the first. I am afraid that her symptoms were aggravated by the overfeeding. As a result, tympanites became troublesome about the fifth day, and curdled milk appeared in rather large quantities in the stools. The milk was stopped at once, and a mixture of castor oil, mucilage of acacia, camphorated tincture of opium and essence of peppermint was given. In fact, the patient had been having this mixture in small amounts almost from the first. In answer to the criticism that the castor oil may have caused the hemorrhage, I may say that in the routine use of the above mixture in typhoid, in both adults and children, I very rarely have hemorrhage to deal with, and that I am firmly convinced that the direct cause of hemorrhage, in a vast majority of cases, is tympanites and the accumulation of milk curds. Many physicians have a mistaken idea that castor oil is irritating to the inflamed mucous membrane, when as a matter of fact it is a very soothing dressing for an inflamed surface. It hardly seems logical to stop a milk diet and prescribe castor oil in a case of simple enterocolitis, and to use milk freely and abstain from castor oil in a condition so similar as is typhoid fever.

Other symptoms, of course, must be met as they occur. Diarrhœa in typhoid I know very little about, as it is almost never met with if the castor oil treatment is begun early, and if milk is not taken in large amounts. In fact, I do not consider diarrhœa a symptom of typhoid, but rather an indication of an overloaded and irritated intestinal tract. As a heart, or rather as a circulatory, stimulant, I use much less alcohol and more digitalis than formerly. Aromatic ammonia is also of great value. Camphor should always be ready for hypodermatic use, but the preparation from which I have seen the most remarkable results in dangerous collapse is tincture of capsicum. It may be given diluted in oil or water, in from five to fifteen minim doses, preferably by rectum. If necessary, it may be repeated every ten minutes for several doses. The almost instantaneous return of color to the face of a comatose patient after its use is at times startling.

In regard to intestinal antisepsis, I differ from those men who treat the whole question with contempt, simply on the theory that typhoid is a systemic infection. Granting that it is the bacteria in the blood that produce the chief symptoms, there is surely something to be gained by preventing the production and absorption of putrefactive toxins in the intestinal tract. If we can

get such excellent results along the urinary tract by the administration of antiseptics, why should we not expect to accomplish similar results in the intestines?

The continuous use of an ice-cap on the head, and the intermittent use of one on the abdomen serve the double purpose of reducing the temperature and quieting the nervous system. In my experience, the cold sponge bath does not work well in children. As a rule, one or more luke-warm sponge baths in addition to the ice-cap are all that are needed to keep down the temperature. It is, of course, unnecessary to condemn the use of antipyretic drugs in typhoid at a meeting of this kind. Again, it is just as important to keep the feet warm as to keep the head cool; as a rule, the young typhoid patient will need a hot-water bottle at the feet much of the time.

To sum up briefly:

Typhoid in children is almost invariably of brief duration.

The temperature as a rule is not excessive.

The chief danger is in overloading the digestive tract, and thus producing tympanites, intestinal irritation, etc.

These dangers are to be avoided by the substitution of real liquid foods for the continued use of milk, and the free use of laxatives, more particularly castor oil.

DISCUSSION.

Dr. L. E. LaFétra, of New York City, said that typhoid fever was comparatively rare in children. There were reasons for this. Parents were more careful about the kind of food they gave children; they did not, as a rule, give them lettuce, oysters, etc., and they were also more careful about boiling the water for children to drink. In certain localities, however, typhoid in children was quite common. Philadelphia furnishing, perhaps, the greatest number of cases.

In private practice, Dr. LaFétra said, he had only seen two cases of typhoid fever in children. One was a child of three years; the other of seven. In the Babies' Hospital in this city during the past fourteen years there had been less than ten cases, and during the past three years, only seven cases had been observed among 2,700 children under three years of age admitted into that institution. This proved the relative infrequency of the disease among infants and young children in this city. Among older children the disease was more common. In recent years, typhoid fever had been doubtless more frequently recognized because of the Widal and diazo reactions. During the past two years, the speaker said, he had seen two cases of typhoid fever in children in his service at the Babies' Hospital, one was in a child of three years; the other in an infant of ten months, which was the youngest case on the hospital records. This child, up to the time it was taken sick, had never been fed otherwise than by nursing. The mother was taken

sick with typhoid fever while nursing the baby, and the child had probably become infected from the skin of the mother, or from the saliva or other excretion.

Typhoid fever usually ran a milder and shorter course in children than in adults, and was often of abrupt onset, beginning with vomiting and rather high fever. This occurred in perhaps one-half the cases. In the other cases there was restlessness and irritability. In the cases of abrupt onset the symptoms suggested meningitis or pneumonia; not infrequently there was bronchitis, with respiratory disturbance and high temperature; in other cases, the nervous symptoms predominated. Hemorrhages were occasionally observed, sometimes of tarry blood; at other times, where the hemorrhage seemed to be low in the ileum or high in the colon, the blood was bright red. One of the surgeons at Mt. Sinai Hospital had recently reported a case of typhoid perforation in a child, with subsequent local peritonitis and ultimate recovery, after operation. Another case had occurred at the same hospital of perforation with recovery, without operation, where four physicians had agreed in the diagnosis.

The mortality of typhoid fever in children was much less than in adults; it was probably not more than 1 per cent., and then usually from complications. The disease in children would often go unrecognized were it not for the Widal and diazo reactions, which had been found very helpful. In some cases, the Widal reaction was obtained earlier in children than in adults; in others it was not obtained until after the temperature had fallen to normal, and in those cases it was, of course, of no value as a diagnostic aid. Another feature of great value in making the diagnosis was the look of the patient. This, while quite characteristic, could be only partially described; there was apathy, with congested, blood-shot eyes; there was irritability and nervousness, without definite signs of meningitis, together with the absence of Kernig's sign, and the absence of stiffness of the muscles in the back of the neck. In doubtful cases, lumbar puncture might be resorted to. Other symptoms of value were the abdominal distension, which appeared sooner or later, and often, before the Widal reaction could be obtained, there was enlargement of the spleen. This might be fleeting, but would appear sooner or later.

As regarded complications, the first that should be mentioned was the severe toxæmia, which carried off some of the patients. The other important complications were the same as those observed in the adult, pneumonia, and so on. Pertussis had been observed in two cases treated by Dr. LaFétra at the Roosevelt Hospital during the past summer on Dr. Jacobi's service. Both of these children had a bronchitis which continued right through the course of the typhoid, and subsequently the cough became more and more severe; finally, both children began to whoop. He could not say how long the pertussis

had been developing in those cases, but in one of them the incubation had lasted at least four weeks. Pyelocystitis had occurred in one of the cases at the Babies' Hospital.

In regard to the treatment of typhoid fever in childhood, the most important features were rest and feeding. He did not approve of an exclusive milk diet, but favored a food which was liquid and remained so. Milk became coagulated into a hard curd and formed hard feces. He favored the use of broths, beef juice and peptonized milk, together with panopeptin, the peptonoids and cereal gruels, properly mixed with milk. The abdominal distension is best relieved by keeping the bowels open and the liver active by the use of biniodide of mercury and salicylate of soda—given alternately in small doses.

The sponge bath and the cool pack accompanied by friction are better borne than cold tub baths. Urotropin should be given to prevent urinary complications as well as to disinfect the urine.

Dr. Frank DeWitt Reese, of Cortland, said that in the hospital with which he is connected it is the custom to let these patients go without food. When they are hungry, they are given a little milk or albumin water. Personally, he believes that typhoid fever patients are largely overfed. The gastric juice is deteriorated; therefore, why not imitate nature by doing what will stimulate the gastric juice, and for that purpose he favors nitro-muriatic acid, which is also a disinfectant. He referred to one physician in his town who has had remarkable success in the treatment of fevers by starving the patients for prolonged periods.

Dr. Ager, in closing the discussion, said that in regard to the comparative frequency of typhoid fever in childhood, his experience differed from that of Dr. LaFétra and others, and looking back over his work since his graduation he had probably seen more cases in children than in adults. The abrupt onset of the disease was much more frequent in children than in adults, and in some instances there was as distinct a chill as in pneumonia.

DEMONSTRATION OF A CASE OF RAREFYING OSTEITIS.¹

BY E. S. McSWEENEY, M.D.,
New York City.

THESE bones form the skeleton of a fairly nourished woman 40 years of age, five feet seven inches tall. Their weight is seven pounds. Some few of the vertebræ have been practically destroyed in handling, which was unavoidable, as they were mere shells of compact tissue. The skeleton attracted my attention in the dissecting-room two months after death, so I have no knowledge of its more recent state or of coincident lesions in other organs except that I was able to verify the diagnosis of cause of

death—pneumonia. Careful observation showed that no additional loss of substance was incurred by the boiling, plain water being used, and the changes to be noted are quite as evident in the bones forming the thorax, which have not been subjected to the process. As a whole in gross outline the skeleton shows, aside from this moderate cervico-dorsal kyphosis, but little change from the normal, these slight evidences of compression of the femur heads and necks being practically the only other change that might be classed as a distortion. The pelvic outlines are normal. There are and have been no fractures or ankyloses. The individual bones, without exception, show a considerable loss of substance, chiefly the cancellous tissue, the compact tissue here and there being defective, evidently an extension of the process, the outline, however, remaining unchanged. The skull vault is almost sieve-like, the scapulæ hardly thicker than heavy paper and extraordinarily translucent; the innominates are thin compact plates held together by a lace-like web, and the long bones are all affected. The hardly more than feather weight of the individual bones is remarkable. The picture is typical of the condition known as osteoporosis, or rarefying osteitis.

The etiology of many of these bone lesions is obscure and the literature meager. I can find no report of a skeleton showing such extensive changes as in this specimen. A local osteoporosis is frequently seen the expression of disturbed nutrition, due to pressure or traumatism, but as a general process it is rather uncommon, senility or osteomalacia being credited with its production. In this instance, aside from the age of the woman, characteristic senile changes are lacking, which excludes the former. Osteomalacia is characterized rather by its distortions than an osteoporosis, whereas here the reverse is the case, which makes me hesitate to classify it under this head. Unfortunately, no history could be obtained.

The case is interesting surgically, in that with so extensive a process in a woman who probably had to make her own living, and judging from the fact that she was committed to the workhouse, probably led a rather hard life, there should be not even one fracture and so little deformity.

TIME AS AN ELEMENT IN ABDOMINAL SURGERY.

"In reviewing my failures in abdominal surgery for the past twenty years," says Dr. Maurice F. Richardson, in the *St. Paul Medical Journal*, "I am deeply impressed with the direct dependence of these failures upon the waste of time. It is not justifiable to waste precious moments in emergencies waiting for symptoms to confirm a diagnosis."

The symptoms which most of us regard as safe guides to surgical intervention do not appeal as widely to the profession as one would desire;

¹Read before the New York Pathological Society, April 12, 1905.

hoping that acute abdominal symptoms are not as serious as they appear, that a few hours will see the patient on the road to recovery, we are too much inclined to wait and see if the outlook is as bad as is feared. Such tendencies exist in all communities, and are responsible for the terrible consequences in abdominal emergencies. These disasters are especially common in rupture of the intestines, spleen and liver; from general peritonitis, from hemorrhage or both.

Most of the author's cases have been fatal owing to delay in getting the patient to the operating table or to delay in endeavoring to be sure that rupture had taken place. The most serious results frequently followed trivial injuries with insignificant symptoms at the onset, excepting pain. Many sudden disasters take place in the course of unsuspected diseases, as in acute infections of the appendix, gall bladder and pancreas; perforations of unsuspected gastric or intestinal ulcer; twisting of pediculated tumors, intussusception and volvulus, without any premonitory signs, and if unrelieved they prove fatal. In such acute emergencies of doubtful nature it is not permissible to wait for a development of the lesion sufficient to make possible a positive diagnosis. In well-recognized lesions, which demand immediate investigation, time will not be lost. In the obscure case, in which such lesion is only suspected, time must not be lost. Finally, in cases in which the lesion is only suspected, time should not be lost if that suspected lesion is one essentially fatal if not promptly relieved. Time for observation, diagnosis and prognosis can be profitably taken only in that class of cases in which the lesion is so well recognized as to justify delay.

The one symptom that best determines necessity for operation is pain; if we look on every case of severe abdominal pain as a case which demands immediate investigation, we shall avoid nine-tenths of the terrible misfortunes of abdominal disease, and as our experience in abdominal emergencies becomes larger we shall find that the number of unnecessary explorations diminishes and the number of successes increases. W.

Book Reviews.

ANATOMY AND PHYSIOLOGY FOR NURSES. By Leroy Lewis, M.D., Surgeon to and Lecturer on Anatomy and Physiology for Nurses at the Lewis Hospital, Bay City, Michigan. Philadelphia and London: W. B. Saunders & Co., 1905.

This little manual of about 300 pages contains probably all that is necessary for a nurse to learn of the subjects discussed. The arrangement is good, and the Review Questions at the end of each chapter are a distinct aid in impressing on the student the more important and essential facts.

ATLAS AND EPITOME OF DISEASES OF THE SKIN. By Dr. Franz Mracek, Professor of Dermatology in the University of Vienna. Authorized Translation from the German. Second edition, revised and enlarged, edited by Henry W. Stelwagon, M.D., Ph.D., Professor of Dermatology, Jefferson Medical College,

Philadelphia; Physician to the Department of Skin Diseases, Howard Hospital; Dermatologist to the Philadelphia Hospital, etc. With 77 colored plates by the artists J. Fink and A. Schmitson, and 50 half-tone illustrations. Philadelphia and London: W. B. Saunders & Co., 1905.

It is with much pleasure that we review the second edition of Professor Mracek's admirable hand atlas. That the work is a success and of practical usefulness needs no further proof than the demand for a second edition. The author has added some twenty-six new plates, fifteen of them colored lithographs, and all of exceptional merit. The text he has thoroughly revised to include the most recent dermatologic advances, especially along the line of histopathology. As in the first edition, there is evidence of the conscientious editorial work of Dr. Stelwagon, many additions being interspersed throughout the text.

THE PRINCIPLES OF BACTERIOLOGY. A practical manual for students and physicians. By A. C. Abbott, M.D., Professor of Hygiene and Bacteriology, and Director of the Laboratory of Hygiene, University of Pennsylvania. Seventh edition, enlarged and thoroughly revised. With 100 illustrations, of which 24 are colored. Philadelphia and New York: Lea Brothers & Co., 1905.

When a textbook has survived to go to a seventh edition it would seem that there would be little left to say in criticism of it. Dr. Abbott's little book is so well known that one can only reiterate that it is the best textbook of its kind yet given to students.

Slight changes have been made in the chapter on methods in order to bring it up to date. These are most important and valuable. Preventive medicine has received further attention, and the latest advances along this line of thought have been incorporated in the text.

THE DIAGNOSTICS OF INTERNAL MEDICINE, a clinical treatise upon the recognized principles of medicinal diagnosis, prepared for the use of students and practitioners of medicine. By Glentworth Reeve Butler, Sc. D., M.D., Chief of the Second Medical Division, Methodist Episcopal Hospital; Attending Physician to the Brooklyn Hospital; Consulting Physician to the Bushwick Central Hospital; formerly Associate Physician, Department of Diseases of the Chest and Diseases of Children, St. Mary's Hospital, Brooklyn, N. Y.; Fellow of the New York Academy of Medicine; Member of the Medical Society of the County of Kings; Fellow of the Society of Sciences, Letters and Art (Lond.), etc. With 5 colored plates and 288 illustrations and charts in the text. Second revised edition. New York and London: D. Appleton & Co., 1905.

An excellent work on clinical diagnosis; the division into two parts is natural. The first part, the Evidence of Disease, covers a full history of the patient, the approved method of examination, the signs and symptoms, and its diagnostic significance. Part two treats of the diagnosis, both direct and differential, the description of recognized diseases and their symptoms, with special reference to the diagnosis of each disease. Great care has been taken by the author to make such additions and alterations as were necessary since the first edition. The work has increased its value, and is second to none on diagnosis, and a very necessary book for the general practitioner of medicine.

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 City Hospitals, Randall's Island, New York; Consulting Ophthalmologist to the French Hospital and to the Red Cross Hospital, New York; Adjunct Ophthalmic Surgeon to Mt. Sinai Hospital, New York, etc. Fourth edition, revised. With 360 original illustrations, including 21 plates, with 60 colored figures. New York: William Wood & Company, 1905.

This fourth edition, following within one year the third edition, is evidence of the popularity and practical

value of this work. The author has revised and re-edited a valuable book covering subjects of examination of the eye, affections of the eyelids, diseases of the orbit, together with a few operations. It is eminently useful to the student and general practitioner of medicine.

A MANUAL OF ACUTE POISONING. By John W. Wainwright, M.D., member of the American and New York State Medical Associations, the American Chemical Society, etc. Price, 75c. New York: E. R. Pelton, 1905.

The author gives the classification, varieties and individual substances usually met with in emergency poisoning, with special symptoms, simple tests, chemical antidotes, physiologic antagonists and treatment. A handy little book and very useful to the general practitioner of medicine.

MANUAL OF DISEASES OF NOSE AND THROAT. By Cornelius Godfrey Coakley, A.M., M.D., Professor of Laryngology in the University and Bellevue Hospital Medical College, New York City; Laryngologist to Columbus Hospital, the University and Bellevue Hospital Medical College Clinic; Consulting Laryngologist to the New York Board of Health. Member of the New York Academy of Medicine, Society of the Alumni of Bellevue Hospital, Medical Society of the County of New York, Medical Society of the State of New York, American Laryngological, Rhinological and Otological Society, etc., etc. Third edition, revised and enlarged; illustrated with 118 engravings and 5 colored plates. New York and Philadelphia: Lea Brothers & Co., 1905.

A compact manual for the use of the student and general practitioner. It is concise and clear, and tells all that the busy man can find time to look up for a hasty examination. The book is profusely and well illustrated, the colored plates being clear and particularly good.

A MANUAL OF THE DISEASES OF INFANTS AND CHILDREN.

By John Ruhräh, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. Illustrated. W. B. Saunders & Co., 1905.

There is much to praise and very little to criticize in this excellent little book. As a handy reference volume either for student or practitioner it is valuable, because in addition to the information given it has numerous foot-notes referring to the best and latest articles, which enable one easily to get further and more complete knowledge of the subject. In the endeavor to keep the volume small, many subjects have been omitted which we believe should be included in such a volume, as the various forms of acute and chronic bone and joint diseases, in which early diagnosis is so important and in which errors of diagnosis may lead to most serious consequences.

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 to St. Agnes' Hospital; Fellow of the College of Physicians of Philadelphia, etc. Seventh edition, revised, illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

This little well-known manual of the practice of medicine deserves the prominence that it has obtained. It has made for itself a place in the textbook world that is most enviable. Simple in its construction, it is within the easy grasp of every student. If a compendium may be called ideal, Dr. Stevens' little book is worthy of that name.

In this, the seventh edition, the only changes made have been those to bring the book up to date in its subject, thereby including all the most important of the scientific advances in medicine which will better enable the student to understand the subject.

NATIONAL STANDARD DISPENSATORY, containing the natural history, chemistry, pharmacy, actions and uses of medicines. Including those recognized in the pharmacopœias of the United States, Great Britain and

Germany, with numerous references to other pharmacopœias. In accordance with the eighth decennial revision of the United States Pharmacopœia, 1905. By Hobart Amory Hare, B.Sc., M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Member of the Committee of Revision of the United States Pharmacopœia, Eighth Decennial Revision, 1905; Charles Caspari, Jr., Ph.G., Ph.D., Professor of Theoretical and Applied Pharmacy in the Maryland College of Pharmacy (Department of Pharmacy of the University of Maryland), Baltimore; General Secretary of the American Pharmaceutical Association; Member of the Committee of Revision of the United States Pharmacopœia, Eighth Decennial Revision, 1905; Henry H. Rusby, M.D., Professor of Botany and Materia Medica in the College of Pharmacy of the City of New York (Columbia University); Member of the Committee of Revision of the United States Pharmacopœia, Eighth Decennial Revision, 1905; Joseph F. Geisler, Ph.C., Chemist, New York State Department of Agriculture; Edward Kremers, Ph.D., Professor of Chemistry, University of Wisconsin; and Daniel Base, Ph.D., Professor of Inorganic and Analytical Chemistry, University of Maryland. Philadelphia and New York. Lea Brothers & Co., 1905.

All that has been said on the United States Pharmacopœia in a former number of the *JOURNAL* bears directly on the National Dispensatory, with the addium for a dispensatory. In addition, it covers the essentials of the latest foreign pharmacopœias, and the unofficial drugs and preparations so much used. Dr. Rusby has treated the Department of Pharmacognosy; Professor Caspari that of Pharmacy; Dr. Hare writes on Medical Action and Uses. It is a new, practical and authoritative work, containing information on all substances used in medicine and pharmacy at the present day.

OPERATIVE SURGERY. By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospitals; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insane; former Surgeon-General of N.G.S.N.Y.; Fellow of the American Surgical Association; Member of the International Society of Surgeons, and of the American Medical Association; former President of the New York Academy of Medicine, and of the New York State Medical Association; President of the New York State Medical Society, etc. Volume I, General Principles, Anæsthetics, Antiseptics, Control of Hæmorrhage and Shock, Treatment of Operation Wounds, Ligature of Arteries, Operations on Veins, Capillaries, Nervous Systems, Tendons, Ligaments, Fasciæ, Muscles, Bursæ, and Bones, Amputations, Deformities, Plastic Surgery, Operations on Mouth, Pharynx, Nose, Œsophagus and Neck. Fourth edition, printed from new plates, entirely revised and largely rewritten. This volume contains 898 illustrations, 61 of which are colored. Volume II, Operations on the Viscera connected with the Peritonæum, the Scrotum and Penis, and miscellaneous operations, including those for some deformities of the external ear. Fourth edition, printed from new plates, entirely revised and largely rewritten. This volume contains 895 illustrations, 39 of which are colored. New York and London: D. Appleton & Co., 1905.

The author has produced a work of great and eminently practical value. The two volumes cover every known operation, presented in a clear style that can readily be understood. The vast number of changes, additions, and the marked revolution in surgery since the first edition, rendered necessary a complete revision. The excellent evidence of quality is shown in the vigor and vitality. The advantage of clinical teaching is marked in the clear and concise text, together with the large number of illustrations. It is the most complete work on operative surgery which we have. No

subject seems to have been neglected. It contains a large amount of information upon special points in the technique of operations not usually found in works of this character.

PATHOLOGICAL AND MORBID ANATOMY. By T. Henry Green, M.D., F.R.C.P., Consulting Physician and Emeritus Lecturer on Clinical Medicine at Charing Cross Hospital, London, and Consulting Physician to the Brompton Hospital for Consumption and Diseases of the Chest. Tenth American, revised from the tenth English, edition. Revised and enlarged by W. Cecil Bosanquet, M.A., M.D. Oxon., F.R.C.P., London, Assistant Physician (Late Pathologist) to Charing Cross Hospital, London, and to the Brompton Hospital for Consumption and Diseases of the Chest; formerly Fellow of the New York College, Oxford. With a colored plate and 348 illustrations in the text. Philadelphia and New York: Lea Brothers & Co., 1905.

The author is well known, and his work is an evidence of excellent qualities. In this tenth edition a large amount of new material has been added, the subject has undergone many changes, as the growth is both rapid and transforming. It is simple, clear, and adequate to meet the wishes of the busy practitioner.

A TEXTBOOK OF CLINICAL DIAGNOSIS BY LABORATORY METHODS, for the use of students, practitioners and laboratory workers. By L. Napoleon Boston, A.M., M.D., Associate in Medicine and Director of the Clinical Laboratories, Medico-Chirurgical College, Philadelphia: formerly Bacteriologist at the Philadelphia Hospital and at the Ayer Clinical Laboratory of the Pennsylvania Hospital. Second edition, revised and enlarged, with 330 illustrations. Philadelphia and London: W. B. Saunders & Co., 1905

It seems strange that no really complete book on this subject has as yet been published in the English tongue. Dr. Boston's book is as good as the average in this respect, and perhaps a little better than the average. The first edition has been rapidly exhausted, and within the year this second edition has been put upon the market.

The book is a very good one, but the author has overreached himself in trying to make it too comprehensive. Thereby, it loses a great deal of its value as a laboratory guide.

The publishers have done their work remarkably well, and have produced a volume most finished in appearance.

THE PRACTICAL APPLICATION OF THE RÖNTGEN 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 Medical 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 Röntgen Society of London; Associate Member of the American Institute of Electrical Engineers. Second edition; thoroughly revised and enlarged. W. B. Saunders & Co.

This work, as its title declares, is a practical guide in the application of Röntgen Rays in diagnosis and therapeutics. It also gives a practical and concise up-to-date explanation of the apparatus used in medical and surgical cases.

In that part of the work which embraces the application of X-Ray to the treatment of diseases it shows that it has been written by one who has had large experience and knows how to profit by the careful analysis of such experience.

This book is a most valuable addition to the literature upon the practical use of the X-Ray in medicine and surgery, and will be found a safe guide to follow in the proper use of this agent, which is in the infancy of its possibilities as a diagnostic and therapeutic aid in the practice of medicine.

A TEXTBOOK OF THE PRACTICE OF MEDICINE. By James M. Anders, M.D., Ph.D., LL.D., Professor of Medicine and Clinical Medicine at the Medico-Chirurgical College; Physician to the Medico-Chirurgical Hospital; formerly Physician to the Philadelphia and to the Protestant Episcopal Hospitals, Philadelphia; Fellow of the College of Physicians, Member of the Academy of Natural Sciences, Philadelphia, etc. Illustrated. Seventh edition, thoroughly revised. Philadelphia and London: W. B. Saunders & Co., 1905.

Many additions and changes, made necessary by the rapid advances in internal medicine, are presented in this seventh edition. In the department of differential diagnosis no departure has been ventured, the subject being dealt with under a separate heading. The treatment of diseases has received a large share of earnest attention, and is in harmony with the latest approved therapeutic advances. The author's personal experiences, with the examination of the contributions of other observers, has been used with excellent results. It is an excellent work of the present state of our knowledge of the practice of medicine in general, and of the diagnosis and treatment of disease in particular.

A TEXTBOOK OF PRACTICAL THERAPEUTICS, with special reference to the applications of remedial measures to disease, and their employment upon a rational basis. By Hobart A. Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in Jefferson Medical College of Philadelphia, etc. Eleventh revised edition; 113 engravings and 4 colored plates. Lea Bros. & Co., 1905.

This very practical work on therapeutics is clearly and concisely written, and this eleventh revision brings this valuable book up to date.

We counted seventy-nine changes in the strength of drugs to agree with the new pharmacopœia. The drugs and diseases treated are arranged in alphabetical order, and it is a valuable ready-reference book, written by an acknowledged authority upon the subject of which it treats.

It is a work that should be in the library of every physician, since it represents the advancement made in the scientific treatment of diseases, by showing how and why the remedies are given.

A TREATISE ON DIAGNOSTIC METHODS OF EXAMINATION. By Prof. Dr. Herman Sahli, Director of the Medical Clinic, University of Bern. Edited, with additions, by Francis P. Kinnicutt, M.D., Professor of Clinical Medicine at Columbia University, New York, and Nathan' B. Potter, M.D., Visiting Physician to the City Hospital and the French Hospital, New York. Authorized translation from the German. Revised and enlarged edition. Philadelphia and London: W. B. Saunders & Co., 1905.

To those who have had a reading knowledge of the German language this volume has for a long time served as a most valuable aid and guide. The realization of these facts has led the editors to undertake the task of having Dr. Sahli's book translated into the English language in order that the American profession might reap the benefit that the few have so long enjoyed.

The translators have done their work well and the editors have so arranged the book that in many respects it is an improvement on the original. There have been added to this edition a discussion of the subject of blood-pressure, which is contributed by Dr. Theodore C. Janeway. Many other American physicians have added notes to the translated text of the author.

The book is thoroughly up with the times and should be found in the library of every practitioner, where it will be of inestimable assistance to him in his daily reading of his cases.

THE VERMIFORM APPENDIX AND ITS DISEASES. By Howard A. Kelly, A.B., M.D., Professor of Gynecology in the Johns Hopkins Hospital, Baltimore, and E. Hurdon, M.D., Assistant in Gynecology in the Johns Hopkins University, Baltimore. With 399 original

illustrations, some in colors, and 3 lithographic plates. Cloth. Pp. 827. Price, \$10 net. Philadelphia and London: W. B. Saunders & Co., 1905.

This work is a most complete and valuable study of the vermiform appendix in health and disease, and will be a valuable addition to the library of physicians, as well as to those of the specialist in abdominal surgery. After a careful review of the history of our knowledge of appendical disease, the anatomy and physiology of the organ are elaborately set forth, as is the technic of the various operations for the removal of the organ. Especial mention may be made of the chapters on appendicitis in its relation to typhoid fever; of its peculiarities in children; of its relation to the pelvic organs; of its medico-legal status, as well as to that on treatment. Too much cannot be said in praise of the excellence of the illustrations and presswork—in fact, it may be well said that the book is a great credit to all concerned in its production—authors, artists, printers and publishers.

A SYSTEM OF PRACTICAL SURGERY. By Prof. F. von Bergmann, M.D., of Berlin; Prof. P. von Bruns, M.D., of Tübingen, and Prof. J. von Mikulicz, M.D., of Breslau. Translated and Edited by William T. Bull, M.D., Professor of Surgery, College of Physicians and Surgeons, Columbia University, New York, and Edward Milton Foote, M.D., Instructor in Surgery, College of Physicians and Surgeons, Columbia University, New York. Volume V. Surgery of the Pelvis and the Genitourinary Organs. New York and Philadelphia: Lea Brothers & Co., 1904. Pp. 789.

This book is a translation of articles by Steinbach, Körte, Sonnenburg, von Bramann, Ramstedt and Schede upon the surgery of the pelvis, rectum anus and the urinary and male genital organs. The work, in addition to its own index, contains a general index to the other volumes.

A TREATISE ON OBSTETRICS, for students and practitioners. By Edward P. Davis, A.M., M.D., Professor of Obstetrics in Jefferson Medical College; Professor of Obstetrics and Pediatrics in the Philadelphia Polyclinic, etc. New second edition, thoroughly revised and much enlarged. Octavo, 800 pages, with 274 engravings and 39 full-page plates in colors and monochrome. Cloth, \$5 net; leather, \$6 net.

This is a thoroughly scientific and practical book on the subject of which it treats, the author's method being original, and the scope of the work includes cognate subjects of much value which are not met with in other similar books. In preparing this new edition Professor Davis has completely revised the text and added much new matter, resulting in an enlargement of the book by about 250 pages. In its new form, the book represents the science and art of obstetrics fully up to date, and is abundantly illustrated.

A TEXTBOOK OF MATERIA MEDICA, including Laboratory Exercises in the Histologic and Chemic Examinations of Drugs. By Dr. Robert A. Hatcher, Ph.G., M.D., and Torald Sallmann, M.D., Pp. 411. W. B. Saunders & Co., Philadelphia.

This book is intended to popularize the "Laboratory Method" in the study of organic materia medica, and is divided into three parts, Part I treating of the Systematic Study of Crude Drugs, and containing chapters on Roots, Woods, Barks, Leaves, Herbs, Flowers, Fruit Seeds, and Drugs Other than Plant Organs. Part II treats of Plant Histology, with chapters on the Cell and Its Contents, Special Morphology of Cells, Tissues, Organs, and the Histologic Study of Powdered Drugs. Part III treats of Chemic Exercises in Materia Medica, with chapters on constituents soluble in water but not in alcohol, on chemic examination of drugs containing important alkaloids, drugs containing glucosids, drugs containing resinous principles, drugs containing aromatic acids, volatile oils or fats. The appendix contains a list of reagents for histological investigations, a posological table, glossary of medical terms used in the body of the work, and a complete index. The book is recommended to those who desire practical informa-

tion on the subject of organic materia medica, and it is a reliable guide in the scientific method of investigating the drugs treated in its several parts.

HUMAN PHYSIOLOGY. Prepared with Special Reference to Students of Medicine. By Joseph H. Raymond, A.M., M.D., Professor of Physiology and Hygiene, Long Island College Hospital, New York City. Third edition, thoroughly revised. Octavo volume of 687 pages, containing 444 illustrations, some in colors, and four full-page lithographic plates. Philadelphia and London: W. B. Saunders & Co., 1905. Cloth, \$3.50 net.

The review of this book will be found in the November issue of the JOURNAL.

BOOKS RECEIVED.

PHYSICIAN'S POCKET ACCOUNT BOOK. By J. J. Taylor, M.D. Published by the Medical Council, 4105 Walnut street, Philadelphia, Pa. Patent applied for.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK FOR THE YEAR 1905. Published by the Society, 1905.

A TEXTBOOK OF PRACTICAL THERAPEUTICS, with especial reference to the application of remedial measures to disease and their employment upon a rational basis. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; Laureate of the Royal Academy of Medicine in Belgium; of the Medical Society of London; Member of the Committee of Revision of the United States Pharmacopœia of 1905. Eleventh edition, enlarged, thoroughly revised and largely rewritten. Illustrated with 113 engravings and 4 colored plates. Philadelphia and New York: Lea Brothers & Co., 1905.

ANATOMY AND PHYSIOLOGY FOR NURSES. By Leroy Lewis, M.D., Surgeon to and Lecturer on Anatomy and Physiology for Nurses at the Lewis Hospital, Bay City, Mich. Illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

A MANUAL OF THE DISEASES OF INFANTS AND CHILDREN. By John Ruhrah, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. Illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

TREATISE ON DISEASES OF THE SKIN FOR THE USE OF ADVANCED STUDENTS AND PRACTITIONERS. By Henry W. Stelwagon, M.D., Ph.D., Professor of Dermatology in the Jefferson Medical College and Woman's Medical College, Philadelphia; Dermatologist to the Howard and Philadelphia Hospitals; Member of the American Dermatological Association; Associate Member of the French Society of Dermatology and Syphilography, and of the Italian Society of Dermatology and Syphilography. Fourth edition, thoroughly revised, with 285 illustrations in the text, and 32 full-page lithographic and half-tone plates. Philadelphia and London: W. B. Saunders & Co., 1905.

A TEXTBOOK OF PHYSIOLOGY FOR MEDICAL STUDENTS AND PHYSICIANS. By William H. Howell, Ph.D., M.D., LL.D., Professor of Physiology in the Johns Hopkins University, Baltimore. Illustrated. Philadelphia and London: W. B. Saunders & Co., 1905.

THE BLUES (SPLANCHNIC NEURASTHENIA); CAUSES AND CURE. By Albert Abrams, A.M., M.D. (Heidelberg), F.R.M.S. Consulting Physician Denver National Hospital for Consumptives, the Mount Zion and the French Hospitals, San Francisco; President of the Emanuel Sisterhood Polyclinic; formerly Professor of Pathology and Director of the Medical Clinic, Cooper Medical College, San Francisco. Illustrated. Second edition, enlarged. New York: E. B. Treat & Co., 241-243 West 23d street, 1905.

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