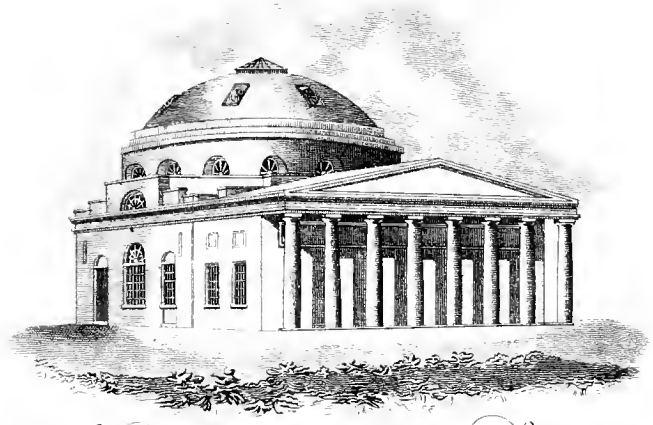

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ORGANOTHERAPY.

By HUBERT RICHARDSON, M.D.

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Organotherapy has made very considerable advance during the last decade, being a revival of ancient theories and superstitions based, however, on scientific theory and physiologic experiment.

Plinius states that the Greeks and Romans used the testicles of asses and the semen for impotence in Albania. These organs are used for the same purpose today, as well as for amenorrhea. Paracelsus recommends the spleen for the latter disease. Among barbarous and semi-civilized people, as well as among the peasantry in all countries, these customs exist. The Chinese physician prescribes dried mouse and lizard; the native African uses the liver of snakes, both internally and externally, as an antidote for snake bite showing the empyricle application of an antitoxin; the warrior eats the heart of the lion to give him courage. In Southern France raw snails are used for indigestion, as well as a luxury when cooked; in Cornwall and Devonshire earthworms are given for the same purpose, and are probably effective, as they contain a very powerful digestive ferment. In the Materia Medica, pepsin, pancreatin, ingluvin, cold liver oil and Fels Bovis are officinal, all of which are animal extracts connected with the digestive functions, so that to the use of other secreting organs or their extracts is but a short step, and today, the thyroid and suprarenal glands have obtained a permanent place in therapy, while the use of other organs is still *"sub judice."*

Theoretically, the administration of the active principle of any gland should be a specific for any pathologic condition that is the result of a glandular insufficiency eliminating the effects of complications; this is true.

The thyroid is a specific in myxadema and cretinism, provided there is no involvement of other organs and that the drug is absorbed into the system in an active condition; the latter being a point often overlooked in treating these diseases. It should be remembered that thyroiodin, the active principle of the gland, is precipitated by acids, but is soluble in alkaline solutions and in solutions of neutral salts. In many cases of the diseases under consideration, the intestinal tract is acid through its whole length, owing to constipation and faulty digestion. Pepsin and hydrochloric acid will digest protein bodies in the test tube as well as in the stomach, and if administered properly and continuously are a specific for absence of these two substances from the succus stomachi.

The hydrochloric acid has a further and more important function; upon its entrance into the duodenum it stimulates the secretion of secretin; the ferment which is absorbed into the general circulation serves to stimulate the pancreas to secretion, further, the hydrochloric acid stimulates the secretion of enterokinase, the ferment which converts trypsinogen into active trypsin; it is probable that it also stimulates the secretion of erepsin, a ferment which, though occurring in every organ of the body, is found in by far the largest quantity in the intestine and in the kidney, having a peptone-splitting power.

If hydrochloric acid or pepsin be absent or decreased in quantity in the succus stomachi, it is probable, and analyses have proven it, that rennin and invertin are also deficient. Recently Pawlow, of St. Petersburg, and his school have endevored to prove that rennin and pepsin were the same ferment, a view contradicted by Dr. Hemmeter, of the University of Maryland. Be that as it may, there is no doubt that rennin has other functions to perform besides simply clotting milk, the very fact of its presence in the succus stomachi from infancy to old age goes to show that it is necessary to digestion, and further, it exists in the stomachs of both birds and fishes, neither of whom, at any period of their lives, are on a milk diet. Definite experiments on the presence of cane sugar in the stomach contents under patho-

logic conditions are lacking, but there are many patients in whom cane sugar produces marked indigestion, due to its not being inverted. Theoretically and practically, we have a specific remedy for achylia if we administer a sufficient quantity, and at frequent intervals, during digestion, an artificial succus stomachi containing hydrochloric acid, pepsin, rennin, calcium chlorid, and invertin; the failure of hydrochloric acid, alone or with pepsin to relieve cases of achylia is due to the absence of the other ingredients of normal succus stomachi and to imperfect methods of administration. The administration of Fels Bovis has fallen into disrepute, probably from the inability of the patient to take a sufficient quantity. Theoretically, if the bile contains a sufficiency of sodium glycocholate and taurocholate, the cholesterine and bilirubinate of calcium, precipitation of which, either in the hepatic bile ducts or in the gall-bladder, will produce gall-stones and be held in solution, consequently, no stones will be formed; further, if an excess of the bile acids be present in the bile, stones already formed will be dissolved; therefore, sodium glycocholate mass should be a specific for gall-stones, which is borne out by clinical experience.

Pancreatin does not give very satisfactory clinical results, the reason probably being that it is affected in its passage through the stomach, and that the cause of the pancreatic insufficiency may be in the absence of secretin or interokinase, in which case its administration could not possibly do any good.

Suprarenal extract has not found much of a field in internal medicine in Addison's disease; where it should theoretically be a specific, it has given practically no results. Its use in Basedow's disease, owing to its physiologic action being directly opposed to that of the thyroid, has given some results. From its power of contracting the blood vessels and thus arresting hemorrhage, it is much used in minor surgery, some good results having been also obtained in hematemesis and hemoptysis.

There can be no doubt that the testicles and ovaries have a distinct function other than the secretion of the substances necessary for procreation. The effect of castration on the mental and physical condition is well known, especially in the arrest of puberty. The Russian chemist Phœl obtained certain results by the injection of "spermin," extracted from testicles, which he claimed was the active principle, but they have not been confirmed by other experimenters. Ovarian extract has been used during the menopause in chlorosis and dysmenorrhea.

The thymus has recently been shown to have some connection with the organs of generation, and has been given in Basedow's disease. Bone marrow has also its advocates in anæmia, but the clinical results are conflicting. Dessicated brain and cord have been used by hypodermic injection in locomotor ataxia, and good results obtained. The parotid gland is claimed to have some connection with menstruation, and has been given in dysmenorrhea. Extracts of the spleen and prostate have also been tried in various diseases, but without apparent benefit.

The antitoxins are a form of organotherapy, and have given some very brilliant results, and our hopes of successfully combating those diseases which, up to the present, have resisted medical science, are placed upon the development of this form of therapy.

MALE CATHETER IN FEMALE BLADDER.

By Hugh W. Brent, M.D.,

Late Resident Gynecologist University of Maryland Hospital.

The patient (N. C. gynecological) was admitted to the University Hospital in March, 1904.

For several weeks she had been suffering with frequent and painful micturition, pain being especially pronounced at the completion of urination. She was anæmic, highly neurotic and rather poorly developed. She gave the following history:

For some time patient had been in the habit of catheterizing herself, using for this purpose a soft rubber male catheter. About six weeks previous to her entrance into the hospital the catheter had slipped entirely into her bladder, and nothing had been seen of it since. From the evasive way in which questions were answered, and the general behavior of the patient, it is most probable that the catheter was not used for its proper purpose, but rather as an aid to masturbation. This was, however, stoutly denied by her.

The abdomen over the bladder was tender and very sensitive to pressure; pressure on the base

through the vagina gave rise to exquisite pain. Pain prevented any satisfactory beinanual palpation of the bladder.

After urination the suffering of the woman was really pathetic, and could only be relieved by the use of hypodermics of morphia. The urine was cloudy, alkaline, and loaded with pus and vesical epithelial cells; albumen was present, probably due to pus; no sugar.

Soon after entrance she was taken to the operating room and the urethra rendered insensitive with a 10 per cent. solution of cocaine. The bladder was emptied, and after the assumption of the genu pectoral position, a medium-sized Kelly Pawlik cystoscope was introduced. The entire bladder was much reddened, the systilus being especially marked around the trigonum. The catheter, curved upon itself and thickly encrusted with lime salts, had dropped forward into the fundus. It was removed with much difficulty, the patient, by her frequent changes of position, making the operation a very tedious one.

It was finally caught with a small tenaculum and pulled out through the cystoscope. After treatment consisted of bi-daily vesical irrigations of warm boric acid solution, tincture hyocyamus and potass. acetate, internally. In three weeks she left the hospital apparently entirely cured, no symptoms referrable to the bladder, and normal urine.

REPORT OF TWO CASES OF DISLOCATION OF SHOULDER.

By R. P. Bay, M.D.,

Assistant Resident Physician, University of Maryland Hospital.

These cases are reported, not because dislocation of the shoulder is uncommon, but because two men in same accident should be injured in identically the same manner. On December 25, 1905, two men were brought into the accident ward of the University Hospital, giving history of a fall of about twenty feet from scaffold to street, while engaged in painting. The scaffold, tilting, caused one man to fall ahead of the other, the first man striking on his left shoulder and side, while No. 2 caught on a window with his left hand, but was unable to hold, somewhat checking his fall.

On entrance to the hospital, about two hours after the accident, both men were seen to support their left arm and to carry it rigid. On further examination, both men had a dislocation of their left shoulder—one having a sub-femoid variety, which was easily reduced by slow, direct traction outward and inward, overcoming the muscle spasm present, his scapular being held firm by an assistant.

No. 2 had a sub-weacoid dislocation with considerable traumea around the joint, due to manipulation previous to entrance into hospital. Several attempts were made to reduce it without anæsthesia, but failed. Patient was given ether drop method, and after relaxed, dislocation was easily reduced by Koehn's method, after which both injured members were held firm by Velpian dressings, and patient discharged.

REPORT OF A CASE OF ECLAMPSIA. POSSIBLE TRAUMATIC ORIGIN.

By B. B. Ranson, Jr., M.D. (*Class of 1902*).

Maplewood, New Jersey.

The following case, occurring in my practice during October, 1905, seemed of sufficient interest to warrant my reporting it to the Hospital Bulletin:

Mrs. W., aged 20; pregnant for the first time, came under my care when two months advanced. Early months ran a normal course; slight morning nausea, for a period of two weeks at second month.

Family History—Mother and father living and in good health. Father has had evidences of slight nephritis occasionally during past ten years, at which time there was some little albuminuria, with presence of few casts. No recurrence during past three years.

Past History—Had measles, whooping cough and a mild attack of scarlet fever when a child. Has had no severe illness.

Present History—First urinalysis at second month revealed normal urine, chemically and microscopically. Examinations made at fourth, fifth and sixth months normal. General health excellent; able to attend to household duties and go about as usual until September 28, at which time she was nearly seven months advanced. Upon this date, while boarding a trolley car, she was thrown violently to the platform, falling upon her back. She sustained superficial contusions of

back and buttocks and nervous shock, together with some abdominal pain. Was taken home and put to bed, and immediately began to suffer with headache and backache, which increased the following day. Examination of urine two days later showed the presence of albuminuria, with hyaline and granular casts. Patient was kept in bed, put upon a milk diet, and active treatment with diuretics and cathartics. For two weeks the condition improved somewhat, with, however, a continuance of the albuminuria. The symptoms became aggravated—headache and backache; dizziness recurring; secretion of urine lessened, albuminuria and number of casts increasing. Induction of premature labor was advised, but opposed by family. On the eighteenth day after accident, vomiting and disturbance of vision occurred, and on the twenty-first day two severe eclamptic convulsions. These further seizures were controlled by the inhibition of chloral and bromide and the administration of m. x. of Squibb's fluid extract of veratrum viride every two hours hypodermically. Three doses of the veratrum were required to reduce the pulse rate from 130 to 80 degrees. Large doses of saturated solution of Epsom salts given by mouth, high rectal irrigation with saline solution and hot packs employed, with only slight response. Large soft rubber bougie was introduced into the uterine cavity, and vagina packed with sterile gauze. Patient's condition fairly good, fœtal heart sounds faintly perceptible. Active labor pains commenced within eight hours after introduction of bougie, increasing in severity. Twenty hours afterward patient began to exhibit signs of a recurrence of the convulsions. The vaginal packing was removed and an examination revealed the os dilated to the breadth of three fingers, membranes unruptured and breech presenting. Another, but less severe, convulsion occurring, chloroform was administered and the cervix dilated manually. A dead child, weighing 5½ pounds, was delivered—fifteen minutes in all being required. Patient was *profoundly shocked*. Strychnine and digitalin given hypodermically, and one pint of normal salt solution given by hypodermoclysis beneath each breast. Intrauterine douche of saline solution and high rectal injection of brandy and salt solution, together with twenty minims sal. adrenalin chloride administered. Reaction only moderate and condition remaining critical for twenty-four hours, active stimulation being continued all of the while. Improvement then became more marked, and an uninterrupted *recovery* ensued, the secretion of urine increasing, the albumin and casts disappearing, and within three weeks becoming practically normal. The patient was out of bed in three weeks and has since been as well as ever.

The most interesting feature of this case is the deduction of how great a factor in the etiology of the acute nephritis was the traumatism. It would appear to have been the immediate cause of the pathological changes occurring in the kidneys. There was, however, nearly four weeks between the last examination of the urine prior to the accident and the urinalysis made immediately afterward. It is possible that during this period some renal disturbance may have occurred, but if such were the case, there were no clinical symptoms manifesting nephritis.

A RELIABLE OPERATION FOR CYSTOCELE.

BY I. S. STONE, M.D. (*Class of 1872*).
Washington, D. C.

Definition—By reference to a medical dictionary, we will find that a "Cystocele is a vesical Hernia." It would perhaps be well for our patients if we would remember this when undertaking the cure of these annoying conditions. A cystocele is at least a prolapse of the base of the female bladder, and appears as a rounded tumor at the introitus vaginæ. It is, of course, unnecessary to carefully describe the precise anatomical and pathological changes which have brought about this vesical prolapse, and mention will only be made of such structures as are usually involved in the formation of the tumor and are necessarily to be utilized in the treatment.

Size of the Tumor—We now rarely see large cystoceles, for the excellent reason that physicians generally recognize the futility of the former treatment by pessaries, and have surgical methods practiced at a very much earlier period than formerly. We, therefore, usually find most of our cases of what may be called medium size. Such cystoceles will be found associated with a rectocele, and the two conditions will distend the introitus vaginæ and be plainly visible when the patient is in the dorsal lithotomy position. But

such tumors may be found of much larger size, and we occasionally see one which is apparently the entire bladder protruding between the patient's legs.

Anatomical Relations—Given a cystocele of medium size we will find the uterus rather low in the pelvis, and not infrequently the cervix will be found presenting at the introitus. The organ is extremely movable and the ligaments are elongated. The broad ligament, if inspected, will be found distended, with large venous sinuses, which undoubtedly cause symptoms in women much like those due to variocele in men. Still further search and study will often reveal an enteroptosis or an elongation of the mesentery, which permits great pressure upon the pelvic organs and especially upon the uterus and bladder. Therefore, we should remember that a cystocele is a complex affair and its proper treatment is by no means an indifferent proposition.

Office of the Fascia in Supporting the Uterus and Bladder.—Since Emmet taught us all we know about the office of the fascia we still gladly accord him the credit for his great work. We have learned but little about the pathology of these conditions, and, in fact, very little about their etiology since he wrote upon the subject, and must content ourselves with having learned certain matters of practical importance in regard to treatment. Perhaps we may now claim that the role of intra-abdominal pressure has more to do with the hernias and prolapses of abdominal organs than was formerly thought probable, but with this exception we are inclined to give Dr. Emmet full credit for a comprehensive view of the realm of gynecological pathology.

Treatment.—We find nearly all patients with cystocele are in sufficiently good condition to bear the necessary treatment. We rarely see greatly neglected cases, because physicians and patients alike have generally found the former methods quite inadequate and the present or surgical method of abdominal section with fixation of the methods giving greater satisfaction. In selecting cases for operative treatment we usually make a division into two classes. One, with extreme prolapse of the uterus, we treat by the combined fundus uteri to the rectus muscle. Besides this fixation we make the same careful plastic narrowing of the vagina with elevation of the bladder, as in the less complicated cases. But we see many more cases where we can rely upon plastic surgery alone for a permanent cure. The former or fixation cases we reserve for women not in danger of impregnation; the latter may be used in women of any age, but has its best field in those having a retroversion with a partial but not complete prolapse. We can always cure the cystocele if the uterus can be relied upon for support. In fact, we have seen the uterus again descend in the vagina after our operation, but we have never seen the bladder return to its former condition of prolapse. But while we think this is proof of the efficiency of our methods as far as the bladder is concerned, we do not consider any patient cured who has her uterus prolapsed, and hence we can only promise a cure by plastic work alone, when the uterus can be relied upon to support the bladder. Our first departure from the Emmet or Stolz methods of treating cystocele was expressed in a paper read in Philadelphia in 1900. In the following year we read a paper in Cincinnati, giving some modifications of a practical nature, and, finally, in 1902, we read a paper before the American Gynecological Society in which we described the present technique. Since then Dr. J. R. Goffe has read a paper before the section on "Diseases of Women," of the American Medical Association, giving substantially the same views and methods as had already been published by myself.

Method.—The object in view is to elevate and attach the bladder in an entirely new and higher position upon the uterus and anterior vaginal wall. We usually proceed as follows: The crest of the cystocele is grasped with the index finger and thumb of the left hand and the vaginal wall fearlessly divided with the scissors. This incision is extended until it reaches from the urethra to the cervix. The edges of the incised vagina are now caught with small clamps and the bladder is pushed away with a small gauze sponge until the entire case of the organ is quite free from uterus and vaginal wall. The scissors are needed when the utero-cervical vesicular ligaments are divided just above the cervix, and the technique is precisely as when we separate the bladder from the uterus in vaginal hysterectomy. In operating for small cystocele we do not enter the peritoneal cavity, but are content to stop our dissection at the superior reflexure of the bladder, a little short of the peritoneal or utero-vesicular reflexure. If the bladder has been very much prolapsed, we make it convenient to place one or more catgut

sutures far out toward the pelvic wall on each side, so as to stretch the base of the bladder and prevent folds or duplications on its lower surface and also to assist in sustaining the organ in contact with the exposed fascia as far upward and outward toward the pelvic wall as possible. The long flaps are now drawn together and as much shortened as necessary to permit their edge to edge approximation. The uterus is now brought forward and sutured to the vaginal wall, so that the bladder must be held above the point of contact of wall and uterus. We always secure the uterus in strong anteversion in the cases of extreme bladder prolapse. It is evidently impossible for the bladder to return to its former position, for if the operation has been properly done the new attachments upon the anterior vaginal wall and uterus must hold it in place. We have now had several years' experience with this method, and, as far as we are able to follow our patients, we can positively state that no recurrence has been reported.

CORRESPONDENCE.

ONE OF THE MANY VISITORS TO DR MILTENBERGER.

The editorial in last month's BULLETIN, entitled "Professor George Warner Miltenberger," and the equally interesting "In Memoriam," by his no less distinguished associate for many years in this University, Dr. Samuel C. Chew, were such beautiful and deserving tributes from the living to the dead, that those less gifted might reasonably hesitate the venture of anything supplementary. Beyond that, a given subject can ill-afford to claim from a journal or its readers unusual attention, yet it is believed a moderate forbearance will be tolerated in favor of that noble physician—"I shall not look upon his like again," whose life among us, so filled with generous impulses and characteristics, served not only as a shining beacon to the weary and half-blinded, but a veritable and healthy stimulant to all those with whom he came in direct contact. Though of a younger generation, the character, yes! individuality, of Dr. Miltenberger, was impressed indelibly upon the writer at occasional meetings, professional and otherwise, in the heyday of his career. His personality seemed so strongly marked—indeed unique, as on my part to awaken an ungovernable magnetism, kindred to filial respect—love, such as could not have been subverted, without flagrant cause, by even the exercise of will. On the other hand, I claimed from him only a friendly relationship—that so thoroughly enjoyed by the many in his life's meridian, and by the few near its nightfall.

In following my nature's impulse, visits, now and then, were made to his home, more especially during the declining period, where, in diversified talk, an hour would most agreeably be spent. The calls were made usually about noon, after his return from an accustomed walk, as this was to me most opportune; seldom at night, in spite of he and his faithful nephew importuning the evening hours. At best, my own busy life made these rare, only several each year, but upon returning home the result of each talk was reduced to writing in my "diary" of sermons, lectures, etc., volumes I have managed to compile and preserve as evidence of pleasures enjoyed, passed.

Few fail to remember with what surprise and regret, fourteen years ago, they read in the morning papers, editorially and locally, their first intimation of his professional retirement. The *Sun* articles are in my possession, and to show the editor's kindly sentiment I reproduce the opening and closing sentences: "Thousands of people in Baltimore and Maryland will learn with genuine regret this morning of the retirement from the active practice of his profession of that exceptionally able physician and accomplished gentleman, Dr. George W. Miltenberger. His withdrawal from the field in which he has so long been a prominent figure, and in which he has so successfully ministered to human health and happiness, falls little short of a personal bereavement to the many hearts to which he has become endeared by years of friendship, as well as of skillful service. The pathetic circumstances which surround his closing years and which have compelled him to devote himself to the care of his afflicted wife, will call forth the earnest and heartfelt sympathy of those to whom he has so often carried help in their hour of need."

Meeting him shortly thereafter, I jocularly remarked in reference to this, his publically lamented action: "Doctor, you certainly must have been reading your friend Mr. Wallis' 'Essay on Leisure,' in which he deplores and criticises the persistent struggle of Americans, its acceptance being often through demands apparent, not real," and

reminded him, in substance, of the following passage: "The retirement of those who can afford to break off from a system which coerces them—ought not to be difficult, and is not, where the will exists. It is a matter of everyday occurrence, in other countries—certainly on the continent of Europe. Men wind up their affairs, invest their money, accommodate their expenses to their means, and sit down to be happy, while there is yet enough of the vigor of life left to make enjoyment healthy and robust—while there is enough of taste, appreciation and thought remaining to be cultivated and developed—to be made useful as well as graceful." The doctor dissented from the application somewhat, impressing the causes to have been domestic demands and personal physical disability since his accident.

Soon thereafter I used my persuasive powers to convince him of the debt he owed the profession he had so faithfully and unselfishly served for fifty-five years, to write its local history, including personages, for that period. This, however, he would never accept seriously, but as a laughable jest. Certainly no one has graced medicine, in our State and generation, better calculated to have performed that mission, but, alas, the golden opportunity was doomed never to materialize. My last satisfactory visit was on his 86th birthday, March 17, 1905, where, surrounded by friends, relatives, floral and other tokens indicative of the reverence, respect and love of those near and dear, we sat in his bed-room, second story, corner of Eutaw and Monument streets, and at his own volition, without apparent effort or disinclination, he buried his personal discomforts and related with his usual charm, the pleasures of the birthday, the one present, those gone, along with many other reminiscences. He seemingly, like most others infirm and half-sick, needed the friendly smile, cheery voice—those to encourage the retrospect, the living over that which had been, not that which is, or is to be. One other visit—the last—was paid in the early summer, when he no longer was thoroughly himself; it is true often perfectly rational, but at moments a little dopy and sleepy, sufficient to destroy largely the continuity of thought as well as expression. It is the purpose to give here one of the earlier conversations, which will indicate the nature and possibilities of many, as well as the mental strength of the man. After sitting in the parlor a few minutes, his light, quick and elastic step, so characteristic, was heard, recognized in the hall; I arose and advanced to take his already outstretched hand. Short and small in stature, slightly stooped, large, clear, penetrating eyes, well receding and crowned with prominent hairy orbits; rounded face, covered mostly with grayish beard; strongly marked nose and forehead, but, oh, what a cordial grasp! "Doctor, I fear this a trespass upon hallowed time for your lunch or nap." "Oh, no! I never nap in the morning, seldom in the afternoon, and this is not our dining hour, that being at 6 o'clock. I have just returned from a visit to my niece, who has all her life been a care to me. I was a very young practitioner when my married sister became *enciente,* and one day during this condition she was accompanied by a friend to the apple orchard, where she saw a very beautiful cluster of blossoms, for which she made an upward jump, but in coming forcibly to the ground felt something give away. She, however, carried the fœtus to full time, and at the birth I and her regular physician, twice my age, were present. He decided to strangle the child, but I positively told him he should not do that. We found the fœtus with limbs flexed upon the shoulders, feet locked around the throat and backward. Upon getting it clear we observed the limbs without patellæ, and for over a year there were no signs of any. We kept her on pillows for sixteen months, and for five years she was unable to walk, while at the critical age she developed spinal trouble, and for years I have seen her daily—often three or four times. For seventeen years my last visit of a night was to her. She married, is the mother of four children, fine specimens, and at sixty is in fairly good health. I even yet try and pay the daily visit. My business affairs claim some little time, although I am relieved of this mostly by my nephew. While it is true I am out of medicine entirely, yet I continue to take in it much interest. Indeed, I feel as though I had been connected with the University of Maryland before it was established in 1807, chiefly because, when I came to study medicine there, its founders were enjoying the full harvest of reputation and years. There were Doctors Potter and Alexander, both fine practitioners, and with these gentlemen I became a full member of the faculty. Doctors William and Samuel Baker were also then great men in the profession; William had anatomy and surgery, Samuel the practice of medicine. I was associated with Dr. Nathan R. Smith for several years—in

his office. Dr. Gross, of Philadelphia, was very anxious that Dr. Smith deliver lectures at the Transylvania Medical College, so he gave up his original engagement at our University in order to spend six months there, but returned to Baltimore in the summer to renew his extensive surgical practice. This interruption compelled him to abandon a permanent office here, with the result of displacing me personally as an understudy. I then immediately entered the office of the Baker brothers, just referred to, and from there graduated in the spring of 1840. Dr. William Baker died in February, 1841, in mid-session, and while attending the funeral Dr. Aiken approached me and affirmed it to be the wish of the faculty that I assume Dr. Baker's chair, giving a lecture on the morrow, where he left off—temporal nerves. I expressed surprise as well as regret at not being advised a day or two in advance, as the subject next was very difficult, for surely the faculty could have determined its action without such unnecessary deliberation. I, however, said to myself—the opportunity must not be missed, and to the doctor, through whom the invitation came—'kindly request the faculty to say nothing tomorrow concerning Dr. Baker, and I will prepare an eulogy of him,' thus giving me a day to make ready for my new duties. I studied hard for that first lecture, walked the floor all night, and committed to a piece of paper the size of a small envelope simply the head-lines. I never did that again, but carried in my pocket that same memoranda, and the fact of having it seemed ever thereafter to inspire confidence for any and all subjects. This mental confidence reminds me of a noted lawyer of our city, who must always have in his hand a goose quill sheered of its plume except the tip end, which he would continuously twirl around while speaking or trying a case; if deprived of this his composure vanished and he was unable to speak. This was largely my case, or at least I felt so.

"I entered the University of Virginia in the fall of 1835, remaining the sessions of 1835-1836, 1836-1837, taking while there only academic studies. I was led to enter that institution chiefly through the influence of my uncle, Dr. Augustus L. Warner, who was its pro- but at that time Mr. Jefferson's remark- professor of anatomy, physiology and surgery, able personality and identification with that University gave to it a reputation that was very inviting to the then youthful. Prof. George Blaetterman was on modern languages; Gessner Harrison, ancient languages; George Tucker, moral philosophy; John P. Emmet, chemistry; Charles Bonnycastle, mathematics; John A. G. Davis, law, and chairman of the faculty. Prof. Robley Dunglison had been called to the University of Maryland, being then quite a medical writer, with an established but growing reputation. I have often seen him at the bedside. His was a striking and inspiring personality — tall, affable, profound thinker, beautiful lecturer. In consultation he always knew the ideal combination, above the attending physician, which would bring the best results. He diagnosed thoroughly each portion of the body in turn, and knew every part to a remarkable degree. I knew him well in after years, being brought in contact with him often —he certainly was a man ideally fashioned for medicine.

"Our journey to Charlottesville in those days was one of bitter experience. Steam cars carried us to Washington, stages thence the remaining distance. We would leave Charlottesville at midday and usually reach Washington at midnight. In rainy spells we would be compelled to alight and walk the streams on logs, letting the horses swim across with the stage. At night we sometimes would awaken the country inn-keeper for stimulants to keep us warm, and thereby prevent catching cold. He usually would be provoked, sometimes mad, but would go down into the cellar and draw us some of the most fearful stuff, which, several hours after taking, caused us many regrets. Steam cars in those days were double-deckers, and I preferred always riding in the second story.

"I consider Dr. Nathan R. Smith, and Dr. Randolph, of Philadelphia, originally from Charlottesville, and of the Jefferson-Randolph family, who was a specialist in genito-urinary troubles, the two finest surgeons in my experience. By all odds Dr. Smith was the best general surgeon I ever saw. He was bold in cutting, never hacked with mincing strokes, drove deep and told through what he was going, but in passing sounds he invariably drew blood—this, Randolph never did, nor did he hold the organ, preferring the patient to do that for himself, and before striking the stricture would always exclaim: 'We are approaching an obstruction.' Dr. Smith left Transylvania, and came a second time into the faculty

of the University of Maryland.

"I remember distinctly when in 1827 we entertained Lafayette, and what an enormous procession attended him through the important streets.

"Medicine, as enunciated by the Hopkins University, Dr. Osler, etc., has very much changed. They teach very little materia medica and scarcely any more therapeutics. How men can practice with the best results without knowing thoroughly the characteristics of the implements used is an enigma to me. We certainly get most out of anything when it is operated by intelligent knowledge, even a machine can do much more satisfactory work run by the accustomed and skillful hand than by the ignorant and inexperienced. Science robs all of us of faith when it claims to assign positively certain fixed results, without any possibilities of error.

"Anæsthetics did not come into use until the late forties, consequently prior to then we performed major as well as minor operations under the influence of whisky, brandy, etc."

Of this "Grand Old Man"—a sobriquet he can as justly wear as did the immortal Gladstone, to whom it was assigned originally—may we not hope to have a memorial volume by some one, in order to perpetuate the example of an honest life filled with good deeds, so worthy of emulation by those that are to follow? IPSE DIXIT.

THE ONE HUNDREDTH ANNIVERSARY OF THE UNIVERSITY OF MARYLAND.

BY JOHN C. HEMMETER, M.D., PH. D., LL.D.

"VIRIBUS UNITIS." — *"With united forces,"* this must be the motto of all University of Maryland Alumni, Legal, Dental, Pharmacal, and Medical, and even of all undergraduate students in the vigorous preparation for the hundredth anniversary of our dear Alma Mater. Success can only be accomplished if all these forces pull together with the professors and regents; even the most modest student must feel it his duty to contribute something, and to the best of his ability. If he cannot contribute anything else, let him at least contribute his enthusiasm. The students of all classes of all departments should hold meetings during the month of March, and organize for the purpose of adding their small building blocks to the mighty festival structure which shall commemorate the centennial of the University of Maryland. The regents of the University of Maryland have appointed the following committee to have charge of all preparations for the festival:

W. Calvin Chestnut, LL.B.; Edgar H. Gans, LL.B.; John P. Poe, LL.D.; R. Dorsey Coale, Ph. D.; Charles W. Mitchell, M.A., M.D.; David R. M. Culbreth, Ph. G., M.D.; John C. Hemmeter, M.D., Ph. D., LL.D., Chairman.

On the 21st of February, Professor Hemmeter called a meeting of all the committees of all the elected, by the adjunct faculty, the Medical Alumni Association and the Alumni Associations of the other departments of the University to confer with the above committee concerning the best way to make befitting preparations for the celebration of the one hundredth anniversary of the University of Maryland. At that time the regents had decided that in strict accord with the history of the institution only the centennial of the MEDICAL department could be held in 1907.

By request of all the Alumni attending the meeting of February 21, the regents were induced to reconsider this matter, and on February 27 a very largely attended meeting of the regents met for this purpose, at the offices of Mr. John P. Poe. The following resolution was unanimously passed on that occasion:

MEETING OF REGENTS OF THE UNIVERSITY OF MARYLAND, FEBRUARY 27, 1906.

Dr. Hemmeter in the Chair, John P. Poe, Esq., Secretary.

After an explanation of the object of the meeting by chairman, Professor Poe moved,

RESOLVED, *That it is the sense of the Regents in council assembled that, inasmuch as the School of Medicine, organized in 1807, was the foundation of the University of Maryland, by the annexation to it of other departments, a centennial celebration of the whole University may properly be held in the year 1907.*

This motion was unanimously carried. There is, therefore, no further doubt regarding the scope and extent of a festival to be held in May, 1907. It is to take in the entire University of Maryland. The medical regents, notwithstanding all reports to the contrary, were always, and with one accord, in favor of this view of the

celebration. It was owing to an opinion given by the most prominent of regents of the Law department (Messrs. Bernard A. Carter, Edgar H. Gans, and John P. Poe) that the medical regents reluctantly gave up the hope of celebrating the event of 1907 as one comprising all departments of the University. Even at the last meeting of the regents Professor Poe expressed the opinion that the extension of the centennial idea to embrace all the departments of the University *was won by construction.*

Be that as it may, we need the help of all departments alike, especially of the law department and all of its Alumni. The alumni of the department of law should feel it their duty to aid in this celebration, for it is also the hundredth anniversary of their University. Let us see how the legal brethren that have emanated from this institution will prove their loyalty to it. The sentiment of the faculty of medicine concerning the celebration is clearly portrayed in the address of welcome by Dr. Hemmeter on February 21, which was as follows:

Fellow Alumni and Friends:

The most pleasant duty in calling this meeting to order is to extend to you academic greeting. Be cordially welcomed and assured of the friendship of the regents of the Faculty of Physics.

This representative meeting is not a response to a general call to the Alumni, but only to special invitations sent to committees elected by the various faculties, the adjunct faculties and the various Alumni Associations. I hope we shall have a larger and general meeting in the near future as a result of a call to all Alumni that can reach the Alma Mater by a few hours' trip on the railroad. To the committee of our Washington Alumni Association—an ornament to this University and active factor in the progress of medical science at our National Capital—I desire to express a warm assurance of our joy at this manifestation of their loyalty.

Too seldom have these reunions been held at the hearth of our intellectual mother. *Let us recognize the beauty and power of true enthusiasm, and whatever we may conclude to do,* for the purpose of celebrating the 100th Anniversary of our Alma Mater, *let us guard against checking or chilling a single earnest sentiment.* A university is not an aggregate of buildings, but of thinking men of human minds. And *what is the human mind*—however enriched with acquisitions or strengthened by exercise—when unaccompanied by an ardent and sensitive heart? Its light may illumine, but it cannot inspire. Knowledge without a heart may shed a cold and moonlight radiance upon the path of life—but it warms no mental flower into bloom, it sets forth no ice-bound fountains of conservatism. Dr. Johnson has often been quoted as saying that an obsolete rationality and conservatism prevented him from being a Papist. Does not the same cause prevent many of us from unburdening our hearts and breathing our devotions at the shrine of our Alma Mater—obstinate rationality and conservatism not only among the Alumni, but also among our regents and faculties? There are influences which environ humanity and all leading institutions which are too subtle for the dissecting knife of reason. Let us see whether we cannot make these influences a means of blessing to our present purposes. Let us be in our better moment clearly conscious of our loyalty to fellow-alumni and to the University, and if there is any barrier to sentiment and friendship, may God convert it into a blessing.

The object of this meeting is to make befitting preparation for the celebration of the 100th Anniversary of the University of Maryland.

The regents have determined to hold such a celebration in May, 1907, and they desire your advice and assistance for this purpose.

I cannot conceive of the conclusion of one century of glorious history and meritorious work and the entering upon a new one without the accomplishment of some great object to the advantage of the future of the University, and this should be a warmer, closer relation with the Alumni and the foundation of an Alumni professorship; that is the endowment of a professional chair by the Alumni and that be filled by vote of the Alumni.

On the 2d instant the class of 1876 celebrated its thirtieth anniversary by holding a reunion and banquet at the Hotel Rennert, Baltimore, Maryland. Those present were:

Dr. H. D. Fry, Washington; Samuel Offutt, Greensboro, Pennsylvania; F. H. Gorsuch, George H. Hartman, Thomas C. Worthington, A. C. Pole, Wilmer Brinton, Samuel J. Belt, H. H. Biedler.

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BALTIMORE, MD., MARCH 15, 1906.

EDITORIAL

THE VIRGINIA ALUMNI OF THE UNIVERSITY.—The BULLETIN has urged the Alumni of the University of Maryland residing in North Carolina to come together at the next meeting of the State Medical Society to be held in Charlotte and to organize a State Alumni Association. The response to this suggestion has been so cordial that no doubt remains that this organization will be effected at the meeting in Charlotte.

Having this guarantee of a local association in North Carolina, the BULLETIN now hastens to suggest to the Alumni of the University residing in Virginia the advisability of organizing an association of University of Maryland graduates in the Old Dominion. The University of Maryland has several hundred graduates practicing medicine in Virginia. These Alumni are among the leading physicians of the State and do not only full credit to the University, but are an honor to the profession of Virginia.

Why not come together, fellow Alumni in Virginia, at the next meeting of the State Medical Society and organize an association? The BULLETIN hopes that the suggestion will bear fruit and that Virginia, as well as North Carolina and other States, will have Alumni reunions at stated periods. Now that the Centennial of the University is so near at hand, the organization of the Alumni of the University in all of the States will promote an interest in and add to the proper celebration of an event of great historic interest.

PROPERTY RECENTLY PURCHASED BY THE MEDICAL DEPARTMENT OF THE UNIVERSITY.—The Alumni of the University will recall the row of the two-story buildings fronting on Greene street, at the northwest corner of Lombard street, opposite the University grounds and the Hospital Building. Realizing the value of this property in the future growth of the University the Faculty of Physic has recently purchased four of these houses which have a combined frontal on Greene street of some 75 feet, and extending along Lombard street 85 feet to an alley in their rear. This northwest corner, which has been an eyesore to the University for years, the Faculty believed should be secured at this time and held for development by the University in the near future. With Calvary Hall on the southeast corner of Greene and Lombard streets, the four corners will in future be controlled by the Faculty of Physics, and will be given over to the larger work which the University has in view.

Property in the neighborhood of the University is not only changing hands rapidly, but is growing in value for manufacturing and business purposes. With the northwest corner secured, the University is protected against the encroachment of houses that might injure the character of the locality for educational purposes. The policy of the Faculty of Physics is to enlarge and improve the University plant and to bring the school up to the highest plane of efficiency possible under existing circumstances.

CENTENNIAL OF THE UNIVERSITY.—At a recent meeting of the board of regents of the University of Maryland it was decided by resolution that the University could properly hold its Centennial Anniversary during the year 1907.

It will be recalled that the Medical Department of the University was chartered in 1807 by the Legislature under the name of the College of Medicine of Maryland, with a board of regents. The first meeting of the board of regents was held at the home of Dr. John B. Davidge, on the 28th of December, 1807, at which meeting an organization of the Faculty was effected, and the career of the school had its beginning. The College of Medicine of Maryland began its work in a feeble way, with small classes of students and in buildings poorly equipped for educational work. Numerous changes took place in its Faculty by reason of deaths, resignations and accessions, but the college grew each year and took

on a more prosperous outlook. The first public commencement was held in April, 1810, at which degrees were conferred on five graduates. The want of a suitable building was felt from the beginning, and as soon as the money could be raised the ground at the northeast corner of Lombard and Greene streets was purchased from Col. John Eager Howard, and the present building was erected. This building was begun May 7, 1812, and was so far completed that it was partially tenantable during the fall session.

The idea of engrafting a University upon the College of Medicine seems to have been conceived about this time, for at the session of the Legislature, held in the fall of 1812, an act founding the University was passed with the approval and advice of the board of regents. The date of the passage of this act was December 29, 1812. The College of Medicine of Maryland was "authorized to constitute, appoint and annex to itself the other three colleges or faculties, viz: The Faculty of Divinity, the Faculty of Law, and the Faculty of Arts and Sciences, and the four faculties thus united shall be, and they are hereby constituted an University, by the name and under the title of the University of Maryland."

Whilst in a strict legal sense the University of Maryland as a University was established by the act of December 29, 1812, in a more liberal sense the origin of the University began with the act of 1807, which founded the College of Medicine of Maryland and which subsequently amended its charter and annexed to itself the other departments in 1812, thus changing its name to the University of Maryland.

The liberal construction given to the act of 1807, and the determination of the board of regents to celebrate the one hundredth anniversary in 1907, we believe, will meet with the cordial approval of all of the friends and Alumni of the University.

That the College of Medicine had its origin and entered upon its educational work in 1807 cannot be denied. Its change of name and annexation of other departments was incidental to its development, and in this sense may be considered a continuous function, since other departments not mentioned in its charter have been and may be annexed in future.

It is the spirit and the actuating principle which are to be celebrated in the centennial of the University to be held in 1907, and not a technical construction of the act of the Legislature establishing its several departments.

It seems to be wise and proper that the Medical department of the University should celebrate the Centennial of its organization.

There can be no breach of propriety or of good sense in having the other departments of the University take an active part in this celebration. All should join hands and determine to make the occasion worthy of the historic event it will celebrate.

Beginning of Vol. II of the "Bulletin."—With the present issue the Bulletin enters upon the second year of its publication. To those of its readers who have watched its progress during the first year of its existence it must be apparent that it has come to stay and that it has a future among the list of periodicals now offered to the medical profession. As the Bulletin occupies an unusual position as a periodical, its claims upon the medical profession are limited to the alumni of the University of Maryland; hence it must rely upon this class of readers for its support. During the past year copies of the Bulletin have been sent to every alumnus whose address was known. This policy will be adopted during the present year, but as the number of alumni is much larger than the regular monthly edition it is manifestly impossible to send the Bulletin each month to all who do not subscribe. As the subscription price is only one dollar a year it is hoped that many of the alumni will become regular subscribers and will not rely upon the occasional free visits which it makes. The material support given to the Bulletin will be fully returned to the subscriber in the improvements which will be made in the character of the publication. The Bulletin is now published at a heavy expense, and up to this time this expense has been largely borne by the stockholders. It is but just that every alumnus who takes a pride in the University should contribute the small subscription price of the Bulletin to aid in the work it is trying to do for the University and for all of the alumni.

Numerous letters from old students go to show that the Bulletin is fully appreciated by many readers who enjoy its monthly visits and approve of its efforts in the work it has undertaken. That the Bulletin has a great future we feel assured. It asks the alumni of the University to

write for its pages and to subscribe for its regular issues. Many improvements are contemplated in the near future if its financial returns will justify them. It is up to the alumni to say whether the BULLETIN shall occupy a low plane or expand into a publication that will reflect credit upon the University and upon the alumni as well. Its matter is made up entirely of the contributions of the alumni or those connected with the teaching and hospital staffs. Its news items, personal notices and miscellany have reference entirely to the doings, sayings and happenings of students and graduates of the University. This material can be enlarged upon and improved upon in many ways by the co-operation and support of those who have a personal interest in the work of the University, and in her future as well as past. Every alumnus should feel that the BULLETIN has an interest in him and a claim upon his consideration. It is within his power to add to the interest of its reading matter and to keep himself within touch of his old classmates, and in the view of former and of future graduates of the University. When an alumnus writes a paper or address and publishes it in another publication he should send a marked copy or abstract of the same to the BULLETIN. When he is honored in any way or does something which he feels is worthy of notice he should send a notice to the BULLETIN. Marriages, deaths, change of residence and other items are inserted when brought to the attention of the editors, the desire being to make the columns of the BULLETIN entertaining as well as instructive.

It is proposed during the coming year to publish short biographical sketches of the alumni with half-tone portraits, when the subject and the occasion seem to call for such insertions.

In many ways the field which the BULLETIN is trying to cultivate as a literary and scientific publication can be so improved by the co-operation of the alumni that its interest and value to the reader will be greatly enhanced.

In this age of novel and original features in literary ventures it is quite possible to bring out in connection with the BULLETIN some striking ideas and suggestions which may give it a unique position among the list of college and university publications. Will not the alumni of the University give encouragement to the effort which the BULLETIN is putting forth in trying to create a University spirit and loyalty among its graduates and students?

NOTES AND ITEMS

Among the visitors to the University Hospital during the past month were the following:

Dr. J. L. Hopkins, class of 1897, Havre de Grace, Maryland.

Dr. Charles H. Kriete, class of 1895, of Aberdeen, Maryland.

Dr. J. Vance McGougan, class of 1893, of Fayeteville, North Carolina.

Dr. William Ellicott Elisha Tyson, class of 1905, of Laurel, Maryland.

Dr. H. A. Zepp, class of 1904, of St. Michaels, Maryland.

Dr. E. B. Quillan, class of 1904, of Rocky Mount, North Carolina.

Dr. R. O. Lyell, class of 1902, of Warsaw, Virginia.

Dr. William H. Whitehead, class of 1870, of North Carolina.

Dr. F. N. Nickols, class of 1902, of Denton, Maryland.

In the *Journal of the American Medical Association* of September 23, 1905, Dr. James A. Nydegger, 1891, of the United States Public Health and Marine Hospital Service, reports a rather unusual gonorrhœal complication occurring in a Swede, the inflammatory process spreading to the chain of lymphatic glands situated about the external iliac artery. After a careful search of the literature Dr. Nydegger was unable to find a single reference to a complication of this nature.

As a preliminary to lumbar nephrectomy in tuberculosis or malignant growths of the kidney, Dr. George Walker, 1888, in the November 25, 1905, issue of the *Journal of the American Medical Association*, suggests transperitoneal ligation of the renal vessels, preparatory to a lumbar nephrectomy, as he has been led to believe in such cases the possibility of the operator squeezing infectious material into the general circulatory or lymphatic system, thereby setting up a general tuberculosis or malignant metastasis. As yet he has not performed this operation, but has been led to advance the proposition purely upon theoretical grounds.

Dr. Andrew J. Crowell, class of 1895, of Charlotte, North Carolina, writes to one of the editors of the BULLETIN:

"I see from the University BULLETIN, which just came to hand, that there is an effort on the

part of our North Carolina Alumni to organize an Alumni Association in this State, and I write to say that I am heartily in favor of this movement, and will do all I can to help it on. A number of us have been talking of this for a long time and I think now is the time to act. If you say so I will go right at it and do all I can to make it a success. I think it would be well for us to have a little social gathering of some kind, that we might have some pleasant words with each other."

Dr. William Baker Morrison, class of 1895, of Hagerstown, Maryland, has been appointed physician to Bellevue Asylum.

Dr. M. S. Wilson, class of 1903, who has been engaged, since graduation, as a contract physician, in the mines at Clarkville, New Mexico, has resigned, and expects, in the near future, to locate in Wyoming. According to the Doctor, living conditions in this Southwestern State are not very attractive. There is practically no society, the larger proportion of the population being composed of Mexicans and Indians. Water is very scarce, consequently vegetation not very luxuriant. The ground is very fertile and productive when irrigated, but is too far away from water to be treated in this manner. Where he was located, was practically a desert—water being obtained by means of artesian wells, sunk several thousand feet into the soil, and sage bushes and cacti being the only plant life hardy enough to flourish in such environments.

We are glad to report that Dr. William A. Parvis, class of 1905, who has been forced to take up a residence in the Blue Ridge Mountains, owing to an incipient phthisis pulmonalis, is reported to be making a recovery. The BULLETIN extends its sympathy and best wishes for an early recovery.

The members of the Delta Chapter of the Kappa Psi Fraternity of the University of Maryland held their annual banquet, February 13, 1906, at the Belvedere Hotel. The committee in charge of the banquet was composed of Messrs. J. P. Harrell, H. P. Hill, Jr., W. D. Campbell, R. B. Hayes, and I. D. Chaney, all of the class of 1906.

Dr. Benjamin R. Teff, class of 1905, of Anthony, Rhode Island, has been appointed by Governor George B. Utter, of Rhode Island, subject to the confirmation of the Senate of that State, Medical Examiner for the first district of the county of Kent, which includes the towns of Coventry and West Greenwich. The appointment will not expire until January 31, 1908. The BULLETIN extends its hearty congratulations to Dr. Teff, and wishes him success in his new sphere of activities.

Dr. William S. Love, class of 1890, a prominent practitioner of Northwest Baltimore, and a warm friend and supporter of the Old University, has been appointed one of the coroners for the city of Baltimore, Maryland, by his Excellency, Governor Warfield.

Among the coroners reappointed by the Governor are the following of our Alumni: Dr. G. Frank Jones, class of 1889; Dr. Silas Baldwin, class of 1867, and Dr. Patrick Martin, class of 1900.

At the regular meeting of the Library and Historical Association, held February 27, 1906, in Chemical Hall, addresses were delivered by Dr. Randolph Winslow and Dr. Charles W. Mitchell upon subjects of interest.

In a well-played basket ball game at Gettysburg, February 14, 1906, the University team was defeated by Gettysburg College, 16 to 7.

In a closely contested game of basket ball during the latter part of February, at Cross Street Hall, the team of the College of Physicians and Surgeons defeated the University five by the score of 22 to 19.

Dr. Oliver T. Everhart, class of 1856, of Hanover, Pennsylvania, celebrated the fiftieth anniversary of his graduation, March 5 instant. In honor of the event, all the physicians of Hanover tendered him a complimentary dinner. Among the invited guests were a number of physicians from Baltimore and York. Dr. Everhart was born at Manchester, Maryland, in 1832. He was educated at Franklin and Marshall College, Lancaster, Pennsylvania, and was graduated

from the University of Maryland, March 5, 1856. He began the practice of medicine in Goldsboro, York county, and later opened an office at Marysville, Dauphin county. In 1878 he went to Hanover and soon established a large practice. During the Civil War Dr. Everhart was a surgeon in the Federal Army.

Dr. Summerfield B. Bond, class of 1883, has been appointed chief medical examiner of the Baltimore and Ohio Railroad.

Dr. H. D. Purdum, class of 1902, resident obstetrician of the University Hospital, has resigned to take a position in an insane hospital in Michigan.

At the January 22, 1906, meeting of the University of Maryland Medical Society, the following gentlemen contributed to the entertainment of those present: Prof. Randolph Winslow, Dr. Page Edmunds and Mr. Bowlus. We desire to call the attention of the medical profession in general, and our Alumni especially, to a standing invitation to attend these meetings. Upon request the superintendent of the University Hospital will be glad to give any information concerning the night and time of calling the society to order.

Prof. Randolph Winslow exhibited the photographs and the skiagraph of an exostosis of the tibia occurring in a colored man, 21 years of age. Not on account of the rarity of the lesion was it brought to the attention of the society, but from the fact of its resemblance to a displaced astragalus.

He next exhibited a little colored girl, 7 years of age, upon whom he and his assistant, Dr. Bagley, had operated upon for double congenital inguinal hernia, a malformation of exceedingly rare occurrence.

His final case was a man with a hard, nonpainful, growth of the neck, which he first noticed about nine years ago. It is about the size of an egg, and is situated between the thyroid cartilage and the base of the tongue, according to Dr. John R. Winslow, who made the laryngoscopic examination, being incorporated with the epiglottis. As the patient's breathing had become very bad, a laryngotomy was performed, since which time his condition has not been such as to warrant operative interference. According to Von Bergman, tumors of the hyoid bone are of the utmost rarity, only two or three cases occurring in the literature; nevertheless, from the symptoms and a radiograph, Professor Winslow is led to believe this to be a tumor of the hyoid. Since this report, the patient has undergone an operation, and the diagnosis verified, the growth being a sarcoma. As the patient's condition did not warrant a general anæsthetic, cocaine had to be employed to deaden the pain; nevertheless, the base of the tongue, a considerable portion of the pharynx, and the larynx, were extirpated, an undertaking of great magnitude without a general anæsthetic.

At the time this article goes to print, we are happy to report that this man is up and walking around the ward. His general condition is much improved, and taking everything into consideration, he is leading a much happier life than previous to the operation.

Dr. Guy Steele, of Cambridge, Md., writes to the BULLETIN: "I notice that with the February number THE BULLETIN has completed its first volume. Please allow me to extend my congratulations on the excellent paper you are getting out. You surely have accomplished far more than your earnest well-wishers could have expected, and the future of the venture is assured, as you supply just what I, in common with hundreds of University men, have longed for and have at last obtained—a medium of keeping up with old friends in faculty and class, and of knowing what is going on at our old school. Perhaps the greatest defect of the University in the past has been its modesty. The trumpet has blown long and loud over the achievements or claims of other schools, while we have plodded along turning out some of the best men in the country with no one the wiser but our Alumni. These have hardly been loyal, and have allowed themselves to drift apart and often into obscurity for want of even a small pipe to herald their coming and going and to announce their often brilliant work. Though I am one for whom the blasts will never blow, I am thrilled with pride when one of ours has achieved success or fame, and my heart warms at recollection of the friendships formed in student days. So, more than any of the many journals that reach me, I welcome the BULLETIN, supplying, as it does, the means of keeping in touch with friends old and new, with all that pertains to old Maryland.

At a meeting of the New York State Club of the University of Maryland, held in the Y. M. C. A. rooms, February 13, 1906, the following officers were elected: President, A. H. Wright, medical department, '06, New York city; vice-president, C. A. Gifford, dental department, '06, Easton, N. Y.; secretary, Wm. Blakeslee, dental department, '09, New York city; treasurer, R. W. Jackman, dental department, '09, Lockport, N. Y.: sergeant-at-arms, J. W. Keeler, medical department, '06, Hammondsport, N. Y.

DEATHS

On February 6, 1906, Mr. J. Howard Hughes, class of 1906, of Jersey City, accidentally shot himself in the abdomen with a revolver, at his home in Jersey City, the injury in a very short time proving fatal. Members of last year's graduating class, of which Mr. Hughes was originally a member, will regret to hear of his untimely demise, for he was very popular with his classmates.

Mrs. Fanny J. Smith, of Madison, Dorchester county, Maryland, wife of Dr. Benjamin L. Smith, class of 1859, and for many years chief clerk of the Maryland House of Delegates, and mother of Dr. William S. Smith, class of 1883, of Baltimore, Maryland, died February 14, 1906, at the residence of her husband, aged 65.

Dr. John Williamson Palmer, class of 1847, a Baltimorean, a worthy son of a worthy mother; poet, editor, war correspondent, and physician; one of the most distinguished graduates of the University of Maryland, died, February 26, 1906, at the residence of his sister-in-law, Mrs. William C. Palmer, 1104 McCulloh street, Baltimore, Maryland, of a complication of diseases, superinduced by old age, in the 81st year of his age. He is survived by a widow, and a son, Mr. Courtland C. Palmer, of Colorado. After graduating, Dr. Palmer traveled in the West and the Orient, gathering a mint of literary wealth, which he later published in magazines of the day, in the form of travel and fiction. While in the East, as a volunteer surgeon in the British Army, he saw active service in the second Burmese War. At the outbreak of the Civil War he became a war correspondent, and while engaged as such, his pen produced his masterpiece, a poem, "Stonewall Jackson's Way."

From the conclusion of hostilities until his last illness Dr. Palmer has actively pursued his literary labors, his facile pen finding especial vent

Dr. John Williamson Palmer

in lyrics of more than usual merit. In 1866 he contributed to the medical profession, "A Treatise on Epidemic Cholera." In the death of Dr. Palmer the University loses an illustrious son and an ardent admirer.

Dr. Lawrence G. Mitchell, class of 1884, of Downing's, Richmond county, Virginia, died February 28, 1906, at the home of his brother-in-law, Mr. F. W. Motley, near Sharp's Wharf, after an illness of three weeks, in the 45th year of his life. Dr. Mitchell was one of the most skillful physicians in the Northern Neck of Virginia and enjoyed a large practice.

MARRIAGES

Dr. Oswald O. Kafer, class of 1905, of Newberne, North Carolina, and formerly a house student in the University Hospital, was married at Baltimore, Maryland, March, 7, 1906, to Miss Lillian May Taggart, of Baltimore. The BULLETIN extends to the young couple its best wishes for a long and prosperous married life.

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REPORT OF A CASE OF ROUND CELL SARCOMA OF TONGUE, TONSIL AND PART OF SOFT PALATE—EXTIRPATION—NO RECURRENCE IN FOUR YEARS.

BY ST. CLAIR SPRUILL, M. D.,

Clinical Professor of Surgery, University of Maryland, Baltimore, Md.

The condition from which this man was suffering—round cell sarcoma of tongue—is sufficiently rare to justify my bringing this patient before you. Only thirty-six cases are recorded in the literature of sarcoma of tongue where operation was done; seven of this number were treated with total extirpation of tongue, with but one recovery. I wish to indicate briefly some of the most important points in making a diagnosis, and to describe the technique of the treatment after operation.

Diagnosis.—The clinical diagnosis of sarcoma of tongue is extremely difficult. It is most frequently mistaken for gummata, less rarely for tuberculosis and actinomycosis. When ulceration takes place, the clinical picture is very similar to that presented by gummata. They should be differentiated by the history of onset and evolution of the disease, and the use of antisyphilitic treatment.

Sarcoma of the tongue usually occurs between the ages of forty and fifty, occasionally prior to these limits. Metastasis is the exception, rather than the rule. The superficial epithelium usually remains intact, unless the tumor grows very rapidly, then it ulcerates, becoming crater-like in shape. The growth is generally soft and not well differentiated from the surrounding tissues. The pain resembles that of carcinoma, radiating to all parts supplied with sensation by the fifth nerve, especially to the ear, and templar regions, being conducted by the lingual nerve, and from it to the other branches of the inferior maxillary nerve, especially the auriculo-temporal. Possibly pain in the ear may be due to the implication of the fibres of the glosso-pharyngeal nerve, which by tympanic branch is conducted to the tympanic plexus.

Gummata, on the other hand, may occur at any age, and are usually seen at the tip or margin of the tongue. They may be multiple or single, generally painless, ulcerate early if untreated, having a base covered with a tough secretion, which can be removed without causing bleeding, while in sarcoma the ulcerated base bleeds freely upon manipulation.

With clinical history, anti-syphilitic treatment and microscopical examination of a section of the growth, there should be no doubt as to the proper diagnosis.

Treatment.—The treatment should be thorough and complete, as sarcoma of the tongue presents no feature different from sarcoma in other parts of the body. I cannot understand why there should be any difference in the treatment, when located in the tongue, from that of sarcoma of the breast or elsewhere. If we operate and fail to remove entire growth, it is sure to return in this location as in any other. When the growth is located at the base of the tongue, it is best to extirpate the whole tongue, together with submaxillary, sublingual, and nearest lymphatic glands, and all affected surrounding tissue. The procedures for the the excision of the tongue are many; it may be removed through the unaltered mouth; through an incision in the neck; through the mouth after splitting the cheek; or temporarily dividing the interior maxilla and after incision of the inferior maxilla. The choice of the operation should be influenced by the extent of the disease. I selected Kocher's operation, slightly modified.

Case.—Mr. McC., age 40, was admitted to the University Hospital on March 25, 1902, complaining of dryness of the mouth, pain, difficulty in swallowing, and a tumor on the dorsum of the tongue. He first noticed this growth about two months before consulting his phy-

sician, Dr. Monroe. At this time, it was very small. On admission to the Hospital, I found a crater-like tumor about the size of a walnut at base of tongue, involving the right tonsil and soft palate, somewhat harder than the substance of the tongue, raised well above its surface, and slightly elevated at the top, and bleeding easily upon palpation. The right submaxillary, sublingual, and the chain of glands along the carotid artery were found to be enlarged. A small section of the growth was removed for microscopical examination, and was returned from the pathological department with the diagnosis round cell sarcoma.

Operation.—April 4, 1902—Patient being anæsthetized with chloroform, and field of operation rendered aseptic, an incision was made on the right side along the anterior border of the sterno-mastoid muscle, from the mastoid process to about the centre of the muscle, thence transversely forward in the crease between the floor of the mouth and the neck, to the hyoid bone; thence along the anterior belly of the digagstric muscle to the symphysis meti. The skin and subcutaneous fascia being divided, the flap was turned back by dissection over the cheek. All enlarged glands from the upper end of the sterno-mastoid and from beneath the angle and body of the inferior maxilla were removed en masse. The submaxillary gland was dissected up, working from behind, and removed simultaneously with the cervical glands. The sublingual gland was similarly removed. The facial artery and vein were tied as soon as exposed in the process of raising the submaxillary gland. The lingual artery was tied near its origin before passing under the hyoglossus muscle. The incision was continued on the left side from the one at symphysis to the border of sterno-mastoid, and the above steps repeated on this side. The mylohyoid muscle was now exposed and divided as far as necessary, the mucous membrane cut close to and parallel with the inferior maxilla, and the mouth entered. The tongue was now seized and drawn through floor of mouth and wound in the neck. The jaw was held up by an assistant and the tongue removed with curved blunt scissors, together with the tonsils and soft palate. The glands under and posterior to the sterno-mastoid on each side were removed through a second incision back of this muscle. Korcher always performs a tracheotomy before this operation. In this case it was not done, and only a few drops of blood were lost during the excision of the tongue. The denuded surface was now swabbed over with chloride of zinc, 40 grains to the ounce, which prevents immediate sepsis by causing the wound to be covered with inflammatory exudate. The cavity was packed with gauze and the flaps brought into place, leaving a small drain at the bottom of wound. Following the operation, the maximum temperature was 102.5 degrees on the second day.

Patient was discharged from the Hospital April 24, 1902, in good condition, with no evidence of post-operative metastasis. At the present time, four years since the operation, patient is in good health, works daily, presents no sign whatever of recurrence, and, I think, may reasonably be reported as the second recorded recovery of sarcoma of the tongue treated with total extirpation.

MECHANISM AND MANAGEMENT OF OCCIPITO—POSTERIOR POSITIONS *

By L. M. Allen, M.D.,

Associate Professor Obstetrics and Chief of Obstetrical Clinic, University of Maryland; Consulting Obstetrician to the United Charities Hospital, Cambridge, Md.

The subject of posterior occiput is certainly not a new one, but is one concerning which there is considerable difference of opinion. It may be safely said that there is no variety of labor in which easily avoided ill results are so commonly incurred as in posterior positions of the vertex, and for that reason no subject in obstetrics better deserves the attention of the physician than the means of its detection, its complicated mechanism and the varied measures advised for its management. In bringing the matter before you, it is not my purpose to attempt anything original, but with the hope that it may be possible to clear up some of the difficult points. Labor, when the occiput is posterior, is usually longer and more difficult, for two reasons:

1. Entrance of head into the pelvis is more difficult, and

2. Even under the most favorable circumstances, labor is sure to be lengthened by the

*Read before the Baltimore Medical and Surgical Society.

more extended rotation of the occiput necessary to its completion.

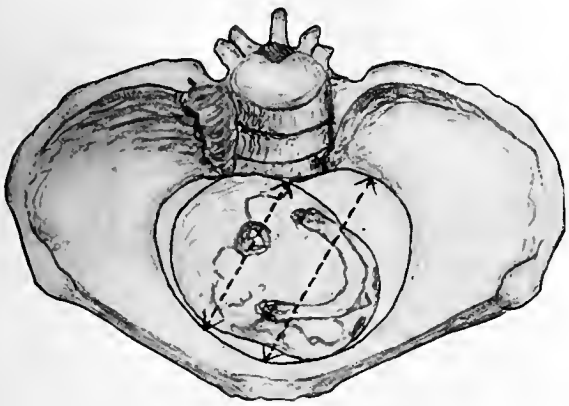
1. Difficult entrance of the head is due to two factors:

A. Physiological.

B. Mechanical.

Physiological—As a rule, during the first stage of labor, in these cases, the pains are very irregular and imperfect, due not especially to the position of the occiput, but the height of the head. It is not low enough to stimulate the nervous reflexes, which can be explained in very much the same way as the reflexes occurring in the micturition and defecation. In any case, where the head remains high, e. g., "contracted pelvis, hydrocephalus," etc., the same effect is brought about.

Mechanical—Shape of head and the pelvic brim explained by the following figure:



R. O. I. P.

Two factors of difficulty are produced.

1. The widest portion of the head is in apposition with the narrow portion of the pelvis, and, therefore, requires a powerful driving impulse to force it through the brim.

2. This retarded widest portion of the head is situated on the occipital end of the head lever, while the sincipital end is almost free. The result is extension; the degree varying according to the disproportion between the head and pelvis.

Another difficulty is due to the lack of adaptation between the head and the pelvis in these cases. When the occiput is directed to the front, the concave surface formed by the lower part of the occiput and neck adapts itself well to the convex surface of the symphisis, and on the other hand the convex surface formed by the forehead and face adapts itself to the concavity of the posterior pelvic wall. When the occiput is directed to the rear these mechanical conditions are reversed. *Slight disproportion* between the head and the pelvis may, after a long time, allow the head to pass the brim; or it may prevent its entrance, in which case artificial interference will be necessary. *Marked disproportion* between the two will prevent passage of the brim and result in extension, which, if allowed to continue, will cause a face presentation. Let us now consider the rotation of the head after it has passed into the cavity of the pelvis:

A. When the head is well flexed.

B. When the head is poorly flexed, and

C. When the head is partially extended.

In the first instance flexion is increased owing to the large cavity behind and the sinciput meeting the resistance of the anterior pelvic wall. In such a case, the conditions being favorable, rotation usually occurs naturally.

B. Rotation when the head enters the pelvis, poorly flexed, may or may not occur, and when it does occur, will be under the following conditions:

1. Adaptation between head and pelvis is easy.

2. Powerful labor pains.

3. When the loss of flexion is so slight that only a little change is needed to restore it.

C. Rotation when the head enters the pelvis, partially extended.

In this case the sinciput is as low as the occiput and reaches the deeper portion of the anterior groove as soon as the occiput reaches the deeper portion of the posterior groove. Both tend to rotate forward by the forward trend of their respective grooves, the result being a deadlock, which can only be broken by artificial means. In rare cases the occiput may rotate into the hollow of the sacrum, which can only occur (a) when the adaptation between the head and the pelvis is easy, (b) when the sacrum is exceptionally hollow, and lateral concavity is but little marked. The escape of the occiput into the hollow of the sacrum usually so far diminishes the pressure of the occiput as to permit of its rapid advance. The descent of the sinciput is still delayed by the normal resistance of the anterior wall of the pelvis. Rapid descent of the occiput re-establishes flexion with the head in directly occipito-posterior position. Expulsion is then possible by nature or artifi-

cially; the conditions being much less favorable by reason of shape of the head and pelvis. Before delivery can occur, the occiput must be elongated and the sinciput compressed, causing an elongated flexion and reversing the natural curve. The necessary compression causes a large number of stillbirths or very serious asphyxia, from the severe pressure. In addition to this, the prominence of the occiput exposes the soft tissues of the pelvic floor to a degree of tension which makes laceration almost inevitable. The expulsion of a persistent posterior occiput requires, in addition to lax adaptation, the presence of powerful uterine contractions, or the application of powerful traction by the forceps, and under any condition the progress is slow.

MANAGEMENT.

It is with special reference to the management of the posterior occiput that I wish to speak this evening, believing from past experience that so many of the evils incurred in the delivery can be avoided by a thorough knowledge of the mechanism and proper care in the necessary manipulations. If we always have before us the *three* (3) important factors necessary for the easy and comparatively rapid delivery in these cases, the result will possibly be more easily obtained. These three factors are:

1. Good flexion of the head.
2. Strong and regular uterine contractions.
3. A firm and resisting perineal floor.

It is an established fact in practice that in the comparatively few cases in which these conditions are present, and are maintained throughout, labor in case of posterior occiput is hardly less favorable than in the anterior; and the degree of difficulty increases just as the degree and persistence of any or all of these conditions (especially flexion) decreases until we reach the point when flexion is lost and not promptly restored by art; posterior position yields long, difficult and exhausting labors for the mother, and a large proportion of stillbirths for the child. According to my own experience, the prevention of a posterior occiput is not so easy as we are led to believe. Our experience in the Hospital, with the various methods advised for the prevention, has been rather unsatisfactory, so much so indeed that, unless the case is considered an especially favorable one, we do not interfere, believing that in many instances more harm than good is done by efforts which so often prove of no avail. However, there are a few cases in which we believe the attendant is justified in such efforts, the cases being those in which the head is not engaged or membranes not ruptured. If the patient is seen in the last few days of pregnancy, and it has been recognized that the occiput is posterior, the *postural treatment* may be advised. If the patient is placed in the knee-chest position, the anterior wall and fundus uteri will be the lowest portions of the uterus. So long as the patient remains in this position there is a tendency for the fœtus to sag away from the pelvic brim under the influence of gravity; and since the recession of the head from the brim leaves the fœtus free to turn upon its own axis, while the presence of the spinal column makes the dorsal side the heavier, there is a tendency toward a rotation of the fœtus as a whole, until the dorsum is in opposition to the anterior wall of the uterus. In such cases the woman should be instructed to assume the knee-chest posture several times daily during the last few weeks of pregnancy, to remain in this position as long as possible without fatigue, and before rising to recline on the right side for a short time, in the hope that as the child's head again settles down against the brim it may become fixed in an anterior position. The postural treatment is especially useful when instituted before the labor pains have begun, but, of course, may be used afterward when the head is not engaged. Should the method prove successful, but the head show a tendency to revert to the old position (provided the woman is in labor), the attendant is justified in rupturing the membranes in order that the uterus will be better able to hold it in the pelvis. Should the efforts prove unsuccessful and the case continue as a "posterior occiput," the head will pass the superior strait by natural efforts only after considerable delay, and after the occurrence of some extension and much moulding. The attitude of the physician should be determined by the degree of extension. When not extreme he should not be alarmed by the apparent failure of progress, but avoid interference and expect good results as long as both patients remain in good condition. When extension becomes so extreme that the eyebrows are below the pelvic brim, there is little prospect that the head will pass the brim by natural efforts, and unless active progress is present, it is wise to abandon the expectant treatment, and resort to operative

measures. If the condition be favorable, i. e., amniotic fluid present, internal podallic version is the operation of election. If version be not possible, it may be that the occiput can be rotated manually, to the front, after which forceps can be applied. This the author considers one of the most important steps in the treatment, and if it be carefully performed, seldom will it be necessary to apply forceps to the "high arrested" posterior occiput. Should manual rotation be decided upon, the whole hand should be passed into the uterns, the head raised until the forehead is grasped by the hand. The head is then gradually and carefully rotated until occiput is well anterior. If the body fails to rotate with the head, the head will return at once to its original position. After the head is rotated, it is held by counter pressure on the fundus, while the forceps application is made. The forceps being applied to the sides of the head, axis traction instrument being used. If version is absolutely contraindicated and manual rotation fails, an attempt should be made to bring the head through the superior strait by application of the forceps, the occiput remaining in the same position. As a preliminary to this operation the head should be flexed if possible. In this position it is, as a rule, impossible to apply the blades to the sides of the head, owing to the position of the parietal eminences in the narrow space between the ilio-pectineal eminence and the sacral promontory. In such a case the blades will be applied in relation to the sides of the pelvis, and will grasp the head in the oblique diameter. But as soon as it has passed the brim, the blades should be removed and re-applied to the sides of the head. As was said in the discussion of the mechanism, the maintenance of complete flexion is the most essential condition for the progress of the head through the pelvis. It follows that when it is present it must be maintained, and when lost, it must, if possible, be re-established. When the relation between head and pelvis is easy, and good flexion is present, the rotation is comparatively easy and rapid, and assistance is not necessary; but in the majority of cases the head enters the cavity in a condition of partial extension, and in such cases the careful application of some simple manipulations will very often save the patient hours of suffering or a severe operation. The fingers should be placed firmly against the forehead and pressure maintained during the whole of each pain. In this process the sinciput is held up while the occiput is forced down by uterine contractions. When extension occurs it must be reduced before any further progress is possible, and this is accomplished by either—

A. Pushing the sinciput up.
B. Pulling the occiput down, or
C. A combination of the two.

In some cases when extension is well established it is necessary to resort to instrumental means for reduction, and here the "reversed application" of the forceps might be attempted. It must be borne in mind that this application is to be utilized only for the production of flexion, and as soon as this result is obtained the blades should be removed and reapplied in the ordinary way. During the traction the fingers of the unemployed hand should note carefully the motion of the head. It is important that the blades be applied to the sides of the head regardless of the pelvis, and that the application be made as nearly over the occiput as possible. With this grip, flexion is aided or promoted rather than retarded. If the forceps be applied in relation to the pelvis, the oblique grasp upon the forehead and occiput will prevent rotation. It will be remembered that it was above advised to apply the blades in relation to the pelvis, but this was before the head had passed the brim. This is the one exception. In all other conditions the forceps should be applied in relation to the head. The tractions should be made at first rather far backward, and not until the head has reached the floor of the pelvis should any efforts at rotation be made. Attempts to rotate before this time will not be successful and may do harm. I am aware of the fact that some authors consider artificial means of rotation unjustifiable, but having had such excellent results with this method of treating in these cases, I consider it thoroughly justifiable, and, in the hands of a comparatively experienced operator, the one to give the very best results. In an experience in the Lying-In Hospital of the University of Maryland of ten years, during which time a large number of such cases have been treated, this method has proven so satisfactory that for the last five years it has been used exclusively. Where rotation occurs spontaneously or artificially, bruises and lacerations of the soft parts are no more frequent than in ordinary cases.

THE ABUSE OF LAVAGE.

By Joseph T. Smith, M.D.,

Associate Professor of Medical Jurisprudence and Hygiene and Clinical Medicine, University of Maryland.

That stomach washing is abused there is no doubt. It is the same old story of running to extremes. Much that we do is exaggerated by our patients. They will follow a course of treatment, have their prescriptions renewed and continue to follow advice after the occasion for it has passed. Is it small wonder that we desire to keep our work secret in many cases? I well remember an address delivered in Baltimore by Dr. Battey, of Georgia, when his operation was in the hands of gynecologists, and of how earnest and emphatic he was in defining the field which his operation was designed to cover, he felt obliged to do so on account of the abuse which had been made of it. In view of this, I thought it might be of interest to note two cases, in one of which, I think I can truly say, that lavage came near causing death, and in the other by not allowing it to be resorted to, danger was averted.

The first case was that of a lady, who told me upon my first visit that she had been growing worse for the past year, and now she felt as if life was not worth living. She had been suffering from her stomach for a long time, and more than a year ago she had gone to Europe and had placed herself under the care of one of that country's eminent specialists. It is not necessary to note her treatment while there; suffice it to say, that she learned to wash out her stomach, and in case she should not be able to do so her husband also was taught. She improved to a considerable extent while under treatment, though she was never entirely well. It was after her return and a year before I saw her that her gradual but steady decline in health began. Upon inquiry, I learned that she suffered much from nausea, at times vomited, and had a sense of fullness in the region of the stomach the greater part of the time, usually increased after eating. She was excessively nervous, starting at the least sudden noise, despondent and crying at times. Sleep bad and broken by dreams, so that she arose in the morning unrefreshed. Appetite poor and capricious. She usually felt so badly after eating that she had restricted herself to one meal a day and that at 6.30 in the evening. No temperature at any time. Pulse weak, though regular. After eating, her stomach often felt so badly that her husband would wash it out, sometimes every day and again two or three times a week, as occasionally, though suffering, she could get along without the washing. The washings, she said, looked as though they contained bile. She was very weak, and could with difficulty accomplish her usual household duties. These she had been obliged to make as few as possible, as the least exertion tired her. Examination did not reveal any abdominal troubles, either about the stomach or liver or elsewhere. She had never had any children, and her menstrual function was right. Urinary examination negative. A test breakfast was given and the drawn stomach contents revealed nothing abnormal. After careful examinations, subjectively and objectively, it seemed to me that the lady, naturally weak, was being starved to death, partly by not taking sufficient food and partly by the constant washing out of the stomach, which destroyed her appetite, and what food reached the stomach was not allowed to be completely digested and assimilated.

The washings were at once stopped. She was given a special diet table, which provided for four meals a day. She protested very strongly against so much eating, but agreed to follow the plan for a little while to see what it would do for her. She was ordered long periods of rest in bed each day, to give up all outside and inside work and deny herself to all except her husband and nurse. Tonics were given and other treatment as was found needed to meet the many conditions which arose. At the end of seven months she came to see me in my office for the first time, and said the previous week had been her "banner week." She was able to eat three good meals a day, and was to all intents and purposes well. Her stomach had not been washed out once in the seven months, and there was a slow, though constant, improvement in her physical condition and in her digestion and assimilation of food.

What her condition was that caused the stomach washing to be instituted I do not know, but its continuance nearly cost her life. I saw her at the end of nineteen months, and she said she felt well enough to do anything. She is not robust, and any severe strain is apt to make her feel weak, but rest and care brings back her strength.

The second case is that of a gentleman who, when I saw him first, said he had been suffering from stomach trouble for a long time. He was not able to walk far on account of weakness. Had vague pains in his back and limbs. It is not necessary, for the purposes of this article, to go into his symptoms in detail. He feared to eat much, except for dinner, at which he usually made a fair meal. Blood examination negative. Urinary examination negative, except marked diminution in the amount of urea. Physical examination revealed nothing abnormal. I was unable to discover anything abnormal about the stomach from his symptoms and by palpation, and, as I did not care to teach him lavage unless necessary, resolved to give the treatment without it, not even drawing the stomach contents for examination. He was given a diet table which provided three meals a day; he was given tonics and other forms of treatment to meet special indications. At the end of six months he was able to eat comfortably three meals a day, and was stronger and able for his duties. I saw him at the end of fifteen months, and he expressed himself as feeling well.

BILATERAL FACIAL (BELL'S) PARALYSIS, WITH DOUBLE IRITIS.

By Richard H. Johnston, M.D.,

Demonstrator of Diseases of the Throat and Nose, University of Maryland.

Since bilateral facial paralysis is rare, the following case is worth recording:

C. B., twenty-eight years old, druggist; retired on the night of July 3, 1905, in his usual good health. On arising next morning he found that the left side of his face was paralyzed. He consulted his family physician, who expressed the opinion that sleeping in a draught must have caused the trouble. He was placed upon treatment at once, and followed it carefully for a month, at the end of which time he was surprised to find that the right side of the face was also motionless. He suffered no pain or unpleasant sensations. Having derived no benefit from his home physicians, he came to Baltimore about the middle of August to consult a prominent nerve specialist. During the first week of September both eyes suddenly became red and painful, and he was referred to me for examination. His condition at this time was as follows: Both lower lids drooped so that, with the eyes closed, the balls remained uncovered below, while the conjunctiva of the lower lids was visible; the cheeks were sunken in and immobile, and the lines leading from the nose to the upper lip were obliterated. The patient could not pucker the lips, and all such movements as whistling, laughing, etc., were impossible. The voice was thick and heavy and sounded as if the patient was "blowing his words out." The movements of the tongue were normal. The eye-balls were red, with a marked pericorneal injection. From the fact that both eyes were involved, I at first thought of corneal abrasions from non-closure of the lids. Careful examination failed to reveal such lesions. The history was that both eyes became diseased the day before with pain and photophobia and had steadily grown worse. As the pupils were contracted and the lesion normal, I instilled an atropine solution. As the pupils dilated, a few points of adhesion could be seen in each eye. The lower lids were raised with adhesive strips during the day and the patient instructed to tie a bandage around the eyes at night. With the use of atropine, mercury and heat, the eyes gradually improved. The paralysis persisted, and when I last saw the patient he was as bad as ever. The ears were examined with the hope of finding something to explain the trouble, but nothing abnormal could be detected. A specific history could not be obtained, and rheumatism was excluded.

In looking up the literature of the disease in question, one is struck with the scarcity of reported cases. Most text-books say that it is very rare. My patient lived in another city, and, after treating his eyes, I did not see him again. From the fact that one side of the face was suddenly affected, followed in a month's time by a similar affection of the other side, the lesion was probably due to pressure in or near the fourth ventricle. Hemorrhage into the ventricle usually causes coma and death. In Osler's "Practice" we find the following reference: "Facial diplegia is a rare condition, occasionally found in affections at the base of the brain, lesions in the pons, simultaneous involvement of the nerves in ear disease and in diphtheritic paralysis. Disease of the nuclei or symmetrical involvement of the cortex might also produce it."

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EDITORIAL

THE UNIVERSITY CENTENNIAL.—At a recent meeting of the various committees representing the Alumni and Board of Regents of the University, an organization was effected and the work of arranging for the celebration of the centennial of the University during the month of May, 1907, was so formulated as to give a definite direction to the purpose in view. Verious subcommittees were appointed to take charge of specific functions and to arrange the programme, provide ways and means, and to attend to the many details which will insure a proper observance of an event of great interest and importance to all who have a heartfelt interest and pride in the old University. The celebration of one hundred years of continuous service as an educational institution is an event of no common importance in the history of American institutions. The University of Maryland began its work when there were only some eight State Universities and less than half a dozen medical schools in the United States. At the time of its birth the City of Baltimore had a population of less than 35,000. When the University Building was erected in 1812, it was located in the suburbs of the city. It was not until after the war of 1812 and 1814 that the University began to assume a national importance. On April 22d, 1813, the Faculty of Physic annexed to itself the Faculty of Divinity, the Faculty of Law and the Faculty of Arts and Sciences.

At the commencement of the Faculty of Physic held in 1813, the graduating class numbered ten and a gold medal was conferred for the first time upon John D. Sinnott for the best thesis in the Latin language.

The session lasted from November 1st. to February 28th. An oral examination was conducted at the end of the second session when those passing were graduated. The University was governed by a Board of Regents from 1812 to 1825, by a Board of Trustees from 1826 to 1839 and from 1840 to the present time by the Board of Regents. The growth of the University during the first fifty years of her existence was characterized by marked disturbances and dissentions in her governing bodies and by frequent changes in her faculty. There were periods of great prosperity and of corresponding embarrassments, but the work grew and methods improved through the wise policy which finally prevailed in her government. The University claims to have been the first to give instruction in dentistry in 1821. She was among the first to teach hygiene and medical jurisprudence in 1833. She was among the first to meet the modern demand for instruction in specialties in 1866. She was the first medical school to make dissection a compulsory part of the curriculum in 1833. She was among the very first to provide for clinical instruction by the erection of her own hospital available at all times for the use of students. At all times in her history she has been in the front rank in the endeavor to improve the courses of medical education. The purpose of this Centennial Celebration should be to bring to the notice of the present generation the splendid work the University has done in the past century for the people of Maryland and to show the claims which the University has upon the public.

The Alumni have just cause for the pride in her useful and honorable history and should now exercise their influence in an effort to improve her future development.

At no time in her history has she exhibited more striking signs of progress and growth than exist today. The future seems ominous if her friends will rally to her support and give encouragement to her present policies. This Centennial year should be taken advantage of to raise endowments for all of her departments, for her laboratories, her library and her hospital. The occasion is one which should be made to appeal to every class of citizens for gifts and bequests. It should create a sentiment in favor of a great State University to which her present policies now tend. With a new Maryland and a new Baltimore so rapidly forging to the front in all progressive and advanced methods

of government and material progress, a great State University of Maryland can only meet the demands of the day and the spirit of the times.

THE ALUMNI ASSOCIATION OF THE UNIVERSITY OF MARYLAND IN NORTH CAROLINA.—The BULLETIN is glad to announce that the suggestion to the Alumni of the University residing in North Carolina to organize an Alumni Association has taken such a practical shape that the movement promises to be a success. A number of prominent Alumni have taken the matter in hand and have issued a call for a meeting of University graduates to be held in Charlotte on May 29th, when the State Society meets in that city. The BULLETIN herewith publishes a letter addressed to the Alumni by Dr. A. J. Crowell, a distinguished Alumnus of the University, residing in Charlotte, which better expresses the purpose of the meeting than any statement it can make. Dr. Crowell says:

"There has been a long-felt need and frequently expressed desire on the part of the University of Maryland graduates in North Carolina to have an Alumni Association in North Carolina, but it seems no one felt like taking the initiative to organize such an association.

"As the State Medical Society meets with us this year, I take the liberty of calling a meeting of all the Alumni immediately after the afternoon session of the society, May 29th, 1906, to consider the advisability of organizing such an association.

"As an alumnus of this institution, I am sure you are interested in the movement, and personally I shall appreciate very much your hearty co-operation in perfecting this organization, and making it both profitable and pleasant, therefore we shall be very glad to have you present at this meeting. A good beginning means much."

In addition to this call for a meeting, Dr. Crowell purposes to give an informal smoker at his office and to dispense some of the hospitalities for which North Carolinians are noted. It is earnestly hoped that this meeting will be largely attended. To give encouragement to the movement and to promote a careful organization of the alumni into a permanent association, Dr. T. A. Ashby and Dr. St. Clair Spruill of the faculty of the University, and possibly other members, have promised to attend this meeting in Charlotte. The University of Maryland is so largely represented in the profession of North Carolina that no doubt remains but that this organization of the State Alumni will be of great advantage both to the University and to her graduates. It will be the means of strengthening and of perpetuating the cordial relations which have existed between old students and their Alma Mater. The University of Maryland has not a more loyal body of alumni than can be found in North Carolina. The example which this movement will set will, we feel assured, be followed later on by the Alumni residing in other States. A recent communication to the editor of the BULLETIN from an alumnus of the University living in South Carolina, gives the assurance that an Alumni Association will soon be organized in that State. Now that the centennial of the University is so near at hand, will not our Alumni in distant places, where two or three can be gathered together, formulate some plan to aid in the proper celebration of this event?

THE GENEROSITY OF THE STATE OF MARYLAND TO MEDICAL INSTITUTIONS IN THE STATE. —.The General Assembly of Maryland, which has recently adjourned after a three months' session, has shown a wise and generous appreciation of the value of the hospitals and medical schools of the State to the people of the State by continuing the appropriations allowed by its predecessor two years ago. In addition to the usual sums given for the care of the State poor in the leading hospitals of the State, in several instances these sums were increased and liberal sums were given for building and equipment. The four leading unendowed medical schools of Baltimore were granted $4,000 a year each for the next two years in spite of the fact that the Board of State Aid and Charities had urged that these appropriations be discontinued. These schools were able to show the great value of the educational work they are doing in this city and how the aid given by the State has contributed to the success of their work. With the assistance again rendered by the State the next two years will show more substantial gains than have been made in previous years. Baltimore is fast becoming one of the leading centers of medical education of this country and the members of the General Assembly of Maryland have had the wisdom to recognize this fact and to encourage these schools, which are doing a valuable work for the people of the State. In the generous aid given by the General Assembly to State institu-

tions of learning, the Medical Department of the University of Maryland has been treated with the kindest consideration and liberality. In view of the Centennial next year the Faculty of Physic applied for a centennial fund of $100,000. It was proposed to apply this sum to the erection of an addition to the present hospital building to be used chiefly as a lying-in-department. Recognizing the past services of the University to the State and her future possibilities, the General Assembly has appropriated $30,000 a year for two years to the Faculty of Physic, which sum will be held as a centennial fund, and will be used by the Faculty for enlarging the present Hospital capacity. The plans for these improvements have not been worked out, but the people of Maryland can rest assured that this State money will be used for the improvement of the University property, which belongs to the State, and can not be diverted to personal uses. The aid given by the State will enable the Faculty of Physic to carry out large plans for the improvement and development of the educational and clinical work of the University. The University of Maryland will enter upon a new field of activity and progress with the advantages placed at its command by the State. Those in charge of her interests at this time realize their responsibility and duty to the people of the State and will endeavor to measure up to both.

Present Knowledge of the Curative Power of the X-Ray.—On January 26, 1906, at the regular fortnightly meeting of the Baltimore Medical and Surgical Association, Prof. Joseph E. Gichner addressed those present upon our present knowledge of the curative power of the X-ray in disease. Sufficient time has not yet elapsed since the discovery of this physical force for us to collect enough physiologic and therapeutic data to absolutely determine its position in our therapeutic armamentarium, as one group of operators report in heretofore incurable discases remarkably good results, whereas another set of just as competent observers in the same conditions have met with nothing but failure. We are still further handicapped in reaching a correct estimate of its real therapeutic value by another class of men heralding to the world, conditions not present, cured. Low and high tubes produce different influences upon the skin, the rays from the latter exerting their influence upon the more deeply situated structures, those from the former not penetrating so freely. After carefully eliminating all adventitious rays with a soft tube, which has more of a local action than the hard, we note the following changes taking place in the skin: The first effect is a decided tumefaction, due to a dilatation of the capillaries of the skin, and from an outpouring of plasma from those vessels; an exposure from five to ten minutes, if not employed too often, does nothing more than mildly stimulate the skin; if longer or more frequent applications are persisted in, a pigment is deposited in the skin, giving it a bronzed or tanned appearance; a greater irritability of the cutis manifests itself in an erythema; when this occurs it is but a short step to ulceration, gangrene and other degenerative changes, so cease the raying until the condition clears up. Some individuals have marked idiosyncrasies to X-ray influence, and in these, when such subjective symptoms as burning sensations, feeling of tension in the parts, malaise, and in raying malignant growths, one should record the temperature, pulse and respiration twice daily, as the liberation of toxines elevates the temperature. In these cases raying should be discontinued until the fever subsides. Injudicious raying often causes malignant growths to take on undue activity. The later workers are not so prone to the aforesaid mishaps, as they have profited by their predecessors' blunders. Nothing has given so much promise and such good results as the X-ray in the cure of psoriasis, allopecia areata, lupus vulgaris, chronic eczema and epithelioma. In other instances the X-ray has not proven superior to the methods in vogue, but when these fail, as a last resort, raying in good hands may be beneficial. In internal affections good observers claim to have effected a gradual disappearance of malignant growths; others, again, have reported no results. Therefore, in accessible growths, as of yore, summon the surgeon. If the surgeon is not sure of having removed every vestige of infiltrated tissue, apply the rays, with the hope of destroying the remaining foci. Some authorities advise preoperative raying in widely disseminated growths. In post-operative recurrence, raying may retard further development, stimulate tardy ulcerations to heal and diminish pain, if properly applied. Its analgesic property is further shown in neuritis. Chronic ulcers clear up readily under this treatment. Keloids disappear when exposed to the

rays. Some observers have reported improvement in leucemia and Hodgkins' disease. Under the stimulating action of the X-rays the exudates in chronic inflammatory conditions, such as rheumatoid thickening and tubercular joints, have been absorbed. As a diagnostic aid in concretions of the different hollow viscera, in tuberculosis, in the locating of foreign bodies, and in the various osseous lesions, we have an instrument of great precision in the Roentgen ray; in chronic skin disease this light has been of immense value, but so far few have reported much success in deep-seated malignancy from the use of this agent. Time, and time alone, will unfold to us its potency as a therapeutic agent in malignant tumors.

CORRESPONDENCE.

To the Hospital Bulletin:

In a most interesting letter in the current issue of the BULLETIN, "Ipse Dixit" describes recent visits to the late venerable Professor Miltenberger, and quotes him as saying that "Dr. Randolph, of Philadelphia, originally from Charlottesville, and of the Jefferson-Randolph family," was one of the finest surgeons in his experience. Dr. Jacob Randolph, of Philadelphia, formerly professor of clinical surgery in the University of Pennsylvania, was my great-uncle, and it is gratifying to me to have such a high encomium of my near relative. But Dr. Miltenberger is in error in supposing that he was a native of Charlottesville, or that he belonged to the prominent family named. He was born in Pennsylvania, and probably in Philadelphia; was the son of Capt. Edward Fitz Randolph, of the Continental Army, who, after the Revolutionary War, dropped the Fitz from his name and became a plain Quaker. Brig.-Gen. Wallace F. Randolph, U. S. A., is his grandson. Dr. Jacob Randolph married the daughter of the great Dr. Philip Syng Physick, and succeeded to his practice. He died probably somewhere between 1845-50.

RANDOLPH WINSLOW.

Baltimore, March 17, 1906.

ABSTRACTS AND EXTRACTS

A STUDY OF ECTOPIC PREGNANCY, WITH A REPORT OF TWENTY-SEVEN CASES.—In the *International Clinic*, Vol. IV, Fifteenth Series, January, 1906, Dr. T. A. Ashby, Professor of Diseases of Women, University of Maryland, relates his personal experience with ectopic pregnancy in order to show from a study of twenty-seven cases operated on in his Hospital and private work some points of interest in the clinical history, diagnosis and treatment of this condition.

The number of cases coming under the observation of a single operator is sufficient evidence of the frequency of the condition. This study of the clinical history of ectopic pregnancy presents a strong argument in favor of the importance of prompt diagnosis and radical treatment of a dangerous pathological condition, for whatever view is taken of its etiology, one important fact is shown in the treachery and danger which attend it.

The report gives a concise history of each case, with comments when necessary to explain the peculiar features presented by the individual cases. The first case was operated on in June, 1889, and the last case in November, 1905. Of the twenty-seven cases, twenty-five were operated on by Dr. Ashby, and two in his service by his assistant, Dr. Hugh W. Brent. Of the twenty-seven cases, twenty-six recovered and one died—Case IV of the series, operated on by Dr. Ashby for septic peritonitis, due to a ruptured tube with intra-pelvic hemorrhage. Over 75 per cent. had borne one or more children. The diagnosis of the condition was not made in 50 per cent. of the cases until the abdomen was opened, the intra-pelvic condition not being recognized until the tube was exposed or removed.

In those cases where the pregnancy was diagnosed prior to the operation, striking illustrations were presented to show the importance of a prompt diagnosis and immediate operation. Cases XI and XXVII are herewith presented to illustrate these facts:

Case XI.—This patient was referred to me by Dr. Morris Robbins, formerly of Baltimore. Upon examination a tumor the size of a baseball was found in the left ovarian region. She presented a history of pregnancy of some eight weeks' duration. The diagnosis of tubal pregnancy was made by Dr. Robbins, and she was advised to go to the University Hospital for immediate operation, as symptoms of rupture were indicated by colicky pains, simulating those of uterine colic. She was admitted to the Hospital late at night and was prepared for an

early operation. When the abdomen was opened at 10.30 o'clock the next morning the tube was found ruptured and a small fœtus of not over seven or eight weeks' development was found half-way expelled through a rupture in the tube which probably occurred only an hour or two before operation. A small vessel at the seat of the rupture was discharging arterial blood into the abdominal cavity, which contained some ten or twelve ounces. The patient had already become blanched and weak from loss of blood from the upper surface of the tube, the most dangerous point where rupture could occur. A ligature was thrown around the tube close to the uterus and the tumor mass removed. But for the promptness of the operation this patient would have perished from a concealed hemorrhage.

The case demonstrates one of the great dangers of primary rupture with leakage into the general abdominal cavity, and the treacherous nature of tubal gestation. In the absence of an abdominal section primary rupture of the tube cannot be considered otherwise than hazardous, since in the absence of operation the physician in attendance can form no opinion as to the location of the rupture and possible limit of hemorrhage. The symptoms of collapse and shock may give some indication of the necessity for immediate action, but these symptoms are not reliable and can seldom be trusted. A secondary rupture usually indicates an encysted form of hematocele—by far the most common form of tubal leakage, as is shown by this series of cases. It is probable that the primary rupture into the general abdominal cavity leads to death in the larger number of cases before the symptoms of pregnancy are observed, and in this way we may account for the sudden deaths which are now and then observed from concealed hemorrhage, and in which an autopsy is not made to clear up the cause of death.

This case teaches the important lesson that tubal gestation is not an innocent condition, and that when the condition is recognized before rupture has taken place an immediate operation should be done to remove the treacherous tube. No confidence can be placed in nature's method of dealing with ectopic gestation, either before or after rupture has occurred. The fact that we find in intra-abdominal work such a large number of old hematoceles of tubal origin, showing a partial escape from the consequences of rupture and leakage cannot be used as an argument in support of delay when a diagnosis of ectopic pregnancy has been made. An immediate exploratory section to establish a diagnosis in a suspected case would be less hazardous than the expectant line of treatment.

Case XXVII.—Mrs. M., multipara, youngest child fifteen years of age. had married her second husband four years ago. She had missed two menstrual periods. She had all the usual signs of pregnancy. For several days she had suffered with colicky pains in her pelvis, but attached no importance to them. At 3 P.M., of November 7, 1905, she was seized with violent pains, followed by shock and collapse. Dr. La Bara, a young physician, was hastily called in, and upon examination diagnosed a ruptured tubal pregnancy with concealed hemorrhage. He had the patient conveyed to the University Hospital as soon as the ambulance could be obtained. She reached the Hospital between 5 and 6 o'clock in a profoundly collapsed condition, with a pulse weak, thready, and over 150 per minute, respiration quick and shallow, and hemaglobin under 50 per cent. It was necessary to give normal salt injections and strychnine to keep up the flagging circulation. I reached the Hospital at 7 o'clock, and an abdominal section was imperative at once. The blanched and collapsed condition of the patient gave little encouragement. Upon opening the abdomen over one quart of fresh arterial blood was found in the pelvis and among the intestines. The tubes were hurriedly sought for, and the left tube was found ruptured from over-distention on its upper border and still leaking at the site of rupture. It was tied off promptly and hemorrhage at once ceased. The intra-abdominal cavity was thoroughly cleansed and then filled with normal salt solution. No foetus was found. The patient rallied slowly from the operation and within four weeks' time had regained her loss of blood. But for the prompt abdominal section this patient would have perished in a few hours. Too much credit cannot be given to her family physician for his prompt diagnosis and action in sending her to the Hospital.

Conclusions.—Ectopic pregnancy is a much more common cause of intrapelvic disease than has been supposed. Rupture of the tube from over-distention is the chief cause of intrapelvic hematocele. Primary rupture into the folds of the broad ligament occurs far more frequently

than any other form of rupture, and is attended with less danger to the patient. Tubal abortions are infrequent, but the death of the foetus at a very early stage of development may result in a hematoma of the tube or give rise to a hemato-salpinx requiring a removal of the damaged tube. Gonorrheal salpingitis is the most frequent cause of tubal gestation, and of early death of the embryo. Tubal pregnancy is the common form of ectopic gestation and the primary stage of the abdominal variety. The tubo-ovarian variety was found in one case of this series of twenty-seven cases. Ectopic pregnancy is a treacherous condition, and should be arrested by an abdominal section as soon as it is recognized.

NOTES AND ITEMS

Among the physicians who visited the University Hospital during the past month were the following:

Dr. G. R. Myers, class of 1902, Maryland;

Dr. Willis Alston, class of 1903, North Carolina;

Dr. A. Leo Franklin, class of 1902, Cumberland, Md.;

Dr. L. B. Henkel, Jr., class of 1903, Annapolis, Maryland;

Dr. Louis C. Skinner, class of 1901, Ayden, North Carolina;

Dr. G. C. Winterson, class of 1902, New Windsor, Maryland;

Dr. J. L. Hanes, class of 1902, Winston- Salem, North Carolina;

Dr. Camillus P. Carrico, class of 1898, of Cherry Hill, Cecil Co., Md.

Dr. Thomas S. Latimer, class of 1861, 211 West Monument street, who has been ill for several months, is reported to be convalescing.

Dr. C. T. Young, class of 1903, of Plant City, Florida, after a competitive examination has been appointed assistant to the State Health Officer.

Dr. John A. Tompkins, class of 1898, will spend the summer at Warm Springs, Virginia, where he has been appointed resident physician.

At the municipal election of Oakland, Garrett County, Maryland, held March 12, 1906, Dr. H. W. McComas, class of 1888, the incumbent, was re-elected Mayor.

Dr. William S. Maxwell, class of 1873, who has been ill at the University Hospital, has recovered his former health and has left for his home, Still Pond, Maryland.

With a joint catalogue and an active President looking after the general interests of all of the departments, the reorganization of the University will be practically effected.

With the accession of St. John's College as a department of Arts and Sciences, which is now assured, the University will assume its proper position as a great State University.

Dr. Jay Ralph Shook, class of 1899, assistant surgeon, United States Army, has been advanced from the grade of Lieutenant to captain, his promotion to date from March 6, 1906.

Dr. William Ellicott Elisha Tyson, class of 1905, has been appointed assistant obstetrican in the University Hospital, to fill the unexpired term of Dr. H. D. Purdum, class of 1902, resigned.

Dr. William N. Bisphan, class of 1897, captain and assistant surgeon, United States Army, has been ordered to proceed from Fort Logan, Colorado, to Fort D. A. Russell, Wyoming, for temporary duty.

Dr. C. G. W. Macgill, class of 1856, who has been confined to his home at Catonsville, Maryland, with a severe attack of bronchitis, we are happy to report, has sufficiently recovered to resume his practice.

Dr. Eugene Crutchfield, class of 1887, upon whom a surgical operation was performed by Dr. Frank Kirby, class of 1892, and Dr. Samuel T. Earle, class of 1870, at St. Joseph's Hospital, Baltimore, Maryland, is now recovering.

The University of Maryland was represented at the convention of the Association of American Medical Colleges, held in Pittsburg, Pennsylvania, during the latter part of March, by Professors Randolph Winslow, and R. Dorsey Coale.

Dr. J. A. Nydegger, past assistant surgeon, United States Public Health and Marine Hospital Service, has been ordered to proceed to Perth Amboy, New Jersey, for special duty, upon the completion of which he is to rejoin his station at Stapleton, New York.

Dr. Oliver J. Purvis, class of 1904, of Annapolis, Maryland, who has been in the University

Hospital, suffering from septicemia, contracted by injuring his finger while operating, we are glad to report, is out of danger, and expects in the near future to be able to resume his practice.

For the first time in the history of the University of Maryland, a joint commencement of the Medical, Law and Pharmacy Departments will be held on June 4th, in the Academy of Music. It is believed that this is the beginning of a movement which will result in a more complete union of all departments under a common university management.

The University Hospital has never been so crowded with patients as during the past month. At times no vacant rooms, and few vacant beds in the wards were available. The surgical work has been unusually heavy. This overcrowding emphasizes the importance of the new addition to the Hospital which is now assured by the generosity of the State.

In honor of the 100th anniversary of the founding of the University of Maryland, the Baltimore Germania Maennerchor gave an academic concert in the hall of the society, 410 West Lombard street, Tuesday, April 3, 1906. Among the selections rendered was the University of Maryland Ode, "Alma Parens! jam annorum," composed by our distinguished alumnus, Dr. Eugene F. Cordell, and set to music by Professor Theodore Hamberger.

Dr. R. H. Hargrove, class 1877, and his brother, Dr. W. F. Hargrove, class 1891, both successful practitioners residing in North Carolina, have recently spent several weeks around the University and Hospital taking in new methods of work and reviving old associations. Dr. R. H. Hargrove has practiced his profession with success at Robersonville, N. C., and after some 29 years of hard work, is able to take life more quietly than the average country physician. Dr. W. F. Hargrove, so well-known and popular among recent graduates of the University is an active member of his State society and a good mixer at the society meetings. He has characteristics in his make-up which will insure him a useful and successful professional life.

In the March number of the *Old Maryland*, Oregon Milton Dennis, the newly-elected president of the General Alumni Association of the University, issues an open letter to the alumni of the University to affiliate themselves with the General Alumni Association. In every University, he says, there is a body of this character, banded together to advance the welfare of their alma mater. He is greatly surprised at the lack of interest manifested by the alumni in this body, and asks why? The BULLETIN is heartily in accord with the ideas of Mr. Dennis, and urgently appeals to the graduates of the School of Medicine, especially those located in the City of Baltimore, to become members of the General Alumni Association. The dues are $1 a year, which upon remission to Dr. Eugene F. Cordell, 857 Hamilton Terrace, Baltimore, Maryland, secures without any further formalities membership to the association. But three meetings a year are held and at these some prominent personage is invited to deliver an address to the Socity, after which a smoker is in order.

MARRIAGES

Dr. William Whitehill Requardt, class of 1896, was married February 10, 1906, at Baltimore, Maryland, to Miss Chesley Fenton. Immediately after the ceremony the Dr. and his wife left for an extended Northern tour.

Dr. Isaac Howard Davis, class of 1885, also a graduate of dentistry in the School of Dentistry of the University of Maryland, and now holding the chair of associate professor of operative dentistry in the dental department of the University of Maryland was married February 27, 1906, at Baltimore, Maryland, to Miss Eleanor Beale McParlin, daughter of the late Surgeon-General Thomas Andrew McParlin, class of 1847, United States Navy. After the ceremony the young couple left for an extended tour of the South. The BULLETIN extends to the newly-married couple its congratulations.

At the residence of Mr. A. C. Moore, Charleston, West Virginia, March 8, 1906, Dr. A. Leo Franklin, class of 1902, and formerly an assistant resident gynecologist in the University Hospital, but physician in the Allegheny Hospital in Cumberland, was married to Miss Lelia Weston Jordan, formerly of Norfolk, Virginia. They were married according to the rites of the Catholic Church by the Rev. Father Connell, of Cumberland. The wedding itinerary included visits to Richmond, Washington and Baltimore. The BULLETIN extends the young couple its best wishes for a long and happy married life.

DEATHS

Nicholas J. Dorsey, class of 1847, for many years a practitioner of Chicago, died at Joliet, Illinois, March 11, 1906, aged 84.

Dr. Benjamin S. Roseberry, class of 1874, died during the latter part of March at his home, Gardner, New Mexico. Dr. Roseberry was born in Kent County, Maryland in 1853, and was graduated from the Maryland University School of Medicine in 1874. He practised his profession in Kent County and Baltimore until 1887. While in Baltimore he was associated with the Baltimore University, as professor of materia medica. He removed to Lacon, Illinois, where in a few years he acquired a large practice. Later, owing to ill health, he removed to Colorado, and finally to Gardner, where for several years he has been in charge of the Gardner Hospital. He is survived by a widow, a son, and a daughter, all residing in the West, and by one son Mr. James Roseberry of Baltimore, Maryland.

Dr. Robert E. Bromwell, class of 1850, a prominent physician of Cecil County, Maryland, died at his home in the seventh election district, March 21, 1906, after a protracted illness, aged 79 years. Dr. Bromwell was a son of the late William Bromwell, a native of Pennsylvania, who spent the greater part of his life in Baltimore. Dr. Bromwell was born February 28, 1827, on the farm upon which he died. When 18 years of age he began teaching, and during his leisure moments read medicine under Dr. Henry B. Broughton, class of 1822. In 1848 he entered the medical department of the University of Maryland , from which institution the degree of doctor of medicine was conferred upon him in the year 1850. Dr. Bromwell was married in 1860 to Miss Josephine Evans, who with one daughter survives him.

SUBPHRENIC ABSCESS.

Prior to 1880, subphrenic abscess was rarely recognized, even now with our improved methods of precision, its diagnosis is difficult, but immeasurably easier than formerly, for every phase of the disease has been fully considered and described. The pus sac may be either extra or intraperitoneal. If the suppurating focus is in the general peritoneal cavity, its walls will be the stomach and lesser omentum behind, the diaphram and the left lobe of the liver above, the falciform ligament on the right, and adhesions between the stomach, omentum and anterior abdominal wall below, the transverse colon being its lowermost demarcation. Should the pus lie behind the stomach, in the lesser peritoneal space, it is prevented from escaping by obliteration of the foramen of Winslow, and its limiting structures are identical to the boundaries of the lesser peritoneal cavity. Any infected area may serve as the disseminating focus for the subphrenic abscess, but inflammatory diseases of the abdominal viscera, namely, an inflamed stomach or doudenum, perinephritic abscess, perityphlitis, and affections of the biliary passages, is a prolific source of the primary nidus from which subphrenic abscess takes its origin, but its most frequent forerunner is a gastric or doudenal ulcer, either from an extension of the inflammatory process or from a perforation in the sub-diaphragmatic region. The abscesses are variable in size, their contents are fetid, and 15% of them contain gas, which gains ingress through perforation in the stomach or other hollow viscus communicating with the abscess cavity, or is due to the presence of the bacillus aerogenes capsulatus.

The diagnosis, rarely easy, is arrived at by a consideration of the possible complications of the diseases from which subphrenic abscess arise, in conjunction with the history of the case and the logical signs encountered. Subjectively the patient will complain of a non-radiating, localized pain in the upper quadrants of the abdomen. Upon percussion one will note the area of liver dullness markedly increased, unless the abscess contains gas in which instance tympany will be present at the site involved. The lower margin of the liver will be found to lie from one to two inches below the costal margin. In subphrenic abscess this depression of the liver is the ordinary course of events, but in pleurisy such a position is exceedingly rare. As the fluids of empyema and subphrenic abscess differ in character, exploratory puncture with the aspirating needle may be of benefit in localizing the pus cavity. In passing it may be noted that subphrenic abscess is frequently overlooked until autopsy. The prognosis depends upon the general condition of the patient, an early diagnosis, and the promptness with which operative intervention is instituted. As soon as you are reasonably sure of the diagnosis open and drain. The line of incision depends upon the locality of the abscess. If the

course of the incision should pass through the pleural cavity, stitch the pleura together so as to shut off the remainder of its space, if it is already involved, both may be drained through the same opening.

(Abstract from an address, delivered by Dr. A. C. Harrison, 1887, on Subphrenic Abscess, before the Section of Clinical Medicine and Surgery of the Medical and Chirurgical Faculty, December 1, 1905.)

PYLORIC STENOSIS.

Although at variance with the subject allotted me to speak upon tonight, the surgery of the case which I am about to present, pertains to the same locality, i. e., pyloric stenosis, necessitating a partial gastrectomy, so much of the stomach having been removed, the intestinal and gastric orifices were closed, and a gastro-enterostomy was made, with recovery and marked improvement in the patient's health. The stenosis was complete, stomach dilated, the man a living skeleton, he had lost many pounds and could take no nourishment. Since the first of October, he has gained 18 pounds, and is now enjoying rather good health, but has some uncomfortable sensations in the region of the operation.

Gun-shot wounds are a class of injuries belonging to traumatic surgery. Abdominal surgeons have no worse lesions to contend with, and no injuries with more fatal results. The damage is widespread, the solid and hollow viscera, as well as the great vessels may be involved in the destruction, only in 3-5% of the cases of penetrating abdominal wounds inflicted with missils, do the viscera escape injury. The intestines cannot escape lasceration if the bullet passes from side to side, the small gut is more often penetrated that the large. Only a few years back, these injuries were treated by the expectant plan, with a mortality of 87%, and it remained for Dr. Sims to be the first to suggest laparotomy. In 1884, Dr. Bull of New York, saved the first operative case. Today it is not a question whether the abdomen should be opened, but at the earliest possible moment, as no one in these times waits for the shock to pass off, the depression being due to hemorrhage, so the earlier the bleeding is controlled the better the patient's chances of recovery. In my series of eight gun-shot and one stab wound, only one has died, a mortality of 11 1-9%. Dr. Martin concluded his address with a short sketch of his nine cases, dwelling principally upon the salient features of each individual case, rather than a resume of the symptoms common to all gun-shot wounds. The secret of success is getting the cases early, speedy work, closure of visceral lesions, and give as little shock as possible.

In opening the discussion upon this paper, Dr. Randolph Winslow mentioned that his first successful operation upon a case of this character occurred in 1893, at one time he had three patients in the hospital recovering from penetrating wounds of the abdomen, and in one week five cases entered the hospital, four of whom were operated upon, three recovered, one died, the other an unoperated case succumbed. In his career he has had charge of 29 cases, five of whom were operated upon, with a mortality of 80%, or four died and one recovered. The omentum protruded from the external wound of the one who recovered. In 1883, just prior to the time of Dr. Sims' memorable address in the Chemical Hall of this University, a case of perforation of the liver, incurred while running from a policeman, as junior surgeon, came under my supervision, as all my superiors were away I consulted Professor Chisolm, who advised against operation. This case would in all probability have recovered. In one of the other cases the aorta was penetrated in two places, still the patient, a woman, survived the accident five days and two hours, death being due to subperitoneal hemorrhage. In 1883 my first operative case occurred. A man stealing coal, was shot by a watchman, the bullet piercing both the ileum and ilium, the former in four places, all of which were sutured. Subsequently a pulsating tumor occurred in the wound, an aneurysm of the deep circumflex iliac artery which was exposed and ligated, and the patient made a good recovery. Many of the cases were very bad, and my percentage of recoveries have not been as good as Dr. Martin's. Of his 24 operative cases, 15 recovered, 61 1-2%, and nine died. Four of these case were stab wounds of the hollow viscera, all of which recovered. In four of the cases these cases there was no injury to the viscera, all of these made uneventful recoveries. Results vary, sometimes you have a run of good luck, sometimes of bad, mine recently have been bad.

(Dr. Frank Martin, paper read before the Medical Society of the University of Maryland, December 19, 1905.)

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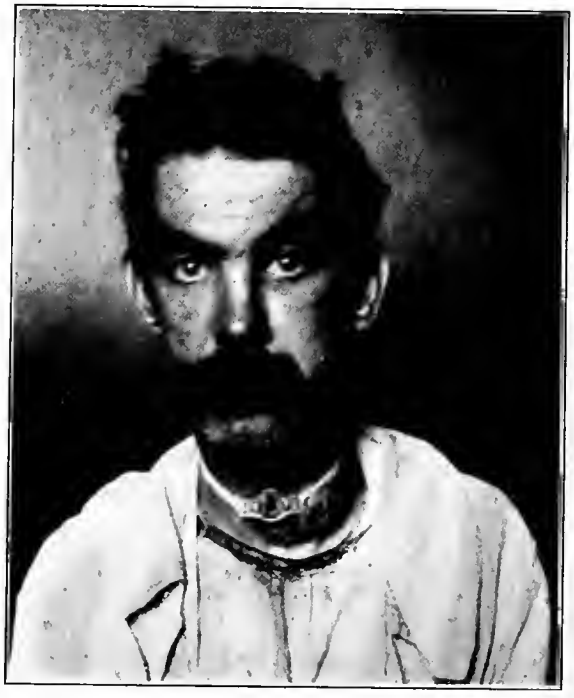
A CASE OF SARCOMA OF THE HYOID BONE AND LARYNX WITH EXCISION OF THE TUMOR OF THE HYOID, BASE OF THE TONGUE, LARYNX AND PART OF THE PHARYNX, UNDER LOCAL ANAESTHESIA.

BY RANDOLPH WINSLOW, M.D.,

Professor of Surgery in the University of Maryland.

On January 9, 1906, Joseph Ward, age 45, white, tailor by occupation, was admitted into the University Hospital, having been sent in from the throat and nose dispensary, where he was examined by Professor John R. Winslow. He was at that time suffering from dyspnœa, due to a growth in the region of the hyoid bone, which so pressed upon the epiglottis and larynx as to produce difficult respiration, and to prevent a laryngoscopic examination of the air passages. The diagnosis was tumor of the hyoid bone involving the larynx. The patient is married and has four healthy children. His parents lived to a good old age, and he does not know the cause of death of either of them. He has had the usual diseases of childhood, as well as smallpox, and sixteen years ago had a sore on the penis with suppurating inguinal glands, but this was not followed by any secondary symptoms. Thirteen years ago he noticed a small lump in the left side of the neck, which was excised by Professor W. W. Keen at the Jefferson Hospital, Philadelphia. Through the kindness of Professor Keen, the following history has been obtained: "Ward, Joseph, age 34, was admitted to the Jefferson Hospital on March 31st, 1893; discharged April 6th, 1893. He had a tumor in the right side of the neck, the size of a hulled walnut. He complained of no pain or any other symptom. The presence of the tumor was the only physical sign. There was no family history of tuberculosis or malignant disease. The tumor was removed by Dr. W. W. Keen, April 1st, 1893. He found it attached to the hyoid bone and the side of the larynx. Five days later the patient left the hospital with the wound entirely healed." No pathological examination of the growth was recorded. The history is probably erroneous in stating the tumor to have been located on the right side, as there was a well-defined scar on the left side of the neck and none on the right, and the patient said the growth was on the left side.



Excision of base of tongue, hyoid bone and tumor, larynx and part of pharynx. Recurrence in neck.

He has been a regular drinker, but never to excess. After the removal of the growth mentioned above, he enjoyed good health for three years, when he noticed a recurrence, and it has been increasing in size, slowly, ever since. About five weeks before admission to the hospital, the respiration began to be interfered with, and there was also some difficulty in deglutition. His voice is altered and he has some cough. He is pale,

emaciated and weak. There is a marked dyspnœa, with stridor, which makes an examination of the chest difficult. The heart is exceedingly feeble, and beats from 110 to 140 times a minute. The apex beat is not visible or palpable, but the heart sounds are clear and the second aortic sound is eccentuated. The abdomen presents nothing of importance. There is a large swelling occupying the location of the hyoid bone and extending more towards the left than the right side of the neck. This enlargement is globular, as large as a goose's egg, hard and freely movable. It is not painful, but causes discomfort. The Adam's apple can be seen and felt below the tumor, and the larynx is not enlarged or displaced. A skiagraphic picture fails to show the hyoid bone, but a shadow of a growth is faintly seen in the area between the jaw and the larynx.

On January 11th, his respiration had become so impeded, that immediate relief was demanded, and a laryngotomy in the crico-thyroid space was done under cocaine. This relieved his dyspnoea and rendered him much more comfortable. He was desirous of having the growth removed, but his condition did not justify such a serious procedure. He was, therefore, put on tonics, with digitalis, and fed well, and his pulse gradually increased in strength, and diminished in frequency, ranging from 70 to 100 per minute, but still of very poor volume. As he still wished to be operated on, it was thought unwise to place him under a general anesthetic, hence he was given one ounce of whiskey every hour by mouth from 3 to 8 A.M., and morphia grain one quarter and scopolamin grain one one hundredth.

One-half hour previous to operation, an infiltration anesthesia of the skin with Schleich's solution was effected. On February 1st, 1906, he was properly prepared and whilst still awake the operation was undertaken and completed. The tumor of the hyoid was first removed with a part of the base of the tongue, when it was seen that the larynx was also involved. The incision was therefore extended downwards in the middle line, the skin reflected and the whole larynx easily removed without hemorrhage. The end of the trachea was brought out at a lower level and sutured to the skin. A large gap was left, leaving a wide opening into the pharynx. The pharynx was sutured to the base of the tongue and closed in the middle line so as to make a funnel-shaped canal, and the skin was loosely sutured. The patient stood the operation very well, complained of but little pain, and was in as good condition at its close as at its beginning. I am confident he would not have survived a general anæsthetic. He was returned to bed and put in an almost upright position to facilitate the swallowing of the saliva, and a tracheal tube was kept in the trachea. At first a large soft rubber catheter was passed from the mouth into the œsophagus and water and milk allowed to run into the stomach, but subsequently the lower part of the pharynx opened and the tube was passed into the œsophagus from the neck. There was a free discharge of saliva from the opening in the neck, which was kept from entering the trachea by wrapping the tracheal tube with gauze. The incisions healed promptly except a small place at the bottom, and the patient gained in strength. Three quarts of milk, with eggs and whiskey, were administered daily. He soon sat up, and walked around the ward, and in a measure enjoyed life, but in the latter part of March there was a recurrence in the lower portion of the neck, as well as in situ, and he gradually failed and died on March 27th.

The tumor was a round sarcoma. A few injections of Coley's mixed toxines were given, as well as X-Ray treatments, without benefit. The autopsy showed extensive matastases in the lungs, bronchial glands, liver and mesenteric glands, as well as in the tissues of the neck.

Laryngectomy, whilst not frequently performed, is done sufficiently often not to excite much comment, and it is not so much on account of the extirpation of the larnyx and contiguous structures that this case is reported, as on account of the rare occurrence of neoplasms of the hyoid bone. I regard this as a case of primary sarcoma of the hyoid bone, subsequently extending to the larynx, but of this there is doubt. Professor Hirsh, who examined the tumor of the hyoid, not finding any myeloid cells, is inclined to think the starting point was in the epiglottis. The hyoid bone was completely destroyed by the growth, only some calcareous particles remaining, whilst the epiglottis was not entirely destroyed, nor was the larynx as much involved as one would expect if the growth had originated in the epiglottis. The patient said the growth began to occur three years after the removal of the tumor by Dr. Keen, approximately ten years ago. In most of the works on surgery at my disposal there is no mention of tumors of the hyoid bone at all, and the literature on the subject is ex-

ceedingly scant. It is stated in Von Bergmann's System of Surgery, that only two cases of primary tumor of the hyoid bone are found in all literature, but I have been able to find two other cases, which with the one just reported makes five. The occurrence of a primary neoplasm of the hyoid bone is then without doubt of great rarity, and even secondary involvement occurs also very seldom. Dr. J. Spisharny, of Moscow, in the Deutsche Medicinsche Wochenschrift, vol. xviii, page 853, 1892, says: "Tumors of the hyoid are of the greatest rarity." In all literature he could only find one case of primary tumor and one of metastsatic growth of this bone. In the Zurich clinic of Billroth, of 558 cases of neoplasms, there were none of the hyoid bone. (Langenbeck, B'd x heft, 3, p. 813). Gurlt, in 16,637 tumors, found none of the hyoid bone. (Langenbeck's Archiv B'd xxv heft 2, p. 421), and Williams (in the Annals of Surgery, October, 1891, p. 527), collates 15,481 cases of new growths of the various organs and structures, but none of the hyoid bone. The following are all the cases I have been able to find reported in literature:

Case I.—Enchondroma of the hyoid bone, reported by E. Boekel in the Gazette de Strasbourg in 1862, which the author remarks, "is unique in literature":

A woman, 50 years of age, observed in 1859 a tumor on the right side of the throat, which gradually increased in size. The neoplasm was the size of two fists, fluctuating, and hard at its base like cartilage. It raised up the inner head of the sterno-cleido-mastoid and pressed against the larynx, then extended under the chin, and terminated in a blunt point two centimeters below the sterno clavicular articulation. It was somewhat movable, and the skin was not adherent to the growth. The thyroid gland was small and not involved. Swallowing solids was very difficult, but respiration was not impeded. On puncture of the tumor, several grammes of liquid jelly escaped. There was no pain. Extirpation was done and the growth was found to arise from the horn of the hyoid bone, which was resected and the tumor easily removed. There was very slight bleeding. The growth was 12 centimeters long and 7 centimeters thick. It rose from the periosteum of the horn of the hyoid bone, and consisted of hyaline cartilage, with a great number of cells. The patient did well until the fourth day, when secondary hemorrhage set in, and notwithstanding the ligature both external and later common carotid arteries, she died of anæmia and exhaustion."

This case is quoted by Dr. J. Spisharny, of Moscow, in the Deutsche Medicinische Wochenschrift, vol. xviii, p. 853, 1892:

Case II.—Tumor springing from the horn of the hyoid bone, causing suffocation through lateral compression of the epiglottis. "On November 5th, 1867, a man aged 23, appeared, of fair and delicate complexion, who spoke in a very guttural manner, as if his mouth was full of food. Six months previously his voice had become affected, commencing with a cold and sore throat. A swelling formed on the left side of the neck, which affected speech and swallowing, with dyspnœa at times, especially at night, and sometimes a little cough. He could swallow solids and liquids, but as the tumor increased in size this varied and he became thinner. His previous health had been excellent. He became very weak with a feeble pulse. The fauces appeared healthy. By larygoscopic examination a rounded tumor, the size of a large walnut, was seen on the left side of the throat at the root of the tongue and pushing the epiglottis to the right and compressing the epiglottis laterally, so it looked as folded in two. The entrance to the larynx was obstructed. The tumor appeared somewhat ulcerated, and was hard but not painful. In the neck externally there was a swelling above the thyroid cartilage and connected with the left horn of hyoid bone. It had increased in size somewhat rapidly of late. No operation was done, and the man returned home, where he died suddenly on November 9th, 1867. The growth was supposed to be malignant, but no microscopic examination was made." Reported by Sir Duncan Gibb, in the Transactions of the Pathological Society of London, vol. xix, p. 59, 1868.

Case III.—Primary enchondroma springing from the great horn of the hyoid bone. Excision and recovery. "On March 22, 1891, a man 25 years old came under observation. On the right side of the throat, immediately below the lower jaw, in the location of the hyoid bone, was a tumor the size and form of a hen's egg. The skin was not altered and was movable. The tumor was rough, hard and but slightly movable, and was connected with the right horn of the hyoid bone and followed the movements of this bone. It was not painful. The thyroid cartilage was pushed to the left of the middle line. The orifice of the larynx could not be seen, but a lump,

the size of a walnut, could be felt at the base of the tongue, which was rough, hard, and but little movable, and was connected with the growth in the throat. The corresponding tonsil was swollen. A laryngoscopic examination was impossible. Swallowing solids was difficult, the voice hoarse and respiration labored, when he was on his back. The respirations were 26 to the minute. The patient well nourished, and the other organs normal. Eleven years ago he noticed that his voice was hoarse. No lump was observed at that time, but five years later the swelling was noticed and grew slowly. Five months before coming to the clinic he began to have dysphagia and marked hoarseness of voice. On April 10th, 1891, under narcosis, Professor Sklifosowsky operated in the following manner: An incision was made at the level of the angle of the mouth and extended in a curved manner to the cricoid, the sterno-mastoid and vessels pulled outwards and the growth enucleated, when it was seen that it had developed from the right horn of the hyoid bone. Releasing the growth was not easy, and was accomplished by blunt dissection with the index finger. The bleeding was slight, only the facial, lingual and a few small vessels were ligated. The right horn was excised at its junction with the body of the bone. He was discharged well in a month. After the operation the temperature remained normal, the voice became clear, and the breathing and swallowing perfect. The tumor was irregularly oval in shape; length, 7 centimeters; breadth, 6 centimeters, and thickness, 4½ centimeters. The structure was mostly hyaline cartilage, rich in cells, and the tumor surrounded with a connective tissue capsule." Reported by Dr. J. Spisharny, Deutsche Med. Wochenschrift, vol. xviii, p. 853, 1892.

Case IV.—Mixed, round and spindle-celled sarcoma of the hyoid bone. Recovery. "The patient was a negro, aged 24 years, married, tuberculosis. Has had gonorrhœa, but not **waiter. No family history of malignancy, but of** syphilis. There was a lump, the size of an English walnut, beneath the chin. The skin was stretched and ulcerated at one point, the larnyx was not involved. The tumor is away from the median line and upon the right greater cornua of the hyoid bone. It has been growing for five months, and has been painful one month, and is now very tender. Deglutition and respiration are interfered with. Chloroform anesthesia. Operation on April 7th, 1898. Dr. Dawbarn excised the left external carotid artery. Ten days later, the right carotid was excised and the growth abated. The tumor was encapsulated and easily removed. It was attached to the greater horn of the hyoid bone and one-half of the hyoid was removed. The mouth was not opened, nor was the thyro-hyoid membrane torn. Some suppuration occurred, but the man recovered and resumed work.". Prize essay by Dr. R. H. M. Dawbarn. The treatment of certain malignant growths by excision of the external carotids, page 33.

Spisharny also mentions one case of metastatic involvement of the hyoid bone, in which Peter found a metastasis in the body of the hyoid at the autopsy of a person who died of cancer of the œsophagus.

Tumors of the hyoid bone, as far as they have been reported, have been either sarcomata or enchondromata in about equal proportions, and in similar cases we may expect to find one or the other of these neoplasms. Whilst one variety is malignant and the other benign, the treatment should be the same, and the tumor should be extirpated, with as much of the contiguous tissues as may be necessary. The operation is not attended with extraordinary danger, even when it becomes necessary to excise the larynx and other contiguous structures, but the possibility of a permanent cure depends upon an early removal in the case of sarcoma.

A STUDY IN RHUS POISONING.

By A. K. Bond, M.D., of Baltimore.

There are very few plants in this region of America whose mere touch or gathering is poisonous to the average citizen. Growing to manhood in Harford County, Maryland, I was by precept and by experience taught to avoid only one plant—the three-leaved creeping or climbing vine—popularly known there as Poison Oak, which abounds in fence corners and in forests throughout Maryland. I remember being poisoned only once by this vine, and then very slightly on the hands; although in gathering flowers and autumn leaves contact with its leaves was very frequent. Breaking its stems or crushing its leaves with the hands was always avoided, as few persons can resist the poisonous effect of the juice when rubbed into the skin.

Certain of the sumacs growing into shrubs were dimly rumored to be poisonous to the skin,

but in Autumn we gathered the beautifully-tinted frond-like leaves of the common wayside sumac shrub (that which gows to the height of from three to five feet and is crowned by a spike of crimson berries) with impunity; and I often wondered what sumac shrub could be meant by those who warned me.

Writers concerning Rhus poisoning leave the reader quite confused as to the identity and comparative harmfulness of the plants against which they warn us—Rhus radicans, Rhus vernix, Rhus toxicodendron, Rhus venenata, and others. There seems to be confusion of names, writers calling the same plant by different names, or including under the same name plants (vines) with leaves of various forms.

Wood's Botany, the standard of my school days, says of the Rhus genus in the sumac or anacardiaceæ order that its members abound in a poisonous juice; and this genus includes vines, shrubs and trees. One member is the (in my experience) harmless wayside shrub just mentioned. Another shrub, a partial creeper, of North Carolina, is said by Wood to be "very poisonous."

A very handy little pamphlet issued by the Government Department of Agriculture in 1898, entitled "Thirty Poisonous Plants," mentions a poison ivy limited to the Pacific Coast States, and beside this mentions only two members of the Rhus genus—Rhus radicans and Rhus vernix, the former a creeping plant, the latter a tree.

Duhring and Hyde, who may be taken as representative dermatologists of the Atlantic and Mississippi Valley States, respectively, ascribe their cases to Rhus venenata and Rhus toxicodendron. This is very confusing in treatises not designed for expert botanists. I have not been able to harmonize the accounts, nor to identify the Rhus toxicodendron which Duhring, of Philadelphia, says poisoned his patients, and which Wood says is a small, weak shrub, one to three feet high (apparently neither three-leaved nor a climber) with anything in this region.

Rhus Radicans, of Wood's Botany and the "Thirty Poisonous Plants," seems to be our common Poison Oak, the climbing vine, which we are all taught to shun. Rhus venenata, of Wood, a tree ten to fifteen feet high growing in swamps, is apparently the tree called Rhus vernix by our Department of Agriculture. My inference is that I do not know the Rhus toxicodendron; and that the Department of Agriculture has left out a very common poisonous Rhus shrub, I do not specially desire to investigate, having recently been too familiar with a swamp sumac tree found about Baltimore. Wandering in the suburbs on the 20th of October, I discovered a *tree* (not an overgrown shrub) with particularly gorgeous foliage, of all hues, from green to yellow and red, most ravishingly blended. With considerable exertion and by drawing down the limbs with my hooked umbrella handle, I gathered a lot of the boughs and leaflets and made a triumphal march to the trolley cars, the foliage exciting remarks of admiration from passersby. Stopping at the home of some relatives, who were familiar with the flora of Harford County, I presented them the bouquet; and we together arranged them in jars for parlor decoration. A discussion elicited the opinion that as the long leaves with their side-leaflets were very like those of the common wayside sumac, and, as they were gray underneath, although bright-hued above, they were probably a variety of sumac; but that they might be poisonous was not possible.

None of these relatives who handled the boughs and leaves were poisoned in any respect.

I observed nothing unusual for two or three days. Then the wrists broke out with fine papules, not itching. The thumb roots, the forehead, the right side of face and eyelids, the ears, the back of fingers and the palms of the hands erupted slowly in the order named, the palm eruption beginning from ten to fourteen days after exposure. Severe itching in paroxysms came on two days after the eruption began. At the time of writing (November 11) the inflammation has all subsided, and deep peeling of the skin, where the lesions were most abundant, has reached its height.

The poison of the Rhus vine and Rhus tree are believed to be the same. It was formerly said to be a volatile acid (toxicodendoic), but more recent investigators declare it to be a non-volatile oil, which can be obtained from all parts of the plant, even from its long-dried wood. This oil is insoluble in water and therefore cannot be washed off the skin with water. It is readily removed by alcohol, and easily destroyed (rendered inert) by a weak alcoholic solution of lead acetate.

Experiments with the extracted oil show that when a small portion is placed on the skin it is gradually absorbed throughout several days, and

the poisonous effect is roughly proportioned to the length of time it remains in contact. The spots at which the oil was applied were an inch apart only, yet the eruption did not spread over the intervening spaces, showing clearly that only the parts of the body in contact with the juices of the plant inflame. This is quite contrary to public opinion on the subject. Undoubtedly it does away with the belief that a miasm surrounds the plant, affecting poisonously sometimes persons who have not touched it; and also with the alleged recurrence of Rhus poisoning on successive years without repeated contact with the plant.

The writer had recently to dispute this latter point with a patient who had the eruption of alleged Rhus-vine poisoning only on parts of the body which could not possibly have touched the plant. Untrained thinkers are very much inclined to ascribe symptoms that are similar to the same cause. For years after one has been poisoned by Rhus he is apprehensive of its repetition, and if an itching from any source affects the skin he ascribes it to Rhus. The young man I speak of had probably an indigestion rash from eating fish or crabs, yet was perfectly certain it was Rhus dermatitis. For Rhus poisoning is normally a dermatitis. From scratching, pus sores may develop; and in certain conditions eczema may be added, but neither of these belong to the Rhus sepsis. When one part of the body has an itching disease, there is apt to be itching from time to time in other healthy parts, and these may be rubbed or scratched into traumatic dermatitis, which is likely to subside as soon as it is left alone. The Rhus oil may, of course, during the few days it is on the skin, be scratched into any number of places in the skin—each becoming a centre of inflammation from which an erythema extends to a portion of an inch (or more?) around it

In my personal infection I became convinced that the Rhus tree poisoning was deeper than that of the common Rhus vine. It seemed to cause essentially an inflammation around the sweat glands, with itching only when these became tense with retained fluid from closure of their ducts by the inflammation. This I inferred from the fact that daily shaving of the affected cheek did not give any distress, did not cause bleeding, did not increase the inflammation. Evidently neither the surface nor the hair shafts were seriously affected. The presence of the eruption for a day or two before itching appeared harmonizes with this view. Also the fact that as the swelling became less a small number of tiny vesicles were left behind in the centres of the inflamed areas, and the fact that by crushing and mashing the itching parts (at least after the disease had been on them a few days) these vesicles were flattened or made larger, and for many hours all itching would cease. This cessation, with a temporary soreness about the arm far above the crushed parts, led me to believe that the fluid in the distended sweat glands was driven into the tissues, relieving the tension which caused the itching; and that this fluid was somewhat irritating to the lymph channels. Toward the latter part of the disease I used no wash or soothing salve to check the itching; but simply kneaded the part with the other hand as strenuously as possibly, refraining carefully from scratching. The vesicles never burst under this kneading, though hard rubbing off of the surface skin would cause a momentary moisture—from which I inferred that there was no eczema present, and that the inflammation was in the deep layers of the skin. All this is different from the common Rhus-vine poisoning, in which the seat of the trouble is, I think, very much more superficial.

The peeling which affected all the poisoned parts was deep, like that of scarlatina, rather than like that of measles.

TREATMENT.

The treatment of the disease naturally falls into three parts. In the first few days great care should be taken not to rub the poison into unaffected parts. It would be wise, therefore, even to cover with gauze all the affected parts. If lead acetate is really a neutralizer of the oil, and since alcohol dissolves it, the hands and nails should be frequently scrubbed with alcohol and a wash of acetate of lead in dilute (40%) alcohol should (with due caution against systematic lead poisoning) be applied to the part. A quantity of the acetate should be put into the bottle of alcohol. Only a portion will dissolve, and more dilute alcohol may be added as the bottle is emptied.

After the first few days the oil will presumably be no longer in reach of these agents. Then the second part of the treatment begins, which has for its object the soothing of the affected regions and the aiding of the body in its effort to restore the skin to a normal condition. The digestive tract should be put into first-class order, since it

is well known that the skin is frequently distressed by unwholesome digestive fermentations and absorptions. The compound licorice powder is beneficial in some cases, containing the thoroughly purgative senna, and also sulphur, which may have a beneficial action on the sweat glands. A grain or two of calomel, followed next day by weak senna tea, is a good alternative. Or cream of tartar and sulphur lotion, of each a heaping teaspoonful, may be given once or twice a day.

The food should be easily digestible; and abundance of water should be taken between meals, to dilute the urine and favor the removal of wastes. Occasional teaspoonful doses of sodium bicarbonate mollify the urine.

For the itching, the fluid extract of grindelia robusta (1 to 30) was, in my case, the best wash, applied on cloths, at the early period when the heat of the skin was considerable. Later, as I have said, I heavily kneaded the skin, thus avoiding the danger of body chilling at night and the nuisance of washes.

In the hot stage no salves, I think, will be tolerated. Later they aid by protecting the skin. Parts so covered that they will not bear salves and cannot admit of wet cloths may do well under talcum powder, preceded, possibly, by a wash of dilute alcohol. I think hot soaking of the hands in dilute bichloride solution, lead water, tincture of iodine, pure carbolic for a moment in a small area, followed immediately by alcohol, did little good. A spot on the forehead which I curetted and did little else to soothe healed earliest of all. For covered parts of the body in a case of superficial poisoning, as from the Rhus vine, the lead and opium wash on cloths is good; but it stains skin and clothing. I found that washing off daily of all salve and gum residues with hot water and soap and the reapplication of the remedy was helpful, clearing the pores. For the slight conjunctivitis, drops containing boric acid, 5 grains; zinc sulphat, ½ grain to the ounce of water, were very healing. The baggy swelling under the eyes became less noticeable after gentle massage.

My belief is that in the more superficial inflammations with greater heat and redness of the skin only soothing agents should be employed. In my case this was but transient, and the itching and distress came almost wholly from the deep tough vesicles which slowly formed; the skin not seriously resenting the most vigorous handling.

Cases very protracted suggest diabetes, complicating eczema or general ill nourishment.

During the scaling and peeling and terminal stage of tender skin a glycerine lotion or an ointment of calomel, 10 grains; Bismuth subnitrate, 1 drachm; zinc ointment, 1 ounce, worn with dogskin gloves at night, or a quick drying "glycerine jelly," were most healing.

The whole course, from contact with the tree until peeling ended, was about one month.

CONSERVATIVE OPERATIONS ON INFLAMED TUBES AND OVARIES.

By J. M. Hundley, M.D.,

Clinical Professor Diseases of Women, University of Maryland.

This Winter we reported before the surgical section of the Medical and Chirurgical Faculty nineteen cases of conservative operations on inflamed tubes and ovaries. This work extended over a period of four years. We do not know the number of cases operated on during that time. Only the cases remaining under our personal observation, or heard from by letter, or through the medical attendant, were reported.

It is difficult to keep in touch with a certain class of hospital patients, and for that reason statistics relating to the results of surgical work may be and are often misleading. Patients apparently cured on leaving the hospital return not benefited, or are worse than before operation. Many fall into the hands of other surgeons. The results known to us at the time of making the report are as follows: Of the nineteen cases, eight were not improved, seven improved and four cured. Since making the report two cases tabulated as not improved, and one as improved, have been operated on. More recently we learn that a case tabulated as not improved is greatly improved, and that a gonorrhœl pus tube case operated on eleven years ago by section through the posterior vaginal fornix gave birth to a full-term child a few weeks since. It is now pertinent for us to define what we mean by conservative operations on inflamed tubes and ovaries. Within a comparatively short time the ovaries and tubes in pelvic inflammatory cases were removed without regard as to whether or not one ovary and tube, or a part of an ovary, could be conserved. Very probably the teaching

of Lawson Tait encouraged this radical method of operating. Tait removed both ovaries when one had to be removed for the reason, in his experience, that an ovary apparently normal at the time of operation usually became diseased in two years, when a second operation had to be done. It is needless to say that this view is not held today.

In the conservative operations done by us we have only removed an ovary when, in our judgment, it was hopelessly diseased. If part of an ovary could be saved we excised the diseased portion and left so much as appeared normal. The tubes were dealt with in like manner. One tube would be removed and the abdominal end of the other opened up, and, if needed, the mucosa sutured over the denuded surface to prevent readherence. Frequently this was done in the presence of pus. A pus tube with the corresponding ovary would be removed; the other tube might not contain an appreciable amount of pus, but would be adherent. This tube and ovary after being freed from adhesions might need nothing more to be done. Frequently a hasmatoma would be excised from the ovary, and the tube opened and sutured. In doing these conservative operations we have endeavored to get a working formula to guide us in dealing with subsequent cases presenting the same conditions. In this way only can we hope to arrive at any definite plan of procedure. We are satisfied, in spite of our failures, that this work is along proper lines. It has its limitations, and may be carried too far, but the ovary and tube are possessed of wonderful recuperative powers, and for that reason should not be heedlessly sacrificed. The radical removal of inflamed tubes and ovaries is quite analogous to the way in which serious crushing injuries were treated years ago. At the time to which I allude there was but one way, and that was to amputate the injured member. Now it is rarely done, and the recoveries are often miraculous. And so it is, in great measure, with inflamed tubes and ovaries.

We have not done conservative operations on chronically inflamed tubes containing pus.

When we first began these conservative operations we saved any part of an ovary, however small. After several failures we gave it up, and now remove the ovary, unless half can be saved. We have selected three cases out of the nineteen which we wish to report in detail. They will give some idea of what we have been trying to accomplish, as well as showing the difficulties encountered. One of the difficulties, and a serious one, is the lack of co-operation on the part of the patients. That was not true with all of them, but a majority were unwilling to suffer pain, forcing us, frequently against our best judgment, to operate.

Case 13.—Mrs. A. N., married, aged 28, one child 8 years old; no miscarriages. Has not been well since birth of child. Suffers with pain in lower abdomen; pain is more acute in left inguinal region. Has pain in rectum. Menses scant and painful. Previous and family history negative. Diagnosis—Retroverted uterus, chronic pelvic inflammation. Operated January 17, 1905. Uterus tubes and ovaries retrodisplaced and adherent, adhesions released and suspensio-uteri done. September 27, 8 months after the first operation, returned with the same acute pain in left inguinal region, and in no way improved. Has dargging pain at site of suspension of uterus. A second operation was now done. Left ovary and tube removed and uterus released from its abdominal attachment, and round ligaments shortened. It was now hoped she would be benefited, but she was not. A third operation was done in February of this year for the same symptoms. At this time a supravaginal hysterectomy was done. She says in a letter received April 10th that she is now well. We had every reason to believe at the time of operation that it was a case suitable for conservative work. It was noted at both the first and second operation, that the uterus was unusually large and baggy. It is probable that this condition of the uterus caused the symptoms complained of, and that the ovary played a secondary part in keeping up the pelvic distress.

Case 10—Gertie G., aged 22. Single. Had gonorrhœa one year previous to admission to hospital—April 22, 1904. Has now a profuse leucorrhœa. Menses recur every two or three weeks, and profuse. Had pain in lower abdomen for one year. Family and previous history negative. Diagnosis—Subacute pelvic inflammation. Operated April 24. Curettage of uterus, followed by laparotomy. Both tubes and ovaries were prolapsed and adherent in a common mass. Resected the left ovary for a hematoma, leaving about half of the ovary. Tube patulous. Right tube and ovary freed of adhesions. It was thought that they could be left. March, 1906, two years after the previous operation, she re-

turned suffering pain in the left inguinal region, which had existed since operation. The resected ovary was at this time about the size of a small hen egg, and had degenerated into a cyst containing blood fluid. It was removed. The right tube and ovary appeared normal, and as she had had no pain except in the left inguinal region, was not disturbed. In a similar case we should now remove the ovary instead of resecting it, as in our experience, where one ovary is in good condition microscopically, and we have a reasonable hope that it will perform its function normally, it is best not to resect the palpably diseased ovary, but remove it.

Case 11.—This case presents some points of interest. Mrs. B., aged 28, married, has one child 7 years old, and has had two miscarriages since his birth. She has suffered pain in lower abdomen for six years; menses irregular. Diagnosis—Chronic pelvic inflammation. Operated December 13, 1904. Removed left tube and ovary and appendix. Right tube and ovary freed from adhesions, and fimbicated end of tube opened and suterned. Continuing to suffer pain, she consulted us September 20, 1905, when we found her six weeks pregnant. At this time she was having pain and a slight discharge from the vagina. She miscarried October 10. After the miscarriage she continued to suffer pain, and returned to the hospital November, 1905. At this time we removed the right tube and ovary. The points of interest in this case are two. First—She became pregnant after the conservative operation. Secondly—The symptom pain. In spite of our efforts to persuade her to wait and see what time would do in mitigating the pain, she insisted upon the removal of the ovary. She said she knew women who were well after having their ovaries removed, and she was unwilling to suffer any longer. It is difficult to place the proper significance upon the symptom pain in nervous women, and for that reason we are cautious in advising operation in many of these cases, especially when the pelvic condition does not appear sufficient to account for the pain apparently suffered.

Prof. J. C. Hemmeter, of the University of Maryland, delivered an address before the State Medical Association of Ohio, at Canton, on May 9th. He was also invited to give a clinic at the Western Reserve University in Cleveland and one in Chicago.

DISPENSARY PHYSICIANS, 1905-1906.

Department.		
Stomach	R. A. Warner. J. H. Iglehart.	
Skin	J. R. Abercrombie	Chief of Clinic.
Throat and Nose	R. H. Johnston F. J. Wilkins. ——— Davis.	Chief of Clinic.
Children	W. H. Mayhew A. B. Lennan	Chiefs of Clinic.
Eye and Ear	E. E. Gibbons Wm. Tarun	Chiefs of Clinic.
Women	F. J. Wilkins. W. K. White. H. W. Brent.	
Genito-Urinary	W. D. Scott	Chief of Clinic.
Medical	G. Wilson G. C. Lockard. H. J. Maldeis. G. S. Kieffer. H. D. McCarty.	Chief of Clinic.
Surgical	J. G. Jay M. J. Cromwell. J. A. Thomkins. J. F. Adams. N. Winslow. G. H. Stewart. O. P. Penning.	Chief of Clinic. John Houff, M.D., *Dispensary Physician.*
Nervous	H. Richardson J. J. Spear.	Chief of Clinic.

DISPENSARY REPORT.

April 1st, 1905, to April 1st, 1906.

Departments.	New cases.	Old cases.	Total.
1—Surgical	1312	4962	6274
2—Medical	1109	4206	5315
3—Genito-Urinary	929	2859	3788
4—Nervous	363	2160	2523
5—Women	757	1306	2063
6—Stomach	409	1388	1797
7—Skin	525	1153	1678
8—Throat and Nose	607	1069	1676
9—Eye and Ear	623	970	1593
10—Children	529	792	1321
Grand total	7163	20865	28028

JOHN HOUFF, M.D.,
Dispensary Physician.

THE HOSPITAL BULLETIN

A Monthly Journal of Medicine and Surgery

EDITED BY
A COMMITTEE OF THE HOSPITAL STAFF.

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BALTIMORE, MD., MAY 15, 1906.

EDITORIAL

COLLEGE JOURNALISM.

Whilst the BULLETIN has not assumed the role of a college journal, it has aimed to represent the interests of the Medical Department of the University and to be of service to its teaching staff, to its alumni, and to its students. It has a definite purpose in view in trying to stimulate literary work and in promoting good fellowship between the teaching and student bodies and the alumni, who are no longer connected in an official way with the University. If these purposes are carried out successfully the BULLETIN may hope to enlarge its scope of work by educating members of the student body in editorial work in connection with its editorial staff. The rapid development of medical journalism in recent years has opened up a large field for the exercise of medical talent in the direction of literary medicine. Men must be trained for literary work in connection with the teaching and practice of medicine if they aim to reach a high standard in literary medicine. Among the students of the University there may be a number of young men who have a literary career in view. To any such the BULLETIN wishes to extend a helping hand by offering such opportunities and inducements as will aid them in the development of their aspirations. With this object in view a students' column will be opened whenever the material is presented for publication.

In this connection the BULLETIN presents the following article taken from the *New York World* of May 6, 1906:

"More than a local interest will attach to the celebration by the *Cornell Daily Sun* of its twenty-fifth anniversary next Thursday.

An eight-page college daily exhibiting all the outward signs of prosperity, including those of well-filled advertising columns, is something to make the old graduate rub his eyes. The evolution of the college metropolis has brought its accompanying development in other lines.

The *Cornell Sun*, by reason of a condensed telegraphic service supplied by *The World*, is enabled to occupy a unique field among college newspapers. In the absence of morning papers in Ithaca it furnishes the general public there with an acceptable substitute.

The *Daily Echo*, founded at Harvard in 1879, but since deceased, antedated the *Sun* by two years. The *Harvard Crimson*, begun as a weekly in 1873, has been a daily for some twenty years. In the college world there are twelve daily papers, comprising in addition to those mentioned the *Yale News*, the *Princetonian*, the *Columbia Spectator*, the *Pennsylvanian*, the *Brown Herald*, the *Nebraskan*, published at Lincoln; the *Iowan*, of Iowa City; the *Palo Alto*, the *Berkeley Californian* and the *Madison Cardinal*.

Of other college publications there are 171, most with a circulation of less than 1,000. Seventeen exceed this figure, the *Michigan Alumni Weekly* claiming 5,610. The Alumni weeklies of Yale, Pennsylvania and Princeton, the Columbia University, the *Harvard Law Review* and the *Kansas Jayhawker* circulate 2,500 copies each.

For the most part they are creditably written, and not infrequently the style shows the man destined for larger things. A liberal percentage of college editors become professional journalists. Viewed in its relation to the college curriculum, the student newspaper supplements theme-writing and practice in English composition. It reflects also an interesting side of that ceaseless activity of the printing-press which is perhaps the most distinctively American of all American things."

THE CENTENNIAL AS OTHERS SEE IT.

The following notice, published in the editorial columns of the *Baltimore Sun* of April 25, 1906, is a just compliment to the University of Maryland and a strong argument in support of the movement now in progress to celebrate the centennial in a manner in keeping with the dignity and importance of an event of great historic interest to the people of Maryland.

The *Sun* has quoted a recent article in the BULLETIN in its advocacy of this movement. The BUL-

LETIN is glad to have the support of the daily press in its efforts to arouse a general interest in the centennial celebration:

"*The Sun* recently announced the purpose of the alumni and board of regents of the University of Maryland to celebrate, in May, 1907, the centennial of the founding of the university. It is felt that an institution which has done so much in the past hundred years for the cause of medical education should signalize the rounding out of an eminently creditable record. Founded when Baltimore had a population of but 35,000, the university has shared the spirit of enterprise that has always characterized this city. The work has been in many respects that of a pioneer in medical education. It was the first educational institution in the world, says the HOSPITAL BULLETIN, to give instruction in dentistry, and was the first also to make dissection a compulsory part of the curriculum. It was among the very first to teach hygiene and medical jurisprudence, to teach medical 'specialties' and to provide clinical instruction by having a hospital of its own for the benefit of students. In the field of operative surgery the faculty and graduates of the University of Maryland have been leaders, giving this city an enviable distinction in this most progressive section of medical science. The achievements, for example, of 'Emperor' Smith in surgery called the world's attention half a century ago to the skill of Baltimore practitioners. The alumni of the University, thousands in number, are found all over the globe, and particularly in Pennsylvania, the South and West, where they contribute to the prestige the city enjoys with the masses of the people as well as with the commercial and professional elements. Its graduates are proud of the record of their alma mater, and will, no doubt, be greatly interested in the proceedings of the celebration of its centennial. Recognizing the university's special relation to the cause of medical education and its practical services to the people in its hospital, the last General Assembly appropriated $30,000 a year for two years for the promotion of its beneficent enterprises. It is gratefully conceded that, largely through the university's influence, Baltimore has attained its present position of eminence as a great center of medical education, attracting yearly many hundreds of students to its various schools. The appropriateness of the proposed celebration is, accordingly, indisputable, resting, as it does, on a long record of worthy achievement. 'Its purpose,' says the HOSPITAL BULLETIN, in its last issue, 'is to bring to the notice of the present generation the splendid work the university has done in the past century for the people of Maryland and to show the claims which the university has upon the public.'

The future, as well as the past, it is understood, is had in view by the organizers of the centennial celebration, a large part of their program being shaped with a view to increasing the resources and widening the usefulness of the university."

COMMITTEES ON THE CENTENNIAL.

At a meeting of the Committee on Organization of the Centennial, held recently, it was decided that a chairman and two members should be appointed on each important committee, and that the three members thus appointed should add to their number such additional members as may be necessary to carry on the work of each committee in a thorough manner. This plan places the work of organizing the committees in the hands of men who will be able to make selections and additions to their numbers from the large number of friends and alumni of the University. After the committees are fully made up, they must be approved by the Executive Committee before notifications are made. As the Summer months are approaching, no attempt will be made to form these committees until next Fall.

The work of organization is now in careful hands, and at the proper time the machinery will be set in motion which will bring about a fitting celebration of the Centennial.

THE NURSES' COMMENCEMENT.

The graduation exercises of the Training School for Nurses of the University Hospital were held in the nurses' parlor on Friday afternoon, May 11th, in the presence of a large and appreciative audience. Diplomas were presented to thirteen young women who have completed their training in the school with credit and honor, both to themselves and to the University Hospital. These young women are thoroughly equipped for the profession they have adopted, and the BULLETIN extends to them most cordial wishes for their future success and happiness. The Training School now has some fifty-five students in its different classes, and its work is conducted in a most careful and efficient manner,

under the superintendent, Miss Flannagan. The school has grown each year with the rapid growth of the hospital work. Its graduates have shown that their training has been up to date and in keeping with the best traditions of the University system, which has aimed to be practical, conscientious, and thorough in its methods of instruction.

As a department of the educational work of the University the Training School for Nurses is holding up a standard which will command the respect and confidence of the public.

REUNION OF THE CLASS OF 1881 ON THE OCCASION OF ITS TWENTY-FIFTH ANNIVERSARY.

The Class of 1881, which has the distinction of having two of its members—Dr. C. W. Mitchell and Dr. L. E. Neale—as members of the present Faculty, will hold a reunion on the occasion of its 25th anniversary on the evening of June 2d at the Hotel Rennert, in this city. In reply to a circular addressed to the members of the class, now scattered over wide sections of our country, by Dr. Mitchell, chairman of the Executive Committee, a number of most interesting facts have come to our notice.

Answers were received from twenty-two members of the class living outside the corporate limits of Baltimore. Of these five were from members living in North Carolina, four from Maryland, four from Pennsylvania, two from Virginia, and one each from Kentucky, Missouri, New Mexico, New York, Texas, West Virginia, and Wyoming. Only those members living adjacent to Maryland expressed the purpose of being present, but all expressed the desire.

In answer to the question, About what members of the class can you give us the fullest information? the reply was both sad and disappointing. Only eight members knew of the present location of as many as three of their classmates, whilst fourteen either failed to answer the question or replied that they had lost all trace of them.

In answer to the question, Are you engaged in the active practice of medicine? twenty answered, Yes. One stated that he did only consultation work and one had retired to his farm.

In answer to the question, Are you married? eighteen answered, Yes. Two are widowers, one unmarried and one failed to answer the question.

The information obtained from those who have replied to the circular is both pleasing and disappointing—pleasing in the cordial response to the invitation and desire to meet again with old classmates after twenty-five years of professional life—disappointing in the fact that so few had kept in touch with old classmates and had dropped out of the life of the old University.

The BULLETIN will see to it that future classes will not make an exibit of this character. If it exists for no other purpose it will aim to bring all of the old students of the University to a knowledge of each other. It will strive to keep the membership of each class in touch with those who have been fellow-students and who should be bound together with ties of affection and common interests. The following is a list of those who were heard from:

Oliver G. Fells.....Kings Mountain, N. C.
James S. Lafferty.....Greensboro, N. C.
J. L. McMillan.....Red Springs, N. C.
B. F. Long.....Hamilton, N. C.
W. W. Ward.....Plymouth, N.C.
C. D. Baker.....Rohersville, Md.
C. W. Heffenger.....Sykesville, Md.
C. A. Hollingsworth.....Belair, Md.
J. A. Wright.....Sharpsburg, Md.
George W. Bahn.....Spring Forge, Pa.
F. C. Riller.....Allentown, Pa.
W. T. Vance.....Orangeville, Pa.
J. E. Willetts.....Pittsburg, Pa.
A. L. Blanding.....Walnut Hill, Ky.
C. C. Webb.....Webb City, Mo.
C. G. Duncan.....Socorro, New Mexico.
E. L. Meirhof.....New York City, N. Y.
C. W. Bowman.....Caddo Mills, Texas.
W. W. S. Butler.....Roanoke, Va.
T. F. Keen.....Hamilton, Va.
H. L. Walls.....Poca, W. Va.
E. P. Rohbaugh.....Carper, Wyoming.

TO OUR NORTH CAROLINA ALUMNI.

The BULLETIN desires to remind the alumni of the University residing in North Carolina of the important meeting which will take place in Charlotte at the time of the meeting of the State Medical Society, May 28th and 29th. At this meeting the State Alumni Association will be organized and a social reunion of the alumni will be held

at the residence of a distinguished alumnus—Dr. Crowell, of Charlotte.

It is earnestly hoped that this meeting will be largely attended, and that the enthusiasm will be in keeping with the high spirit and loyal patriotism for which all North Carolinians are noted. Drs. Ashby and Spruill, of the Faculty of the University, will attend this meeting as representatives of the Faculty.

NOTES AND ITEMS

Among the physicians who visited the University Hospital during the past month were the following:

Dr. F. C. Moor, class of 1902, of Tallahassee, Florida.

H. W. Wood, class of 1902, of Massachusetts.

Dr. Charles W. Gentry, class of 1903, of Spartansburg, South Carolina.

Dr. McLane Cawood, class of 1902, Maryland.

Dr. Vance W. Brabham, class of 1905, Bamberg, South Carolina.

Dr. James M. Josey, who has been quite ill, we are glad to report, is making a good recovery.

Dr. Thomas C. Baldwin, formerly located at Whitehall, but now of York, Pennsylvania, has been re-elected health commissioner of that city.

Dr. William Hewson Baltzell, class of 1889, who has been abroad for two years, is now in Paris, and does not expect to return to America this year.

Dr. B. Frank Lansdale, class of 1866, of Damascus, Montgomery County, Maryland, who has been quite ill for the past three weeks, is still confined to his bed. We wish the doctor an early recovery.

Dr. George W. Mahle, class of 1905, assistant resident physician at Bayview Hospital, who has been ill with typhoid fever, we are glad to report, is convalescing.

Dr. Eldridge C. Price, class of 1874, of Baltimore, has written an article upon the "Genesis of Homeopathy," which appeared in the January number of the *North American Journal of Homeopathy*.

The annual meeting of the alumni association will be held Friday evening, June 1st. The place of meeting will be announced by card addressed to all members of the Association.

Dr. Benjamin N. Dorsey, assistant surgeon, United States Navy, has been detached from duty with naval recruiting party No. 4 and ordered to his home, Ellicott City, Maryland, to await orders. Dr. Dorsey was graduated with the class of 1901.

Dr. Martin Jarrett, class of 1864, who has been spending the winter with his brother, Dr. James H. Jarrett, class of 1852, of Towson, has returned to his home, at Jarrettsville, Harford County, Maryland.

Dr. William L. Councilman, class of 1878, Professor of Pathology, Harvard University, and son of the late Dr. John T. Councilman, class of 1844, of Pikesville, has been made president of the Southern Society of Boston.

On April 22, 1906, fire partially gutted the stable of Dr. Nicholas Dashiell, Jr., class of 1882, of 2340 Madison avenue, Baltimore, Maryland. The horses and carriages, we are glad to report, were gotten safely out of the burning building.

Dr. William H. Smith, class of 1900, a former resident physician and surgeon of the University Hospital, and superintendent of the Bayview Hospital, and Hebrew Hospital, who has been pursuing his medical studies abroad during the past year, will spend the month of April in Italy and Switzerland.

Dr. Joel D. Whittaker, class of 1900, of Raleigh, North Carolina, also a graduate of the Dental Department of the University of Maryland, has been appointed resident physician to the Presbyterian Eye and Ear Hospital, Baltimore, to fill out the term of the present superintendent, who has resigned.

Dr. B. Merrill Hopkinson, class of 1885, choirmaster at Brown Memorial Presbyterian Church, Park and Lafayette avenues, Baltimore, Maryland, will sing several solos at the concert to be given Monday evening, May 20, 1906, at the Fourth Regiment Armory for the benefit of the San Francisco sufferers.

The final examinations at the University began on May 12th and will close about May 22d. The joint commencement of the Medical, Law and Pharmacy Departments will be held Monday evening, June 4th. The address to the graduating classes will be delivered by the Hon. Francis King Cary, of the Baltimore bar.

Mr. Devlin, a member of the class of 1906, has been appointed, as the result of a competitive examination, an interne to St. Francis Hospital, New York City, which is managed by the Little Sisters of the Poor, and has a capacity of 250 patients. He begins his year of service on the first day of July. We are glad to hear of Mr. Devlin's success and hope many more members

of the present graduating class will receive hospital appointment.

His excellency, Governor Warfield, has appointed Misses Emma Daily and Margaret S. Brown, graduates of the University of Maryland Training School for Nurses, members of the State Examining Board for Nurses. To those nurses who successfully meet the requirements of this board is issued the title, registered nurse.

About the middle of last month Professor John C. Hemmeter addressed the Medical Association of Greater New York on "Diseases of the Intestines that are on the Borderland between Internal Medicine and Surgery." While in New York, Dr. Hemmeter was the guest of Dr. Thomas E. Satterthwaite, the president of the association.

At the meeting of the University of Maryland Medical Association, held April 17, 1906, interesting papers were read by the following gentlemen: Dr. J. E. Gichner, "Recent Progress In the Diagnosis and Treatment of Tuberculosis"; Dr. T. H. Cannon, "Treatment of Pulmonary Tuberculosis by the High Frequency Current"; Dr. W. P. Stubbs, "The Culture Products of the Tubercle Bacillus."

The athletic association of the University of Maryland has elected the following officers for the ensuing year:

President.....Dr. Harry L. Thomson.
Vice-president.....Dr. Albert H. Carroll.
Secretary.....Mr. C. C. Buck.
Treasurer.....Mr. R. C. Rose.
Executive Committee—Mr. H. P. Hill, Jr., chairman; Hon. J. P. Poe, Dr. C. W. Mitchell, and Mr. E. G. Lee.
Manager Foot Ball Team. Mr. Carson D. Fowler.
Manager Basket Ball Team. . Mr. G. P. Morison.
Manager Base Ball Team. . . Mr. I. F. Fullings.
Manager Track Team.....Mr. B. B. Benson.

The athletic association is in better financial condition than ever, no debts remaining unpaid.

Words of encouragement and approbation are appreciated by the editors of the BULLETIN. Dr. Josephus Wright, class of 1881, of Sharpstown, Wicomico County, Maryland, told one of the editors that there never was an issue he had not read with pleasure, the policy of personal mention meeting especially with his approbation, as it put him in touch with old friends and classmates. Such remarks encourage the editors in the belief that the BULLETIN is accomplishing the purpose for which it was instituted, *i. e.*, the welding of the University interests and the bringing of the alumni into closer touch with each other. Dr. Wright does not only show his appreciation by word of mouth, but in a more substantial manner, his name appearing upon the subscription list, and his faith in his alma mater being still further attested by matriculating a son, Mr. Arthur Wright, in the medical department. If we had more alumni of the above-mentioned calibre, a useful and continued success of the BULLETIN is assured.

In a letter from Cairo, Egypt, to Professor Randolph Winslow, Dr. N. Kenawy, class of 1905, of Alexandria, announces his appointment by the Egyptian Government as a sanitary inspector of bubonic plague. He has already seen two cases of this dreaded malady in Alexandria, but says his government is taking heroic measures to prevent its propagation. If a sufficient number of cases comes under his observation he promises to write an article upon this subject for the BULLETIN, otherwise he intends publishing an article upon the occurrence of ankylostoma duodenalis in Egypt, with which disease he has had quite an experience. He also asks to be remembered to his old friends, and expresses a desire to attend the 1907 celebration. If our native alumni took as great an interest in the welfare of the HOSPITAL BULLETIN as our Egyptian fellow-alumnus, its ultimate success would be assured. The BULLETIN is delighted to hear of Dr. Kenawy's appointment, and entends to him its best wishes for a successful termination of the difficult task with which his government has entrusted him, as well as a successful and honorable medical career.

We are pleased to report that Doctor Charles Hicks, class of 1877, is steadily improving from a recent attack of apoplexy. Soon after graduating, Dr. Hicks located in Montgomery County, Georgia, and was immediately appointed coroner, but a few years later removed to the small town of Dublin. During his career he has held many offices of trust. For many years he was a member of the County Board of Education. His brethren of the Georgia Medical Association elected him censor and president of their society, and further honored him with the appointment of chairman of the committee which secured the enactment of a bill by the State Legislature constituting a State Board of Health. Owing to his interest in the improvement of the sanitary condition of his State, the Governor named him one

of the number to constitute the first board, upon the organization of which he was elected by his fellow members vice-president. This selfsame year he was appointed by the Governor, chairman of a committee to investigate and report methods for the detection, regulation and prevention of tuberculosis. During these years he was actively engaged in practice, besides being surgeon-in-chief to a local railroad. He has also found time to contribute some excellent articles, to-wit: Hemophilia, Malaria, Nephritis, to the medical literature. Each of the above positions he has filled with great ability and distinction and his Alma Mater is justly proud of a son who has conferred so much credit upon her. We sincerely trust he will in the near future be completely restored to health.

MARRIAGES

Dr. James R. Bishop, class of 1904, of Nanticoke, Maryland, was united in wedlock Saturday, April 14,1906, at Mount Vernon Methodist Episcopal Church, Baltimore, Maryland, by Rev. B. F. Devries, to Miss Elizabeth Pyle, daughter of Mr. and Mrs. J. W. Pyle.

Dr. Charles Denbeigh Marchant, class of 1897, of Harmony Village, Middlesex County, Virginia, was married Monday, April 30, 1906, at Saint Paul's Protestant Episcopal Church, Baltimore, to Miss Katherine Pyles, daughter of Mrs. Sarah T. Pyles, of Boyds, Maryland. After a short sojourn in Baltimore, Dr. and Mrs. Marchant will reside in Harmony.

Dr. Arthur Bruce Eagle, class of 1904, of Martinsburg, West Virginia, was married April 12, 1906, to Miss Bessie Harley, of Martinsburg, at the home of the bride, on John street, by Rev. Dr. I. W. Canter, pastor of Trinity Methodist Episcopal Church South, assisted by Rev. W. A. Sites, of Haberson, Delaware, uncle of the groom. Dr. Edgar B. Le Fevre, class of 1905, of Bunker Hill, Berkeley County, West Virginia, was the best man.

Dr. Samuel Claggett, class of 1898, of Frederick County, Maryland, was married Wednesday, April 18, 1906, at Christ Episcopal Church, Baltimore, Maryland, by Bishop Paret, assisted by Rev. H. W. Stowell, to Miss Jeannette B. Chew, daughter of Mr. Thomas J. Chew, of 1228 North Calvert street, Baltimore, Maryland. Dr. Levin West, class of 1886, of Frederick County, was one of the ushers. After an extended Northern tour the couple will reside at Oakland, near Petersville, Frederick County, Maryland.

Dr. Vance Wells Brabham, class of 1905, of Bamberg, South Carolina, formerly a resident physician in the obstetrical department of the University Hospital, was married Monday morning, April 16, 1906, in the Trinity Methodist Episcopal Church, of Bamberg, to Miss Gwendolyn Risher, daughter of Mr. Benjamin Risher, of Bamberg. Dr. Brabham has already assumed a position of prominence and is rapidly acquiring a large and lucrative practice. Dr. Brabham spent a few days of his wedding trip in Baltimore, then continued upon a prolonged Northern tour.

DEATHS

Dr. Walter B. Rowe, class of 1862, of Aberdeen, Maryland, died April 8, 1906, at his late residence, Aberdeen, aged 69.

Dr. Henry L. Stone, class of 1868, a veteran of the Civil War, died at his home, in Montgomery, Alabama, January 12, 1906, after a long illness, aged 59.

Dr. Randall Holden, class of 1861, died February 3, 1906, at Petersburg, Virginia, aged 86. He was an assistant surgeon in the Confederate States Army.

Mr. J. Herbert Beatty, son of Dr. J. E. Beatty, class of 1861, formerly of Middletown, Maryland, but now of Baltimore, died at the home of his aunt, Miss Ella Trapnell, Middletown, from an attack of pleurisy resulting from a cold contracted a year ago, aged 28.

Word has just been received in Baltimore of the death of Dr. Frank Donaldson, April 12, 1906, at San Francisco, California. Dr. Donaldson, aged 49, was the son of the late Dr. Frank Donaldson, who was in his day one of the most prominent physicians of Baltimore and a professor in the Medical School of the University of Maryland. Death was due to tuberculosis.

By the death of Henry J. Lamontague, from a recurrent sarcoma, March 9, 1906, at Meridan, Connecticut, another popular member of the class of 1906 has been claimed by the Grim Reaper. Those who knew the deceased, both classmates and teachers, will be sorry to hear of the fatal termination of the dreaded malady whose presence was only discovered after an operation last fall. The BULLETIN extends its deepest sympathy to the parents in the hour of their bereavement.

Dr. Andrew Jackson Smoot, class of 1852, died at his home, Society Hill, Charles County, Maryland, April 11, 1906, after a lingering illness of heart disease, aged 77. He was a son of Captain John Weems Smoot, a veteran of the War of 1812, and Elizabeth Elinor Ann Hawkins, both of Charles County. Dr. Smoot was born July 7, 1828, and received his preliminary education at Charlotte Academy and Dickinson College. He was graduated in medicine from the University of Maryland in the year 1852. He married in 1855 Miss Nannie Wood Crain, a daughter of Dr. Robt. Crain and a niece of ex-Judge Peter Wood Crain. Dr. Smoot is survived by three children—Miss Amelia T. Smoot, of Charles County, G. W. C. Smoot, and Hungerford Smoot, both of Baltimore.

Dr. Louis Mackall, class of 1851, the oldest and one of the most prominent physicians of Washington, District of Columbia, died at his home, 3040 Dumbarton street, Georgetown, April 18, 1906, aged 75. Dr. Mackall was graduated from the medical department of the University of Maryland in 1851, and shortly afterwards began the practice of medicine in Georgetown, where he has ever since resided. He came of an old Maryland family and was born in Prince George's County, April 10, 1831. Dr. Mackall was a member of the medical society of the District of Columbia, of which he has filled the offices of secretary, vice-president and president. He formerly held the chair of clinical medicine in the Georgetown University Medical School, and later was professor of physiology in that institution. Dr. Mackall married Miss Margaret Whann McVean in 1851 and had nine children by this marriage, five of whom survive him—Dr. James McV. Mackall, Dr. Louis Mackall, Jr., Mr. Upton Beall Mackall, Mrs. E. J. Wild, and Miss Sallie S. Mackall.

Dr. William Reindollar, class of 1847, of Westminster, a native and lifelong resident of Carroll County, Maryland, died at the home of his son-in-law, ex-Sheriff George W. Motter, in Taneytown, Sunday, April 29, 1906, of heart disease, in his eighty-sixth year. He was for many years engaged in the practice of his profession in Taneytown, but retired eight or ten years ago owing to bad health. He was a prominent and influential member of the Lutheran Church at Taneytown and frequently a member of the church council. He was singularly mild and gentle in demeanor and was much endeared to all with whom he came in contact, professionally or otherwise. His deep interest in public education led him to accept an appointment as one of the school commissioners of this county in January, 1876, an office to which he was repeatedly reappointed and in which he served until some time in 1898, a period of nearly twenty-three years. His wife has been dead for many years and his only surviving children are Mrs. George W. Motter and Mrs. Eudora Crossfield, of Taneytown.

Dr. Charles H. Tilghman, class of 1866, well known both in this city and in Talbot County, died suddenly April 25, 1906, at his home, 831 Hamilton Terrace, Baltimore, Maryland, from angina pectoris, aged 60. Though he had been suffering from an affection of the heart for about a year, he was as well as usual when he retired Tuesday night, after spending the day at Annapolis, attending the exercises in memory of John Paul Jones. Shortly after midnight he complained of feeling ill, but was not considered in imminent danger until shortly before death. Born at Grosses, Talbot County, 60 years ago, he was the son of the late Capt. Richard Lloyd Tilghman, of the United States Navy, and through his father was a descendant of Gen. Tench Tilghman, a member of General Washington's staff. He obtained his early education in private schools, and when 18 years of age entered the medical department of the University of Maryland, whence he graduated in 1866 with honors, and the following year went abroad, where he completed his education in the universities and hospitals of London and Paris. He was visiting the Continent during the Franco-Prussian War, joined the Red Cross Society and saw service. He was repeatedly commended for bravery, and at the close of war was presented with a medal by the Bavarian Government for breaking ranks and carrying to the rear, while under fire, a wounded officer who had fallen between the lines of battle of the combatants. He was in Paris during the Commune and was subjected to some exciting experiences. Since his return to his native land, in 1871, he has devoted his life to caring for his father's large estate, and has not engaged in the practice of medicine. Dr. Tilghman was married in 1881, and is survived by his widow, who was Miss Eilizabeth Donnell, and eight children—Messrs. Richard Lloyd, Charles Henry, William Donnell, W. H. DeCourcy and Donnell Tilghman, and Misses Elizabeth, Agnes R., and Mary Donnell Tilghman.

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THE UNIVERSITY OF MARYLAND IN 1871 AND IN 1906.

RANDOLPH WINSLOW, A. M., M. D., *Professor of Surgery, University of Maryland.*

For almost thirty-five years I have been connected with the University of Maryland in some capacity. I am not only her offspring medically, but she has been indeed my alma mater, and to her service and interests I have devoted the best years of my life. In considering the advantages and opportunities that have come to me as the result of my connection with this honored and now venerable institution, well might I exclaim in the words of Horace, *"O et praesidium et dulce decus meum."* She has indeed been both my bulwark and my sweet reward. I was nurtured by her, when she herself was struggling for an existence, and I am one of those who have been instrumental, in some degree, in placing her in a position of greater usefulness and increased honor. The University of Maryland by its charter was granted great powers, and was founded upon a broad and firm foundation. Eminent men filled its chairs, and great success and prosperity followed. A splendid museum was purchased, a library of standard works was established, philosophical and scientific apparatus was procured, and one of the most beautiful, and for those times commodious, college edifices was erected. Soon a hospital for clinical instruction of its students was built, and large medical classes were attracted to the school. She ever strove to be in the front, and not to lag in the rear. This prosperous condition through dissentions in the faculty, came to an untimely end, and the institution became almost disrupted. Upon the restoration of the property to the regents, in 1839, the Medical School began to regain its former prosperity, and in the early fifties its faculty was the equal of any in this country. The Civil War drew on apace, and again a period of depression set in. The people were impoverished, and education was at a low ebb, and these conditions were sensibly felt at the University. It was during this period that I first became a member of the school. On October 1st, 1871, I entered the Medical Department as a student. I was a callow youth, not quite 19 years of age. I had had a fair college training, but had so many other things to occupy my mind, that I had not found a convenient time for much study. I was, however, a much better educated person than most of those who were in attendance. At this time the University of Maryland consisted of a Medical Department with about 114 students, a re-organized Law School only two years of age, and a decadent School of Arts and Sciences, which was now the private enterprise of Rev. E. A. Dalrymple, D. D. The faculty of Divinity had never been established, but it was represented in the Board of Regents by the Rev. J. G. Hamner, D. D. There was absolutely no co-operation between these departments, and each worked out its own salvation, or extinction in its own way. Whilst the State had granted the University ample powers by its charter, it had made no financial provision for its ward, and had left it to eke out an existence the best it could, and at the time I entered the school, its affairs were at low ebb. The grounds of the Medical School were surrounded by a high wall, behind which various diabolical practices were supposed by our colored brethren, and by many white ones also, to take place. Bold indeed was the citizen of color, or the half-grown boy, who would venture within the portal of this enclosure after dark. So dread was this locality and so great the fear of the "night doctors," that many people passed by on the opposite side even in the daytime. Within these walls stood the classic looking Medical School, rather dilapidated in appearance for lack of paint, but in its outward features the same as at present. In the right hand corner as you enter, stood the Practice Hall, a two-story building, with a lecture room below,

(Read before the Alumni Association, June 1st, 1906.)

and a desperately cold (in winter) and not very clean room above, in which the museum was housed. This museum had been collected by Alan Burns, of Scotland, and after his death was purchased by the University.

It contained originally many beautiful and valuable preparations, but had been allowed to go to ruin for lack of care. Twenty years subsequently Dr. J. Holmes Smith, whilst demonstrator of anatomy, rescued many of these preparations, and with great labor and skill renovated them, and they now form useful and unique specimens, which cannot be duplicated in this city. The lecture halls in the main building were practically as at present, except that fixed benches with a rather broad rail for a back, were used instead of opera chairs. Probably on account of the uncomfortableness of these seats, as well as to avoid the puddles of tobacco juice which formed in unpleasant proximity to their coat tails, the students usually perched on the backs of the benches, like flocks of crows on the branches of a tree. The dissecting room was in the front of the building in the room now used as a museum and osteological class room, and when the weather was warm, the odors that ascended and pervaded the house were not those of Araby. Various winding passages, devious stairways, and dark and mysterious apartments were to be found in unexpected places, the object of which seemed to be, to prevent too accurate inspection by the police. The Hospital, known as the Baltimore Infirmary, was a plain three-story and basement building fronting on Lombard street, very much smaller than the present structure, which served however fairly well for the purposes of clinical instruction at that time. The Greene street wing was not built until 1874 or '75, and was due to the munificence of the State, though hard conditions were imposed on the school as a consequence, under which it labored for 20 years. All things considered, the faculty of 1871 was able and distinguished, though in some instances a change would have been desirable. Prof. Aiken, who held the chair of chemistry, was elected in 1837, and had grown old and deaf in the service. He was probably not up to date in his lectures, and as he did not hear himself speak, the students heard but little and profited to the same extent by his efforts. He was, however, an imposing figure upon commencement occasions, with his fine physique and flowing beard, resembling, as said by a contemporaneous writer, a cross between Rip Van Winkle and Gideon Wells.

George W. Miltenberger, whose recent death is still fresh in our minds, was professor of obstetrics. He was at the height of his usefulness and popularity as a physician, and though usually late to his lectures, was an able and instructive didactive teacher. We had no lying-in-hospital, and most students went into practice without having seen a normal or abnormal case of labor. Dr. Miltenberger was also noted for the excellence of his horses, the number of which "Ned," his colored driver, usually doubled when a curious student became too inquisitive. Ned himself was as well known as the doctor, and enjoyed to the full, the distinction of being the driver of the busiest physician in the city. How have the mighty fallen! Today I saw Ned in rusty livery perched on the box of a rusty hack.

Richard McSherry, a courtly gentleman of a by gone period, a dignified lecturer, and punctillious in the performance of his duties, was professor of the principles and practice of medicine. His lectures were read from manuscript, and whilst carefully prepared and expressed in chaste and elegant language, they were not delivered in a very entertaining manner. He had the universal respect and regard of the students.

Christopher Johnston, a man of rare attainments, wide culture and imposing appearance, was professor of surgery. He did not lecture, when it was possible to avoid it, and gave no systematic instruction in surgery. He used his lecture periods for holding clinics, which is the method of teaching now advocated by certain high authorities, but certainly was not best for the students of 1871-73. I heard lectures on inflammation, gonorrhoea, syphilis and hernia, and as far as I can recall, on nothing else, from the professor of surgery. We had pretty good surgical clinics, but more operations are often done in a day at the University Hospital now, than were done in a month then: Surgery, as we know it now, did not exist then. The appendix was an unoffending organ; the gall bladder was a cavity for the retention of calculi, which were not to be removed under any circumstances; and gastrectomy and gastroenterostomy and many other barbarous names, were still uninvented. The kidney was allowed to retain its stones, and was not made naked and ashamed by stripping

off its coat. Intestines were not resected, hernias were not radically cured, and the pancreas and spleen still slept in peace. Ovaries and tubes remained in the pelvis where nature placed them, pus tubes were not recognized as a pathological entity, and only ovarian cystomata, or fibrocysts of the uterus, were subjected to operative attack. The surgery of the thorax was limited to aspirating collections of fluid, and the head was trephined only for depressed bone. What little I may know of surgery, I have learned since I sat on the benches as a medical student.

Samuel C. Chew was professor of materia medica and therapeutics and clinical medicine, and was then and is now, an able, erudite, instructive and conscientious teacher, and I esteem myself fortunate to have sat at his feet as a pupil, as well as more recently, to have been associated with him for many years as a colleague.

Frank Donaldson, professor of physiology and hygiene, was not a lucid teacher, though a man of marked attainments and great reputation as a physician. His lectures on physiology were not instructive, and he did not lecture on hygiene at all.

Wm. T. Howard, who still survives, full of years and honors, was professor of diseases of women and children and clinical medicine. His didactic lectures were always delivered in such a forcible manner, as to make a lasting impression on his students, but it was as a clinical, and especially as a bed side, teacher that his personality, his prodigious memory, his vast experience, and his knowledge of men and books, was displayed. He was one of the most instructive clinical teachers that I have ever seen. He was an autocrat in the hospital, and every one stood in great awe of "Uncle Bill."

Julian J. Chisolm, professor of operative surgery and eye and ear diseases, was, I think, the best teacher I have ever listened to. His speech was terse, and incisive, neither ornate or elegant. He sometimes taught incorrectly, but he taught. One could not get away from his views, his very words stick in the memory after more than a third of a century. Upon one occasion he said, "There are many ways of doing this operation, one of them is right, the others are wrong, I will teach you the right, the wrong you will learn quickly enough yourselves." He was of attractive appearance and personality, exceedingly neat in his attire, and for many years the most distinguished member of our faculty.

Francis T. Miles, professor of anatomy and nervous diseases, was a most attractive man, of great urbanity and charm of manner, and of wide and exact knowledge of anatomy and diseases of the nervous system. He was a beautiful speaker, and his lectures attracted many physicians as well as students to his auditorium. He was a great ornament to the school up to the time of his death, in 1903. I am inclined to think, however, that he was more eloquent than instructive, and that in the pleasure of listening to his graceful and pleasing language, one sometimes forgot the subject matter he was striving to impress on the mind.

We had but one laboratory, that of practical anatomy, at that time under the charge of Dr. L. McLane Tiffany, subsequently so widely known as a surgeon and professor of surgery. The students were only required to dissect one session, and the character of work done was usually very poor; my own work was especially so. The course of instructions was of two sessions' duration, so one could enter as I did, in October, 1871, and receive his degree on March 1, 1873. The same lectures were delivered each session, hence the ignorant freshman listened to the same instruction as the seniors. Of course this was time wasted, as it would be several months before the new student could understand the lectures at all. Examinations were held only at the end of the second year, and were oral, the students being divided into sections, who reported to the professors, usually at night, and generally at their private offices. I was examined by Professor Miltenberger at 1 A. M. on Sunday. The examinations were by no means perfunctory occasions, and a reasonably good idea of the proficiency of the student was reached. My class consisted of 52 members, of which 6 were rejected. Forty-six of us received our diplomas from the provost, Hon. Severn Teackle Wallis, LL.D., on March 1, 1873, at Ford's Opera House. This class, though few in numbers, has not been without distinction; Michael, Winslow and Ashby have served their Alma Mater as professors; the genial and versatile Rohe cast his lot with the College of Physicians and Surgeons, and was professor of materia medica and therapeutics at the time of his death, besides occupying a prominent position in the

community as alienist and citizen. T. Morris Murray is at this time professor of laryngology in Georgetown University. V. W. Gayle has filled a professional chair in the middle west, and many others are prominent and useful physicians in their respective communities. In looking over the time-stained order of exercises of the commencement of 1873, I find that just 50 per cent. of the class are either known to be dead or cannot be accounted for. *"Pallida Mors aequo pulsat pede pauperum taburnas, Regumque turres."*

I have been attempting to give a hasty sketch of the conditions obtaining at the University during the period in which I was an undergraduate student, and now let us hasten on. In 1874 the State appropriated a sum of money, with which the Greene street wing of the hospital was built. In 1882 the Dental Department was established, and has enjoyed a high degree of success, attracting students from all over this country and from many foreign lands. In 1887 the Lying-Inn-Hospital was founded, and has enjoyed a great measure of usefulness, so that about 900 cases of obstetrics have been treated in the hosuital and at the homes of the patients during the past year. A young man has just informed me that he has seen over 50 cases of labor before going into practice, contrast this with no cases in 1871-1873. The Training School for Nurses was established in 1890, a dormitory being erected for them. This school is now in a flourishing condition, with about 60 pupils in attendance. In 1892 the course of instruction in the Medical School was lengthened to three sessions. In 1893 Practice Hall was rebuilt and made into commodious laboratories, chemical, histological, pathological, and anatomical. No sooner had it been reconstructed than it was destroyed by fire, and was at once rebuilt at a cost of $10,000 extra. In 1895, the course of instruction was increased to four years. In 1896 the old Baltimore Infirmary was demolished and the handsome new University Hospital was erected, and this at once placed the Medical School in a greatly increased state of prosperity. This building has been erected by the faculty of physic at a large cost, which is being paid out of their professorial fees. At various times additional property has been purchased, and we now own three houses on Lombard street adjacent to the hospital, upon which it is expected soon to erect a large addition to be used partly as a maternity, partly to increase the overtaxed capacity of the present general hospital. We also control all the four corners of Greene and Lombard streets, though we have not as yet been able to secure clear titles to the church, and to one of four houses on the northwest corner. This recent negotiation is for four houses, and it is proposed at some time in the near future to erect a large dormitory building, for the accommodation of students. It is felt that this is an urgent need, and I hope to see a handsome building take the place of the shabby houses now occupying this space. In 1903, a handsome new building was erected for the joint use of the Dental Department and the pathological and physiological laboratories of the Medical School. At this time a very important step was taken in the annexation of the old and reputable Maryland College of Pharmacy, as the Department of Pharmacy of the University, an union that has been mutually very satisfactory. This department is also housed in the new building.

In 1906 there are about 60 instructors in the Medical School, in 1871 there were ten. In 1873 there were 114 medical students; in 1906, 340. In 1871 there were no laboratories, except the dissecting room; in 1906 there are two large buildings devoted to laboratories. In 1871 the course of instruction was of two sessions, of five months each; in 1906 it requires four sessions of eight months each before one is eligible for graduation. In 1871 the instruction was almost entirely didactic, by lectures; in 1906 the most important part of the instruction is clinical and demonstrative. In a recent communication published in *Old Maryland* the writer states the disinclination of some of the alumni to help the medical school because the faculty was "milking the cow," and the writer adds, "The impression I obtained was that personal interests superceded loyalty to the Alma Mater." There are none so blind as those who will not see. "Having eyes see ye not, and having ears hear ye not." Since 1893, a period of 13 years, the faculty has expended and obligated itself in the purchase of property and the erection and reconstruction of buildings, etc., to the extent of about $270,000, or more than $20,000 a year. This does not include current running expenses, the purchase of apparatus and supplies, or ordinary repairs. The medical faculty has done its duty, it has not

"milked the cow," but has expended the greater part of its income in nourishing the school.

On the threshold of the centennial year I seem to be set as a watchman, to declare unto you what I see, and the cry cometh, "Watchman, what of the night? Watchman, what of the night?" The watchman saith, "The morning cometh." I verily believe that the morning cometh, that the dawn is already visible in the east. The various schools of the University of Maryland are in a higher degree of efficiency and prosperity than ever before, but there are gaps to be filled. The Faculty of Arts and Sciences, never a healthy offspring, died an untimely death. Within a year it is probable that St. John's College, at Annapolis, will by adoption take the place of the defunct department, and it is possible that other institutions may also be assimilated. The Baltimore Medical College has already appointed a committee to confer with a similar committee from the Faculty of Physic to formulate terms for the consolidation of that institution with the University, an union which it is believed will greatly advance the interests of the schools, and of medical education.

Old things are passing away, the future is bright with promise. There is much to be done; it will not be accomplished by carping criticism, but by earnest work, sympathetic encouragement and united effort.

GONORRHOEA IN THE FEMALE.

HUGH W. BRENT. M. D., *Late Assistant Resident Gynecologist to the University Hospital.*

In the whole gamut of diseases there is probably not one which has caused more heartaches, more unhappiness or more real harm to society than the subject of the following article.

The absolute ignorance of the general public, and, even sad to relate, many members of our own profession as to the far reaching harm of gonorrhoeal infection had done much to foster rather contempt than fear for the ravages of Niesser's diplococcus. Gonorrhoea has for so many years been scoffed at and joked about that almost criminal negligence has been practiced in the management of thousands and thousands of cases.

We must realize that "dabbling" and procrastination are not becoming in even minor ailments. They are not to be tolerated in association with so serious a condition.

In the adult, to all practical purposes, there is only one mode of infection—coitus, it may, of course, be acquired by contact with intermediate objects, but the gonococcus is so easily killed and dies so quickly when removed from its natural habitat that this mode of transference is rare, to say the least.

It is not, however, either profitable or desirable to quibble over the etiology; infection by indirect contact is balm to the feelings of many, and it is well for the community to be always careful. So why destroy the illusion?

The period of incubation varies according to the virulence of the organism and the resistance of the soil on which it has lodged. As in other diseases the behavior of the organism in its original host bears no relation to its activity in new surroundings. A seemingly mild infection may give rise in another subject to a violent form of the disease.

The severest forms are seen in pregnant women and recent virgins; in the prostitute there may not be a very decided reaction, the disease in many cases being only subacute, and not in the beginning giving rise to very distressing symptoms.

The germicidal qualities of the vaginal secretion and mucosa are too well known to warrant discussion here; infection of the vagina, except under conditions very favorable to the growth of the organism, is not especially common, and should it become infected, it, as a rule, quickly recovers. The most distressing cases are those occuring in newly-married women, the genital tract in these cases offering through reason of the delicacy of its structures a most favorable field for the development of the disease.

Mucous membranes are tender, easily abraded and altogether place at the disposal of the organism a medium in which it flourishes with unusual violence.

A few days after exposure the patient will note a certain amount of pruritus vulvae accompanied by a feeling of uneasiness in the affected parts. The discharge at first, barely preceptible, soon increases in amount, is purulent and intensely irritating. The vulva becomes reddened and swollen. The process extends to the adjacent skin surfaces if the utmost cleanliness is not practiced.

Infection of the urethra with the concomitant burning and painful micturition, is a practically inevitable complication of gonorrhœal vulvo-vaginitis.

The vagina itself is in these cases the seat of a rather violent inflammation, small ulcers are frequently encountered, occuring in the sulci between the rugae, the result of long-continued contact of the mucosa with confined pockets of the corrosive pus. The bright red macules often seen studding the vagina in these cases are due to erosion of the superficial epithelial layers by the irritating discharge.

With the infection of the vulva, vagina and urethra the disease may be said to be in full blast, but if it could only be stopped at this stage we would indeed be thankful.

Next in order are the extensions of the process into Bartholin's and Skene's glands and the cervix uteri.

Bartholinitis is recognized by swelling and tenderness of one or both of the vulvo-vaginal glands. The opening of the gland is marked by bright red macule, and on gland pressure a few drops of creamy pus may be squeezed from the orifice. If drainage through the duct is prevented by œdema of the mucosa or if the inflammatory process is very active a vulvo-vaginal abscess is formed, producing marked swelling, bulging and exquisite tenderness. The knife or spontaneous rupture effects a termination more or less complete.

Skene's glands, when infected, show a reddening of the orifice of the ducts, when they are exposed by separating the labia urethrae and making traction downward, a drop of pus may be squeezed out. Abscess of the gland, however, is not especially common.

Accompanying the local manifestations there is usually in the beginning at least of severe infections more or less constitutional disturbance, such as fever, acceleration of the pulse and general malaise. In not a few cases enough reaction is induced to render rest in bed a necessity rather than a luxury. Particularly malignant cases may send the temperature to 103 degrees or 104 degrees with accompanying chills, nausea and vomiting, with more or less collapse. If such symptoms do supervene however, we should at once suspect an extension of the process to the uterine tubes and peritoneum.

Creeping along the mucosa the organism at last effects an entrance into the cervix, setting up the so-called gonorrhoeal endocervicitis; once securely installed in the deep mucous glands of the canal we encounter indeed an enemy worthy of our steel. The cervix becomes eroded, reddened and œdematous, the mucuos membrane of the cervical canal everts (ectropion) and bleeds easily on manipulation (the cause of the hemorrhage sometimes seen in association with marked endocervicitis). The discharge is thick and tenacious, muco-purulent and with difficulty removed. Fortunately in a number of cases the disease is checked at the internal os, the valve-like constriction of the canal at this point having a tendency to limit the further extension upward.

Passing the internal os the endometrium next falls a victim. The discharge from the uterine cavity itself is serò-purulent, thus being readily distinguished from the muco-purulent discharge evolved in the cervix.

From the uterine cavity extension to the tubal mucosa readily occurs, the same cycle of changes is gone through here as in the other membranes. The tendency of nature is to limit further spread of the disease by inversion and sealing up of the fimbriated extremity. When this once occurs the extrusion of pus into the peritoneal cavity is stopped, but before this occurs enough material has been liberated through the fimbriated extremity to start an infection in the adjacent peritoneum.

Fortunately the gonococcus is not an especially virulent organism, and again fortunately the pelvic peritoneum is rich in lymphatics, and far more resistant to infection than other portions of the membrane. Intestinal and omental adhesions soon wall off the infection and prevent its spread. In the pelvis itself, however, the pus may be produced so rapidly as to form large abscesses, usually pointing posterior to the uterus in the cul-de-sac of Douglas. The reasons for this are two: In the first place the tubes in the majority of cases are displaced downward and backward, thus the peritoneal infection as a rule begins here. Secondly, there is walling off above by peritoneal adhesions, and the natural tendency of gravitation is to carry the products of infection downward into this the most dependent portion of the pelvic cavity.

In the great majority of cases the peritoneal process is limited to an adhesive peritonitis with

consequent formation of agluttinated masses of intestine, omentum and adnexa. Pelvic abscesses are more frequent in puerperal infections, where the streptococcus and staphylococcus are the causitive agents.

To return to the tubes, we see that by inversion and closure of the fimbriated extremity one source of drainage is eliminated; drainage into the uterine cavity could only be imperfect through the normal small opening. When the mucosa has become swollen and oedematous this avenue for the escape of the products of infection is eliminated. If the infection in the tubal mucosa is still active there can be but one result—a pyosalpinx or collection of pus within the lumen. The size of the abscess of course varying with the violence of the inflammation and the length of its duration.

In association with tubal and peritoneal involvement there is usually more or less temperature, may be chills and reflex nausea and vomiting. Tenderness and rigidity of the lower abdomen and extreme pain on vaginal or bimanual palpation of the pelvic contents are noted. The uterus is found in many cases fixed and comparatively immovable, tightly wedged in the mass of exudate and adherent viscera. Rigidity and bulging in the posterior fornix with tenderness to pressure are indicative of the formation of a pelvic abscess. The size of the lump will guide us to a certain extent in determining whether the abscess is merely intratubal. The intense congestion of the uterus may give rise to uterine hemorrhage. While this is not by any means constant a certain number of cases present this condition.

Fortunately for the race, gonorrhoea is a self-limited disease. In the tubes and pelvic collections of pus the gonococcus soon perishes in its own toxins. In a few months the pus becomes sterile, and the disease has run its course in these locations. The end products, however, remain behind to harass the woman and render her life miserable until the proper methods of relief may be instituted—medical or surgical—as the case requires.

Even with the greatest care and skill we can never hope to restore the genital apparatus to its former state. The delicate adjustment has been forever destroyed or so markedly injured that no power of man can create from the ruins its virgin prototype.

The process in the vulva, vagina and uterus gradually becomes chronic, the discharges lessen, the mucosa more nearly assumes its natural hue, burning, pruritis and pain abate and the disease enters upon that long period of semi-quiescense—requiring months and years for its elimination, in many cases persisting throughout the life of the unfortunate victim.

It must not be assumed that all infections follow out the picture drawn above. There may be only a mild vulvo-vaginitis, easily treated and quickly recovered from. The process in the vagina may be so slight as to escape notice. Tubal inflamation may be mild, without destruction of the mucosa or even pus formation, and the peritoneum may never become involved. Between the two extremes occur the majority of cases.

As in all pathological processes "resistance" and "strength of the invader" are the opposing forces, as one or the other plays its part so may we expect that character and severity of the lesions influenced.

It must not be forgotten that women are also liable to the arthritis, endocarditis, cystitis, pyonephritis, and opthalmia occuring in association with gonorrhoea in the other sex.

It has been the intention of the writer, however, to deal only with those manifestations of the disease peculiar to women alone.

In this connection two other processes deserve mention.

Especially in uncleanly women moist condylomata of the vulva and adjacent skin surfaces are encountered, they are to be distinguished from the mucous patches of secondary syphilis, and are the direct result of the irritating discharges in association with the natural moisture and heat of the parts.

Another complication of no mean importance is gonorrhoeal proctitis, the virus running down over the perineum infecting the anus and later the rectum. The usual symptoms of rectal inflammation such as tenesmus, difficult and painful defecation and occasionally hemorrhage are noted.

CASE OF TRAUMATIC ASPHYXIA.

By Fairfax G. Wright, M. D., *Resident Surgeon University Hospital.*

On April 23, 1906, in response to a hurry ambulance call, this case was seen at one of the

large manufacturing plants near the Hospital. About ten minutes before our arrival, a boy, C. C., aged 14, was caught by an ascending elevator between the floor of the elevator and one of the landings, his head and chest remaining on the floor of the elevator and the rest of the body hanging over the edge, so that compression was made on a line just about the level of the nipples.

The whole chest had been crushed and death had evidently been instantaneous. The face, neck and chest were dark blue and the cheeks almost black. On close examination it was seen that the discoloration was made up of very dark blue punctate spots with lighter areas between. Pressure had no effect on the blueness, it did not look like post-mortem lividity, and the rest of the skin was perfectly normal looking. Across the chest there was a distinct line, as though drawn with a pencil, dark blue above and pale below.

In February, 1905, Prof. Randolph Winslow in the *Medical News* reported a pronounced case in a living individual. In this the microscopical examination of an excised piece of skin showed it to be normal except for a dilitation of the capillaries, thus confirming the statements of other writers about the few reported cases.

REPORT OF A CASE OF INTESTINAL OBSTRUCTION.

BY J. E. ROOKS, M. D., (CLASS 1905) ROCKY MOUNT, LA.

The following case occurred recently in my practice and is seemingly of sufficient interest to make report of same for the HOSPITAL BULLETIN.

The evening of May 23, I was called to see Frank J., a negro boy, aged 10. Upon arrival I was told he was "costless" and hadn't had an action for three days.

He gave a history of having been eating "Mayhaws," a berry about the size of a small marble, which contains a number of seeds resembling grape seeds. In eating these he swallowed hull, seed and all.

For sometime he had been making violent, straining efforts without any result but causing the rectum to prolapse about an inch. There had been no escape of flatus for 48 hours, and so far he had not vomited any. Had no fever. Pulse 85. Respiration 20.

On palpation found a small, rounded mass in left inguinal region at Sigmoid Flexure, also some rigidity of muscles over same. Abdomen not much disturbed. Patient was exhausted from the constant straining efforts he had been making. After diagnosing the case one of faecal impaction I gave a warm soap-sud enema of 3 quarts. It passed the obstruction alright, but did not return, thereby setting up strong peristaltic action accompanied by terrific straining. Tried to reach the impacted mass by introducing my finger, but could not reach it. After a great effort at stool without result he was held in a half standing, stooping position for a minute, when suddenly 3 quarts of water shot out over the floor preceded by an accumulation of mayhaw seeds, hulls, etc. Relief was immediate and complete.

The only after treatment was a dose of Magnesium sulphate and recovery was uneventful.

The amusing part of the incident occurred when his black mammy saw the sudden outburst of water from the rectum and ran out crying, "My boy done bus' open; my boy bus' open."

EXOSTOSIS OF THE LOWER LIMBS.

BY NATHAN WINSLOW, M.D.,
Instructor of Surgery, University of Maryland.

The occurrence of four cases of exostosis of the lower limbs in the Sugical Wards of the University Hospital at practically the same time is somewhat noteworthy. These neoplasms may appear on any of the bones, but especially upon the long bones of the lower extremity, and are usually found at or near the epiphyseal lines of these bones. They belong to the class of osteomata, but are generally more pointed and projecting than the usual form of osteoma. They are often developed after a fracture or some known injury, whilst in other cases there is no known exciting cause for their formation. They may be hard as ivory or spongy in structure, and the surface of the exostosis may be covered with cartilage if it is situated near the epiphyseal line; often they are enchondromata which have become ossified. They may be single or multiple, and may project like fingers or may be branched like horns, or may present various uncommon shapes. The exostosis may be covered with a

bursa containing fluid and rice bodies, which is derived from the synovial membrane of the joint. These growths are entirely benign in character; do not tend to reproduce themselves, or to form metastases, and only cause trouble from their size or location; and, indeed, frequently do not cause inconvenience at all, and are discovered accidentally. They may usually be readily removed with the chisel or saw, and a prompt and permanent cure be effected.

Case I.—M. T., white, aged 19 years, a factory girl, was admitted to University Hospital on October 14, 1905, and was discharged cured on November 11, 1905. There is nothing of interest in her family history. She had measles and diptheria, but denies having any venereal diseases. She did not menstruate until she was 17 years of age, and has one child, 17 days old. Two years ago she began to experience sharp stabbing pains just above the right knee, which were not constant, but at times were sufficiently severe to awaken her at night. A lump was detected about one year ago at the inner side of the thigh immediately above the knee, and she now enters the hospital for treatment. This lump is situated about the epiphyseal line at the lower end of the femur, and is hard and immovable, and appears to be about one and a-half to two inches in diameter, and is rather conical in shape. After an examination the limb burns. The diagnosis of exostosis of the lower end of the femur was confirmed by skiagraphic examination. On October 20, 1905, under ether anesthesia, Professor Spruill made an incision about five inches in length and exposed the projection, which he removed with the chisel and rongeur forceps, suturing the overlying parts. A back splint of plaster of paris was applied to prevent motion at the knee joint. The patient did well, except for an infection, which caused suppuration, and delayed healing.

Case II.—(Exostosis of the lower end of the femur—Cured)—D. J. S., white, male, aged 21 years, was admitted to University Hospital on November 1, 1905, and was discharged cured on November 21, 1905. His family history is unimportant, nor is there anything in his past history to account for his present trouble. About two years ago he first noticed a lump at the lower and outer part of the left thigh, just above the knee. His attention was directed to the condition by striking the limb against something, when he felt the projecting bone. It was at that time as large as at the time of admission and was hard, but caused him no inconvenience. For several months there had been pain, especially when the limb is much exercised and when it is flexed at the knee. About three weeks ago he jumped down a distance of three feet and since then there has been more discomfort in the limb. An exostosis was diagnosticated, and removed by Professor Randolph Winslow, through an open incision, by means of a chisel, the wound sutured and healing took place by primary union.

Case III.—(Exostosis of the lower end of the femur—Cured).—White, male, aged 27, admitted to University Hospital on December 14, 1905, and discharged cured on January 9, 1906. His family and previous history throw no light on the present condition. Fifteen months ago his right thigh was smashed in a railroad accident, compelling him to lay up for several weeks. He was then able to work only a month, when he was obliged to stop on account of pain. He then discovered a solid growth from the femur. This was partially removed in July, 1905, without benefit, and he sought relief from his ailment at the University Hospital. At this time there is a large irregular bony growth arising from the lower third of the femur, about the termination of Hunter's canal, apparently about one and one-half inches thick and five inches in length. The patient was operated on by Prof. Frank Martin, who, with considerable difficulty, separated the large vessels from the growth without injuring them, and chiseled off the very irregular mass, which sprang from one of the arms of the linea aspera. The patient did well except for some suppuration, and was discharged on January 9, 1906.

Case IV.—(Exostosis of lower end of the tibia, shaped like the astragalus—No operation).—Colored boy, about 16 years of age, entered the medical ward of the hospital for ordinary sickness about the same time as the cases just mentioned. Upon examining his legs, he was found to have a very peculiar and hard growth projecting from the tibia, which bore a striking resemblance to the astragalus. The ankle joint was, however, entirely normal, and, indeed, one could scarcely imagine a dislocation of the astragalus to occur in such a manner. A skiagraphic examination showed the growth to be an exostosis of the tibia. He declined any operation for its removal, as he was not inconvenienced by its presence.

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EDITORIAL

A UNIVERSITY OF MARYLAND CLUB.—There is a prevalent sentiment that the time is rife for the establishment of an organization by the alumni of the various departments of the University of a University of Maryland Club. Such a movement is a decided advance in the unification of the now widely separated schools, known as the University of Maryland, and should be nurtured as far as possible by the various faculties and alumni of the University. The advantages to be derived from such an organization are too self evident to be dwelt upon at any length; suffice it to say that this club would be a valuable adjunct in furthering the very work for which the HOSPITAL BULLETIN and *Old Maryland* were instituted; namely, the engendering of better fellowship between the faculties, alumni and students, the fostering of love and reverence for the old alma mater, the furtherance of the interest of the University, the dissemination of its importance among the populace, especially of the city of Baltimore. Is there any one who has the temerity to gainsay, that such an organization will not be the means of reclaiming the loyalty and reverence of many of those weaned from their allegiance? Moreover, through the facilities offered by such an organization for the lawyers, pharmacists, dentists, and physicians to fraternize with each other upon terms of equality, closer bonds of union will be the inevitable result. Such a home besides being a mecca for our alumni, may also be the headquarters of the General Alumni Association, the special alumni associations, the Library and Historical Society, etc. There has been an awakening of the long dormant power of the University of Maryland We are just beginning to fully realize that "in Unity there is Strength." Some pessimists harp on the past glories of this venerable institution, and long for the good old days that are n'er to be again, nevertheless there are some enthusiasts left who can perceive a glimmer of sunshine in the future, who can still see a field in which the energies of the University may be usefully and honorably employed, who are confident that the University is again to assume its former glories, but it is through such an organization as above outlined that dormant interest in its weal is to be materially awakened.

THE CLASS OF 1906.—The class of 1906 numbered one hundred and five members who took the final examination. Of this number only eighty-three were successful in passing all of the branches and received the degree conferred at the commencement.

The large number of rejections by the Faculty indicates the increasing care which is exercised in admitting students to the privileges conferred by the University. Rejections at the final examination have less significance than in former years and are less mortifying to the students. Many students make good averages on the majority of the branches, but fall down in one or more subjects, which makes it incumbent upon them to take these branches another session. When it is remembered that each student must make an average of 75 on all branches out of a possible 100, it will be understood that the requirements for graduation are sufficiently high to eliminate a number of good students each year, who in another year of study will be better equipped for professional work. It works no injustice to these young men to hold them up to this high standard, whilst it places a mark of approval upon those who have been able to reach the standard now enforced.

The present standard is none too high and might be enforced with greater rigidity in exceptional cases to the benefit of the candidates for the M. D. degree. The class of 1906 has perhaps been held up to a higher standard than any class yet graduated from the University. No compromises were made for expediency and no doubtful cases were rushed through. The class as it now stands was an exceptionally good one. It contains a number of splendid young men who may be relied on to bring credit to the Uni-

versity and success to themselves in their professional careers. They have earned the reward the University has bestowed on them, and they leave their alma mater with the best wishes of the Faculty for their future happiness and success in life. They will carry with them to their respective fields of labor the assurance that they have been deemed worthy of the honor the University has conferred upon them and the confident hope that their future relations towards their old alma mater may be as cordial and pleasant as those which have existed during their student days.

Our North Carolina Alumni.—At the recent meeting of the State Medical Society of North Carolina a number of the alumni of the University of Maryland met and organized a State Alumni Association. There were some thirty or more alumni present at this meeting and a number who could not be present expressed a desire to be enrolled as members.

The meeting was earnest and loyal in expressions of affection for the University. The warmth and cordiality of these sons of North Carolina for their old alma mater has been exhibited in many ways in the past. It will in future be expressed in more positive terms and the University may expect practical helpful influences from this organized association of her graduates in the old North State.

The movement has taken such a definite form that the growth of the Alumni Association is now assured. The Bulletin hopes to be able to publish in an early number the names of all members with officers and committees.

NOTES AND ITEMS

Dr. S. R. Donohoe, class of 1902, has settled at Edgerton, West Virginia.

Dr. Ridgely B. Warfield, class of 1884, of Baltimore, will spend the summer in Europe.

Dr. Philip Travers, class of 1902, of Easton, Maryland, has been appointed physician to the Talbot County jail.

Dr. Arthur H. Mann, class of 1890, has reopened his country home on Edmondson avenue, Catonsville, for the summer.

Dr. J. Whitridge Williams, class of 1888, has been appointed by Mayor Timanus, of Baltimore, a member of the board of charities.

Dr. A. C. Harrison, class of 1887, has been appointed surgeon to the Pennsylvania lines to succeed the late Dr. T. S. Latimer, class of 1861.

Dr. J. F. H. Gorsuch, class of 1876, has been appointed secretary of the Board of Health of Baltimore County by the county commissioners.

Dr. Benjamin H. Dorsey, class of 1901, assistant surgeon, United States Navy, has been ordred to report upon the war ship Lancaster for duty.

Dr. Oliver A. Howard, class of 1906, has received an appointment as resident physician to the Kings Daughters' Hospital, Portsmouth, Virginia.

Dr. B. F. Lansdale, class of 1866, of Montgomery County, Maryland, who has been sick for the past two months, is able to be about again.

Drs. Ashby and Shipley represented the University of Maryland at the North Carolina State Medical Society Convention at Charlotte, May 28, 1906.

Dr. J. M. B. West, class of 1901, of Catonsville, Maryland, has been appointed chairman of the horse show committee of the Catonsville Country Club.

Dr. John C. Hemmeter has been made an honorary member of the Royal Imperial Society of Austrian Physicians, whose headquarters are in Vienna.

We are glad to report that Mrs. Rogers, of San Francisco, wife of the late Dr. William Hayes Rogers, class of 1850, was not burned out in the great disaster.

Dr. H. E. Jenkins, class of 1905, late of the resident staff of the University Hospital, has accepted a position with the Western and North Carolina Railroad.

Dr. E. Miller Reid, class of 1864, has resigned as a member of the faculty of the Baltimore University School of Medicine, of which he has been a member twenty years.

Dr. J. H. W. Weedon, class of 1864, of Church Hill, Maryland, has been elected by the Queen Anne's County Medical Association a delegate to the State convention.

Miss Millicent Geare, class of 1905, of the Training School for Nurses, has been appointed Superintendent of nurses at the Emergency Hospital, Annapolis, Maryland.

Dr. Josiah Bowen, class of 1903, of Mount Washington, who has been laid up with a sprained ankle, we are glad to report, is able, with the aid of crutches, to be about again.

Dr. Gardiner, class of 1896, a member of the Isthmus of Panama's medical corps, recently visited the University and gave a glowing account of the efficiency of the medical corps.

Dr. T. A. Ashby attended the annual convention of the American Gynecological Society at Hot Springs, Virginia, the sessions of which began May 22, 1906, at the Homestead Hotel.

Dr. R. C. Massenburg, class of 1884, of Towson, sanitary officer of the ninth district, is taking steps to overhaul and improve the sanitary conditions of Towson and the district generally.

Drs. Shipley, Stubbs, White, Rudolph, Winterson, Maxwell, members of the class of 1902, held a reunion and banquet at the New Howard House, Baltimore, Monday evening, June 4, 1906.

Last month Dr. Gichner and Dr. Fulton assisted in the inaugural exercises of the Wicomico and Dorchester branches of the Maryland Society for the Prevention and Cure of Tuberculosis.

Now that alumni associations are becoming popular, the BULLETIN hopes that our alumni in Syria and Egypt will band themselves together to keep up their memories of their mother in the West.

Dr. Thomas A. Mann, class of 1903, of Durham, N. C., has recently been in Baltimore inspecting dairies. He came to gather information for the improvement of the Durham dairy system.

Miss Sarah A. Sanderson, a graduate of the University Training School for Nurses in the class of 1906, has been appointed Assistant Superintendent of the Peninsula General Hospital, Salisbury, Maryland.

Dr. Gordon Wilson, associate professor of clinical medicine, will go abroad in June, and after traveling in France and Switzerland will go to Vienna, where he will take a special course in medicine next winter.

The University Annual—*Terra Mariae*—has just been received from the publishers and is fully up to the high standard set by preceding classes. The BULLETIN wishes the editors all success in the disposal of their book.

A lawn fete was held May 23, 1906, at the home of Mrs. Howard Towles, Walbrook, by the May Committee of the Ladies' Auxiliary, Board of the University Hospital, the proceeds of which will be devoted to the Private Halls.

Among the alumni of the University who attended the 57th annual session of the American Medical Association were: Drs. R. Winslow, C. Riely, C. McElfresh, D. Reeder, F. Martin, J. C. Hemmeter, R. Randolph, F. Kirby, M. Lynch.

Now that a break in the old regime of separate commencement exercises of the different departments has been made, why not start the agitation for a combined banquet, keep before the graduates that they are a part of a great university and not of a department.

Miss Gray, a graduate of the Nurses' Training School, University of Maryland, class of 1900, who has been rendering heroic service to the typhoid sufferers of Woodberry, Baltimore, we are sorry to report, has through constant exposure contracted the disease.

Dr. J. E. Rawlings, class of 1904, of Latona, Florida, who has been spending a few days renewing old acquaintances about the hospital, reports that he has been eminently successful in the practice of his profession, and says, there are fine opportunities in Florida for energetic conscientious physicians.

Dr. William S. McPherson, class of 1848, who was recently appointed a justice of the peace for Frederick county by Gov. Warfield, qualified in Frederick, May 1, for the office. Dr. McPherson is 83 years of age and resides at his handsome estate, Auburn, at Catoctin Furnace, to which he moved 56 years ago.

At the meeting of the American Medical Association, Dr. J. C. Hemmeter read a paper on "An Improved Operative Method of Forming an Experimental Accessory Stomach on the Dog;" and Dr. R. L. Randolph, class of 1884, "The Eye Injuries of Independence Day and What has been done in Baltimore towards Lessening Them."

A reunion and dinner of the class of 1871 was held June 1 at the New Howard House. About 20 members were present and spent an enjoyable evening. THE BULLETIN hopes that as a precedent has now been established every succeeding and as many preceding classes as can will yearly meet over the festive board and recall the happenings of their college days.

In his address to the graduates of the department of dentistry of the University of Maryland, May 9, 1906, Governor Warfield paid a high compliment to the University of Maryland, alluding to it as the equal of any institution of its kind in the world, and he urged those about to leave its portals to be true to its traditions, to which words we add a hearty assent.

During the annual meeting of the Ohio State Medical Association, held the first week in May, at Canton, Dr. John C. Hemmeter delivered an address upon "Auto-Intoxications from the Digestive Tract." While in the Middle West he also read a paper at Cleveland on "Certain Diseases of the Digestive Tract that are on the Borderland between Internal Medicine and Surgery."

Dr. Charles A. Wells, class of 1862, ex-Mayor of Hyattsville, Maryland, and a physician of that locality for more than 40 years, was presented with a beautiful punch bowl May 30, 1906, by his friends. The ceremonies attending the presentation were held in Odd Fellows' Hall. The newly-elected Mayor, Dr. Joseph R. Owens, class of 1859, registrar of the Maryland Agricultural College, made the presentation address.

Dr. Willis B. Fitch, class of 1903, of St. Johnsbury, Vermont, recently the radiagrapher of the University Hospital, and a former practitioner of Baltimore, who was forced to leave this city owing to poor health, recently stopped at the Hospital, looking hale and hearty. He said he never felt better in his life. As there have been persistent rumors of Dr. Fitch's demise, we are glad to report that we saw him with our own eyes.

Dr. Joseph H. Hartman, class of 1869, of Baltimore, at the Niagara Falls Convention, June 2, 1906, of the American Laryngological Society, was elected a member of the council for four years, and Dr. John R. Winslow, Clinical Professor of Nose and Throat Diseases in the University of Maryland, was elected a member.

At the semi-annual meeting of the Montgomery County Board of Health, Dr. William L. Lewis, class of 1892, of Kensington, was reappointed health officer to serve two years, and the following of our alumni were named vaccine physicians: Drs. Harry G. Spurrier, class of 1889; R. T. Gott, class of 1868; James E. Deets, class of 1882; P. S. Lansdale, class of 1902; John L. Lewis, class of 1888; J. R. Batson, class of 1880; William L. Lewis, class of 1892; Roger Brooke, class of 1887.

We regret to announce that the nomination of Dr. Love as one of the coroners for the City of Baltimore by Governor Warfield was inadvertently reported by the BULLETIN as equivalent to an appointment. The Senate failed to confirm the appointees, so the old coroners will hold office for two more years. Among them are the following alumni of our school: Dr. Otto M. Reinhardt, class of 1893; Dr. Patrick F. Martin, class of 1900; Dr. Frederick Carruthers, class of 1892; and Dr. Silas Baldwin, class of 1867.

At the National Conference of the State and Provincial Boards of Health, held in the City of Washington, D. C., which came to a close May 22, 1906, Dr. John S. Fulton, class of 1881, was elected secretary. In the open discussion Dr. Fulton advocated a better understanding and more co-operation between the State and National Health Guardians, and used the condition of affairs existing last fall at New Orleans as an example of the lack of co-operation between the local and government authorities.

Dr. William Kirkwood Robinson, class of 1883, a resident physician in the University Hospital, 1893-94, formrely of Denver, Colorado, but now of Goldfield, Nevada, and his wife are the guests of Dr. Robinson's parents, Dr. Robert Kirkwood Robinson, class of 1859, and Mrs. Robinson, of Great Meadows, Sharon, Harford County, Maryland. Dr. and Mrs. W. K. Robinson are both of Maryland, the latter being a daughter of Mr. Harrison W. Vickers, of Chestertown, Maryland, and as they have not been East since their marriage, several years ago, their return has been the occasion of a family reunion at Great Meadows.

The police commissioners of Baltimore by an unanimous vote have reappointed the board of police surgeons for a period of two years. All but one member is a graduate of our medical department. Dr. Wirt A. Duvall, class of 1888, is the chief surgeon, and Drs. J. Claggett Robertson, class of 1900; J. D. Norris, class of 1878, and Henry Lee Smith, class of 1894, are his assistants. Their work has been generally commended for its efficiency and impartiality. The position of chief surgeon was created by the first Legislature of Governor Warfield's administration. The Govenor was interested in the plan,

and Dr. Duvall was strongly recommended by him for the position. Dr. Duvall was born in Anne Arundel County, and, after attending the public schools there, he was graduated from St. John's College, Annapolis, in the class of 1885. He then migrated to Baltimore and matriculated at the University of Maryland, where he studied medicine. He was president of his class.

Dr. Joseph R. Owens, class of 1856, treasurer of the Maryland Agricultural College, has been elected Mayor of Hyattsville, Maryland, after a spirited and exciting contest. Dr. Owens has always been a public spirited citizen, during the last six years being at times a member of the town council, chairman of the committee in charge of the installation of the waterwork system, a member of the committee for the introduction of a sewerage system, and chairman of the electric lighting committee.

The following physicians have visited the University Hospital during the past month:
Dr. J. E. Rawlings, class of 1904..Latona, Fla.
Dr. Wm. B. Gambrill, class of '78.Alberton, Md.
Dr. Philip Travers, class of 1902..Easton, Md.
Dr. Guy Steele, class of 1897..Cambridge, Md.
Dr. Thos. A. Mann, class of '03..Durham, N.C.
Dr. Arthur E. Ewens, class of '04.Atlantic City.
Dr. Northrup, class of 1897....St. Pauls, N. C.
Dr. H. E. Clarke, class of 1901.....Michigan
Dr. Maxwell, class of 1902.....Georgia
Dr. Rudolph, class of 1902.....Georgia
Dr. Winterson, class of 1902.New Windsor, Md.
Dr. Quillen, class of 1904..Rocky Mount, N. C.
Dr. W. Sappington, class of 1901.Webster's Mill, Pennsylvania.

The General Alumni Association, with Mr. Oregon M. Dennis, the president in the chair, held its 11th stated meeting Monday, May 21, 1906, in the lecture room of the School of Law, Lombard and Greene streets. Mr. A. S. Niles read a sketch of William Pinckney, the eminent Maryland statesman and lawyer, and Mr. J. Harry Tregoe, spoke of the endowment fund. Dr. Cordell on behalf of the French Ambassador, M. Jusserand, presented to the Association and the University a large colored engraving of Gen. LaFayette, the University of Maryland having conferred the degree of LL. D. upon our French ally upon his visit to the United States. Dr. Nathan Winslow read a paper advocating the foundation of a University of Maryland Club. The proposal was received with enthusiasm and referred to a committee of five, to wit: N. Winslow, J. L. V. Murphy, C. J. Grieves, O. P. Penning and Charles Caspari, Jr., to draw up a report. A committee of three from each of the departments was appointed to find means to increase the membership of the association. Mr. John Henry Keene was elected assistant secretary-treasurer.

The portrait of the late Dr. Richard McSherry, Professor of Materia Medica, and Practice of Medicine in the University of Maryland from 1863 to 1884, painted by Mr. Paul Hallwig, has been completed and presented to his sons, Dr. H. Clinton McSherry, class of 1872, and Mr. Allan McSherry, to the Medical and Chirurgical Faculty of Maryland, of which Dr. McSherry was president during the term 1883-1884. In accepting the portrait, Dr. S. K. Merrick, class of 1872, said, in part: "He belonged to a type which has been aptly styled 'the old school gentleman,' for the present generation is not producing them. There was a nameless something which gave grace, charm and dignity to the manners of this type of man, which requires a peculiar environment for its development, and I fear that environment is fast disappearing. Let us hope that we will not lose entirely the noble sentiments which inspired these worthies, even if we are not able to imitate their graces and charming manners. It may be truthfully said of him, in the language of the great writer, 'His life was gentle and the elements so mixed in him that Nature might stand up and say to all the world, This was a man!'"

The annual meeting of the Montgomery County Society was held in the Circuit Court room at Rockville, Maryland, Tuesday, April 12, 1906. Among those present were the following of our alumni: Dr. A. C. Harrison, class of 1887, Baltimore; Dr. Muncaster, class of 1883, Washington, District of Columbia; and the following physicians from Montgomery County: Otis M. Linthicum, class of 1890; Edward Anderson, class of 1875; William E. Magruder, class of 1854; Roger Brooke, class of 1887; James E. Deets, class of 1882; John L. Lewis, class of 1888; and Edward Wootten, class of 1861. Dr. Edward Anderson, class of 1875, of Rockville, was elected president for the ensuing year; Dr. James E. Deets, class of 1882, vice-president; Dr. John L. Lewis, class of 1888, of Bethesa, secretary-treasurer; Dr. Roger Brooke, class of 1887, of Sandy Spring, was chosen to represent the

society at the annual meeting in Baltimore of the State Medical Society, with Dr. James E. Deets, class of 1882, as alternate. Dr. Otis M. Linthicum, of Rockville, was elected censor for a term of three years. Dr. Elisha C. Etchison, class of 1874, of Gaithersburg, was unanimously elected to membership. Papers were read by Drs. A. C. Harrison and Roger Brooke.

A Pennsylvania branch of the General Alumni Association was founded May 14, 1906, at Philadelphia. Dr. Eugene F. Cordell and Mr. Oregon Milton Dennis attended as representatives of the Central Alumni Association and delivered addresses. The formation of this society marks another milestone in our efforts to bring the alumni of our University into closer personal relationship with one another and we hope our graduates in other states will follow the good example of our Pennsylvanian brethren. Mr. Dennis said in part: "There are two things a man should cling to and be more proud of than any other thing in life, and these are his mother and his alma mater. The latter gives him a new birth and fits him for his life's work. As graduates of that University we should feel proud. Go where you will, you will find eminent men in all the professions foremost in the arena of professional life. Those who have gone out from the University of Maryland need offer no apologies for the great strides they are making to any school, college or university in this broad land. I want you not to forget your alma mater, but to band together and be true to it. We owe it to the University. We owe it to ourselves." Dr. Charles P. Noble, class of 1884, to whose efforts the above mentioned society owes its existence, was elected president, and Dr. J. J. C. Beale, secretary-treasurer.

At the meeting and exhibition of the Maryland Milk Exhibition inaugurated for the purpose of educating the public and profession in the uses, economic phases, and methods of collecting and handling milk, held in Baltimore, May 7 to 14, 1906, our alumni took a prominent part and were upon the following committees: Committee on Chemistry of Milk, Dr. H. M. Fitzhugh (1897); Committee on Pathology and Bacteriology, Dr. W. R. Stokes (1891), Dr. J. L. Hirsh (1895); Committee on Statistics of Milk, Dr. Marshall L. Price (1903), Dr. J. S. Fulton (1881); Committee on Infant Feeding, Dr. J. L. Hirsh (1895), Dr. C. W. Mitchell (1881), Dr. C. O'Donovan (1881), Dr. W. T. Watson (1891); Committee on Dairy Schools, Model Dairies and Dairy Rations, Dr. J. S. Fulton (1881); Committee on Commercial Milk and Milk Products, Dr. J. S. Fulton (1881), Dr. J. Gichner (1890), Dr. M. L. Price (1903); Committee on Municipal Control of Milk Supply, Dr. J. S. Fulton (1881), Dr. Marshall L. Price (1903); Committee on Foreign Exhibits, Dr. J. S. Fulton (1881), Dr. J. E. Gichner (1890); Committee on Technical Uses of Milk, Dr. J. S. Fulton (1881), Dr. M. L. Price (1903); Committee on Literature of Milk, Dr. J. S. Fulton (1881). Among the directors of the exhibition were: Drs. Samuel T. Earle (1870), John C. Hemmeter (1884), and Charles W. Mitchell (1881). Instruction on the care and feeding of infants was given by Drs. Charles O'Donovan, Charles W. Mitchell and Jose L. Hirsh.

The 14th annual commencement of the University of Maryland Training School for Nurses was held Friday, May 11, 1906, in the nurses' parlor in the University Hospital. The occasion was made memorable by the presence of His Excellency Edwin Warfield, Governor of Maryland, who was the principal orator of the day. The Governor spoke in a light vein, his remarks being terse and extremely appropriate. After congratulating the successful candidates upon the attainment of their ambition, namely, the acquirement of a diploma from one of the oldest and most renowned medical institutions in the United States, he especially urged them to be true to the traditions of their alma mater, to be cheerful in the sick room, and above all to be careful of their personal appearance. The diplomas were conferred by Professor R. Dorsey Coale, Dean of the Faculty of Physics, and Bishop Paret, of Maryland, offered the opening prayer and delivered the benediction. The graduates were as follows: Ethel Palmer Clarke, Virginia; Sarah A. Macfarlane Sanderson, Canada; Clara Estelle Query, North Carolina; Sarah White Cunningham, South Carolina; Katherine K. Landwehr, Maryland; Nellie Hutchings Carter, Virginia; Annie Elizabeth Chapman, Maryland; Mary Carroll Ellicott, Maryland; Aeri Magdaline Phillips, Maryland; Leonore Griffith Doyle, Maryland; Annie Georgiana Truitt, Maryland; Miriam Louise Jessop, Maryland; Margaret Eleanor Lawrence, South Carolina.

During the 108th annual session of the Medical

and Chirurgical Faculty, held in this city, April 24 to 26, inclusive, our alumni took a prominent part in the proceedings. The meetings were presided over by Dr. S. T. Earle, Jr., class of 1870, and during the convention addresses were delivered by the following graduates of our school: Dr. Hiram Woods, Jr., 1882, "Dispensary Abuses"; Dr. H. O. Reik, class of 1891, "The Advisability of the Faculty Publishing Its Own Journal"; Dr. S. T. Earle, Jr., class of 1870, "The Message of the President"; Dr. H. O. Reik, "New Home for the Faculty"; Dr. J. E. Gichner and Dr. Randolph Winslow, "A Case of Sarcoma of the Hyoid Bone and Larynx, with Excision of the Tumor of the Hyoid, Base of the Tongue, Larynx and Part of the Pharynx, under Local Anæsthesia." The committee in charge of the arrangements of the annual banquet were: Drs. A. C. Harrison; H. W. Kennard, class of 1899; I. J. Spear, class of 1900; L. M. Allen, class of 1896; and Guy Steele, class of 1897. Officers were elected for the ensuing year, as follows: Again the University of Maryland has been honored by the election of Dr. Hiram Woods, Jr., Professor of Diseases of the Eye and Ear in the University of Maryland, and a graduate of the class of 1882, to the presidency of the Medical and Chirurgical Faculty, succeeding in the chair our esteemed fellow alumnus, Dr. S. T. Earle, Jr., an ornament to the medical profession of Baltimore City; vice-president, Dr. William T. Watson, class of 1891; members of the Council, Drs. S. T. Earle, Jr., and Guy Steele, class of 1897; library committee, Drs. J. Whitridge Williams, class of 1888, and J. F. Crouch, class of 1890; delegate to the American Medical Association, Dr. G. Lane Taneyhill, class of 1865.

At the annual banquet of the Baltimore County Medical Association, held at the Hotel Stafford, Baltimore, May 9, 1906, of which Dr. George H. Hocking, class of 1879, is president, the following of our alumni are reported to have been present: Drs. N. R. D. Cox, class of 1903; H. L. Naylor, class of 1866; H. A. Naylor, class of 1900; Charles O'Donovan, class of 1881; R. C. Massenburg, class of 1884; W. S. Smith, class of 1883; J. F. H. Gorsuch, class of 1876; Wilmer Brinton, class of 1876; Samuel Theobald, class of 1867; M. L. Price, class of 1902; J. Carroll Monmonier, class of 1886; L. E. Neale, class of 1881; J. H. Drach, class of 1880; W. R. Stokes, class of 1891; L. M. Allen, class of 1896; H. F. Cassidy, class of 1890; A. D. McConachie, class of 1890; I. R. Trimble, class of 1884; C. G. W. Macgill, class of 1856; J. R. Winslow, class of 1888; J. M. Hundley, class of 1882; G. Lane Taneyhill, class of 1865; John Turner, class of 1892; T. H. Emory, class of 1896; E. M. Duncan, class of 1884; Jackson Piper, class of 1853; H. T. Harrison, class of 1874; A. R. Mitchell, class of 1877; J. W. Patterson, class of 1882; Hiram Woods, class of 1882; B. B. Brown, class of 1867; Herbert Harlan, class of 1879; W. P. E. Wyse, class of 1886; B. F. Bussey, class of 1885; M. G. Porter, class of 1886; G. H. Hocking, class of 1879; M. B. West, class of 1901; J. E. Gichner, class of 1890. Toasts were responded to by Dr. J. S. Bowen, class of 1903, and Dr. J. F. H. Gorsuch, class of 1879. Among the officers of the society are the following of our alumni: President, Dr. George H. Hocking; Corresponding Secretary, Dr. R. C. Massenburg; Recording Secretary, Dr. Henry A. Naylor. At an election of officers for the ensuing year, Dr. James H. Jarrett (1852) was elected president; Dr. R. C. Massenburg was retained in his position, and Dr. N. R. D. Cox was appointed recording secretary.

The annual reunion and banquet of the Alumni Association of the Medical Department of the University of Maryland was held Friday, June 1, 1906, at the Eutaw House. Dr. Randolph Winslow made the annual address, which will be found elsewhere in this issue. Dr. Howard E. Ames, class of 1874, medical inspector, United States Navy, presided. At the business meeting officers were elected as follows.

President—Prof. Samuel C. Chew, class of 1858. Vice Presidents—Dr. Eugene F. Cordell, class of 1868; Dr. N. L. Dashiell, class of 1882; Dr. M. Gibson Porter, class of 1886. Recording Secretary—Dr. Charles E. Sadtler, class of 1873. Assistant Recording Secretary—Dr. John A. Zepp, class of 1887. Corresponding Secretary—Dr. George H. Hocking, class of 1879. Treasurer—Dr. G. Lane Taneyhill, class of 1865. Executive Committee—Dr. B. M. Hopkinson, class of 1885; Dr. S. B. Bond, class of 1883; Dr. S. T. Earle, class of 1870; Dr. Joseph Blum, class of 1885; Dr. John Houff, class of 1900.

Executive Committee—Dr. Wilmer Brinton, class of 1876; Dr. John I. Pennington, class of 1869; Dr. Joseph T. Smith, class of 1872; Dr. S. B. Bond, class of 1883; Dr. T. O. Heatwole, class of 1897. Among the older alumni present may be mentioned:

Dr. S. R. Waters, class of 1858, a loyal supporter of the school, of Watersville, Carroll county, Maryland, a member of the Medical and Chirurgical Faculty, of the General Alumni Association, and of the Medical Alumni Association, retired from practice. Dr. Waters is connected with the tax commissioners office, Treasury Department, Annapolis, Md.; Dr. Naylor, class of 1869, Pikesville, Maryland; Dr. J. H. Jarrett, class of 1852, a practitioner of medicine for more than a half a century, and appears to be good for 50 more years; Dr. H. H. Biedler, class of 1876; Dr. John T. King, class of 1866; Dr. W. E. Wiegand, class of 1876, and Dr. I. S. Stone, class of 1872, Washington, D. C. Toasts were responded to by Dr. J. L. Hirsh, Prof. Chas. Caspari, Dr. B. Merrill Hopkinson, Dr. A. M. Shipley, Prof. L. E. Neale, Dr. Victor C. Carroll and Dr. W. H. Pearce.

The 99th annual commencement of the School of Medicine, 36th of the School of Law, and 54th of the School of Pharmacy, was held at the Academy of Music, Baltimore, June 4, 1906. Prayer was offered by the Rev. Hugh Johnston, the deans of the various departments read the Mandates, the degrees were conferred by Mr. Bernard Carter, Provost of the Board of Regents, and Mr. Francis K. Carey delivered the address to the graduates. Those to receive the degree of Doctor of Medicine and the prizemen and class officers were as follows:

GRADUATES IN MEDICINE.

Gaius Williams Billups	Virginia
Henry Blank	New Jersey
William Benjamin Borden	North Carolina
Edward Lingan Bowlus	Maryland
Earle Holt Brannon	West Virginia
Christopher Brenner	Ohio
William Landon Brent	Virginia
Alan Goodwin Brooks	Maryland
Lay Gordon Burroughs	Maryland
Charles Overton Burruss	Virginia
William Dick Campbell	Maryland
Harry Arthur Cantwell	Maryland
Romulus Lee Carlton	North Carolina
Victor Calvert Carroll	Maryland
William Bradford Casey	Connecticut
Irving Drury Chaney	Maryland
T. Morris Chaney, Jr.	Maryland
Bascomb Lanier Chipley	South Carolina
Arthur Blake Clarke	Canada
Earle Somerville Coster	Maryland
Robert Williams Crawford	Virginia
Ralph Erastus Dees	North Carolina
Rigdon Osmond Dees	North Carolina
Joseph Angelo Devlin	New York
Thomas Duncan, Jr.	North Carolina
Matthew Clement Freilinger	Maryland
J. Sterling Geatty	Maryland
Julian Paul Harrell	Georgia
William Lee Hart	South Carolina
John Frederick Hawkins, Jr.	Maryland
Robinette Burns Hayes	North Carolina
Newton W. Hershner	Maryland
James Chisolm Hill	South Carolina
James Herbert Hope	Maryland
Oliver Arnold Howard	Canada
Richard Caldwell Hume	Virginia
Jose Miguel Infante	Cuba
Oliver Victor James	Delaware
Kyle McCue Jarell	West Virginia
Charles Litner Jennings	South Carolina
Thomas B. Johnson	Indiana
Leo Karlinsky	Maryland
John William Keeler, Jr.	New York
Louis A Kelly	Canada
John Knox, Jr.	North Carolina
Leonce J. Kosminsky	Arkansas
LaFayette Lake	New York
Fay Frederick Larrabee	Maine
Louis Limauro	Connecticut
Samuel Howard Lynch	Delaware
Joseph McElhattan	West Virginia
Peter McLean	North Carolina
Lou Murray Mitchell	Pennsylvania
William Wade Olive	North Carolina
Louis M. Pastor	New Jersey
Kivy I. Pearlstine	South Carolina
Calvin Cyrus Peters	West Virginia
Eugene Florencio Raphel	Maryland
Manney Murdoch Rice	South Carolina
Henry B. Robbins	New Jersey
Charles Wesley Roberts	Georgia
Ernest Harrison Rowe	Maryland
Joseph William Scannell	Maine
Edwin Laurence Scott	Florida
J. G. Fowble Smith	Maryland
John William Smith	North Carolina
Paul B. H. Smith	Ohio
Dempsey William Snuffer	West Virginia
Alejandro Ruiz Soler	Porto Rico
Walter Franklin Sowers	Maryland
Clarence Winfield Stansfield	Pennsylvania
W. Waters Stonestreet	Maryland
Eugene Michael Sullivan	Massachusetts
Mohamed Tawfik	Egypt
Bernard O. Thomas	Maryland
Jorge L. del Toro	Porto Rico
Arnold Dwight Tuttle	South Dakota
Caley Geoffrey Upchurch	North Carolina
Elijah W. White	Maryland
John Watkins Williams	North Carolina
FitzRandolph Winslow	Maryland
Allen Henry Wright	New York
Ahmed Hussein Zaki	Egypt

PRIZEMEN.

University Prize, Gold Medal—Robinette Burns Hoyes. Certificates of Honor—William Wade Olive, Charles Leitner Jennings Leo Karlinsky, Charles Wesley Roberts, Oliver Victor James, Joseph McElhattan, William Dick Campbell, Newton W. Hershner, Samuel Howard Lynch.

CLASS OFFICERS—*Medicine*—Victor C. Carroll, *President;* M. M. Rice, *Vice-President;* Walter F. Sowers, *Secretary;* FitzRandolph Winslow, *Treasurer;* J. Sterling Geatty, *Historian;* Leo Karlinsky, *Valedictorian;* J. del Toro, *Poet;* J. Knox, *Prophet;* W. W. Stonestreet, *Sergeant-at-Arms.* EXECUTIVE COMMITTEE—Arthur B. Clarke, *Chairman;* Leonce J. Kosminsky, Matthew C. Freilinger, Oliver A. Howard, Eugene Sullivan, Allen H. Wright, J. G. F. Smith.

Dr. R. R. Norris, class of 1904, has been appointed superintendent (medical) of Bay View, Drs. J. Holmes Smith, Jr., Bay, Hayes and Roberts, surgical assistants in the University Hospi-

tal; Drs. White, Winslow and Olive, medical assistants in the University Hospital; Drs. Mitchell and Crawford, gynecological assistants in the University Hospital; Drs. Tyson, R. O. Dees and Cantwell, obstetrical assistants in the University Hospital, and Dr. W. V. S. Levy, pathologist to the University Hospital. Drs. Jennings and Hershner, of the present graduating class, have been appointed internes to St. Joseph's Hospital, Baltimore, Md.

MARRIAGES

Dr. J. S. Malloy, class of 1904, Shinnston, West Virginia, was married April 25, 1906, to Miss Rhoda Lowe, of Clarksburg.

Lieutenant Commander Lewis Morris, M. D., class of 1890, surgeon, United States Navy, was married May 12, 1906, in New York City, to Miss Mary Gibbs Murphy.

To Dr. Romulus Lee Carlton, class of 1906, of North Carolina, belongs the honor of being the first benedict of his class since graduating. He was married Saturday, June 2, 1906, at Oak Ridge, North Carolina, to Miss Elizabeth Dearing Lancaster, daughter of Mr. and Mrs. J. F. Lancaster.

Dr. George Carroll Lochard, class of 1903, of Baltimore, Maryland, an assistant in the pathological department of the University of Maryland, and Miss Louise Cummings Wright, daughter of Mr. and Mrs. John Randolph Wright, were married at Rosemont, Howard Park, Maryland, June 12, 1906. Dr. and Mrs. Lochard will reside in Baltimore.

Dr. John Aldridge Gibson, class of 1901, of Leesburg, Virginia, a former resident physician in St. Agnes' Sanitarium, Baltimore, and Miss Frances Louise Perry, were married Saturday, June 2, 1906, at the home of the bride's parents, Judge and Mrs. William Hartwell Perry, "Beckelbronn," Rubermont, Virginia, by Rev. Dr. Stacey. Dr. and Mrs. Gibson will reside in Leesburg.

Dr. Jay Ralph Shook, class of 1899, an associate editor of the 1899 year book, Bones, Molars and Briefs, and formerly an assistant surgeon in the University Hospital, but now a lieutenant and assistant surgeon in the United States Army, was married May 23, 1906, to Miss Helen Slade, of Des Moines, Iowa. Dr. Shook since receiving his commission in the army has seen considerable service in the Philippine Islands, and is one of the most prominent of the younger physicians in his branch of the United States military service.

Dr. Ejnar Hansen, class of 1904, formerly an assistant resident surgeon in the University Hospital, and a general favorite with his classmates, now practicing in New York City, New York, was married May 23, 1906, to Miss Sara Frances Jenner, daughter of Mr. and Mrs. William A. Jenner, of New York, at the Church of the Epiphany. Dr. Hugh Brent, class of 1903, was the best man. Dr. and Mrs. Hansen will spend their honeymoon in Denmark, Dr. Hansen's fatherland, and will be away the greater part of the summer.

Dr. William E. McClanahan, class of 1902, a well known physician of East Baltimore, and formerly chief of clinic to the professor of Diseases of the Nose and Throat in the University of Maryland, and Miss Susie Cecilia McGuinness, daughter of Mr. and Mrs. Thomas McGuinness, 222 Bank street extended, Highlandtown, Maryland, have just announced that they were quietly married November 26, 1905. The ceremony was performed by Rev. John J. Murray, pastor of St. Elizabeth's Church, and only the respective parents of the couple were informed of the wedding.

Dr. Cooper R. Drewy, class of 1902, of Mineola, Chesterfield County, Virginia, nephew of Dr. Charles G. W. Macgill, class of 1856, of Catonsville, Maryland, and formerly an interne in Spring Grove Insane Asylum, Catonsville, and one of the most popular and athletic members of his class, was married Saturday, June 2, 1906, at St. Timothy's Protestant Episcopal Church, Catonsville, by the rector, Rev. Percy F. Hall, to Miss Mary Tasker James, daughter of Mr. and Mrs. Charles I. James, of Tower Hill, North Bend, near Catonsville. Dr. William D. Scott, class of 1904, of Curtis Bay, a former resident surgeon in the University Hospital, and now chief of clinic to the professor of Genito-Urinary Diseases, was among the attendants. On their return from their honeymoon Dr. and Mrs. Drewy will spend the summer with the bride's parents.

Dr. Louis Bernard Henkel, Jr., class of 1903, of Annapolis, Maryland, a member of the visiting staff of the Emergency Hospital, Annapolis, also ex-Health Officer of Annapolis, was married Wednesday, June 6, 1906, at the home of

Mr. Adreon Posey, La Plata, Maryland, to Miss Etta Sheppard H. Rayle, of Winston-Salem, North Carolina. Miss Rayle is a graduate nurse, having received her degree from St. Joseph's Hospital, Baltimore, with the class of 1904, and took her obstetrical training at the University of Maryland Lying-In-Hospital. She was until recently Superintendent of nurses at the Emergency Hospital, Annapolis. Dr. H. C. Davis, class of 1902, chief of clinic to the professor of Diseases of the Nose and Throat, University of Maryland, professor of Laryngology at the Woman's Medical College, Baltimore, and late resident physician to the Presbyterian Nose and Throat Hospital, Baltimore, was best man. The honeymoon will be spent in the North, the itinerary including Boston and the American Medical Association, Hartford, Kingston, Philadelphia, Atlantic City and other points of interest. Dr. and Mrs. Henkel will reside in Annapolis.

DEATHS

Dr. Howard R. Weber, class of 1886, formerly of Highland, Illinois, died at the Illinois Southern Hospital for the Insane, April 26, 1906.

Dr. John Monroe Lawson, class of 1892, for a time house surgeon of the University Hospital, a practitioner of Union, South Carolina, assistant surgeon of the First South Carolina Regiment of Infantry, United States Volunteers, in the Spanish-American War, died suddenly in the Keeley Institute, Columbia, South Carolina, from pneumonia, after an illness of three days, aged 35.

Dr. Louis A. Weigel, class of 1875, of Rochester, New York, an authority on the Roentgen ray, died May 31, 1906, in Rochester, as the direct result of his experimental work. He had practiced his profession in Rochester for 31 years. Dr. Weigel was president of the American Orthopedic Society, president of the Rochester Academy of Medicine and a member of many medical societies. He was among the first to realize the possibilities of the Roentgen ray and did much experimental work with it, believing that it would be of great use to his profession. In October, 1904, it became necessary to remove his right hand and three fingers of his left hand on account of cancer, a heritage of too constant exposure to the influence of these powerful light eminations. In a few months metastatic growths had to be removed from the muscles of the left breast. Since which time four more operations were performed before the fatal termination.

Dr. Basil B. Crawford, class of 1851, one of Montgomery County's leading citizens, died at his home, near Laytonsville, Thursday, May 4, 1906, aged 73 years. Although his death was somewhat sudden, it was not unexpected, as he had been in poor health for some time. Dr. Crawford has been a practicing physician for over 50 years, having begun his practice at Laytonsville, after graduating from the University of Maryland in the class of 1851. He was born in Elkridge, Howard County, Maryland, in August, 1832. His mother was a Miss Cross, sister of three illustrious men of Maryland—Colonel Trueman Cross, who was killed in the Mexican War just prior to the battle of Palo Alto; Captain Joseph Cross, of the United States Navy, who was voted a sword by the State of Maryland for gallant and meritorious service, and General Osborne Cross, of the United States Army. Dr. Crawford is survived by a widow, who was a Miss Griffith, and two daughters, Mrs. William Banks, of Mount Airy, and Mrs. Jack Bowie, of Kensington.

Dr. Julius A. Johnson, class of 1871, aged 57 years, died at his country residence, the Harbor, on Miles River, about five miles from Easton, Maryland, May 9, 1906, from a prolonged attack of jaundice. Dr. Johnson was one of the foremost physicians of Talbot County. He was born in Easton, where he has since resided, July 15, 1849. When 18 years of age he began the study of medicine with Dr. Richard McSherry, of Baltimore, at the same time taking a course of lectures in the University of Maryland. He graduated in the class of 1871, and returned to Easton where he associated himself with Dr. James A. Anderson. At the time of his death he was physician to the county jail and president of the Talbot County Medical Association. He was a thirty-second degree Mason and was past master of Coates Lodge, No. 102. He had passed through all the chairs of the Odd Fellows, being a member of Miller Lodge, of Easton, and was past grand master of the lodge. In February, 1880, he married Elizabeth T., daughter of the late Commodore Charles Lowndes, of the United States Navy, who resided at the Anchorage, in Miles River Neck, who with two sons, C. Lowndes and Julius Graham Johnson, survives him.

Dr. Thomas Sargent Latimer, class of 1861, professor of medicine at the College of Physicians and Surgeons, teacher and editor, one of the most widely known physicians in Baltimore, and a gallant Confederate soldier during the Civil War, died at his home, 211 West Monument street, Baltimore, Maryland, May 16, 1906, in the 67th year of his age, from nephritis. For six months Dr. Latimer had been in failing health and had not lectured at the College since last fall, so his death was not unexpected. Dr. Latimer was born in Savannah, Georgia, on June 15, 1839. On the death of his father, William Geddes Latimer, in 1845, the family removed to Shrewsbury, Pennsylvania, and he attended school in York, Pa., at the Shrewsbury Academy, and at the age of 18, came to Baltimore and began the study of medicine at the University of Maryland, graduating just prior to the outbreak of the war between the States, in 1861. Through conviction and association his sympathies were wholly with the cause of the South, and in May, 1861, he went to Richmond, and enlisted as a private in the company of the First Maryland Regiment, commanded by Captain E. R. Dorsey, in which command he served with gallantry until his promotion and appointment as assistant surgeon, in November, 1861. His next service was in the medical corps of the Army of Northern Virginia, and his ability was rewarded by promotion to the rank of full surgeon, by assignment to duty in charge of hospitals as assistant medical purveyor of the army and other posts requiring skill and intelligent business qualities. He was a participant in the first battle of Bull Run, in the battles of the Valley Campaign of 1862, under Jackson, the seven days' battles in front of Richmond, including Gaines' Mills and Malvern Hill, second Bull Run, and Fredericksburg and Spottsylvania campaigns. In one of the battles the young surgeon exhibited his fearlessness. During the thickest of a fight, when shot and shell were tearing heaven and earth, Dr. Latimer noticed one of his comrades 100 feet away fall. Without hesitation he hurried to the spot and discovered that the wounded man had a severed artery. While ligaturing the vessel a shell burst about ten feet away, and the earth was thrown in the air, but when the dust cleared away, physician and wounded man were seen in the same position, and Dr. Latimer was still in the act of tying the artery. His career as a soldier closed with the surrender of Appomattox. Returning to Baltimore in 1866, after a short visit to Porto Rico, he received an appointment as resident physician to the University Hospital, and subsequently located in Baltimore, where his skill and personality soon brought him reputation and success. He gave a large measure of his time and labors to medical institutions, having been connected for many years with the Faculties of the College of Physicians and Surgeons, and the Baltimore College of Dental Surgery. In 1872 he was appointed to the professorship of surgery in the College of Physicians and Surgeons, and filled the chair until 1877. In that year there was a reorganization of the faculty and Dr. Latimer was assigned to the chair of physiology. In 1884 he was transferred to the chair of the principles and practices of medicine, which he held until his death. In 1880 he was elected president of the College of Physicians and Surgeons, attending physician at the Nursery and Child's Hospital, and president of the Clinical Society. He was professor of diseases of children at the Baltimore Polyclinic in 1884, vice-president of the Medical and Chirurgical Faculty in 1882, and president in 1884. As a teacher, he was earnest, faithful, and indefatigable, and he had the power of inspiring those under him to be definite and accurate in their work. In the lecture room he was eloquent, clear, concise, and accurate in all his statements. He had the power of graphically portraying every type of disease in the fewest possible words, and in his choice of language there was always evidence of a cultivated and literary mind. In his private practice his zeal, fidelity to duty and conscientiousness caused him to be appreciated as few physicians have been. His life was ruled by the highest sense of duty. In private life Dr. Latimer was known to his friends and associates as possessing a gentle and generous nature and the willingness to serve at all times those who needed his assistance regardless of pecuniary reward to himself. He gave his service without reserve and was a doer of good. Dr. Latimer never married, his nearest relatives being three sisters who live in Pennsylvania. Among the pall-bearers were the following of our alumni: Dr. Charles F. Bevan, class of 1871; Dr. Samuel Theobald, class of 1867; Dr. James McH Howard, class of 1869; Dr. I. E. Atkinson, class of 1865; Dr. W. C. Kloman, class of 1855.

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"PLACENTA PRAEVIA."

BY LOUIS M. ALLEN, M. D.

Associate Professor of Obstetrics in the University of Maryland.

The formation of Placenta Praevia occurs when the ovum becomes attached to the uterine mucosa in the immediate vicinity of the internal os.—*Primary Placenta Praevia.* It may also occur with higher attachment of the ovum, where from unusually large placental area, the lower segment is encroached upon.—*Secondary Placenta Praevia.*

In the arrangement of the vascular supply of the uterus, the central points on the anterior and posterior walls are particularly fortunate, as it is here that the four great arterial trunks (2 uterine and 2 ovarian) unite. That the function of the uterine mucosa is most energetic at these points, and diminishes as we approach the three openings into the cavity of the womb (2 tubal and 1 cervical), has already been observed in the menstruating uterus. Here it is that the mucosa is thickest and richest in glandular structure, becoming gradually thinner towards the angles, especially the lower one, although less so towards the tubal openings. This condition is especially noticeable when we examine a uterus that has recently aborted. Here the decidna is thickest in the upper division of the uterine body, and especially on the spot where the ovum made its nest. At the angles the mucosa is thinner and often presents merely a loose meshwork of tissue that can be easily pulled apart. The change of mucosa into that of the tube is a gradual one, while the line of demarcation from that of the cervix is tolerably sharp. It is easy to conclude from this, that the middle of the anterior and posterior walls of the uterus offers the best source of nourishment for the developing ovum. "Holtzapfel," by palpation of the uterine ligaments and inflation of the amnion, determined the location of Placenta to be decidedly more frequent on the anterior and posterior wall, but not on the side, and only occasionally in the fundus or tubal angle. In 188 autopsies the Placenta was located on anterior wall in 77 cases; on posterior in 93; right side in 12; left side in 8. Similar observations have been made by Caruso, Tridondoni, Leopold, et al. As thus far no impregnated human egg has been found before being imbedded in the uterine mucosa, observations had to be made on animals, and here it has been established that the imbedding of the ovum in the mucosa is an active process of the egg. "Graf Spee" has observed that the ovum in the porpois sends out branches directly into the maternal mucosa, and after the positive findings of Peter, the term Decidua Reflexa is retained for the want of a better one, but it no longer has the same significance. Just why the ovum should select these particular spots we do not know. The union of maternal and foetal cells depends upon certain chemical relations and molecular conditions, of which we are ignorant. This law of relation, however, is not invariable, as the ovum may exceptionally find other nutritive areas, e. g.—the tube and lower uterine segment. In general it may be said that such faulty attachment is due to an error in those conditions that should bring about the more normal insertion, which, in Strassman's opinion is essentially dependent upon the nutritive properties of the soil in which the ovum is to be implanted. If one denies this active role of the ovum in selecting its site, and asserts that it is passive and that its point of attachment is determined by purely anatomical and mechanical conditions, it would seem that the region of the internal os would be its most natural and normal location; indeed, as the calibre both of uterine end of the tube and the os uteri internum measures more than the diameter of the ovum, the egg should be lost entirely. The ideal attachment of the ovum and its corresponding form of Placenta in the human race occurs but exceptionally, and is seen only when the egg attaches itself exactly in the centre of the anterior or posterior uterine wall.

When the ovum is somewhat removed from this most favorable nutritive area, it is still reached by a sort of compensatory vascular distribution, as is seen in marginal and belamentous insertion of the cord. Even when the ovum is completely covered by villi (Holochorial stage), the basal chorion (C. Frondosum) corresponding to the point of attachment of the ovum to the uterine mucosa, is developed far more than over the rest of the ovum (C. Saeve), for this point is the best nourished and the best protected. Larger maternal vessels supply this area and there is greater functional activity here at the seat of the future Placenta than elsewhere. The remaining villi over the surface of the ovum become less active and gradually atrophy, until a distinctly circumscribed organ of nutrition, the Placenta, is formed. We see indeed in the external form and lobes of Placenta in the course and ramification of its vessels, the very best arrangement for procuring nourishment for the foetus. While the ovum may adhere to almost any part of the tubal or uterine mucosa, only certain parts, as we have seen, are well adapted to its nutrition and growth, and when not located on these particularly favorable parts, the attempt of the villi to reach this more nutritious soil, either by spreading out over a larger superficial area or burroughing deeper into the substance of the uterine mucosa, Strassman terms ovular or chorionic "Trophotropism." By this term he wishes to indicate: 1. That the ovum preferably seeks this anatomically more favorable spot. 2. That here the most suitable location for the Placenta is found. 3. When this nutritive soil is not used primarily, it will be drawn upon secondly as far as possible. This "Trophotropism" is applicable to the ovum from the moment of its attachment to the uterine mucosa; indeed the activity of the ovum in mammalia begins as soon as the zona pellucida disappears. (The first evidences of activity afforded by the ovum in attaching itself will be slight, but we can imagine that even from the very first a certain selective affinity exists between the egg and this mucosa, by which a spot will be chosen for its attachment not far from the uterine ostium of the Fallopian tube, near the middle of the interior surface of the body of the uterus.) For the earlier stages of ovular development probably any surface affording a place of attachment for the chorionic villi may prove sufficient, such as is found inside the uterus, the tube, and possibly even inside the graffian follicle. But for its further development the probability of its reaching the end of pregnancy diminishes in proportion to the unfavorable nutritive quality of the soil in which the ovum is imbedded. Hence the rarity of tubal pregnancies going to full term, and the frequency of uterine abortions in abnormal developments. That the chorionic villi find a heterotopic attachment in the lower uterine segment, and that only exceptionally does this comparatively poor nutritive soil hold the deeply-lying ovum—must be either because in a given case the mucosa of the body of the uterus is less adapted to this end, or that of the lower uterine segment more. It has also been observed that marked fertility and rapidly recurring pregnancies, by exhausting the nutritive soil, predispose to the occurrence of Placenta Praevia. Strassman observed that when Placenta Praevia occurred in primipura it was those advanced beyond the age of 25 years, i. e. (beyond the time of greatest fertility), and with multipiral it was in those at various advanced periods of life. In general, incongruence of age and number of child births disposes to Placenta Praevia. Pohl noted that over one-third of all his cases of Placenta Praevia offered an endometrium over 35 years old. These changes in the endometrium collectively considered as endometritis, have long since been recognized as disposing to Placenta Praevia, and also may be mentioned in this connection, Cervical lacerations, Prolapse, Retroflexio Uteri Gravidi, Syphilis, Myomata, Intra Uterine Manipulations, and operations such as the manual removal of the Placenta. From the foregoing, it may be concluded that from the unusual demands made upon the uterus, by multiple pregnancy, this condition disposes to the occurrence of Placenta Praevia. Even here it is not so frequent as might be supposed—out of 231 cases of Placenta Praevia 4 women had twins—1.73 per cent., and all 4 had the partial variety. Shonewald, however, found 3 cases of twins in 55 cases of Placenta Praevia, showing the varying results of statistical evidence. Out of 77 cases of Placenta Praevia 7 mothers had had twins 8 times before, and one of these mothers was herself a twin. In these cases of course the endometrium must be severely taxed, but as yet, we know of no permanent evidences by which the Placental site of former pregnancies may be recognized. From the clinical evidence at our disposal we are only justified in concluding that by multiple

pregnancy the nutritive quality of the endometrial soil is diminished and thereby disposes to the heterotopic development of chorionic villi in subsequent pregnancies. Two cases of Placenta Praevia occurring in women the previous subjects of tubal pregnancy are cited to show some causative relation between these two conditions. From what has been said, it might be expected that one Placenta Praevia disposes to another in the same patient in a subsequent pregnancy. Here, however, statistical evidence is difficult to obtain, for in the first place, obviously all primipiral must be eliminated, and even in multiperal, Placenta Praevia generally marks the last pregnancy, for a woman will resort to any expedient to avoid the repetition of such a risk to her life as Placenta Praevia. Strassman, however, was able to collect from the Charite Ploliklinic records 95 cases of Placenta Praevia in 7 of which —7.36 per cent.—the women had successfully passed through a previous pregnancy, complicated by Placenta Praevia. Pohl had 9 such cases, and Fitzpatrick records the case of a woman 36 years old who had been pregnant 14 times, of which 9 terminated in spontaneous deliveries, and then 5 consecutive times Placenta Praevia occurred in 3, out of which 5 pregnancies, Fitzpatrick delivered her himself, while the remaining two terminated in abortion. Moreover, the frequent attachment of the Placenta to a given site on the endometrium may ultimately so effect (by vascular and chemical changes) that site as to render other parts of the uterine mucosa more favorable for the requirements of Placenta, hence the use of the lower segment, and the development of Placenta Praevia. This ectopic site, however, may not prove sufficient for the ultimate requirements of the developing ovum, and consequently early interruptions of pregnancy are the direct result of the nutritive and topographical errors in Placenta Praevia. It is well known that Placenta Praevia has been ascribed to the development of chorionic villi upon the capsularis outside of the basilis. From the preparations which were studied by Hofmeyer and Kaltenbach, there can be no doubt that such a condition may also occur in the latter months of pregnancy. The growth of the chorionic villi in the capsularis only indicates the effort of the ovum to avail itself of every source of nutrition. This is especially well seen in the Placenta of ectopic pregnancies. S. is of the opinion that the importance of the capsularies in Placenta development has been overestimated. As has been shown by Olshausen and Veit, he believes there is some ground for the view that in diseased conditions of the basalis (endometritis, etc.) the ovum may offset this nutritive deficiency by at least temporarily obtaining some of the food supply from the capsular mucosa.

Morphology:—Seeking an explanation of Von Herrf's conclusions, (formation of primary and secondary Placenta Praevia) S. considered that both the appearance and form of the Placenta must change when it cannot become attached to its normal site, or when being so attached, this site is altered by disease. As the development of an organ is influenced not only by its parenchymatous growth and the food with which it is supplied, but also by the peculiarities of its neighboring organs, so the Placenta, at least as regards its external form, is affected to a certain degree by the condition of that part of the uterus to which it has become attached, there being a constant struggle both for food and developmental space. Peculiarities of form, size and shape, etc., constitute an attempt to compensate for nutritive disturbances, and conditions interfering with such compensation (endometritis, abnormal uterine positions, etc.) dispose to untimely interruptions of pregnancy. In general the developing cotyledons of the deeply attached ovum are not adapted to the making of the discoid form of Placenta, and thus we find with Placenta Praevia exceptional forms resembling those in the lower animals. Therefore all varieties from the round form of Placenta, with central implantation to the most irregular type, should not be regarded as accidental, but rather as due to topographic conditions. The enlargement of the Placenta as a cause of its praevial insertion, was described by Hegar and Kaltenbach. The real cause of this enlargement, however, depends upon abnormal trophic conditions, and is very probably compensatory, the organ seeking to make up in size what is lost in the deficient nutritive conditions afforded by the uterine decidna in the lower segment But for this anatomico-physiological compensation in Placenta development probably more fruit would be lost. This compensation pertains both to the area covered by the villi, and the depth to which they penetrate into the uterine decidua. E. G.—The average normal size of the Placenta is 15x15 c. m.—225 sq. c. m., Large: while Praevia Pla-

centae have been known to measure 23x18 c. m.—414 sq. c. m.

30 x 22.5 c. m. = 675 sq.: and a double

Placenta Praevia $\left\{\begin{matrix}29 \text{ x } 24.5 \text{ c. m.} \\ 24.5 \text{ x } 10.5 \text{ c. m.}\end{matrix}\right\}$ = 958 sq. c. m.

This intimate connection of a foetal tissue with so large a uterine surface accounts for the fact that Placenta Praevia are often abnormally adherent and require manual separation. When the ovum settles in the lateral angle of the lower uterine segment, or directly over the internal os, then will both anterior and posterior wall be equally taxed for nutritive materials, and the zonal or girdle form of Placenta Praevia be produced. By stretching an atrophy at the point of funic insertion, there may be produced the accessory Placenta Praevia; and finally the Placenta Praevia Duplex; and even Triplex. Another form is the diffuse Placenta, (Placenta Membranacea Praevia) a holo-chorial villous development resembling that of swine, hippopotomi, etc., and the non-decidual mammalians.

The Placenta of a woman the subject of endometritis, shows numerous wasted areas and infarcts as evidence of decidual and chorial degeneration, a condition that may be seen in a less degree on many Placenta, but when existing to any marked degree, may cause the death of the foetus and miscarriage. On the diseased areas, no villi develop, and thus owing to the numerous areas of chorial degeneration, little islands of Placental tissue spread out over a large area, giving the Polycotyledonous form of Placenta not unlike that in the herbional. It is very evident by comparison that a marked similarity exists between the Polycotyledonous Placenta of ruminants, e. g., the antelope, and that of man. S. maintains that the various mechanical and trophic conditions of the uterine walls influencing Placenta Praevia are quite sufficient to explain its varied forms, so closely resembling those of the lower animals, (cow, antelope, ape, orangoutang, etc.) without the necessity of resorting to the theoretical explanation of a retrograde atavism. Finally it should not be forgotten that infarcts may cause atrophic changes in the villi supplied by such vessels, and thus influence the form and shape of the Placenta.

"CONCERNING THE INSERTION OF THE UMBILICAL CORD."

As early as the fourth week, the umbilical cord is formed from the ventral stalk of the embryo, which conveys the blood vessels, and its length is proportionate to the development of the embryo. Its insertion corresponds with the attachment of the ovum, or at least occurs very early with the development of the embryonal ventral plates. The point of insertion of the cord into the Placenta, is to be regarded as the point of first vascular supply to the ovum from the side of the foetal attachment. At the point of first vascularization of the villi there is also greater development of the villi, the so-called basal chorion, which indicates the site of the future Placenta long before its formation. The villi and their contained vessels are better developed the nearer they approach the insertion of the cord in the Placenta. If the villi find the conditions in all directions about the point of attachment of the ovum equally favorable for their nutrition and development, then there will be a round Placenta with central insertion of the cord. (The eccentric insertion of the cord is due to the fact that as the ovum enters the uterine cavity from the side it becomes nested before it reaches the centre of the anterior or posterior wall, and the vascular villi develop growing toward the life-giving stream). The in other directions, not unlike the root of a tree growing toward the life giving stream). The further the original attachment of the ovum takes place from the centre of the anterior or posterior uterine wall, so will the insertion of the umbilical cord be removed from the centre of the Placenta, and inasmuch as the villi grow from their original point of attachment towards the most nutritive spot, there will consequently be produced a marginal insertion of cord, or more correctly, there is a marginally disposed Placenta about the funic insertion. When to this active outgrowth of the villi the distention of the ovum, by virtue of its rapidly increasing contents is added, the Placental insertion of the cord is so far pressed aside as to produce a velamentous insertion. That the marginal and velamentous insertions originally belonged together and were one, can be readily determined by the course of the large blood vessels. The velamentous insertion is therefore simply the result of an unfavorable attachment of the ovum, and on account of those villi in the immediate vicinity of the point of funic insertion, together with the distension or stretching of this particular segment of the ovum from increasing intra-ovular contents. In other words, it is an ac-

quired condition, and without secondary atrophy of the chorionic villi, is inexplicable. Besides the velamentous and the praevial insertions, there are also transitional forms, such as "Insertio Funiculi Umbilicalis Praevia," and "Vasa Praevia." These conditions, while apparently only of theoretical interest, have an important practical value. It has already been observed that the nearer the insertion of the cord, the larger the vessels, and the further removed from the cord, the smaller the vessels. Now, for example, take the case of high imbedding of the ovum where it secondarily becomes Praevia. The greater part of the Placenta lies beneath the point of funic insertion, and the blood vessels course downwards. In this case the portion of the Placenta that is Praevia, or adjacent to the internal os., is the part containing the least blood supply. Clinically speaking then, it is much more favorable, as pressure and separation will cause a minimum amount of hemorrhage. In the other case—deep funic insertion—the Placenta grows away from the lower segment—Placenta Praevia ascending—the point of funic insertion, and consequently the large vessels are near the internal os., and separation will cause a greater hemorrhage. In the above mentioned Transitional forms, especially the "Vasa Praevia," the life of the foetus is in great danger, for it is evident that in such a case the membranes must rupture, either in the vicinity of, or directly upon the velamentous vessels, and a maximum amount of hemorrhage will result.

SUMMARY.

On account of what may be termed the tropho tropionic—trophotaxic peculiarities of the chorionic villi does the ovum preferably seek for its point of attachment the most favorable nutritive soil, which is usually the anterior or posterior uterine wall. When, for some of the reasons given above, this locality has been so changed that part of the uterns around the internal os. offers a more fertile soil, the ovum lodges at this point and Placenta Praevia results. This is Primary Placenta Praevia. The ovum may lodge in its usual locality, and not finding sufficient nourishment will seek this by growing toward it, and if this more fertile soil happens to be near the internal os., Placenta Praevia will be the result—this is the secondary form. To the very last degree is the form and development of the Placenta dependent upon chemical and physical causes. The chemical causes refer to the relation of the foetal to the maternal cells: the foetal being the more active as they are constantly struggling for nourishment from the soil in which they are implanted. The physical causes pertain to the form of the uterine cavity as corelated with the space in which the Placenta must come to lie. Therefore upon anatomical grounds we may have several forms of Placenta Praevia. By considering the point of insertion of the umbilical cord, we may determine the primary attachment of the ovum the starting point of the embryonic coverings and that of the entrace of the foetal vessels. The course of these vessels indicates just how the Placenta acquired its growth and shape. The examination of the Placenta and its vessels is therefore of the greatest importance in a proper understanding of the after birth, and it is as important to observe whether the vessels are ascending, descending, or zonal, as to know that they are afferant or efferant. Different varieties of funic insertion correspond to different types of Placenta Praevia, even th evelamentous insertion not being excluded. When the insertion of the cord is in the lowest angle of the internal uterine surface, it can, in the course of development become so influenced by the stretching of the membranes that after the beginning of labor, it seems to lie directly in the center over the intrnal os., giving the so-called "Insertio Funiculi Umbilicalis Praevia." In the angular Placenta, both the marginal and the velamentous insertions are the necessary results of the peculiar functional activity of the ovum. The villi stretch out from the laternal angle of the uterine cavity over the anterior and posterior walls, giving rise to various shapes and forms of the Placenta. The vessels may develop in the form of a girdle, giving the zonal Placenta more or less complete. Even the small slit of the internal os. does not absolutely prevent Placental growth at this point, although the effort of the villi to avoid it can be seen by the corresponding area of comparatively thin and degenerated Placental tissue. We should not, therefore, classify Placenta Praevia according to metric measurement, but rather from a clinical standpoint, at least according to the encroachment of the chorionic villi upon the lower pole of the ovum, and the corresponding so-called passive lower leterine segment, which will be dilated during porturition.

FOUR CASES OF OVARIAN CYSTS PRESENTING RARE CONDITIONS.

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The following cases of Ovarian cyst have been selected from those operated upon by Prof. T. A. Ashby during his service of the past year. They are interesting and instructive since they present characteristics quite different from the usual cystic tumors of the ovary. These characteristics do not appear in the structure and size of the tumor, but in their behavior and the dangerous symptoms presented by them in each case. The diagnosis was made in each case prior to operation.

Case 1. Ida W., single, age 27, colored, was admitted to the University Hospital November 17th, 1905, and assigned to the Surgical ward. One year previous she first noticed an enlargement of her abdomen, which gradually increased in size until it became enormously distended with fluid. About two weeks prior to admission a "sore" made its appearance on the great toe of left foot. This rapidly extended until the whole foot was involved. A few days later the right foot became involved in the same manner. There was no history of trauma or frost bite. Both lower extremities were in a gangrenous condition, the line of demarcation on the left leg extending above the ankle and on the right foot nearly up to the medio-tarsal articulation. The condition of the patient was deplorable. She was greatly emaciated, very feeble, with temperature 101 4-5 degrees Fahrenheit, pulse 124. The only explanation for gangrene of both lower extremities was found in the pressure of the tumor mass within the abdomen upon blood supply to the lower extremities. Owing to the feeble condition of the patient the surgeon, Dr. Randolph Winslow, to whose service she had been assigned, first aspirated the cyst and drew off some three gallons of fluid, with temporary relief to the patient. On November 27th, Dr. Winslow amputated the left leg just above the ankle joint and did a Chopart operation on the right foot. For a time the stumps granulated well and the condition of the patient improved. The cyst began to fill rapidly and with its increased size the amputated stumps again showed signs of low vitality and poor repair. The patient was then referred to the gynecological department, and on December 9th Dr. Ashby removed a large thick wall cyst of the ovary filled with thick slimy fluid, somewhat infected from the aspiration. After the removal of the cyst the stumps granulated rapidly, so that the patient was discharged from the Hospital on January 13th, 1906, entirely cured and in good health. The occurrence of gangrene of the lower extermities from the mechanical pressure of an intra-abdominal tumor has not been observed in the Hospital records, and it is difficult to explain the relation of cause and effect in this case upon any definite principle apart from local conditions in the circulation of the lower extremities in this unusual case.

It is no doubt probable that the early removal of the ovarian cyst prior to the occurrence of the gangrene would have prevented the loss of the lower extremities, and we may regard this as another condition calling for the removal of intra-abdominal tumors in their primary stages of development.

The following cases furnish additional evidence of the dangerous behavior of ovarian tumors when left undisturbed until alarming symptoms are occasioned by their presence.

Case 2. Mrs. P., aged 35, mother of five children, was admitted to the University Hospital January 19th, 1906, at 6 P. M. She had been sent to the Hospital by Dr. Ashby for an immediate operation, as she had been seen by him for the first time at 3 P. M. of the above date.

History. This patient was delivered of a full term living child on January 11th, after normal labor. Until January 16th, she had a normal puerperium, and was apparently doing well. She was seized with a chill, followed by high temperature, which her physician attributed to a puerperal infection. Examination of her uterus presented no evidence of intra-uterine infection, but her abdomen was greatly distended, tympanitic, painful on pressure and showed signs of general peritonitis. The patient was a large, fleshy woman, and the tympanitic distension masked the underlying condition.

When Dr. Ashby saw the case in consultation at 3 P. M. he diagnosed the condition to be a large ovarian tumor with twisted pedicle, gangrene of tumor, general sepsis and peritonitis. The patient had at that time a temperature over 100 degrees, rapid, wiry pulse, and was critically ill from sepsis. An immediate operation was urged and the patient was admitted to the Hospital at about 6 P. M. The operation was per-

formed as soon as preparations could be made, about 7.30 P. M. After making the median incision the tumor about the size of an adult head was found in a semi-gangrenous condition, rotated on its pedicle as previously diagnosed. The abdomen contained a quart or more of foul smelling, bloody serum and lymph deposits. A general septic peritonitis was in full force. The removal of the cyst and cleaning out of the abdominal cavity were attended with no delay or difficulty, but the septic process was not arrested and the patient died during the night. Had this tumor been removed twenty-four hours earlier it is highly probable that the life of this patient could have been saved. Ovarian tumors complicating pregnancy are not uncommon, and this condition of rotation of the pedicle should be borne in mind as a dangerous development not only during pregnancy, but at any period in the life history of such tumors.

Case 3. Miss S., age 20, single, white, was admitted to the Hospital March 11th, 1906, at 6 P. M. with the following history: During the previous month, while playing, the patient fell, striking her abdomen with considerable force. From that time she began to experience soreness and discomfort. On March 4th the intra-abdominal pain became more violent, but somewhat subsided under rest and local applications. The family physician was called to see her for the first time on March 7th. He made out a distinct intra-abdominal tumor, but from the symptoms present in the case assumed that she had a typhoid fever developing. Whilst waiting for a report from an examination of the patient's blood, the tumor disappeared during the night of March 9th, from sudden rupture of its sac wall and escape of sac contents into the abdominal cavity. Symptoms of peritonitis at once set in, and when Dr. Ashby was called to see the case at 4 P. M. March 11th, he found her critically ill from peritonitis and sepsis. He diagnosed a ruptured ovarian cyst with sepsis and advised an immediate operation. She was sent to the University Hospital as soon as arrangements could be made. Her temperature when admitted at 6 P. M. was 103 3-5, pulse 140, and very weak. The abdomen was opened at 7.30 P. M. A large multilocular cyst of the left ovary was removed, as also a smaller one of the right ovary. The abdominal cavity was filled with over one-half gallon of dark disintegrated blood clots, which had escaped from the ruptured cyst. This was removed by flushing out the cavity with large quantities of sterile hot water. Both ovaries were removed and the stumps carefully tied and covered. The peritoneum was covered with lymph deposits and was in a state of active inflammation. Owing to the condition within the abdominal cavity it was deemed best to close the wound with a large gauze drain.

When returned to bed the patient had no radial pulse, although normal salt infusions and strychnia were used freely. After twenty-four hours she began to recover from the shock and made a safe recovery, leaving the Hospital on April 25th.

This case is unusual from the age of the patient and behavior of the tumor. She had two well developed ovarian cysts, the left holding over one gallon of chocolate colored material and the right about one quart. Rupture of the right cyst had occurred, and but for the cleaning out of the abdominal cavity the patient would have died within a few hours.

Case 4. Mrs. H., age 37, white, entered the University Hospital March 14th, 1906, suffering from a large intra-abdominal mass. She first noticed the enlargement of her abdomen about one year ago, and at that time was told that she was pregnant. It continued to grow larger and larger, and in June last she was examined in the University Hospital and told that she was not pregnant, but had a tumor. She was advised to come into the Hospital and have it removed. She did not follow this advice, however, but undertook by means of patent medicines to reduce the tumor. These medicines, together with opium, which she used freely, greatly undermined her health, the large cyst also draining her system. On entrance to Hospital patient was very much emaciated, complexion sallow with the characteristic anxious expression present about her face. She had had a very good appetite. Rest had been secured by the use of opium, of which she partook great quantities. Pulse was of good tone, rate varying from 90 to 105. Temperature 97 3-5. Respiration 24, very shallow. Lungs were compressed, causing great discomfort on breathing. Patient had hacking cough, dry ropy mucous expectoration. Large mucous sonorous rales could be heard all over both bases and particularly over the bronchi. Heart negative. Her abdomen was very much distended, tense and dull on percussion over front and sides. Slight tym-

panites in upper left quadrant. No pain on pressure. At some points hard nodules could be felt, though for the most part the cyst wall was smooth and tense. On vaginal examination cervix found to be hard and small. Only the lower portion of the uterus could be made out; this was found about normal in size. The mass of firm consistency completely filled the pelvis. Patient was prepared for operation in the usual manner, and when the abdomen was opened a large mass was exposed adherent in places to the abdominal wall. The thick colored material which filled the cyst was drawn off by means of a trocar before the cyst could be removed. It was multilocular, the fluid in the different sacs varying somewhat in shade from light to dark green. The consistency remained the same. When weighed the cyst wall and contents weighed 50 pounds. Patient made a rapid recovery; cough cleaning up. Breathing became much easier and rales in great part disappeared. She took on flesh and general appearance improved greatly. She was discharged April 2d, 1906.

This case is of interest from the large size of the tumor, extremely emaciated condition of the patient, and rapid recovery of health after the removal of the tumor.

REPORT OF A CASE OF PSEUDO TUMOR OF THE BRAIN.

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In the latter part of February, 1906, I examined a patient in whom I made a diagnosis of tumor of the brain and localized the same in the posterior part of the parietal or the anterior part of the occipital lobe of the left side of the cerebrum. The patient was sent to me by Dr. E. E. Gibbons, Chief of Clinic of the Eye Dispensary of the University of Maryland Dispensary, who had had the man under observation for several months. He had made repeated examinations of the patient and made a probable diagnosis of tumor of the brain. The patient came to me in the Nervous Department of the University of Maryland Dispensary, complaining of headaches, dizziness, loss of vision and nausea.

History: F. B. Aged 23; sailor; single.

F. H., Father, has been markedly alcoholic for the past thirty-one years, has had several attacks of delirium tremens and also gives specific history. Mother has had one miscarriage; all her children were sickly. One aunt died of tuberculosis; one uncle insane at the age of 17 years; one brother very nervous. Two sisters dead, one of diphtheria, one of typhoid. Patient's birth was normal. Teethed, walked and talked at the proper period.

P. H., At the age of three years, had an eruption on the body and inability to void urine. Difficulty in walking; duration one month with perfect recovery. Measles at the age of 8 years, loss of speech for three or four days, but recovered. Abscess of the jaw at the age of nine years. At the age of ten years went to school, remained for three years. From the age of fourteen until the age of sixteen worked in canning factory. At the age of sixteen worked on the water, rowing boats until his eighteenth year. From 18 until 22 worked at Druid Hill Park. Has always been steady and brought home to his mother any money which he earned.

Present History: Patient had cough in June, 1905. In October first began to notice impaired vision. Intelligence became impaired, speech stammering in character. In December patient had trouble in getting around. Stopped work on account of impaired vision. In January began to complain of frequent headache. For the past month complained of frequent attacks of nausea and dizziness, not followed by falling, but there was a tendency to stagger; also became very forgetful. Mother says that his intelligence has failed very much in the last two or three months.

Physical Examination, March 2, 1906: Duration of disease not obtainable from patient. Speech slow and uncertain; memory poor. Expression rather apathetic. Nutrition and development good. *Motor functions.* Extensors and flexors of upper extremities and shoulders fairly good; slightly weaker on the right side (patient is left-handed). Flexors and extensors of lower extremities are good. *Reflexes*: Deep knee reflexes very much exaggerated. Tendo Achilles about normal. Triceps reflex exaggerated on both sides. Wrist reflexes both present. *Superficial reflexes*: Plantar reflex exaggerated on both sides. Babinski negative on both sides. Cremasteric and abdominal reflexes are exaggerated. No clonus elicited. Kernig's sign is negative. Coordination of the upper extremities fairly good. In the lower extremities coordination is poor, better on the left

than on the right side. Rectal and vesical reflexes are not altogether under patient's control, due more to mental indifference than to actual loss. *Abnormal movements*: Fine fibrillary tremor of fingers and tongue and occasionally he has irregular spasmodic movements of both legs. *Sensory functions*: Tactile sensation about normal. Muscular sense practically normal with the exception of right foot where it is somewhat impaired. Pain sense practically normal with the exception of slight obtundation of the right foot. Temperature sense, normal. Pain is complained of in head. Abnormal sensations. He complains of numb feelings in both hands and legs, but points more toward right arm and leg. Patient feels as if he had no head and head feels numb and empty. Complains of a great deal of giddiness. Head feels as if it were always going round. No trophic or vasomotor disturbances. Romberg, negative. Gait, very uncertain, but not reeling, due more to loss of vision than any motor disturbance. *Cranial nerves*: Olfactory, markedly obtunded. Second, third, fourth and sixth examined by Dr. Gibbons, who sends the following report: Progressive simple optic atrophy, not preceded by choked disc. Vision, very poor. Patient unable to count fingers held before the eyes. Ocular muscles are normal, pupillary reflexes, light, consensual and direct sympathetic, and accommodation, all present and active. The left eye was affected before the right. *Fifth nerve*: (trifacial). Some weakness of the motor branch in the right side. Sensory branch seems normal. *Facial*: Some weakness on right side. *Eighth auditory*: When he lies down complains of ringing and singing in his ears, more marked on the right side. Ninth, tenth and eleventh seem normal. Twelfth (hypoglossal). The tongue seems to be protruded in the middle line. *Mental symptoms*: There is extreme difficulty in holding patient's attention; marked retardation of thought with an occasional silly and senseless laughter. *Throat*: Pharynx and uvula swollen and congested. There is a granular, nasopharyngitis. *Chest*: Well formed, costal angle about 45. Slight prominence over upper part of the right front. Expansion, good and equal on the two sides. Percussion note clear. Respiratory sounds, normal. *Heart*: P. M. I. not visible. Sounds best heard over the fifth interspace inside nipple line. Sounds at base and apex are clear. *Pulse*: Volume, small, force, tension and rhythm, fair; rate 75-90. Temperature normal throughout time of observation. *Abdomen*: Soft and nothing abnormal noticed. Hepatic flatness begins in about the sixth rib, extends to costal margin. Liver and spleen not palpable. Inguinal glands, slightly enlarged. Genitals appear normal.

On examination of vocal cords they appear normal. After examination and observation of the patient for about two weeks from March 1 to March 15 in the hospital, and after vigorous anti-syphilitic treatment, which was instituted without improvement, but with progression of symptoms, an operation was advised. This was refused and patient left the hospital. He gradually became weaker, and in the early part of May, 1906, or about six weeks after he left the hospital, he died.

Permission for a partial autopsy was obtained and the brain removed. The following is the report of Dr. Hirsh, Director of the Pathological Laboratory of the University of Maryland: The autopsy was performed, three days after death, the body having been embalmed. Nothing but the brain could be removed. The brain has a strong odor of formalin and the blood vessels are apparently injected with this fluid. Nothing abnormal is to be noted about the meninges. The brain is very well preserved and externally shows no alterations. The entire brain was sectioned in the usual manner and every part thereof was carefully examined, and as far as could be made out there was no deviation from normal. Sections were taken from various parts of the brain for microscopical study, which at the time of this report have not been completed, although they show nothing which would lead one to believe that they would be otherwise than normal.

Cases very similar to this occur in literature. Nonne *(Deutsch Ztschr. f. Nervenheilkunde, 1904, XXVII, 169) reports 14 somewhat similar cases, some of which recovered completely after a positive diagnosis and localization of cerebral tumor had been made. Others, one operated upon without finding a tumor, and afterward complete recovery. Others that revealed no evidence of tumor at autopsy. Englehard *(Munch. Med. Wchnschr., 1900, No. 36) reports a case very similar in a girl 18 years of age in whom a tumor of the brain was diagnosed, localized in the posterior parietal lobe, who refused operation and died at the expiration of about 15 months after the first appearance of symptoms. Autopsy revealed only an intense

anaemia. Oppenheim regards these cases as cases of localized encephalitis. Gowers also regards these cases as general cerebritis. On page 170, 1904, Vol. XXVII of the Ztschr. f. Nervenheilkunde, is an extract of a letter written by Strumpell to Nonne. "I have seen many cases of severe cerebral disease that I have thought to be tumor or some organic brain disease that eventually completely recovered and remained well. Among these cases there were several with choked disc. Other experienced neurologists have undoubtedly seen similar cases. I have frequently spoken with Erb concerning these cases. I cannot explain them, nor do I know their significance. There also occur cases that die with symptoms of tumor of the brain and at autopsy show nothing."

X-RAY IN FRACTURE.

By Nathan Winslow, A. B., M. D.
Skiagrapher to the University Hospital.

Since the introduction of the X-Ray apparatus into the University Hospital it has been the rountine practice to subject all fractures after reduction, and all obscure bone and joint injuries where the diagnosis is doubtful to an X-Ray examination. By this practice many indefinite bone lesions have been accurately diagnosed and in some instances the patient saved weeks of inconvenience from retentive dressings and confinement to bed. As fractured femurs are immobilized for 10 to 12 weeks an improper diagnosis means considerable loss of time and earning capacity to the afflicted party. Not only then in the detection of suspected fractures, but also in the treatment of actual fractures have the X-Rays been found of immense value. For many times after breaks have been apparently reduced a skiagraph shows mal-apposition. Formerly a week or two was allowed to elapse before the surgeon deemed it wise to remove the initial dressings to investigate the condition of the fracture for fear of displacing the fragments. But now without any interference with the retentive appliances, immediately after the reduction a shadow picture is obtained and the surgeon knows within 24 hours the exact position of the fragments, thereby saving the patient at least two weeks if the fracture has to be reset and himself much unnecessary worry. Even in cases of vicious union the skiagraph gives valuable information as regards the position of the fragments and a line upon the treatment to be pursued in the correction of the deformity. Moreover every negative is preserved so as to be a protection to the surgeons in those mal-practice suits so frequently instituted by unscrupulous, irresponsible patients.

Indeed, I cannot urge too strongly upon every physician the importance of subjecting fractures to an X-Ray examination whenever possible before discharging his patients, in order not only to occasionally avoid unjust censure, but also to protect himself against suit.

FORMALDEHYDE AS A GASEOUS DISINFECTANT.*

By Daniel Base, Ph. D.
Professor of Chemistry, Department of Pharmacy, University of Maryland.

In these days when the discussions of medical men in the meetings of Public Health Associations, Sanitary Congresses, etc., are given the widest publicity and circulation in the daily papers and periodicals, even the ordinary layman cannot fail to take note and be impressed with the importance of disinfection. While many efficient liquid disinfecting agents have been known and used for a long time, such as phenol, corrosive sublimate, tricsesol, etc., there are instances where these cannot be conveniently used, as, for example, in disinfecting a room with its wall-paper, curtains, furniture, etc. To wash all the surfaces, nooks and crannies, furniture, etc., of a room with a liquid disinfectant would be a laborious work, not to mention the possible damage to the objects. For room disinfection, therefore, an efficient non-corrosive gaseous agent has long been sought. Although formaldehyde gas is not a perfect disinfectant, it is the nearest approach to it that we have at present. One author† recommends it because, as he says, there is nothing better. Although experimental investigations of its efficiency are still being carried on in numerous laboratories, formaldehyde plays an important role in disinfection of houses, etc., at the present day. It penetrates corners and crevices, does not injure objects or persons, and its unpleasant odor can be removed by injecting ammonia gas into the rooms. It is somewhat

*Read at the meeting of the Maryland Pharmaceutical Association, June 20, 1906.

†Engels: "Experimentelle Beitrage zur Wohnungsdesinfektion mit Formaldehyd," *Archiv fur Hygiene*, 49, 129-199 (1904).

deficient in one respect, namely, the power of penetration. Germs that are covered up by several folds of cloth, paper, cotton-wool, straw, etc., are not easily reached by the gas during disinfection. It appears that formaldehyde is more especially suited as a surface disinfectant.

Although formaldehyde was discovered in the year 1867, the disinfecting power of its solution was first observed in the year 1888 by Loew and Trillat, and in the following year, Buchner and Segale showed that the gas has much greater power than the aqueous solution.

Since Hofmann's discovery of formaldehyde gas, the method of manufacture has been greatly improved, so that enormous quantities are now sent out into the market yearly as an aqueous solution popularly called formalin, which contains approximately 37 per cent. by weight of the gas. In Germany alone over 400,000 kilos (880,000 pounds) are manufactured yearly.

Since formaldehyde gas is to be used in disinfecting rooms, the question arises as to how the gas can be liberated from its aqueous solution. Attempts have been made to solve this problem in various ways. Some experimenters caused formalin to evaporate at ordinary temperatures in a room by various devices, the best of which probably is the method of spraying with formalin large muslin sheets hung up in the room.

The sheet-spraying method has been tested repeatedly with a fair degree of success, but it is cumbersome and a long time is required for evaporation and disinfection. A desideratum in disinfection work is a large quantity of formaldehyde gas liberated in a short interval of time. Dr. Engels in the article cited states that "the total result of all experiments with formaldehyde gas, which is generated by simple evaporation of solutions, is negative as far as practical application is concerned."

An apparatus devised for obtaining formaldehyde gas, not from formalin, however, but from methyl alcohol, is the so-called methyl alcohol lamp, in which the alcohol is in part oxidized to the aldehyde by means of platinized asbestos. The yield of aldehyde is small and the lamps are uncertain in their action and they have been pretty generally condemned.

A far more efficient method of obtaining formaldehyde gas from formalin than by simple evaporation is to heat the formalin in metallic retorts, and to pass the vapor by means of a nozzle into a room through a hole in the door. In one type of such apparatus, the formalin is distilled under ordinary atmospheric pressure, in another type, the pressure is allowed to rise to 3 or 4 atmospheres before the vapor is allowed to pass into a room by opening a valve on the machine. The latter form of apparatus is known as an autoclave, the first one to be devised for disinfecting purposes being that of A. Trillat, of France. In the case of both kinds of retorts, even when the distillation is continued until only a small quantity of liquid is left, less than 50 per cent. of the weight of absolute formaldehyde in the amount of formalin taken enters the room. In experiments carried out by me in the Hygienic Laboratory, U. S. P. H. and M. H. S., Washington, to determine the amount of formaldehyde in a room when changed by various methods, it was found that when charging a room by distilling formalin from a retort under atmospheric pressure till very little liquid was left, an average of about 47 per cent. of the weight of absolute formaldehyde introduced into the retort was present in the room. In the case of the autoclave, an average of about 42 per cent. of the formaldehyde was found in the room.

That not all of the formaldehyde introduced into the retort or autoclave enters the room is due, no doubt, for the most part at least, to polymerization of formaldehyde to solid paraformaldehyde, which is much less volatile than the former. It is a well known fact that when formalin is concentrated, either by evaporation or boiling, polymerization takes place. In order to prevent this change, Trillat recommended a mixture of formalin calcium chloride and water to be used in the autoclave; this mixture was used in my experiments, but apparently it did not prevent the loss of formaldehyde. The experiments were conducted in a large room (2,000 cu. ft.) which was fairly tight and lined throughout with zinc except the two windows. The quantitative determinations were made by absorbing the formaldehyde of a definite volume of air in suitable apparatus and titrating it by the potassium cyanide method. The room contained no objects which might absorb or unite with formaldehyde, and the moisture in the air after charging was always short of saturation, so that it is not likely that formaldehyde condensed on the zinc surfaces. Hence, as the room was fairly tight and the teterminations were begun in about 15 minutes after charging was fin-

ished, the percentages found may be taken to represent approximately the yield of formaldehyde from the two types of apparatus described.

There is an interesting fact that might be referred to here in regard to polymerization of formaldehyde. M. von Brunn* showed that paraformaldehyde is formed, as far as it can be judged by cloudiness or opacity of the solution on cooling, only when formalin is concentrated beyond 40 per cent., but that when solutions of formaldehyde of 20 per cent. or less are boiled or distilled, there is little tendency for the portion in the flask to increase in percentage strength as distillation is continued, and hence no tendency to form paraformaldehyde. Moreover, he found that the amount of formaldehyde in the distillate plus that in the residue of the flask is practically equal to the amount of formaldehyde in the quantity of solution taken, or, in other words, there is no loss of formaldehyde. Accordingly a still has been constructed for charging a room by distilling diluted formalin, which has the additional advantage that an abundance of moisture is produced in the room by vaporization of the large amount of water. It is generally accepted at present that abundance of moisture is an important factor in formaldehyde disinfection. The apparatus is known as the "Breslau Still," having been devised by C. Flugge, of the Hygienic Institute, at Breslau, and is frequently employed in Germany. The strength of the formaldehyde solution employed in this still is about 8 per cent.

Excepting the evaporation of formalin at ordinary temperatures, the methods of obtaining formaldehyde gas from its aqueous solution involve the use of expensive and sometimes heavy apparatus and the application of flame which necessitates care. I will now refer to a method which requires extremely simple and inexpensive apparatus and no heat nor skill on the part of the operator. It has been tested with seemingly excellent results and bids fair to supplant some of the older methods because of its simplicity and expedition. The method was proposed in 1904 by Henry D. Evans, chemist, and Dr. J. P. Russell, bacteriologist, of the Laboratory of Hygiene, Augusta, Maine, and consists in pouring formalin upon fine crystals of potassium permanganate contained in a metallic pail. It is a case of destroying a part of the formaldehyde in order to liberate another part. The permanganate in oxidizing a part of the formaldehyde produces a great amount of heat, sufficient to evaporate nearly all of the liquid. From my experiments, it appears that the lest proportions to use are 100 cc. of formalin to 50 gm. of permanganate. With this ratio approximately 38-39 per cent. of the weight of formaldehyde taken is given off to the air of the room. The action is very vigorous, being practically over in five minutes. All that is necessary to charge a room is to place a large metallic pail of 3 or 4 gallons capacity containing the permanganate in the center of the room, pour in the formalin quickly and close the door securely. It need hardly be mentioned that in practice all cracks of windows, doors, etc., should be stuffed with some material in order to make the room as nearly air-tight as possible. In my experiments the room was charged with 600 cc. of formalin (35.66 per cent. by volume) and 300 gm. of permanganate. After charging, the humidity of the room was still considerably short of saturation. In practice it would probably be necessary to provide a simple still for introducing aqueous vapor into the room in order to bring the moisture nearer to the saturation point, which increases the disinfecting power of the formaldehyde gas. It has been shown that dry formaldehyde gas has very little effect on germs. My experiments were carried out at summer temperature, 69 degrees Fahrenheit or above, and there was no cloudiness in the air of the room after charging with either the retort, autoclave or the permanganate-formalin method. The absence of cloudiness indicated that polymerization of formaldehyde gas in the room had not taken place. But it was shown by M. B. Porch, of the Hygienic Laboratory, Washington, who made experiments in all respects like mine, but at low temperatures, that polymerization of the formaldehyde gas begins at about 62 degrees Fahrenheit, and is more pronounced the lower the temperature as is evidenced by the low yield of the gas in the room and the disposition of paraformaldehyde. Pareformaldehyde as such has no power of disinfection. Hence, when the temperature of a room about to be disinfected is less than 65 degrees Fahrenheit, it should be raised by some heating device before charging with formaldehyde gas.

To conclude this brief article, I might mention what are considered the necessary conditions to accomplish successful disinfection by formalde-

*Formaldehyd disinfektion duerh verdampfung verdunnten Formalius," *Zeitsch. fur Hygiene und Infectionskrankheiten*, 30, 201 (1899).

hyde gas. In many of the earlier investigations, quantitative exactness was often ignored, as a result of which there are many conflicting statements in the literature. During the last six or seven years, attention has been given to the quantity of formalin introduced into a room, effect of temperature, moisture, etc., with a consequent greater uniformity of views. The following are the conclusions of a recent experimenter, G. Werner:* "In all cases, an average of 5 gm. of formaldehyde per cubic meter of space (0.1416 gm. per cubic foot) should be present with seven hours action. In exceptional cases, where loss of formaldehyde can not be avoided, or where numerous objects or a good deal of matter of an organic nature are present in the room, which cannot be conveniently removed, the quantity of formaldehyde should be doubled. In all cases, when the room temperature is below 50 degrees Fahrenheit, it should be raised. 68 degrees to 77 degrees Fahrenheit is an efficient temperature. The strength of the formalin used should be known." Werner employed the "Breslau Still" of Flugge in his experiments and saturated the air of the room with moisture, using a hair hygrometer to determine the latter.

While there seems to be pretty general agreement on the importance of moisture and temperature in formaldehyde disinfection, there is a difference in the statements of various experimenters as to the amount of formaldehyde per cubic meter of space required to insure disinfection. Thus Flugge in an article† six years before Werner's, recommends 2.5 gm. of formaldehyde and seven hours' action. No doubt further experiments under exact quantitative conditions will result in defining within narrow limits the amount of formaldehyde gas per unit of space necessary to bring about certain disinfection.

With the permanganate-formalin method, in which about 38 per cent. of the formaldehyde is given off to the air of the room, it would require 520 cc. of formalin of 36 per cent. by volume for each 1,000 cubic feet of space to produce formaldehyde gas at the rate of 2.5 gm. per cubic meter or 0.07 gm. per cubic foot, the proportions recommended by Flugge.

*"Zur Kritik der Formaldehyd disinfektion," *Archiv fur Hygiene*, 50, 305 (1904).

†"Die Wohnungs desinfektion durch Formaldehyd," *Zeitschr. fur Hygiene und Infektionskrankheiten*, 29, 276 (1898).

NEW BOOKS

Among the books recently announced by the W. B. Saunders Company as "in preparation" is one on "The more prevalent diseases of the eye"—a volume of over five hundred pages, octavo, with nearly two hundred illustrations, in addition to a number of original colored plates—by Dr. Samuel Theobald, of Baltimore, an alumnus of the University of Maryland, and now clinical professor of ophthalmology and otology in the Johns Hopkins University.

The author's aim, as set forth in the preface, has been to produce not a complete treatise upon diseases of the eye, but a book dealing with the commoner ocular maladies, which shall really meet the needs of the general practitioner. Most text-books upon eye diseases, it is pointed out, have been written ostensibly with this end in view; but, as a matter of fact, they have with few exceptions been adapted more to the wants of the physician engaged in general practice, but to the requirements of the specialist in this department of medicine.

In carrying out his purpose the author has given but scant consideration to the rarer affections of the eye, which the general practitioner will seldom encounter; to the more delicate operations, which it is assumed he will not care to undertake; to the ophthalmoscope, which in his hands is not apt to prove a trustworthy means of diagnosis; and to the methods of testing the refractive and muscular anomalies of the eyes, which are regarded as not within his province. On the other hand, the more prevalent diseases of the eye which he must often meet with, the simpler operations which he is justified in performing, and the aids to diagnosis which can but prove helpful to him, are described in detail.

The difficulties with reference to diagnosis which beset the general practitioner in dealing with eye affections are kept constantly in mind, and every effort is made to afford him needed help in this direction. With reference to treatment, the directions are definite and precise, so that even the inexperienced reader, when once he has reached a correct diagnosis, is left in no doubt as to the thereapeutic measures to employ.

Just such a work upon diseases of the eye has not heretofore been written, and it would seem that Dr. Theobald's contribution to ophthalmic literature would meet a long felt want.

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BALTIMORE, MD., JULY 15, 1906.

Dr. F. P. Gates, of Manteo, N. C., writes to the BULLETIN:

"I wish to express through your BULLETIN my gratitude for the pleasant and profitable post-graduate course taken in the University College and Hospital. After twenty years of rough country practice, I feel that I was more than fortunate to have the opportunity to spend a couple of months in a post-graduate course in the University of Maryland. Before I left my home I negotiated with every hospital and medical college in three of our large cities for post-graduate instruction, and the University of Maryland, through her congenial and proficient Dean, offered me the best inducements.

"While away I visited several colleges and hospitals, and I think I am justified in my statement when I say that a doctor who is looking for information and instructions can get more for his money in this institution than any place in our country. I hope to avail myself of the privilege again in the near future. Physicians who want post-graduate instruction will not find a more genteel and courteous corps of professors in any college. To express myself modestly, I must say that I am fully renumerated for my time and money, and am well pleased."

NOTES AND ITEMS

Dr. S. R. Donohoe, class of 1902, has located at Lambert's Point, Virginia.

Dr. Henry B. Thomas, class of 1888, is spending the summer at Blue Ridge Summit.

Dr. J. Homer Hoffman is spending a few weeks at St. Leonard's, Calvert county.

Dr. William Pawson Chunn has taken a cottage at Ocean City, Maryland, for the summer.

Dr. J. Fred Adams, class of 1894, has opened his country home, Glenville, Catonsville, for the summer.

Dr. William H. Buckler, class of 1888, is spending his summer vacation at Narragansett Pier, R. I.

Dr. J. S. Geatty, class of 1906, has been appointed an assistant resident physician at Bay View Hospital.

Dr. Charles Bagley, class of 1904, has been appointed superintendent of the Hebrew Hospital, Baltimore.

Dr. D. A. Medders, class of 1900, has removed to Omaha, Nebraska, where he intends to practice his profession.

Dr. Ridgely B. Warfield, class of 1884, of Baltimore, sailed July 3, 1906, for Europe, where he will spend the summer.

Dr. Hiram Woods has sailed for Europe and will spend three months visiting Italy, Switzerland, France and England.

Dr. William E. Wiegand, class of 1876, of Baltimore, has taken for the summer an estate in Dulaney's Valley, Maryland.

Dr. T. M. Chaney, class of 1906, has been appointed Superintendent of the South Baltimore Eye, Ear, Nose and Throat Hospital.

Dr. George Hume Steuart, class of 1899, has left the city upon an extended Southern tour and before returning will visit Lake City, Florida.

Dr. A. B. Lennan, class of 1904, formerly an assistant surgeon in the University Hospital, has located at 2205 Orleans street, Baltimore, Maryland.

Dr. H. O. Reik, class of 1891, was elected at the convention of the Ear, Nose, and Throat Association, held in Kansas City, June 12, a fellow.

Dr. John C. Hemmeter is spending his summer vacation visiting the clinics of Europe. Dr. Hemmeter writes that he is having a most enjoyable time.

Dr. Martin J. Cromwell and Dr. Nathan Winslow have been appointed by the Faculty of

Physics of the University of Maryland visiting surgeons to Bay View.

Dr. W. Guy Townsend, class of 1888, of 2017 North Charles street, Baltimore, Maryland, has been named by the health commissioner as health warden of the 12th ward.

At the sixty-second annual meeting of the American Medico-Psycological Association, held at Boston, June 13, 1906, Dr. J. Clement Clarke, class of 1880, read a paper.

Dr. W. A. Parvis, class of 1905, who was forced to leave town on account of his health, we are glad to report, is somewhat improved and is now located at Denver, Colorado.

Dr. Francis W. Patterson, class of 1889, of Catonsville, Maryland, who on Thursday, June 14, 1906, while on a jury at Towson, suffered an attack of vertigo, we are glad to report, is improving.

Mr. Edward D. Todd, class of 1908, while in bathing at Atlantic City, Friday, June 22, as the result of a dislocated shoulder incurred in attempting to save a woman from drowning, narrowly escaped drowning himself.

Dr. Somerset R. Waters, class of 1858, the veteran chief clerk of the State tax office, having occupied the position since the office was created in 1878, has handed in his resignation to Colonel Buchanan Schley, the State Tax Commissioner.

The engagement of Dr. Walter Walton White, class of 1896, of Baltimore, to Miss Lenore Griffith Doyle, a graduate of the University of Maryland Training School for Nurses, class of 1906, has been announced. The wedding will take place this summer.

In the May issue of the St. Paul Medical Journal, there is an article, "The Preparation and After-Treatment of Operative Cases," by Dr. A. Aldridge Matthews, class of 1900, formerly Superintendent of the University Hospital, but now practicing at Spokane, Washington.

The engagement of Dr. J. Howard Iglehart, class of 1903, and Miss Nancy H. Kinirey, a graduate of the University Training School for Nurses, class of 1902, has been announced. The wedding, which is to be a quiet affair, will be solemnized in July. The couple will locate in Baltimore.

Dr. Randolph Winslow, Professor of Surgery, and Dr. J. Mason Hundley, Clinical Professor of Gynecology, sailed on the North German Lloyd steamship Rhein for Bremen, Wednesday, June 27, 1906. They will visit the leading hospitals and surgical clinics of Germany, Austria, Switzerland, France and England, and expect to return to America about September 15th.

Dr. A. L. Wilkinson, class of 1903, formerly an assistant resident physician in Bay View Hospital, assistant resident gynecologist in the University Hospital, and superintendent of Hebrew Hospital, Baltimore, who was recently operated on at the University Hospital by Dr. Richard Johnston for a nasal affection, is doing nicely and expects soon to be able to leave the institution.

Following his custom of years, Dr. Thomas H. Brayshaw, June 21, 1906, entertained the members of the Anne Arundel County Medical Society at dinner at his home, Bachelor's Joy, Glen Burnie. The following of our alumni were present and delivered short addresses: Dr. Wm. T. Watson, class of 1891; Dr. Louis M. Allen, class of 1896; Dr. Samuel T. Earle, class of 1870, all of Baltimore, and Dr. Frank H. Thompson, class of 1879, of Annapolis.

Professor John C. Hemmeter, of the department of Physiology, delivered an address before the Medical Society of Berlin, Germany, on June 21, 1906. Professor Hemmeter, while in Berlin, was the guest of Professor C. Anton Ewald, of the University of Berlin. During the summer he will visit Heidelberg, Carlsbad and Vienna, and in September will go to the University of Groenigen. Later he will attend the celebration of the 400th anniversary of the University of Aberdeen, Scotland.

Dr. Edward E. Tull, class of 1887, a Marylander by birth, but a New Yorker by adoption, who has already performed more than a 1,000 public laparotomies, has formed a copartnership with Dr. J. Dougall Bissell, class of 1888, originally of South Carolina, but now a resident of New York City. It is worthy of note that Dr. Tull was the first resident obstetrician to the University Hospital. The doctor has had splendid success, and is one of the most promising of the younger surgeons in New York. Dr. Tull recently visited Baltimore.

Now that the institution of state branches of the General Alumni Association is in fashion, theBULLETIN wishes to call the attention of alumni located in the States of Virginia, South Carolina, Texas, Louisiana, Tennessee, Georgia, Alabama and Florida to the well organized and branch alumni associations in the States of Pennsylvania and North Carolina. One of the objects of the BULLETIN is to bring the alumni into closer touch with one and other, and it is through the establishment of these branch associations that it hopes partially to accomplish this task.

Dr. Henry E. Palmer, class of 1892, of Tallahassee, Florida, who has been spending a few days around the hospital, is one of the most prominent practitioners of medicine in the State of Florida. He is president of the Regular Board of Medical Examiners, State of Florida, and Vive-President of the Florida State Medical Association. Dr. Palmer was formerly an assistant resident gynecologist to the University Hospital, and during the cholera scare back in the nineties was an acting assistant surgeon in the United States Navy, and was stationed at Fortress Monroe.

In an article, "The Bacteriology of Blood in Typhoid," in the Journal of the American Medical Association, of the issue of June 23, 1906, by Professor Jose Hirsh, and Drs. Levy and Quillen, resident pathologists in the University Hospital, there is a report and the deductions drawn therefrom, on the examination of 100 blood cultures from typhoid cases in the wards in the University Hospital, with 78 per cent. positive isilation of the organisms extending over the 1-4 week of the disease. The article maintains that typhoid fever is a septicemia and not as formerly believed a local disease with general manifestations, and that in every case at some period or other the organisms gain entrance into the general circulation and should be isolated in pure culture if sought for at the proper time.

At a meeting of the Board of Regents of the University of Maryland held Monday, June 25, 1906, for the purpose of hearing the report of the Committee on the amalgamation of St. John's College, Annapolis, the Maryland Agricultural College, College Park, Maryland, and the various faculties of the present University of Maryland into an University, to be known as the University of Maryland, the following resolutions were adopted:

Resolved, That the report just read of the Committee on the proposed University of Maryland, be and the same hereby is approved by this Board, so far as its approval signifies a concurrence in the general plan outlined by the report; but this Board reserves to itself the right to adopt or reject the plan proposed when it is put in more definite shape, through the medium of the contracts, which are to be submitted to this Board for its approval and execution hereafter;

Resolved, That the Committee heretofore appointed, and which has just made its report, be continued and directed to confer with the authorities of the several institutions mentioned, with a view to the preparation and submission of the contracts proposed; or to continue the meetings with the committees of the several institutions interested in this subject, for the purpose of preparing such contracts;

Resolved, That the representatives of the Regents of the University of Maryland, in connection with the representatives of the other institutions interested, be requested to draw a contract to carry into effect the foregoing resolutions.

MARRIAGES

Miss Marcia Dodge, daughter of the late Dr. Augustus W. Dodge, class of 1864, was married at Baltimore, June 12, 1906, to Mr. Eugene B. Heath.

Lewis M. Eastman, class of 1893, son of the late Lewis M. Eastman, class of 1859, was married June 19, 1906, at Baltimore, Maryland, to Miss Mamie C. Miller.

Dr. John F. Armentrout, class of 1903, of Staunton, Virginia, and Miss Mary Louise Merritt, daughter of Captain and Mrs. C. G. Merritt, were married June 27, 1906, at the residence of the bride's parents, in Augusta county.

Dr. Philip Lee Travers, class of 1902, of Cambridge, Maryland, was married Saturday, June 16, 1906, at Ocean City, Maryland, in the Church St. Mary's, Star of the Sea, by the Rev. F. G. O'Neill, of St. Thomas' Church, Baltimore, to Miss Maude Emily MacHale, daughter of Mr. and Mrs. John H. MacHale, of Easton, Maryland. After an extended honeymoon, Dr. and Mrs. Travers will reside at Easton, where Dr. Travers practices his profession. Dr. Travers was formerly an assistant resident physician at Bay View Asylum, Baltimore, and while a student was prominent socially and athletically.

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A BRIEF REPORT OF FOUR CONSECUTIVE CASES OF PERFORATION OF THE ALIMENTARY CANAL BELOW THE DIAPHRAGM.

BY ARCHIBALD C. HARRISON, M.D. (Class of 1887)

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These four cases represent all the perforations (except the appendix) which have come into my service at the City Hospital during the last three years. They embrace one each of the stomach and duodenum, from chronic ulcers. One of the ileum from typhoid ulcer and the fourth, multiple perforations in the upper part of the jejunum from a pistol shot.

Perforations of the alimentary tract may occur from several causes and in almost any part. The most common causes, however, are the various forms of ulcer and penetrating wounds. Of the intrinsic causes, by far the most common is perforating appendicitis. This, however, is part and parcel of the condition we term appendicitis and is not usually classed as a perforation of the alimentary tract.

Dysenteric ulcers occasionally perforate, but not often, and the dysenteric condition is so well established beforehand as to leave but little question as to its source. Tubercular ulcers perforate not infrequently, as does also the ulceration which is sometimes established above the seat of a cancerous stricture of the canal. The remaining types are the perforations of typhoid ulcer and the peptic or round ulcers of the stomach and duodenum.

The perforating ulcers of the intestines which follow burns need hardly be mentioned, because they occur mostly in cases which are fatally burned.

Perforating ulcer of the stomach and duodenum is by no means as common in this country as it seems to be in some foreign lands, especially that of Great Britain. Nevertheless, it occurs here with comparative frequency, and I believe it occurs more frequently than is commonly supposed.

The general symptoms of perforations of the alimentary canal below the diaphragm are more or less the same and are those of perforative peritonitis. The sudden terrific pain, the tremendous degree of shock; the boardy belly walls, the dusky hue and clammy skin are common to them all, being modified somewhat in degree and by the previous condition of the subject. They are indications only of some terrible intra-abdominal catastrophe. The differentiation must be made by taking up each variety separately and must sometimes remain unsolved until after operation. The most important point to establish is that something has occurred within the abdomen which requires operation. This must be done without delay, for time is an all-important factor.

We do not deny the possibility of recovery in some degree, after perforations of this tube, without operation, but such cases are always extremely doubtful and their number is so entirely insignificant as to leave them unworthy of consideration. It is but a few years ago since these conditions were considered inevitably fatal regardless of procedure; at present, however, the outlook is fairly good, provided only the individual may be brought to operation at an early period after the accident.

Many conditions combine to make a large difference in the probabilities of recovery even with the best surgical treatment. The length of time elapsing between the moment of perforation and the time of operation, the position and size of the opening and the contents of the viscus being the most important. The death rate increases progressively the greater the length of time and jumps to a very high point after the first 12 to 18 hours. In a general way it may be said that the higher up the tube the breach occurs the better the chances. This is due to the difference in poisoning power of the contents of the various parts of the canal. The

contents of the stomach are not infrequently practically sterile, and in its ordinary condition its bacterial guests are of a low degree of virulence. The number and virulence of the bacteria of the intestine increases as we descend the tube until we reach the large intestine where it reaches its maximum. If the perforation occurs shortly after a full meal, as is not infrequently the case and the opening be large, the entire abdominal cavity is apt to be filled with the stomach contents; on the other hand, if the stomach be empty or nearly so and the opening be small, the area of peritonium involved will be proportionately small. Leakage from the duodenum is apt to be slow and its contents of low virulence. The previous condition of the patient also has much to do with the prognosis. This is typified in the perforations of typhoid ulcers. The opening is situated in the lower part of the ileum, which is usually filled with fluid feces charged with bacteria of a high degree of poisoning power. Furthermore, the patient already has typhoid and is much reduced in resistive power and, even if he recovers surgically from the local condition, he still must make his long fight with the general disease. Unfortunately this element but too often defeats the results of otherwise promising cases.

The similarity of gastric and duodenal ulcer is so marked that they may be well considered together. They, however, possess some distinctive features which will sometimes serve to differentiate them more or less definitely. The method of treatment and technique of operation are so nearly the same as to make but little difference so long as we recognize that one or the other has perforated.

No more appalling disaster can befall the human being than the perforation of a gastric or duodenal ulcer. The onset of the symptoms is sudden and overwhelming; the course rapid and unless surgical measures are adopted early the disease hastens to a fatal termination in almost every instance. These perforations are usually described as being acute and chronic. Some also speak of a sub-acute variety. The usual type is the acute, where the ulcer gives way suddenly and completely; a variable-sized hole occurs, through which the contents of the viscus leaks. The sub-acute and chronic forms are much more rare and are produced by the gradual giving way of the walls, allowing time for adhesive peritonitis to form or for plugging to occur from lymph coagula, portions of omentum, etc. These latter types form a large factor in the causation of subphrenic abscess.

The diagnosis is to be made largely by a careful inquiry for previous symptoms of ulcer and the character of the symptoms in the acute onset. In about eight per cent. previous symptoms of ulcer are lacking. Ulcer on the anterior wall of the stomach frequently gives but few symtoms, and the anterior wall and lesser curvature are the situations most commonly perforated.

The initial symptom is almost constantly a sudden, sharp, stabbing pain, altogether intolerable and overpowering. It is usually situated in the epigastrium and rapidly invades the whole abdomen. Very quickly a condition of collapse of varying degree is present. The face is drawn, the surface of the body pale, cold and clammy; the lips blue and a dusky hue throughout the skin. Respiration is shallow and quick, pulse rapid and small. Vomiting may or may not occur, but most often does, dependent probably upon the amount of fluid in the stomach. Thirst is urgent and the urine suppressed or scanty. Perhaps the most important symptom is that of the hard, boardy belly walls. This symptom is always present in the early periods of the condition; later the abdomen may be distended and somewhat softer, but is usually exquisitely tender. Death may occur in the stage of collapse, but if the patient rallies, the symptoms will be those of general peritonitis.

In the sub-acute and chronic forms the symptoms are much the same, but are usually milder in character and show a tendency to become circumscribed. The other conditions from which these must be differentiated are other perforations within the abdomen, ruptured tubal gestation, acute internal obstructions, acute pancreatitis, thrombosis of the mesenteric veins and acute perforative appendicitis; all of which cannot be gone into here. At first the symptoms of perforated duodenal ulcer are the same as those of the gastric variety. Later, however, the train of symptoms develops somewhat differently. When the opening occurs in the stomach the later symptoms are those of general peritonitis. When duodenal they are apt to be limited and usually, partially at least, to the right side. This is due to two principal causes, the fluid extravasated is smaller in amount and will ordinarily occur more slowly; the course taken by the extravasation is along the right colon and

finally into the right iliac region where, at some period, the symptoms of appendicitis may be so mimicked as to make differentiation very difficult. Under these circumstances the patient will usually denominate the right side as the seat of greatest pain and tenderness, and the rigidity of the abdominal muscles will be more marked on the same side.

Second only to perforating appendicitis in frequency comes typhoid ulcer. When perforation occurs in the course of typhoid fever there is practically no question as to its source, save in that rare type called ambulatory, but the patient is frequently already possessed of so many abdominal symptoms and his mental and physical condition is such as to make it extremely difficult to arrive at correct conclusions. In this class of cases the many things which must be taken into consideration present too bulky a problem to be handled in a general presentation like this. A few generalities may be given to advantage along with the presentation of a case.

The most significant symptoms are sudden and severe pain with tenderness generally in the right iliac fossa, accompanied with marked drop in temperature and signs of collapse. In three-fourths of the cases these signs appear suddenly; in the other one-fourth their onset is more latent or even may be entirely unnoticed. The leucocyte count is of some value, especially when marked and persistent. The general facts deducted from the analysis of a large number of cases may be stated as follows: (W. D. Haggard).

1. It occurs more often in men than in women—80.9 vs. 19.1 per cent. It is, like hemorrhage, rare in children.

2. It occurs in about 2.5 per cent. of all cases of typhoid fever.

3. It occurs most often in the second and third week; but may occur at any time.

4. It occurs more frequently in severe attacks, but may occur in mild cases, being occasionally the first real symptom of typhoid.

5. It occurs in the ileum in 95.5 per cent., usually within 18 inches of the cœcum, nearly always in the first 3 feet. The remaining cases occur in the large intestine.

6. Cases with diarrhea and tympany are more likely to have perforation.

7. The death-rate is usually given as about 95 per cent. Dr. Osler stated that he could not recall a single case that had recovered after perforation. (That is without operation).

The analysis of 362 cases operated on shows 94 recoveries and 268 deaths, a total mortality of 74 per cent. (According to Harte and Ashhurst). This represents a saving of nearly 25 lives in a hundred cases of perforation, which leaves no question as to whether we shall or shall not operate. The real problem is the diagnosis and in most cases this is easy, but in the lesser number it may be fraught with the greatest difficulty. The earlier the case is brought to operation after the accident, the better his chances. General anæsthesia is preferable to local. Usually but little is needed, and it should be limited to the shortest possible time. The operation should be conducted with the greatest speed (not hurry) and the least handling consistent with thorough work.

Case I.—Male, aged 40 years; has been a fairly heavy drinker of alcoholics for a good many years and has been steadily losing weight for a year past. He has frequently suffered with pain after eating, for more than a year, and for several months has always had pain and usually vomiting after taking food. He had also a small area in the epigastrium, which was tender to pressure. About one hour after taking a rather full breakfast and while walking on the street, he was suddenly seized with violent pain in the epigastrium, which quickly became general and overwhelmed him. When seen, eight hours later, he presented a typical picture of some intra-abdominal catastrophe. His features were pinched and his body covered with clammy sweat. Pulse 80 to 100, very irregular, small and hard. Abdomen distended, very tense, tender and flat to percussion. Immediate operation, cavity filled with fluid and partially digested food. Large perforation on lesser curvature of stomach immediately at œsophageal juncture. Closed with double layer of silk sutures and omental graft. Recovery good. About a year later, gastro-jejunostomy for recurrent ulcer and hemorrhage. Final recovery complete.

Case II.—Male, aged 42, with previous history of dyspepsia for many years, but only occasionally severe. August 18, 1905, about 9 A. M., and while at work, was suddenly seized with violent pain in upper abdomen, more marked on right side. Seen August 19, at 12 noon. Usual picture of peritonitis. Skin dusky, abdomen tense and tender; general symptoms came on

rather slowly; right side more tender and muscles harder then left side. Especially tender in right colonic area. Duodenal perforation diagnosed. Immediate operation. Amount of fluid rather small and limited to right side. Small opening in first portion of duodenum. Closed with double layer of sutures and omental graft. Recovery uneventful. Subsequent health good.

Case III.—Male, aged 24; in third week of typhoid fever. Perforation occurred in the early morning and operation performed at 12 M. Perforation in ileum 18 inches from coecal junction. Opening size of lead pencil surrounded by necrotic area. Abdomen filled with dirty fluid and peritonitis very extensive. Opening closed with purse-string and mattress sutures. General anaesthetic used. The entire procedure required just 20 minutes. Recovery complete. Gauze and tubular drainage was established in each of these three cases. Irrigation used in Case I, none in Cases II and III.

Case IV.—Negro, male, aged 21; previous history negative. Pistol shot in abdomen 5.30 P. M. after full meal. Operation at 10 P. M. On examination he showed wound of entrance 2 *C. M.* in advance of and slightly below tip of 12th. rib. According to the patient's statement the party doing the shooting was directly in front of him and ten feet away. Calibre not known. General condition good, pulse below 90, temperature normal. No indication of shock nor loss of blood. Catheterized urine showed no blood. Leucocytes 13000. Complained of some pain in abdomen and thought there was no boardy condition, the recti were definitely in plus tension. Nothing could be determined as to direction taken by bullet from the appearance of wound nor with probe. In view of the stated fact that he stood directly facing his assailant there might have been a reasonable doubt as to whether the bullet had penetrated into the abdominal cavity. Operation was promptly determined upon, however, because of the high leucocyte count, definite tension and definite pain increased by pressure. Opening through left rectus. There were seven punctures in the first 18 inches of jejunum; four of them in first 6 inches and two within less than one inch of the beginning of the jejunum. All closed with purse-string sutures. There was some blood, but bleeding had not been marked. Leakage of intestinal contents from the openings was free. Leakage wiped out where found. No irrigation and abdomen closed without drainage. For the next four days he ran a temperature from 100 degrees to 101 degrees, otherwise entirely normal throughout convalescence. The course of the bullet was direct from left to right as far as spinal column. It passed immediately over the descending colon, producing a definite bruise. There was no visecral injury to right of midline. All of which goes to show that trying to calculate the direction taken by the bullet from the supposed relative positions of the combatants can be of but little value and may be gravely misleading.

ANESTHETICS.

Lecture delivered at University of Maryland by Randolph Winslow, M. D., Professor of Surgery, University of Maryland.

The introduction of anesthetics into surgical practice marks an epoch in the history of surgery. Previous to 1842 surgical operations were performed without the administration of an anesthetic, except that an effort was made to benumb the sensibilities by the internal use of opium and alcohol; even the hypodermic syringe was an appliance of the future. One can scarcely conceive the terror and suffering incident to surgical work in those days. The best surgeon was the one who most quickly completed his operation. Only those affections received attention which imperatively demanded it. Surgery, as we know it today, did not exist. As far as is known the first person to administer an anesthetic for the performance of a surgical operation was Dr. Crawford W. Long, of Athens, Georgia, in 1842, but as he did not publish his work, it had no influence in popularizing the method, and the credit for the introduction of ether as an anesthetic is due to the dentist, William T. G. Morton who, on October 16th, 1846, etherized a patient at the Massachusetts General Hospital, whilst Dr. John C. Warren removed a vascular tumor from the neck. At this time surgical anesthesia was born, and at once began an active existence. In 1847 Sir James Y. Simpson, of Edinburgh, Scotland, introduced chloroform into general practice. Since that time these two agents—chloroform and sulphuric ether—have been used for the purpose of abolishing consciousness during operations almost to the exclusion of all other drugs. In 1844 Dr. Horace Wells, of Hartford, Connecticut, inhaled nitrous oxide gas for the extraction of a tooth, and it has continued to be used in dental practice since that time, but its action is

too short to make it available as a general anesthetic for prolonged operations. As an adjuvant to the use of ether it has a field of usefulness.

Local and General Anesthetics.

General anesthesia signifies the loss of sensibility with the loss of consciousness, for which purpose ether, chloroform, nitrous oxide, and bromide of ethyl are the agents usually employed.

Local anesthesia signifies the loss of sensibility without the loss of consciousness, and may be induced by the use of ice and salt locally, carbolic acid, ether spray, rhigolene spray, chloride of ethyl spray, cocaine, eucaine, holocaine, etc., applied to the mucous membranes or injected into the skin and subcutaneous tissues, or by injecting a few drops of solutions of these drugs into the subarachnoid space of the spinal cord.

For most serious operations, and in the case of highly nervous persons, it is very desirable that the patient should not be conscious of his surroundings or of the pain inherent to such procedures, and consequently the administration of an anesthetic to the point of complete unconsciousness is necessary. Whatever the anesthetic agent that may be used, there is always an element of danger in its administration, and when we abolish all the functions except those of respiration and circulation, it is not surprising that occasionally these are also abolished, and the patient is "dead."

Choice of Anesthetic.

The choice of an anesthetic practically lies between chloroform and ether, and each of them has its field of usefulness. In a large part of the United States and especially in the North and West, ether is used most extensively. In the South and the tropical possessions, chloroform is the agent of choice. In military practice chloroform is preferable, owing to its small bulk and quickness of action.

Certain general considerations are applicable to the employment of any general anesthetic, and first of all and of great importance is the one who gives the anesthetic, the anesthetist. When an operation is about to be performed some person of ample experience should be chosen to administer the anesthetic. He should have a due regard for the importance and dignity of his position. He must confine his attention to his duties, and must not take any interest in the operation, except as it concerns the safety of the patient. He must keep the surgeon informed of any untoward circumstance which may demand his attention, but must not worry him with trifling matters or distract him by whispering or talking. He must keep an alert watch upon the pulse of the patient, upon the character of the respiration, and upon his facial appearance. In private practice the anesthetist should always receive an adequate fee for his services, in order that he may devote his energies and abilities exclusively to his own duties, and because the position is one of great importance and responsibility. In addition to whatever appliance may be used as an inhaler, he should have a suitable mouthgag, for forcing the jaws apart when necessary, a tongue forceps for drawing the tongue forwards without injury, a long-handled forceps and small pieces of gauze or absorbent cotton, for wiping out the fauces and pharynx, a hypodermic syringe in good order, and tablets or solutions of strychnia, atropia, digitalin and nitroglycerin, also perles of nitrite of amyl for inhalation, a cylinder of oxygen is also a desideratum, but one which is not usually available.

At the last lecture I considered the examination of the patient from a somewhat general point of view, now I wish to consider it also, as it effects our choice of an anesthetic. For most cases sulphuric ether is the safer agent to use, but in the extremes of life, under 10 and over 60 years of age, chloroform is preferable. When the arteries are atheromatous any general anesthetic should be avoided, as death is likely to occur from apoplexy or later from suppression of urine, but if one must be used, chloroform should be chosen. In diseases of the kidneys and lungs, as well as in glycosuria and brain diseases, chloroform is the safer agent to use. In diseases of the heart ether should have the preferance, as it stimulates, whilst chloroform depresses the heart. In operations on the mouth, nose, pharynx, or larynx, chloroform should be generally used, and always so when the actual cautery is to be applied to any of these cavities, as ether is highly inflammable. In operating at night by candle or gas light be sure that the light is held some distance above the patient, as the ether vapor is heavy and falls to the floor. Where a careful dissection is to be made at the root of the neck amongst large venous trunks ether by causing a distention of these vessels, adds greatly to the danger of the operation; in such cases use chloroform. Alcoholic and obese persons do not bear ether well, and to such chloroform

should be given. With the exceptions noted, and perhaps of others that I do not recall at this time, ether is the anesthetic of choice in the temperate climates; in hot climates the concensus of opinion is that chloroform is better borne.

Chloroform is a much more dangerous drug than ether, about 1 in 2075 administrations of chloroform die, whilst only one in 5112 administrations of ether prove fatal. Bromide of ethyl also has a low mortality of one in 5396. Nitrous oxide is almost without mortality in dental practice.

The especial toxic effect of chloroform is upon the heart, as it is a depressant of this organ, hence the anesthetizer should keep careful watch upon the pulse. Ether when it proves fatal, does so usually by overwhelming the respiratory function, hence the chief source of anxiety is from interference with the respiration, and usually timely notice is given in the gradual asphyxia which supervenes. Whatever anesthetic may be used, the patient should always be recumbent; never give an anesthetic with the patient in the upright or much raised position, though it may safely be administered with the patient in the dependent position, as in the Trendelenburg posture. Always see that no false teeth, tobacco, or any other foreign body remains in the mouth during anesthesia. Always see that the clothing is loose, and that respiration is not impeded by corsets, collars or bands of any kind. In case of obstruction of the bowels, always wash out the stomach previous to the administration of the anesthetic, as the danger of suffocation during vomiting is thereby obviated. The administration of ether may be preceded by that of nitrous oxide, by means of which the induction of insensibility is not only greatly shortened, but the extreme sense of suffocation is obviated. The ether should be given gradually in small quantities and the patient not overwhelmed at once. Let a sufficient quantity of air be admitted to lessen the suffocating feeling mentioned, until the patient is accustomed to the drug. We may use a cone made of towels with pasteboard between the folds of the cloth, but the Esmarch frame with several thicknesses of gauze over it, makes the best appliance for this purpose, the ether being dropped steadily upon the gauze. After a few whiffs of ether have been taken, the patient becomes confused, flushed, the pulse increased in frequency, and the respiration augmented. A short period of primary anesthesia is soon produced, during which minor operations can be performed. The primary anesthesia soon passes off and the patient becomes noisy and excited, and often requires to be restrained by force. Soon muscular relaxation occurs, stertor or snoring often follows, the eye reflex is lost, and the patient is ready for operation. Bear in mind that ether kills by its action on the respiration and not by syncope. Chloroform is a much more pleasant anesthetic than ether; it produces insensibility in a much shorter time and the after effects are usually much less marked, but to offset these advantages, it is twice as fatal. The period of greatest danger is in the early stages of its administration, previous to complete insensibility. At this time the heart suddenly ceases to beat and the patient is dead at once and cannot be resuscitated.

Sometimes, like ether, it kills by arresting the respiration, but this it not usually the case. Chloroform should be administered with the utmost caution. The best inhaler in my opinion is that of Esmarch, a wire frame covered with gauze, upon which the drug is slowly dropped. An abundant supply of oxygen is thus allowed. Furthermore, an inhaler may be improvised by making a cone widely open at the top so that a free supply of air may be permitted. In obstetric practice chloroform is almost absolutely safe, deaths occurring with the greatest infrequency. Wait until the patient is completely relaxed and thoroughly insensible before beginning the operation, as reflex inhibition of the heart may occur with a fatal termination, if this is not done. All the precautions incident to the administration of ether should be observed in chloroform anesthesia, with the addition of those mentioned above.

Recently scopolamin, a drug nearly allied if not identical with hyoscine, has been largely used in combination with morphia as an adjuvant to general anesthesia by ether or chloroform, and in some cases as a substitute for these agents. When used preliminary to ether or chloroform, bromide of scopolamin, gr. one one-hundredth, and sulphate of morphia, gr. one-sixth, is given hypodermically half hour previous to anaesthetization by one of these drugs. It is claimed that anesthesia is more quickly and easily induced, danger lessened, and subsequent unpleasant after effects avoided. I have now used this method in a number of cases, but am unable to notice any particular advantage over previous methods. Scopolamin and morphia may be given for the

purpose of producing general anesthesia, and in many instances with satisfactory results. When used in this manner, three doses of these drugs are to be given, scopolamin, gr. one one-hundred and fiftieth, and morphia, gr. one-sixth, at two and one-half, one and one-half and one-half hours, respectively, before the operation. In most cases the patient will be rendered unconscious, and the operation may be performed without suffering. In some cases it will be necessary to give a few whiffs of chloroform or ether to produce complete insensibility. Even when the patient appears to feel pain, he has no recollection of it after regaining consciousness.

Nitrous oxide is a safe anesthetic, but its action is too evanescent for prolonged surgical procedures. It is, however, of great use as an adjuvant to ether anesthesia, as the time required to produce unconsciousness is reduced to a few minutes. A special apparatus is required which very materially limits its use. It is not unpleasant to the patient, but produces cyanosis and frequently marked muscular contractions and rigidity, symptoms which are rather alarming to the spectator.

Bromide of ethyl is an agent used for general anesthesia, and which has marked advantages in certain cases. It produces complete anesthesia in half a minute, the insensibility lasts about three minutes and the patient wakes up suddenly. It was introduced into use in this city by the late Professor Julian J. Chisolm, who used it extensively in his eye practice. In minor operations requiring insensibility it is a useful agent. Various mixtures of chloroform, ether, and alcohol are used extensively in Europe, but do not appear to possess any especial advantages over ether and chloroform separately.

The anesthetizer must be alert to detect and prevent or remedy any evil effect of the anesthetic. The pulse should always be under observation, and upon any indication of failure or bad action, the anesthetic should be withdrawn, air freely admitted, and stimulation with strychnia, grain one-thirtieth, or digitalin, grain one-sixtieth, hypodermically administered. The head should be lowered in dangerous conditions or the patient actually held up by the legs. The inhalation of nitrite of amyl will frequently overcome the peripheral resistance in the blood vessels and restore the regular action of the heart. Cessation of breathing must be met by withdrawing the anesthetic, and if it does not cause a resumption of the function, artificial respiration must be performed; vomiting often occurs, during which the pulse is depressed and fatal syncope may follow; the greatest danger, however, is from the entrance of the ejecta into the larynx, with suffocation of the patient. Turn the head to the side and mop out the pharynx. If food gets into the larynx, a rapid tracheotomy may save the life of the patient, if done quickly enough.

An anesthetic should not be given in your office. Never give an anesthetic without the presence of a third party, especially in the case of females, who at times have erotic delusions, and accuse the physician unjustly of having had intercourse with them.

Local Anesthesia.

Local application of cocaine to a mucous membrane renders it insensible to pain. However, this drug is not always safe, and in some cases fatal results have attended its use. It may be applied locally by means of an atomizer or a pledget of cotton. For the vagina with its thick mucous membrane a 5 per cent. solution is about the proper strength. Cocaine applied to the unbroken skin does no good, but to be of use has to be injected both into the skin and subcutaneous tissues by means of a hypodermic syringe. Cocaine is a toxic agent, hence not more than one-third of a grain should be infiltrated into the tissues at a time. For ordinary skin anesthesia one-half per cent. solutions are all that is required. Be careful not to inject it into a vein, as symptoms of fainting, dizziness, dilatation of the pupil sometimes follow, even after the injection of a moderate amount into the tissues. A modified solution of cocaine, known as Schleich's solution, gives excellent results. It is marketed in three different strengths, Nos. 1, 2 and 3. No. 2 is the formula usually employed; ℞ cocaine one and a half grains, morphia two-fifths of a grain, common salt three grains, aqua three ounces. This is known to surgeons as the infiltration method of producing anesthesia. If you determine to use this solution you need a large hypodermic syringe for its injection. We find this method very useful in operations for varicocele, hernia, etc. If a nerve trunk or the tissue around a nerve is injected with cocaine, the parts below anesthetized, we now have a physiological barrier to the transmission of nervous impulses; this is known technically as blocking the nerve. Still another method of produc-

ing local anesthesia is that of injecting cocaine into the subarachnoidean space. We speak of this as intra spinal cocainization. The injection usually takes place between the fourth and fifth lumbar vertebrae. We aspirate the cord and draw off 20 minims of the cerebro-spinal fluid, and inject slowly into its place 20 minims of a two per cent. solution of sterile cocaine. We are unable, however, to control the course of such a method, as it may travel up the cord and affect the vital centers, thereby causing a cessation of their functions. It is claimed to be 20 times as dangerous as chloroform. In some cases it may, however, be used, as in arterio-sclerosis or diabetes, or in heart disease or nephritis. In such conditions operations may be successfully performed, that would terminate fatally if a general anesthetic was administered. Eucaine is supposed to have certain advantages over cocaine, but it must be used in larger doses, and the subsequent smarting is greater. On the whole there does not seem to be any good reason for substituting eucaine for cocaine as a local anesthetic.

(Original Paper.)

CASE OF HEART BLOCK OR STOKES ADAMS DISEASE.

C. L. Jennings, M. D., Class '06, St. Joseph's Hospital.

Clinically, Stokes Adams disease presents the following features: 1. Slow pulse, which may be permanent or paroxysmal, falling to 40, 18 or even 6 per minute. 2. Cerebral attacks, vertigo of a transient character, syncope, pseudo-apoplectiform attacks or epileptiform seizures. 3. Visible auricular impulses in the veins of the neck as noted by Stokes, the beats varying, a 2.1 or 3.1 rhythm being most common.

The cases of heart block are divided into several groups. Those cases which are the result of senile changes associated with arterio-sclerosis. Those of syphilitic origin, one myocardial, seen most commonly in young adults. There is also a neurotic group presenting all the features, but at post mortem no lesion is to be found to explain the symptom. The prognosis in the last group of cases is good, in the other two groups it is always bad. (Osler).

The case which has recently come under my observation belongs to that group, the result of senile changes associated with arterio-sclerosis.

Case. A. V., age 82, single, male, German, laborer. Patient was brought to St. Joseph's Hospital in a semi-conscious condition, pulse beating 28 to the minute, respiration 26, pupils small and equal, react to light and accommodation. Patient was stimulated with strychnine sulph. 1-30 hyp. and whiskey half-ounce by mouth, was put to bed in half an hour without any change in pulse rate. The following history was elicited: F. H. negative. P. H. Had measles and malaria. No history of typhoid, pneumonia or rheumatism. No history of any venereal disease. Was never injured.

Present Illness. Patient has always enjoyed good health until the latter part of December, 1905, when he began to have attacks of vertigo, followed by severe frontal headache. On June 3d, while at work cutting grass, patient fell and remained unconscious for a short while. This was followed by severe headache, lasting several hours. On June 6th had another attack, since then has had these attacks almost daily, some days having as many as three. Feels perfectly well between the attacks, except that he frequently feels light headed. Appetite is good, bowels regular, no trouble in voiding urine. Passes more than he did a few years ago. Frequently gets up during the night to void urine. Sleeps well. Habits: Drinks beer, tea and coffee, chews tobacco. Physical examination: Well nourished male, no deformities or broken bones. Skin is moist.

Eyes. Conjunctiva not discolored, pupils small, equal, react to light and accommodation. M. M. of mouth is pale, teeth poor, breath foul. Lungs are negative.

Heart. Area of cardiac dullness increased down and to the left P. M. I. in 6th space in nipple line. Action is slow and rather feeble. No valve lesions. Arteries are sclerotic, radials being well beaded. Pulse small and slow. Pulsation of the veins of neck are quite distinct. 3.1 rhythm.

Abdomen. Negative. G. W. Has a phymosis. No scars, sores or discharges.

Nervous System. Intellect is fair, speech slow. Gait is unstable. Fine tremors. Superficial reflexes slightly diminished.

Urine Examination. Clear, acid. S. G. 1016. Slight ring of albumen. No sugar. Hyaline and granular casts, amorph. urates and small amount of mucus.

While in the hospital patient had eleven epileptiform attacks, two while in bed, others

while walking about the ward. On the third day he had two attacks, on no other day did he have more than one. The maximum pulse rate while under observation was 40 per minute; the minimum pulse rate was 14. Average pulse rate being 28. Average respiration 26. The auricular pulsation in veins of neck was quite characteristic. Pulse rate was unaltered by posture or exercise.

Treatment. Strych. sulph. 1-30 gr. every 3 hours; whiskey half ounce every 3 hours; tr. chlor. iron gtts xx tid.; warm baths and soft diet; nitroglycerine 1-100 every four hours was tried. Patient had two epileptiform attacks the day upon which it was given. This line of treatment in my opinion lessened the number of seizures according to the history of the patient. Patient went home July unimproved.

(See Osler's Practice of Medicine, sixth edition, for the physiological explanation of the clinical features of the disease.)

CORRESPONDENCE.

BERLIN, GERMANY, *July* 13, 1906.

To the Hospital Bulletin:

The desire to revisit the hospitals and surgical clinics of Europe has been ever present with me for many years, but the convenient season seemed to recede farther and farther, as the years slipped by. This year, however, I determined to make the necessary break, and here I am in the imperial city of the German Empire. On June 27th, in company with Prof. J. Mason Hundley, I left Baltimore on the good ship Rhein, and after less than twelve days of a propitious voyage we landed at Bremen. Notwithstanding the very smooth and comfortable ocean trip, it was a great pleasure to see the green clad shores of Germany, and to be able to stretch our legs upon firm land, rather than upon the deck of an ocean liner. Our first stopping place was Bremen, about 40 miles from the landing point. This is an old, beautiful but still quaint looking place, a free and independent city, having its own government, but of course being a portion of the empire. We were very much pleased with the nice private residences, and Dr. Hundly was delighted to see the gyneologist living in such style. From Bremen we journeyed to Hamburg, which is the greatest commercial city in Germany and one of the largest shipping marts in the world. It is a fine modern city, with the bustle of busy life, but has nothing of great interest to the casual visitor. It has, however, a very large and well equipped general hospital, the Eppendorfer, with 2,000 beds. We inscribed our names in the registry book and saw the signatures of Drs. Hugh W. Brent and Eijnar Hansen, who were there just a year ago. Not very many Americans visit this hospital, and we were the first from Baltimore this year. Doctor Kummel is the chief surgeon, and has 500 beds under his care. We saw Kummel do an appendectomy, which was not done in any way better than it is done at the University Hospital, and I do not think as well. He did not appear to take as much pains with his asepsis as we do, and neither he nor his assistants wore gloves. He also opened the knee joint for a collection of blood, and used his ungloved hand to turn out the clots from the joint. He used a chloride of ethyl spray on the skin, and made his incision without any manifestation of pain on the part of the patient. We saw also a refracturing of the tibia under spinal anaesthesia, a 5 per cent. solution of novocain being used. It is claimed that this agent is safer than cocaine and equally as efficacious. This Eppendorfer Hospital is built on the pavilion plan, each building being separate, without even a corridor to connect them. It is especially well fitted with orthopedic and electrical apparatus and baths of every kind. It is an immense place with driveways and shrubbery within its enclosure and a beautiful park directly opposite its front entrance. From Hamburg we took train for Berlin, and not only came near losing our train, but our tempers as well, owing to our ignorance of the customs of the country; however, we came through all right and landed in this imperial city last Wednesday night, July 11th. The country between the North sea and Berlin is flat, and well watered with small streams. It is beautifully cultivated, and there is but little ground lying fallow. As far as the eye can see the green fields stretch without any farm houses, the people living in villages and not on farms. There is a great dearth of woods, but strenuous efforts are now being made to grow trees and young forests are seen here and there. The old windmills with their long arms waving are a feature of the landscape. Every one who has travelled in Europe is familiar with their funny looking railway trains, divided into compartments, and drawn by locomotives with stovepipes for smokestacks, and a noise like that of a whistle instead of the

shriek of our engines. The speed is usually not more than twenty-five miles an hour, though some trains run swiftly. We bought second-class tickets at Hamburg, but the conductor must have thought we looked like important people, as he put us in a first-class compartment, and we travelled like lords. I visited Berlin twenty-three years ago and find it much improved in appearance and enormously increased in population. It is indeed a city worthy of the great German Empire; its magnificent buildings, and many splendid statues and memorials in bronze or marble make it a very attractive city. Art galleries, and museums abound, and great care is taken to cultivate a love for the beautiful, as well as to stimulate the patriotism of the people, by the representation on canvas or stone of the heroic deeds of the nation in the past. Frederick the Great and William the First are depicted everywhere, though the other royal personages are not neglected. The streets of Berlin are mostly wide and splendidly paved with asphalt, and the sidewalks are paved with flagstones in the centre and a coarse mosaic of stone in different colors and patterns on the side, making an effective and ornamental walk. There are no back alleys, with their accumulation of dirt, but the houses are built around courts, which are also paved and kept clean. The corner of Frederick street and Unter den Linden is the most congested portion of the city, and one must look alive or he will be run down by the stream of coaches, automobiles, motorcycles, bicycles, motor carts of every kind and description, or by the horses of the police or the soldiers. Hotels abound, in all of which English is spoken, so one can get on fairly comfortably, even if he cannot speak German. Doctor Hundley had met Professor Duhrssen in Baltimore, and he called him up and we went to his private clinic and saw him operate. He was most cordial to us, and we expect to see more or his work before leaving the city. We also called on Professor Hoffa, who received us very pleasantly, and we are to go to his private hospital tomorrow. It will be remembered by many of our readers that he held a very attractive clinic at the University Hospital three years ago. We also visited the Charité, a large city hospital, which has been much improved since my last visit to it. Of what we have seen in a medical way I will write in another letter.

RANDOLPH WINSLOW.

The following of our alumni have passed the Maryland State Board of Medical Examiners and are entitled to practice medicine and surgery in the State of Maryland: G. W. Billups, E. L. Bowlus, W. L. Brent, L. G. Burroughs, C. O. Burruss, W. D. Campbell, H. A. Cantwell, V. C. Carroll, A. B. Clarke, E. S. Coster, R. W. Crawford, R. E. Dees, R. O. Dees, Thos. Duncan, Jr., M. C. Freilinger, J. S. Geatty, J. F. Hawkins, Jr., R. B. Hayes, N. W. Hershner, J. H. Hope, O. A. Howard, O. V. James, C. L. Jennings, L. Karlinsky, S. H. Lynch, W. W. Olive, L. M. Pastor, W. J. Riddick, C. W. Roberts, W. F. Sowers, E. M. Sullivan, B. O. Thomas, E. W. White, FitzRandolph Winslow. All these gentlemen are members of the present graduating class with the exception of Dr. Riddick, class of 1905.

Members of the class of 1906 will no doubt be glad to hear the following abstract of a letter from Dr. Kivy Pearlstine to one of the editors of the BULLETIN: "I passed the South Carolina State Board in June and managed to make an average of 86 6-8 per cent. In surgery my grade was 97. W. L. Hart and J. C. Hill also passed. We were the only University of Maryland boys who stood the Board this year. The records go to show in this city, Branchville, that I performed the first laparotomy for ectopic gestation, and yet had only been practicing about two weeks. The fetus and secundines weighed about five pounds and by calculation I diagnosed the case as five months pregnant. It was an abdominal pregnancy and on account of my recent coming here I cannot ascertain when the rupture occurred. This was the first laparotomy that was ever performed in this city and from the success of this operation my practice is increasing daily. I have several more operations to do in the near future." The BULLETIN desires to congratulate Dr. Pearlstine upon his success and sincerely hope that in all his future surgical work he will be as successful as in his initial laparotomy.

Dr. James Carroll, class of 1891, assistant surgeon, United States Army, and the last survivor of the Immortal Yellow Fever Commission, has been detailed to represent the Medical Department of the Army at the meeting of the British Medical Association at Toronto, Canada, August 21-25, 1906.

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BALTIMORE, MD., AUGUST 15, 1906.

EDITORIAL

ORIGINAL WORK FROM THE LABORATORY OF PATHOLOGY AT THE UNIVERSITY OF MARYLAND.—Some months ago the trustees of the Charles Frick Fund set apart the sum of two hundred dollars to encourage original work in the Laboratory of Pathology at the University. The result of this action is now shown in a most excellent paper on the "Bacteriology of Blood in Typhoid Fever" from the pen of Prof. Jose L. Hirsh, professor of pathology in the University, assisted by Dr. E. B. Quillen and Dr. W. V. S. Levy, resident pathologists to the University Hospital. This paper, published in the *Journal of the American Medical Association* of June 23d, 1906, is a valuable contribution to the subject of which it treats and reflects credit upon the careful and painstaking work of its authors. The investigations consist of a study of 100 cases of typhoid fever in the wards of the University Hospital. In this study the typhoid bacilli were found present circulating in the blood in 78 cases and absent in 22 cases, and as to the time of the disease were distributed as follows:

First week—16 cases, 12 positive, 75 per cent.

Second week—50 cases, 43 positive, 86 per cent.

Third week—24 cases, 19 positive, 79.3 per cent.

Fourth week—7 cases, 1 positive, 14.3 per cent.

Relapses—4 cases, 4 positive, 100 per cent.

As to the stage of disease the largest positive findings were in the second week of the disease, a time when the bacilli are probably present in largest numbers. After the third week the positive findings are greatly reduced and in the majority of cases the authors believe they are absent after the twenty-first day.

The earliest positive findings was on the fourth day of the original attack and the latest the bacilli were present was on the 28th day. The authors believe from their study that the organism is present in a large majority, if not in all cases, of typhoid fever in the blood early in the attack and that it disappears by the end of the third week, or soon thereafter, and that a relapse is a second infection, associated with the reinvasion of the blood by the organism. In 23 cases the authors found the Widal reaction negative or merely suggestive at the time the bacilli were obtained. The value of a bacteriological examination as a means of diagnosis in certain obscure cases of typhoid fever they claim can not be questioned. If the bacteriological examination is positive, the diagnosis is assured. While the Widal reaction is more easily carried out, it is often misleading, as it is occasionally absent or does not appear until late in the attack, and is occasionally found in those very diseases which clinically resemble typhoid fever.

The authors conclude: 1. That the bacillus typhosus is present in the circulating blood in every case of typhoid fever at some time during its course. 2. The bacilli invade the blood very early in the disease. 3. The bacilli usually disappear from the blood by the end of the third week. 4. Relapse is associated with reinvasion of the blood by the organism. 5. The bacteriologic examination of the blood is a valuable adjunct in the diagnosis of obscure cases of typhoid fever.

The BULLETIN regrets that it did not have the privilege of publishing this most excellent paper in full. In giving this abstract of its more important conclusions it takes great pleasure in commending the careful study made in the pathological laboratory and in the wards of the University Hospital by Drs. Hirsh, Quillen and Levy, and the encouragement given by the trustees of the Charles Frick Fund which made this work a more agreeable task. There can be no doubt of the fact that even a small reward for original investigation is a great incentive to careful and painstaking study, and we are glad to know that the University has a small fund which can be used for such purposes.

REUNION OF CLASS OF 1881.—The reunion and dinner held by the class of 1881, in celebration

Dr Hirsh says it was offered [illegible]

of its twenty-fifth anniversary, at the New Howard Hotel on June 1st, was an unqualified success. The room was beautifully decorated and the menu and wines excellent. But the spirit of the men present lent the great charm to the occasion. Never was a reunion more like a homecoming. Never was the comradeship of the past more joyously and lovingly taken up afresh. Never was there displayed a more loyal and devoted class spirit. Never was there a more convincing proof of what the Old University really stands for: Not brilliancy, perhaps, but well poised intelligence; not great fame, but faithful service; not riches, but sturdy character; not great honors, but the spirit of humanity. There were no set speeches, but every man of the twenty-one present had something to say. The man to whom special honor was done was Dr. H. W. McNatt, of North Carolina, who literally arose from a bed of illness, and made his way by interrupted stages back to the reunion. Such a son is an honor to any Alma Mater. The men present looked uniformly well and fairly prosperous. The lapse of twenty-five years had indeed left its marks on face and form alike, but they were the signs of hard and earnest work, not of dissipation; the deepening lines of matured character, not the tell-tale evidences of a misspent life. And as the men looked, so they talked. No boasting, but a frank and cordial narration of "what's been doing;" not much "shop," but a great deal of comradeship; no "hard luck" stories, but a healthy, almost buoyant optimism; above all, a deep and heartfelt love for the "Old School," and an intelligent and thoughtful interest in her welfare. Would that we could have more such reunions. A very prominent member of the class remarked to the writer that the dinner had done more to attach him to the University than any or all other things in twenty-five years.

Seventy-two men graduated in the class. Of these seventeen are known or believed to be dead. Of the remaining fifty-five reports were received from forty-four. When one considers the very large proportion of men who drop out of medicine, and in view of the fact that this was the only attempt ever made to canvass the class, one must regard this as a very remarkable showing.

The BULLETIN would strongly urge class secretaries to keep in touch with their class mates. The strongest asset any educational institution can possess is a loyal and well-organized body of alumni. Nearly all the letters received gave expression to the deepest interest in the University. What is true of the members of this class is doubtless true of the general body of the alumni throughout the country. Let us foster and cultivate this spirit for the sake of Alma Mater.

Besides the members of the class there were present Professors Hiram Woods, J. M. Hundley and J. M. Craighill, all members of the class of 1882. The men answering "here" when the class role was called were:

H. J. Berkley.....Maryland
J. S. Fulton.....Maryland
H. H. Goodman.....Maryland
J. H. Hoffman.....Maryland
C. A. Hollingsworth.....Maryland
O. E. Janney.....Maryland
J. L. McMillan.....North Carolina
H. W. McNatt.....North Carolina
E. L. Meierhof.....New York
C. W. Mitchell.....Maryland
Z. C. Myers.....Pennsylvania
L. E. Neale.....Maryland
C. O'Donovan.....Maryland
A. C. Palmer.....Virginia
H. G. Prentiss.....Maryland
F. O. Ritter.....Pennsylvania
H. M. Simmons.....Maryland
J. A. Wright.....Maryland

The following members of the class have filled professorships in well known medical schools: H. J. Berkley, J. S. Fulton, O. E. Janney, E. L. Meierhof, C. W. Mitchell, L. E. Neale, C. O'Donovan and B. Pitts.

THE SUMMER OUTING FOR THE CITY DOCTOR AND NURSE.—It is quite evident to those who have been in the practice of medicine for some years that the many changes which have taken place in scientific work are not the only evidences of progress which the profession has made. Before the era of the specialist the city physician worked over his cases year in and year out with little relaxation from the drudgery and responsibility of the sick room. We have known more than one hard worked doctor who in over fifty years of active practice has seldom had a vacation lasting over a few days. The times are rapidly changing these hard conditions for the city and also for the country practitioner. The man of hard work now fully realizes the

need of rest and relaxation at stated periods. All who can get away from the grind of hard work during the summer months in this climate do so. The doctor and the nurse both need rest and both should have it if they wish to keep in training for the exacting duties of their respective callings. The country outing for the city practitioner is just as necessary for the development of his highest faculties and for efficient work as is the winter inning to the country practitioner. Both classes are greatly improved mentally and physically by changes of residence, by new views and studies of life, and by the relaxing influences which comes from rest. Every busy city doctor should make either long or frequent breaks in his routine work. Every country doctor should do the same as often as circumstances will admit as he has, as a rule, fewer social privileges and harder physical labor than his city brother. The number of medical men who recognize these principles is increasing each year. There are more physicians out of this city this summer than in any previous year of its history. A large number have gone abroad, others are visiting neighboring States, and not a few have suburban homes where for the larger portion of the twenty-four hours they enjoy a contact with more pleasant environments. This same fact applies to the country practitioner. Each year larger numbers are taking advantage of post-graduate courses of instruction in the cities or are frequent visitors to the city hospital with patients. In many ways both city and country doctors are learning each year the better how to enjoy themselves and how to work to better advantage. What both classes need is more frequent intercourse with each other, closer association, the better division of labor and of responsibility. The ideal life of the physician should not be self-sacrifice, but efficient service. He is the best humanitarian who does the best work for himself as well as for others for by the care and development of the best that is in himself he is the better able to render the best service to others. The healthy mind and healthy body are the best gifts of inheritance. They can only be preserved to their possessor by careful attention to hygienic laws for a few score years at best. The morbid mind is more fatal to true progress than bodily disease, and how often is this morbidity traceable to the selfish grasp for gain or influence at the expense of every noble faculty? Physicians know better than any class of men the influences which bring so many men to early graves or to invalidism in its varied forms, and yet with these illustrations ever before their attention and often under their guidance they conduct their own work or lead lives which bring to themselves the disasters which they witness among their patients. It is true that very few, if any, can control all the conditions which surround them in their varied duties in life, yet it is true that every condition is subject to some modification which will reduce its severity or bring it under better control. The practical application of the doctrine which the BULLETIN is trying to teach is this: City physician go to the country as often and stay as long as circumstances will permit. Country physician visit the city as often and stay as long as circumstances will permit. The enforcement of this general rule of action will be advantageous to both classes; it will make broader, healthier and happier men of both classes; it will promote more pleasant relations, a better division of labor and responsibility in the treatment of disease by an exchange of patients, the one needing the visit to the country and the other the special attention only possible in a large city. The time is fast coming when the overcrowding of city life must bring about a reaction in favor of the country home for shorter or longer periods of residence. The country practitioner must deal with this class of patients often referred to him by his city brother, hence the relations between the city and country doctor must become closer and more confidential than in the past. Civilization is making such strides that new problems in work must measure up to conditions as they arise. Those physicians who recognize and prepare for the requirements of a rapidly growing social life will be best equipped for success in professional work.

NOTES AND ITEMS

Dr. B. O. Thomas, class of 1906, has located at New Market, Maryland.

Dr. Charles G. W. MacGill, class of 1856, spent the month of July at Narragansett.

Dr. Otto M. Reinhardt, class of 1893, has been spending his vacation at Atlanta, Georgia.

Dr. Henry Berkley, class of 1881, is spending the summer at Illchester, Howard county, Maryland.

Dr. J. G. F. Smith, class of 1906, has been appointed superintendent of Springer's Sanitarium, Towson, Maryland.

Dr. Louis McLane Tiffany, late professor of surgery, is spending July and August at Gloucester, Massachusetts.

Dr. M. R. Bowie, class of 1907, who is ill at the University Hospital with typhoid fever, is reported to be doing nicely.

Dr. W. F. Sowers, class of 1906, who was recently operated upon at the University Hospital by Dr. Frank Martin, is doing nicely.

Dr. J. T. Yourtee, class of 1865, is one of the most respected and honored physicians of Brownsville, Frederick county, Maryland.

Dr. Ernest Harrison Rowe, class of 1906, of Forrest Park, Baltimore, will leave shortly for Washington State, where he intends to locate.

Dr. Guy Steele, class of 1897, has been honored by Governor Warfield by being appointed a member of the State Tuberculosis Sanitarium Commission.

Dr. A. B. Clarke, class of 1906, who was recently operated upon at the Hebrew Hospital by Dr. St. Clair Spruill, we are glad to report, is able to be out again.

Dr. Louis M. Allen, class of 1896, associate professor of obstetrics in the University of Maryland, has been appointed assistant surgeon to the Maryland Naval Brigade.

Dr. Vernon F. Kelly, class of 1904, of 405 Falls road, Baltimore, has been appointed Health Warden of the Thirteenth ward, to succeed the late Dr. D. S. Williams, class of 1865.

Dr. Carey B. Gamble, Jr., class of 1887, has been advanced from associate professor of medicine to professor of clinical medicine at the College of Physicians and Surgeons, Baltimore.

In a letter to the BULLETIN, of which the following is an abstract, Dr. Parvis, class of 1905, says: "Later in the year after gathering sufficient statistical matter, I will write an article for the BULLETIN, regarding the work done here (Fort Stanton, New Mexico) on the treatment of tuberculosis and its complications. This is a Government hospital for the benefit of the officers and men of the Marine Service who have contracted phthisis. Through the medium of your paper I wish you would express my gratitude and appreciation to Professors Randolph Winslow, Ashby, Hundley, Coale and Gichner, of our staff, also Professors J. H. Branham and H. H. Biedler, both of Baltimore, for their services in securing me this appointment, (Acting Assistant Surgeon, United States Public Health and Marine Hospital Service)."

The committee appointed by the General Alumni Association to consider ways and means for the formation of a University of Maryland Club have had several meetings, and are so pleased with the prospects of success that they have decided to canvas the entire city for prospective members. Out of the hundreds of worthy alumni located in Baltimore it should be no herculean task to enlist 200, the lowest possible number to insure the success of the club.

The object of the club, as formerly stated, is to foster and create good fellowship among our alumni; to keep the University before the public; to increase its prestige, and to furnish a home where lawyers, pharmacists, dentists, and doctors can fraterize with each other upon terms of equality.

Although there was an abortive attempt to organize the Medical Alumni in 1844, the late Professor Miltenberger being elected the first president, the organization did not survive, but gave to us as an inheritance our present motto, *"Filius sim dignus, ista digna parente."* Not until 1880, under the presidency of Professor Miltenberger, was an organization perfected and by-laws and a constitution adopted. This organization was the successor of a voluntary association formed and in existence since 1874. Since 1880 the Medical Alumni Association has been in a flourishing condition, and meets annually after the announcement of the graduates, at which meeting the annual election of officers, addresses and a banquet are held. Though not as large as it should be the membership is ever increasing. It is not only the privilege, but the duty of every alumnus to join this association in order to make its voice an active force in behalf of the University, and it is to be hoped in the future every graduate will feel it incumbent upon him not to leave the portals of the old University without affiliating himself with this worthy and honorable organization. As previously reported, the present president is Professor Samuel C. Chew. The members are as follows: Drs. H. C. Algire, 1895; Howard E. Ames, 1874; John R. Abercrombie, 1895; Josiah S. Bowen, 1903; James S. Billingslea, 1878; Wilmer Brinton, 1876; John B. Brawner, 1872; H. H. Beidler, 1876; A. K. Bond, 1882; W. R. Bruin, ——;

William H. Baltzell, 1889; S. B. Bond, 1883; J. Blum, 1885; Edward M. Bush, ——; H. F. Cassiday, 1890; Theodore Cooke, Sr., 1859; J. M. Craighill, 1882; Hobert Claytor, 1886; Joseph Coleman, ——; James J. Carroll, 1891; F. M. Chisolm, 1889; C. C. Cook, ——; Lee Cohen, 1895; A. T. Chambers, 1898; E. F. Cordell, 1868; Charles C. Conser, 1900; Samuel C. Chew, 1858; Thomas M. Chaney, 1866; Charles R. Davis, 1890; N. L. Dashiell, 1882; I. H. Davis, 1885; N. S. Dudley, 1901; John Dixon, ——; P. G. Dausch, 1868; Benjamin H. Dorsey, 1901; S. Demarco, 1900; H. C. Davis, 1903; Samuel T. Earle, Jr., 1870; C. B. Earle, ——; William R. Eareckson, 1890; Page Edmunds, 1898; W. H. Fahrney, ——; W. H. Feddeman, 1888; F. V. Fowlkes, 1887; Henry D. Fry, 1876; George A. Fleming, 1889; Robert Fawcett, 1892; Charles R. Foutz, 1901; Charles Getz, 1879; Joseph E. Gichner, 1890; Frank D. Gavin, 1874; Joseph E. Gateley, 1902; John Girdwood, 1894; George R. Graham, 1883; G. H. Hammerbacher, 1894; George E. H. Harman, 1867; John C. Hemmeter, 1884; R. Lee Hall, 1901; Charles B. Henkel, 1889; Henry T. Harrison, 1874; Charles W. Himmler, ——; George H. Hocking, 1879; B. M. Hopkinson, 1885; J. M. Hundley, 1882; H. C. Hyde, 1899; N. R. Hotchkiss, ——; August Horn, 1888; John Houff, 1900; H. L. Hilgartner, 1889; Jose L. Hirsh, 1895; T. O. Heatwole, 1897; Louis B. Henkel, Jr., 1904; Norman F. Hill, 1882; C. W. Heffenger, 1875; A. L. Hodgdon, 1884; James H. Jarrett, 1852; John G. Jay, 1871; Charles J. Keller, 1898; John T. King, 1866; Samuel J. King, ——; N. G. Keirle, 1858; Howard Kahn, 1900; W. B. Kirk, 1864; Thomas W. Linthicum, 1879; John W. Linthicum, 1884; Howard D. Lewis, 1900; Charles W. Larned, 1893; W. S. Love, 1890; J. P. La Barre, 1901; R. C. Massmore, 1901; C. G. W. Macgill, 1856; Frank Martin, 1886; A. D. McConachie, 1890; J. Norfolk Morris, ——; W. S. Maxwell, 1873; C. M. Morfit, 1861; W. P. Morgan, 1862; W. H. Marsh, 1876; H. C. McSherry, 1872; A. A. Matthews, 1900; G. W. Mitchell, 1898; J. C. Monmonier, 1886; W. H. Mayhew, 1901; L. E. Neale, 1881; Vernon L. Norwood, 1885; Charles P. Noble, 1884; H. P. Naylor, 1860; Henry C. Ohle, 1886; Charles O'Donovan, 1881; William J. Pillsbury, 1889; Henry G. Prentiss, 1881; W. H. Pearce, 1891; W. Gibson Porter, 1886; A. C. Pole, 1876; John I. Pennington, 1869; H. O. Reik, 1891; J. Dawson Reeder, 1901; G. G. Rusk, 1867; J. C. Robertson, 1900; J. H. Robinson, 1883; John H. Rehberger, 1873; S. W. Seldner, 1872; Frank R. Smith, 1891; Joseph T. Smith, 1873; W. A. B. Sellman, 1872; I. S. Stone, 1872; St. Clair Spruill, 1890; H. M. Simmons, 1881; W. I. Skilling, 1883; E.L. Sensindiver, ——; C.E. Sadtler, 1873; George H. Steuart, 1899; W. R. Stokes, 18—; C. Urban Smith, 1889; J. Tyler Smith, 1877; M. Spragens, 1899; L. J. Turlington, 1892; G. Lane Taneyhill, 1865; John R. Winslow, 1888; Hiram Woods, 1882; Randolph Winslow, 1873; C. R. Winterson, 1871; E. M. Wise, 1877; William Whitridge, 1862; S. R. Waters, 1858; Robert T. Wilson, 1856; W. T. Watson, 1891; James H. Wilson, 1868; Nathan Winslow, 1901; W. E. Wiegand, 1876; Robert A. Warner, 1885; J. A. Zepp, 1887.

These alumni are located in the following states:

Alabama:—Dr. John M. Benton, class of 1899, Birmingham, Jefferson County; Dr. Joseph T. Coulbourn, class of 1886; Birmingham, Jefferson County; Dr. Howel T. Heflin, class of 1893, Birmingham, Jefferson County; Dr. Lewis G. Woodson, class of 1887, Birmingham, Jefferson County; Dr. Stephen S. Carter, class of 1897, Dixon's Mills, Marengo County; Dr. Henry L. Stone, class of 1868, Montgomery, Montgomery County; Dr. William G. Harrison, class of 1892, Talladega, Talladega County; Dr. Devotie Jones, class of 1872, Woodlawn, Jefferson County. Dr. Lewis G. Woodson is Professor of Physiology and Diseases of the Eye, Ear, Nose and Throat in the Birmingham Medical College.

Arizona:—Dr. Milton M. Walker, class of 1867, Phoenix, Maricopa County.

Arkansas:—Dr. J. M. King, class of 1897, Texarkana, Miller County; Dr. Leonce J. Kosminsky, class of 1906, Texarkana, Miller County; Dr. George W. Hudson, class of 1875, Camden, Ouachita County; Dr. A. H. McKenzie, class of 1872, Centreville, Yell County; Dr. Henry T. Harr, class of 1892, Ellicott, Ouachita County; Samuel J. Chesnut, class of 1892, Hot Springs, Garland County; Dr. Gilbert C. Greenaway, class of 1867, Hot Springs, Garland County; Dr. Joseph S. Horner, class of 1883, Hot Springs, Garland County; Dr. John Bagby, class of 1867; Lake Village, Chicot County; Dr. William L. Williamson, class of 1869, Moro, Lee County.

California:—Dr. Charles C. Benson, class of 1883, Berkeley, Alameda County; Dr. Oscar

Stansbury, class of 1873, Chico, Butte County; Dr. William Hammond, class of 1847, Livermore, Alameda County; Dr. Josian Evans Cowles, class of 1880, Los Angeles, Los Angeles County; Dr. Joseph Le Doud, class of 1889, Los Angeles, Los Angeles County; Dr. W. Gray Smith, class of 1880, Oakland, Alameda County; Dr. William D. Groton, class of 1879, Rivera, Los Angeles County; Dr. Henry R. Bell, class of 1879, San Francisco; Dr. Walton Saunders, class of 1856, San Francisco; Dr. Albon E. Hall, class of 1866, San Jose, Santa Clara County; Dr. Edward W. Day, class of 1853, Vacaville, Solano County.

MARRIAGES

Dr. James Albert Melvin' class of 1887, of Baltimore, Maryland, was married July 7, 1906, to Miss Elizabeth Dorothy Gilch, at the home of the bride's mother, Mrs. Dorothy Gilch, Odessa, Delaware. After a bridal tour spent in the North Dr. and Mrs. Melvin will reside at 1303 West North avenue, Baltimore, Maryland.

Dr. Charles J. Keller, class of 1898, of Baltimore, was married July 14, 1906, at Mount Calvary Protestant Episcopal Church, Baltimore, by the Rev. Dr. Robert H. Paine, assisted by the Rev. Robert H. Gernand, the father of the bride, to Miss Mary Theodora Gernand, daughter of Rev. and Mrs. Robert H. Gernand, 5 West 25th street. After a honeymoon spent at Atlantic City, Dr. and Mrs. Keller will reside at 222 West Monument street, Baltimore, Maryland.

Dr. Watson S. Rankin, class of 1901, formerly resident pathologist at the University Hospital, and for a time resident obstetrician at the University of Maryland Lying-in-Hospital, but now one of the most prominent of the younger pathologists of North Carolina, and professor of pathology at Wake Forrest College, North Carolina, was married Tuesday evening, August 14, 1906, to Miss Elva Margaret Dickson, daughter of Mrs. M. S. Dickson, of Wake Forrest, at the Baptist Church, Wake Forrest.

Dr. Walter W. White, class of 1896, of Baltimore, Maryland, was married August 1, 1906, to Miss Leonore Griffith Doyle, daughter of Mr. and Mrs. J. Clarence Doyle at the home of the bride, 2033 North Calvert street, Baltimore. Miss Doyle is a graduate nurse of the class of 1906 of the University Hospital Training School for Nurses. Dr. William K. White, class of 1902, was his brother's best man. Miss Evelyn Bull, a member of the Ladies' Board of Managers of the University Hospital, was the maid of honor.

Dr. J. Howard Iglehart, class of 1903, of Baltimore, formerly resident obstetrician at the University Hospital, but now a practitioner of Baltimore, was married Wednesday, July 18, 1906, at the parsonage of the Franklin Square Presbyterian Church, to Miss Nancy Kinnirey, of Sweet Chalybeate, Virginia, a graduate of the Nurses' Training School of the University Hospital, of the year 1902. Miss Mary H. Cooke, class of 1901, a graduate of the Nurses' Training School, was the bridesmaid. Dr. and Mrs. Iglehart, after spending their honeymoon in the mountains, will reside at 539 North Carrollton avenue, Baltimore, Maryland.

DEATHS

Dr. James Willard, class of 1843, of Lovettsville, Virginia, died Monday, July 30, 1906, at his home in Lovettsville, aged 90 years.

Dr. William H. Wolfe, class of 1886, one of the most prominent and esteemed physicians of Martinsburg, West Virginia, died suddenly June 14, 1906, while driving home from a professional call.

Dr. Samuel L. Frank, class of 1862, of Baltimore, a retired practitioner, president of the Hebrew Hospital and Orphan Asylum, and a public spirited citizen, died Friday, August 3, 1906, at the Chattolanee Hotel, Green Spring Valley, Baltimore County, Maryland, of heart disease, aged 65. Dr. Frank is survived by a widow, who is a sister of Senator Isidor Rayner.

Dr. Denard Silas Williams, class of 1865, health warden of the Thirteenth ward, Baltimore, Maryland, died Friday, July 13, 1906, at his residence, 254 Carroll street, Woodberry from uremic convulsions, superinduced by Bright's disease, aged 61. Dr. Williams was one of the oldest and most prominent physicians of the Northern portion of the Annex. Since 1888, with the exception of the two years of Mayor Malster's incumbency of office, Dr. Williams has been continuously connected with the City Health Department. Dr. Williams is survived by a widow, who before her marriage was Miss Ida M. Hush, of Baltimore, a son, Mr. C. D. Williams, and a daughter, Miss Annie C. Williams.

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A REVIEW OF THE MODERN OPERATIVE TREATMENT OF DEVIATION OF THE NASAL SEPTUM, WITH ESPECIAL REFERENCE TO THE ADAPTATION OF OPERATION TO THE VARIOUS TYPES OF DEFORMITY.*

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Clinical Professor of Nose and Throat Diseases in the University of Maryland.

DEVIATED SEPTUM.

The normal septum is so seldom in the median line that deviation may be almost regarded as its normal condition. (Zuckerkandl, 75 per cent.; Heymann, 99 per cent.) Zuckerkandl claims deviations do *not* exist *before* the *seventh year,* while others maintain they can be found at any age. Ingals says they may be found in *newborn* infants, and Jacob has demonstrated by showing anatomical preparations that such deformities exist in the fœtus.

The symptoms are those resulting from *nasal obstruction,* and its consequences upon the lower respiratory tract (catarrhal affections) and adjacent organs (accessory sinuses and ears), and those of *reflex nervous* origin resulting from *pressure* upon the soft parts (neuralgia, sneezing, hay fever, asthma and other *neuroses*). Bosworth says that deformity of the septum probably more than any other single cause gives rise to attacks of *epistaxis.*

In some cases there is also *deformity* of the external nose (wry nose). (flattening and broadening).

Classification:—Deflections may involve the bony (10 per cent.) or cartilaginous (30 per cent.) portions of the septum, or most frequently both. (60 per cent.) The anterior is its commonest site.

From an operative standpoint it is essential for us to know the following details as to the deformity:

1. *Location.* Whether anterior, posterior, superior or inferior, which determines the accessibility, *i. e.,* ease of operation.

2. *Composition. i. e.* The parts which take part in it, whether quadrangular cartilage, nasal spine, vomer, lamina perpendicularis, etc., determining the kind of instruments available, whether knife, saw, chisel or forceps.

3. *Thickness.* (Interstitial) Also governing the selection of instruments and method.

4. *Shape.* Whether having a plane or ridged surface, with or without an overhang. Also whether of a simple or a complex form, determining the selection of method.

Detailed preliminary study of each individual deformity as a distinct entity and an exact knowledge of the anatomical and clinical peculiarities of the different forms of deformities is absolutely essential to enable us to select the right method and perform the same properly;

But inspection alone often yields erroneous impressions; careful preliminary inspection under cocain is essential to accurate diagnosis. The graduated probe is often requisite to determine the distance and extent of the deformity, the consistence of projections (tubercle of septum, etc.), and the depth of the concavity in angular deformities; at times the finger-tip may profitably replace the probe; the septometer is sometimes necessary to determine the thickness of the septum.

The possible sites of deflection in the order of their frequency are:

1. Dislocation of the lower border ("pyramidal cartilage.")

2. Deviation or dislocation at the chondro-vomeral articulation (angular).

3. Incurvation of the face of the quadrangular cartilage itself (bowed, angular and sigmoid).

4. Deviation or laxation chondro-ethmoidal (vertical angular).

*Based upon thesis presented to American Laryngological Association, May 31st, 1906.

5. Chondro - vomero - ethmoidal deviation (ascending angular).

6. Incurvation of the face of perpendicular plate of the ethmoid (bowed or angular), usually associated with deformity of the cartilaginous septum (sigmoid).

SHAPE.

There is an innumerable variety of septal deformities, which may be classified as simple and complex.

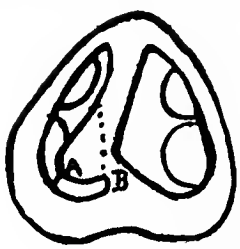
A simple deformity presents an incurvation to one side only, having a regular, smooth surface.

A complex deformity consists of a combination of deflections and a variety of shapes, which may be so irregular as to defy description, or it may be associated with various complications, either septal (dislocation thickening) or extraneous (turbinal-polypi-ordenoidi).

Treatment of deviation of the nasal septum is necessarily surgical. The question of *operation* rests not merely upon anatomic irregularity, but entirely upon the production of definite symptoms, which can rationally be attributed to the deformity—a deviation becomes pathological only when it interferes with nasal functions. Many marked deformities cause no complaints (according to Beaman Douglas only 11.3 per cent. of cases).

Bear in mind that the operation for deviated septum is a *serious surgical procedure,* and should never be undertaken for the relief of minor symptoms. Careful selection of the operation according to the *age, temperament* and *physical condition* of the *patient* must be exercised.

The operation should be *adapted* also to the *character* of the deformity, as to its *location, composition, shape* and *thickness.*



Thickening may be superficial or interstitial. In some cases where there is a *general thickening* or localized thickening (ledge) along the crest of the deflection, or elsewhere, this may be removed with the knife or saw—Bosworth's operation—by associating with this treatment of the catarrhal inflammation of the mucous membrane we may frequently relieve the symptoms and render replacement of the septum unnecessary. When such simple means are inadequate others become necessary.

The *principles* involved in the correction of these deformities are:

1. To overcome the *resiliency* of the septum.
2. To provide for *redundency,* vertical or horizontal excess of septum (not thickening) with relation to nasal chambers.
3. To *replace* the septum in its normal position.
4. To *retain* it in the median position until it becomes fixed.

All operations that fulfil these requirements will be successful.

The rubber-like resiliency of the cartilage has proven the stumbling block in operations for the correction of septal deviation. To overcome this various methods have been employed.

1. Comminution or fracture with forceps—Adams, Roe, Kyle.
2. Incisions of varying number and direction—Asch, Moure, Douglass, Allen, Roe, Gleason.
3. Resection of entire deviated area with preservation of the fibro-mucous covering on one or both sides—Krieg, Killian, Ballenger, Freer.

The test of success is not architectural symmetry, but the restoration of the defective nasal functions to normal. Experience has demonstrated the utter failure of methods dependent upon crushing alone, owing to the impossibility of fracturing the uncut cartilage with forceps, as well as that of crowding a "redundant" septum into a nasal chamber too small to contain it. Most methods are based upon a combination of incision and fracture.

From among the numerous methods, no more than an epitome of those with which I have had personal experience, can be expected in an article of this character. Consultation of original publications is strongly advocated, however, for all those employing these methods in order to become familiar with the minutiæ of each of them.

The Asch Operation (Trans. Amer. Laryngol. Asso., 1890) consists in making a crucial incision through the cartilaginous septum at the most prominent portion of the deviation, the horizontal incision being parallel with the floor of the nose, and the vertical incision crossing

this at right angles. Each segment is then fractured at its neck with the fingers and the segments made to overlap by compression with forceps. Asch devised special scissors for the performance of this operation, which is usually performed under ether anesthesia.

After Treatment. Iced compresses and cold antiseptic spray for 12 hours. The septum is *supported* in position by hollow splints of vulcanite or metal (Mayer's, McKernon's or Kyle's).

In his final paper Asch (The Laryngoscope, April, 1899) emphasized the most important points in connection with the operation, and the main cause of failure or complication in results; the method is applicable to the cartilaginous septum only and the forceps are intended neither for fracture nor for torsion, but for compression alone. Observation of numerous operators will demonstrate that these restrictions are being constantly ignored. They should be engraved upon the mind, if not the instruments, of every one employing this method.

Another essential is that the crucial incisions shall be placed over the most prominent part of the deviation. Here we find the great defect of the Asch and similar fixed instruments, inasmuch as in high grade bowed or angular deformities. This is an impossibility, especially under anesthesia, even with the small sized scissors now available. The horizontal ones are particularly hard to introduce, may strip off the mucous membrane, and are intended for exceptional use only.

Since the modification in the Asch splint by Emil Mayer, there have been no alterations in the method except that they are now boilable without change of shape.

Kyle's modification of Mayer's splints, being made of block tin, are both aseptible and *malleable so that they can be adjusted in situ,* as occasion demands, and seem to have distinct points of advantage over the original ones. A longer size for posterior deviation is now available.

The suggestion first made by C. W. Richardson, of Washington, that the splint be left in the nose continuously for a period of 7 to 10 days with careful supervision, and then removed permanently, has simplified the after treatment in the many cases in which it has proven applicable.

Asch claimed 5 minutes as the average time of performance of the operation and 4 weeks as the average of after treatment.

While the Asch operation may be available in other varieties of deformity, it is best adapted to deviations of the cartilaginous septum without thickening, either evenly bowed with a plane surface or moderately angular, when there is ample room on the concave side.

The deflection must be well above the nasal and vestibular floor, and not too acutely angular, else the Asch instruments cannot be properly inserted.

In the variety of cases to which it is specially adapted, it yields excellent results, and if there be any method suitable for the general practitioner, this is the one par excellence.

The character of my early cases, in which the nose was so narrow that the Asch instruments could not be inserted, compelled me to devise instruments of my own. My early operations were upon the Asch principle, but the incisions were made with special knives devised by myself (1892). These originally presented a double-edged triangular pointed blade, at right angles to the shaft, cutting both forward and backward, but are now made with a rounded point and resemble somewhat an old-fashioned gum lancet. The shaft is graduated so that the distance of the point of maximum deflection, having been previously measured, operation under anesthesia is facilitated. There are two of these knives, one cutting horizontally and one vertically, and two lengths of blade, a short one for thin and a longer one for thick septa. The knives are usually inserted on the narrow side and the crucial incisions made clear through the septum at its most projecting portion. I have always regarded it as essential to cut entirely through the septum to enable one to satisfactorily fracture it with the finger, hence have seen no necessity for a guard on the blade.

In high grade deviation, it has been at times easier to operate from the wide side, and then the narrow nostril must be protected from injury by the insertion into it of a thin plate of metal or of hard rubber.

These knives have the advantage that they can be used in an extremely narrow nostril and

wherever the deformity is located, whether high up or near the floor of the nose. Having become skilled in their use and satisfied with the results, I have employed them in all of my subsequent septal work.

The principal improvement that I would suggest and have often carried out is the performance of the operation with knives under cocain adrenalin anesthesia in all suitable cases under direct visual inspection when used for compression only. The application of forceps is not very painful and may be omitted when the septum is not very redundant, and the fracturing with the fingers is thoroughly done; if the flaps are so long as to cause a thickening upon the wide side, they may be resected at once, thus obviating a secondary operation.

Number of cases by this method, 45 (bowed, 19; angular, 26).

Number of perforations, 5 (10 per cent.).

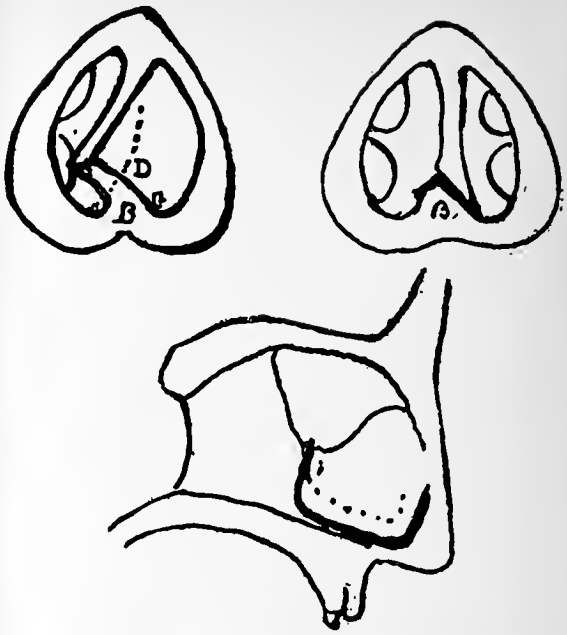
Severe hemorrhages, 0.

Results: Good, considering that cases were not selected with the same discrimination as now.

THE GLEASON OPERATION.

A U-shaped flap is cut out of the whole thickness of the septum (bone or cartilage) by inserting a thin saw beneath the overhang and sawing at first horizontally, and then vertically upward parallel with the septum. Both crura are then extended upward as far as possible with the saw; the incision must include the entire deviation, and not pass through it; the flap is then forced over into the opposite nostril with the finger and an effort made to fracture its neck and destroy its resiliency; thus the pendulous flap is retained by the margins of the incisions and there is seldom necessity for splints or other support. This operation can be performed in from 3 to 5 minutes in simple cases, under cocain-adrenalin anesthesia, with a minimum of pain or reaction, and gives ideal results in suitably selected and well performed cases. An essential point in the success of this method is to completely free the flap by passing the finger or a curved knife around the incisions, so that it may be subsequently efficiently fractured.

It is particularly indicated in pronounced deflections with an overhang, especially the angular form, and gives the best results when the deflection involves the bony septum. We then have a redundant flap containing bone, which is readily fractured. This remains in situ without the use of a splint. Cartilaginous slightly bowed deformities are probably better corrected by the Asch, Douglass, Roe or other method.



Illustrating the correction of an angular deformity by the Gleason Operation.

It is not adapted to deviations without an overhang, whether bowed or angular, although in some cases with but moderate overhang. A start may be obtained by using Phillips' bevelled edge saw. It is especially effective in vertical or horizontal angular deviations involving only a limited area of the septum; in such cases it is only necessary to push the long tongue-shaped flap through the septum without fracturing it. It is not adapted to very thin or excessively thick septa; the former buckle and tend to return to the deviated position, whereas it is difficult and painful to saw through very thick septa, especially when containing bone; also in thick septa it is sometimes difficult to fracture the neck of the flap, in which case this may be facilitated by incompletely incising it with Kyle's saw or Tetterolf's saw file.

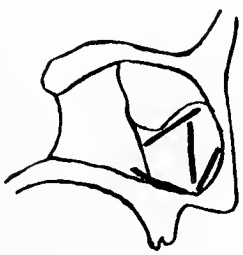
In deviations extending far back into the bony septum, the posterior crus of the U-shaped incision is more effectively made with the saw through the wide nostril; deformities located in the extreme posterior regions are better corrected by other methods. This also holds true with regard to sigmoid deflections and those near the floor of the nose.

Deformities in the body of the flap or irregularities left in the formerly obstructed nostril

may have to be removed by subsequent operation; it is well, however, to give nature a chance to adjust these spontaneously

Since I first became acquainted with this method in 1897, I have used it in every deformity in which it was applicable, especially of the bony septum—3 cartilaginous and 20 "mixed" cases—with the most eminently satisfactory results Contrary to the originator's experience, I found it very satisfactory in two cases of mixed deformity in children, owing to the simple after-treatment

*The Douglass Operation** differs from the Asch, in that it is performed with a special perforator and knife, and not only the crucial incisions, but the crossing of incisions at any point is avoided. The incisions are made along the lines of deflection in *whatever direction* and as far as they may lead, in the belief that these are the seats of old fractures. These lines are determined by preliminary examination, either tactile or visual.



Illustrating the correction of a complex angular deformity of the septal cartilage by the improved Douglass Operation.

The next step is to force the septum over into the unobstructed side with the finger.

Certain modifications of his original method have recently been advocated by the author. (Nose and Throat Surgery, F. A. Davis Co., Phila., 1900.).

Having disproved both by anatomical and microscopical observation that the cartilaginous septum is ever fractured by forceps, but per contra that it is torn loose from its articulations and its mucous membrane lacerated, the author has ceased to use the forceps for this purpose. He, however, deliberately attempts to separate the triangular cartilage from the bony septum with them.

The author lays particular stress upon the part played by the superior maxillary spine in maintaining the septum in its deviated position and has adopted breaking it *as a routine measure* in his operations—either by crowding the forceps down to the floor of the nose and twisting them from side to side, or by the supra-labial method or Harrison Allen.

Since the method of cutting this spine has been adopted it is often possible to remove the splints in five days. The author prefers to splints, Berasy's sponge inserted in small strips. I have used the Douglass principle exclusively in 37 cases of cartilaginous deviation, and found it a scientifically conceived and successful operation in those cases to which it is applicable. I have had no serious complications nor failures by it. This method can be performed in from 5 to 15 minutes, and is possible in the vast majority of simple cartilaginous deviations, but it is especially adapted to moderately angular or "ridged" deflections extending in various directions, or in markedly "angular" forms. In the "bowed" variety, a single horizontal or oblique incision is made along the greatest curvature. This principle is also available for removal of localized lines of deviation during or remaining after other operations. (Gleason operation).

With the finger as a protection under anesthesia, or guided by the eye under cocain, there is but little risk of injury to the turbinals. I have therefore never employed the spear-knife and the probe-knife of Douglass, but have used the same vertical and horizontal knives as in the Asch operation. These can be inserted anywhere, wherever there is a deviation, hence there is no need of a perforator, which is a complicating and unnecessary step. There is no central point of insertion, but incisions may be made anywhere, hence meeting or crossing of incisions is avoided. It makes no difference from which side the incision is made, as the turbinals on the narrow side may be protected. In my earlier cases by this method the operation was done under general anesthesia; later the incisions were made under cocain and the nasal spine fractured when necessary with forceps after preliminary saw incision under light etherization. (Kyle).

Roe's operation consists essentially in the use of a special fenestrated forceps, by means of which either the cartilaginous or the bony septum may be fractured. Experience has shown that for satisfactory results incision of the cartilage with a knife (Roe's) is required to overcome both resiliency and redundancy.

Roe's forceps for a long time constituted the only safe and successful method of fracturing

the bony septum, and my personal experience is limited to their use for this purpose as an accessory to some other method. Inasmuch as even this instrument is not free from the possibility of danger, it has been suggested to control the line of fracture by means of preliminary fissure with the trephine or Kyle's saws; another resource is to use a male blade smaller than the one intended to go with the female blade of a given size. This instrument is especially useful in limited mixed deviations at the chondru osseous articulations. In my opinion no rhinologist's equipment is complete without it. I have performed this operation under cocain with satisfactory results and no complications of any kind.

The *Kyle-Fetterolf* operation is more available as an accessory to other procedures than a distinct method, although undoubtedly successful in certain types of deformity. (Irregular and thickened septa). It consists in the removal of wedges of tissue from the septum (bone or cartilage) by means of Kyle's saws or Fetterolf's saw-files, followed by compression with forceps.

Bosworth's and Krieg's methods differ merely in degree, the latter being an extension of the former. In each the preservation of a flap of mucous membrane upon the convex side may be attempted.

Bosworth's plan of "sawing a new septum out of a thick and crumbled one, just like a straight board is sawn out of a crooked log," is applicable in cases of very thick septum.

[To be continued.]

REPORT OF A CASE OF TUMOR OF THE BRAIN.

By Prof. Randolph Winslow and Dr. Irving J. Spear.

The reason we report this case is not so much because of the comparitive infrequency of these cases, but because of its very close simulation of a case of general paresis, in fact it being impossible at the time of examination to state with certainty whether it was a case of tumor of brain or one of paresis in the late second stage.

On February 27th, 1906, I was asked by Prof. Winslow to see a patient whom he suspected of having a tumor of the brain, with the idea that if it were possible to localize the same so that it it were accessible it might be removed. At time of first examination the diagnosis of tumor of the brain was concurred in, but the localization was not possible. The patient was then kept under observation and repeated examinations were made without being able to localize the tumor or to positively exclude paresis. The following is the history of the case:

Mr. G. W. T., aged 61, white, married, carpenter.

Family History:—Father died at age of 33 of typhoid fever; mother, age 46, cancer of the stomach; one half brother and three sisters living and healthy, ages 53, 55, 59, 65. Otherwise family history negative.

Past History:—Always healthy, married at the age of 21, wife had two or three miscarriages without cause, one child died at the age of ten months, from teething and whooping cough; one aged three years and one four years died of diphtheria; one daughter living, aged 35, healthy, has one child, aged 14 years, healthy. Denies using alcohol and all venereal troubles. Age 44 had lumbago. Age 53 had supra-pubic cystotomy done by Prof. Winslow. Age 57 had several ribs resected by Prof. Winslow for the cure of an empyema. Three years ago was struck on head by a falling board, was unconscious for a short time, but did not sustain a fracture of the skull.

Present Trouble:—About 18 months ago patient began to complain of uncertainty of locomotion, dimness of vision, some headaches and occasional vomiting spells; later on his gait became ataxic and he was unable to go up and down steps, his vomiting spells became more frequent and more severe, accompanied by very little nausea, often eating a hearty meal after vomiting spell, some days vomiting as often as six or eight times without apparent cause.

At this time, March 27th, 1905, Dr. Harry Adler examined patient and sends me the following report of his condition: "Patient suffering with continued attacks of vomiting, with but little nausea preceeding, vomiting will occur on an empty stomach as well as after taking food. Vomited matter is fluid and bile stained, containing mucous, but no food stuffs.

Examination of patient:—Sight very poor in left eye, fairly good in right; has frequent attacks of vertigo with blurring of vision; arteriosclerosis marked; heart, lungs and liver normal, stomach no dilatation nor displacement, stomach contents, free hydrochloric 16, total acidity 54.

His headaches continued, were constant, but were never very severe; became confined to bed, due to incoordination of lower extremities, and about four months ago became totally blind. About nine months before death the patient developed stuperous spells, lasting from one to three minutes, resembling petit mal. On regaining consciousness he continued to do that which he was doing on being affected. At first these spells occurred only every day or so. Later he had four or five every day, and they would last longer. In the last six months he became dirty in his habits; the bladder was first affected. In the last three months has had epileptiform attacks, followed by short period of unconsciousness. These attacks would begin sometimes in one hand and sometimes in the other, then become general, or they would begin as a general tonic spasm, followed by clonic spasm.

During the past six months vomiting has ceased. Three or four months before death patient became disoriented, thinking he was not at home, but in a stable, and begged to be taken home. About the same time he developed delusions of persecution, thinking his wife was trying to poison him.

Physical Examination:—Well developed, very well nourished white male; at time of examination lying quietly in bed on his back; breathing easily and regularly; expression perfectly blank, but not imbecilic; speech stuttering and explosive in character, with elision of syllables and words. Scar over bladder where supra-pubic cystotomy had been done, and a large scar in the side where ribs had been resected. No deformities nor abnormal movements observed. *Heart*:—No murmurs heard, rate and rythm normal; accentuation of second aortic sound; pulse 78. Volume and force good; arteries are thickened and show calcareous degeneration. *Lungs*:—Sounds clear, with the exception of an area situated in the region of the old operative sight. *Skin*:—Moist and elastic. *Urine*:—Examined several months previously shows the presence of slight amount of albumin and casts. *Motor System*:—Muscular development and nutrition good; no atrophies, muscle tone good, strength of the flexers and extensors of the four extremities good and apparently equal on both sides. There was a fine regular intention tremor of both hands and fingers. *Coordination*:—Upper extremities very poor. Lower extremities also very poor. He could no longer walk unassisted, as he was unable to control the movements of his legs. *Gait*:—When supported on both sides was reeling and ataxic. There occurred at intervals irregular spasmodic contractions of both lower extremities; also there occurred clonic convulsive seizures lasting about one to three minutes, followed by a period of unconsciousness fifteen to thirty minutes, sometimes several hours. At other times these periods of unconsciousness were not preceeded by clonic convulsions, but by a brief tonic spasm. *Reflexes*.—Deep: Knee, tendo achilles, wrist, elbow and jaw are all very much exaggerated. Superficial also exaggerated. Rectal and vesical reflexes are much disturbed, patient voiding urine and feces without calling attention to the fact. Babinski's sign present. Kernig's sign positive.

Sensory Functions:—As far as was possible to elicit from patient there were no changes in temperature, tactile pain or muscular sense, although at times it appeared as if there were considerable obtundation. There were no parasthesias, nor was there any marked tenderness. Romberg's sign was present. There was complaint of some general pain in head.

Cranial Nerves:—Olfactory: Seemed normal. *Optic*:—Absolute blindness; patient could not distinguish day from night, but if bright light were directed directly into eyes he seems to be able to perceive the flashing. *Pupils*:—Are widely dilated and do not react to light. *Fundas*:—Show optic atrophy. *Third, Fourth and Sixth Nerves*:—Movements of the eyes seem good in all directions. *Trifacial*:—Motor branch, normal on both sides. Sensory branch seems to be normal on both sides. *Facial*:—There seems to be some weakness on both sides and patient was not able to whistle or show upper teeth plainly. Whether this was due to mental defect or muscular weakness is very difficult to say. Facial expression is blank and there is an obliteration of the facial folds, giving the face a mask like appearance. This was equally marked on both sides. *Auditory*:—Patient seems to hear fairly well. Glosopharyngeal and pneumogastric seem disturbed, as patient frequently has difficulty in swallowing and has choking spells, but voice is not altered. *Spinal Accessory*:—Equal on both sides. *Hypoglossal*:—Tongue protruded in the median line with marked fine tremor. There were no trophic or marked vaso motor disturbances present.

Physical Examination:—There was present

disorientation, marked weakness of memory for recent events, memory fairly retentive for remote events. Delusions of persecution, but no illusions or hallucinations. At times he was very noisy, crying out and abusing his relatives and friends. At times refused food for fear of poison. Other times he was very tractible. His speech at times became inarticulate and incoherent, merely the production of meaningless sounds. In past few months has always been slow, hesitating and explosive with the elision of words and syllables. In the early part of May the patient died after two days' unconsciousness, and permission was secured for a partial autopsy.

Report of the examination of the brain by Prof. Hirsh:

A tumor situated on the right side of the under surface of the brain, rather loosely attached by fibres to the medulla and above to the middle peduncle of cerebellum. It measures 3.5 c. m. long, 2 c. m. wide and 2.5 c. m. thick; general appearance that of brain tissue, although somewhat softer There are several areas that are translucent and contain fluid, the remainder of the tumor being more or less dense and flesh colored in appearance. To its outer aspect the tumor seems to be encapsulated, but on the inner and superior aspects it merges into the surrounding tissue. On section there are several cystic areas corresponding to the translucent areas mentioned above. *Microscopically*:—Tumor is very cellular, both round and spindle cells being numerous. Nuclei are well stained and rather characteristic of connective tissue cells. There is but little connective tissue separating these cells. Numerous blood channels traverse the section and considerable free pigment is found scattered throughout.

Diagnosis:—Mixed cell sarcoma of brain. Examination of rest of brain negative.

In conclusion I would like to call attention to the fact that although the tumor was situated in the place where it should have given rise to distinct localizing signs, yet at the time of the examination, two months before death and about eighteen months after beginning of the trouble, they were not present or were not discovered after repeated careful examinations. The presence of delusions, the marked speech disturbance, failing mentality, the epilepitform attacks, the sudden and unaccountable short maniacal attacks with the physical signs, optic atrophy, immobile pupil, exaggerated reflexes, fine tremor, marked inco-ordination of the extremities make the differential diagnosis between general paresis at the involutional period and tumor of the brain very difficult.

A STRIKING ILLUSTRATION OF THE EFFICACY OF CONSTITUTIONAL MEASURES IN CONTROLLING INFLAMMATION OF THE MASTOID CELLS.

By Samuel Theobald, M. D., *Clinical Professor of Ophthalmology and Otology, Johns Hopkins University; Ophthalmic and Aural Surgeon to the Johns Hopkins Hospital and to the Baltimore Eye, Ear and Throat Charity Hospital.**

I have on so many occasions, in season and possibly out of season, insisted upon the value of constitutional measures in the treatment of inflammation of the mastoid cells, that doubtless I have created in the minds of some the impression that I am opposed, in general, to operative procedures in this condition. This, I wish to say emphatically, is not my attitude. On the contrary, I am only too ready to admit that, when the indications for it are clear, few surgical procedures yield more gratifying results than does a well executed mastoid operation.

What I have contended for, and what I still believe to be true, is that many cases of mastoiditis interna are operated upon which might be cured more promptly, and as safely, without operation, if those into whose hands these cases fall possessed a broader knowledge of medicine —were more familiar with the measures, other than operative, with which this condition, in many instances, may be successfully combatted. "When shall I operate?" not "What can I do to avoid operation?" is the attitude, it seems to me, of most aural surgeons in dealing with mastoid inflammation.

To cite a single case in support of my contention in this regard seems almost absurd; but the particular case which I wish briefly to describe is so strikingly in point that I prefer to let it stand by itself rather than to report, as I might do, a series of somewhat similar cases.

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*A paper read before the American Otological Society, New York, Jan. 26, 1906.

A little girl, five years of age, as a result of an acute middle-ear inflammation, had an otorrhoea, which had lasted five weeks. She had been under the care of a competent specialist in Baltimore, by whose direction the ear had been syringed with a solution of boracic acid.

On Monday of the week in which the case came under my observation the physician in charge noticed, for the first time, slight evidences of mastoid implication. The previous treatment —syringing with boracic acid—was continued. On Thursday of the same week he found such marked signs of mastoid involvement that operation was advised without further delay.

My opinion as to the advisability of this course being desired, her physician communicated with me by telephone, and the patient was brought directly from his office to mine.

There was no room for a difference of opinion as to the true nature of the condition. All the signs of mastoiditis interna were present. The auricle was prominent; the integument over the mastoid was swollen, red, and very sensitive to pressure; the otorrhoea was exceptionally profuse; and the canal walls were sodden and swollen.

On the other hand, there were no symptoms of retention; the profuseness of the discharge showed that there was a capacious passage-way between the antrum and the middle-ear, and the child was bright and gave no evidence of suffering.

Although I had grave doubts as to the possibility of an operation being avoided, I concluded, in view of the absence of any indications of retention, and the favorable general condition of the patient, that it was permissible to try other measures, at least for twenty-four or forty-eight hours.

This advice was accepted, and treatment was begun without loss of time. Sodium pyrophosphate,* in ten-grain doses, to be taken every three hours, was prescribed; an energetic purgative, containing calomel, scammony and rhubarb, was ordered to be given at bedtime, and, as the boracic acid syringing had seemingly been without avail, a 1:4000 sublimate solution was substituted, with which the ear was to be syringed three times a day.

The patient was seen, in consultation with her physician, at three o'clock the next day—just twenty-four hours after the commencement of the treatment. There was already an unmistakable change for the better in her condition. The discharge was not so profuse, the appearance of the canal walls was more favorable, the ear was less sensitive to the introduction of the speculum, and the mastoid tenderness and swelling were less pronounced. Her temperature at this time was a fraction above 99 degrees. The calomel purgative was ordered to be repeated at bed-time, and the other measures were continued as previously directed.

Later in the afternoon of the same day the patient had a fall, which was followed by some pain, and I was asked to see her in the evening. However, I found her sleeping quietly, with a normal temperature; and from this time the improvement in her condition was so marked that my visits ceased.

Two weeks subsequently the patient was brought to my office, that I might see the progress she had made. No traces of the mastoiditis were left; the perforation in the membrane had evidently been closed for several days, and the membrane, itself, had regained nearly its normal appearance. Whispered words were heard with the affected ear, somewhat indistinctly, at 20 inches.

The discharge from the ear, I was told, had rapidly diminished, and had ceased altogether within five days of the inception of the treatment I had suggested. The administration of the sodium salt had been continued until nearly one ounce (not quite forty-eight doses) had been taken, and the syringing with the sublimate solution had been stopped only the previous day.

Six months have elapsed since the date of this last mentioned visit, and so far there have been no signs of recurring trouble.

It may be that the change in the local treatment was a factor in the rapid improvement which occurred in this case; but, for myself, I am inclined to attribute it, in far greater measure, to the energetic purgation induced and the influence of the sodium pyrophosphate; and so I have not hesitated to report the case as a striking example of the efficacy of constitutional measures in controlling inflammation of the mastoid cells.

*For an account of this drug, the method of administering it, and the indications for its employment, see the writer's paper, "What means, other than operative, have we for preventing and combating inflammation of the mastoid cells," *New York Medical Journal*, Sept. 13, 1902, also his treatise on "Prevalent Diseases of the Eye," pp. 62, 110, 120, 136 and 519.

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EDITORIAL

THE FUTURE OF THE UNIVERSITY OF MARYLAND.—There are a few pessimists in the ranks of the medical profession who hold the view that the unendowed medical schools will sooner or later be forced to close their doors and give up the teaching of medical students. These men base their opinions upon the ground that the endowed schools, like the trusts in the industrial world, are driving out competition through the special advantages which a large capital gives them. The use of money is a great power and the advantages it gives can not be denied, still there are compensating conditions which act as checks and in spite of the Trust small industries continue to live and reap fair profits. It is claimed that the Trusts cheapen the commodities they handle and are able to do business at a smaller profit than the individual manufacturer. This may apply to the Trusts in the industrial world, but does it apply to the so-called educational Trusts? Have tuition fees been lowered by the largely endowed educational institutions? On the contrary they demand more of the student's money, except in a few instances where scholarships are given, than any of the unendowed schools. They claim not to be in competition for the average student, but in search for the uncommon student with a big brain and big purse. The chief claim of the endowed school is that it is educating men for positions as teachers, original investigators or for specialized fields of labor. In doing this high order of work the endowed institution is not coming into competition in a large way with the unendowed school. On the contrary it is giving a helpful stimulus to institutions with small resources and in many instances supplies them with teachers, text-books and better systems for imparting knowledge. The unendowed medical school may be said to hold the same relation to the richly endowed medical school that the small college, the high school and other institutions giving a secondary education hold to the large universities with their superb facilities for post-graduate as well as undergraduate work. In the American system of education there will always be a field for the small institution as well as for the large. Should the principles of democracy cease and the government usurp all the functions of educating the people, then we may look for a weeding out process that will drive the small institution out of business. Until that day comes let us cherish the hope that every institution which aims to impart knowledge and to improve the condition of society by its educational work will have the right to exercise its functions. The law of survival will act sufficiently well in the vast majority of cases to eliminate the undeserving without the aid of legislation or harsh systems of competition.

The term endowed, as here used, must be viewed as a relative term. Every institution of any historic standing has, in a sense, an endowment. The possession of large property interests is not at all times the best possession of an institution. The few men of large wealth in a community are not of necessity the men of highest character in that community. Institutions as well as individuals must have something more than money and the influence which it brings to give them standing and character.

As desirable as the possession of property may be to an institution it should not be its chief asset. Money simply gives an advantage in enlarging the scope of work, a better plant for the conduct of the work, larger salaries to the teacher, and the opportunity to confer scholarships upon deserving students. These are all meritorious functions as well as desirable privileges, but are not absolutely essential except in a relative sense.

There are a large number of meritorious institutions in this country doing good work and occupying honorable positions in their respective communities which have earned their own capital and lived entirely on tuition fees received from students. The University of Maryland in her ninety-nine years of continuous work has had but little assistance from the City, State or from private bequests. She has carried on this

work through the aid of tuition fees, which have been expended as liberally on the property she now owns as circumstances at the time required. Yearly her property holdings have increased and her student body has grown. She has lived through the conditions which have surrounded her in the past ninety-nine years and there is no reason to assume that she will not continue to grow and prosper in the future. The conditions which surround her today are more favorable than they have ever been if she will adhere to the policy of giving her students a value in education for the money they give for instruction. When she attempts to usurp the functions of the endowed school, or becomes ostentatious and arrogant without capital to back her pride of intellect, then she will cease to be what she has been and should be an honest, practical and successful educational institution. The University has a distinct field in which she can develop the most useful functions in medical education. She has the very best clinical facilities and can give a thorough, practical education. While a few of her graduates have reached high positions in the profession as teachers and as original workers the vast majority of her graduates have been first class physicians and surgeons, good citizens and useful men in the communities in which they have lived. Her alumni, wherever found, are an honor and credit to her and tell the true story of her useful work as an educational institution. This record should be her pride and stimulus for the future. She has no need to fear that the views of the pessimists will prevail. She has only to press forward with hope and vigor along the lines she adopted in her early history when she established her hospital and began to teach clinical medicine at the bed-side.

Recent Purchase of Property by the University of Maryland.—The Faculty of Physic of the University has recently purchased four houses on the Northwest Corner of Greene and Lombard streets, fronting 76 feet on Greene street and about 90 feet on Lombard street. This property gives the University the control of the four corners of Greene and Lombard. In acquiring this property the Faculty has in view the future needs of the University. It is proposed at no distant day to erect a dormitory building on the property recently purchased for the housing of students who may desire to live in close proximity to the Hospital and University building. It is believed that a large dormitory building will be a most valuable addition to the present educational plant of the University. In addition to a large number of sleeping rooms, study rooms and baths, it will be equipped with a gymnasium, reading rooms and rooms for the use of college fraternities. The housing of a large body of students in one building will promote a larger University spirit in the student body and will exercise a beneficial influence over the morals and habits of the students. The Faculty is desirious of promoting the interests of the students in every way. Nothing is being left undone within the means of the Faculty to enlarge and develop the educational work of the University. Having full faith in the future of the University, it is the purpose of those in present charge of her interests to enter upon the second century of her history with large views of her possibilities and to lay a broad foundation for her future growth. It is believed that the Alumni and friends of the University will give a helpful encouragement to work which is now being undertaken and will contribute to the growth of the endowment fund which is yearly increasing in the hands of the Trustees having charge of this Fund. The Bulletin feels assured that if the Faculties in control of the different departments of the University will do their full duty in building up their respective departments by a vigorous and up-to-date educational work, th friends and Alumni of these departments will give their loyal support.

The University of Maryland is a State University in name and should be made to assume the same relations to the State of Maryland as are assumed by State Universities in other States. These relations have grown to a marked degree in recent years since the State has appropriated liberal sums of money to aid the University. The property which the Faculty of Physic has acquired in recent years belongs to the State of Maryland and not to the Faculty of Physic. The latter has only a control over its management and it can not be used for any other than educational purposes. Every dollar of money expended by the Faculty of Physic in the purchase or in the improvement of the university plant out of tuition fees is a permanent gift to the State. No advantage can come to the Faculty except through the larger growth of the student body and possible increase in tuition fees as a result of a more liberal expenditure of money on the

educational plant. This advantage is as favorable to the people of the State as it is to the Faculty. Whatever prosperity the University may enjoy the people of Maryland indirectly share. Her larger growth is in the interest of the people and every citizen should feel a pride in her welfare.

BOOK NOTICES.

A MANUAL OF NORMAL HISTOLOGY.

ADAPTED FOR THE USE OF MEDICAL STUDENTS IN THE CLASS ROOM AND IN THE LABORATORY.

BY TILGHMAN BRICE MARDEN, A. B., M. D., CLASS OF 1892, *Professor of Histology, Bacteriology and Biology at the Baltimore Medical College. Press of A. Hoen & Co., Baltimore, Md.*, 1906.

The BULLETIN welcomes this second edition of Professor Marden's book on Histology and takes great pleasure in commending it to the use of the medical student and general practitioner. Prof. Marden is a distinguished graduate of the University of the Class of 1892. For some ten years he has been engaged in teaching histology, bacteriology and biology in the Baltimore Medical College, where his success as a teacher and writer has brought him well deserved promotion to a full chair in that institution.

This edition of his book has been re-written and enlarged, and in its present form presents a practical and concise statement of the subjects of which it treats. It gives a thorough knowledge of the essential facts of the science so arranged that the student can study and comprehend them with ease. The book is beautifully illustrated by the author and not by an artist, who is liable to sacrifice exactness for artistic effect. The author has sketched directly from specimens which he has prepared and then submitted to the microscope. Experiments have been introduced to illustrate the text and to furnish the student the means of verifying the reading matter. The author has added an appendix which besides describing stains, etc., gives a table showing methods of preparing specimens as taken from the body until stained and mounted for microscopical examination.

The book is well written and well printed on good paper. It will be found of great value to every student of histology.

CORRESPONDENCE.

VIENNA, AUSTRIA, July 28, 1906.

To the Hospital Bulletin:

The summer is a bad time for visiting the foreign clinics, but we have been very fortunate in this respect, as we have been able to see the work of some of the best men in Europe. In Berlin we were very cordially received by Professor Albert Hoffa, and were shown everything in both his private and public hospitals, besides taking a ride with him and his wife in his automobile. We saw him operate on two cases, and as far as I can judge, he is doing fine work in orthopedic surgery, and especially in the transplantation and substitution of tendons and muscles for those that are paralyzed.

In gynecological work we saw Professors Bumm and Duhrassen do several operations. Whenever possible they operate through the vagina, and it looks to me as if the uterus was being removed unnecessarily in many cases; and the vaginal route does not appeal to me as being the best for the removal of uterine fibroids. Professor von Bergmann is the chief professor of surgery, but he is now an old man. He has a fine clinical amphitheatre, and an abundance of material, but he is getting too old for his position, and will soon resign. We had hardly taken our seats in his lecture room, when my former assistant, Dr. Wm. H. Smith, came down and spoke to us. He has been studying in Vienna and Dresden, and will remain awhile in Berlin. He says he has followed the best men, but does not think he has done any better than he would have done if he had been going around the wards with Dr. McElfresh. Bergmann operated on a case of supposed cancer of the side of the tongue, and I was not pleased with his method, and as far as I could see, he took almost no care in his aseptic technique. The technique of the men we have seen has been far simpler than ours, and according to our ideas entirely insufficient. They do not wear masks; and but few of them wear gloves of any kind, and they do not seem to devote much care to the cleansing of the hands.

Berlin is making great efforts to improve her hospitals, and is now completing a huge institution called after Virchow, which, it is claimed, will be the largest hospital in the world.

At Leipsic we were treated most kindly by Professor Frederick Trendelenburg, known all over the world as the originator of the famous

and useful Trendelenburg position. We took tea at his house, where we met his family, who were most cordial in their welcome. Professor Trendelenburg has a fine amphitheatre, which can be darkened in a few minutes, and then by means of a huge electric lantern, pictures, solid objects, or pathological specimens can be thrown on the screen, even the colors of the objects being preserved completely. He has an immense service of about 350 beds, and we had the opportunity of standing by him while he performed a number of interesting operations, such as intestinal obstruction, resection of colon, resection of upper jaw, appendectomy, and excision of tunica vaginalis. He is a quick and good operator, and we were much pleased with him and his work. We met Professor Zweifel, the distinguished gynecologist, but unfortunately were not able to see him operate. From Leipsic to Dresden is only a short journey, and we improved the opportunity by visiting the famous picture galleries and collections of works of art in that city, but did not visit any medical institutions, though I understand there's a fine new hospital located there. Leaving Dresden, we traveled through the mountains of Saxony and Bohemia, to Carlsbad, where we met our friend and colleague, Professor John C. Hemmeter, who has been sojourning there for some weeks with his wife. His health has been much improved by his residence at this famous resort. It is very amusing to see the long lines of people waiting for their turn to get a glassful of the hot water from some of the various springs. The famous Sprudel jets up with great force, and a number of girls are stationed here continuously, who dip up the water and give it to the patrons. Thousands of people from all over the world are to be found here, and among them we saw one well dressed man as black as the ace of spades, and I strongly suspect he was one of Uncle Sam's ebony boys. The people buy their own bread and often ham or other meat, and then go to some open air resort and get coffee and eat their own provisions, while bands are playing in many places. Carlsbad is beautifully situated in a narrow valley between mountains, the houses being built also in tiers on the mountain sides. The air is invigorating and the scenery refreshing, which, with the enforced regimen and regular hours restore many persons to at least temporary health. From Carlsbad to Vienna is a journey of about 11 hours, for the greater part through a charming mountainous country, where almost every inch of ground is in a high state of cultivation, the tilled fields extending in many cases quite to the top of the mountains. Austria differs in many respects from Germany in appearance and the people do not look so prosperous, and both man and woman work hard in the fields, even on Sundays. We reached Vienna on July 22 and have had a very pleasant time in every way. As the holidays have come, nearly all the distinguished men have either left the city or have ceased to operate, and many whom I would like to have seen I have been unable to come in contact with. In one respect we have had exceptional opportunities, which, however, will be of more use to Professor Hundley than to me in the observation of the work of Professor E. Wertheim at the Elizabeth Hospital. He is doing magnificent work in uterine cancer, and by his vaginal operation he claims 60 per cent. of immunity from recurrence after 5 years, provided the pelvic lymphatic glands are not involved. If there is glandular infection very few are permanently cured. We were fortunate enough to see him perform this operation several times, in one of which he dissected the ureter out from a bed of infected tissue. We also saw him operate many times for myomas, and other pelvis conditions, in which he made use of the vaginal route. I do not see the advantage of this method. Professor Adolph Lorenz was most cordial to us, and although he was about to go on his summer trip, he took us in his automobile through the beautiful Wiener Wald, over the mountains to his splendid chateau, where he lives in a simple but elegant manner. His residence overlooks the Danube river and has a wide view of valley and mountain, and is an ideal place for a busy surgeon to seek release from the cares of his daily work. We spent a night at his hospitable home, where we were made welcome by both the Professor and his charming wife. I saw some operating in cases of general surgery at the clinics of Professors Eiselberg and Hochenegg, but was not fortunate enough to meet either of them; in fact Professor von Eiselberg is just recovering from an operation for appendicitis himself.

RANDOLPH WINSLOW.

Dr. Hiram Woods has returned from his European tour; Drs. Winslow and Hundley expect to return about September 15, 1906.

ABSTRACT.

At the meeting of the University of Maryland Medical Association, held February 20, 1906, Dr. Gordon Wilson exhibited a case of Stokes-Adams Disease. The following brief abstract may be of interest to our readers, as it includes our entire knowledge of this peculiar and rare disease:

Stokes-Adams Disease is interesting on account of its excessive rarity. Adams, of Dublin, being summoned to see a man who had frequently had attacks similating apoplexy from which he afterward recovered without any paresis, the pulse during the attack often being as slow as ten beats per minute, was the first observer to call the attention of the medical profession to this pathological phenomenon, but it remained for Stokes between the years 1836 and 1846 to discover the disparity between the number of contractions of the auricles and ventricles. Yet not until recent years was a satisfactory reason advanced by Erlanger why the component parts of the heart were pulsating independently of each other. The essential symptoms as in the case of this colored man, first seen in 1902 in the Dispensary of the University Hospital, and his condition diagnosticated by Dr. Carroll Lochard, consist of vertigo, pain in the abdominal region, ascites, more frequently in males, roaring in the ears, edema of feet, an irregular heart, the ventricles pulsating in this case 34 times to the minute, while the jugular veins dilate and contract 68 times per minute, constituting what is known as a partial block. In some cases there is no relationship between the rate of auricular and ventricular contractions, which phenomenon is spoken of as a complete block. In the case of this individual, as he had not only smallpox but also syphilis, he was put on specific treatment.

Pathology and Physiology:—Formerly it was taught that the heart beat rhythmically owing to the nerve ganglia of Remak and Bidder transmitting the impulse from the auricle to the ventricle, thus acting as it were as the connecting link in the mechanism of the heart. Now it is known that the musculature of the heart contracts from its own inherent vitality, and no nerves have to be present for the fibres to exhibit the property of contracting in a rhythmical manner and can transfer this stimulus from one fibre to the other. In 1903 he further enlightened us upon the construction of the heart by discovering a bundle of muscle fibres extending from the foramen ovale of the auricle through the auriculo-ventricular valve, thus connecting the musculature of the auricle and formerly it was believed that the muscles of the upper and lower chambers of the heart were entirely independent of each other. The existence of these fibres were confirmed by Erlanger, who still further worked out the idea by discovering that by destruction of these fibres the auricles and ventricles beat independently of each other. If the fibres are only partially destroyed the upper and lower compartments beat independently of each other, but in definite ratio, *i. e.*, either 1-2, 1-3, etc. Where the beats bear some definite ration to each other such as that enumerated above, the condition is spoken of as partial block. All these facts have been confirmed experimentally as well as in the post mortem room.

NOTES AND ITEMS

Dr. P. F. Martin, class of 1900, has been elected president of the Maryland branch of the Ancient Order of Hibernians.

Dr. Alan G. Brooks, class of 1906, of Philapolis, Maryland, has been appointed a resident physician in the Columbus Hospital, New York.

Dr. Melchoir Cockey, class of 1879, of Fort Riley, Kansas, during the past month came to Maryland to see his mother who was very ill and has since died. Dr. Cockey has been in the West about 27 years.

Dr. S. Griffith Davis, class of 1893, captain and assistant surgeon in the Fifth Regiment Infantry, Maryland National Guards, has been promoted to the position of major and surgeon, vice Dr. St. Clair Spruill, class of 1890, resigned.

We are glad to report that Dr. William C. Kloman, class of 1855, of 2422 Linden avenue, Baltimore, who recently received a dislocation of his left shoulder by being thrown from a street car, has improved sufficiently to be out again.

Dr. D. W. Snuffer, of the class of 1906, has recently passed the examination of the West Virginia State Board with an average percentage of 98, which speaks well for his training at the University of Maryland. Dr. Snuffer has opened his office at Beckley, W. Va., his old home. The BULLETIN wishes him success.

Dr. Harry Adler, class of 1895, associate professor of diseases of the stomach and one of the most popular of the younger members of the faculty, was elected president by the board of directors of the Hebrew Hospital and Asylum, Monument street and Hopkins avenue, Baltimore, at a meeting of the board September 2, 1906.

We are glad to report that Dr. J. G. Selby, of West Virginia, a well known and popular member of the class of 1899, and M. R. Bowie, class of 1906, equally well known and popular with the present generation, who have for the past month been very ill with typhoid fever in the University Hospital, are now convalescing and on the high road to recovery.

Dr. Joseph G. Evans, class of 1903, assistant quarantine officer at Christobal, Colon, in the Panama Canal Zone, recently stopped in Baltimore a few days while on his way South to his home at Marion, South Carolina. Among other of our alumni stationed in the Canal Zone are Dr. H. R. Carter, class of 1879, director of the hospitals; Dr. Taylor E. Darby, class of 1904, physician, Aneon Hospital; Dr. Howard V. Dutrow, class of 1904. After a leave of absence of six weeks Dr. Evans will return to his post.

Dr. J. Ridgely Andre, class of 1850, of 2021 St. Paul street, Baltimore, Maryland, was severely hurt about the right breast and head August 21, 1906, while driving along Mount street, near Edmondston avenue, through his carriage breaking down and himself thrown into the street. Though 82 years of age Dr. Andre daily visits his patients, and has a large practice. He was en route the day of his accident to the home of a patient when the front axle of the carriage broke. The horses became frightened and the aged physician was thrown into the street, striking his head.

Dr. A. J. Crowell, a distinguished alumnus of the University of Maryland, residing at Charlotte, N. C., has recently been offered a professorship in the College of Physicians and Surgeons, of Dallas, Texas. Some months ago Dr. Crowell declined a similar offer from Baylor University, Texas. Dr. Crowell is now professor in the North Carolina Medical College, located in Charlotte, and he has succeeded so well in his profession in his native State that he declines the offers from other institutions. The old North State needs such men as Dr. Crowell in her educational development. The BULLETIN congratulates him upon his decision to "let well enough alone." He has a splendid future in Charlotte.

These alumni hold the chairs appended to their names at the College of Physicians and Surgeons, Baltimore: Dr. Charles F. Bevan, class of 1871, Professor of the Principles and Practice of Surgery and Clinical and Genito-Urinary Surgery; Dr. N. G. Keirle, class of 1858, Professor of Medical Jurisprudence and Director of the Pasteur Institute; Dr. I. R. Trimble, class of 1884, Porfessor of Anatomy and Clinical Surgery; Dr. George W. Dobbin, class of 1894, Professor of Obstetrics and Gynecology; Dr. Wm. Royal Stokes, class of 1891, Professor of Pathology and Bacteriology; Dr. Cary B. Gamble, Jr., class of 1887, Professor of Clinical Medicine; Dr. Archibald C. Harrison, class of 1887, Associate Professor of Surgery and Demonstrator of Anatomy.

These alumni are located in the following States:

Colorado:—Dr. Wm. J. Baird, class of 1881, Boulder, Boulder county; Dr. Wm. C. Mitchell, class of 1889, Denver, Arapahoe county; Dr. Edmund C. Rivers, class of 1879, Denver, Arapahoe county; Dr. Wm. A. Sedwick, class of 1893, Durango, La Plata county; Dr. Benjamin L. Jefferson, class of 1893, Steamboat Springs, Routt county; Dr. Benjamin S. Roseberry, class of 1874, Victor, Teller county. Dr. Mitchell holds the chair of Bacteriology in the University of Denver.

Connecticut:—Dr. Fred. Jackman, class of 1880, Clinton, Middlesex county; Dr. Isaac Farrar, class of 1857, Harford, Harford county; Dr. N. R. Hotchkiss, class of 1896, New Haven, New Haven county; Dr. Fred. Baker, class of 1888, South Norwalk, Fairfield county.

Delaware:—Dr. G. Frank Jones, class of 1889, Georgetown, Sussex county; Dr. Joseph B. Waples, class of 1869, Georgetown, Sussex county; Dr. W. T. Skinner, class of 1870, Glasgow, New Castle county; Dr. Wm. T. Jones, class of 1895, Gumboro, Sussex county; Dr. Edward Fowler, class of 1858, Laurel, Sussex county;

Dr. E. F. O'Day, class of 1891, Little Creek, Kent county; Dr. Merideth Samuel, class of 1900, Marshallton, New Castle county; D. I. Vallandigham, class of 1868, Middletown, New Castle county; Dr. John B. Butler, class of 1877, Newark, New Castle county; Dr. Dorsey Lewis, class of 1896, Odessa, New Castle county; Dr. Millard Corkran, class of 1884, Wilmington, New Castle county.

MARRIAGES

Dr. Albert A. Singewald, class of 1902, of Baltimore, and Miss Jennie Morrison, of Lynchburg, Virginia, were married at Lynchburg, June 20, 1906, at the home of her brother, Mr. J. A. Morrison, by the Rev. J. J. McGuirk, rector of the Holy Cross Catholic Church. After a honeymoon spent in the North Dr. and Mrs. Singewald will reside at 103 South Broadway, Baltimore, Maryland.

Dr. Joseph William Holland, class of 1896, of Baltimore, demonstrator of anatomy in the University of Maryland, and for years a resident physician in the University Hospital, and also an ex-resident physician at Bay View Asylum, was married Wednesday, June 20, 1906, to Miss Pearl Huntington Robins, daughter of Mr. and Mrs. Harrison Robins, at the home of the bride's parents, 1714 Madison avenue, Baltimore, by Rev. Dr. Ezra K. Bell, pastor of the First English Lutheran Church. After the honeymoon spent in the north, Dr. and Mrs. Holland will reside at Deer Park, Maryland, where Dr. Holland has been appointed resident physician for the summer.

DEATHS

Dr. Robert Gover Allen, formerly of Washington, Illinois, but now a resident of Darlington, Maryland, who in the early fourties took a special course in surgery at the University of Maryland, died June 24, 1906, at Darlington.

Dr. John W. Farmer, class of 1868, one of the oldest citizens and physicians of Radford, Virginia, was fatally injured August 25, 1906, by a wagonload of lumber being overturned on him. Besides being injured internally several bones of his body were broken.

Dr. Howard H. Hopkins, Sr., class of 1869, one of the best known physicians of Frederick county, died at his home in New Market, Tuesday, June 26, 1906, aged 58, of consumption. He is survived by a widow, who was Miss Downey, daughter of the late William Downey, and five children—Dr. Howard H. Hopkins, Jr., class of 1895; Dr. W. H. Hopkins, of Mt. Airy, and Dr. Stephenson Hopkins, of Belair, and Misses Mary and Margaret Hopkins, of New Market.

Dr. Calvin D. Snyder, class of 1898, a lieutenant and contract surgeon in the United States Army, was killed August 9, 1906, in a hand-to-hand fight with an overwhelming force of Pulajanes at Julita, Island of Leyte, Philippine Islands. The news of Dr. Snyder's death came as a great shock to his numerous friends and professional brethren located in this city, where during his early professional career he was very popular. Dr. Snyder was born at Baltimore, July 15, 1878, and obtained his early education in the public schools and the City College. Later he matriculated at the University of Maryland, where the degree of Doctor of Medicine was conferred upon him with the class of 1898. After graduating he spent several years in Bay View Hospital and the University Hospital as interne. In 1900 he entered the medical service of the United States Army and served two years in the Philippines, after which he returned to this city and opened an office; but in 1903 the fever came over him again and he re-entered the medical service of Uncle Sam's land forces. At the time of his death Dr. Snyder was attached to the Eighth Cavalry. The BULLETIN extends to the afflicted family its heartfelt sympathy.

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A REVIEW OF THE MODERN OPERATIVE TREATMENT OF DEVIATION OF THE NASAL SEPTUM, WITH ESPECIAL REFERENCE TO THE ADAPTATION OF OPERATION TO THE VARIOUS TYPES OF DEFORMITY.*

JOHN R. WINSLOW, B. A., M. D.

Clinical Professor of Nose and Throat Diseases in the University of Maryland.

(Continued from September.)

THE SUBMUCOUS OPERATION.

This should be defined as the removal of larger or smaller areas of the septum in between the muco-perichondrial and periosteal layers, and should not be applied to the mere preservation of larger or smaller shreds of soft tissues upon the convex side.

It has been recently so fully and ably discussed by Killian, Freer, Ballenger (Annals of Otology, etc., June, 1905) and others, as to warrant but little further mention. This type of operation is based upon the assumption that the septum is a mere partition and not a support of the external nose. While it may be feasible, personally I do not believe that it is indicated or justifiable in all varieties of deformity, any more than the operations which have preceded it.

Final judgment cannot as yet be passed upon the method. It supplements the other methods and constitutes an operative advance so great that the word "inoperable" may almost be removed from septal terminology.

I believe that ultimately it will be employed in these hitherto inoperable and other difficult cases, as well as in simple cases in which very limited resection is necessary. Extensive resection for the relief of minor deformities is defensible.

It is contraindicated in very young or very nervous patients, and in the debilitated or those afflicted with local or constitutional disease. Its results are much better in cases without cicatrices or adhesions from previous operation.

For simple anterior and median deformities I prefer the Killian method, owing to the shortened period of healing and the limited crust formation in simple ledge-like and in complicated cartilaginous and osseo-cartilaginous cases the Freer method is more suitable. Also in narrow noses and in children. The length of time (30-90 minutes) required and consequent nervous and physical strain have been the main objections to the operation. The technic is being constantly improved and new instruments invented, with the view of removing this disadvantage. My personal experience consists of 6 cases by the Killian and 9 by the Freer method; all of these were carefully selected cases of complex cartilaginous or bony deformities, and gave excellent results, with the exception of a wall perforation in 2 early cases. The operation has occupied from 30 to 60 minutes, and both the patient and myself have felt the physical effects of the seance. I have performed two operations under general anesthesia by this method, one in a child and one in an adult; they were attended with such difficulty that I shall hereafter resort to other methods when forced to operate under these conditions.

The *Harrison-Allen* supra-labial operation (A. A. Bliss, Tr. Amer. Lar. Assn., 1901) consists essentially in severing the maxillary crest by means of a small chisel placed beneath the upper lip. The mobilized septum is then forced over with the finger and retained in position with a splint until it becomes fixed. The operaton is usually done under light etherization, although it may be successfully performed under cocain injection. This operation is indicated in a well defined class where there is a displacement of the whole mass of the partition, so that its whole lower border rests on the floor of one or the other nostril. There is little or no curvature of the surface, but there is always more or less encurvation of the anterior nasal spine to-

ward one or the other nostril often combined with hyperostosis, so that the vestibular floor is converted into a narrow fissure. It is also very valuable as an accessory to other methods. (Asch-Douglass.)

Every case of septal deviation is an individual one and its correction a matter of individual study. Deformities vary from simple plane deflection to forms so complex as to defy description or illustration. There are many methods of correcting these deformities, varying from a simple single incision, to maneuvers so complicated as to deserve the name of plastic operation. The majority of operators combine the best features of each of these methods. To variable deformities must be adapted an equally variable treatment.

I—Simple deformities:

(a) Cartilaginous—

Moderate, bowed or angular. | Asch. Douglas. | Single or several incisions.

Extreme bowed or angular. | With overhang—Gleason. Without overhang—Douglass.

Plane deflection | Slight curvature of cartilage | Tongue-shaped flap, knives forceps.

Dislocation of cartilage from surfaces articular. | Knives.

Irregular and thick—Bosworth, Krieg, Kyle, Fetterol.

(b) Bony.

At face of ethmoid—Roe, Kyle saws.

At nasal spine—Harrison Allen.

At osseo-cartilaginous junction—Roe forceps.

II—Complicated deformities:

(a) Cartilaginous-complex shape—Submucous.

(b) "Mixed," with overhang—Gleason.

"compound"—Submucous.

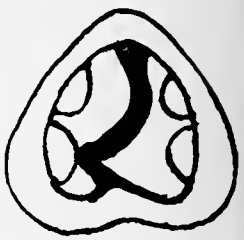
Some deformities are so complex and the operations for their relief so intricate that they deserve to be classified among the performance of plastic surgery.

A medical man, 23 years of age, as the result of a football injury some years before, presented complete nasal occlusion on the right side and consecutive postnasal and tubal catarrh.

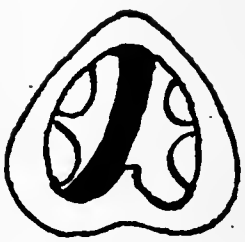
Type of Deformity: The septum had been fractured horizontally into the bony septum; the upper segment completely separated from the lower and carried into the opposite nostril, where it became embedded in hyperplastic material and adherent to the floor of the nose; the right surface of the triangular cartilage presented almost vertically at the right nostril. A fine probe could scarcely be inserted between the cartilage and the laternal nasal wall. A vertical ridge one-half inch in height, ran antero-posteriorly along the floor of the nose, consisting of bone with a capping of cartilage; between this ridge and the septal plate was a deep pocket on the concave side. Operation was done under local anaesthesia (cocaine 20 per cent. mop, eucaine 5 per cent. by injection) and adrenalin, and was almost painless and bloodless, modified Gleason operation; duration about 1 1-2 hours. The vertical ridge was first denuded, (b) then, with a saw and knife, a modified Gleason U-shaped flap was made, (a) consisting of bone and carti-

SOME TYPES OF DEFORMITY WITH CORRESPONDING OPERATIONS.

Bowed (chondral), with overhang near nasal floor. Operation: Gleason or Douglass.

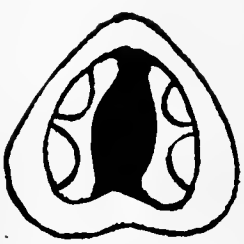


Compound deviation (bowed ethmoid-angular cartilage). Operation: Rose, Kyle. Submucous resection.



Plane deflections and dislocation from nasal spine: may be embedded in mass of hypertrophy at nasal floor. Operation: H. Allen (Hajek [old]) alone, or combined with chisel in trephine.

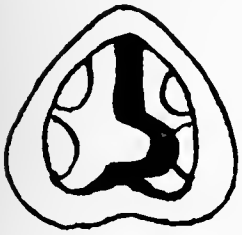
"Crumpled" septum. Operation: Bosworth. Submucous resection.



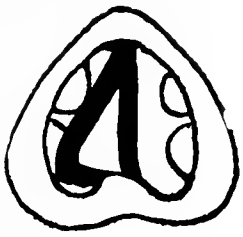
Interstitial fibrosis. Operation: Bosworth (flap). Submucous resection.

Angular (or bowed) deviation (ethmoid-chondrol dislocation from nasal spine, and projection into opposite naris. Submucous resection.

lage, and forced over this ledge into the opposite nostril. To lessen the resiliency of a much-thickened septum, a horizontal groove was cut in the neck of the flap along its greatest convexity. (c) No splints were employed; ice compresses. Considerable post-operative hemorrhage ensued, causing some worry, which yielded, however, to continued cold. After two days' rest in bed, convalescence began and continued without event. After recovery a vertical ledge was seen in the right nostril posteriorly, at the point of section, which was easily removed with cutting forceps, about one month after the first operation. There is considerable redundant cartilage in the floor of the right nostril, but as respiration is free and the ear can be satisfactorily treated, no further operation is contemplated. Previous to these operations a submucous cauterization had been done on an hypertrophied left inferior turbinated.

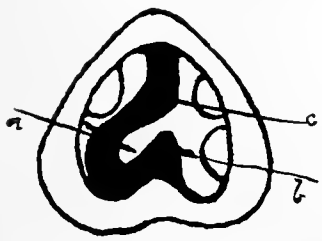


Cup (or cone) shaped indentation of septal cartilage. Operation: Submucous resection.



Vesicular separation of one septal plate operation: Submucous resection.

Vesicular separation (bilateral) flaring out of one plate into opposite naris. Operation: Submucous resection.



CONCLUSIONS.

The majority of these cases can be satisfactorily treated by short operations under cocain-adrenalin anesthesia, and this should be employed whenever possible. The use of cocain admits of exactness in placing a limited number of incisions with adjustable instruments under visual inspection, in the location where they will be most effective. Success depends more upon thoroughness in making the primary incisions and exactness than any other element. By exercising judgment in the selection of patients and skill in the use of cocain, carefully guarding it with adrenalin, strychnin or alcohol, strong solutions or even pure powder can be used with safety.

The simple deviated septum operation is practically in difficult cases, all the preliminary incisions should be made under cocain, and the painful part use of forceps, etc., done under light general anesthesia. Prolonged general anesthesia is now seldom required in these cases.

The trend of operative improvement should be toward simplification of technic and shortening of duration rather than toward complexity. All obsolete and unnecessary instruments or manoeuvers should be eliminated. In a large percentage of cases the use of forceps, either as a crushing or a compressing instrument, is ineffectual or unnecessary. Fracture and replacement with the finger is efficient and painless, when the incisions are made completely through the cartilage. Therefore this, the most painful step of the septal operation, can often be omitted. Fracture or incision of the nsal spine eliminates the necessity for forceps, shortens the period of splint-wearing, and should be an integral part of all operations to which it is adapted.

We now have a number of time-tested and successful operations, each one especially adapted to one or more of the infinite variety of deformities. It is a mistake to claim that every operation will correct all varieties; operations must be selected and adapted to individual deformities, and it is often a difficult matter to decide which operation is best in a given case. I believe that success is as much dependent upon good judgment in this respect as in marked operative ability. Here the tyro fails.

If there be any excuse for the existence of specialism at all in nose and throat work, it is surely in the line of septal orthopedics. To successfully treat these cases one must possess a special mechanical ingenuity and dexterity in endonasal technic, both in operating and in after-treatment, that can only be acquired by constant practice. It is a specialty within a

specialty; one must be not only a specialist, but an expert in this particular line of work. We must moreover become experts in several methods, as we may have to combine one with the other. (Douglass-Roe; Roe-Kyle; Douglass-Allen, etc.)

CHEMICAL ADAPTATION OF THE SECRETORY PROCESS.

By Hubert Richardson, M. D.

Clinical Lecturer on Neurology and Psychiatry and Lecturer on Physiologic Chemistry at the University of Maryland. Pathologist to the Maryland Asylum and Training School for Feeble Minded Children. Late Pathologist to Mount Hope Retreat.

The capacity of adaptation to their environment is found in all living organisms from the lowest to the highest, it being necessitated by changes in the food or by presence of harmful substances in the surrounding medium. This is exemplified in the mould Penicillium Glaucum, which, when grown on calcium lactate, forms invertase, when grown on starch it produces amylase in addition, when on milk it produces a proteolytic ferment and rennet; acquired immunity to toxins is an example of the power of adaptation of the organism to its environment.

There is in the higher animals an adaptation of the secretions of the digestive tract to the nature of the food taken which it is of great importance to understand in order to regulate diet. The reaction of any part of the body to external changes involves alterations in its relations to other parts and there is a complex system of internal corelation of the activities of the organs, affected partly by the action of the nervous system and therefore determinant of changes in form, through the means of the internal medium, the blood or similar fluid. The profound influence of the thyroid secretion of the nutrition of the whole body especially on the central nervous system and of the secretion of the suprarenals which maintain the tone of all contractile tissues are examples of the far reacting functions of secretions which require some controlling influence to keep the supply in touch with the demands of the organisms.

Certain chemical changes produce adaptation in certain cells in the digestive tract which are of great practical importance. Each division of the digestive tract has its own set of reactive mechanisms arranged so as to pour a secretion upon the ingested food which will dissolve one or more of the food constituents and further the secretions are poured forth in varied quantities and of different constitution, in order to obtain the maximum digestion with the minimum amount of energy.

The mechanism of the flow of the saliva is entirely nervous, the mucous membrane having distinct sensibilities for the different classes of food, the salivary glands being excited reflexly, according to the nature of the substance present in the mouth. In the stomach there is also a nervous controlling influence as shown by the secretion of the psychic juice at the sight, or smell of food, by appetite or by reflex impulse arising in the mouth, after the food is swallowed the quantity and quality of the secretion is independent of the nervous system and is determined by the nature of the food in the stomach. There is also a habit secretion. A person who is in the habit of eating large quantities of protein calling for a large secretion of acid will secrete more acid than is necessary; should he take to a carbohydrate diet he will suffer with digestive disturbances. It is, therefore, very necessary that the quantity of the protein in the diet should be reduced gradually, thus accustoming the stomach to secrete less. The strongly acid fluid containing the products of gastric digestion in solution on entering the duodenum meets the bile and pancreatic juice secreted in a definite amount so as to neutralize the acid juice to practically neutral reaction. Pawlow and his school claimed that the time of their secretion and the quantitative composition of ferments was due to a nervous reflex from the duodenal mucous membrane excited by the chyme. Popielski and Wertheimer showed that the introduction of acid into the duodenum produced pancreatic secretion after severance of all nerve connections of the pancreas and alimentary tract with the central nervous system and destruction of the sympathetic ganglia of the solar plexus; they also pointed out that pancreatic secretion could be induced by acid inserted in any portion of the small intestine except the lower six inches; further when a loop of intestine isolated by the destruction of all nerve connections was acidified pancreatic juice was secreted as under normal conditions. As the introduction of acid into the blood vessels does not provoke pancreatic secretion it is evident that the acid in-

troduced into the intestine is either changed in its passage to the blood vessels or it provokes the secretion of a substance which entering the blood stream stimulates the pancreatic secretion. On rubbing up the mucous membrane of the intestine with acid and injecting the mixture into the blood stream pancreatic secretion can be invoked due to the presence of a substance named by Bayliss and Starling secretin, which is produced by the action of the acid on a precursor contained in the epithelial cells of the intestinal mucous membrane. Secretin is not a ferment nor coaguable proteid; it can be boiled, neutralized or made alkaline without loosing its activity. Neither is it an alkaloid nor a diamido compound nor is it a colloid. It is probably of relatively small molecular weight and may be compared to adrenalin. It acts by its physicochemical properties and its physiologic effect is determined by the total configuration of the molecule. It is a substance which acts upon organs distant from the point of its production at repeated intervals in proportion to its quantity; it is easily oxidised and is probably destroyed in this way in the organism. It is not specific, for the individual species the extract of the mucous membrane of the dog will induce pancreatic secretion in the monkey, birds, rabbits, frogs and cat, proving that the evolution of the mechanism is to be sought for at some period prior to the development of vertebrates.

The activating power of secretion is also exerted upon the excretion of bile. It has long been known that in order for the pancreas to exert its full activity on food stuffs the presence of a sufficient quantity of bile is absolutely necessary; without it the digestion of fats is impossible and that of carbohydrates and proteins is defective. By the frequent injection of secretin exhaustion of the pancreas can be produced; after the discharge of the granules, the cells seem to pass to a still further involution, losing the whole of their chromophylic substance, diminishing in size, finally being transformed into cells not to be distinguished from those forming the islets of Langerhans'. These islets are not preformed structures, but represent stages in the functional activity of the secreting cells of the gland, rendering the hypothesis that a pathologic condition of the islets was the factor in producing diabetes more than improbable.

The chemical control of digestion depends upon a sufficient secretion of hydrochloric acid by the stomach. The succus stomachi is squirted into the duodenum in small quantities, causing the formation of secretin, which is absorbed by the blood vessels and carried to the pancreas, continuing to be formed until sufficient bile and pancreatic juice have been excreted to neutralize the acid of the chyme. The amount of acid chyme passing the pylorus is controlled by a reflex from the duodenum excited by the acidity which closes the pylorus relaxing as soon as the duodenal contents are neutralized, allowing a further quantity of acid gastric chyme to enter the duodenum. The pancreatic juice contains only a very weak proteolytic ferment, but it also contains trypsinogen, which is activated by enterokinase, a ferment whose secretion depends upon the presence in the duodenum. It is evident from the above that the quantity of both biliary and pancreatic secretion depends upon the acidity of the stomach and its failure must produce grave digestive disturbances. The failure of the hydrochloric acid in the stomach also reduces the amount of secretin.

Considering that secretin is active in acid medium it should be capable of administration by the mouth without being destroyed in the stomach and would undoubtedly be of great therapeutic value in digestive troubles. Pathologic conditions may occur in which the hydrochloric acid in the succus stomachi is reduced or absent, which is followed by failure of the secretions of enterokinase, secretin pancreatin and bile. We can administer artificial succus stomachi and sodium glococholate mass, the latter increasing the amount of bile, but there our therapeutics means end. The administration of pancreatin has never been of much value owing to the action of the stomach juice and from our inability to administer it in continuous doses and in sufficient quantity. To obtain results with the administration of any of the digestive secretions it must be continuous and in sufficient quantity arriving at the proper portion of the digestive tract at the proper time. Secretin would from its regulating functions be a valuable addition to our digestive armamentarium.

Dr. Sydenham R. Clarke, class of 1905, formerly an interne at St. Joseph's Hospital, Baltimore, Maryland, has opened offices at 101 East Lanvale street, Baltimore. He has succeeded far better than he had expected.

PURULENT CONJUNCTIVITIS.

(Abstract from The Eye, Its Refraction and Diseases.)

By Edward E. Gibbons, M. D.

Chief of Clinic and Demonstrator of Ophthalmalogy in the University of Maryland Hospital.

Purulent Conjunctivitis, Blenorrhoea, or Pyorrhoea, occurs most frequently in infants at or soon after birth. The disease is essentially the same in the infant and adult and arises from a contagium, and endangers the welfare of the eye through implication of its cornea. The disease as manifested in the baby and in the adult will be considered separately for sake of convenience.

Ophthalmia Neonatorum:—The lids of the newborn infant remain red and somewhat sticky for a day or two, but simple cleanliness or washing with a solution of borax in water (one teaspoonful to the pint) will be all sufficient. Now and then there is slight swelling of the lids and a limited amount of catarrhal secretion from the conjunctiva. The fornix is thickened and swollen in some cases. As long as this continues the eye keeps red and watery. Borax water and cleanliness are all that is needed. If the hypertrophy continues after the child is a month or so old, the swollen tissue should be painted with a solution of nitrate of silver (gr. 10 to oz. 1) once a day, care being taken to keep the solution from the cornea, by applying it sparingly and washing the eye afterwards with a solution of table salt (gr. 5 to oz. 1) to precipitate any free silver nitrate. These cases are often considered by some general practitioners as typical ophthalmia neonatorum cases and they point to their cures with pride as a proof that the ophthalmologist overestimates the seriousness of mattering eyes in the new born. The cornea never becomes implicated in such cases and they are therefore innocent.

True ophthalmia neonatorum may be present at birth, the eyes of the child having been infected in utero. Indeed the child may be born with ulcerated or sloughed corneae, showing that the disease has existed for some time. Just how the eyes chance to become infected before birth is not understood. The foetal membranes evidently are primarily the seat of the disease. More frequently the disease manifests itself on the third or fourth day, but may be delayed as long as the eighth, in which case it is likely, however, that there has been a post partum infection. At the beginning the secretion is comparatively thin, but ere long becomes thick and creamy, indicating an abatement in the activity of the process. There is frequently decided swelling of the lids and the ocular conjunctiva adjacent to the cornea becomes infiltrated and edematous, although not as frequently in the child as in the adult. This chemotic conjunctiva overhangs the edge of the cornea which it endangers by pressure. The lid conjunctiva and that of the folds of transition become thickened and spongy, with ridges and prominences, and cleft by fissure between enlarged papillae. This tumidity increases from the edges of the lids up to the fornices. The cornea may remain clear, but it is in great danger, from the maceration of its conjunctival covering by the pus, with subsequent infection; from direct spread of the inflammation to its structure; from the inability to properly clean the eye, on account of the swollen lids and infiltrated conjunctiva surrounding the cornea and pressing upon its nourishing vessels. The danger of corneal complication is slight in the child as compared with what it is when the disease affects the adult eye, because the lids in the latter case become much more infiltrated and heavy and press upon the cornea, the conjunctiva more chemotic, and the eye less resistant. The place of ulceration of the cornea may be anywhere. Its invasion may first show as a diffuse haziness, or as a single spot of infiltration, or the whole cornea may suddenly break down and slough away. The number that go blind from this disease varies in different localities from 20 per cent. to 79 per cent., so that its prophylaxis is a very important matter.

Etiology:—The origin of the contagion is morbid vaginal secretions, which come into contact with the eyes of the child during the passage of the head through the parturient canal, or as the writer thinks is more frequently the case the eyes are infected after birth by the washing of the child's head and face. During the passage of the head the eyes are tightly closed and smeared over with the cheesy vernix, and infection improbable except in delayed births. Inoculation of the eye with healthy vaginal secretion is without effect. In the great majority of cases the gonococcus of Neisser is the specific organism of the disease. Urethral infection with pus from a typical case of oph-

thalmia neonatorum will give rise to a urethritis. Lochial secretions may at times be the cause. A suppurating navel is also a possible source of infection.

The cases caused by pyogenic organisms, streptococci or staphylococci are apt to be mild ones; on the other hand one of these organisms present with the gonococcus gives rise to the severest cases. Gonococci in pure culture are seldom found, and such cases are rather mild in comparison. The xerosis and diphtheritic bacilli are not infrequently found along with the gonococci.

The prophylactic measures to be employed are as follows: If the mother is found to have a leucorrhoea of more than the usual amount prior to the beginning of labor, she should have vaginal douches with a 3 per cent. carbolic solution, especially if the gonococci are demonstrable in the secretion. A copious douche should be given after labor has been begun with plain water, so as to mechanically wash away any secretion. This method is objected to by some obstetricians on the ground that the secretions of vagina are necessary for the proper performance of labor, and that any effort to sterilize the canal is dangerous to the welfare of the woman.

That antepartum douching is an important prophylactic feature the writer is convinced, as demonstrated by the remarkable manner in which the percentage of cases falls when it is employed. Of course the proper thing is for the obstetrician to ascertain before hand, especially in hospital practice, whether the female has any abnormal vaginal discharge or not prior to labor. After the birth of the child, the nurse should wash the eyes of the child first, and then place a piece of cotton (not absorbent) over each eye, and hold them in place while she washes the head and face of the child. As the washing is usually done, the nurse gathers up the organisms from the scalp and face and deposits them in the eyes as she passes over these parts frequently in succession. If there has been demonstrated gonorrhoea in the mother or if it is suspected, in accordance with the recommendation of Crede, a single drop of a 2 per cent. solution of nitrate of silver is dropped into the eye upon the lower lid. Crede said to drop the solution from a glass rod upon the cornea so that it would be evenly distributed, but this endangers the welfare of the cornea, and not infrequently a haze will develop showing how irritating the silver nitrate was to it (this haze finally disappears). In the lying-in hospital at Leipsic where Crede himself instituted the method, the number of cases fell from 7.5 per cent. to 5 per cent. Many ophthalmologists use a 1 per cent. solution of silver nitrate, fearing a too decided caustic effect of the stronger solution. One eye is usually affected before its fellow, and every attempt should be made to keep the infection from passing to it.

Crede experimented with various solutions, such as 1 per cent. solution of corrosive sublimate, sterilized water, iodine trichloride, carbolic acid, silver nitrate in 1 per cent. and 2 per cent. solutions. All were of benefit in materially reducing the number of cases of ophthalmia neonatorum, but none as effective as the 2 per cent. solution of silver nitrate, except, perhaps, the 1 per cent. solution of corrosive sublimate, and that was too irritating for most eyes.

Treatment:—If seen at the very beginning when the swelling of the lids and a watery secretion are the chief symptoms, nothing but cold applications and careful cleaning should be employed. Cold evidently lessens or destroys the vitality of the germs in a great measure. For the cleansing boric acid in half saturated solution may be used. (gr. 10, oz. 1). The cleaning should be often enough to keep the eyes free of pus, day and night. The lids are opened and closed by the attendant and the pus worked up from the fornices by burying the ends of the thumbs gently beneath the orbital ridge, then with a wet piece of cotton, the lids are everted and the conjunctival surface carefully and gently cleansed. This must be repeated in some cases every quarter to half an hour, according to the amount of secretion after it is well established.

It is unwise to use cotton wrapped around match-sticks or tooth-picks or what not in cleaning the eyes, as the operation has to be repeated so often that there is great danger in abrading the cornea and thus making an inroad for organisms. The cold applications consist in laying pledgets of cotton that have been soaked in iced water or laid upon a block of ice upon the eyes and changing them every two minutes. As soon as the secretion grows thicker and the swelling of the lids less, we are to resort to the use of silver nitrate solution in varying strengths. Usually gr. 10, 1 oz. is the strength used. This is not to be dropped into the eye or upon the everted lids, as it will endanger the cornea if

repeatedly so applied. But a small mop made with cotton and a wooden tooth-pick is dipped into the solution and passed up under the upper eye-lid which has been everted, care being taken to ever press the mop from the eyeball so that the cornea is not injured. The everted surface of the lid is then painted over.

The lower lid is similarly treated. The mop must be pushed well into the fornices, because there the germs often have their hiding places. To properly treat the eyes, the physician takes the head of the child between his knees while the nurse supports the body of the child upon her lap. If the cornea is at all hazy the eye should be washed with salt solution after the silver has been applied. The silver solution is applied once in the twenty-four hours. If, after a few days the secretion is no less and the swelling of the lid persists, a stronger solution of silver nitrate is used; that is, one of twenty grains to the ounce of water, but this must never be allowed to come into contact with the cornea. For several hours the secretion is held in check, after awhile flocculent portions of the eschar and secretion reappear, when cleansing is again in order. By the use of too strong solutions of silver, or their too frequent application, it now and then happens that the discharge becomes almost nil, but the chemosis and swelling of the lids persist, the silver should then be stopped. The newer silver compounds have lately been extold as superior to silver nitrate in ophthalmia neonatorum both as a prophylactic and curative agent, especially protargol, which is used in from 10-20 per cent. solutions, and argyrol in 10-25 per cent. solutions. Their action is non-caustic and non-irritating and they are said to have a superior penetrating power. Whether they are more efficacious than the silver nitrate in solution the writer is not altogether sure, as he has had many cases that did well with each and those that did badly with each. If the physician can not see the patient very often I think a 10 per cent. solution of protargol or argyrol may be given for home use, to be instilled three times a day without any fear of danger to the integrity of the cornea. (See appendix.)

The organisms hide themselves away in and between the deeper layers of the conjunctival epithelium, and a superficial caustic which will cause the exfoliation of the superficial cells, and thus expose the germ, as nitrate of silver will do seems indicated. However, with the best care possible some eyes go out from this disease, while again others get well on almost any method. It is not easy to get a good view of the cornea which should be carefully watched for ulceration. To separate the lids a Desmarre's lid retractor is used, one for each lid. Care must be exercised in introducing this instrument not to wound the cornea. The upper lid is elevated as much as possible with the finger and the blade of the elevator pushed beneath it while constantly keeping it from the eyeball.

In the event of the cornea becoming affected whether by opacity or ulceration, the treatment continues as before, and in addition a solution of atropia is instilled several times daily to secure dilatation of the pupil, and the cold is replaced by hot applications. Cotton compresses soaked in hot water are applied from 15 minutes to one hour in every two hours, according to the way they are borne. If the ulcer threatens to perforate, a careful paracentesis at its thinnest point will sometimes do good, by lessening the amount of iris that will pouch through the opening in the cornea like a hernia. As the aqueous flows out of the eye the iris is washed up to the opening in the cornea and even partly through it. This temporarily affords relief, but the sight suffers permanently. The protruding iris should never be excised, but may be punctured with a fine needle held at a tangent to the lump. Some have gotten very good results by dusting the everted lids frequently with powdered iodoform, by the use of yellow acid salve; permanganate of potash solution (1500 to 2000) H_2O_2 (1-4; bichloride, 1-400, and formalin, 1-2000. Either of these agents may be used instead of boric acid solution after cleansing. The duration of the disease in favorable cases is from four to six weeks. Sometimes the conjunctiva takes on extreme hypertrophy; the secretion almost ceases and the cornea may be clear, but the swelling does not subside. Silver and other caustic solutions in this case do harm. Keeping the eyes well greased with vaseline, by putting a little between the lids every few hours, seems to do much good in these cases. Iodoform, gr. 5 to oz. 1, may be advantageously combined with the vaselin. The eyes should be cleansed less often as the discharge grows less. Now and then the upper lid becomes everted and on account of the swollen conjunctiva of the fornix remains so, and as soon as reduced everts again. A free canthotomy must be done, or if there is no discharge, the lids stitched loosely together.

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EDITORIAL

THE OBSTETRICAL DEPARTMENT.—The growth of the obstetrical clinic and the changes in the method of teaching have been so noticable in recent years that it may be interesting to note the more important of them.

In 1896 there were a few more than 300 confinements. With the large number of graduates it was impossible for each one to see more than five or six cases. At that time there were certain rules for the guidance of the student in his work, but as there was no one to see that these were carried out, they amounted to little. The teaching consisted in three didactic lectures a week, one or two forceps demonstrations on the mannikin during the year, and the same number of classes in abdominal palpation. This work was not compulsory and no note was taken of it when members were absent. At the present time the teaching begins in the third year and is continued until graduation. During the third year there are two didactic lectures a week and one operative demonstration. In the operative course, each student is required to make three applications of the forceps, high and low in vertex presentations, and one to abnormal presentations, etc. Various kinds of version are performed with manual extraction of Breech, and finally the destructive operations. In addition to this there is a special course in pathology in which fifty to sixty sections are studied. This work aids the student very much and is no less important than the pathology of general medicine. The fourth year is made very interesting for the student as well as instructive, for it is then that he comes in contact with the patient and is able to reap the fruit of the seed sown the previous year. Once a week during the year the Professor of Obstetrics holds a "Clinical Conference," in which the entire class takes part. This conference takes the form of a medical society, with the Professor of Obstetrics as the presiding officer. The interesting cases are discussed by the students as well as the presiding officer, and occasionally formal papers are presented. Four times a week during the entire year the class is taken in squads into the maternity wards, where they are taught abdominal palpation, auscultation and pelimitry, and are shown the puerperal patients and have demonstrated all the interesting conditions of this period. During the last year there were 892 confinements in the clinic, allowing each member of the graduating class to see twenty-five cases. In this large number the students have the opportunity of observing a number of operations, and in certain cases one is allowed to apply the forceps under the direction of the Resident Physician. By far the most instructive part of the work is the out-patient department. Here the student is placed considerably upon his own responsibility and given a bit of what is coming later. After the patient has registered her name and address at the hospital, two students are assigned to the case. They call upon the patient and make a preliminary examination, and if some time elapses before her confinement, they call on her from time to time to see that she is in good condition; in other words the case is managed as it should be in private practice. The responsibility puts the men on their mettle, and he must be a poor one, indeed, who does not measure up to a pretty high standard. The practical work counts 50 per cent. in the final examination and this is also a stimulus to good and faithful discharge of their duties. With a continuous association with the work for two years, the graduate leaves the University pretty well prepared to practice obstetrics.

OUR CENTENNIAL CELEBRATION.—With the resumption of active work at the University the BULLETIN now urges the different committees on the Centennial of the University to get together and to get down to earnest work. The success of the Centennial will depend entirely upon the activity and enthusiasm of those who have charge of the committee work. The occa-

sion which it is proposed to celebrate is a most important event in the history of any institution of learning. To allow this occasion to pass by without a fitting review of the work which the University has done in the past one hundred years, without presenting her claims to public attention, without laying a broad and deep foundation for her future development, without bringing all of her graduates back to a grand housewarming and jollification reunion, will be a shame and reproach to those who have personal management of the interests of the University.

Not only the medical, but every department of the University—law, dental, pharmaceutical, St. John's College, so soon, we hope, to be annexed to the University as the department of arts and sciences—should take advantage of the occasion which will be presented to enlist their friends and alumni in the work of strengthening the claims of the University as a whole upon the pride and affection of the people of Maryland.

A great opportunity will be presented by the Centennial celebration to review the history of the University in all of her departments and to create a stronger bond of union between the departments. The Centennial, while in large measure belonging to the medical department by reason of seniority of birth, should be regarded as the common ground upon which all of the alumni and friends of the University, irrespective of the department, should meet. The occasion should arouse a stronger University spirit and lay the foundation for a great State University in government and influence as in name. The occasion should be used as a means of promoting the material prosperity of the University, which should be expressed in the form of an improvement and enlargement of the educational plant, better laboratories, larger lecture rooms, dormitories for students, a general assembly hall, library hall and other buildings needed by a great State University.

The BULLETIN has no thought that all of these suggestions will be put in force at the present or in the near future, but it is optimistic enough to assert that they will come long before the next Centennial arrives if the friends and alumni of the University have breadth of view and liberality of spirit sufficient to put the machinery in motion at the present time, which will bring about the results so necessary to promote a live and vigorous State University.

THE ONE HUNDREDTH ANNUAL SESSION OF THE UNIVERSITY OF MARYLAND.—The one hundredth annual session of the University of Maryland opened on October 1st under the most encouraging auspices.

In the Dental, Pharmaceutical and Law Departments the prospect of an increased attendance of students is promised, whilst in the Medical Department, at this time of writing, the number of matriculates is slightly larger than at the corresponding date of last year. The first year class will be about the same as last year, whilst the third and fourth year classes will most probable be larger than for several years past. The increase in the third and fourth year classes is due to the fact that many of the universities and colleges in the South are now giving courses of instructions in the first and second year branches of medical education, and their students take their third and fourth year work in medical schools which are able to offer the best clinical instruction. The University of Maryland is so well equipped for clinical work that it is attracting each year larger numbers of students conditioned by other institutions.

The growth of clinical work at the University has been both so large and rapid that few medical schools in this country can offer the student a more thorough and practical preparation for professional work than she does. Both the outdoor and indoor departments of the University Hospital give the greatest abundance of clinical material which is being utilized to the very best advantage by the large staff of clinical teachers connected with the University. Clinical lectures, ward classes, demonstrations and dispensary attendance make up the larger bulk of the students' work. All who desire to profit by this rich field of clinical study have the opportunity to do so. The system of instruction is systematic and thorough and is conducted by men well equipped to give a practical insight into the various forms of disease and accident found in the Hospital. The student body presents this year a striking picture of robust health and intelligent interest in student work. Each year the number of well-educated and matured men who enter upon the study of medicine is greatly increased through the requirements of the Association of American Medical Colleges.

No one can view the student body at the University today in contrast with that of some few years back without realizing that the higher

standard of entrance requirements has done much to improve the student's capacity for work and to give earnestness and industry to his efforts.

The student who enters the University or who graduates from the University during her Centennial year is to be congratulated upon the fortunate incident which will associate him with a great historic occasion.

CORRESPONDENCE.

ZURICH, SWITZERLAND, *August* 8, 1906.

To the Hospital Bulletin:

We left Vienna on August 2, and since then have been constantly on the move. Our first stop was at Salzburg, a quaint and picturesque old city, situated on the Bavarian frontier, but within the Austrian dominions. It was formerly the residence of the Archbishops of Salzburg, who possessed temporal as well as spiritual authority over a large extent of territory. The city is situated on both sides of a swift stream, and is dominated by lofty hills and mountains. The streets are narrow and crooked, with many covered passageways leading in every direction. Upon an elevation is situated the old castle or festung, built originally in 1077, where the ruling archbishops lived, almost secure from molestation, and which was later captured by Napoleon the First, and occupied by him. Both the city and the castle are now shorn of their glory, and are only of importance as historical places, and as a summer resort for tourists.

Munich was our next stopping place, and here we remained several days, seeing the huge collections of pictures and other works of art that have made this city famous. Whilst viewing the old masters in the Alte Pinakothek, a hand was placed on my shoulder, and to my surprise the genial features of my friend and classmate, Dr. J. W. Humrichouse, of Hagerstown, Md., met my gaze. There is a fine university here, with a famous medical school, and good hospitals, but the attractions of the city are too great, and where one's time is limited, it is as a tourist and not a seeker after medical knowledge, that one visits the city. I also met Dr. G. W. Mitchell, of Baltimore, strolling through the galleries of the Alte Pinakothek. Munich is a very attractive city, and is the capital of the kingdom of Bavaria, but has lost some of its importance since the establishment of the German Empire; it is, however, one of the show places of Europe. From Munich to Innsbruck, in the Austrian Tyrol, is not a long journey, and this was our next stopping place. The trip itself was very picturesque and interesting through the Bavarian and Tyrolean Alps, where the whole country seemed to be a summer resort, and where thousands of people in green walking costumes, with jaunty hats and feathers, and hob-nailed shoes, with alpen stocks in their hands and knapsacks on their backs, were to be seen. Innsbruck is the capital of the Austrian province of the Tyrol, and is an odd city crowded in between the mountains, with high houses and narrow streets and passageways. It is the seat of a flourishing, but not very large university and medical school, where a number of celebrated surgeons have held clinics.

The Krankenhaus is a very good hospital with 750 beds, 150 of which are devoted to surgical cases. We were most courteously treated here, and saw some excellent surgical work. Goitre is very frequent in those mountainous districts, and two hundred cases are operated on annually at this clinic. We saw a difficult operation on a large soft bronchocele, which extended beneath the sternum and compressed and displaced the trachea. The skin was infiltrated with Schleich's solution No. 2, and no general anesthetic was given. Another similar case was also to be operated on that morning, but we could not wait to see it. A man bed-ridden with sciatica, who had gone the rounds of the nerve specialist, without benefit, was made to take up his bed and walk by an injection of eucain into the sciatic nerve. The surgeon said the injection into the nerve not only gave temporary relief, but was curative in character. Several cases of tetanus were treated successfully by injecting antitetanic serum daily into the sub-arachnoid space, into the subcutaneous tissues and filling the wound with the serum. Balsam of Peru is much used in this hospital in extensive injuries, such as compound fractures, with or without opening of the joints. No effort is made to disinfect the wound, but it is filled with balsam of Peru, and fine results follow. This treatment is not of use in suppurative cases. Two men whose faces had been torn to shreds by an explosion of dynamite were treated with balsam of Peru, and what appeared to be hopeless conditions, healed with some semblance to human countenances.

A boy with a great depression of the skull from the kick of a horse was trephined and the depressed fragment removed, and though he had not spoken a word for three weeks, he immediately began to talk, and made a good recovery. A boy received an injury by falling, and ruptured both spleen and left kidney. The spleen was removed and the kidney tamponned, and boy recovered. Some years ago when Professor Victor R. Hacker was Professor of Surgery and chief surgeon at this hospital, he wrote me that he had one of the best clinics in all Europe, and from my observation of the work of the hospital, I think his remark was justified. Professor Schlotter is now in charge. Leaving Innsbruck we journeyed through the Tyrolean Alps into Switzerland, our destination being Zurich. On both sides were lofty mountains with narrow valleys, and every portion of arable land cultivated almost to the tops of the mountains. Women seemed to do the greater part of the agricultural work, and could be seen often on the steep hillsides, cutting or gathering the crops, whilst high up the side of the mountains the little cottages could be seen, surrounded by a patch of green, and one wondered how they could maintain their lofty perch. The deep verdure of the forest-clad hills, the grey rocks of the mountains, the rushing torrents, the placid lakes, the Wallensee, and finally the large and beautiful lake of Zurich, with both shores thickly populated, all combine to make an indellible picture on the mind. Zurich is situated at the end of the lake, and is a nice city of about 160,000 population, not differing much in appearance from other modern European cities. The University of Zurich is known throughout the world, and there is a flourishing medical school in connection with it. Kronlein, a distinguished surgeon, is Professor of Surgery, but he was absent at the time of our visit. We visited his clinic at the Kanton Spital, and found it well equipped, with good operating rooms and amphitheatre, but no operations were posted for the day, so we went to the Frauen Klinic, or hospital for women, in the immediate neighborhood, where we saw some gynecological work of no special importance. In one respect there was a peculiar feature in the work here, inasmuch as the closure of skin incisions is not done with sutures, but with little toothed clamps, which are fastened to the edge of the wound. I do not know what the advantage of this method of closure is; the surgeon said it was quicker, but I think sutures could have been put in equally as quickly and would have held just as well.

RANDOLPH WINSLOW.

NOTES AND ITEMS

Dr. Eugene McE. Van Ness, class of 1891, has moved to 200 West Lafayette avenue, Baltimore.

We are glad to report that Dr. Francis J. Kirby, who is ill at St. Joseph's Hospital, Baltimore, with scarlet fever, is quite improved.

Dr. T. M. Chaney, Jr., class of 1906, the middle of last month, sailed on the steamer Joseph di Giorgio for Port Antonio, Jamaica.

Dr. A. W. Disosway, class of 1905, has been appointed chief of clinic of the Northwestern Eye, Ear and Throat Dispensary, Baltimore, Maryland.

Dr. Gideon McD. Van Poole, class of 1899, United States Army, has been advanced from the grade of first lieutenant to that of captain, the promotion to date from June 29, 1906.

The University of Maryland Maternity Department reports that during the past year 685 cases of confinement were treated, 271 in the hospital, and 414 in the out-patient department. The members of the senior class averaged 25 obstetrical cases per member.

The annual reception of the Y. M. C. A. of the University of Maryland was held at the Central Y. M. C. A. Building on Friday, October 5, 1906. There were present of the Faculty of Physic Professors Chew and Woods. Mr. Morris, secretary of the Y. M. C. A., also attended and about twenty-five students.

Dr. John R. Winslow, class of 1888, Clinical Professor of the Diseases of the Nose and Throat in the University of Maryland, and Dr. Francis M. Chisolm, class of 1889, demonstrator of opthalmology in the University of Maryland, announce that they have opened branch offices at 1424 K street, Northwest, Washington, for the treatment of eye, ear, nose and throat diseases.

Football prospects at the University of Maryland are believed to be bright. Many of last year's squad have already returned, and the

freshmen classes are expected to furnish some promising material. The loss by graduation of Blank, Garneau, Casey and Stonestreet will be keenly felt. Manager Fowler has secured the services of Coach T. Marshall West, of Syracuse University. Mr. West has entered the third year of the Medical School. An attractive schedule has already been arranged.

It is interesting to know that a complete set of the former *University Bulletin,* the predecessor of the HOSPITAL BULLETIN, and published between 1896 and 1898, has been preserved and bound by Dr. Randolph Winslow. This is probably the only set now extant.

Monday, October 1, 1906, marked the opening of the 100th session of the Medical Department of the University of Maryland. Most of the old students have returned, and the enrollment of the freshman class far surpasses that of last year. It is gratifying to note that the recent restrictions of the American Association of Medical Colleges, a certificate of a four-year high school course or its equivalent, has not hampered the development of the school.

The BULLETIN is indebted to Dr. John I. Barron, class of 1901, for the following item of interest, namely, that "Dr. W. L. Hart, class of 1906, has been appointed by the Governor of South Carolina, assistant surgeon with the rank of Captain in the National Guard of South Carolina, and has been assigned to the Second Regiment. Dr. Hart is to be complimented on receiving this appointment, as it is made over the heads of older officers and furthermore the appointment of such a young man to captaincy is unprecedented in this State."

Dr. T. A. Ashby, chief of the editorial staff of the BULLETIN, is now taking a much needed rest by an outing which will take in St. Louis, Kansas City, Chicago and other places of interest in the West, including Rochester, Minn., the home of the Mayo brothers, the great surgeons of the Middle Northwest. Whilst this outing is taken chiefly for recreation, Dr. Ashby will visit all the hospitals and medical institutions within his reach, and will also take occasion to look up the alumni of the University along the route of travel. He will return home on October 22.

The following announcement of the officers of the Athletic Association of the University of Maryland has been made: *President,* Harry G. Thomson; *Vice-President,* Albert H. Carroll; *Secretary,* Courtney Buck; *Treasurer,* Richard C. Rose; *Executive Committee,* Phil H. Hill, J. P. Poe, Dr. C. W. Mitchell, Thomas Dryden and P. F. Lee; *Foot-Ball,* Carson D. Fowler, manager; P. F. Lee, assistant manager; Harry L. Thomson, captain; *Basket-Ball,* Garnet P. Morrison, manager; *Track Team,* B. R. Benson, manager; *Base-Ball,* W. J. Fullings, manager; Carson D. Fowler, assistant manager; Robert W. Crawford, captain.

The following members of the present senior class have been appointed clinical assistants to the University Hospital for the ensuing year: J. H. Bates, S. H. Adler, F. E. Jamison, F. Herrmann, R. O. McCuchen, T. H. Legg, E. L. Sutton, J. E. Gross, W. H. Daniels, A. E. Landers, J. I. Kemler, A. H. Carroll, S. McElroy, B. R. Benson, H. Y. Righton, R. C. Franklin, F. S. Lynn, O. P. Argabrite, L. Vogel, J. B. Piggott, M. J. Brown, H. B. Hiatt, E. S. Perkins, J. S. Fox, G. D. Moose, A. J. Gable, M. R. Bowie, E. W. Glidden, J. C. Joyce, J. W. Bird, R. C. Bowen.

The following of our alumni are connected with the Baltimore Medical College with the titles appended to their names: Dr. R. H. P. Ellis, class of 1877, Emeritus Professor of Materia Medica and Therapeutics; Dr. Wilmer Brinton, class of 1876, Emeritus Professor of Obstetrics; Dr. A. C. Pole, class of 1876, Professor of Anatomy; Dr. S. K. Merrick, class of 1872, Professor of Nose, Throat and Chest; Dr. Samuel T. Earle, Jr., class of 1870, Professor of Physiology and Diseases of the Rectum; Dr. J. Frank Crouch, class of 1890, Professor of Materia Medica and Therapeutics; Dr. Charles O'Donovan, class of 1881, Professor of Diseases of Children; Dr. Tilghman B. Marden, class of 1892, Professor of Biology, Histology, and Bacteriology; Dr. Charles E. Simon, class of 1890, Professor of Clinical Diagnosis; Dr. William T. Watson, Professor of Hygiene and Public Health; Dr. R. B. Warfield, class of 1884, Associate Professor of Anatomy; Dr. Francis J. Kirby, class of 1892, Lecturer in Surgical Pathology; Dr. Wirt A. Duvall, class of 1888, Associate in Nervous and Mental Diseases.

These alumni hold the chairs appended to their names at the Maryland Medical College:

Dr. J. B. Schwatka, class of 1882, Professor of Dermatology; Dr. J. Wm. Funk, class of 1888, Professor of Diseases of the Eye; Dr. Fred. Caruthers, class of 1892, Professor of Anatomy and Genito-Urinary Surgery; Dr. W. S. Smith, class of 1883, Professor of Diseases of Women; Dr. C. U. Smith, class of 1889, Professor of Theory and Practice of Medicine and Gastro-Enterology; Dr. Harry Gross, class of 1896, Professor of Operative and Clinical Surgery; Dr. J. C. Linthicum, class of 1859, Professor of Medical Jurisprudence; Dr. A. D. McConachie, class of 1890, Professor of Materia Medica and Therapeutics and Clinical Professor of the Diseases of the Eye and Ear; Dr. W. H. Pearce, class of 1891, Professor of Diseases of Children and Clinical Medicine; Dr. E. C. Lehnert, class of 1902, Associate Professor of Materia Medica; Dr. T. J. Talbott, class of 1895, Associate Professor of Gynecology; Dr. W. S. Love, class of 1890, Associate in Surgery; Dr. C. R. Davis, class of 1890, Lecturer on Bandaging and Minor Surgery; Dr. T. J. O'Donnell, class of 1903, Associate in Surgery.

Dr. L. M. Mitchell, class of 1906, of Belle Vernon, Pennsylvania, writes to the BULLETIN that he had no difficulty in passing the Pennsylvania State Board of Medical Examiners, and that he has been far more successful in the practice of his profession than his fondest anticipations. As in the case of most of our subscribers the doctor extends his best wishes for the success of the BULLETIN. To the men of the classes just graduated the BULLETIN owes a debt of gratitude, as they almost to a man have been loyal supporters to its endeavors, and through their encouragement have lightened the burden of the editors. Especially the class of 1906 the editors wish to thank for the interest it has taken in the welfare of this publication, and on its part sincerely hopes that each and every individual of that class will experience a successful, prosperous and honorable professional life.

The Cumberland (Md.) *Daily News* has the following to say about Dr. A. Leo Franklin, of the class of 1902, now practicing his profession in that city: Caesarian section, one of the most dangerous and delicate operations incident to surgery and performed only in rare instances and then usually in the best appointed maternity hospitals of the large cities, was successfully undertaken at the Western Maryland Hospital by Dr. A. Leo Franklin, '02, assisted by Drs. Charles Cole, '02; Hodges, Owens, '04; Cowherd and Watson, the patient being Mrs. Mamie Twigg, who resides with her husband on the Baltimore pike, some six miles distant from this city. Singularly enough, the patient had previously undergone three severe abdominal operations, these, however, necessitating the more radical and dangerous operation, as cohesion, due to the causes above narrated, prevented child birth, although the effort had been vainly prolonged five days, and caesarian section offered the only hope. Mrs. Twigg rallied remarkably well from the shock of the operation, and the offspring, a baby girl, is progressing as favorably as might be expected, considering the enfeebled condition of the infant.

The medical library continues to grow and new shelving has been called for for the large additions. Gifts have been received from Drs. Sadtler and Gorter. Mrs. Dr. Powell has made another gift of instruments and books. Nearly the whole of the Miltenberger collection—about 1,000 volumes—has been catalogued and shelved. A large number of duplicates in good condition are offered for sale at merely nominal prices. Among recent additions of interest are the Catalogue of the William Hunter Museum, Glasgow, 1900, 2 vols., presented by Mr. J. H. Teacher, of Glasgow, through Professor Winslow; Milligan's Celsus, Edinburg, 1831; James Jackson's Letters to a Young Physician, Boston, 1855; a rare work on Diseases of the Eye, published in Baltimore in 1856 by F. A. Moschzisker; Index Catalogue Surgeon General's Office, 2d Series, Vol. XI, 1906; Terra Mariae, 1905; Dress and Habits of England, Strutt, London., 1799, 4to., handsomely illustrated; Trans. Col. Physicians, Phila., for 1905; Scharf's Chronicles of Baltimore, 1874, and many of the New Sydenham Society's publications, bound volumes of the *Lancet* and other journals.—*Old Maryland.*

Dr. E. F. Cordell, who has worked so zealously and faithfully in the interest of the Endowment Fund of the University of Maryland, writes as follows to the *Baltimore Evening News*, October 12:

I note in yesterday's issue a proposition that the Fire Memorial Fund should be devoted to the purpose of securing the removal of the Johns Hopkins University to Homewood, its new

suburban site. I suggest that a better use of it would be the endowment of our older university, the University of Maryland, which is about to celebrate its centennial anniversary. The Hopkins has been liberally endowed, not only by its original founder, but by this community. It is a blot upon this city and State that it has allowed an old university to grow up in their midst and reach an age which fewer than a dozen of our American universities can claim without having provided it with an endowment.

Just think of it! A city of 600,000—a university 100 years old! Where else in the United States could such an anomaly—such a blot upon a wealthy city and community—exist? Therefore, I am emboldened to present what I think are clearly superior claims to this fund—if such a use should be made of it—by the older of our two universities, which was doing its useful and beneficent work in this community 69 years before the Hopkins came into existence!

At the semi-annual and 108th meeting of the Medical and Chirurgical Faculty, held at Annapolis, Maryland, September 27 and 28, 1906, Dr. Hiram Woods, Professor of Eye and Ear Diseases at the University of Maryland, and president of the Faculty, in behalf of the Faculty responded to Governor Warfield's address of welcome, and Dr. H. B. Gantt, class of 1880, president of the Anne Arundel County Medical Society, as host of the delegates. Others of our Alumni who took an active part in the meeting were: Dr. William Herbert Pearce, who spoke on medical organization; Dr. P. S. Rossiter, Passed Assistant Surgeon, United States Navy, who delivered an address on Leprosy; Dr. N. W. Owensby, class of 1904, superintendent of the insane department Bay View Asylum, who exhibited specimens of nails, glass and other foreign bodies passed through the alimentary tract. Some of those present were: *From Baltimore*—Dr. Hiram Woods, class of 1882; Dr. Thomas A. Ashby, class of 1873; Dr. G. Lane Taneyhill, class of 1865; Dr. Samuel T. Earle, class of 1870; Dr. Harry C. Hyde, class of 1899; Dr. Henry Lee Smith, class of 1894; Dr. Wm. H. Pearce, class of 1891; Dr. Horace M. Simmons, class of 1881. *From Annapolis*—Dr. George Wells, class of 1867; Dr. J. J. Murphy, class of 1896; Dr. Charles B. Henkel, class of 1889; Dr. Walton H. Hopkins, class of 1904; Dr. Louis B. Henkel, Jr., class of 1903; Dr. J. Oliver Purvis, class of 1904. Dr. Harry B. Gantt, of Millersville; Dr. Benjamin R. Davidson, class of 1867, of Davidsonville; Dr. S. R. Waters, class of 1858, of Watersville; Dr. Wm. L. Lewis, class of 1892, of Kensington; Dr. John L. Lewis, class of 1888, of Bethesda; Dr. Samuel H. Anderson, class of 1870, of Woodwardsville; Dr. John E. Legge, class of 1899, of Oakland. In responding to Governor Warfield, Dr. Woods said, in part: Of late years physicians have been less backward than formerly in making known their opinions concerning matters affecting public health. Some of their endeavors have taken practcal shape during your administration. Co-operation of physician, engineer, executive and legislative branches of the State and city government is essential to promotion and maintenance of public health, and they exist today in our State as never before. Did time permit I should like to speak of other matters of importance. I can allude only in passing to the patent medicine evil. Largely through lack of organization and failure of support where we had, as we thought, right to expect it, the effort to regulate this evil at the last legislative session was ineffectual. But the position of the profession on this matter is, if anything, more definite than ever. The education of the public by the profession seems to me the most powerful weapon at present in our hands. This matter, fellow members of the Faculty, demands our active, unremitting and serious attention, not for our sakes, but for the sake of those whose worth as members of the community is being undermined. Even without legislation, we can do a great deal. Dr. Woods thoroughly voices the sentiments of the BULLETIN. The patent medicine evil as it regards the profession exists from the lack of training of the student in prescription writing, lack of knowledge of the compounding of drugs. If every medical institution saw to it that its graduates were thoroughly competent in this branch of medicine when they left its portals, the patent medicine vender would be deprived of a neat little income.

DEATHS

Dr. William T. Skinner, class of 1870, aged 55, of Glasgow, one of the most prominent physicians of Delaware, and his daughter, Miss Rhea Skinner, aged 22 years, were killed September 29, 1906, by their horse running away

near Porter's Station, on the Delaware Railroad. Death in each instance was due to fracture of the skull. The doctor died almost instantly, but Miss Skinner survived long enough to be taken to the Delaware Hospital, at Wilmington.

We regret to announce the death of Mrs. Marshall G. Smith, wife of Dr. Marshall G. Smith, class of 1887, of Baltimore.

Dr. Thomas H. Helsby, class of 1859, of Roland avenue, Tuxedo Park, Baltimore county, Maryland, formerly a surgeon in the Union Army during the Civil War, died Wednesday, September 26, 1906, at his home in Tuxedo Park, after a lingering illness, aged 71. Dr. Helsby was a native of Baltimore and received his early education in the public schools and the Baltimore City College. He was graduated in medicine with the class of 1859, and practiced in Baltimore for several years. At the outbreak of the Civil War he enlisted in the Union Army, and served as a surgeon in the Fifth Army Corps, being a participant in the battles of Antietam, Gettysburg, etc. During the latter part of the war he was in charge of the Government Hospital at Frederick, Maryland. After the cessation of hostilities he went to Williamsport, Pennsylvania, where he practiced for 30 years. Since his retirement from the practice of medicine 10 years ago, he has resided in Baltimore. He is survived by a widow, who was Miss Sarah R. Jones.

ABSTRACT.

DISEASES AND HOSPITALS OF INTERIOR SOUTH AFRICA.

In the *Journal A. M. A.*, September 22 and 29, N. Senn, Chicago, describes the health conditions of the interior mountain plateau. The striking feature is the disappearance of malaria, which does not prevail to any great extent above an altitude of 300 feet, as well as the rarity of other tropical diseases. The natives have also lost their primitive customs and habits, and with this, their resistance to certain civilized diseases, notably tuberculosis, carcinoma and appendicitis. In the Buluwayo Hospital (altitude nearly 6,000 feet), which is very highly spoken of as regards construction and management, malignant disease is not by any means unknown, and local tuberculosis seems to be rather frequent. A number of cases of malaria are treated, but largely originating elsewhere. None of the figures in the statistics is large, the diseases covering almost the entire nomenclature, and the absence of tropical diseases and the small number of gastrointestinal disorders is noteworthy as indicating the general healthfulness of the region. The Carnarvon Hospital at Kimberly was also visited and is commended. Senn also visited the hospitals in the mining compounds, each of which has its own hospital and doctor. Each of the five diamond mines employs from 2,000 to 2,500 blacks, who have to undergo a physical examination before being employed. They are isolated and not allowed to communicate with outsiders, and are subjected to a rigid examination on discharge to prevent them from carrying off any diamonds; they are kept under close observation for a week, their hands confined in stout locked leather mittens and dosed with castor oil. The principal diseases among them are pneumonia, bronchitis and scurvy, the latter due to the lack of vegetable food which they refuse to buy in sufficient quantity on account of its high price. The average mortality of pneumonia in these compound hospitals is given at 25 per cent. On the whole, the physical condition of the blacks thus employed is much better at the time of their discharge than when they are first employed, as Senn was able to determine by personal observation. The sanitation of Johannesburg under the efficient management of Dr. Porter receives the highest praise from Dr. Senn. The health statistics show an almost absolute freedom from tropical diseases. Typhoid fever seems to be fairly prevalent, but many of the cases are imported from elsewhere. Its mortality among the whites is 13.8 per cent., while among the blacks it is 56.5 per cent., this ratio possibly being due in part to the fact that only the grave cases among the blacks figure in the statistics. There is only one general hospital in Johannesburg, with accommodation for 380 patients. Another is being projected which will open its doors more freely to physicians other than those on its staff. The ratio of paying patients, 44 per cent., was the same both for whites and blacks. The surgical statistics of the hospital cover almost the whole field of surgery and the results certainly speak well for the skill of the operators.

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THE SYNTHESIS OF LIFE.

By HERBERT RICHARDSON, M. D.

Clinical Lecturer on Neurology and Psychiatry and Lecturer on Physiologic Chemistry at the University of Maryland. Pathologist to the Maryland Asylum and Training School for Feeble Minded Children. Late Pathologist to Mount Hope Retreat.

That the earth was once in a condition in which its temperature was enormous, the presence of water being impossible, rendering the existence of living matter, as we know it, impossible, is an accepted generality of all branches of science, astronomy, physics, geology, geogony, mineralogy and chemistry, all agree in this. Moreover, modern science, with the help of the telescope and the spectroscope, has brought the fact directly before us, that even now everywhere in the universe the same process of evolution that the earth has passed through is being repeated and that there now exist in space gaseous nebulæ, molten spheres and solid ice-cold masses, the last representing the present condition of the moon and the future fate of the earth. It is natural for the inquiring mind to propound theories as to the origin of life upon this planet, and these speculations are of more than passing interest, as they have gradually been made to conform to the scientific discoveries of the age. The theory of cosmazoa and that of continuity of life are based upon the hypothesis that life is eternal, while that of spontaneous generation, as taught by Heckel and elaborated by Pfluger, is based upon the scientific teachings of the day. The theory of spontaneous generation or abiogenesis in its general form is as follows: Since there was a time in the evolution of the earth, when the existence of living substance was impossible, living matter must have arisen from lifeless matter at some later period. To the ancients the idea that worms, insects and even fishes could come into spontaneous existence out of mud, offered no difficulties, and the invention of the microscope gave new support to the theory, as it led to the discovery of a world wholly unknown and excessively rich in living forms, when it was shown that the aqueous infusion of dead matter, after a short time, swarmed with minute living organisms, which are still termed Infusoria, proof positive appeared to have been obtained, but modern bacteriology, with its special technique, has permanently destroyed this evidence. Heckel, in 1886, placed the theory of spontaneous generation upon a firmer basis; he argued that as there must have been a time when the earth was in condition that excluded all organic life, living substance must have originated at some time during the earth's development from lifeless substance and the time at which it developed, could not possibly antedate the precipitation of the water vapor suspended throughout the, atmosphere, *i. e.*, when the temperature had been reduced considerably below 100 degrees, and that the first organisms must have been, not cells, but the lowest and simplest organisms that can be imagined, "completely homogeneous, structureless, formless lumps of proteid," which he termed "monera," refusing to discuss in detail how they originated, on the ground that we have no knowledge of the conditions existing on the earth's surface at that time, but that it is conceivable that these lumps of living proteid arose from the mutual action of substances dissolved in the primitive sea. Pfluger discusses in a strictly scientific manner the problem of the origin of the monera of Heckel from the known facts of physiologic chemistry. There exists a fundamental difference between dead and living proteid in the power of self-decomposition of the latter, partly spontaneously, but more through external influences, whilst dead proteid, under proper conditions remains unaltered for an unlimited time. The chief condition of decomposition is the intramolecule oxygen occurring in the living proteid molecule and which is being continually received by it from the outside world. That oxygen is the essential

condition is shown by the formation of carbon dioxide by dissociation, *i. e.,* by an internal rearrangement of the atoms and the separation of the new atomic groups from one another. Living substance contains oxygen already in combination in the living molecule, as Pfluger has shown that animals can exist in an oxygen free atmosphere and yet continue to expire carbondioxide for longer than 24 hours. A comparison of the decomposition products of living and those obtained by the artificial oxidation of dead proteid, show that the non-nitrogenous products are essentially the same, while the great majority of the nitrogenous products have not even a remote resemblance to one another. It follows that then the non-nitrogenous atomic groups are the same in both living and dead proteid, but that a fundamental difference exists between nitrogenous atomic groups. The nitrogenous decomposition products of living proteid as area uric acid and the nuslein bases, as xanthin, etc., contain cyanogen, CN; urea the most important of the nitrogenous decomposition products of living proteid can be produced artificially from cyanogen compounds by a rearrangement of atoms, seeming to prove that living proteid contains a cyanogen radical, this being the fundamental difference between living and dead proteid. In Pfluger's words: "In the formation of cell substance, *i. e.,* of living proteid out of food proteid, a change of the latter takes place, the atoms of nitrogen going into a cyanogen like relation with the atoms of carbon with the absorption of considerable heat." Calorimetric investigations showing that cyanogen is a radical possessing a great quantity of internal energy, therefore, there is introduced into the living matter energetic internal motion.

The similarity of cyanic acid to living proteid is marked, both bodies grow by polymerisation, both spontaneously decompose into ammonia and carbonic acid in the presence of water, both form urea by dissociation, both are liquid and transparent at low temperatures, coagulating at higher ones. "The similarity is so great that I might term cyanic acid a half-living molecule," says Pfluger. Cyanogen compounds only arise at an incandescent heat, hydrocarbons and alcohol radicals can likewise arise synthetically with heat.

Fire, therefore, is the force that produced the combinations of the elements to form cyanogen and other constituents, the primordial living proteid, which has cyanogen as its fundamental basis, its evolutionary end being carbonic acid, ammonia and water.

The foods proteins, carbohydrates and fats are derived from the simple inorganic molecules by the action of sunlight upon chlorophyl, a substance which has not as yet been isolated in a pure state, it occurs not only in plants, but also in some of the lowest forms of animal life, existing in the cells of the leaves combined with the albuminous bodies, these chlorophylic granules have the power of locomotion as they can approach the surface of the leaf in sunlight, retreating when the heat is too great. In the cotyledens of plants germinating without sunlight occur yellowish leucoytes, which become green when exposed to light. Chlorophyle is the agency by which the kinetic energy of the sunlight is converted into the potential energy of the food stuffs. During the action of sunlight upon a chlorophyl-bearing plant the C_2O of the air is decomposed with the liberation of oxygen at the same time water is reduced, which is proven by the presence in the plant of more hydrogen than is necessary to form water with all the oxygen present, therefore CO_2 plus H_2O equals CH_2O plus $_{20}$ formic aldehyde and oxygen. Polymerization of the aldehydes and hydrolysis will produce meno. di and polysaccharides $_6CH_2$ Oequals $C_6H_{12}O_6$ glucose; $_{12}CH_2O$—H_2O equals $C_{12}H_{22}O_{11}$ cane sugar; $_6CH_2O$—H_2O equals $C_6H_{10}O_5$ starch.

Fats are probably also formed from CO_2 and H_2O by chlorophyl or some similar substance $_3CO_2$ plus $_4H_2O$ equals $C_3H_8O_3$ plus $_{70}$ glycerine with elimination of oxygen and $_{34}CO_2$ plus $_{31}H_2O$ equals $C_{18}H_{36}O_2$ plus $_{16}CH_2O$ plus $_{680}$ stearic acid, formic aldehyde and oxygen. The formation of the proteid molecule is not so simple and its composition is as yet imperfectly known; the nitrogen is, however, derived from nitrates which are decomposed in the rootlets of plants, liberating nitric acid, which acts on formic aldehyde $_2HNO_3$ plus $_3CH_2OO$ equals $_2HCN$ plus $_3CO_2$ plus $_3H_2O$ forming cyanogen, which by oxidation will produce cyanic acid HCNO, which is Pfluger's fundamental labile group in the proteid molecule.

The plant, through the agency of chlorophyl and sunlight takes up carbonic acid and water, separating the oxygen from these compounds, forming other compounds poorer in, but with

great affinity for oxygen and which therefore contain potential energy derived from kinetic energy of the sun, which potential energy is assimilated by the animal as food; on being oxidized it produces the kinetic energy of work and heat, the oxidized products being eliminated in their original forms as cargon dioxide and water to be again absorbed by the plant, thus maintaining an eternal synthetic and analytic cycle of matter.

CONJUNCTIVITIS PURULENTA ADULTORUM.

By Edward E. Gibbons, M. D.
Chief of Clinic and Demonstrator of Opthamology in the University of Maryland Hospital.

(Continued from October issue.)

Purulent ophthalmia or conjunctivitis as it occurs in the adult is essentially the same disease, as affects the eyes of the infant. In the vast majority the source of contagion can be traced to the genitals of the patient, who may either be suffering with an acute or chronic specific urethritis or vaginitis, or the infection has been conveyed from a similarly diseased eye, or by direct contact with soiled handkerchiefs, towels, clothing or rags. Severe cases of catarrhal conjunctivitis may present the clinical picture of an incipient purulent ophthalmia, and the latter oftimes is taken at first for an exaggerated catarrhal conjunctivitis. If there is any reason from the severity of the symptoms to suspect gonorrhoeal infection, the pus from the eye should be examined microscopically for the organism of gonorrhoea. The right eye is, as a rule, the one affected primarily, as most individuals use the right hand in the toilet of their genital organs, and, as the right hand is also used to scratch the eye, thus acts as a direct transfer of the contagion. The specific organism occurs in twos and fours, within the pus cells or in isolated groups, and are also found at a considerable depth in the epithelium of the conjunctivita. Many half-grown children in which the disease varies in severity between that in the infant and that in the adult, have at the same time a specific vaginal or urethral discharge, contracted through towels or wash cloths used by adults in the home who are suffering with gonorrhoea.

The more active the organisms at the time of the infection, the more violent will be the ocular inflammation. The physician and nurse should always be on their guard less they infect their own eyes.

Care must be taken in opening the lids, which oftimes are distended with pus, or eyes. The hands must be carefully washed in strong bichloride (1-1,000) after each cleaning of the eye. If a drop of pus should accidently spurt into the eye of the attendant, he should immediately wash the hands, and then the eye, and neutralize the pus by dropping a drop of two per cent. solution of silver nitrate in the eye. Pus diluted to 1-1,000 still contains decided contagious properties. It has also been shown that one-quarter per cent. of silver nitrate solution, by its coagulating effect upon albumen, renders the infection practically innocuous. The symptoms are like those before described in the same disease in the infant, except more severe. The lids are more swollen and much infiltrated, so much so, in fact, that it is impossible to open them to get a fair view of the cornea. The ocular conjunctivita also participates to a greater degree in the inflammation and chemosis soon develops. Unlike that in the child, the chemosis (infiltration of the conjunctiva surrounding the cornea) is dense and infiltrated. When the secretion is wiped away from the lids, the conjunctivita bleeds. Ulceration of the cornea most often begins near the limbus, where the chemotic conjunctivita overhangs it and causes a pocket for pent-up pus. The duration of the disease is from four to twelve weeks.

Treatment.—From the beginning the treatment must be active. The patient should go to bed. If there is intense initial swelling, several leeches may be applied to the temple, or the artificial leech used to abstract several ounces of blood. Continuous cold should be applied by frequently changing compresses wet with iced water or laid upon a piece of ice to keep them cold. They must be changed every minute or two. If pain is occasioned by the cold, it should be modified by using compresses less cold. It is very difficult to properly clean the eye which should be done every fifteen minutes to half hour after secretion forms; on account of the great swelling and infiltration of the lids. A Callan lid irrigator greatly facilitates this. The bulb is filled with some bland antiseptic solution, boric acid, gr. 10 to oz., or bichloride 1-6,000. The instrument is then

held between the thumb and index finger, the bulb resting between the other fingers and the palm of the hand; and pushed gently beneath the upper lid well up into the fornix, the bulb is then squeezed. By this means we are able to thoroughly cleanse the eye quite up to the fornix, which is seldom reached by the ordinary methods. The instrument should be handled very gently so that the conjunctiva or cornea is not wounded. It should not be used oftener than three or four times a day, and the eye cleansed in the interim in the usual manner. Cleansing the eye can be greatly facilitated by the use of a diluted solution of hydrogen peroxide, it should not be used stronger than 1 to 4 parts of water. Its use as an antiseptic has recently been proposed by Landolt. By the evolution of its oxygen the pus is brought down from the fornix, and can then be wiped away. It is not irritating to the eye provided it is free from sulphuric acid. If it is decidedly acid in reaction, it should be neutralized with sodium bicarb. Putting vaseline hourly between the lids preserves the corneal epithelium. Should the cornea become involved, atropia solution should be instilled three or four time a day. Cauterization of the corneal ulcer seldom does any good (unlike ulcer from other causes), but if it is rapidly progressive, its surface may be touched with a solution of nitrate of silver in the strength of 60 grains to the ounce, applied with a small mop made by twisting a tiny piece of absorbent cotton tightly about a wooden toothpick. In the gonorrhoeal ulcer nitrate of silver is the best caustic and its use as a caustic in corneal disease is almost limited to this condition. As long as the cornea is intact cold applications are indicated, but when it breaks down cold is contraindicated, because then we want as much blood in the parts as possible so that nourishment may be carried to the ulcer and the effete matter carried away. Cold constricts the vessels, both the blood vessels and lymph vessels, and interferes with nutrition. The only thing that cold does is in a measure to prohibit swelling of lids and conjunctiva, and perhaps lowers the vitality of the infection, but nutrition of the tissues is lowered, while hot water hastens absorption. The eye may recover with perfect vision and a normal conjunctiva, but frequently there is more or less hypertrophy of the conjunctivita which persists for weeks. The resistance of the eye has often been so lowered by the disease that it is subject to repeated catarrhal inflammations of the conjunctiva for some time. When only one eye is affected great care should be exercised that the infection does not get into the sound eye. The patient should never be allowed to touch either eye. When the wel eye needs wiping, it should be done by the nurse after she has thoroughly cleansed her hands. Bandaging the well eye to protect it is harmful, as the eye is very apt to develop a catarrhal inflammation of its conjunctiva under the bandage and its resistance is then lowered so that a tiny amount of infection that it could otherwise tolerate, finds a soil favorable for its development. Buller's Shield, likewise, is not only ineffectual, but experience has shown it to be hurtful. Buller's Shield is a watch glass held in place over the eye by means of adhesive plaster strips.

An indication to be borne in mind in severe cases is the relief of pressure by incising the swollen tissues, and unloading the blood-vessels. Tyrell was the first to lay stress upon the sacrification of the chemosis. After scarifying the chemotic conjunctiva the infiltration does not flow away because of its plastic nature, but the tension upon the circumcorneal loops of vessels is lessened to a considerable degree. The incisions should be made radiating from the edge of the cornea, in the course of the circumcorneal vessels, so that as few of them as possible will be divided. A canthotomy to relieve the pressure of the lids upon the cornea somewhat should always be done if the cornea is threatened. Critchett resorts to a medial section of the upper lid to facilitate cleansing of the eye and to relieve pressure upon the cornea. The resulting deformity he repairs subsequently. That this is good treatment in extreme swelling and infiltration of the lids there is no doubt.

It would be impossible to mention all the various methods and drugs used in the treatment of gonorrhoeal ophthalmia in an article of this kind, suffice it to call attention to several methods other than those already described which are still in vogue with certain ophthamologists. The use of bichloride has not long since been again revived in the treatment of this malady. It is used in two ways: It is applied to the everted lids, in 1 to 500 strength often enough to hold the suppuration in check. Great pain is produced. A lacol anes-

thetic, best holocain, is then instilled and cold compresses placed upon the eyes. Another method is to put the patient to sleep, and then to scarify the conjunctiva, and rub into it the solution of bichloride by means of a toothbrush. This procedure causes a remarkable abatement of the secretion, but there is great swelling of the lids. The treatment is repeated at intervals of several days for two or three times. The conjunctiva of both eyeball and lids is scarified and brushed. This treatment is effective according to those who have employed it, but now and then the case is complicated by formation of a number of fine adhesions extending from the lids to the eyeball. It is customary among the French ophthalmologists, especially in hospital work, to use the mitigated nitrate of silver caustic stick in the treatment of these cases. The plan of treatment is somewhat as follows: An extensive canthotomy is done, the lids everted and rubbed over with the caustic stick, and then washed with salt water. When the eschar separates, the operation is repeated if suppuration is renewed. Brilliant results have been obtained in the Hospital des Infants a Paris by this method. The treatment being so harsh it would seem that many cases under this plan get well despite the treatment.

In the severer cases of purulent ophthalmia in the adult and those of mixed infection, a pseudo-membrane forms upon the palpebral conjunctiva, often extending to the ocular conjunctiva. It is ascribed to the too energetic use of silver nitrate solution, to the presence of staphyloccocci, streptococci, Klebs-Loeffler bacilli and diplococci,. When it occurs the secretion should be examined for the diphtheritic bacillus, and if found, antitoxin administered. It is useless to remove the membrane, as it is quickly reproduced. If of pyogenic origin powdered caroid should be sprinkled in the eye. This drug is the most active artificially digesting agent upon the market and is otherwise inert. Cases complicated with a pseudo-membrane are very apt to be followed by corneal involvment.

X-RAY FOR RING WORM OF THE SCALP.

By Nathan Winslow, A.B., M.D.

From time immemorial tinea tonsurans has offered stubborn resistance to treatment, usually not succumbing until after weeks of patient, persistent treatment. The whole gamut of the pharmacopeia has been tested. Sulphurous acid, white precipitate ointment, oleate of mercury, tincture of iodine, sulphur ointment, oil of cade, carbolic acid and cantharadis have had their periods of especial popularity, only to be found more or less wanting.

Epilation in conjunction with parasiticides as formerly practiced, though very efficacious, was impractical, until the lesion was well advanced. We now have an agent at our disposal, the X-Rays, which painlessly removes the hair after 2-3-4 exposures of 10-15 minutes each. The technique consists of covering the entire area of the scalp with lead foil, except that which you desire to render bald. With the anode 8-12 inches from the infected area an exposure of 10 minutes three times is in order. If the diseased area is not rendered bald, repeat the performance. During the X-Ray treatment and afterwards the involved area is anointed with ammoniated mercury ointment. This method not only lessens the duration of the attack, but also the tendency to transmission.

The object of epilation which should include a margin of healthy hair, is to remove the source of food from the tricophyton and to enable antiseptics to come into more intimate contact with the parasite.

Due care must be exercised in not burning the scalp or too frequent exposures employed, as the hair follicles may be destroyed. If the denuded area manifests no signs of a new growth of hair within a month, do not worry unnecessarily, for it usually returns.

CORRESPONDENCE.

A TRIP THROUGH THE NORTHWEST.

Rochester, Minn., *Oct. 19, 1906.*

To the Hospital Bulletin:—

Through the courtesy of the Commonwealth Bank, in which it is my privilege to be a director, I was appointed a delegate to the American Bankers' Association, which held its annual meeting in St. Louis, Mo., on October 16th, 17th and 18th. The opportunity to secure a much needed rest from professional work and to visit the Mid-

dle West was one I could not neglect. Leaving Baltimore Saturday afternoon, October 13th, in company with a number of friends and prominent bank officials, we boarded the "Bankers' Special" at Harrisburg, Pa., at 8.30 P. M., where we joined a large delegation of the banking fraternity from New York, Philadelphia and other Eastern cities.

The "Bankers' Special de luxe," as it was designated, was run in two sections. Section 2, in which I took a berth, was made up of twelve Pullman coaches, a dining and one observation car. It was a palatial hotel on wheels, provided with every comfort for its one hundred guests. In the observation car were a piano, library of selected books and current literature, and a stenographer and typewriter to render service to anyone who desired to carry on a correspondence.

The run from Harrisburg to St. Louis, a distance of over 900 miles, was made in less than 22 hours. Ideal weather and agreeable companions made the first day's journey one long to be remembered.

Reaching St. Louis, I stopped at the Southern Hotel, a very large and handsome structure now left in the business section of the city by the growth of trade towards the north and west. As the main object of my visit was for pleasure, I deserted my friends of the banking fraternity the morning after my arrival in St. Louis and gave the entire day to sight-seeing. I was not greatly impressed with the importance or grandeur of the city. At the time of my visit the sky was darkened with clouds of black smoke and the entire business section was dingy and dirty. The streets and sidewalks are not as good as we have in Baltimore and the street-car service will not compare with the United Railways. If comparisons are odious our St. Louis friends can take little comfort from this statement.

My stay in St. Louis was too short and hurried to take in the medical interests of the city. The population and wealth of the city are increasing rapidly. Evidences of material prosperity are to be seen in the size of business houses, banking establishments and enormous railroad terminals. I was told that the largest brewery—Annheuser-Busch—and the largest trust company in the world are located in St. Louis. Many will recall the great Eades Bridge, which in its day was considered a phenomenal feat in engineering, across the Mississippi at St. Louis. It now looks like a commonplace affair in contrast with other huge bridges spanning the river at that point.

The University of Maryland has several distinguished Alumni practicing medicine in St. Louis, notably Dr. Hugh Y. Bond, Dr. Eustacius Chancellor and Dr. Edward Borck. My time was so limited that I was unable to call upon any of these gentlemen.

Leaving St. Louis Monday night at 10.40, over the Missouri Pacific, the next morning at 7 o'clock I was in Kansas City, 275 miles due west. Here I met relatives and friends whom I had not seen since my visit to that city in 1887. The nineteen years which had intervened had brought marvelous changes in the growth and population of that city. With a present population of over 300,000 and the largest railroad center in the United States—Chicago not excepted—Kansas City is destined to become the largest center of population and wealth in the Middle West. Her public-spirited business men evidently appreciate this fact, for they have laid out a city of enormous proportions and built upon a most lavish and up-to-date plan. Miles of wide and handsomely-paved boulevards have been projected far into the suburban sections in advance of houses. Beautiful parks, cemeteries and private residences are to be seen in every direction, giving evidence of a present material prosperity and future development not to be found in any city in the United States. The Capital of the nation will some day take off her hat to this great metropolis at the junction of the Missouri and Kaw.

Several days were spent most pleasantly in Kansas City, but here again I was too pressed for time to give attention to the medical institutions of the city.

I was unable to call upon Dr. C. B. Irwin, class of 1904, who is a most successful practitioner in that city. Taking leave of Kansas City on Wednesday night at 9.40 o'clock, I took breakfast the following morning on the diner between Omaha, Neb., and Sioux City, Iowa, and enjoyed the remainder of the day in an observation car, traveling through northwest Iowa and southeast Minnesota, a country of vast agricultural possibilities, now yielding rich harvests of wheat and corn. The country for miles is as level as a plank floor and almost barren of trees except those planted by man. The soil is deep and rich and every acre

capable of yielding abundant crops under proper cultivation. The distance from Omaha to Rochester, Minn., is over 300 miles, and the entire day was consumed in making the journey.

I reached Rochester, Minn., at 7.40 P. M., both dirty and tired. I retired early to bed in the only vacant room in the Rochester Hotel, the only hotel in the place not filled with visitors. I was informed that the town was full of visiting doctors and patients who were bent upon the same purpose I had in view—a visit to the Mayo brothers.

I had thus far traveled a distance of nearly 2,000 miles to see what was to be seen in this small city of less than 8,000 people, situated 100 miles southeast from St. Paul and 400 from Chicago, known to the medical world as the home of the Mayo brothers.

Rochester is rather attractive, but unpretentious, and until a few years back had few claims upon public attention. I asked an old citizen what were the chief industries of the place. He answered: "We have a moderate-sized brewery and the Mayo brothers; the latter support the town." Here is a large community which enjoys a unique position and prominence due to the work of two remarkable surgeons whose fame has reached every civilized section of the globe. I propose to give the readers of the BULLETIN as clear a view of the Mayo brothers and of their remarkable work as it is possible to make it in the space at my command. The subject is a big one and pages could well be devoted to a study of their work and its influence upon the surgery of today. An object lesson could be drawn which would have a value to every man who undertakes surgical work either in rural or urban districts. This lesson may be briefly summed up in the words—simplicity, thoroughness and practical ability. Two young physicians of good education, hard sense, uncommon ability—administrative as well as surgical—energetic and progressive, the sons of a physician who had practiced his profession for many years in Rochester, some 18 or 20 years ago, took charge of St. Mary's Hospital, conducted by the Sisters of Charity in that city. The hospital was well located on the suburbs, with ample grounds and every hygienic condition favorable. In this institution Drs. William and Charles Mayo began their surgical work. The opportunity and the men met at the right moment and a development has been the result which has aroused attention in every center of medical learning. This development has followed the most natural course. A superb hospital building, with every modern equipment and every needed facility, has offered a large field for surgical work. Two brilliant surgeons with skill, industry and administrative ability have taken hold of this field and have cultivated it with a success that has surprised men who take an academic view of work and who regard precedent and authority as the only route of travel to success and brilliant achievement. The Mayo brothers have worked in surgery as a skilled artisan works in metal. They have seen the practical, common-sense side of surgery and have worked out problems, perfected methods and handled the knife as a skillful mechanic handles tools. They are close students of disease, of surgical procedures and of all questions having a practical bearing upon results.

They are not slaves to authority, but by reason of their isolated position have been self-reliant, independent and courageous workers. The original work they have done may be attributed to two factors: first, uncommon surgical ability; second, uncommon boldness and independence. Where others have hesitated to venture they have gone boldly forward, first as pioneers and next as constructive and painstaking workmen.

My visit to St. Mary's Hospital was too short to give me a full insight into the practical workings of the plant. I saw enough, however, to satisfy me that it is the most perfect, up-to-date surgical institution in this country. It is a perfect machine and like the "Corliss Engine," does a large work without noise or friction. The machinery is so perfect that it runs as smoothly as a watch. I saw twelve cases operated on by Dr. William Mayo and his assistant, Dr. Judd, between 8 A. M. and 1 P. M. There was no delay for the surgeon. The patients were anæthetized by women with years of training, were brought into the operating room thoroughly prepared, and the work of the surgeon was made so easy that he was able to accomplish a great deal in a short time. All the operations I saw, except one, were on clean cases. I take it that this one advantage has done much to secure the good results credited to the Mayo brothers.

They have far less pus to deal with than surgeons connected with large city hospitals, and they operate more frequently on primary condi-

tions. They have a rural and distant clientele and not material drawn from the slums or from densely populated sections. A striking advantage they possess is in the fact that they are not teaching medical students and nurses. Their assistants have been long and carefully trained and work in harmony with the operator like pieces of machinery.

These advantages are all to the credit of these surgeons who have organized, built up and now so successfully administer this remarkable surgical plant. During my short stay in Rochester I saw over twenty physicians and surgeons from all parts of this country in attendance upon the Mayo clinics. Rochester has become a Mecca for the surgeon, and if all are as much profited by their visits as I was, it should continue to draw the surgeon and physician who wish to learn from men who teach a splendid lesson in simplicity and common-sense methods.

What the Mayo brothers have done in Rochester can be done in the smaller cities and even larger, where the men and the plant combine to give results. During my visit Dr. Charles Mayo was absent from home, and I was only able to exchange a few words with Dr. William Mayo. I found him a courteous, unassuming gentleman, with cordial and gentle manners.

He impressed me as being an earnest, honest and conscientious surgeon, more anxious to get results and perfect the art of surgery than to make money. In addition to his ability as a surgeon he has administrative talents which would guarantee him success as the president of a railroad corporation or of a banking institution, or in any commercial enterprise in which he might have engaged. He is the business man in surgery, bent on securing the best results in his work and bringing to his assistance all of the art and science necessary for constructive work. In his make-up and methods he differs from the surgeon who relies upon scholarship and learning to make an impress upon professional attention. He holds no professorship in a medical college, has not written elaborate text-books, illustrated with chromos and lithographs, has not stamped his name upon surgical instruments and appliances, and, as far as I know, has no priority claim upon surgical procedures or methods, yet in his simple, direct and practical way he has done more to improve surgery than many of the world's most renowned surgeons.

The amount of work he has done and his statistics entitle him to the front rank of operating surgeons. I would class Dr. William Mayo with the leading surgeons of the world and I would claim that his success is due to his simplicity of technic, to his practical sense and to his dexterity with the knife.

Wide experience and opportunity have improved his natural talents. His isolated position has developed self-reliance and boldness in action, whilst his administrative talents have enabled him to perfect the plant so necessary for progressive surgical work. The greatness of the man is the outcome of his simplicity of character and natural ability. His genius is a genius for work.

I understand that his brother, Charles Mayo, whom I did not have the pleasure of meeting, is equally gifted as an operator, has less of the administrative, but more of the æsthetic temperament than his brother William. The two brothers are so well mated that they work in perfect harmony. Dr. Judd, a relative by marriage, is an assistant to Dr. Charles Mayo, and fills his place in his absence. He is being thoroughly trained to relieve the two brothers in the enormous work which is pouring in on them. Dr. William Mayo is assisted in his work by Sister Joseph, Sister Superior to St. Mary's Hospital. I should say that this good sister is the best trained woman in surgery in America. Her skill as an assistant is simply invaluable.

The Mayo brothers have a well-trained corps of physicians who do the pathological and clinical work so necessary to the surgeon. This is a part of the hospital plant which seems complete in every detail of administration.

My stay in Rochester was too hurried for my own edification, but it was sufficient to quicken lines of thought which cannot fail to be profitable.

I would advise all who desire to see the surgery of today, as practiced by men who are up-to-date in every method of work, to make a visit to the Mayo brothers.

T. A. Ashby, M. D.

Paris, France, *August 13th, 1906.*

To the "Hospital Bulletin":—

From Zuerich we journeyed to Lucerne, a beautiful city of about 40,000 inhabitants, situated on the lovely lake of the four cantons. The city is quaint and old-looking, with narrow streets,

and a swift stream dividing it into two portions. Crossing this stream are two wooden bridges which do not cross in a straight line, but are curved or bent, and upon the panels of these bridges are paintings, depicting various historical episodes. One of these bridges is said to date from the twelfth century. There are also a number of modern stone bridges, but these are not so interesting as these old covered passages of a long gone past. There is also an old tower still standing in the middle of the river, which was formerly used as a safe deposit for the preservation of valuable records, but it is not now used. An enormous number of tourists go to Lucerne, as from here side trips to the Rigi, Pilatus, and other snow-clad mountains, are conveniently made. Our next journey was to Interlaken. Taking steamer at Lucerne, we had a fine view of the mountains and beautiful green lake, and at Alpnachstad transferred to the cogwheel train for Meidingen, crossing the mountains at an altitude of 3,000 feet. The little cottages on the hill-sides were mostly deserted, as at this time of the year the women and children go still higher up the mountains with the cattle, leaving, perhaps, the husband to gather wood and provender for the winter's use. The view from the cars as we laboriously and slowly climbed these lofty hills was very enchanting. Leaving the train we take a steamer at Brienz and ride down the lake of the same name to Interlaken, which, as its name signifies, is between the lakes Brienz and Thun. Interlaken is jammed between the mountains, and is the gateway for numerous excursions. The white mass of the Jungfrau dominates the secenery and is a beautiful object as it lifts its hoary head into the sky. Here again is a meeting place of the nations, and people from all parts of the world jostle each other in the streets and public places of this little Swiss town. We were unable to secure lodgings in a hotel, but were sent to a private house, where we obtained a fine room, and got our meals at a nearby hotel. The reputation of Baltimore as a live place is well established in Interlaken, as the advertisement of the familiar Hunter's Rye Whiskey, "the first over the bars," adorns the boards in that far away resort. We left Interlaken by steamer down Lake Thun to Sherzlingen, where we took a train for Berne. These green lakes, dotted here and there with towns and villages, and with the neighboring hillsides covered with the ripening grain, and other produce, quite up to their tops, whilst in the near distance the lofty snow-clad Alps encompass the scene, form a panorama of wonderful beauty. The country from Scherzlingen to Berne is less mountainous, though by no means flat, and is in a high state of cultivation. Berne is the capital of the Swiss Federation, and has a population of about 70,000 inhabitants. It is a very picturesque place, situated on hills, between which flows the swift river Aar, of a beautiful green color, and crossed by several very lofty bridges. The city is quaint and provincial looking, differing in appearance from any other European city that I have seen, but resembling Salzburg and Innsbruck somewhat, inasmuch as the sidewalks are mostly covered, forming long arcades or passageways, over which the houses are built. The public buildings are handsome, but the general appearances of the city is not very attractive, and there does not appear to be much bustle and actvity on the streets. One of the objects I had in coming to Europe was to visit the clinic of Professor Kocher at Berne, and to observe some of the surgery of the thyroid gland for which the clinic is noted. Professor Kocher has now removed the thyroid gland for goitre several thousand times, with almost no mortality, and I desired to learn his methods at first hand. He operates at the Insel Spital, a well-equipped hospital, and we were fortunate enough to find his son, Dr. Kocher, at work when we called at the clinic. As we entered the room he was making an incision across the neck of an old man for a thyroidectomy, and this case was followed by a similar operation on a young woman. The patients were in an almost upright posture,, and no general anesthetic was administered, but the skin was injected with novacain. Great care was taken to doubly clamp and ligate all blood vessels before dividing them, and to avoid any injury to the recurrent laryngeal nerve. We saw a number of other operations for other conditions, as fecal fistula, appendicitis, fracture of the internal condyle of the humerus, and hernia. In the operation for the radical cure of inguinal hernia, Kocher pursues a method of his own, which is the dragging of the sac out through an opening in the external oblique aponeurosis, and saturing it there and cutting off the redundancy. We were not able to see Professor Kocher, as he was taking his holiday.

Switzerland is a small country, but three distinct languages are spoken, German, French and

Italian. Leaving Berne for Geneva, in a short time we reach the French-speaking portion of the country, and to all intents, a foreign land. The railroads are good and two heavy engines were attached to our train. We were traveling in what is called the lowlands, but it is quite hilly enough, and the Alps are always in view. Everywhere was evidence of industry and thrift; fat herds, sleek horses, and fields cultivated to the limit. The farmhouses are built under the same roof as the barn and stables, and while doubtless convenient for the farmer, would scarcely be considered desirable residences by Americans.

Coming to the mountains again, we plunged into tunnels, and emerged on the shores of the beautiful Lake Geneva, or, as it is called here, Leman. Skirting this large and fascinating body of water, set like a jewel in its ring of hills and mountains, we passed through the old city of Lausanne, and forty miles farther alighted in the lovely city of Geneva. We reached here in the evening, and I find recorded in my notes that "we had the best dinner that we have eaten in Europe, and a plenty of it." Geneva is a beautiful city of 150,000 population, situated on both sides of the extreme eastern end of the lake. It has splendid hotels overlooking the water, and with numerous bands playing and crowds of people promenading, it is very lively and attractive to the tourists. There is an University here, and Socin is professor of surgery, but I did not visit the hospitals or clinics. The manufacture of watches and jewelry are important and famous industries, and one can obtain bargains in these directions. The Swiss are very patriotic people and everywhere their beautiful red flag, with the white cross in the center, is displayed. There are numerous excursion boats on the lake, with the Swiss flag at the stern and the French tri-color at the peak, as France also has a coast line on the southern shore of the lake. We returned to Lausanne by steamer, stopping here and there at the French lakeside towns in Savoy, where the people thronged the wharves, dressed in their holiday attire. Crossing to Ouchy on the Swiss side, we take the funicular railroad up the hill to Lausanne. This is an old city perched on the hills overlooking the lake, and is a favorite resort, both in summer and winter, for travelers to sojourn. We found a good hotel and a high price, and did not tarry long. Leaving Lausanne at 6.20 A. M., we passed through an agricultural and pastoral country to Vallorbe, thence up hill to Pintarlier, where the French custom officials examined our satchels, and thence by fast train through a highly cultivated, but not especially attractive country, to Paris. The trip was very hot and dusty, and especially unpleasant after the cool and bracing atmosphere of Switzerland. At Paris we were cheated by a cab driver, the first time since we landed.

RANDOLPH WINSLOW.

WASHINGTON, D. C., *October 20th, 1906.*

To the Editors of the "Hospital Bulletin":—

Occasionally we read in the newspapers where individuals and whole families have been killed or made seriously ill by eating toadstools in mistake for the edible mushroom.

Whether the accounts are overdrawn or not, I am not prepared to say, but there is one thing, however, that is very evident, and that is, city physicians are rarely called upon to treat the condition. This, then, is my excuse for this communication.

The text-books say very little upon the subject, the literature is also scant, although there is an article in the *Medical News* (Oct. 21, 1905), by Dr. N. W. Ford, of Baltimore. The author states that he has examined the literature since 1884 and finds a number of cases with quite a number of fatalities.

Dr. Ford, it seems, at that time, was engaged in finding an antitoxin for the poison, and was experimenting on different animals by injecting an extract of the fungi, he also published the result of other experiments, and as far as I know, with negative results. The author goes on to state ante-mortem and post-mortem conditions which, briefly stated, are profound prostration, with cynosis, headache, vomiting and diarrhea. Of the latter he finds ecchymoses and hemorrhages into the serious membranes, together with fatty degeneration of the liver and kidney.

Dr. Ford remarks that the toxic properties are due to a principle called phallin and the cause of death to blood-laking, caused by a hemolysis of the erythrogtis.

The case that I have in mind presented several peculiar features worth mentioning, the chief of which was the long interval between eating the fungi and the appearance of the symptoms, also

the lack of the cynosis, but rather of extreme pallor.

Several weeks ago I was consulted by a gentleman who seemed in great distress; he informed me that the evening before he had gathered a quantity of what he supposed was the real article.

The next morning his wife prepared them and at breakfast he ate what he said was a mess. Four hours after, he presented himself. While he was talking he suddenly collapsed and had to be placed on a couch.

Examination revealed a diffused tenderness over abdominal region with widely dilated pupils, rapid small pulse, conscious, but disinclined to talk or move. Great beads of cold perspiration stood out upon his forehead; in fact, it was a picture of profound shock.

Treatment.—I administered 1-30 grain strych. sulph., followed by 1-40 grain in thirty minutes, after which he vomited great quantities of a brownish-black substance. I then administered 1 oz. of Rochelle salt (contrary to the treatment for shock). This was followed by a copious evacuation.

After a few hours' rest in the recumbent position, he was able to return home, but remained in a weakened condition for a week. After treatment consisted of iron, quinine, strychnine.

A. W. VALENTINE, M. D.

KANSAS CITY, KAN., *October 15, 1906.*

To the Hospital Bulletin, Baltimore, Md.:

GENTLEMEN.—It gives me much pleasure to write the BULLETIN.

I took the Kansas State Board at Topeka, October 9-10, and am happy to inform you that I was not only successful, but made the highest average given. Twenty-eight took the examination. Twenty-five passed, 3 failed. This speaks well for the University of Maryland and her many professors.

I hope that all the graduates will always look upon the University as one of learning and high merit.

Sending best wishes to professors and alumni,

Yours fraternally,

C. BRENNER, M. D., Class of 1906.

These alumni are located in the District of Columbia: Dr. Henry Darling, class of 1867, Brightwood; Dr. Benjamin Logie, class of 1890, St. Elizabeth; Dr. Alfred V. Parsons, class of 1889, Tacoma Park; Dr. A. W. Valentine, class of 1903, Washington; Dr. Oliver E. Belt, class of 1886, Washington; Dr. Francis B. Bishop, class of 1883, Washington; Dr. W. Sinclair Bowen, class of 1888, Washington; Dr. Josiah R. Bromwell, class of 1871, Washington; Dr. James Carroll, class of 1891, Washington; Dr. Thomas I. Chew, class of 1868, Washington; Dr. Horace B. Coblentz, class of 1896, Washington; Dr. G. B. Cole, class of 1887, Washington; Dr. G. Wythe Cook, class of 1869, Washington; Dr. Joshua L. Dulaney, class of 1868, Washington; Dr. Henry D. Fry, class of 1876, Washington; Dr. Monte Griffith, class of 1896, Washington; Dr. Hunter B. Hollifield, class of 1882, Washington; Dr. Henry Hurtt, class of 1895, Washington; Dr. Frank Hyatt, class of 1872, Washington; Dr. Thomas A. R. Keech, class of 1856, Washington; Dr. Wilson P. Malone, class of 1888, Washington; Dr. Robert F. Mason, class of 1895, Washington; Dr. Andrew B. Mitchell, class of 1866, Washington; Dr. George G. Morris, class of 1884, Washington; Dr. John B. Mullin, class of 1887, Washington; Dr. Magruder Muncaster, class of 1866, Washington; Dr. T. Morris Murray, class of 1873, Washington; Dr. Chas. W. Pence, class of 1894, Washington; Dr. J. Julius Richardson, class of 1889, Washington; Dr. William L. Robbins, class of 1890, Washington; Dr. Aurelius R. Shands, class of 1884, Washington; Dr. Chas. G. Stone, class of 1892, Washington; Dr. Isaac S. Stone, class of 1872, Washington; Dr. W. Norwood Suter, class of 1876, Washington; Dr. J. Ford Thompson, class of 1857, Washington; Dr. Allan Walker, class of 1886, Washington; Dr. Guy F. Whiting, class of 1878, Washington; Dr. Bruce Thomas, class of 1852, Washington.

Dr. Charles O'Donovan, class of 1881, has been elected president of the Baltimore Medical Club.

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BALTIMORE, MD , NOVEMBER 15, 1906.

EDITORIAL

A HANDSOME LEGACY TO THE UNIVERSITY HOSPITAL.—By the will of the late Joshua G. Harvey, who died recently in this city, the University Hospital has been made one of the three residuary legatees of Mr. Harvey's large estate, which is estimated to be worth between $600,000 and $1,000,000.

Mr. Harvey leaves his estate in trust for his only son, Mr. F. B. Harvey, a gentleman near fifty years of age, and after his death to the University Hospital, Union Protestant Infirmary and Home for Consumptives share and share alike.

For many years Mr. Harvey was one of Baltimore's most active and influential citizens. He was a most useful and benevolent man. After making provision for his family, he found that the institutions above named had the largest claims upon his benevolence.

As president of the Western National Bank, where the accounts of the Faculty of Physic of the University of Maryland have been kept for years, he had numerous opportunities to observe the work of the University and to form an opinion as to the value of the claim which the University Hospital had upon his charity. During his life-time, so far as we know, there was no intimation of his purpose, hence the announcement of his generous gift came as a most agreeable surprise to the many friends of the University Hospital.

Whilst it is more than probable that many years will intervene before the gift becomes available, this should in no manner diminish the appreciation which is due Mr. Harvey's benevolent purpose. In a proper time and way his name will no doubt be associated with the endowment by those who will have charge of the interests of the University at the time the legacy is available. It is more than probable that the needs of the University Hospital will be just as great in ten, twenty or thirty years from this time as at present, hence the looking forward to the attainment of results should in no manner lessen present duties to the Hospital, but rather stimulate the work of development so much needed at the present time. The fact that a handsome sum of money will some day come to aid the work of the Hospital should be made to arouse a much wider interest in the work now being done.

Institutions, as also individuals, should regard inheritances of money as trusts and added responsibilities. To waste the money given by generous friends, or to dissipate it in unwise undertakings, are the worst possible uses which can be made of it.

We have no doubt that the cause of charity has been made to suffer by the many unwise and misdirected uses of money left to institutions. Many disposed to give have been turned aside by the observations of large waste in the administration of charity funds by those who act as Trustees of such funds.

When those who have the management of institutions which are largely aided by state or private benevolence learn to recognize the responsibilities which these trust funds impose on them, we have no doubt that such institutions will receive a much more liberal pecuniary assistance from such sources.

Up to the past few years the University of Maryland has had but little financial help from outside sources. Quite recently several small bequests have come to the Faculty of Physic and one large one, the Crim legacy, will some day become available.

These, with the Harvey bequest point the way to a large endowment for the Hospital and Medical Department in the future. With the Centennial year, it is believed that a handsome addition will be made to these endowment funds, as well as to the general fund for the benefit of the University as a whole. The friends of the University should be appealed to at this period in the life of the institution to lay a broad and deep foundation for the future of the University of

Maryland as a State University. The time has come when the departments of the University should be gathered together under a strong executive management, when the direction of the University as a whole should be made to stimulate and develop the work of its departments.

THE LARGER UNIVERSITY OF MARYLAND.—We are glad to inform the readers of the BULLETIN that the proposed Union of St. John's College, at Annapolis, as the Department of Arts and Sciences of the University of Maryland, has reached a stage of development which will soon bring about an affiliation between the two Universities which will be highly beneficial to both.

The University will profit by a reorganization of the Department of Arts and Sciences, whilst St. John's College, in assuming a place in the University, will enjoy the prestige which belongs to a State University. The larger University, as thus provided for, will be in a position to exert a more powerful influence in the educational work of the State and should in the future claim all the functions which belong to a great State University.

For the present no radical changes in the Government of the different departments of the University are contemplated. The Board of Regents will be enlarged by the addition of members of the Faculty of St. John's College. Under the present system each department has its officers and separate management under the general supervision of the Provost and Board of Regents. The office of Provost is at present largely an honorary position, as he has comparatively few administrative functions and is required to give but little of his personal attention to the affairs of the different departments.

The Board of Regents, in like manner, is largely advisory in its functions, and exercises only a general supervision over the property interests of the University.

With the annexation of St. John's College, a new impulse should be given to the work of the University, not only in its departments, but in its general government, as a State University. The Board of Regents should give closer personal direction to the affairs of the University, an active President and Secretary of the Board should be chosen and clothed with such administrative duties as will give energy and force to the work of a larger University. With an efficient and able Executive Officer at the head of the University, the work of the departments need not be disturbed, but it can and should be enlarged and quickened to bring the standard of the University up to the highest state of efficiency and usefulness.

It is not only possible to bring about a reorganization of the administrative work of the University without embarrassing in any respect the present system of departmental management, but we believe that every department will profit by an executive head directing the general interests of the larger University.

A stronger union of the departments, a closer supervision and direction of matters effecting their respective interests by an active Board of Regents and an Executive Officer, will bring larger results than are possible under the present system.

The annexation of St. John's College to the University and the influence which the former institution can exert through its present efficient Executive Head and Board of Trustees, suggests that the time is approaching when the University of Maryland will enter upon a larger scope of work and assume a more commanding position in the State.

NOTES AND ITEMS

Dr. W. D. Campbell, class of 1906, has located at Piedmont, West Virginia.

The engagement of Dr. John Diedrich Moritz, class of 1904, to Miss Martha W. Jennings has been announced.

Dr. George H. Cairnes, class of 1864, of 21 W. Twenty-fifth street, who has been quite ill, we are glad to report is able to be out again.

Dr. Alan G. Brooks, class of 1906, has received an appointment as interne at the Columbus Hospital, 226 East Twentieth street New York city.

It is rumored that Bishop Luther B. Wilson, of the Methodist Episcopal Church, a graduate of the class of 1877 in medicine, may be assigned to a jurisdiction in Africa.

Dr. C. Urban Smith, class of 1889, at an election of officers of the section of clinical medicine

and surgery of the Baltimore City Medical Society was elected president for the ensuing year.

Dr. L. G. Burroughs, class of 1906, has located at Collinsville, Illinois, and Dr. D. W. Snuffer of the same class at Beckley, West Virginia.

Dr. T. J. O'Donnell, class of 1903, of 405 Warren avenue, Baltimore, was thrown out of his buggy October 13, 1906, and sustained a painful, though not serious, injury to the right leg.

Dr. T. O. Heatwole, class of 1897, has been elected Professor of Materia Medica, Therapeutics and Orthodontia in the Dental Department of the University of Maryland, vice Professor Culbreth resigned.

At a meeting of the Montgomery County Medical Society, held in Waters' Hall, Germantown, October 20, 1906, the following of our graduates were present and partook in the proceedings: Dr. Roger Brooke, Dr. W. L. Lewis and Dr. John L. Lewis.

The body of Dr. Calvin D. Snyder, class of 1898, contract surgeon in the United States Army, who was killed in the Philippines, August 9, 1906, in a fight between soldiers and a band of natives, reached Baltimore October 11, 1906, and was interred in Loudon Park Cemetery.

Dr. Howard S. Holloway, class of 1903, of Jacksonville, has resigned his position of Bacteriologist to the State Board of Health of Florida, to take effect January 1, 1907. After a visit to Baltimore and New York, Dr. Holloway will return to Jacksonville, Florida, where he will specialize in internal medicine.

The Freshman class has elected the following officers to serve for the following year: *President,* Norman Kirk, Rising Sun, Maryland; *Vice-President,* John H. von Dreele, Jr., Baltimore; *Secretary,* Robert Truitt, Baltimore; *Treasurer,* Cyril Elmo Fowble, Switzerland; *Sergeant-at-Arms,* Samuel G. Glover, South Carolina.

Dr. W. A. Parvis, class of 1905, acting assistant surgeon, Public Health and Marine Hospital Service, stationed at Fort Stanton, New Mexico, advises the BULLETIN that he is much improved in health and feels encouraged as regards an ultimate and permanent recovery. The BULLETIN is glad to hear of Dr. Parvis' improved condition and extends to him the best wishes for his speedy recovery.

Professor Ernest Wertheim, of the University of Vienna, one of the most distinguished gynecologists of the world, held a clinic at the University of Maryland, Saturday, October 27, 1906, and demonstrated some of his specialties, namely the shortening of the round ligament *per vaginam.* He was accompanied by his assistant, Dr. Mann, of the Elizabeth Hospital, in Vienna.

At the regular meeting of the University of Maryland Medical Association, held in the ampitheatre of the University Hospital, Tuesday, October 16, 1906, the following officers were elected to serve during the ensuing year: *President,* Dr. Charles W. McElfresh; *Vice-President,* Dr. A. J. Thompkins; *Secretary,* Dr. W. H. Mayhew; *Chairman Executive Committee,* Dr. Jose L Hirsh. The program included besides the election of officers, an address by Professor Randolph Winslow on his European travels and an exhibition of cases by Dr. I. J. Spear.

Mr. Rufus Cecil Franklin, of Statesboro, Georgia, has been elected president of the senior class, department of medicine. The other officers for the ensuing year are as follows: *Vice-President,* John Cox Keaton, Georgia; *Chairman of the Executive Committee,* A. E. Landers, Ireland; *Secretary,* Harry V. Harbaugh, Cumberland, Maryland; *Treasurer,* Joseph L. Valentini, Baltimore; *Sergeant-at-Arms,* Lewis Vogel, Baltimore; *Historian,* Alexander C. Mitchell, Baltimore; *Orator,* Robert A. Warren, Virginia; *Artist,* E. S. Perkins, Baltimore; *Prophet,* A. J. Gable, Georgia.

At a meeting of the General Alumni Association of the University of Maryland, held in the lecture room of the School of Law, Lombard and Greene streets, Monday, October 29, 1906, the following interesting program was rendered: 1. Address on Recent European Travel, by Edwin G. Farber (Law), Randolph Winslow (Medical), and LeRoy Robinson (Pharmaceutical). 2. Discussion of the part to be taken by the Society in the Centennial celebration. 3. Smoker.

At a joint meeting of the Carroll and Howard County Medical Societies, held at the Springfield State Hospital, near Sykesville, October 18, 1906, Dr. James H. Billingslea, class of 1864, oc-

cupied the chair, and Dr. A. D. McConachie, class of 1890, read a paper on "Essential Eye Knowledge for the General Practitioner." The following of our alumni were present: Drs. J. H. Billingslea, class of 1864; J. W. Hering, class of 1855; J. T. Hering, class of 1885; G. H. Brown, class of 1864; Edwin Cronk, class of 1890; A. Cronk, class of 1884; A. D. McConachie, class of 1890; J. W. Hebb, class of 1901; S. R. Waters, class of 1858; S. L. Bare, class of 1905; George Winterson, class of 1902; C. W. Heffinger, class of 1881.

Anent the General Alumni Association, it may be interesting as well as instructive to our alumni to hear that it was founded January 21, 1903, since which time it has been gradually growing in size, importance, and power, and in the near future is to wield an important influence in University affairs. Any alumni of the several departments is eligible to membership upon the payment of one dollar, the annual dues. This association is unique in the history of the institution, as it is the first attempt to bring the schools composing the University of Maryland into more intimate association with each other. Every year there are four meetings and smokers at which representative men deliver addresses.

A committee to arrange for the alumni mass-meeting in January, of which Dr. H. H. Biedler is chairman, was also appointed.

According to the will of the late Joshua Harvey, President of the Western National Bank, a handsome bequest, consisting of part of his estate is eventually to pass to the University Hospital. Upon the death of Mr. Harvey's son, and only child, Francis Burns Harvey, the residue of the estate is to be equally divided among these three institutions: University Hospital, Union Protestant Infirmary and Hospital for the Consumptives of Maryland. It is estimated that the residue will be more than $500,000, so that each of the three institutions mentioned will inherit about $200,000. The bequests are absolute, "But it is my wish," Mr. Harvey states in his will, "so far as the same may conform to the general plan of conducting the institutions, that the income from the bequests may be used to furnish free beds to the poor and needy who may be received therein."

Dr. T. A. Ashby, of the editorial staff of the BULLETIN, has returned from an extended trip West and gives in the present number the results of his observations. His visit to the Mayo brothers, at Rochester, Minn., was both pleasant and profitable. He says these two surgeons are doing about the same class of work that is being done by the surgical staff of the University Hospital, and that taking into consideration the difference in the character of the surgical material, and the fact that both students and nurses are being trained at the University, the mortality rate and results will bear a most favorable comparison with those presented by the Mayo brothers. He has a high admiration for the surgery of the latter and for their superb hospital equipment, but thinks that the University Hospital is doing a splendid work in training students and nurses, as well as in relieving human suffering.

At a meeting of the Adjunct Faculty of the University of Maryland, at the University Hospital, Tuesday, October 30, 1906, called for the purpose of discussing the coming Cenennial celebration, the members in order to show their appreciation to the Faculty for the favors bestowed upon them, pledged to raise from their number between $1,000 and $1,500 to help defray the expenses. Dr. Hundley said in part: "We all owe something to the University. None would have succeeded so well if he had not been associated with the institution. The connection, no one can gain-say, is not advantageous." Drs. Lochard, Craighill and Tompkins were appointed a cimmittee to solicit from the Adjunct Faculty, and we are glad to report their endeavors have met with excellent success, and from present indications the desired sum will be realized. The one-hundredth anniversary of the University marks a mile-stone in its career, so far an honorable and proud one, and THE BULLETIN hopes that our alumni by their presence and sympathy will assist the faculty in making the celebration worthy of the occasion.

A meeting of the general centennial committee of the University of Maryland was held November 2, 1906, in the club rooms of the Germania Club, and arrangements for the program next spring were discussed. The executive committee, which met on Tuesday at the home of Dr. John C. Hemmeter, Linden avenue and Laurens street, reported that the exercises will continue for three or four days. A prominent alumnus, probably, Bishop Luther B. Wilson, class of 1877, will be asked to preach the baccaleureate sermon. One day will be chosen as academic day, at which time the joint commencement of the Medical, Dental, Law and Pharmaceutical Schools will take place. On the same night a banquet will be given. At the suggestion of Judge Stockbridge the commencement will take place in the afternoon, at the Lyric, instead of in the evening. The program for the third day will consist of a house-warming and home-coming, followed in the evening by social affairs. A gymnastic carnival will also be held at some stated time. A committee was appointed to set the date for the exercises. It consists of Dr. John C. Hemmeter, Dr. R. Dorsey Coale, Dr. Charles Caspari, Jr., Dr. Ferdinand J. S. Gorgas, Mr. John P. Poe and Dr. Thomas Fells, of St. John's College.

MARRIAGES.

Dr. Christopher Brenner, class of 1906, of Gahanna, Ohio, was married September 27, 1906, to Miss Emy Morton, of the same place. Dr. Brenner will practice in Kansas in partnership with Dr. Orus Barker.

Dr. Oakley S. Gribble, class of 1904, in his day one of the most popular members of the student body, was married October 3, 1906, at Huttonsville, West Virginia, to Miss Neva Hutton, of the same place. After graduating Dr. Gribble was for a time interne at the Elkin's Hospital, West Virginia.

Dr. Baird Urquhart Brooks, class of 1905, of Durham, North Carolina, was married October 24, 1906, at the Central Methodist Episcopal, Church, South, to Miss Annie Eloise Sills, only daughter of Mrs. Eloise William Sills, formerly of Nash county, North Carolina. Dr. and Mrs. Brooks will make their home in Durham, North Carolina.

Dr. John T. O'Mara, class of 1903, of 1033 Edmondson avenue, Baltimore, Maryland, formerly an interne at St. Agnes' Sanitarium, Baltimore, and one of the most popular members of his class, was married October 10, 1906, at Pelham, New York, to Miss Josephine Euphrasia Larkin. The ceremony took place in St. Catherine's Catholic Church, and was performed by the rector, Reverend Francis McNickol, an uncle of the bride. The honeymoon was spent at Atlantic City. Dr. and Mrs. O'Mara will reside at 1033 Edmondson avenue.

DEATHS

Dr. Edgar A. Brooke, class of 1887, died September 3, 1906, at Bonner, Montana, of heart disease.

Dr. Frank W. Schuessler, class of 1887, one of the most prominent physicians in Canton, Baltimore county, Maryland, died at his home, 101 Canton street, October 16, 1906, from a complication of diseases, aged 40. Dr. Schuessler was born in Bavaria, Germany, whence he emigrated to this country in 1884. He is survived by a widow, son and father.

Dr. Philip Skinner Wales, class of 1856, died September 15, 1906, at Paris, France, of cancer of the intestines. The year of graduation he entered the United States Navy, where he attained considerable distinction. From 1879 to 1884, he held the position of surgeon-general. He was retired in 1896. His remains will be interred in the Naval Academy Cemetery, at Annapolis, Md.

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MENTAL SYMPTOMS OF PELLAGRA.

BY N. KENAWY, M. D., *Class of* 1904, *Cairo, Egypt.*

During my study in America I had never heard of or seen a case of Pellagra. In Egypt the disease is one of the most common.

We often meet here an insanity which is common in only a few countries where maize is the staple food of the natives; namely, insanity due to pellagra.

Although this subject has been much written about, I think a few words might be of interest in a country where this malady is practically unknown.

Let me state in brief the history and etiology of this disease:

(The following history is taken from Dr. Sandwith's book, page 281: "Pellagra has been known in Spain since 1735, following on the introduction of maize from America about 1700. About 1750 it was found in Italy, towards 1820 in France, and about 1840 in Roumania. Since 1856 it has been epidemic in Corfu. In 1893, he began to suspect the existence of this disease in Egypt.")

The disease is common in adults between the ages of 15 and 40, 80 per cent. of the cases being fellaheen (peasants).—(Dr. Sandwith.)

The chief etiological factor is the diseased dura (maize). The dura is cut before it is ripe, gathered in rainy seasons, stored away damp, and possibly sown from affected seed; all contribute to the engendering of some toxic development in the grain, which forms the true pellagra poison. In the year 1903 Ceni and others have found in cultures of bad maize (Aspergiltin) mental symptoms. In the early stages of the affection there will be retardation of ideas, loss of memory, mental depression, and insomnia. From this the patient sinks gradually into either deep melancholia or mania, ending in secondary dementia. Melancholia here in Egypt is comparatively uncommon, but a marked percentage of the melancholics here suffer from Pellagra.

Patient is always discontented and craving incessantly for food, yet he loses weight in spite of being overfed. He may be so depressed and solitary all the time, or he may fall into the state of resistiveness, refusal of food, self-accusation, hypochondriacal delusionary ideas, and suicidal tendencies. Occasional instances of homicidal but more frequently suicidal impulses occur.

Paralysis due to pellagra is fairly common. It comes on very late in the disease. It is very difficult to differentiate between pellagrous paralysis and general paralysis or paralytic dementia. Even after death I have seen some pellagrous paralytic brains resembling those of the general paralytic brains. Symptoms of the paralysis come on very late, where the reflexes are usually diminished, but may be exaggerated. Drop foot is often met with, with wasting of muscles.

The following cases have been selected from the Case Books in the asylum with the permission of Dr. J. Warnock, the director of the asylum:

Case I.—M. M. W.: Case Book XI, 212. Male, age 30. Peasant; admitted 24th July, 1905.

State on admission: Not dangerous and not suicidal. He is demented; does not answer to questions. If left alone he will walk without knowing where he is going to or what he is doing. Silent and sad. Pellagrous rash found over chest, elbows, knees, hands, hips and feet. Old scratches and bruises over the abdomen. Pupils are normal, has unsteady tongue. July 28: In bed, weak and wasted, is said to have cystitis, mumbles to himself, silent, can't give an account of himself, taking no interest in his surroundings. August 5: He is dull, restless, dirty in habits, incoherent, solitary and weak. August 9: Died. P. M.: Dura mater thickened. Brain substance soft and flabby. Dilated brain ventricles, atheromatous aorta.

Case II.—A. S.: Case Book XIII, page 124. Male, aged 40, admitted July 22, 1906; beggar.

State on admission: Not dangerous, suicidal, shouts loudly, talks incoherently, dirty in habits, and sleeps with his head between his legs. Pupils normal, tongue unsteady, cautery marks over sacrum and marked pellagrous rash. Knee jerks diminished. July 23: Has diarrhoea. October 13: Died. P. M.; Brain anemic and flabby; lateral ventricles of brain dilated; aorta atheromatous.

Case III.—H. A. S.: Case Book XII, 21. Male, age 30. Peasant, admitted 17th September, 1905.

State on admission: Suicidal and dangerous. Dirty in habits, eats his bedding and rubbish; kills fowls and eats them raw; resistive, silent and helpless; pellagrous skin and old cautery marks; bruises all over body; gait impaired; rigid; patilla reflexes exaggerated; emaciated, confined to bed; feeble. September 19: In padded room; facial muscles tremulous; ankle clonus; right pupil larger than left; won't speak. October 9: Has diarrhoea; going down hill. December 21: Died. Post-Mortem: Dilation of ventricles of brain. Pia mater not adherent to cortex. No atheroma of aorta.

Case IV.—M. B. S.: Case Book X, page 378. Male, age 28. Soudanese porter from Cairo; admitted 26th October, 1904.

State on admission: "Ruminates," says he died twice in the day; shouts and weeps; thinks he is to be killed; anxious and restless; incoherent; admits use of alcohol; dirty in habits; memory impaired; nothing noted as to syphilis; tongue very tremulous; speech and movements shaky; B's badly pronounced; strips himself; replies to voices; sleepless. November 9: Rigid; seems scared; pellagrous elbows, face, knees, trochanters. November 29: Speech thick and faltering; general paralysis. November 27: Slight foot-drop; patilla reflexes exaggerated; right pupil very small; sluggish in its light reaction; bedsore beginning. November 25: Died. Post-Mortem: Pia arachnoid opaque, milky with much subarachnoid fluid, not adherent to cortex; ventricles of brain dilated. Some atheroma of aorta existed.

The last two cases have been quoted from the hospital annual report, 1904-5, made by the director.

Delusions of pellagrous lunatics are various; but I noticed here in the asylum that many of them have the same kind of delusionary ideas. They think their skin is pulled away, that they are possessed by devils and are poisoned.

A boy, A. H. H.: Case Book XII, 18: Age 17; admitted September 12, 1905.

State on admission: Criminal; not dangerous; and not suicidal; got a marked pellagrous rash over elbows and knees. September 13: Childish; dull and refuses to talk. September 22: He still refuses to talk; making signs that something is holding his tongue. September 23: He talks quite coherently and says that a devil is in his body, holding down his tongue like a weight; he comes and goes. May 27: He recovered and was discharged.

REPORT OF A CASE OF TRAUMATIC EPILEPSY WITH OPERATION FOR CURE OF SAME.

By St. Clair Spruill, M. D., and Irving J. Spear, M. D., of Baltimore.

We think this case is of special interest because the convulsive seizures did not begin until at least five years after the injury; as illustrating the fact that it is not necessary to have the focus of irritation in the motor area in order to give rise to epileptiform seizures and the probable curability of these conditions even after the existence of the spells for years in those who are not heriditarily predisposed.

In this case the patient was a strong country boy with very good family history. His brain received injury from which it recovered perfectly with the exception of a focus of irratability in what we know as a silent area. This irritative focus at first was not sufficient to give rise to marked outward symptoms, but as time went on the constant irritation made itself felt and at a period when the patient's organism was undergoing the metamorphisis from youth to manhood, at which period the entire nervous system is particularly susceptible to irritative influences. Irritation starting from the seat of injury spread itself over the entire cortex and gave rise to the epileptiform attacks; these gradually became worse and more frequent. After vainly trying all curative measures at home he came to the hospital for examination.

On August 12 the patient came to the University Hospital during the service of Dr. Spruill.

Name—S. K., age 18. Complaint, epileptic

spells, duration 15 months. Getting worse. Family *History*—Father, healthy; mother, complains of nervousness. Otherwise history is negative to T. B., neurosis, cancer, etc. *Past History*—Had measles and chicken-pox during childhood. At the age of 12 years was hurt by being struck on head by falling tree, was unconscious for four days, was in bed about three months. Ever since this time has been complaining of more or less headache. At time of injury there was no paralysis. The winter following the injury he went to school, got along fairly well; the next spring went to work as laborer, the following fall went to work in saw-mill, where he remained three years, then went back to school and after this worked until September, 1905. *Present trouble*—Headache seems to be getting worse; in April, 1905, patient first began to notice that there seemed to be a tendency for his chin to be jerked toward the left and upwards; this was not accompanied by unconsciousness. In June, 1905, during one night, patient was seized with a spasmodic attack, accompanied by unconsciousness; then from June until September he had several minor attacks. In September had an attack accompanied by unconsciousness; from September, 1905, until August, 1906, patient had attacks once or oftener per week. These attacks were generally preceded by a jerking of th chin towards the left and upwards. During an attack in February, 1906, broke a leg; in June, 1906, during attack, cut himself over the right eye. In these attacks patient has tonic and clonic spasms, accompanied by unconsciousness, followed by a period of somulance lasting several hours; these attacks are getting more severe and more frequent. *Physical Examination*—Well developed white male, well nourished, laying quietly on his back and breathing naturally. There are no deformities. A scar one and a half inches in diameter on internal surface of left arm, due to a burn. Small scar over right eye. Scar one inch and a half long over right parietal prominence. A depressed fracture of the right parietal bone half inch wide by two inches long situated two and a half inches above the right ear. Its anterior extremity being at a point perpendicularily above the anterior boundary of the external auditory meatus and posterior end being at a point about one inch posterior to a line erected perpendicularily to the mastoid process, the fracture running downward and backward at an angle of about 45 degrees. Skin is normal and elastic, heart, lungs and abdominal organs are apparently normal, genetalia clears, has a left oblique inguinal hernia. Over the face slight acneform eruption, ears are well-formed, well set. Teeth are well-formed and in good condition. Palate is well shaped. Tongue protruded in median line and is somewhat coated. The nasal passages are patent. Hair rather coarse. Expression, cheerful. Disposition, cheerful and tractable. Speech and gait are normal. *Motor Functions*—Motor power good, no atrophies, no abnormal movements, co-ordination good; reflexes, plantar, cremasteric and abdominal are active. Babinski, negative. The knee reflexes are both, equal and slightly exaggerated. Tendo-Achilles, triceps and wrist reflexes are normal. Rectal and vesicle reflexes are normal. *Sensory Functions*—Tactile, pain, temperature and muscular senses are normal. *Parasthesis*—Patient has a feeling as if insects were crawling up and down both lateral aspects of the chest and abdomen, also complains at times as if he could feel the blood ascending in the left side of his neck. No pains, tenderness, trophic or vasomotor disturbances. Romberg's sign is negative. Cranial nerves are all normal. Pupilary reflexes are normal. A slight lateral nystagmus of both eyes to the left. It was thought that the depression of the skull was the primary cause of the cerebral irritation and operation was advised.

On August 21, patient was operated upon by Dr. Spruill, who opened skull at the seat of depression, removed all the depressed bone and a small area anterior to this. Upon opening the skull it was noticed that there was no pulsation and a yellowish white mass came into view instead of the normal dura, and it was at first supposed that we had uncovered a new growth, but, upon making the bony opening larger and opening dura we found this mass was oedemetous brain tissue that was adherent to the dura. The dura was separated from the brain and immediately pulsation returned and in a short time this brain area again assumed a normal appearance. There were no further adhesions.

Silver foil was introduced between the dura and the brain and the dura closed. Silver foil was also placed between the dura and the skin and the wound closed. The boy made a rapid and uneventful recovery. The first week he was

rather irritable and cross, after that he again became cheerful and obliging. Since this time, now about four months, he has been free from headaches or spells of any kind.

It is, of course, too early to say with certainty that patient is cured, but we hope with the silver foil introduced between the brain and dura, and dura and skin, to prevent the recurrence of the adhesion and in this case with the source of irritation removed, we have every reason to believe that he will have no more spells. This case, with similar history of several other reported cases, should encourage us in our efforts and endeavors to relieve these unfortunates, even if we do not see them until years after the caustive injury.

INTESTINAL OBSTRUCTION DUE TO WANDERING GALL-STONES.

By Frank Martin, M. D., *Clinical Professor of Surgery, University of Maryland.*

Intestinal obstruction, whatever may be its cause, is oftentimes, and I might say, in fact, always one of the most serious and dangerous as well as one of the most fatal surgical conditions that the surgeon is called upon to face. It frequently is insidious in its manifestations, but more often rapid in its progress, and liable to sudden and progressive changes which steadily but surely put the patient in a condition of extreme peril.

I always have a feeling of dread when I am told the case I have been called to is one of intestinal obstruction, because so often, in the past, at least, surgical relief has not been sought until the patient is exhausted or until necrosis of the bowel-wall has taken place and a general infection has developed; when seen in this condition the symptoms, to say the least, are formidable and the mortality under any method of treatment is excessive.

It has so happened that I have met with most of the conditions which are generally known and are assigned as the causes of the various forms of intestinal obstruction. These forms are usually considered and classified under two heads:

1. Acute intestinal obstruction, or complete, in which the symptoms come on suddenly without any previous history of disease.

2. Chronic intestinal obstruction where there is a previous history of disease, either intestinal or what not, and a slow gradation from partial to complete occlusion.

The cases that are classed as the true obstructions are the ones which result from lesions which contract or obliterate the intestinal lumen. Of course, we have often the same clinical picture dependent upon a peresis of the muscular wall of the bowel as seen in spastic ileus, and also in the passive obstruction dependent upon intestinal peresis as is seen in general peritonitis, in mesenteric embolism and thrombosis. Acute obstructions are brought about more often and more commonly by mechanical lesions or non-inflammatory conditions, as by intussusception, (which is said to produce one-third of all the cases of obstructions), volvulus, internal and external strangulation by bands of adhesions, kinks, flexures, etc. Intestinal coils are occasionally caught and strangulated in the obturator foramen, sciatic foramen, foramen of Winslow (a very rare accident) and in the fossa of Treitz, which is a depression in the posterior parietal peritoneum at the duodenojejunalis angle. There is one case in my list of obstruction cases due to this cause, where a loop of small intestines became caught and strangulated in this fossa; patient was operated upon speedily and recovered. The remaining causes are by the impaction of foreign bodies, gall-stones, enteroliths (which are usually formed upon gall-stones), intestinal worms, etc.

Appendicitis is another very potent cause for acute intestinal obstruction, and is liable to produce an obstruction at any time during its course, (many of my cases have been caused by appendicitis). The obstruction usually occurs after operation, (in a number of my cases as long as two weeks after operation), and is brought about by the formation of extensive exudate, (which was nature's provision to wall in an abscess and thereby protect the general peritoneal cavity) and adhesions have formed between this and inflamed intestinal coils by which sharp kinks and bends have occurred and in this way obliterated completely the lumen of the bowel. (My list contains 7 cases of post-operative ileus produced in this way which necessitated perilous operations for the relief of obstructions, six of which recovered).

Chronic intestinal obstructions are more commonly produced by cicatrized and contracted

tubercular, typhoidal, dysenteric and syphilitic ulcerations, but by all odds, the most potent and frequent cause is carcinoma of the adenocarcinoma type and of the annular variety, causing a slowly forming stricture which slowly impinges on the lumen until it produces a complete stenosis. The location most commonly observed of this type of annular adeno-carcinoma is at or about the sigmoid, next at the flexures, and then at the caecum.

Diagnosis:—The diagnosis of acute intestinal obstruction is naturally of the utmost importance; oftentimes it is exceptionally difficult, but if the cardinal symptoms are carefully watched for, the case usually can be recognized early. The symptoms, roughly speaking, are exactly those of strangulated hernia in an aggravated form. The principal symptoms of complete obstruction are pain and persistent vomiting; the abdominal pain is usually severe and often agonizing; frequently, however, it is of an intermittent character; the severity of the pain appears to bear a more or less direct ratio to the force of the peristaltic movement, and this in a measure explains the intermittent character. When the construction becomes complete the muscles wall of the bowel makes an effort to overcome it and we have the waves of peristalsis growing stronger and stronger directed against the obstruction; after this is kept up for a certain length of time the peristalsis abates from exhaustion of muscle fibers and the pain subsides, simply to recur again as soon as the tone of the muscle has returned and with that is a return of the pain. This intermittent character of abdominal pain is usually associated with certain amount of ballooning of the intestines above obstruction, so with these peristaltic waves we see the contour of the ballooned bowel well mapped out on the surface; in watching the abdomen these coils can be seen standing out pretty plainly on the abdominal wall. If it is not an entire and complete obstruction oftentimes a small amount of gas will be passed through the opening and ballooning will go down and the coils will cease to be noticed for a short interval, when it will recur. The other prominent symptoms are vomiting, constipation, collapse, tympanites; temperature as a rule is of little value, often sub-normal; pulse rate, however, gradually increases and leukocyte count in such cases is always high; vomiting is one of the earliest and most important symptoms. As a rule the higher the constriction the more violent the vomiting; of course, at first the ordinary contents of the stomach are usually expelled, then it comes in gushes, without effort or with violent retching, and is described as the projectile vomiting. Later vomit is bile-stained, then of a dark material so often called coffee-ground, and finally fecal matter is vomited more or less diluted. Constipation is of an obstinate character; when the intestine below the seat of obstruction is emptied nothing passes from bowel, except in cases of intussusception, when blood may escape. Some claim that the locality of the obstruction can be pretty clearly outlined by the character of the vomit and contents of vomit; this is a matter of no specific moment.

MacDonald divides the intestines into three portions, as follows:

1. When the obstruction occurs at the duodenum or upper portion of the jejunum the first indication is sudden and intense pain at the epigastrium, followed by violent vomiting; this vomiting is constant until the obstruction is relieved or the patient dies. It never becomes steroraceous, for it is too high up to contain fecal matter.

2. When the constriction is lower than in the upper part of the jejunum then there is accumulation of gas and we find the abdomen becoming rapidly distended; vomiting does not come on suddenly, but it is persistent and changes in its character, first normal stomach contents, next bile and lastly fecal matter.

3. When in the colon or sigmoid flexure the symptoms are supposed to come on more slowly; patient can often point to seat of obstruction by localized pain. Tympanites is a very marked symptom after the first few days; no fecal matter passes from bowel and rectum is empty.

These distinctions seem to me of no special moment. If the symptoms of pain, persistent vomiting, mapping of coils of intestines over abdomen with the pain of this intermittent character, and vomiting of the projectile kind associated with high leukocyte, we are warranted in our diagnosis of obstruction and the sooner surgical relief is offered the better will be the outcome in the case and the mortality statistics will be markedly lessened.

Treatment:—The treatment is entirely a surgical one and it calls for an immediate explora-

tory incision to locate the cause of the obstruction and attempt to overcome it; if this can be overcome without the bowel wall being injured, so that the tissues remain intact and still viable, it seems to me the wisest thing to trust to their recovery rather than do a resection; as in strangulated hernia the bowel that is viable although it is black as ink from congestion still most frequently recovers, so likewise here. If the wall of the bowel is viable the conservative surgery is to be resorted to rather than radical resection or opening of bowel. Cases of acute obstruction with marked ballooning of bowel above the obstruction and with the obstructed area strangulated and necrotic beyond repair, in which resections have to be done, are exceptionally fatal procedures. In cases of acute obstruction due to malignant growth, where the growth is impinged on bowel and closes it, giving rise to condition of acute obstruction with all symptoms of marked distension of bowel above obstruction point have not done well in my hands, where resection of that malignant area was done in the height of the acute symptoms. I am of the opinion that those cases are best treated by a colostomy (because they are more commonly found in sigmoid region of bowel) and allowing the patient to be relieved from the obstruction, and then secondary, if possible, do a resection of the constricted area.

I have called attention to these few clinical facts bearing on intestinal obstruction in general, and time will not admit of my going into the subject in a more thorough way as I should like to. The subject of the causation is an extremely important one and would bear going into with much interest. I call attention to the fact that it has been stated that intussusception is said to produce one-third of all cases of obstruction. This has not been my experience; in my list of thirty-nine cases I have had but two cases of intussusception: so as far as my experience goes it is not in accordance with this statement. I find a majority of acute cases have been due to bands and kinks which have formed as a result of peritonitis, generally following appendicitis; a number of acute volvulus cases are in this list, many cases of post-operative ileus following operations for appendicitis, as I have stated above.

Mortality:—The mortality in all cases of intestinal obstruction has been in the past exceedingly high, and will continue high as long as delayed operations are performed. Operations that are performed in the very early stages of obstruction cases are followed by much higher percentage of recoveries. Unfortunately, the surgeon has not the control of these matters in most of his cases.

Dr. J. W. MacDonald in his work on "Surgical Diagnosis and Treatment" gives statistics showing that the mortality from a few of the causes of obstruction, namely, intussusception, volvulus, strangulation by bands, is as follows:

Intussusception, 65 cases, mortality, 75.4 per cent.; Volvulus, 29 cases, mortality, 71.4 per cent.; Strangulation by bands, 119 cases, mortality, 67.8 per cent.

He further states that in the aggregate of 346 cases from all causes the mortality after the operation was 69.3 per cent. He further states that the mortality may be fairly stated at 95 per cent. in cases treated without operation.

This indeed shows a high percentage of mortality. Probably, resort to later statistics may show an improvement in this way, but I think it has been the experience of most surgeons that the mortality in obstruction cases has been high when all cases (counting in all the various forms) are classed. The list of cases I have collected is thirty-nine in all, with twelve deaths, which is a mortality of about 30 per cent. In the well selected cases, of course, my mortality has been very much less than this, but this counts in all the late cases as well as the early ones.

Gall-Stones Causing Obstruction:—I have thus far not said anything about intestinal obstruction due to gall-stones. It is only recently that I have had an opportunity of seeing such a case, and as to its frequency as a causation of intestinal obstruction that differs according to various statistics. I have not had an opportunity to look into the subject carefully, but I find it seems to be a more common cause than many of us believe.

Osler, (in his System of Medicine) quoting Fitz, makes it as common as one to thirteen cases of intestinal obstruction (twenty-three cases of gall-stones in 295 obstructions). In an article on "Intestinal Obstruction due to Gall-Stones," by H. L. Barnard, London, published in Annals of Surgery, August, 1902, he reports eight cases, and states that these eight cases oc-

curred in the London Hospital out of 360 cases of intestinal obstruction; this proportion is one to forty-five, and so these various statements occur through the literature.

It is pretty well understood how they find their way into the bowels, either by large stone for most part passing into duodenum, where it lies against neck of bladder, by process of ulceration after these parts have become united by adhesions, or as a matter of fact this process of ulceration may take place between gall-bladder and bowel at any point of intestines; less often they ulcerate into transverse colon, and if that is the case can easily be passed on out from bowel. It is possible for a fair-sized stone to pass on through common duct into the bowel and increase in size, as an enterolith with this as a nucleus and ultimately to bring about obstruction. In the cases reported it seems they have been pushed far down into small intestines; the anatomical fact is that the small intestine becomes narrower from its upper to its lower end and it is thicker in upper than in lower portion and is more easily lodged where lumen is small naturally, so that the site is usually in lower part of ileum and at ileo-cecal valve. When obstruction is caused by such a foreign body as gall-stone, the symptoms are those of any other form of intestinal obstruction. The mortality after operation for gall-stone is apparently very high.

I have endeavored to communicate with a few of the surgeons as to their experience with gall-stone as a causation of obstruction of the bowel, and the few that I have heard from here in the city have had a limited experience with this form of obstruction. I have had communications from six of the leading surgeons; two of them have never met with obstruction due to gall-stone and the other four have had one case each. The mortality in these four cases has been high; only one case has recovered out of the four. The three that died did so promptly following operation. I find also a report of one case by Maurice Richardson, of Boston. This patient was a man of sixty and died promptly following operation. The one case that was saved was a younger patient than is usually found in these obstruction cases. The vast majority of the cases I have been able to look up have been patients advanced in life and generally women.

The one case that I have had the fortune of seeing is one that I have recently had and am glad to say was fortunate in getting a successful result.

Case I.—I shall give simply a brief history. Woman, age 59. I was called to see her on October 12, 1906. She had been taken sick on September 30 with acute vomiting and abdominal pain; this condition of vomiting, nausea and abdominal pain persisted in a measure from time she was taken sick on September 30 until night before I was called, October 11, when she was very much exhausted from this long persistent vomiting; bowels had not been moved for quite a while. When I saw her she had pretty typical symptoms of acute obstruction. It was off in the country and I had no means of making leukocyte count, absence of temperature, and pulse that was growing weaker from exhaustion and lack of nourishment. She was much flushed in face and showed evidence of marked general weakness. I operated there at her home in the country, and when peritoneum was opened more or less serum, slightly tinged with blood, came out. Small intestines were deeply congested and ballooned. Passing my hand into abdomen I soon came upon the obstructed portion of small intestine; the intestine above this point was ballooned, below it, tape-like. Pulling it up into wound I found the obstruction due to a very hard lump which was soon recognized to be a gall-stone. This was found about three feet from ileo-cecal valve. It was impossible to budge obstructing body and linear incision was made into bowel and gall-stone removed. Bowel was closed, dropped back into abdomen, and abdomen closed. This patient was much shocked immediately after operation, but soon responded and made an uninterrupted recovery.

I am indebted to Dr. W. S. Halsted for the following references bearing on the subject of gall-stone obstruction:

1. Buzzagli, Un caso di occlusione intestinale acuta da grosso caledo biliare. In Gazetta degli ospedali e delle cliniche 1900.

2. Cant., W. J., Cases of obstruction of the small intestine by Gall-stones. Brit. Med. Journ., 1897, Oct. 20.

3. Carl, R., Ueber Darmverschluss durch Gallensteine. Inaug.-Diss., Freiburg, 1905.

4. Delber et Gueniot, Occlusion intestinale par calcul biliaire. Bull. et Mem. de la soc. anat., 1900, No. 4.

5. Intestinal obstruction due to Gall-stones. Annals of Surgery, Aug. 1902.

6. Bogdanik, Darmverschluss bei Cholelithiasis. Wiener med. Presse, No. 45, 1902.

7. Bradbury, Two cases of obstruction of small intestine by Gall-stone. Brit. Med. Journ. 1897, Sept. 25.

8. Briddon, Intestinal obstruction by Gall-stone. Annals of Surgery, Jan., 1897.

9. Brunke, Alfred, Ueber Darmverschluss durch Gallensteine. Inaug.-Diss, Kiel, 1898.

He also says, "An important article on Gallensteinileus is the Dissectation by Hermann, Iena, 1904. He has collected 249 cases; of these 84 recovered without operation and 78 died. Of 82 cases operated upon, 52 died and 27 recovered. In the Weiner Med. Presse, No. 46, 1904, is a reference to an article of some importance by Gerstt, on Gallensteinileus."

There is also an article in the *Medical News,* Vol LXXII, 1898, on "The Vagaries and Wanderings of Gall-Stones, with Clinical Reports," by Dr. Henry L. Elsner, of Syracuse, New York.

This, I think, bears me out in the statement that it is not only not met with often in the career of each surgeon, but when met with is attended with a high mortality.

CORRESPONDENCE.

ROCHESTER, MINN., *October* 19, 1906.

To the Hospital Bulletin:

The chief object of my visit to the Mayo Brothers was to observe their surgical work and to ascertain, if possible, the real causes which had contributed to their phenomenal success and remarkable surgical statistics.

I was familiar in a general way with their results and hence it was the more difficult to understand how two young surgeons, in a comparatively remote section of this great country, could become the leaders of surgical thought and methods and the highest exponents of surgical practice in this or any other country.

Without the influences which come from association with large institutions of learning and hospital connections, and not residing in a large center of wealth and population which have been considered so necessary to the development of a surgical clientele, here were two surgeons who have broken every tradition in surgery and gotten results which have surprised and astounded men who continue to wear surgical handcuffs.

Those who are accustomed to bow to high authority and to follow the narrow lines of precedent are usually the men who exercise the most domineering influence over methods of thought and work.

Mr. James J. Hill, the master mind in railroad construction and management in this country, has recently remarked, "Commerce will go her own way, even though she must walk in leg-irons. Why not strike them off and permit her to pursue her journey freely to the end?" This statement presents to my mind a perfect illustration of the conditions which have prevailed in surgery. Those men who have had the courage to remove the leg-irons in which she has walked have improved her progress by giving her freedom. This is what the Mayo Brothers have done for surgery. I found no leg-irons retarding their work, but on the contrary the greatest freedom of movement—a perfect adjustment of means to secure results.

The hospital plant in which they work is as near perfect as human ingenuity can make it. This in itself would be a great disideratum to any surgeon, but many surgeons work in more richly endowed hospitals and have a more lavish expenditure on their technic, hence we must have something more than a perfect hospital plant and equipment.

This something more will be found in the men behind the machinery who keep it in motion and make it do the work required of it. Two factors are, therefore, essential—the plant and the men to operate the plant.

At Rochester I found both of these conditions present. The hospital plant is not a pretentious affair. It is neat, well constructed and well kept. It does not represent a large outlay of capital and is probably operated along inexpensive lines as compared with many hospitals in large cities. What strikes one is the air of comfort and cleanliness about the place, and the arrangement and general plan of the operating rooms and laboratories required for surgical work.

It is so well adapted for the rapid and careful handling of surgical cases that it might well be taken as a model for hospital construction where a large surgical work is done. I should say that the in-door hospital staff is an essential part of

a well conducted institution, and in this respect St. Mary's Hospital does not seem to be open to criticism. The assistants I saw were so thoroughly trained that they were like pieces of animate machinery, moving here and there without noise and instinctively doing the right thing at the right moment. The surgeon called for nothing, as every thing he needed seemed to be placed in his hands automatically. Most of the assistants were women in white gowns and caps, and I learned had been connected with the hospital for long periods of time. They were not in course of training, but were thoroughly trained and seasoned.

I could not help drawing mental pictures in which medical students and half-trained young girls figured in the work at the University Hospital in contrast with the perfect system at St. Mary's. The only consolation which can come to one who works in a training school for boys and girls is the hope that he is imparting useful instruction at his own disadvantage and discomfort and not at the expense of his patient. These are some of the leg-irons we must wear until methods of teaching are changed and the work of the surgeon is simplified in institutions set apart for educational work.

The burning question with the hospital surgeon of today is one of technic. This question can only be settled when factors are eliminated which now embarrass the surgeon who, covering his own person with gowns, gloves and masks, works in an atmosphere of green young men and women who, whilst being instructed in habits of cleanliness, do not fully comprehend its significance and importance.

In this one respect we may envy the Mayos, who are not doing class surgery or conducting a surgical kindergarten. The clinics they so successfully conduct are models of their kind and to my mind present the ideal method for post-graduate instruction where men have had a surgical experience. Observation takes the place of manual training and of personal contact with patient and immediate surroundings. In the preliminary training of the medical student and nurse the Mayo system is impracticable. It would serve the same purpose to the medical student as the seat in the amphitheater without ward-class, dispensary and interne instruction. Every teacher of surgery knows how unsatisfactory our present methods of instruction in clinical surgery are under present conditions. The surgeon is greatly embarrassed and the student indifferently trained by a system which recognizes the amphitheater clinic as a *sine qua non*.

These are a few more of the leg-irons in which some of our best surgeons continue to walk. The Mayos solved the problem when they divorced teaching from surgical work, and yet in one sense they have organized one of the most thorough systems of educational work by instructing the surgical world in correct methods of operating and in the system of doing work.

In their plant at Rochester they have practically demonstrated how the physician and surgeon should get together and work in perfect harmony. In this one respect alone they have shown the common sense practical way of doing the very best that can be done for the people who come to them for treatment. To lose sight of their medical clinic and of their pathological laboratory would omit other important factors in their successful work. The Mayos have surrounded themselves with well-trained and thoroughly equipped medical men and pathologists. These gentlemen work up every case coming for operation from the standpoint of the physician and pathologist. The condition of every organ and function is fully investigated before the patient goes into the operating room. In those cases where the necessity for surgical interference is not clearly recognized the assistance of the physician and pathologist is simply invaluable to the surgeon. Upon their decision the surgeon is prepared to explore, to remove or to correct conditions which may be presented to him. In this way he is in a position to do much good surgery in the early stages of disease, where delay would only complicate results.

I know of no hospital in which both surgeon and physician work in such close association as in the Mayo clinics. Recognizing the limitations of surgery they have shown a proper respect and deference for medicine, and by the application of both art and science approach disease with confidence and skill.

I was thoroughly impressed with the careful and practical way the Mayos were doing their work. They were as methodical and painstaking as a first-class banking institution. Their chief aim seemed to be to get results in surgery, and to do this they brought to their aid both art

and science, business talent and conscientious methods.

The commercial side of their work was not displayed and I could not help but feel that it was a secondary object and only used to secure better results in surgery.

Both rich and poor were treated alike and were operated upon before their large audience of visiting physicians in the same operating rooms. No one could say which were charity and which pay patients. The person of the patient was concealed by proper garments so that the individual was in no manner exposed to the inspection of eye witnesses. Their operating room doors bore no such cards as "private operation"—an approbrium which must attach itself to the work of the surgeon engaged in teaching in some of our large city hospitals. I could not but think that here was another leg-iron removed from the work of the surgeon by these practical men. The necessity for such distinctions should not be. Independence and courage upon the part of the surgeon could remove such objections upon the part of patients and their friends. I have never seen surgical work conducted more humanely, considerately and kindly. All patients were thoroughly anaethetized before they were brought into the operating room. Of the twelve cases I saw operated on there was not one who made a sound, had nausea or harsh breathing. The drop method of anaesthetizing was used by thoroughly trained female anaesthetizers, hence the embarrassments which often come to the surgeon from poorly anaesthetized patients were entirely eliminated. The material used and the instruments were of the best quality and in ample quantity. Economies in this direction were not practiced. I saw no waste and no unnecessary display. The method employed was simply business like. The objects sought were results, the means employed were such as would secure the end in view.

This seems to me to be the true aim and ideal of surgery and we may well take lessons from men who have raised the art to a high degree of perfection. These ideals are not circumscribed. They are possible in small as well as large institutions where men have a high conception of the possibilities of surgical work and seek to improve methods which give the best results. The Mayos have demonstrated what the business man can do in surgery when he brings to his aid the system and the skill which are essential to the highest practice of the art. Whilst they stand for all that is modern and progressive in surgery, they also stand for what is best for the profession they have done so much to adorn by their modest, unassuming and ethical methods of work. To have built up such a large professional business and to have reached their present distinguished position without resorting to sensational and irregular practices, is an illustration of what honest and painstaking effort can do when backed by sterling industry and ability. There are no doubt many Mayos in the profession in this country, but few stand on so high a stump and are so widely known as these two surgeons in Rochester, Minn.

T. A. Ashby, M. D.

London, England, *August 17, 1906.*

To the Hospital Bulletin.

Our sojourn in Paris was short; far too brief to gain any except the most superfiicial impressions, and those impressions were not very flattering. The city did not impress me as favorably as Berlin, and does not seem to be as well kept. The travel on the streets is immense, and every variety of vehicle is employed. The driving seems to be quite reckless, and one must be agile or he will be knocked down by one of these rapidly moving conveyances. The streets were formerly paved with asphalt, but this has been taken up, and wooden blocks put down in its place. I suppose the advantage is in the lessening of the noise. The blocks of houses are more uniform in height and appearance than in most cities, and this gives a somewhat monotonous aspect to the city. There are, however, many handsome buildings; and the Place de la Concorde, and the garden of the Tuilleries, with the Louvre, right in the center of the city make an immense open space, which is very beautiful. The first and only bad weather we have had overtook us here, and the rain fell in torrents, but we utilized the time in visiting the Louvre, formerly a royal and imperial palace, but now used to house the immense collections of pictures and antiques of all descriptions. Here we met several acquaintances from Baltimore, and Americans from other parts of the United States were very much

in evidence. The French are a self-centered people, and but few of them speak any language but their own, whilst in Germany and Austria most of the shopkeepers and officials speak several tongues. The French also have some peculiar ideas in regard to public decency, and Doctor Hundley was much shocked when he saw some of the customs of the people. As I had been in Paris before I knew what to expect, and was able to bear their peculiarities with more equanimity. On one day we took a motor car excursion to Versailles. Starting opposite the splendid opera house, we passed by the church of the Madeleine, from the porch of which Napoleon I fired on and scattered the rebellious mob through the Place de la Concorde, along the Avenue Champs Elysees to the Arc de Triomphe, through which the victorious German army marched in 1871. The palatial residence of the Countess Castellane, in imitiation of the Grand Trianon was pointed out to us, which idence of the Countess Castellane, in imitation of the Grand Trianon was pointed out to us, which represents millions of dollars of Jay Gould's American money. The infelicities of the Countess even in this magnificent abode are well known and leads one to agree with the saying attributed, I believe, to Andrew Carnegie, that he would rather see his niece marry a decent hostler than a worthless duke. Our route passed through the famous Bois de Boulongne, a magnificent park of 2,500 acres, formerly a hunting preserve of the kings of France, but thrown open to the public by Napoleon III; through a number of villages, with narrow and walled-in streets to the city of Versailles. The palace of Versailles is a huge building especially rich in memories of Louis XIV, "le grand monarque" and of Madame Maintenon. In the great hall of this palace, King William of Prussia was made Emperor of Germany in 1871. The small Trianon nearby was built for Madame Pompadour by Louis XV, but she died before it was completed, and it was first occupied by her successor in the affections of the dissolute king, Madame DuBarry. It was subsequently occupied by the ill-fated Louis XVI and his wife, Marie Antoinette, the daughter of the great Austrian Empress, Maria Theresa. In the stable are still the great gilded coaches, sleighs and sedan chairs of the above mentioned kings and ladies, and of Napoleon I, as well as the republican equipage of the present government, in black and guilt. The great Trianon, especially rich in memories of Napoleon I and Josephine, is near by, and is a beautiful low structure of pink marble. The royal park of Versailles formerly contained 2,600 acres, but has been very much diminished in size in recent times. The many fountains are still in existence, and play on the first Sunday of each month. A considerable detour brought us to Saint Germain, where there is an immense demesue of 11,000 acres belonging to the public and 6,000 additional, belonging to individuals. From the terrace of St. Germain a beautiful view of country and villages, with Paris in the distance, is had. The castle of St. Germain, an old structure used by Henry IV, is now a museum of French history. The old church built in 1100 or thereabouts, is still in good preservation, and in it is buried James II, of England, who was the last of the Stuart dynasty. At St. Germain, just off the park, is a small and unpretentious house, now used as a restaurant, in which Louis XIV was born, and almost adjoining it, the house in which Thiers, the first president of the French Republic died. Another detour of several miles brought us to Malmaison, the home of Napoleon and Josephine in their earlier married life, and the retreat to which she retired after her divorce from the emperor, and where she did in 1814. After his defeat at Waterloo, Napoleon also retired to Malmaison and remained there until his attempt to escape, which resulted in his capture by the English. It is a nice, homelike residence, originally built by a barber, and not intended for a palace. It is now owned by the Government, and is kept as a Napoleonic museum. At Rueil is the church in which Josephine is buried, and where a beautiful marble tomb was erected by her children, Prince Eugene de Beauharnais and Queen Hortense, whilst on the opposite side of the building is the splendid Mausoleum of Queen Hortense, erected by her son, Napoleon III. As I have already said our stay in Paris was very brief, and did not permit us to visit the hospitals or medical institutions of the city, which I regret very much. We visited the Cathedral of Notre Dame, situated on an island in the river Seine, where elaborate services were being held. This is a magnificent structure and one of the great sights of Europe, but my knowledge of church history and architecture is not sufficient for me to attempt any description of its beauties. The river Seine runs through the city dividing it into two parts, and river-boat omnibusses run every

few minutes up and down the stream, affording a ready means of going from one part of the city to another; in fact there are but few trolley cars, as the city streets are too congested to allow that mode of travel to a large extent. The Alexander Bridge, to commemorate the visit of the Czar of Russia, is a new and striking viaduct crossing the Seine. On August 16th, we entrained for Calais, passing through a beautiful and fertile country, with brick farm houses, often of fanciful design. The trip across the channel was very rough and many people were sick, but we escaped. We reached London in the evening and were glad to get to English-speaking lands again.

RANDOLPH WINSLOW.

TO THE CLASS OF 1901.

Next May will be the sixth anniversary of our graduation. Since that period, as will be seen by a cursory glance at the appended list, the members have scattered far and wide, some even settling in foreign climes. It seems no better occasion could arise than the approaching centenary to send out an appeal to its members to assemble once more within the portals of our alma mater, to renew old acquaintances, and to cement bonds of affection for the old University. Does this appeal strike a responsive chord in your hearts? If so, please notify the writer and the Baltimore members of the class will try to do their part to render the visit enjoyable. As far as I can learn, the present location of the members of the class is as follows: C. R. Ahroon, Baltimore, Maryland; Harry Ainsworth, Thomasville, Georgia; Edgar G. Ballenger, Atlanta, Georgia; John I. Barron, Yorkville, South Carolina; F. C. Bayne, Roland Park, Maryland; J. A. Bond—P. R. Brown—A. S. Byers, Lacy Springs, Virginia; T. H. Cannon, Baltimore, Maryland; R. P. Carmen, Baltimore, Maryland; E. deViel Castel, Homer E. Clark—G. H. Costner, S. C. Lincolnton, North Carolina; W. H. Coulbourn, Crisfield, Maryland; B. H. Dorsey, United States Navy; N. S. Dudley, Church Hill, Maryland; C. W. Famous, Street, Maryland; F. C. Ferguson, Baltimore, Maryland; C. T. Fisher—J. E. Foscue, Tyro Shops, North Carolina; R. C. Fout, Kemptown, Maryland; C. W. Gardner—J. A. Gibson, Leesburg, Virginia; A. H. Giesecn, New York City; R. McC. Glass, Winchester, Virginia; W. W. Goldsborough, Greensboro, Maryland; A. Grumberg—R. L. Hall, Crisfield, Maryland; J. S. Hanna, Tanta, Egypt; A. S. Harden, W. F. Hargrove, Kinston, North Carolina; E. R. Hart, Suffolk, Virginia; N. Y. Hassun, J. M. Hayes, Baltimore, Maryland; F. C. Heath—J. W. Hebb, West Friendship, Maryland; G. W. Hemmeter, Baltimore, Maryland; J. Horace Jenkins—E. L. Jones, East New Market, Maryland; W. E. Kornegay, died; J. P. LaBarrer, Baltimore, Maryland; G. W. Latimer, Hyattsville, Maryland; P. E. Lilly, Baltimore, Maryland; W. L. Mauldin, Greenville, South Carolina; W. H. Mayhew, Baltimore, Maryland; F. E. Medina, Lowell, Massachusetts; W. T. Messmore, Smithfield, Pennsylvania; J. V. Milton, Hamilton, Virginia; R. H. Minor—E. M. Myers—E. C. McEachern, Cardova, North Carolina; W. S. Rankin, Wake Forrest, North Carolina; J. D. Reeder, Baltimore, Maryland; T. E. Reeks, New Brittain, Connecticut; W. M. Riley, F. O. Rogers, Concord, North Carolina; W. F. Sappington, Webster's Mills, Pennsylvania; L. C. Skinner, Ayden, North Carolina; H. B. Smith, died; R. H. Speight, Jr.—J. H. Stemple, Conshohocken, Pennsylvania; Dunlop Thompson—T. S. Tompkins, Chilton, West Virginia; S. P. Watson, Little River, South Carolina; A. F. Williams, Kenanville, North Carolina; N. Winslow, Baltimore, Maryland; W. R. Rogers, Bristol, Virginia; R. M. Little.

A muster of the above list furnishes food for reflection. With the means at hand I am only able to account for 51 of the 71 members, practically two-fifths of our class having become lost to my sight. Should such a condition of affairs exist? Why, certainly not. Each and every one of us should keep in touch with the other.

Corrections of any inaccuracies in the above list and information concerning the present location of those whose address is not recorded will be greatly appreciated.

Numerous classes will hold reunions during this period, and a rousing welcome is in store for them. Do not let our class lag behind the others, but turn out in force, and let its voice be heard for our dear old Alma Mater.

NATHAN WINSLOW.

At the annual meeting of the Frederick County Medical Society, held at the Emergency Hospital, Frederick, November 14, 1906, Dr. J. W. Downey, class of 1869, of Newmarket, was elected president for the ensuing year.

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EDITORIAL

EMERITUS PROFESSOR ISAAC EDMONDSON ATKINSON, M. D.—The familiar saying that "death seeks a shining mark" is painfully illustrated in the unexpected death of Prof. I. E. Atkinson, which occurred at his residence, in this city, on November 24, after an acute illness of some ten days. Up to the time he was taken ill he was one of the most active and energetic practitioners in this city, hence his death in the prime of his usefulness and popularity came as a great blow and unexpected sorrow to his family and friends.

Few physicians in this city have so endeared themselves to their profession and to the general public as had Professor Atkinson. His sincerity, frankness, genial nature and splendid skill as a physician drew to him the respect and confidence of all who were brought in relation with him. He belonged to the modern school of the family physician, which is to say, he possessed those personal qualities which made the old school of the family physician so much loved and respected, coupled with the modern scientific training which gives exactness and patient attention to every detail of professional work. He combined scientific study with clinical observation, which with his sound judgment and large experience made him an expert diagnotician and skillful therapeutist. As a consultant he was helpful and considerate both towards his brother physician and towards the patient, which traits of character made his services greatly appreciated in the consultation room.

His kind attentions, genial manners, skill and careful work in the sick room brought to him the confidence and love both of the patient and friends.

At the time he was stricken down with illness he had the largest practice in general medicine among the leading families of the city.

Professor Atkinson's connection with the University of Maryland began as a student during the Civil War. He graduated in the class of 1865, and from that time until his death his relations to his Alma Mater have been cordial and for many years intimate.

He was elected clinical professor of dermatology in 1879, and from 1886 to 1900 he was professor of materia medica and therapeutics and clinical medicine.

Since 1900 he has been Emeritus Professor. From 1890 to 1893 he was Dean of the Faculty of Physic. As a teacher he was clear, forceful and painstaking, commanding the respect, attention and love of the student body. As a colleague in the Faculty we can pay him that homage due to a just and noble spirit and wise counselor and friend.

ON THE THRESHOLD.—In the history of institutions as well as of individuals, there are certain times and occasions that are epochal in character. The conditions and surroundings that are entirely appropriate and harmonius at one period, are incongruous and detrimental at another. The child requires different nutriment from the adult, and his thoughts and actions are different. Saint Paul, writing in the Corinthians, says, "When I was a child, I spake as a child, I understood as a child, I thought as a child: but when I became a man, I put away childish things." Nations also do not spring Minerva-like full grown and armed from the brain of Jove, but must have a time of weakness, where they need to go carefully and with tottering steps, until they shall have passed the period of infancy and shall have arrived at a stage of virility and strength. The conditions and environment attending the birth of our republic no longer prevail; the infant has grown into the strong man. In a similar manner the conditions attending the birth, infancy and adolescence of the University of Maryland no longer prevail.

That which was appropriate in the early history of the institution, is incongruous at the threshold of the second century of its existence. As we review the work of the school in retrospect, there is much that is admirable and noble that comes to us as a precious legacy from the past, but we must not be satisfied with the meed of excellence that has been attained, often under highly disadvantageous circumstances, but must accommodate ourselves to the changed conditions that confront us. An epoch has now arrived, that has as yet reached but few American institutions of learning; the centennial anniversary of the establishment of the University. The child has, at least, reached maturity. The clothes of the first century of its life are not only worn out, but they are of antique pattern and too small; they do not fit. On the threshold of a new century we must clothe ourselves in new and modern raiment. For one hundred years the University of Maryland has consisted of several Faculties, nominally under the government of a Board of Regents, but practically, there has been but little co-operation between the several schools, and each has managed, or mismanaged, its affairs to suit itself. The Provost of the Regents has been an ornamental, rather than an actual head of the institution.

Whilst perhaps it may not be pertinent at this time to consider whether the organization of the Board of Regents is as effective as it might be, it is certain that there should be some governing body that will exercise an oversight over the affairs of the University, for the benefit of the whole; and that a Provost, or President, or other executive officer, under a suitable salary should be an actual and a nominal head of the aggregation. It is not for me to dictate the manner in which this should be brought about, but is one of the pieces of new raiment that we must don, if we are to keep pace with the march of progress. In this centennial year two very important propositions are presented to us for our serious consideration. For many years the Faculty of Arts and Sciences has been defunct, but by mutual agreement, it is expected, that Saint John's College at Annapolis, will assume the relation of the Department of Arts and Sciences in the near future. In my opinion this union or affiliation will be most helpful to each institution, and a notable event of the new century of our University.

The other proposition is the consolidation of the Baltimore Medical College with the Faculty of Physic. This college is not in its decrepitude, but is actively virile, and at present is a most dangerous competitor. By a union of the two schools many advantages would accrue. If the union is not effected, they expect to enlarge their facilities, and still more strenuously strive to gain the confidence and patronage of the public and the profession. I am confident that it is the part of wisdom to convert opponents into allies; and to consolidate into one body these two competing organizations.

In these days two conditions go hand in hand, scholarship and endowment. No longer is it possible to exact a high degree of scholarship with an empty coffer. This is especially true in regard to medical institutions; laboratories with expensive equipment and skilled instructors cannot be maintained without the expenditure of large sums of money.

Whilst we have striven to maintain a creditable standard of scholarship in the past; we have been hampered by a lack of funds. A large portion of the new apparel with which we must clothe ourselves must be in the nature of an endowment. Our fathers left us a good name, but no revenues. We must now strive in season and out of season, to secure an effective endowment. This must be obtained not only from our alumni, but from the wealthy and philanthropically inclined citizens of this and other communities. Let our needs be proclaimed with insistent voice, and with united effort, and good results will follow. Several very encouraging gifts are either actually in hand or will be available in a few years—the most recent of these being a third interest in the estate of the late Joshua G. Harvey. Let us cross the threshold of the new century with renewed hope and the determination to place our University on a firm financial and scientific foundation; let us adopt modern methods, suitable to our needs, rather than cling to the customs and traditions of the past.

R. W.

THE HONOR SYSTEM.

At a meeting of the Freshman class in the middle of November, the feasibility of adopting an honor system similar to that in vogue at the University of Virginia, was earnestly considered. At this meeting Dr. Louis M. Allen, Dr. Hiram Woods and Dr. Charles L. Jennings, resident

physician at St. Joseph's Hospital, made addresses advocating the system. Dr. Allen said:

"I think it quite probable that the honor system will be adopted at the University of Maryland in the near future. The system has met with favor at the University, and those of us who have been advocating its adoption feel much encouraged. Of course it takes time to do a thing of this sort, but we have been at work upon it for a number of years, and I feel sure that our hopes are going to be realized."

The editors of the BULLETIN are heartily in accord with this movement and thoroughly believe that the adoption of the honor system would be a move in the right direction. Those students who do their tasks conscientiously during the term have nothing to fear at the final test. It is mainly those who trifle away their time during the year that hinder the adoption of the honor system. The reason of this opposition is self evident.

Now that we are entering the threshold of another century, let's discard some of the methods of the past, and adopt new measures for the future. Every student who really has the interest of his Alma Mater at heart will help in the accomplishment of this by forwarding the idea of the honor system.

NOTES AND ITEMS

Dr. Francis Janney, class of 1905, has located at 327 N. Charles street, Baltimore, Md.

Dr. Edward M. Duncan, class of 1884, of Govanstown, Maryland, held his annual family reunion Thanksgiving Day.

Dr. Charles Bagley, class of 1904, formerly an assistant resident surgeon at the University Hospital, and now superintendent of the Hebrew Hospital, Baltimore, spent the middle of November visiting the chief medical centers of the West and Northwest. While away he visited the hospitals of Chicago, Milwaukee, St. Paul, Minneapolis, and Rochester. In two days at the Mayos' Clinic, he saw twenty-five major operations. On his return trip he stopped in Philadelphia, where he was the guest of Dr. Alexander C. Abbott, class of 1884, now professor of bacteriology and director of the laboratory of hygiene at the University of Pennsylvania.

In the plans of the coming centenary, one department, the Training School for Nurses, has been largely neglected. It appears eminently proper that the graduates of this department should be extended a cordial invitation to participate in the festivities of the occasion. We would suggest to these alumnae that they hold a general reunion and banquet. We must not forget that they have the same love and reverence for the old University as their brothers, and should acknowledge their claims to recognition. The joint centennial committee has decided that the occasion would be incomplete without the participation of the student body, so has set apart a day for their amusement.

During the centennial celebrations, which will begin Thursday, May 30, famous educators and physicians throughout the country have been asked to participate and speak, and many have signified their willingness to attend. The plan as laid out by the special committee is:

Thursday—Alumni Day and reception at the hospital, followed by another reception at Tusculum, the country home of Dr. Hemmeter.

Friday—University Day.—Academic functions at the Lyric and a banquet at night.

Saturday—Student's day.—A general entertainment of guests, followed by a trip down the bay on the Steamer Latrobe; Class reunions.

Sunday—Services at churches to be decided by the committee.

Preparations are under way for a big mass-meeting, which will be held some time in January. Dr. Nathan Winslow was appointed chairman of the hospitality committee. The following committee on academic costumes was appointed: Drs. Thomas Fell, Charles Caspari, Jr.; John C. Hemmeter, T. O. Heatwole and Mr. James P. Gorter. Two thousand dollars have been pledged by the faculty of physics and the adjunct faculty.

MARRIAGES.

Dr. Frank E. Brown, class of 1893, of Baltimore, was married October 18, 1906, to Miss Bessie Humphreys Sherk, of this city.

Dr. Clarence Winfield Stansfield, class of 1906, was married September 26, at Dover, New Hampshire, to Miss Martha Phelps, daughter of Mr. and Mrs. George G. Phelps, of the same place.

Miss Nellie Hilliard, class of 1905, of the Training School for Nurses, was married November 28, 1906, at the Church of the Good Shepherd, Rocky Mount, North Carolina, to Dr. L. C. Cov-

ington, a graduate of the University College of Medicine, Richmond.

Dr. H. D. Walker, class '02, of Elizabeth City, N. C., was married November 20, 1906, to Miss Augusta Kramer, of the same place. The ceremony was performed at the First Methodist Episcopal Church, and two of Dr. Walker's classmates were attendants. Dr. B. B. Ranson, of Orange, N. J., acted as best man, and Dr. S. R. Donohoe, of Norfolk, Va., as an usher. After the wedding Mr. and Mrs. Kramer gave a reception at their home on Main street. Dr. and Mrs. Walker had an extended honeymoon, including Boston, New York, Canada, and other points.

DEATHS

Dr. Duncan Sinclair, class of 1855, of Rowland, North Carolina, died recently, aged 84.

Dr. John Lee Gordon, class of 1845, died recently at Columbus, Ohio, of bronchitis, aged 86.

Richard B. Baker, M. D., class of 1846, said to be the oldest practitioner of Hickory, North Carolina, died at his home recently in that place from paralysis, aged 86.

Dr. Robert L. Morrison, class of 1896, of Parkersburg, West Virginia, died October 15, 1906, in New York City, of abscess of the brain, after an operation for its relief, aged 35.

Dr. Thomas W. Greenley, class of 1888, of Trappe, Maryland, died November 16, 1906, at Saranac Lake, New York, of tuberculosis, aged 41. Dr. Greenley was the son of Mrs. George F. Bevan. In October, 1891, he married Miss Nellie B. Clark, youngest daughter of the late I. Davis Clark, of Trappe, Talbot county, who died about seven years ago. Dr. Greenley practiced his profession at Trappe and in Baltimore for many years.

The grim reaper has claimed another of our prominent alumni, Dr. Isaac Edmondson Atkinson, one of the most distinguished and beloved physicians of Baltimore. Dr. Atkinson departed this life Saturday, November 24, 1906, of pneumonia, at his residence 609 Cathedral street, Baltimore, in the 61st year of his age. Dr. Atkinson was born in Baltimore, January 23, 1846, and was the son of the late James E. Atkinson, who came here from the Eastern Shore, and lived on Park avenue. He was educated in the city and graduated in medicine at the University of Maryland in 1865, since which time he has practically never severed his connection with the institution, being at the time of his death Emeritus Professor of therapeutics and clinical medcine. From 1879 to 1881, he held the chair of clinical professor of dematology. In the latter year he was made professor of pathology, and in 1886 of materia medica and therapeutics. In 1900 he retired as an active member of the faculty, but still retained a nominal connection with the institution as Emeritus Professor of Therapeutics and clinical medicine. He was dean of the University from 1890 to 1893, and president of the Clinical Society and vice-president of the Medical and Chirurgical Faculty from 1887 to 1888. During the same years he was also president of the American Dermatological Society. Dr. Atkinson is survived by a widow, formerly Miss Virginia R. Duval, three daughters—Mrs. Philip Gardner and Mrs. John C Rice, both of Boston, and Miss Christine Atkinson—and a son, Dr. A. Duval Atkinson, class of 1894, clinical professor of medicine in the University of Maryland.

At a meeting of the Faculty of Physic of the University of Maryland, held on November 26, 1906, on the occasion of the death of Dr. I. E. Atkinson, Emeritus Professor in the University, the following minute was adopted:

"The Faculty of Physic of the University of Maryland are deeply conscious of the loss which they and this community have sustained in the death of Prof. Isaac Edmondson Atkinson, M. D., who is various relations, as student, instructor and professor, was connected with the University of Maryland for many years.

"Both as a teacher and a practitioner of medicine Professor Atkinson was distinguished for the extent and accuracy of his professional knowledge, for the care with which on its scientific side he imparted it to his pupils and for the conscientious diligence with which on its practical side he applied it for the walfare of the many patients who sought his counsel.

"The Faculty would express also their full appreciation of the integrity of Professor Atkinson's character as a man, and of the noble qualities of his heart, which endeared him to all whose privilege it was to know him.

"As was his work, so be his reward."

It was directed that this minute be entered upon the records of the Faculty, and that a copy of it be sent to Professor Atkinson's family.

R. Dorsey Coale, *Dean.*

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PROF. WERTHEIM'S CLINIC.

By J. M. HUNDLEY, M. D.,

Clinical Professor Diseases of Women University of Maryland.

When in Vienna this summer we were fortunate in finding Professor Wertheim at home and working daily. We were in Vienna about two weeks, which gave us an opportunity to see much of his work.

Elizabeth Hospital accommodates about eighty patients and only gynecological cases are admitted to the hospital. Professor Wertheim is Surgeon-in-Chief, and he and his assistant do the work. The hospital is up-to-date and equal to any I have seen in this country or abroad. I was particularly impressed with the system and the thorough way the hospital and the work was conducted. Both in the dispensary and hospital much time and care were expended in going over the cases, and outlining the various forms of treatment. There were eight or nine assistants, all of whom were graduates of medicine. To each assistant certain duties are assigned, for instance: if a case of erosion of the cervix is seen in the dispensary by the man assigned for that day, he removes a piece of the cervix and makes a report on the findings the following day. I saw such a case when there. The eroded cervix did not look like cancer, but on microscopical examination it proved to be. Nothing is taken for granted. Curiously, but nevertheless true, I was told that the porter had worked so long in the hospital, and as it was his duty to make sections of the various tissues for microscopical examination, he had become entirely competent to make the diagnosis of cancer of the uterus. Prior to the operation, Wertheim makes an examination of every specimen and decides whether it is cancer or not. He told me that uterine cancer was his life-work —and well it might be. He has done more than three hundred operations for uterine cancer, with sixty per cent. cures. No such results have ever been gotten by any other operator. He has become so absorbed in that particular part of his work that much of the other operative work is turned over to his assistant. I was delighted with his technique, and the very radical nature of the operation. Of the various operations I have seen in this country for uterine cancer his operation, in my judgment, is the most radical. No other operator has gotten such a large percentage of cures. When the pelvic lymph glands are involved, however radical the operation, the cases eventually die of the disease. At one time in his work he thought he could dissect out the glands and in that way eradicate the disease. In that, he says, he was mistaken. After the cancer operations the patients are told to return to the hospital for examination every six months, and they generally do as they are ordered. In that particular we are not so fortunate in this country. Certainly not with the class of cases visiting our dispensaries. There is another point which impressed me in connection with the cancer cases. The women everywhere in Europe, and especially in Austria, take cognizance of any irregular uterine bleeding and seek medical advice at once. They have been taught in every way that it is possible to reach them the great danger of ignoring any persistent irregularity in the menstrual function. They are told frankly that it may and is often the beginning of uterine cancer, and that on examination, if it proves to be a case of cancer, the only hope of a cure lies in an early operation. Neglecting to act promptly when this early sign manifests itself gives the disease a chance to invade contagious tissues, the pelvic lymph glands, and to form matastases. Knowing this, many of the cases are seen early and at a time when the disease is entirely local. One of three cases I saw was just beginning. The other two were more advanced, but not advanced to the stage that we usually get them. In the very rarest instance do we get a case that is not on the border line; that is, where it is so far advanced as to be operable or not. Now

when a case is seen at that stage, the primary mortality is going to be high and the percentage of cures few. How are we going to educate the women of our country so they will reach us early when there is a hope of saving sixty per cent. of the lives of those suffering from cancer? It has got to be done by the concerted action of the doctors and nurses. I believe that the nurse can do as much, and even more, than the doctor in this matter. Women will confide in one of their own sex and seek the advice of a nurse often when she would shun the doctor. We must preach over and over again the hazard and fallacy of ascribing every sort of menstrual irregularity to the change of life. The profession must be aroused, and when it is aroused, the women will come to operation earlier, and our results will be better. It is all a matter of education, and it is our duty to keep this matter to the forefront. It is awful to have to say to those suffering from cancer, "You have come too late, the disease is too far advanced to do a radical operation." We can pretend to do some sort of an operation, all the time knowing it will do absolutely no good. I shall say nothing of the technique of the operation, as the details require that it shall be done only by those in this special line of work, if it is to be done thoroughly. We saw Professor Wertheim do all of his special operations. Much of his work is done by the vaginal way, and he is very expert by that route. He would remove six or seven pound myomas by the vagina, and also large ovarian cysts, if not adherent. That line of work did not appeal to me, but I saw two operations which did. One was shortening the round ligaments by the vagina and suturing them into the vaginal wound for cure of retroflexion of the uterus. The other he calls "interposition of the uterus," for complete descent of the uterus, otherwise known as procidentia uteri. I have done the round ligament operation five times, and the interposition operation once since my return. In the journal of the American Medical Association for November, is a description of a new operation for the complete descent of the uterus, by Dr. E. C. Dudley, of Chicago. The essential points in Dr. Dudley's operation are similar to those of the Wertheim operation. Wertheim has been doing his operation five or six years, and, he says, with no failures. Wertheim detaches the bladder entirely from the uterus and pushes it behind the uterus and draws the uterus into the vaginal wound, where it is sutured together with the parametrium. In this operation the uterus is acutely anteposed, which is essential to get a permanent result. He frequently shortens the utero-sacral ligaments at the same time. The redundant vaginal tissue is cut away, and a perineorraphy is done just as in the Dudley operation. Wertheim does not utilize any part of the broad ligaments as does Dudley. Dudley does not detach the bladder entirely from the uterus and place it behind the uterus, though he emphasizes the necessity of pushing the bladder high upon the uterus. Wertheim enters the abdominal cavity. Certainly the operations of both Dudley and Wertheim are in the right direction, and promise better results than those gotten previously by the older methods of operating. Wertheim limits his operation to women past the child-bearing period. If Wertheim's operation of shortening the round ligaments by the vagina for the cure of retroflexion of the uterus gives permanent results, it is superior for many reasons to the other operations I have been doing to correct the mal-position of this organ. I have always hesitated to advise the opening of the abdominal cavity for so trivial a condition as an uncomplicated retroflexion. Suspensio-uteri is rarely done now during the child-bearing period. The Alexander-Goldspohn operation necessitates making two incisions in the abdominal wall and at the weakest points. Scars in the abdomen should always be avoided when possible, in my judgment. For the past two years, I have been doing the Gilliam operation when a pessary failed to give relief. Now if good results can be gotten by the round ligament operation through the vagina, it should be resorted to, in the uncomplicated cases, in preference to the other methods of operating. This preference for the vaginal shortening of the round ligaments, can be supported by many points in its favor. A discussion of these points will be reserved for a future time.

In conclusion, I wish to emphasize that part of my paper relating to uterine cancer. I am sure we have not been doing our full duty in this disease, that we have failed to detect the disease early by looking upon the condition present as an erosion of the cervix, and ascribing irregular uterine bleeding to the menopause, or an endometritis, or what not. In doing this we have failed to do our duty. In every case of erosion of the cervix, of irregular bleeding from the uterus, and

profuse leucorrhoeal discharge occurring in a woman 30 years of age, a piece of the cervix and scrapings from the uterus should be submitted to microscopical examination. A correct diagnosis can not be made in any other way in these early cases. There is no pathognomonic sign or symptom of uterine cancer. As a rule, when cancer can be diagnosed by the eye it is far advanced and valuable time has been lost. In the past four weeks I have operated upon two cases of uterine cancer, one was in a single woman, 30 years old, and the other 54 and married. Cancer was not suspected in either case. Both of these cases were gotten early, and I hope will be permanently cured. The pelvic lymph glands that were removed were free from cancer, as was the parametrium. But for the microscope these two cases would have been mistaken for an erosion of the cervix, as the lesions did not excite any suspicion of cancer. The form of cancer was epithelial and had not penetrated the glands. It should be impressed upon every woman having irregular uterine bleeding or hemorrhage, or profuse leucorrhoeal discharge the necessity of having a thorough examination made. We must take a firm stand in this matter and do our duty at whatever cost.

REPORT OF CASE OF LOCOMOTOR ATAXIA WITH TYPHOID AS PROBABLE ETIOLOGIC.

DR. I. J. SPEAR, *Baltimore.*

I think this case will be of interest for various reasons. First, it is a woman, and, as we know, tabes is rather infrequent in women, occurring in proportion of about 10 to 1. Secondly, patient's age being but 30 years, and this disease occurs rarely before the thirtieth year. The greatest number of cases occur between 35 and 50, and the disease in this woman occurring at about the 23d, 24th, or 25th year. Thirdly, the fact that this condition existing she was operated upon in two different hospitals for conditions that were merely symptoms of her affection. Fourthly, in this case we very probably have the prolonged exposure to the typhoid toxin as the predisposing factor. The following is the brief history of this patient. Her age is 30 years and occupation housework, single. Her complaint is inability to use the right leg.

Family History: Her mother living, age about 45, has heart trouble and rheumatism, father dead, age and cause unknown, has no brothers or sisters. Mother's sisters and brothers are nervous. Otherwise the family history is negative.

Past History: Patient has always been healthy up to the fourteenth year, calling herself strong, country girl. Menstruated at this age. Then shortly after the first menstrual period she developed typhoid fever and was very sick for five months. During this attack, she says she was salivated and several of her teeth dropped out painlessly. Since this attack she has always been more or less sick, suffering with abdominal pain, nausea and difficulty in walking in the dark. Patient says that whenever she walked in the dark she would be giddy and walk into objects even if she knew where they were. At the age of 22 she had a large abcess on the right side of neck below the angle of the jaw. Her habits have always been good. Absolutely no history of drugs, alcoholism or venereal diseases. At the 27th year, or three years ago, her menstrual periods again returned and have been more or less irregular and painful since.

Present Trouble: Ever since patient's attack of typhoid she has been delicate, had pain and nausea and difficulty in walking in the dark. Five years ago, or about March, 1901, patient struck right hip on corner of bed, but suffered no consequences therefrom. Three days later, while patient was leaning over emptying ashes out of the bottom of a small stove, she suddenly heard and felt a snap in her right thigh. She fell over and was unable to arise. She had some pain in the upper part of her right leg. She was put to bed and for four months treated for rheumatism, the doctor never having made an examination. She was then sent to the hospital where a diagnosis of ununited fracture of the upper part of the femur was made and was operated upon. She remained in the hospital 15 months without being benefited. Then remained home two years suffering with pains in the back, head, stomach and both legs, all this time being unable to walk. Fifteen months ago, or in the summer of 1905, she was operated upon after a diagnosis of anterior poliomyletis was made and the anterior tibeal nerve was transplanted into the popliteal; there followed no improvement. One year ago patient had abdominal section done, in which the gall bladder, anterior and posterior stomach walls were explored and the entire abdominal cavity was ex-

plored and proved normal. At the present time the patient complains of the persistent pain in the upper abdomen, spells of unaccountable vomiting and nausea, girdle sensation, sharp pains in both legs, giddiness, inability to walk and general weakness. Physical examination: September 27, 1906. Patient lying in bed quietly, expression rather depressed, breathing quietly and normal in type, skin is soft and elastic and there are no eruptions. A large irregular scar under the angle of the right jaw, scar 6 inches long, extending from a point 3 inches above the costal margin to a point opposite the umbilicus, one inch and a half to right of medium line. Scar 8 inches long over the right hip posteriorly, a scar 10 inches long exterior and posterior to the right knee joint. Right leg is 3 inches shorter than the left and foot turned outward and there is foot drop.

Chest Development: Fair, somewhat flat antero-posteriorly, expansion is good and about equal, breasts are small and slightly atrophic, anteriorly percussion, ausculation and palpation show nothing abnormal. *Back*: Left lumbo-dorsal deviation of the spine exists to a considerable degree, respiratory sounds are not heard as plainly over the right back as over the left. There are no rales. Percussion note a little impaired on the right.

Hepatic dulness begins at upper border of the fifth rib and extends to within 3 fingers breadth of costal margin. *Heart*: P. M. C. I. visible and palpable in fourth interspace, one inch below and one inch internal to the nipple. Both sounds clear at apex and base, the second aortic is slightly accentuated. The area of cardiac dulness is about normal.

Abdominal walls are slightly rigid in epigastric region where pain and a sickening sensation are complained of on palpation. Otherwise the abdomen examination is negative. *Nervous System*: The strength of the extensors and flexors of the upper extremity is very good, strength of the flexors and extensors of the entire left lower extremity and the thigh of the right side is good. The extensors of right foot are good, but the flexor groups is paralyzed. (Perineal group and tibialis anticus) (right foot drop). No abnormal movements.

Atorphics: Atrophy of all the muscles below the left knee anteriorly on the right side. *Trophic Disturbances*: Patient has scars posteriorly over the buttock and sacrum, result of bed sores, some of which are still unhealed. Spontaneous fracture of thigh. *Co-ordination*: Upper extremities poor, lower extremities poor. *Reflexes*: Deep. Tendo-achilles, knee and elbow are entirely absent. *Superficial*: Abdominal is present and planter only elicited on deep excitation and then delayed. Rectal and vesical reflexes are disturbed. *Sensory Functionis*: Tactile; very much delayed, and they are scattered over lower extremities irregular areas of anæsthesia. *Pain Sense*: Very much obtunded in the lower extremities and many areas where it is delayed and others where there is analgisea. *Muscular Sense*: Lost in both lower extremities. There seems to be very slight, if any, sensory disturbance in the upper extremities. Temperature sense is much disturbed and obtunded in the lower extremities. *Vaso Motor Disturbances*: Dermatographia markedly present over back and abdomen. *Pain and Tenderness*: Patient complains of pain in both sides, stomach, right lower abdomen, lower part of back, sometimes extending around the entire abdomen giving rise to girdle sensation, head and posterior part of both lower extremities paroxysmal and sharp in character. *Gait*: Patient unable to walk. *Romberg Sign*: Patient unable to stand. *Present*: Pressure on tendo-achilles. *Cranial Nerves*: First apparently normal. Second, third, fourth and sixth. Vision right eye 20-30. Left eye 20-20. Refraction right eye, hyperopic, left mixed astigmatism. Ocular motion good. Convergence 25 C. M.'s. Right pupil 2 5-10 M. M. diameter. Oblong, vertically irregular, light reflex in all parts of field lost. Accommodation and converging reflexes are absent. Fundus is normal. Left pupil 6 M. M. in diameter, regularly dilated, light accommodation and converging reflexes are absent. Fundus accommodative near point normal. Fifth motor and sensory branches are normal. Seventh, eighth, ninth, tenth, eleventh and twelfth are apparently normal. Pupils dilate on installation of solution of cocaine. Pupils contract on installation of solution of eserine.

In conclusion I would like to make a few remaks as to the etiology of tabes.

Erb and Fornier first called attention to the fact that syphilis occurred in the history of nearly all cases of tabes, they contending that this was the cause of tabes in from 85 per cent. to 95 per cent. of all cases. Fornier even going as far as to say no syphilis, no tabes.

At the present time various investigators ex-

pressed different opinions as to the cause of this disease.

Erb, Rump, Fornier, Mobius contend syphilis is the cause in 85 per cent. to 95 per cent.; Gowers, Bramwell, Senator, Mendol, Oppenheim and Dana, 60 per cent. to 75 per cent.; Peterson, Burr, Fulton, 30 per cent. to 50 per cent., and the followers of Robertson that it is a disease with its own specific organism.

I believe as we pay more attention to some chronic intoxication, be it syphilitic, alcoholic, intestinal, rheumatic, the toxine of an infectious disease, as typhoid, typhus, influenza, etc., as a predisposing cause by viciating the nervous system, and to some extraneous exciting cause, be it an organism, as Robertson thinks, or trauma or exposure, we will be able to do more good for our patients, both as to the prevention, or in the arrest of its progress and the amelioration of the symptom after it has developed.

MUCOCELE AND ITS TREATMENT.

(Irrigation vs. Probing.)

WILLIAM TARUN, M. D.

Chief of Clinic at the University Hospital—Assistant Surgeon at the Presbyterian Eye, Ear and Throat Hospital, Baltimore.

It is my purpose to call your attention to the advantages of irrigating the Lacrimal Sac in the treatment of its most common affection, *i. e.*, mucocele or stricture of the duct.

To bring out the points, for which I contend, it will be necessary to review briefly some of the anatomy of the drainage apparatus. I wish to call especial attention to the distribution of muscular fibres around the canaliculi.

The Drainage Apparatus.—It consists of the puncta, canaliculi, sac and duct. The punctum is a small opening situated on an elevation (the papilla) of each lid margin, about 6 M. M. from the inner canthus. They cannot be seen in the normal position of the lid, and to bring them into view the lid must be slightly everted; they are directed so that they lie against the eyeball at the outer margin of the semilunar fold.

The papilla or small elevation, upon which the punctum is mounted, is a part of the canaliculus, the vertical limb. The one on the lower lid is somewhat more external to the inner canthus than the upper. This position is such that permits a more perfect closure of the lids. The lower is directed up and back, the upper down and back; this direction is the most favorable for the conduction of the tears into the canals.

The Canaliculi.—Each canaliculus consists of a vertical and a horizontal limb. The vertical is partly contained in the papilla, it is about 2 M. M. long and forms a little less than a right angle with the horizontal limb. At its knee the horizontal limb begins, runs parallel to the margin of the lid; the lower upward and inward, the upper downward and inward, and the two, as a rule, uniting before they empty into the sac. The vertical limb is surrounded by elastic tissue, and crescentic muscular fibres from the palpebral portion of the orbicularis (Schirmer). These fibres have been recognized since 1832 (Weber). They are arranged so that they encircle the small canals, and that their action is that of a sphincter there can be no doubt.

The horizontal limb is also surrounded by elastic tissue, and muscular fibres distributed in two ways; those from the orbicularis, in a manner parallel to the canaliculus, and those from the reflected portion of the orbicularis (Horner's muscle) winding around the canaliculus in a spiral manner (Krehbiel). The function of the crescentic fibres surrounding the vertical limb and the spiral fibres surounding the horizontal limb is to lessen the lumen of these small canals and act as a sphincter. This action is supplemented by the contraction of those fibres arranged longitudinally in that during their contraction the canaliculus is shortened and at the same time pressing upon the walls of the canals causes a more perfect closure. The importance of the action of these fibres in the conduction of the tears into the sac cannot be ignored. More of this later.

It may be well to explain what the tensor tarsi or Horner's muscle is. It is a small, thin muscle, situated at the inner side of the orbit behind the internal palpebral ligament. It arises from the crest and adjacent part of the surface of the lacrimal bone, passes across the sac and divides into two limbs; each limb being inserted into the inner extremity of the tarsal plate and the canaliculi. Its action is to pull this portion of the lower lid upward and inward, the upper lid down and in. It, as well as the orbicularis, is supplied by the seventh nerve.

The Lacrimal Sac and Duct.—The lacrimal sac is situated in the groove of the lacrimal bone. It is surrounded by a bony wall except an area be-

neath the skin at the inner angle of the lid. Its landmark is the internal lateral ligament, to which this part of the sac is adherent, a ligamentous band of fibres by which the orbicularis muscle is attached to the lacrimal bone. The sac has a length of about 15 M. M., a breadth of 6 M. M.; its fundus lies about 2 M. M. above the ligament and the remainder below. It is covered by much elastic tissue and lined by mucous membrane similar to that found in the nose. It has no ciliated epithelium. Its lower end passes into the duct, a canal about 18 to 24 M. M. long and on an average of 4 M. M. wide, completely surrounded by an osseous wall formed by the lacrimal bone, the nasal process of the superior maxillary and the inferior turbinated. It is also lined by mucous membrane and between its lining and the periostium is a venous plexus similar to that found in the turbinate bodies. The narrowest part of the duct is the upper extremity. The opening into the inferior meatus of the nose is guarded by a valve (Hasner) and lies about 10 M. M. posterior to the anterior end of the inferior turbinated. The course of the sac and duct is on a line drawn from the inner end of the brow to the naso-labial fold. What factors cause tears to pass into the nose? As a matter of fact a few of the text books give this a passing mention, the majority are silent. The physiology of the passage of the tears into the nose may be divided into two parts: the passage of the tears from the lid fissure into the sac and the passage from this point into the nose. The first act is not difficult to explain; as to the second, this has given rise to various theories.

After the tears are secreted they are swept to the inner angle of the eye—into the lacrimal lake—by the closure of the lids: they remain in this lake until the lids are again opened, when by the relaxation of the fibres surrounding the vertical and horizontal portions of the canaliculus the punctum is opened and as it sweeps along the semilunar fold they are sucked into the canaliculi. In the ordinary act of winking there are several visible movements which take place; Horner's muscle pulls the punctum up and in and the fibres from this part surrounding the horizontal limb in a spiral manner aided by those from the palpebral part of the orbicularis, and the sphincter action of the crescentic fibres surrounding the vertical limb causes a closure of the punctum. That the punctum closes during the contraction of the orbicularis can be easily demonstrated by instilling into the eye a sol. fluorescein or any coloring matter, separating the lids and while separated have the patient wink. At the moment this act takes place it will be noticed the punctum becomes smaller and when the lids are relaxed it enlarges. This is contrary to the statements in several textbooks. We see then that the muscular fibres surrounding the canaliculus play an important part in the passage of the tears into the sac. We must also not lose sight of the possibility of their action preventing the regurgitation of the tears into the lid fissure. It is essential that they remain intact in the treatment of mucocele, and their function not destroyed by slitting up the canaliculus, nor paralyzing them by dilating in the passage of a probe.

By what process the tears pass into the nose cannot be definitely stated. Various theories have been advanced, one or more of which may be factors. The most plausible one is that they are forced into the nose by the elasticity of the sac wall, during this contraction the sac becomes smaller and since they cannot pass back into the conjuctiva, because the canalculi are closed, they must be forced onward into the inferior meatus of the nose.

Other theories are:

Siphon theory (Petit).

Capilliary attraction (Weber).

Nasal aspiration (Hounauld).

Mucocele.—A mucocele is a chronic inflammation of the mucous membrane of the lacrimal sac and duct following an obstruction in the latter. All the symptoms and sequelæ are secondary to this obstruction. It is a disease more commonly found in Europeans; in negroes it occurs rarely, probably because the nasal duct is shorter and wider in this race. Females are more susceptible than males (2 to 1).

Etiology.—Inflammation of the nasal mucous membrane, whether acute or chronic. Chronic inflammation has the greater tendency to produce obstruction.

Cicatrices formed by atrophic rhinitis, œzena or ulcers of the nasal mucous membrane.

Exostoses, polypi, enlarged inferior turbinate and an abnormal deviation of this turbinate toward the lateral wall of the nose.

Syphilitic necrosis, as found in the hereditary form (children) or the acquired (adult).

Symptoms.—The first symptom complained of is epiphora or the passing of tears over the edge

of the lid and down the cheek. This is especially annoying during the winter months. At first it may be intermittent, later becoming constant. Where this is persistent the irritation, produced by the tears passing over the skin surface, causes an eczematous condition with its consequent cicatrices and tendency to pull upon the lower lid with a resultant eversion of the same. To this is usually added a thickening of the conjunctiva, which further increases the ectropion. On examination of a patient with a mucocele one will find the conjunctiva full of tears, and beneath the internal lateral ligament a lump or swelling, pressure upon which causes a regurgitation of the contents of the sac into the lid fissure. The contents may be a clear fluid, watery or ropy, the latter being mixed with a large amount of mucous; or of a slightly yellowish tinge, or even pus. The character of the contents being dependent upon the duration of the disease or the infection. The constant maceration of the epithelium of the cunjunctiva and cornea, by this decomposed fluid, lowers the resisting power of these structures and not infrequently a chronic conjunctivitis or a corneal ulcer with perforation follows.

Further, the sac wall is also susceptible to infection by pyogenic organisms and the more painful phlegmon or acute dacryocystitis occurs.

Treatment.—In the treatment of mucocele it is necessary to remedy any abnormal condition found in the nose which has a tendency to cause obstruction to the flow of tears. Where there is a hypertrophy of the mucous membrane an application of supra-renalin, 1 to 3000, to the orifice in the inferior meatus, followed by an application of Sol. Iodine in glycerin is indicated at each sitting.

Irrigation of the lacrimal sac was done at the time Anel devised the syringe for this purpose. Prior to that time E. Meyer had been using one which had a small canula and its use did not necessitate the slitting of the canaliculus. Anel's syringe was not an improvement over that of Meyer, since it was to be used similar to the probe and for the purpose of syringing the duct and not the sac. This was worse than useless, as one usually succeeded in having the end of the canula in the nose and the fluid washed out the anterior portion of the nasal cavity instead. They are now made with a canula sufficiently small to pass into the canaliculus without slitting the latter or previously dilating it. It cannot be used as the older one for fear of making a false passage. I may say that an ordinary hypodermic syringe can be used provided the canula has a blunt point. This can be carefully made by any of the instrument makers. The diameter of the canula is about the same as that found in Anel's syringe.

Technic.—Before a 4 per cent. sol. cocaine is instilled into the eye, the sac is pressed upon to evacuate its contents. A few drops of the cocaine sol. are now instilled and a minute or two allowed to elapse. It is not necessary to inject any into the sac as the treatment is practically painless.

The operator now fills the syringe with a sol. supra-renalin or adrenalin 1 to 3000, supplies himself with an abundance of cotton, takes a position behind the patient so that the patient may rest his head against the operator's chest. Taking a cotton in the left hand, if one is irrigating the right sac, the lower lid is made taut by pulling it downward and outward. This is for the purpose of bringing the punctum into view and also to straighten the canaliculus. The punctum is at times difficult to find because of the edge of the lid being somewhat rounded, but after a little search one never fails. The syringe is held in the vertical plane or a little toward the median line so as to bring it in line with the vertical portion of the canaliculus and inserted into the punctum. It descends for about 2 M. M. and is now brought to the horizontal plane or a little lower, as the canaliculus runs upward and inward, and gradually pushed inward until it meets a bony obstruction—this is the lacrimal bone. It is well to remember that occasionally one will have a little difficulty in this part of the operation because the canula engages in some of the folds of mucous membrane near the opening into the duct. This is easily overcome by not using any force, but moving the syringe in various directions until the canula becomes disengaged. So long that the lid is movable and a bony resistance is not met with, one can be certain the end of the canula is not in the sac and the operator will surely inject the fluid into the lid tissue. When the canula has met the resistance of the lacrimal bone it is withdrawn about 1 M. M. and the contents of the syringe injected into the sac. There is usually a regurgitation through the upper punctum, but this is of no moment.

The syringe is now loaded with a sol. zinc

sulph., grs. (2) to oz., the contents of the sac are again evacuated and the same procedure gone through as in the use of the preceding solution. If one is reasonably certain that the end of the canula does not lie against the lacrimal bone or is not engaged in any soft tissue, a strong force can be applied to the syringe. Regurgitation through the upper punctum can be avoided by making pressure upon it with the thumb of the left hand. I have succeeded in causing the fluid to pass into the nose at the 2d or 3d sitting. Even though this does not occur so soon as at the 3d one should not despair. It is my opinion that we are not persevering enough and usually condemn a treatment because of insufficient trial. If after the 5th or 6th attempt no fluid is forced into the nose one may pass a small probe, No. 4, into the duct for the purpose of diagnosis or establishing an opening. Great care must be exercised in doing this. It is also not necessary to slit up the canaliculus in the passage of such a small probe. If the probe meets with any exostosis it is useless to continue further treatment as the only treatment in these cases is to drill an opening into the nose or extirpate the sac. It does not seem good advice to slit up the canaliculus in these cases and pass a large probe with sufficient force to break away this bony obstruction.

I would strongly advise against the use of any of the silver sol. as medicaments. Even in the exercise of the greatest care one may possibly inject this in the tissues. It always causes a deposit in the tissues of silver oxide and staining of the lid takes place. In some cases this is permanent, in others it disappears spontaneously. When permanent it can be made to disappear by the injection under the skin of the lid of a sol. kali iodid. gr. 1 to oz. 1 of water. This probably forms an iodide of silver which is taken up by the circulation. This unfortunate accident has happened to numbers of operators and will continue to occur as long as these silver solutions are used.

In a large number of cases of mucocele there is usually found also an eversion of the lid. The amount depends upon the duration of the mucocele. The mild forms of ectropion are largely due to the thickening of the conjunctiva and disappear by the use of the zinc sol. instilled into the eye 3 or 4 times daily. The more advanced ectropion ought to be remedied by operation to put the lid in its normal position.

One gets the best results in the incipient cases and it is unfortunate that patients suffering from mucocele do not consult the physician earlier. I have no doubt that if they are assured they will not have a probe passed and the treatment is a painless one they would be more willing to submit to treatment. I have had several patients make this remark to me.

The sittings are repeated every other day. In the mean time the patient is to make pressure upon the sac several times a day, being careful to do so with clean fingers so as to avoid infection and after the contents are evacuated instill the zinc sol. Usually a cure is brought about in 3 or 4 weeks. The irrigation produces a little burning sensation, but no pain.

That irrigation has been unjustly neglected I am certain. Its advantages may be summed up as follows:

Firstly.—Comfort to the patient in that it is not painful.

Secondly.—A slitting of the punctum and canaliculus is not called for, nor is the sphincter action of the muscular fibres paralyzed as in the passage of probes without the slitting of the canaliculus.

Thirdly.—Surely one can bring about the normal condition of the mucous membrane by irrigating the sac, better than by passing a probe and depending upon the washing by the tears to bring about this result. It can also be accomplished in a shorter time with a medicament than otherwise.

Fourthly.—One avoids the crushing of the mucous membrane following the passage of a probe, and the danger of causing an abrasion and its consequent cicatrices; thereby placing the patient in a worse condition than before treatment was begun.

CORRESPONDENCE.

London, England, *August 29th*, 1906.

To the Hospital Bulletin:

London is a veritable Babel, and here are to be found people from all over the earth. Even in the heat of summer the streets are crowded to repletion, and one wonders how more people and vehicles can be given space. In general appearance the city resembles an American town, the houses being built mostly of gray bricks; even those structures that have been built of stone or marble take on a gray hue, and give a sombre aspect to the city. The Thames river bisects the town, and

brings to its wharves the commerce of the world. The several municipalities known collectively as London extend twenty miles in one direction and eight in the other. The population is probably between five and six millions. London is not only the greatest city in area and population in the world, but in its history and associations it combines as much of interest to the wayfarer, as any other city. The first thing to do on arriving is to secure a domicile, which may be either rooms in large and expensive hotels, where your money escapes before you can catch hold of it, or in less pretentious hostelries or apartments. Rooms may be secured in private houses at moderate rates, with breakfast served, and the other meals eaten where you choose. Dr. Hundley and I secured apartments in the Russell Square district, and at small cost, were able to enjoy a sojourn of two weeks in the metropolis. The policemen are magnificent specimens of men, and were always polite and accommodating. On our arrival at night we inquired of a policeman if there was a hotel in the neighborhood, and he personally escorted us to a very nice and comfortable place, a square or two off. He was not averse to a few coins placed in his palm, but he rendered us a valuable and kindly service. In the middle of August there is but little to see in a medical way. Nearly all the prominent men are away and one does not spend much time in visiting medical institutions. We visited Middlesex Hospital, which is an old institution, but is in good condition, and has fine modern operating rooms. A. Pearce Gould, J. Bland Sutton, with Mr. Clark and Mr. Lang, are the chief surgeons, but they were all away. We saw, however, several operations by an assistant surgeon—such as a gastro-enterostomy with Robson's bone bobbin, which was done very nicely; extra uterine gestation, resection of internal saphenous vein, and arthrotomy of the knee joint. University College Hospital is a beautiful new structure of fine red brick externally and enameled brick within, modern in every respect and practically fireproof. Sir Victor Horsley and Mr. Barker are the best known of the surgeons to this hospital, but they also were taking their vacation. Mr. Johnson operated on several cases, but we did not see anything of especial interest in an operative way, but were much pleased with the fine operating room of marble and stone. Guy's Hospital, situated on the Surrey side near the London Bridge, is an old and famous hospital. It is somewhat eclipsed now by more modern institutions, but is still doing a good work. We met here Mr. W. Arbuthnot Lane, one of the regular surgeons, who treated us very courteously. He is the especial advocate of converting simple fractures into compound ones by incision, and screwing a plate on the bones. He was surprised to learn that we had been using the steel or silver plates on the bones in suitable cases for ten years at least. Mr. Lane believes that much ill health is dependent on a chronic colitis, causing a chronic toxemia, and that it should be treated by dividing the ileum near the cecum and inserting it into the rectum, and in most cases excising the large bowel from the ileum to the descending colon. He says the results are positive, the patients are cured and the mortality very slight. We saw one girl on whom he had done the first part of the operation, the insertion of the ileum into the rectum, but owing to her enfeebled condition, had not excised the colon. She professed to have been much relieved by the operation. Mr. Lane has also devised a special operation for cleft palate, which is done at a very early age, before dentition.

St. Thomas' Hospital, on the Albert embankment overlooking the swift Thames river is one of the finest and best hospitals in London. It consists of seven detached pavilions, connected by a corridor, and contains about 650 beds. There are six or eight operating rooms in marble and metal, with overhead light. We met here Mr. Ballance, a distinguished surgeon, who is especially well known on account of his work on brain surgery and on the arteries. He had attended the meeting of the American Medical Association at Boston, which accounted for his presence in London in August. He operated on a femoral hernia and fastened Poupart's ligament down to the pubic bone with a staple, Roux's Method, I believe. At this clinic we met Dr. W. M. Martin, of Mobile, who, like ourselves, was looking around.

The Royal College of Surgeons is a famous school of medicine, where those who expect to practice surgery, mostly, obtain their education. Here is located the famous anatomical and pathological museum, founded by John Hunter, and added to until it is a magnificent working collection. The dissections of normal human anatomy are superb, and embrace all parts of the body. Every nerve fibre, vascular twig and muscle is beautifully shown, being preserved in some liquid

in large jars, so that inspection and study is easily accomplished. There were a number of young men, with their anatomy text-books before them, carefully comparing the dissections with the text. I would have liked to refresh my own anatomy at such an inspiring and instructive fountain.

No one should visit London without spending some time in the British Museum; we spent a considerable portion of three days there, and were only able to gain a very superficial idea of its treasures. The hands of time are truly turned backwards when one enters the British Museum, and the life of the ancients is brought down to our times. An enormous mass of Roman antiques have been found in England, and deposited in this museum, such as weapons, implements, vessels, pottery, glassware, jewelry, furniture, and even leather shoes worn by the Romans during their long occupation of the island. These, however, are but modern relics compared with those of the ancient Egyptians, Assyrians and Persians, which date from nearly 5000 B. C., down to comparatively recent periods. There is an immense collection of sculptures, statues, figures, tablets, household utensils, furniture, cloth, shoes, seals, rings, jewelry, rope, instruments, armor, chains, beautiful glassware and many other objects that show the methods of life and thought of the ancients, and which display a prehistoric civilization of a high order. Even the prehistoric American sculptures, pottery and other evidences of intelligent peoples on the American Continent, long before the landing of Columbus, are collected here in large numbers.

Far beyond all recorded history, when men dwelt in caves, they engraved pictures of familiar animals on horn and bone, and these faithful representations of life 150,000 years or more ago are to be found now in the wonderful collections of this storehouse of the past.

I must omit all description of Westminster Abbey, St. Paul's Cathedral, the Houses of Parliament, the Tower of London, visits to Windsor Castle, the favorite residence of the late queen, and to Greenwich, from the observatory of which, longitude is computed, east and west, and will briefly describe a visit to the city and University of Oxford. Oxford is about 52 miles distant from London, and a ride by train of one and a half hours. It is a quaint, and at this time of the year, a drowsy looking little city, but at other times full of life and bustle, when the students are in residence. The university is composed of 24 separate colleges, which are autonomous, but subject in certain ways to the university, very much as the States of the American Union are autonomous, but subject to the central government. The oldest authentic foundation is that of Merton College, A. D., 1264, and whilst most of the other colleges are several centuries old, some are of quite recent foundation. The buildings are generally of a soft stone, which slowly disintegrates and gives them an ancient appearance. They are irregular buildings, surrounded by high walls, enclosing quadrangles, and in many instances, gardens with flower beds, walks and extensive pleasure grounds. The different colleges vary in appearance, but usually have imposing towers and pinnacles, and are ornamental and attractive looking. Christ Church College is the largest of these colleges, and is very rich, having an annual income of $400,000. Most of the others are also heavily endowed. The university is governed by a council or senate of 18 members, selected from the heads of the colleges, the professors and the dons, but all laws passd by them must be submitted to a convocation of the Fellows, before they become effective. The University Park is a large pleasure ground, kept by the university and used for recreation and sports. The river Thames is called the Isis, at Oxford, and though only a narrow stream is a source of much pleasure to the students and residents of the city, as is also its still smaller tributary, the Cherwell, both of which in the afternoons are alive with parties in boats of almost all descriptions. The lack of time and space forbids my mention of the various colleges, the names of which are familiar to most of us, from reading "Tom Brown at Oxford," and other books. A pleasant and unexpected instance was meeting Dr. Wm. Osler, whom we supposed to be in America. We called at his house to leave our cards, but had no idea that he was in the city, and we were delighted to meet him on the street a few minutes later. He was most cordial and gave us an insight into Oxford life that we could not have obtained otherwise. A very pleasant recollection indeed is that of the delightful afternoon and evening spent with him and his family.

RANDOLPH WINSLOW.

Dr. Richard Caldwell Hume, class of 1906, has been promoted from fourth assistant to third at the Petersburg Virginia State Hospital.

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BALTIMORE, MD., JANUARY 15, 1907.

EDITORIAL

ALUMNI REUNION.—Elsewhere in the BULLETIN will be found a notice of a meeting of the alumni of all the departments of the University of Maryland to be held in Germania Maennerchor Hall, in this city, on January 22, at 8 o'clock P. M. The committee in charge of this reunion has offered a most attractive program and it is earnestly hoped that the attendance will be large and corresponding in enthusiasm. The object of the meeting, as stated by the committee, is "to acquaint the alumni with the plans now being formed for the centennial celebration of the University of Maryland, to be held in this city, May 30 to June 2, 1907, inclusive, and to invite their co-operation."

The object here stated is one which the BULLETIN hopes will appeal to every alumnus of the University. This centennial celebration is of vital importance to the University. It commemorates an event in which every alumnus and every citizen in Maryland should take pride. After one hundred years of continuous work in the cause of education, the old University reaches the present generation crowned with dignity and honor. The record she has made in the past is one which should commend her to the respect, veneration and confidence of the public. The centennial will be a great historic occasion, during which the past achievements of the University will be brought to the notice of the present generation. It will be a great home-coming and house-warming, a revival of old friendships and associations, a love feast, we trust, for the large body of children this old mother has given birth to and trained for professional work.

Every alumnus of the University with a spark of pride and gratitude in his heart should feel that it is his alma mater who is gathering her children around her at this her golden wedding and that she claims their love and loyalty upon this occasion if upon no other. There are many reasons why this centennial celebration should be made a notable occasion. The past history and work of the University should commend her to respect, but her record, as creditable as it has been during the first one hundred years of her life, is not the chief interest which should engage the attention of her many friends. The past speaks for itself. It is the future university which rises up before her friends and admirers. What shall we do for this venerable State university during the years to come? Shall we permit her to drag along by easy steps and with modest ambition, occupying only a mediocre position among state universities, or will her friends come to her rescue and insist upon greater activity and larger development in her educational possibilities?

The centennial year presents a most favorable opportunity for an inventory taking and general balancing of accounts. Measuring the future by the past, the University must come into possession of larger assets than her present holdings in respectability and honorable achievements. Her policy in the past may have measured up to the conditions which surrounded her, but with the mighty forces around her today new conditions are presented and must be met. Institutions must either make rapid progress or go behind. There is no intermediate ground. The University cannot assert her proper position in this State as a State University unless she adopts methods and brings to her support those influences which are so necessary to the development of a great educational plant.

It is hoped that the alumni and friends of the university will take these suggestions into consideration and that the centennial celebration will be made an occasion for the inauguration of a greater University of Maryland.

DIRECTORY OF LIVING ALUMNI.—The BULLETIN begins with the present issue the publication of a Directory of Living Alumni of the Medical Department of the University.

Beginning with the States in alphabetical order, the name, residence and date of graduation of each alumnus is given.

This list of names has been prepared with great difficulty and it may contain many inaccuracies, as men are constantly changing their places of residence, but it is offered with the view of correcting the record which is now in the possession of the BULLETIN.

It is earnestly hoped that omission of names, improper addresses or other errors will be corrected by those who are in a position to know them. If these corrections are made by the alumni, the BULLETIN will take notice of them and will then be in position to make a complete directory, showing from time to time changes in location, deaths and other matters of interest connected with each alumnus.

It is hoped that every alumnus will lend a helping hand in this very important work.

NOTICE TO ALUMNI.

The committee in charge of the re-union of the alumni of all departments of the University of Maryland request the publication of the following letter:

BALTIMORE, MD., *December* 21, 1906.

Fellow Alumnus:—The Mass-Meeting Committee of the Alumni of the University of Maryland extend to you a cordial invitation to join them at the Germania Maennerchor Hall, 410 West Lombard street, Baltimore, Md., on Tuesday, January 22, 1907, at 8 P. M.

The object of the meeting is to acquaint the alumni with the plans now being formed for the centennial celebration of the University of Maryland, to be held in this city May 30 to June 2, 1907 inclusive, and to invite their hearty co-operation.

Choice music will be rendered and prominent representative speakers from each department of the university will address the audience.

The buildings and laboratories on the grounds, corner Lombard and Greene streets, will be open for inspection on Tuesday, January 22, 1907, from 3 to 6 P. M.

A prompt answer is solicited; this is essential in order that your committee may be enabled to make proper provision for the collation, smoker and general re-union that will follow the addresses.

A ticket admitting to the collation will be mailed to all alumni who return an affirmative answer to this invitation.

Yours fraternally,

H. H. BIEDLER, A. M., M. D., *Chairman.*
G. LANE TANEYHILL, A. M., M. D.,
CHARLES E. SADTLER, A. M., M. D.,
Medical Department.
OREGON MILTON DENNIS, LL. B.,
Law Department.
CHARLES CASPARI, JR., Phar. D.,
Pharmaceutical Dept.
C. V. MATTHEWS, D. D. S.,
Dental Department.
THOMAS FELL, A. M., LL. D.,
Academic Department.
Committee.

NOTES AND ITEMS.

Dr. R. C. Carnal, class of 1905, is located at Rhemes, South Carolina.

Dr. A. B. Clarke, class of 1906, has located at Choppee, South Carolina.

Dr. Norman S. Dudley, class of 1900, who was recently operated on at the University Hospital, has returned to his home.

Dr. R. P. Bay, class of 1905, acting superintendent during Dr. Shipley's absence has been granted a short vacation.

Mr. A. E. Landers, class of 1907, medical, has been appointed student representative upon the joint centennial committee.

Dr. J. Ford Thompson, class of 1857, who has been so ill in England, has so far regained his health as to be able to return home.

Dr. William H. Baltzell, class of 1889, has opened his residence, 807 St. Paul street, Baltimore, after two years absence abroad.

Dr. C. C. Peters, class of 1906, writes to the BULLETIN that he has lately located at Beckley, West Virginia, and is much pleased with the location.

Dr. Gordon Wilson, Associate Professor of Clinical Medicine, has returned to Baltimore after an absence of six months spent in Europe.

For the first time in its history the four departments of the University of Medicine, Law, Dentistry and Pharmacy, will be graduated together.

Through the efforts of Mrs. Dr. J. C. Hemmeter and her brother, Mr. Chas. G. Hilgenberg, a

modern incubator has been presented to the obstetric department of the university.

Dr. George Wells, class of 1867, has been reelected chief of the medical staff of the Annapolis Emergency Hospital.

Drs. T. A. Ashby and St. Clair Spruill of our faculty were chosen consulting surgeons.

Mrs. Fannie Greenwald has announced the engagement of her daughter, Hortense, to Dr. Irving J. Spear, class of 1900, and one of the most active workers among the younger members of the adjunct faculty.

Dr. O. O. Howard, class of 1906, has resigned his position as resident physician at the King's Daughters' Hospital, Portsmouth, Va., and Dr. R. E. Dees, of the same class, has been appointed his successor.

At the regular meeting of the Daughters of Zion, in the early part of December, Dr. Joseph E. Gichner, Clinical Professor of Medicine, delivered a lecture on "Hygienic Aspect of Jewish Laws and Customs."

At a meeting of the Baltimore County Medical Society, held at Catonsville November 14, Dr. W. T. Watson, class of 1891, read a paper on "Infection of the Innocent." Dr. James H. Jarrett, class of 1852, presided.

Dr. W. H. Mayhew, class of 1901, Baltimore, whilst passing along Greene street, Baltimore, was painfully, though not seriously injured, by a brick falling from a building, striking him on his head and lacerating his scalp.

Dr. Leonce J. Kosminsky, class of 1906, writes to the BULLETIN that he has successfully passed both the Texas and Arkansas State Boards, and has located in Texarkana. So far, he says, he has done as well as he could expect.

During the meeting of the Southern Gynecological and Surgical Association, held in Baltimore, during the early part of December, Professor Randolph Winslow read a paper on the "Diseases and Injuries of the Hyoid Bone."

Thursday, December 27, the convalescent patients in the University Hospital were entertained by the lady board of managers. After a musical program, arranged by Mrs. Dr. Samuel C. Chew, was rendered, refreshments were served.

Mayor Timanus has announced the appointment of Professor R. Dorsey Coale, Dean of the Medical Department of the University of Maryland, on the Sydenham Hospital Commission, organized for the purpose of building a hospital for infectious diseases, vice Dr. I. E. Atkinson, deceased.

Dr. Louis Limauro, class of 1906, has successfully passed the Connecticut State Board and has located at New Haven. Dr. Clarence Winfield Stansfield, also of the class of 1906, made the New Hampshire State Board and has located at Dover.

Mr. A. G. J. Gabel, class of 1907, has been compelled to discontinue his medical studies for the present owing to ocular disturbances. The BULLETIN extends its deepest sympathies to Mr. Gable and hopes his health will permit him in the near future to resume his course.

Dr. J. W. Gerber, class 1904, is practicing with marked success at Bridgeport, Conn. He is anxious, however, to perfect himself in hospital work and is now seeking a hospital appointment. Dr. Gerber passed the Connecticut State Board, standing second in a class of twenty.

Mr. J. L. Anderson, class of 1908, has gotten up a centennial calendar, containing cuts of the university buildings and the 1906 football squad which he is disposing of at fifty cents. Anyone desiring a cheap, as well as serviceable souvenir of the occasion, cannot do better than to secure one of these neatly arranged calendars.

During the middle of December Dr. Charles W. Mitchell, Professor of Therapeutics and the Diseases of Children in the University of Maryland, delivered an address before the members of the Citizens' Improvement Association of Northeast Baltimore, at St. Andrew's Hall, corner of Chester and Preston streets, Baltimore, Md.

Dr. Arnold D. Tuttle, class of 1906, recently of the Post Hospital, Fort McHenry, Baltimore, Md., has accepted a position as resident physician in Saint Luke's Hospital, Jacksonville, Fla., and left for his new position during the early part of December. The BULLETIN wishes Dr. Tuttle all the success imaginable in his new work.

Dr. Wm. H. Smith, class of 1900, and formerly an assistant resident surgeon and physician at the University Hospital, as well as for several years superintendent of Bay View Hospital and the Hebrew Hospital, after an absence of eighteen months, has returned from a visit to the clinics of Germany, Austria, Switzerland and France.

At the last regular meeting of the University of Maryland Medical Association, held in the Ampitheatre of the University Hospital, December 18, 1906, the following papers were read: 1. Profes-

sor Wertheim's Clinic and His Work, Dr. J. Mason Hundley; 2. Dysuria, Dr. Page Edmunds; 3. Report of Six Cases of Diabetes in Children, Dr. Chas. W. McElfresh.

The following officers of the Washington County Medical Society were elected November 8, 1906, to serve for the ensuing year: Dr. Edwin M. Schindel, class of 1883, of Hagerstown, president; Dr. H. K. Derr, class of 1881, treasurer, and Dr. J. Walker Humrichouse, class of 1873, delegate to the Maryland Society. The last two also reside in Hagerstown.

Dr. Arthur M. Shipley, class of 1902, Associate Professor of Surgery and Superintendent of the University Hospital, after an absence of four months, visiting the clinics of Europe, has returned to Baltimore and resumed charge of the hospital. The greater part of Dr. Shipley's leave was spent at Strasburg, Germany, but he also traveled through Switzerland, France, England and Scotland.

The centennial committee of the University of Maryland, December 13, 1906, reported, through its chairman on banquet and halls, Dr. G. Lane Taneyhill, that the academic functions will be held in the Lyric on the morning of Friday, May 31, 1907, and that the banquet will be held in Lehmann's Hall in the evening. Bishop Wilson will preach the centennial sermon Sunday, June 2, at the Mount Vernon Place Methodist Episcopal Church.

Word has been received of the serious illness of Dr. J. Ford Thompson, class of 1857, of Washington, in London, England. He was operated on in London, November 12, 1906, for abscess of the stomach, and according to the latest reports is still seriously ill. Dr. Thompson is a native of Maryland, having been born in St. Mary's county, in March, 1837. He achieved distinction as an army surgeon during the Civil War. From 1865 to 1875 he was lecturer on anatomy in the Columbian, now the George Washington, University Medical School, and from 1875 until a year ago, when he went abroad for his health, was professor of surgery.

Dr. John S. Fulton, class of 1881, Professor of State Medicine in the University, and secretary of the Maryland State Board of Health, has returned from a Mexican trip, during which he attended the convention of the All-American Public Health Association in the city of Mexico. Dr. Fulton speaks of Mexico city as a splendid place, with sewerage and water systems better than those of Baltimore. Dr. Fulton sailed from New York for Vera Cruz on November 23, and did not reach Baltimore until December 22, 1906. The delegates to the convention represented every section of the Western Hemisphre, and health conditions in all countries of the two Americas were considered.

The first number of volume three of *Old Maryland* is out. This journal is a meritorious undertaking and should be heartily supported by the student body. The following highly complimentary editorial is taken from the November 10 number of the *St. Louis Medical Review*. "*Old Maryland*, a monthly journal, devoted to the interests of the University of Maryland, surely deserves adequate support at the hands of the alumni of that ancient university. It is edited by Dr. Eugene F. Cordell, honorary professor of the history of medicine at the University and curator of the medical library. Dr. Cordell is well known as a medical scholar, who has written most interesting papers on (among other things) 'The Importance of the Study of the History of Medicine,' and 'Doctors of Horace,' as well as a scholarly volume on 'The Medical Annals of Maryland, 1799, to 1899.' Dr. Cordell's 'Recollections of Slave Days and War Times,' now running serially through *Old Maryland*, are full of interest. We earnestly trust that the support for which Dr. Cordell appeals to old Maryland alumni will not fall on deaf ears."

At a meeting, November 19, 1906, of the representatives of St. John's College and the University of Maryland, held in Governor Warfield's office, a mutual basis of agreement for their amalgamation was adopted and referred back to the governing boards of the various institutions concerned. As finally adopted, the provisions are as follows: That the merger shall last for five years; that the combined institutions shall be governed by a council of eight, two from St. John's College, two from the Law School of the University of Maryland, two from the Medical, and one each from the Pharmaceutical and Dental Departments; that Governor Warfield and his successors shall be ex-officio head of the combined executive department of the combined institutions, with the title of chancellor; that Mr. Bernard Carter, Provost of the University of Maryland, shall be pro-chancellor, and that Dr. Thomas Fell, President of St. John's College shall be the

first vice-chancellor, and the actual executive head of the merged institutions. The financial affairs of the various corporated bodies included in the merger for the time being and under the present agreement are to remain separate. Notice of the alliance is to be published in the catalogues and St. John's College is to be known as the Department of Arts and Sciences of the University of Maryland.

MARRIAGES.

Dr. W. W. Sawyer, class of 1903, of Shiloh, North Carolina, was married November 28, 1906, at Elizabeth City, North Carolina, to Miss Margaret Williams, of Elizabeth City.

Dr. Howard Osborn, class of 1877, of Ripon, W. Va., was married November 10, 1906, at Charlestown, West Virginia, to Mrs. Lilly Singleton, daughter of the late General Singleton, of Illinois.

Dr. Oliver Victor James, one of the most popular members of the class of 1906, and a former house-student, was married December 5, 1906, at Laurel, Delaware, to Miss Verda Ernestine West, daughter of Mr. and Mrs. William J. West.

Dr. Leonard J. Turlington, class of 1892, of 120 East Fort avenue, Baltimore, Maryland, was married December 23, 1906, to Miss Carry V. Tuttle, of Washington, District of Columbia, at the residence of Rev. L. M. Zimmerman, pastor of Christ English Lutheran Church, 421 Hanover street. Dr. and Mrs. Turlington spent a brief honeymoon in Virginia.

Dr. Herbert D. Walker, class of 1902, a former assistant resident physician in the University Hospital, was married November 21, 1906, at Elizabeth City, N. C., to Miss Augusta R. Kramer, of the same city. Drs. B. B. Ranson of Maplewood, N. J., was the best man, and S. R. Donohoe of Norfolk, Va., one of the ushers. Both were classmates of the groom. Dr. Walker spent his honeymoon in the North. Baltimore was included in the itinerary, at which place the doctor received a warm and hearty welcome.

DEATHS.

In the death of Mr. A. J. G. Gable, of Savannah, Ga., the class of 1907 has lost a most popular student, and the medical department of the University a meritorious and conscientious student. Those whose knew the departed were shocked to hear of his untimely death, on Monday, December 10, 1906. Although it was known that Mr. Gable was in poor health for several months past, his death was more or less sudden. As a student he was hard-working and painstaking, and as an instance of his devotion to duty, although his sight was fast failing, he faithfully performed his duties in the surgical department of the dispensary until two weeks before his death. The BULLETIN extends to the bereft parents its heartfelt sympathy.

Dr. E. Oliver Belt, class of 1886, and his two sons, Edward M., and St. Clair, were killed Sunday, December 30, 1906, in the terrible B. & O. Railroad disaster at Terra Cotta, District of Columbia. In the death of Dr. Belt the University of Maryland has lost an ardent and sympathetic supporter, and Washington one of the most prominent and beloved members of the medical fraternity. Dr. Belt was the son of John Lloyd and Sarah Eleanor McGill Belt, and was a grandson of Alfred Belt of Virginia. He was born in Frederick county, Maryland, May 19, 1861, and attended the public schools of Montgomery and Frederick counties and Frederick College. He studied medicine at the University of Maryland, from the medical department of which he was graduated with the class of 1886. For a short period after graduation he practiced medicine in Frederick county, but soon relinquished it to accept a residency in the Presbyterian Eye, Ear and Throat Hospital, Baltimore. In October, 1889, he removed to Washington, where he has since practiced his specialty with marked success. He was Professor of Otology and Opthalmology at Howard University, surgeon to the Episcopal Ear, Eye and Throat Hospital of Washington, surgeon to the Baltimore and Ohio Railroad, etc. Dr. Belt married Miss Emily Walker Norvell, May 18, 1889, who with a son, Norvell, survive. Dr. Alfred M. Belt, of 1031 Cathedral street, Baltimore, is a brother of the deceased. The BULLETIN extends to Mrs. Belt in the hour of her affliction its sincerest sympathy.

Dr. Edwin K. Foreman, class of 1862, a surgeon in the army during the Civil War, and one of the most prominent practitioners of Adams county, Pennsylvania, was found dead in his buggy, near Two Taverns, December 10, 1906, aged 72. Dr. Foreman resided at Littlestown.

DIRECTORY OF LIVING ALUMNI OF MEDICAL DEPARTMENT OF THE UNIVERSITY OF MARYLAND.

ALABAMA.

Coulbourn, Jos. T., Birmingham, class 1886.
Carter, Stephen S., Sweet Water, class 1897.
Heflin, H. T., Birmingham, class 1895.
Floyd, W. G., Roanoke, class 1878.
Jackson, Robert D., Birmingham, class 1872
Jones, D. D., Woodlawn, class 1872.
Woodson, L. G. M., Birmingham, class 1887

ARIZONA.

Lacy, John H., Solomonsville, class 1879.
Robinson, Lewis B., Bisbee, class 1886.

ARKANSAS.

Greenway, G. C., Hot Springs.
Hudson, George W., Camden, class 1875.
Harr, Harry T., Fort Smith, class 1892.
Homer, J. S., Hot Springs.
McKenzie, A. H., Dardanelle, class 1872.
Savin, Thos. L., Pine Bluff, class 1897.
Wooten, W. C., Hot Springs; class 1903.

CALIFORNIA.

Bell, Henry B., San Francisco, class 1879.
Carroll, J. Gideon, Los Angeles, class 1872.
Day, Edward W., Vacaville, class 1853.
Groton, Wm. D., Rivera, class 1879.
LeDoux, J. A., Los Angeles, class 1884.
Reamer, Howard C., Danville, class 1885.
Smith, Benj. M., Gardena, class 1888.
Smith, W. Gray, Oakland, class 1880.
Stansbury, Oscar, Chico, class 1873.

COLORADO.

Ray, Joseph C. L., Denver, class 1888.
Robinson, W. K., Goldfield, class 1893.
Sedwick, W. A., Denver, class 1893.

CONNECTICUT.

Baker, Frederick B., East Norwalk, class 1884.
Casey, W. B., Warwick, class 1906.
Reeks, T. Eben, New Britain, class 1901.

DELAWARE.

Butler, John B., Newark, class 1877.
Beck, C. Anthony, Wilmington, class 1900.
Fowler, Edward, Laurel, class 1858.
Gain, A. T., Frankfort.
Gray, Oliver J., Wilmington, class 1902.
Jones, W. T., Gumboro, class 1895.
Lynch, S. H., Laurel, class 1906.
Lewis, Dorsey W., Middletown, class 1906.
O'Day, E. Frank, Little Creek, class 1891.
Skinner, W. T., Glasgow, class 1870.
Waples, Joseph B., Georgetown, class 1868.

DISTRICT OF COLUMBIA.

Bowen, W. Sinclair, Washington, class 1888.
Bromwell, Josiah R., Washington, class 1871.
Carrico, Albert J., Washington, class 1896.
Coblentz, Horace B., Washington, class 1896.
Cook, G. Wythe, Washington, class 1869.
Dulaney, Joshua L., Washington, class 1868.
Gardner, Jos. N., Washington, class 1889.
Hurtt, Harry, Washington, class 1895.
Hyatt, Franck, Washington, class 1872.
Hollifield, Horatio B., Washington, class 1882.
Keech, Thos. A. R., Washington, class 1856.
Mason, Robert F., Washington, class 1895.
Morris, G. G., Washington, class 1884.
Mullins, John B., Washington, class 1887.
Pence, Chas. W., Washington, class 1894.
Parsons, Alfred V., Takoma Park, class 1889.
Robins, William L., Washington, class 1890.
Shands, A. R., Washington, class 1884.
Stone, Charles G., Washington, class 1892.
Stone, Isaac S., Washington, class 1872.
Thompson, J. Ford, Washington, class 1857.
Whiting, Guy F., Washington, class 1878.
Valentine, A. W., Washington.
Logie, Benjamin R., St. Elizabeth, class 1890.

FLORIDA.

Bond, Benjamin J., Tallahassee, class 1904.
Brevard, E. M., Tallahassee, class 1894.
Brown, G. W., Lawtey, class 1889.
Bartlett, A. L., Tampa, class 1904.
Bartlett, C. W., Tampa, class 1893.
Chowning, W. C., Hawthorn.
Heggie, Norman M., Jacksonville, class 1902.
Izlar, A. L., Ocala, class 1889.
Hoover, Franklin P., Jacksonville, class 1884.
Julian, Abner J. P., Lake City, class 1883.
Jefferson, Rollin, Tampa, class 1903.
Love, James D., Jacksonville, class 1897.
Love, C. W., Lakeland, class 1902.
Munroe, Thos. F., Quincy, class 1868.
Moor, F. Clinton, Tallahassee, class 1903.
Mosher, Hugh, White Springs, class 1890.
McGinniss, R. H., Jacksonville, class 1897.
Nixon, James W., Chulnota, class 1883.
Puleston, Samuel, Sanford, class 1902.
Palmer, Henry E., Tallahassee, class 1892.
Rawlings, J. E. Dayton.
Sedwick, W. A., Tampa, class 1903.
Terry, Chas. E., Jacksonville, class 1903.
Wass, Fred J., Fernandina, class 1905.
Young, Calvin T., Tampa, class 1900.

GEORGIA.

Ainsworth, Harry, Thomasville, class 1901.
Barrow, Craig, Savannah, class 1900.
Ballenger, Edgar G., Atlanta, class 1901.
Carter, Wm. J., Atlanta, class 1898.
Chestnut, Samuel J., Bainbridge, class 1892.
Comas, Philip H., Baxley, class 1882.
Chapman, Wm. A., Cedartown, class 1887.
Cooper, Chas. F., Pitts, class 1897.
Chisolm, Julian F., Savannah, class 1900.
Davis, Marion T., Barnesville, class 1892.
Dorminy, Edwin J., Fitzgerald, class 1890.
Franklin, Virgil E., Graymount, class 1896.
Funkhouser, Wm. L., Rome, class 1904.
Gaulden, Samuel S., Quitman, class 1886.
Glidden, E. W. Jr., Savannah.
Howkins, John S., Savannah, class 1897.
Hicks, Charles, Doublin, class 1877.
McDuffie, J. H., Columbus, class 1887.
Malone, J. D., Marietta, class 1884.
McRae, Charles D., Rochelle, class 1889.
Oliveros, Bartolo P., Savannah, class 1883.
Phillips, S., Latimer, Savannah, class 1885.
Pate, Reuling H., Unadilla, class 1898.
Rogers, Oscar L., Sandersville, class 1897.
Rudolph, H. L., Gainesville, class 1903.
Spengler, N. L., Donalsonville, class 1903.
Thomas, Marion R., Savannah, class 1902.
Van Marter, James G., Savannah, class 1900.
Walker, J. B., Dublin, class 1890.
Wright, Jefferson D., Louisville, class 1882.
Wrighton, A., Savannah.
Winchester, W. R., Macon, class 1874.
Zellers, William, Holliday, class 1882.

ILLINOIS.

Ames, John G., Chicago, class 1880.
Patton, D. H. R., Chicago, class 1895.
Pennington, J. Rawson, Chicago, class 1887.
Sallinger, David, Chicago, class 1894.
Young, G. B., Chicago, class 1887.

INDIAN TERRITORY.

Griffith, Alfred, South McAlester, class 1866.

INDIANA.

Bower, George, Fort Wayne, class 1887.
Johnson, T. B., Wareland, class 1906.
Mayo, Wm. R., Indianapolis, class 1890.
Reed, John H., Logansport, class 1885.
Scholl, Chas. E., Camden, class 1873.
Thompson, Thos. J., Otterbein, class 1856.

IOWA.

Cleaver, J. Harvey, Council Bluffs, class 1880.
Sanders, Ralph W., Collins, class 1892.
Smouse, David W., Des Moines, class 1876.
Waddey, E. J., Watterloo.

KANSAS.

Billingslea, Chas. E., Fort Riley, class 1900.
Clayton, Jere B., Fort Leavenworth, class 1897.
Cockey, Melchor G., Junction City, class 1879.
Middlekauff, Jos. H., Hays, class 1879.
Norris, Stephen G., Ottawa, class 1854.
Phillips, Samuel, Leavenworth, class 1853.
Tobey, Nathan D., Salina, class 1863.
Whitefield, Robert J., Fort Scott, class 1893.

KENTUCKY.

Bales, Caleb J., Richmond, class 1878.
Trigg, Louise B., Lakeland, class 1901.

LOUISIANA.

Boylston, W. A., Coushatta, class 1871.
Hackett, R. G., New Orleans, class 1899.
Mumford, J. E., Pleasant Hill, class 1875.
Vance, Norman K., Shreveport, class 1882.

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REPORT OF THE MEETING OF THE ALUMNI OF THE UNIVERSITY OF MARYLAND.

HELD AT GERMANIA MAENNERCHOR HALL, BALTIMORE, TUESDAY EVENING, JANUARY 22, 1907.

The BULLETIN presents in the present issue as full a report of the Alumni meeting, held on January 22d, as it has been possible to prepare.

The meeting was attended by over four hundred Alumni, representing all of the departments of the University. It was the largest gathering of the Alumni upon any occasion within the history of the University, and in every respect the most enthusiastic and loyal.

The meeting was called to order by the president, Dr. Henry M. Wilson, of the class of 1850, who, after a brief address, introduced the chairman of the committee of arrangements, Dr. H. H. Biedler, of the class of 1876.

INTRODUCTORY REMARKS BY DR. H. H. BIEDLER.

Mr. President, Members of the Faculties and Fellow Alumni of the University of Maryland:

It affords me very great pleasure on behalf of the Mass-Meeting Committee of the Alumni of this great and grand University to welcome you here and to say that the Alumni of the University of Maryland residing in this city, and who have been spared to enjoy a part of two centuries, should not miss the opportunity of a general conference of the Alumni of all departments to determine in what way could we best show our love and appreciation of our Alma Mater; by honoring our University we honor ourselves and each and every one of us should pledge our best efforts tonight to the success of the Centennial which will take place May 30th to June 2d. The importance of University life and success has never attracted the citizens of this country to the extent that it does now. All over our land comes the cry: Onward and upward with universities; give them all the assistance you can—'in unity there is stength"—the Lord helps them who help themselves. The successful and charitable financiers of this country are giving their assistance to universities all over the world. Pray tell me why we should remain silent when we are the sons of such a meritorious and worthy Alma Mater?

Fellow Alumni, this is a day of fads and fancies, and I assure you it is by far the extreme height of the fashion to beg—let us be fashionable if nothing more. You must know that when a university has no wants it is almost, if not quite, moribund, and to this end I have already had pledged to the University the sum of five thousand dollars provided we raise one thousand tonight, so let us duplicate the amount already secured.

This thought with the wants of the University will be further elucidated by the eminent speakers who will follow me.

THE RENAISSANCE OF THE UNIVERSITY OF MARYLAND.

ADDRESS BY JOHN C. HEMMETER, M. D., PH. D., LL. D., PROFESSOR OF PHYSIOLOGY, ETC., UNIVERSITY OF MARYLAND, ON OCCASION OF THE MASS-MEETING OF THE ALUMNI OF ALL DEPARTMENTS ON JANUARY 22D, 1907.

"This day, January 22d, is a day of exceptional historic interest in medicine. On this day in 1720 Lancisi, a physician to the Pope and renowned for meritorious work in anatomy and pathology of the heart, died. He was the teacher of Morgagni, the actual founder of pathologic anatomy as an independent science (1682-1771.) On this day, 1851, Carl Franc Naegele, a Professor of Obstetrics in Heildelberg, an author of an excellen

text-book on obstetrics, died. On this day, 1901, the great American surgeon, Lewis Albert Sayre, professor and one of the founders of Bellevue Hospital Medical College, died, at the age of 81 years. He was the inventor of a plaster of Paris corset for scoliosis, and contributed largely to medical literature of his day. On this day, in 1902, Professor Hugo Wilhelm Von Ziemssen, the celebrated German clinician, Professor of the University of Munich, died. He was the editor of Ziemssen's Encyclopedia of Medicine. On the 22d of January, 1561, Lord Francis Bacon, the celebrated English philosopher and statesman, was born, author of the renowned work entitled, "Novum Organon." He was the originator of the inductive method of investigation, and brought about a reform of philosophy as well as of natural sciences, which caused also a great uprising in the objective investigations in atl natural sciences, especially in physiology, and prepared the way for Harvey. On this day, John Frederick Blumenbach, Professor in Göttingen, died. He was the founder of the science of anthropology.

"To Lord Bacon is attributed the saying, 'A little knowledge is a dangerous thing; drink deep or not at all of the pierian spring.'

"This adage is diagonally opposed to the wisdom of Heraclitus, who in his sixteenth aphorism πολυμαθίη νοον ἔχειν οὐ διδάσκει, meaning 'much learning does not teach one to have understanding.

"But if we were to seek a well adapted sentiment to serve as a guiding line for the teaching of our University, we could not select a better one than the well known Kantian expression which Boas makes use of on the title page of his excellent work on the diseases of the intestines, namely, 'Nec Infra Nec Ultra Scire'—'not to know too little and not to know too much.'

"I was to speak to you this evening on the 'Foreshadowings of Our Centennial,' and in my mind's eye I can see the gathering of a greater host of Alumni to celebrate the second centennial a hundred years hence. I can see the president of a world-renowned University of Maryland step out at the head of an academic procession, from a magnificent marble building, fronted with great white columns, and he will confront the cheering throng of the University's sons on a wide and beautiful green campus, adorned with classical statuary and monuments to the by-gone great teachers of the institution. And he shall refer to the hundred years which expire in May next as the 'Lombard Street epoch,' when all the buildings and institutions of the University were confined to that street, where now, he will continue to say, 'no trace of the former buildings is left; they have all been replaced by factories and stores, and on that street there was a hall belonging to a German musical society in which over 400 of the Alumni of the University of Maryland gathered on the 22d day of January, 1907, just one hundred years ago. At that time our University had really only two faculties —the Faculties of Law and the Faculties of Medicine—for the departments of pharmacy and dentistry were parts of the Faculty of Physics. Our University had then just effected its union with the ancient St. John's College, of Annapolis, whose beginnings really date back to King William's College, the old Colonial school on State House Hill, at Annapolis, which, in 1696, was the first free public school in America. In 1784, this became St. John's College.

"'Now on that evening of January 22d, 1907, this St. John's College was again united with the University of Maryland in Baltimore, the two becoming one institution; and so,' he will continue to say, 'we are in 2007, not celebrating simply the two hundredth anniversary, but if we take into account the glorious history of St. John's College and our former union with it, we are in reality celebrating our three hundredth anniversary.

"'But the first real and earnest efforts to make a genuine university date from the final reunion of St. John's and the University of Maryland in January, 1907.'" So much of prophecy.

Fellow Alumni, here assembled this evening, keep your eyes fixed on this prophetic vision and do all in your power to realize this dream. From the school of medicine should develop in the next few years, a faculty of natural philosophy, bestowing the degree of Master of Arts and Doctor of Philosophy for combination studies in the natural sciences, in general biology, physiology, botany, physics, chemistry, psychology. From the Faculty of Law should develop a department of political economics. From the academic department, St. John's College, should develop a school of philosophy, ethics, logic, philology, mathematics and so on.

"The problem of the feasibility of having a Faculty of Theology should be taken up. There is a great deal to be learned by discussion on this subject. I can divine that we will reach the result that such a faculty, properly constituted, might be of advantage to the University of Maryland, especially as there is no faculty of divinity associated with any of the great universities of the East embracing all academic departments. Most of the universities that are denominational so far have not attained to complete departments in medicine and the natural sciences.

"According to Socrates, a great many of our difficulties in life as well as in the fate and management of institutions, are due to errors of conception. Some of the difficulties of the University of Maryland in the past have been due to the fact and error in conception that the managing faculties did not understand what was meant by the term 'University of Maryland.' Similarly as Louis XIV, when asked a definition of the State, said, 'L'Etat C'est Moi.' So the faculties of the University of Maryland were apt to think, if they did not say it, 'The University, that's ourselves;' and a great many times, I am sorry to say, they acted on that basis; and this is one of the reasons, perhaps the principal reason, why the University of Maryland is no farther advanced in endowment at the present day. If the faculties had not always worked 'Pour Moi,' but had worked on the broad basis, always looking for the foundation of an endowment, grapling and cementing their Alumni to the heart of the University with hoops of steel, there would have been more to show in the way of endowment at the present day. But there has been a splendid awakening of altruism in the present faculty, and the foundation of a solid endowment is highly probable as well as the organization of an independent board of trustees. This Centennial is our great opportunity to increase our endowment, an opportunity which we should not fail to make use of.

Ingalls said of opportunity:

"Master of human destinies am I;
Fame, love and fortune on my footsteps wait;
Cities and fields I walk; I penetrate
Deserts and seas remote, and passing by
Hovel and mart and palace, soon or late
I knock unbidden once at every gate.
If sleeping, wake, if feasting, rise before
I turn away; it is the hour of fate
And those who follow me reach every state
Mortals desire, and conquer every foe
Save death; while those who doubt or hesitate
See me in vain, and uselessly implore;
I answer not, and I return no more."

"Perhaps the most important question affecting the future, not only of science in the limited sense, but of learning of all kinds in this country, is that of the proper relation of faculties of the universities to the trustees. That the question has come into prominence at the present time is due to the fact that, since in business the tendency is towards greater concentration of power in a few hands, so, if we regard education as a business, the control of all educational questions should be in the hands of a few trustees. In the universities, however, there is the purely financial question of the management of the funds, and the question of education considered from the intellectual side; and the two questions are not only essentially different in their nature, but also the training necessary for a business man is not the same as that necessary for one who is to be an educator and a scholar. To the trustee belongs the management of the finances, and it is preposterous to entrust purely business matters to a numerous body like the teaching faculty, even were they not unfitted for such work by their lack of training. To the faculty belong the practical work of education and to the advancement of learning by research. The difficulty at the present time is that when it comes to questions of general educational policy to be pursued there is an increasing tendency on the part of the trustees to assume that it is their business, and not that of the faculty. Practically the board which controls the expenditure of money can, if it wishes, shape the policy without regard to the opinion of others. Whether it is better for education and learning that they should do so is another matter. Probably a large portion of the educated public is of the opinion that the faculty is better qualified than the trustees to decide educational questions, both theoretical and practical, and they would certainly agree in thinking that no educational policy should be adopted without the concurrence of the faculty."

"In answer to the assertion that the trustees cannot manage the finances any better than the present faculties, it can be argued:

"I.—That the present management of the University of Maryland is considered unsatisfactory

by all our alumni (almost unanimously) and even by some of the faculty itself. Every emeritus professor, as soon as he withdraws from the active faculty advocates trustees. The work of teaching in the didactic, laboratory and clinical courses, as well as the responsibility of management in certain work of the hospital is more than sufficient for the teachers. They should be spared the administrative and financial management.

"II.—There may be considered three spheres of action or duties, for a regent in the Faculty of Medicine:

"1—Teaching.

"2—Finance.

"3—Administration.

"By administrative work I mean the duties in attending to the grounds and buildings and contracting for new work and repairs. The employment of officers, clerks, janitors, typewriters, getting up the catalogue and lecture schedule, etc., etc.

"III.—The didactic and clinical discipline is defective because the teachers are overworked in some departments and the medical faculty, for instance, has to consume so much of its time at its regular meetings by financial and administrative work, that the didactic discipline cannot be considered with that earnestness and zeal it requires. **The entire medical discipline needs reformation** There should be a logical graded course of medical discipline. There must be selective courses offered to medical students. 'Concentration, sequence and election are the fruitful principals in the best modern medical education.' (W. T. Porter. Preface to his laboratory text-book of physiology.)

"In 1898 the Committee of Medical Education, appointed by the Harvard Faculty of Medicine, reported in favor of the 'concentration' system urged in the committee by Dr. W. T. Porter in common with Professor W. T. Councilman, an alumnus of the University of Maryland. By this method, the first half-year in the Medical School is devoted to anatomy and histology, the second half-year to physiology and biologocal chemistry, the third half-year to pathology and bacteriology, and the fourth, fifth and sixth half-years to practical medicine and surgery. Work under the new system began in the collegiate year 1899-1900. In 1904, largely through the influence of Professor Bowditch, the seventh and eighth half-years were made elective, each student choosing for himself the studies best suited to his needs.

"Concentration provides that the student shall not serve two masters, but shall study at one time only one principal subject, such as physiology or pathology, disciplines that do not yield readily to a divided mind. Sequence provides that a foundation shall be laid before the superstructure is attempted. Students now have an acquaintance with anatomy before they begin the study of physiology. Election, somewhat tardily intrusts to university men rarely less than twenty-five years of age a voice in the decision of their nearest affairs. The application of these principles to medical teaching has undoubtedly resulted in large savings of time and energy.

"The economy of force secured by concentration and sequence has been highly valuable, though not indispensable, in the new teaching of physiology introduced by Prof. W. T. Porter in February, 1900. The traditional teaching of physiology consists of lectures illustrated by occasional demonstrations and, in some instances, by experiments performed by the students themselves. The new method is fundamentally opposite. It consists of experiments and observations by the student himself. The didactic instruction, comprising lectures, written tests, recitations, conferences, and the writing and discussing of these, *follows* the student's experiments and considers them in relation to the work of other observers. In the old method, the stress is upon the didactic teaching. In the new there is no less didactic teaching, but stress is upon observation. The old method insensibly teaches men to rest upon authority, but now directs them to nature.

"IV.—By continuing in the function of administration of the various faculties they place themselves in a disadvantageous position before the public benefactors and legislators because they have to defend themselves against the allegation that they are managing the financial affairs of the University to their personal interest.

"V.—London, February 5, 1907, Mr. Rockefeller increased the resources of the General Education Board in New York by thirty-two million dollars. The interest of about thirty million dollars is distributed to universities of this coun-

try annually from the funds granted by Carnegie and Rockefeller. Participation in these benefits has been denied us, the University of Maryland, on the ground that it is simply a professional school managed by the faculties, not by trustees, and that it is not a real university. The solidity of this assertion is lost by our affiliation with St. John's College. At a recent meeting, the regents of the University have appointed the following committee for the purpose of submitting a plan for the acquisition of an endowment, as well as for a general systematization of all efforts in that direction that have hitherto been made by different committees, associations, regents, trustees and individuals. The University has a Board of Trustees, incorporated by act of the legislature of the state, as *Trustees of the Endowment Fund of the University of Maryland.* The functions of this board are almost exclusively administrative, but Professor Eugene F. Cordell, the secretary, must be credited with having made the most sustained efforts at increasing its funds. The new committee, appointed by the regents, for the organization of endowments consists of the following gentlemen: Representing the Department of Medicine, Prof. J. C. Hemmeter, chairman; Department of Law, Judge Henry Stockbridge; Department of Pharmacy, Prof. Charles Caspari; Department of Dentistry, Prof. Heatewole; Academic Department, St. John's College, Prof. Thomas Fell; University Hospital, Mr. H. Busick.

Removal of the University to a New Site.

"I would also urge the removal of the professional schools of the University of Maryland, together with the hospitals to some new location in the northwestern section of the city, where there is a more healthy, physical and moral environment, and for this purpose I would urge on the members of the medical and dental faculty, especially the younger members, the organization of a stock company, for the purpose of purchasing land in one of the northwestern sections which are not yet improved by buildings and the erection of modern medical and surgical wards, lecture halls, laboratories and a library and administrative building. This should be considered before any further funds are spent in the construction of new buildings at Greene and Lombard streets.

The present region is being encroached upon by factories more and more; the atmosphere is thick with smoke, the noise is intolerable to the many suffering individuals in the hospital, two important car lines cross immediately through the heart of the present site of the University and add to the general turmoil, dust, restlessness and confusion. It will still be needed in part as an emergency hospital should the University ever move. There is also an increasing demoralization of this neighborhood which is a very heavy factor in determining our desire for a removal, when we reflect the danger to the psychic health of our one thousand students. A very heavy responsibility rests on the regents concerning this latter question. They cannot escape dealing with it by any make-shift or evasive expediency. The erection of a students' dormitory on the northwest corner of Greene and Lombard streets will to a large extent prevent this demoralization.

"The idea once conceived and verified, that great and noble ends are to be achieved, by which the condition of the whole university shall be permanently bettered, by bringing into exercise a sufficient quantity of sober thoughts, and by a proper adaptation of means, is of itself sufficient to set us earnestly on reflecting what ends are truly great and noble, either in themselves or as conducive to others of a still loftier character; because we are not now as heretofore, hopeless of attaining them. It is not now equally harmless and insignificant whether we are right or wrong, since we are no longer supinely and helplessly carried down the stream of events, but feel ourselves capable of buffeting at least with its waves and perhaps of riding triumphantly over them; for why should we despair that reason that has enabled us to subdue all nature to our purposes, should (if permitted and assisted by the providence of God) achieve a far more difficult conquest and ultimately find some means of enabling the collective wisdom of our faculties to bear down those obstacles which individual short-sightedness, selfishness and passion oppose to all improvements, and by which the highest hopes are continually blighted, and the fairest prospects marred. So that from this Renaissance of the University of Maryland, there shall develop a University such as there can be no doubt whatever what was in the minds of the organizers who formulated the plan and charter of the University one hundred years ago; namely, a *University for the People, of the People, and by the People* of Maryland.

"May this truth spread abroad with its all-absorbing power, cementing the links of our various faculties, uniting the interests of the various

schools, until our university shall rise to a standard of perfection, destined by Divine Providence."

THE CHAIR OF MEDICINE IN THE UNIVERSITY OF MARYLAND.

AN ADDRESS DELIVERED BEFORE THE ALUMNI OF THE UNIVERSITY, JANUARY 22, 1907, BY SAMUEL C. CHEW, M. D.,

Professor of the Practice of Medicine.

The subject of the "School of Medicine," in the University of Maryland, having been assigned to me for consideration at this meeting, I think it best not to attempt the story of everything relating to the school which that term might imply, but to confine myself to some reminiscences and traditions connected with the chair of Practice of Medicine, which I have myself occupied for many years.

At the foundation of the school one hundred years ago the first physician appointed to the chair of Practice was Dr. George Brown, who was born in Ireland in the year 1755, and who in 1779 obtained his medical degree at the University of Edinburgh, which was then, as it has continued to be, a famous seat of medical learning, largely through the great reputation of the Monros, who were known successively as Primus, Secundus and Tertius, and who were followed by other teachers of distinguished ability down to John Hughes Bennett and George Balfour of our own day.

In 1783 Dr. Brown emigrated to Baltimore, where he attained great success as a practitioner, and where he was appointed to the chair of medicine in this school at its foundation in 1807, and was president of its Board of Regents until 1812.

Dr. Brown was the grandfather of the late George William Brown, Chief Judge of the Supreme Bench of this city, and at one time an instructor in the School of Law in our University, and he was the great-grand-father of my friend Arthur George Brown, one of the most prominent members of the bar of Baltimore at present, whose hereditary connection by this two-fold tie with the University of Maryland is, I am sure, a source of gratification to others of his friends who are here tonight as well as to myself.

Dr. Brown, though appointed to the chair of Practice, did not enter upon its duties, but resigned the position almost immediately and was succeeded in it by Dr. Nathaniel Potter, who was thus the first actual or active incumbent of the chair, which he filled from 1807 to 1843, the year of his death. I have no personal recollection of him, but there are two things which, when I follow Prospero's counsel and look into "the dark backward and abysm of time," are among the very earliest engraven upon the tablet of my memory. One is the solemn tolling of bells which, on inquiring what it meant, I was informed, being then a little child, was for the death of the first President Harrison, who died, it will be remembered, just one month after his inauguration. The other record upon the tablet is that of someone at my home, I know not whom, uttering the words, 'Dr. Potter is dead.' These two events of the long past have no connection with each other, except the fact that each is the record of the termination of a life.

Although, as stated, I have no remembrance of having ever seen Professor Potter, his face is yet very familiar to me, as it is to others here present, from the portrait of him which for many years has hung in the Faculty room of the School of Medicine. The attitude in which he is represented in the picture is that of a scholar holding in his hand a volume, which was one of his own works, 'Potter on Contagion,' as is shown in the picture. Now it is most interesting to see that in that book, a copy of which is in our library and which was probably the author's favorite among his writings, he maintains the non-contagious character of Yellow Fever, a disease with which he was very famliar, for it had prevailed in Baltimore more than once during his professional life. It is especially interesting to find that in support of his opinion he brought forward the same kind of evidence which was adduced by the United States Army Yellow Fever Commission, as given in their report in 1901; the evidence being the application of handerchiefs and other fomites which had been kept in contact with yellow fever patients, to others not laboring under the disease, with the result that it was not communicated to them. And thus he anticipated what has of late years been fully established by the labors of Dr. Walter Reed, Dr. James Carroll, Dr. Aristides Agramonte and that noble martyr to science and to humanity, Dr. Jesse W. Lazear, a name to be

spoken with reverence, for it is haloed with a martyr's crown.

This anticipation of the truth is, I think, a most interesting fact in the history of this School and of Medicine.

The next incumbent of the chair of Practice was Dr. Elisha Bartlett, of Massachusetts, who was elected to it early in 1844, and who had had experience as a teacher of medicine in several schools, the last of which was the Transylvania University, in which he resigned his position to accept the call to Baltimore. Of him I have a faint, shadowy recollection. I can recall, and yet but dimly, his tall form and his strikingly intellectual countenance. He was a medical philosopher of admirable reasoning powers and high attainments. His treatise on the 'Fevers of the United States,' first published in 1842, should be in the library of every medical scholar, for it entitles him to a place among those great workers who were engaged in differentiating from each other the various forms of febrile disease, a place with Louis of Paris, and Sir William Jenner, of London, and Gerhard of Philadelphia, and James Jackson, Jr., of Boston.

Professor Bartlett's philosophical works are also of great value, his 'Philosophy of Medical Science,' published in 1844, and his 'Inquiry into the Degree of Certainty in Medicine," in 1848.

It was said by Dr. Oliver Wendell Holmes that Bartlett's 'Medical Philosophy' is as remarkable for elegance of style as for liberal and genial spirit and philosophic breadth of view. One passage I can recall as having impressed itself upon my youthful memory and imagination long years ago. The author is drawing a contrast between the various forms of charlatanry, which from time to time seek to rival medical science on the one hand, and legitimate, scientific medicine on the other. He likens them respectively to two kinds of illumination; in the one there is a noise, a rush, a burst into a myriad of coruscations which are soon extinguished, leaving behind them an obscuring cloud of smoke, which parts and is scattered, and, these are his words: "Courage, my friends, look up, and there looking down upon us with their dear old smile of affectionate recognition, undimmed in their brightness and unchanged in their loveliness, the ever-watchful stars." Their light represents scientific medicine.

In 1846 Professor Bartlett, in failing health, resigned his chair and was succeeded in it by Dr. William Power, a native of this city, who had taken his degree of A. B. at Yale in 1832, and of M. D. at this school in 1835, and he was thus the first alumnus of the school to occupy the chair of Practice in it. After his graduation here, he pursued his medical studies in Paris, under that brilliant corps of teachers consisting of Louis, Andrae, Grisolle, Barth and the great pathologist Cruveilheir. Of these, some had passed away when I was myself studying in Paris, twenty-five years later; but Grisolle and Barth, then old men, were still giving valuable and effective instruction, and Cruveilhier, having retired from his chair, could be seen, setting an example of devotion, on his way every morning to the services of his church.

When Dr. Power returned to Baltimore in 1840 he was known as a proficient in auscultatory diagnosis in which he had been well trained by Louis, and he was among the first to practice and teach that art and science here.

The story is told that once when a resident of Baltimore, suffering from some trouble of the chest, went to Paris to consult Louis, he was asked by that eminent physician from what part of America he came, and when he answered "from Baltimore," "Why, then," said Louis, "do you come all the way to Paris to consult me when you have William Power in Baltimore." Such was the impression which the pupil had made upon the teacher. I have a clear recollection of Professor Power, although his connection with this University ceased before I began the study of medicine. I can recall his intellectual face, "sicklied o'er with the pale cast of thought," and with that malady, pulmonary tuberculosis, to which he fell a victim when still comparatively young in his professional life, for he was only in his thirty-ninth year when he died. It is worthy of note that one who was so active in promoting the study and practice of ausculation, should have died of the same disease and nearly at the same age as Laennec, the great medical philosopher and discoverer, as he might be called, of auscultatory diagnosis As a teacher, Professor Power was a strenuous and faithful worker, admired and honored by his students, and when laboring under the distressing conditions of his malady, constant dyspnœa and recurring hemorrhages, he still continued to meet his classes and to impart instruction until in 1852 he was compelled to abandon the unequal con-

test and to resign his chair; his death occurring on the 15th of August in that year.

And here let me depart for a moment from the chronological order to pay a brief tribute to one who was allied by affinity to Professor Power, and was taught by him: I refer to that most accomplished physician and most admirable man, Charles Frick, who, though he never occupied the chair of Practice in this school, was engaged in clinical teaching here and would certainly have acceded to the chair had his life been prolonged. For he was skilful and instructive as a clinician, and if I may modify a classic phrase, *"omnium consensu capax docendi."* He was my friend as well as my teacher, and to this day, though nearly forty-seven years have passed since his death, the lessons of professional learning which I derived from him recur to my mind. The way in which Professor Frick's life ended from devotion to a suffering fellow creature in the lowest walk in life is well known to many here, and it illustrates those words which were uttered by the divinest lips. "Greater love hath no man than this, that a man lay down his life for his friends.

When the chair of Practice became vacant in 1852, by the death of Professor Power, one was appointed to the place in regard to whom it is not for me to offer any words or any thoughts of my own. But how can I omit entirely from the category which I have been surveying one who gave the best years of his life and the richest stores of his learning and experience to the service and welfare of this school, and who, as my most faithful guide and as my wisest counselor was by me honored and beloved. For many years there had been a close and cordial friendship and affection between him to whom I refer and Professor Nathan Ryno Smith, that prince among the surgeons of his day, who had known many men in many places and of various attainments and characters. When this friendship was sundered by death, Professor Smith said to me, "Among all whom I have known in my whole life, I have never known a wiser or a better man than your father." I add no words of my own, but I trust that I do not violate proper feeling in presenting to you a sentiment which was uttered by him before an assemblage in which, as in the one before me tonight, there were many members of the medical profession.

There are other paths which lead more certainly to distinctions, honors and affluence than does medicine. There are other professions which may be more exempt from cares and disappointments. But where shall we find pursuits more favorable than ours to the development and improvement of the best faculties of our intellectual and moral nature? Where shall we find an occupation for the few and fleeting years of life more conducive to progress in wisdom and virtue? To grow old engaged in the acquisition of knowledge was the wish of the wisest of the ancients. The sentiment is purified and elevated by referring it to just and adequate motive. To grow old in the study of science for the purpose of doing good to mankind is a de-elevated by referring it to a just and adequate mobest and holiest of men."

Next in succession to the chair came one in 1864 who was well known to many here present, and known only to be honored and esteemed. I refer, as you know, to Professor Richard McSherry, who brought to the duties of his post an excellent training of mind and the fruits of large opportunities for observation in civil and military practice, for he had held the position of surgeon in both branches of the public service. His lectures were accurate in thought, scholarly in their structure and always fraught with valuable lessons which were deeply impressed upon his students.

At his death in 1885, one was called to his place who can say only this, that none can be more conscious than he is himself of the imperfections and deficiences in the way in which the duties of that place have been performed, but as the time draws near at which the chair will again become vacant, a time which cannot be long deferred, he asks that he may be allowed to plead simply this, that he has striven to do his duty.

DEPARTMENT OF LAW.

Hon. John Prentiss Poe, speaking for the Faculty of Law, said:

"When an institution of learning organized under the laws of a small State has done its work worthily and well for a hundred years in the face of fierce competition of rich and powerful rivals, with but scanty resources and few and small contributions from the public purse, the men who in the centennial of its foundation find themselves charged with the duty and responsibility of lead-

ing it on its high career of usefulness and distinction have a right to exult in the steady progress of its triumphant march and to tell without reserve the inspiring story of its honor and renown.

"They may well invite to its venerable halls from far and near the alumni whom year after year it equipped so completely for the race of life, to rejoice with them in the excellence and power of their professional career and to receive their hearty felicitations that their Alma Mater still strides along the majestic tread in the front rank of her noble competitors.

"While thus pausing to commend in glowing words the splendid record of the learned and accomplished men who during all these long years spread unceasingly throughout the length and breadth of the land the name and fame of the University of Maryland, attracting to its teaching hundreds and thousands of students from distant sections of the country, and in asserting with emphatic earnestness our claim to continued encouragement and support there need be no fear of our overstepping the modesty which invariably accompanies real and distinguished merit.

"Just pride in the work and worth of a long line of eminent predecessors is a high and commendable feeling, for it is at once an ever pressing stimulus to progressive improvement and a constant safeguard against degeneration.

"Without it no university's future is secure, while under its inspiring influences there are scarcely any limits to the field of gratifying achievements.

"The proprieties of the occasion forbid any detailed or extended eulogium upon the master minds under whose leadership the work of which we are so justly proud has been done.

"But an institution which calling the roll of its dead Provosts for nearly a hundred years, finds that roll illumined by the names of such men as United States Senator Robert Smith, Bishop James Kemp, Chief Justice Roger B. Taney, Dr. Ashton Alexander, John P. Kennedy and Severn Teackle Wallis, and which now has at its head so eminent a lawyer as Bernard Carter, need not shrink from comparison with the strongest in the land.

"A Faculty of Physic, which since its organization in 1807, has been invariably composed of the most honored and accomplished leaders in their day and generation of their profession from the days of Alexander McDowell, John B. Davidge, Nathaniel Potter, Elisha DeButts, Samuel Baker and Granville Sharp Pattison down to Samuel Chew, Nathan Ryno Smith and Charles Frick may well and truly claim to have been always equal to the very best anywhere.

"And where will you find a stronger array of renowned lawyers of the past than in our Faculty of Law. Headed by the illustrious William Pinckney and followed by such men as Robert Goodloe Harper, David Hoffman, John Purviance, Nicholas Brice, Nathaniel Williams, Roger B. Taney, Upton S. Heath, Wilken Frick, Charles F. Mayer, Jonathan Meredith, Hugh Davey Evans, Robert M. Martin, Alexander H. Handy, John A. Inglis, George W. Dobbin, John H. B. Latrobe and George William Brown.

"We of the law faculty of today, mourning the loss of Judge Albert Ritchie, Judge Thomas S. Baer, Col. Charles Marshall and Major Thomas W. Hall, and deploring the recent resignations of Judge Charles E. Phelps, who worked with us for 21 years with unwearied diligence and marked success, and of our genial friend, Major Richard M. Venable, who, as the Atlas of our faculty, encouraged and strengthened us for 32 years, feel that we may esteem it a high honor to stand in the places of such distinguished predecessors and to have enjoyed the cherished association of such masterful colleagues in our labor. And alumni of the University we point to you as the most conclusive proof of excellence and strength.

"We welcome you with pride and grateful appreciation to this imposing gathering.

"Doctors of Medicine, Masters and Bachelors of Arts, Bachelors of Law, we extend to you the gladsome greeting of valued friends.

"Your presence here assures us that you still cherish warm memories of your university life, that you still recognize your obligations to your Alma Mater, that you heartily rejoice in our coming Centennial celebration and that you will act as generously in strengthening and enlarging every department of the University.

"You look around you and see that the present Faculty of Physic is aglow with inspiring enthusiasm, stimulated and encouraged by the examples of their great predecessors, recalling with pride grateful memories of their honored teachers, Christopher Johnston, Francis Donaldson, Francis T. Miles, William E. A. Aikin, Alan P. Smith, Julian J. Chisolm, George W. Milten-

berger and rejoicing that William T. Howard is yet spared to witness and commend their zeal, capacity and success, are still vigorously engaged in giving to their students the full benefit of the most advanced thought and attainment in every branch of medical science.

"Representing here tonight the Law Department, with which I have been actively connected since its reorganization in 1869, it is not for me to say how well our faculty has measured up to expectations and acquitted ourselves of the heavy task committed to our charge, nor to pronounce eulogistic judgment upon our work.

"But at least I may mention the significant facts that starting in 1870 with three professors and a class varying from three to seven students, we have now twelve professors and on our roll two hundred and fifty students, and have also the gratification of knowing that from amongst the fourteen hundred who in these thirty-six years have received diplomas, are found today many of the most distinguished leaders of our bar and some of the most honored members of our bench.

"Rather will I speak of the peculiar debt which the University owes to our Medical Department.

"To it is pre-eminently due the well-earned reputation which the University has enjoyed from the beginning. Its professors, with scarcely an exception, have always been conspicuous for their skill, learning and accomplishments, and in filling vacancies in its faculty special care seems to have been habitually taken to secure the men best qualified to maintain and increase its established reputation.

The Law Department, under its first great professor, David Hoffman, who was one of the most learned among Maryland's great lawyers, does not seem to have been favored by the attendance of very many students.

"In those days university education for the profession of law was not at all the fashion.

"Young men who wished to become lawyers read law, as it was called, in the office of some practicing lawyer, and at the expiration of the prescribed period of two years, were usually admitted to the bar almost as a matter of course, after the most perfunctory examination, upon the motion of the gentleman under whose real or ostensible guidance they had gone through their course of reading.

"It is not surprising, therefore, that the work of the Law School languished, and finally ceased altogether for a season when its highly cultured professor departed this life.

"Two of its alumni, the later George W. Dobbin and the late Isaac Nevett Steele, whose distinguished merits need no eulogium before a Baltimore audience, sufficiently attests the high character of the instruction given by Professor Hoffman to his classes, while his published course of study demonstrates that it must have been of unusual thoroughness.

"The school of the arts and sciences, for years known under the familiar name of Baltimore College, kept steadily on with excellent success and most valuable results for many years, but with the college buildings on Mulberry street in opening Cathedral street it ceased to exist.

"Recently a satisfactory arrangement has been made with St. John's College, one of the very oldest of American colleges, by which this ancient and vigorous institution is to come in and fill the place of the temporarily suspended School of Arts and Sciences in our University organization. From this auspicious restoration and union the most gratifying results are confidently expected.

"The University thus strengthened and enlarged is now shaking its wings for a higher and wider flight than ever before. Its coming Centennial will bring prominently before our people the record of its great achievements, a clear understanding of its present full development, and a distinct declaration of its hopes, expectations and purposes for the year to come as a veritable State University, complete in all its parts, with its schools of medicine, law and the arts and sciences thoroughly equipped.

"For the carrying on of this large work to full fruition, we feel sure that we shall receive the generous encouragement and support, not only of our thousands of living alumni, but also the active sympathy and assistance of Marylanders everywhere. That hearty sympathy and assistance we now earnestly ask for.

"The history of our State is rich in inspiring memories and achievements. She has done much for the cause of public education, but our people should feel, and we believe they do feel, a lofty sense of obligation to maintain within our own borders a Maryland State University for the most thorough and complete education of our sons in

every branch of academic, scientific and professional learning.

"We wish to arouse and intensify this feeling; so that as its rich fruit we may speedily witness a great invigoration, a great expansion and a great increase of her hold upon the heart and mind of the people of the State.

"We expect by our Centennial celebration to kindle more and more the glowing flame of State pride and enthusiasm, and to secure for our venerable and honored University a solid and substantial endowment that will abundantly enable her to go forward with ever-increasing power in her noble, beneficent and blessed career."

THE DENTAL DEPARTMENT.

BY FERDINAND J. S. GORGAS, M. D., D. D. S.,

Professor of the Principles of Dental Science, Dental Surgery and Dental Mechanism.

"The history of the Dental Department of the University of Maryland properly begins with the recognition of dentistry as a specialty of medicine by the American Medical Association, the formation in that body of a section of dental surgery and the establishment of dental departments in prominent universities. Harvard, to its honor be it said, was the first to organize a dental department in 1868, followed by the University of Michigan in 1875; the University of Pennsylvania in 1878, and the University of Maryland in 1882. Soon after, the University of Minnesota, the Northwestern and a number of others added dental schools to their departments. At the present time more than twenty universities have established such departments.

"The origin of dentistry must have been contemporaneous with the origin of civilization. Among the earliest records of probable authenticity regarding the appreciation of the utility and importance of the teeth, are perhaps the Scriptures. Jacob in blessing his sons, said of Judah: 'His eyes shall be red with wine and his teeth white with milk,' from which we must infer that the patriarch appreciated the beauty and cleanliness of the mouth. According to Biblical chronology this was in 1689, B. C.

While resting in security of God's protection, David said: "Thou hast broken the teeth of the ungodly;" the idea being that they were rendered harmless to do injury.

While no specific date can be obtained as to the origin of dentistry, we learn that it was practiced among the Egyptians at a very early period. Herodatus, 500 B. C., in writing of the travels through Egypt, at that time one of the greatest and most civilized countries in the world, alludes to the division of medicine in that kingdom into special branches and the existence of physicians, each of whom applies himself to one disease only and no more. Some are for the eyes, others for the head, others for the teeth and others for internal disorders. It is therefore probable that the Egyptians, and also the Etruscans were further advanced in the art of dentistry than any other people of that early period. Teeth filled with gold, found in the mouths of mummies, and also bridge and crown work in the skulls of others, indicate the advanced ideas of these early people, and also the fact that they supplied artificial substances in the mouth. As the Etruscans preceded the Romans in occupying what is now Italy, the antiquity of reparative dentistry is well established. I may also refer to Hippocrates, Aristotle and others, who, hundreds of years before Christ, wrote extensively about the teeth, also of Galen, who taught that the teeth were true bones.

From the time of Galen until Ambrose Paré in 1550 published his celebrated work on surgery, little was added to dental literature. In the eighteenth century about 150 essays and volumes were written upon the subject, as the results of the labors of such men as Hunter, Blake and others. During that century dentistry became a subject of more critical inquiry and thorough investigation than ever before. Men of intelligence and education devoted themselves to it exclusively, and as a result, its advancement in both literary and scientific directions, during the nineteenth century has been most marked.

The position of dentistry among the professions is an index to the progressive development of the times. No vocation has made more rapid advances and the most important of these have been made within the last quarter of a century.

The product of inventive and scientific minds is now enlisted in its interests and among its votaries men of broad culture, whose investigations have done much to illuminate the scientific world.

The province of the dentist today, is not circumscribed, for properly educated he is prepared to exercise the functions of an oral surgeon.

While mechanical skill is an indispensable requisite, yet a pre-requisite to his success is a knowledge that will enable him to treat successfully the various diseases to which the oral cavity is subject. Artificial substitutions in both surgery and dentistry have been gradually perfected through the ingenuity of man, until the part supplied has been made to serve the purpose of the lost member in a remarkably efficient manner. A high type of art has come into play and attention is directed to the concealment of artificiality. Surgery has made notable progress along this line, but dentistry has far outstripped it, probably because the need of it seems the greater.

While general surgery has been greatly aided in its beneficent designs by the assistance of anesthesia, antiseptic and scientific nursing, in all of which dentistry has shared the benefit. Our profession has developed principally along other lines, and while it is not within the province of surgery to prevent the accidents or diseases which call for the exercise of its skill, it is directly within the field of dentistry to arrest, by skilful mechanical means, the ravages of such diseases as attack the oral cavity.

Preventative medicine and its results can scarcely be overestimated or too highly praised, but it should not be forgotten that preventative dentistry has also made wonderful strides and is rapidly advancing day by day. The chief glory of dentistry lies not in the sacrifice of important organs, but in their convservation, thus adding to the health and comfort of the human race.

Experiment, investigation and tentative practice are exhibiting results in the way of prevention scarcely dreamed of even by our immediate predecessors. While it may be said that the field of dental operations is limited, yet we have reason to feel proud of the benefit it has conferred upon mankind and it is a pleasure to know that the skill and earnest efforts of its practitioners are appreciated by a grateful public.

It is of sufficient importance in the world's economy to attract to itself men and women, who give to it the best that their minds and hands are capable of. It came into existence in response to the cry for relief from pain. Its origin may have been lowly, but not more so than that of medicine. In fact all the arts and sciences had their foundations laid in a crude and imperfect manner. A lowly beginning has characterized many vocations that have in time grown into useful and aesthetic aids to the development and refinement of the human race. The subsequent progress of any occupation, and its influence upon the world's betterment, must be the measure of its value. A profession in its essence consists in accomplishing the end toward which special skill and special training is directed.

Dentistry was introduced into America during the period of our war for independence by an Englishman, John Woofendales, and a Frenchman, Joseph Lemaire. The former had been a student of the dentist to King George III. The latter was a surgeon in the French Army.

The first effort to establish a college of dentistry was made by Dr. Chapin A. Harris, assisted by Dr. Horace H. Hayden, the latter having delivered in 1837, in the University of Maryland, the first course of dental lectures in America. It was the object of Dr. Harris to organize a dental school in connection with the University of Maryland, but not being successful in convincing the faculty of the University of the usefulness of this project, he became the principal factor in instituting the Baltimore College of Dental Surgery in 1840, and through his untiring efforts and labors can be justly regarded as the founder of the system of dental education in this country.

In 1882 the legislature of Maryland chartered the Dental School as one of the departments of the University of Maryland. A summer session was first organized, which continued from May to October, when the first regular or winter session of 1882-1883 opened with a class of 60 matriculates. Its later classes have numbered several hundred. That the dental department of the University of Maryland has contributed to the advancement of the science of dentistry is beyond question, and is shown by the rank it occupies among the dental schools of the country.

We have reason to be proud of its alumni, who can be found in the faculties of dental schools, north, south, east and west, upon state dental examining boards, and in prominent positions in state societies.

THE DEPARTMENT OF ARTS AND SCIENCES.

By President Thomas Fell, *St. John's College.*

"It is suggested on the program that I should

speak about the department of arts and sciences as represented by St. John's College.

"In my mind's eye I go back to 1696—more than 200 years ago—and see the old Colonial school, King William's, on State House Hill, in Annapolis, which was the first free public school in America. I mentally review the many ancient men who were educated there and who gave honor and distinction to their State and country.

"A century elapses, and I reach the time when it was urged by the citizens of Annapolis, in 1784, that King William's School, although a classical institution, was inadequate to meet the educational demands of the age, and when the charter now possessed by St. John's was framed—a charter which designated the college as the Maryland University in embryo.

"Another quarter of a century goes by, and in 1807 a medical school was established in Baltimore, very largely due to the efforts and activities of graduates of St. John's College.

Five years later, in 1812, with this school as its base, there sprang, it may be said, from the seed sown by St. John's, a new University of Maryland, instituted by the State in the city of Baltimore, whose centennial is to be celebrated in May.

"It is needless to recount the honors and dignities won in the succeeding years by the sons of these segregated schools and colleges; suffice it to say that the list is one of which we have every reason to be proud, and that it extends throughout another century, until, in 1907, we find St. John's once more taking her position by her sons in Baltimore and adding to them the luster and prestige which she has been accumulating for a period of more than 200 years.

"When so constituted there are but two universities in America that can vie with the University of Maryland in seniority, in history and renown. It is a heritage of which the State of Maryland and this city of Baltimore should be proud.

"A university looked at externally is a thing of buildings, of libraries, of laboratories and lecture halls, of endowments and apparatus, but none of these things make a university. A university justifies itself in the present age just so far as it is a home of idealism. To promote this idea two factors are essential—unity and harmony.

"Faculties, students, plans must all be united, so that without rivalry or needless repetition all our forces may be combined to advance the projects in view.

"Nor should we rest contented with what has already been done. There should be many colleges grouped under the ægis of a true university, and it is not necessary for any member of the group to lose its individuality. We must have our school of technology, our school of music, our school of fine arts, and all these we have right here, under our hand in Baltimore.

"But a university is a good deal more than a federation of colleges. It is the exponent of the idea that beyond the work of any college is the work of all the colleges of the group. This is our dream. It is the picture of a river flowing through a thirsty plain. Up in the hills where the stream rises is the old schoolhouse. To give the spring to the river, the water to the world, the university to the state—that is the task which confronts us here—to place this University of Maryland upon a solid foundation in this grand old State of Maryland."

Dr. A. D. Atkinson has resigned as medical inspector of the public schools of Baltimore.

The following of our alumni succeeded in passing the recent examinations held by the Medical Examiners of Maryland: E. E. Adelsburger, class of 1901; Henry Blank, class of 1906; Alan G. Brooks, class of 1906; Irving D. Chaney, class of 1906; A. W. Disosway, class of 1905; D. St. T. Jenifer, class of 1904; J. G. Matthews, class of 1905; John A. Nice, class of 1905; Rastus R. Norris, class of 1904; Eugene F. Rapheal, class of 1906.

At a meeting of the Western Maryland Railroad surgeons in Hagerstown, January 22, 1907, Dr. Joseph T. Hering, class of 1885, was elected secretary-treasurer of the organization. Other of our alumni present were: Dr. Herbert Harlan, class of 1879, Baltimore; Dr. H. H. Woodford, class of 1882, Belington, West Virginia; Dr. W. Durbin Brown, class of 1894, Union Bridge; Dr. A. M. Fredlock, class of 1889, Elkins, West Virginia; Dr. Henry C. Foster, class of 1889, Clear Spring, Md.; Dr. H. K. Derr, class of 1881, Hagerstown, Md.

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EDITORIAL

THE BALTIMORE SUN ON THE UNIVERSITY OF MARYLAND.—The *Baltimore Sun* at all times loyal and just to the institutions of Maryland and to her people, has taken occasion a number of times to refer to the work of the University of Maryland during the life of this "ancient institution," in a most appreciative and encouraging way.

Referring in its issue of January 23d to the mass-meeting of the alumni, held the previous evening in Germania Maennerchor Hall, the *Sun* gives expression to the new spirit which should in the future dominate the policy of the University of Maryland. The BULLETIN cannot give expression to its own views in more forceful language than by quoting the clear and eloquent words taken from the *Sun*:

"The mass-meeting of the alumni of the University of Maryland in this city last evening is an expression of the new spirit of enterprise that now animates this ancient institution. It grows and proposes to continue to grow by absorbing and assimilating related educational agencies. It now embraces, besides the famous and most efficient medical department, a law department, a dental department, a pharmaceutical department and an academic department, all of which are vigorous and successful individually and capable of adding vigor to the central organization. The component schools of the University have at times in the past been connected by loose ties. There was little joint enterprise and co-operation. The increased strength to be derived from hearty union was inadequately appreciated. But the new movement, to which last night's gathering owes its impulse, means an awakening to the great possibilities to be attained individually and collectively by joint action. St. John's College, Annapolis, supplies admirably the needed academic college, thus rounding out and largely completing the University character of the institution. The recent ratification of the affiliation of St. John's College was, in fact, last night the topic of many congratulations. St. John's, like the University of Maryland, is an institution which may be proud of its history and its accession is an important event worth celebrating. Other accessions are said to be in consideration, the desire being to concentrate resources to meet the requirements of a modern university. In the educational as well as in the commercial and industrial fields, improved results can be obtained by substituting co-operation for competition. More important, however, than the actual results so far achieved are the spirit of co-operation and broadened purpose implied in the movement. They promise expansion. The spirit and the purpose are to obtain further expression in the centennial of the University of Maryland to be celebrated by its alumni May 30 to June 2, 1907. That celebration, by bringing the alumni together, will do much to develop and strengthen the desire for co-operation which will be beneficial to both the university and to its alumni. The greater the prestige of the former, the greater the estimation in which the latter will be held by the public. The advocates and promoters of union have reason to be gratified with the progress the movement has already made. Much has been done. But much hearty work remains yet to be done in order to realize the just expectations of the progressive members of the University."

THE MASS-MEETING OF THE ALUMNI OF THE UNIVERSITY OF MARYLAND.—For the first time in the history of the University of Maryland, so far as we have knowledge, the alumni of all the departments of the University met in a mass-meeting at Germania Hall, in this city, "to determine," in the language of the chairman of the committee of arrangements, Dr. H. H. Biedler, "in which way we could best show our love and appreciation of our Alma Mater."

Over four hundred alumni, representing all of the departments and St. John's College, at Annapolis, now the Department of Arts and Sciences, were assembled to honor the occasion

and to arouse an enthusiasm in the coming centennial celebration.

The addresses delivered by representatives of the different departments are published in full, with one or two exceptions, in the present issue of the BULLETIN, and will no doubt be read with interest by the alumni who were not able to hear them delivered.

The different speakers were permitted to treat their respective subjects from their own point of view, and the interests of the University, both past and future, were dealt with, both in the reminiscent and in a suggestive manner. We were told what the University had done in the past and we were told what the University should do in the future.

The Hon. John P. Poe, dean of the Department of Law, one of the most loyal and able friends of the University, voiced the sentiments of all present when he said, "our people should feel, and we believe they do feel, a lofty sense of obligation to maintain within our own borders a Maryland State University for the most thorough and complete education of our sons in every branch of academic, scientific and professional learning."

President Thomas Fell, of St. John's College, gave a practical suggestion looking to the future development of the University idea when he said, "Nor shall we rest contented with what has already been done. There should be many colleges grouped under the ægis of a true university, and it is not necessary for any member of the group to lose its individuality. We must have our school of technology, our school of music, our school of fine arts, and all these we have right here under our hand in Baltimore."

Dr. J. C. Hemmeter in his address on "The Renaissance of the University of Maryland," which the BULLETIN is privileged to publish in full, takes a forecast of the great work the University has before it and makes suggestions as to ways and means by which the great State University is made. Dr. Hemmeter's delightful optimism is just the spirit that should take hold of all who have the good of the University deep down in their hearts and while it may not be possible even within the next hundred years to see the University occupying "a magnificent marble building, fronted with great white columns on a wide and beautiful green campus," it is within reach to lay now a firm foundation for a great State educational institution in which every department of human learning will be taught in a manner to command the respect and pride of every citizen of Maryland.

To develop the present University of Maryland into a great State University the largest and most liberal views must prevail. Her faculties must see the practical as well as the theoretical side of educational work. Stable institutions are usually of slow growth, but they take deep root in public confidence only through their ability to adapt their work to the best uses and needs of the communities in which they live.

The hopes of the University must center around the wisdom and generous efforts of her governing bodies. She cannot rise higher than the selfishness, narrowness and indolence of those who direct her work. Big-brained, big-hearted working men make big institutions of learning as they make big progress in every form of human activity. In this age results only follow well ascertained causes. Mediocrity is the badge usually worn by the laggard and self-indulgent. The man who honors his calling, however humble, is a success. The man who pulls back or tears down where others build is an obstructionist. Institutions have no life apart from the men who direct their affairs, and they reflect the moods, whims and social characteristics of the individuals who either exert a passive, positive or negative influence. The combination is a success, failure or standstill in proportion as these influences are exercised.

Positive influences have dominated the policies of the University in the past, but these need to be quickened and broadened if the University is to assume a larger scope of usefulness in the future. The times are ripe for the "renaissance," but the new born infant will not thrive on traditions and memories of the past. A new vigor must be given to its growth through the artificial stimulus of vigorous exercise of all its essential organs, through the quickening of its functions, and through the unselfish devotion of those who safeguard its growth in its subsequent stages of development.

The centennial celebration was fairly foreshadowed by the mass-meeting here referred to. The enthusiasm, good humor and generous feelings developed by this meeting will long be remembered by those who were present. It was a great success and too much credit can not be

given to the committee of arrangements for the thorough way in which their work was done, and for the loyal service they rendered their Alma Mater and her children.

NOTES AND ITEMS.

Dr. W. D. Campbell, class of 1906, has located at Lonaconing, Md.

Dr. A. Ruiz Soler, class of 1906, has located at Patillas, Porto Rico.

Dr. C. W. Gardner, class of 1901, has located at Pittsfield, Massachusetts.

Dr. T. M. Chaney, Jr., class of 1906, is visiting friends in Asheville, North Carolina.

Dr. Cooper Drewry, class of 1902, has returned to Catonsville after a visit to his former home in Virginia.

Dr. P. J. Martin, class of 1900, of Baltimore, is convalescing at Atlantic City from an attack of pneumonia.

Dr. C. C. Billingslea, class of 1900, assistant surgeon, United States Army, is stationed at Fort Meyer, Virginia.

Dr. Edward F. Owens, class of 1904, has announced his candidacy for State Senator from Anne Arundel county.

Dr. Kivy Pearlstine, class of 1906, has been appointed resident physician to the Roper Hospital, Charleston, South Carolina.

Dr. Frank R. Smith, class of 1891, of Baltimore, has purchased an estate on the Severn river, which he intends making his country residence.

Dr. Daniel Jenifer, class of 1904, has been appointed one of the physicians of the South and Western Railroad Company, and has been assigned to duty at construction camp No. 5, situated near Marion, N. C.

Dr. Allen H. Wright, class of 1906, after passing the New York State Board of Medical Examiners in November, received an appointment as medical interne to the Willard State Hospital, at Willard, New York, and is now doing service in that hospital. Dr. Wright writes that he fully expects to attend the centennial celebration in June.

At the last regular meeting of the University of Maryland Medical Society, held in the ampitheatre of the University Hospital, January 15, 1907, the following papers were read: 1. Pancreatic Lithiasis, Dr. A. D. Atkinson; 2. The Present Status of Vaginal Cesarean Section, Dr. L. M. Allen; 3. Exhibition of Specimens, Dr. W. V. S. Levy.

DEATHS.

Dr. A. S. Baldwin, class of 1847, died Wednesday, January 9, 1907, in Long Green Valley, Maryland, of paralysis, in the 82d year of his age. Dr. Baldwin was born in Harford county, on July 4, 1825. He was graduated in 1844 from the Washington and Jefferson College, and in 1847 received his diploma from the medical department of the University of Maryland. After practicing in Baltimore for seven years, he migrated to Long Green Valley, where he remained in active practice until two years ago. He was twice married. His first wife was Miss Hyde, of Baltimore, and his widow was Miss Martha E. Street, daughter of Dr. Abraham Street, of Harford county. Dr. Baldwin was a public-spirited man and took a great interest in Democratic politics. He was active in building the Maryland and Pennsylvania Railroad.

Dr. Edward L. Strode, class of 1889, died suddenly at his home in Swan Pond, West Virginia, December 19, 1906, from heart disease, aged 46.

Dr. Abram J. Williams, class of 1886, a well-known physician of Calvert county, died Thursday evening, January 24, 1907, at his home near Prince Frederickstown, Maryland. Dr. Williams was 58 years of age and for many years was prominent in the affairs of the county. He was a member of the House of Delegates of 1898. Afterwards he was county health officer, and recently has been vaccine physician for the second district. He is survived by a widow, who was Miss Francis Robinson, daughter of the late George L. Robinson; a daughter, Miss Bertha Williams and two sons, Tiffany and Ralph Williams.

Dr. James H. Miles, class of 1845, died at his residence, near St. Mary's City, Saturday, January 26, 1907. Dr. Miles was in his eighty-fifth year, and was one of the best known and most popular physicians in Southern Maryland. He was a man of great force of character and retained his vigor of mind and body until a few days before his death. Dr. Miles was a school commissioner of St. Mary's county during Governor Smith's incumbency of office. Death was primarily due to an attack of grip.