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TREATMENT OF GONORRHOEA IN THE FEMALE.

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I. ATTITUDE TOWARD THE PATIENT.

The proper treatment of this disease is a study which should certainly be regarded by every thoughtful physician of such primal importance to the race in general as to merit his closest and most serious attention. I think I may say without fear of contradiction that no disease to which the flesh is heir deserves more consideration than this extremely common and much-neglected affection.

Not only does it maim and render miserable the living, but its influence on the generation to come is one of the most potent factors in so-called "race suicide". Gonorrhœa is by far the most important of the three socio-sexual diseases—the "bete noir" in the array of gynecological affections.

Murder is not unknown in association with it. It has wrecked innumerable homes, crowded divorce courts and filled plots in cemeteries. Much of this could have been avoided by the proper management of the disease in the hands of the general practitioner.

As in all other socio-sexual disorders, the utmost tact and diplomacy are requisite. If you have not these, turn to other fields; if you have, be forever on the qui vive.

In no other way can mortal man ever hope to unravel and keep apart the snarled and twisted threads of outraged decency, fear, anger and despair, concomitant with this social plague.

Be extremely careful in giving a diagnosis. Let microscopic verification of the clinical signs and symptoms be your sheet-anchor, and then—if ever you are to draw on the velvet gloves of discretion—the psychical moment has arrived.

It is my personal opinion that in many cases the protection of criminal males by the delusion or deception of their victims is a misapplied generosity, fraught with danger to the one who certainly has a right to expect sincerity—the patient herself.

We cannot avoid danger without a proper understanding of danger, nor can a woman properly appreciate the method of, or necessity for, co-operation in a disease of which she knows nothing.

Frankly, can we afford to practice deceit or deception? Can we afford to neglect the interests of one to whom sincerity may mean so much, to one who by every precept of ethics is as our patient entitled to it?

Unless through force of circumstances some other course is indicated, I think we are justified in calling a spade a spade.

It must be admitted that under certain conditions "silence is golden," but these conditions have, I'm sure, been grossly exaggerated.

We are too often inclined to look on broad questions of this character through individuals, and in this way draw our conclusions as to the proper mode of procedure in dealing with the conditions as a whole. For example, there may be every reason in the world for not enlightening Mrs. B. as to the exact nature of her illness, but it does not necessarily follow that Mrs. X. should not know just what the trouble is. It must be admitted that, as far as the peace and happiness of the husband is concerned, the first method is the one of election, but even here we may encounter a pitfall in the possible unfaithfulness of the wife. Despite the fact that chivalry would incline us to doubt the existence of this complication, we must for the time being submerge even our faith in woman if we are to successfully cope with the problem.

I think it impossible to conceive a more difficult or embarrassing question to ask a woman than one which touches on her virtue. He who would cast doubt upon the one attribute that a faithful wife prizes above all other things is certainly not lacking in courage. For, if he be

wrong, he will, indeed, have opened the floodgates of righteous wrath upon his unsuspecting head, and if he be right, the vials of unrighteous wrath are just as caustic, and with all his wisdom he will find it difficult to distinguish between the two. Again, should he question any woman as to her marital fidelity in association with some sexual ailment, I am inclined to suspect that any sensible woman would immediately suspect marital infidelity on the other side of the house. In this enlightened age the existence of venereal disease is at least known to most women who have reached maturity. Thus would the proverbial cat stroll forth in all its pristine blackness.

Whenever the disease occurs in unmarried women there is no question as to the propriety of speaking plainly, except in those rare instances where "mental inadaptability" (if I may term it such) acts as a contra-indication.

We can do nothing in the way of prophylaxis if the woman is not frankly informed as to the true condition, and made to realize that she owes to the race her co-operation in preventing the dissemination of this disease as far as it lies in her power.

I think, if talked to in a proper way, most women would be willing to forego mere physical pleasure if they could be made to appreciate the far-reaching harm born of sexual gratification under these circumstances.

Ignorance has been, and always will be, the keynote of failure in our efforts to limit the spread of gonorrhœa.

As to perfect prophylaxis in this regard, that is something beyond the wildest dreams of hope. There will always be sufficient moral degeneracy and human heartlessness in the world to effectually prevent the attainment of this ideal.

The unqualified statement that the disease is communicable is insufficient, and we have only done a tithe of our duty if we remain content with this.

The physician can do more by sincere effort along these lines than all the "anti-vice societies" in the world can ever accomplish through appeals to an indifferent and unheeding public.

I can see no reason for disregarding the best interests of the patient in an effort to save unfaithful and unprincipled husbands. We owe to them nothing other than contempt. Let those who dance "pay the fiddler," and pay no heed to the squeals of the moral coward who would have you shield him at the expense of one he promised to love, honor and protect.

Remember that it is distinctly to the patient's advantage in nearly all cases that she be cognizant of the true condition of affairs. The idea of sacrificing this advantage to maudlin sympathy for the transgressor is something so foreign to fairness and honesty that I can see no reason for its serious consideration. There are four principal reasons for a concealment of diagnosis:

1st. Those cases in which it is impossible to make an absolutely certain diagnosis. We can in these cases, if thought advisable, give our opinion as to the likelihood of the existence of gonorrhœa.

2d. In a certain number of cases it is the husband who consults the physician, through fear that he has infected his wife. If the physician detects the presence of gonorrhœa in the woman he is ethically bound to furnish information only to the husband. There can be no discussion on this point. The husband is in reality his client and to him he owes his first duty.

3d. Those cases occurring in melancholic, hysterical or poorly balanced women, who could only see everlasting ruin in conjunction with such a disease, who would be inclined to even exaggerate the seriousness of this most serious affection, who in time would possibly become hopeless neurasthenics.

We appreciate full well that in many cases gonorrhœa is essentially a chronic disease, sometimes, even with the most scientific treatment, requiring months and years for its eradication, and often persisting throughout life. Continuous mental unrest such as these unfortunates might experience would certainly militate against their final and complete recovery.

I think the course in these cases should be concealment of diagnosis. True, we run the chance of infection in the husband, should he not be the cause of the condition. Unfaithfulness in woman, however, is nominal in comparison with unfaithfulness in men, and the presumptive evidence is that the husband is at fault. I think in these cases we are justified in shouldering the risk on the man. If the husband should fall a victim, we may look for no charity on his part; the wife's little stroll in forbidden paths will have wrecked that home.

So, even in cases in which mental peculiarities in the woman would incline us toward conceal-

ment, there are those elements which almost convince us that the whole truth is best, after all. Some may say it should be possible either to get the woman to abstain from intercourse or have the husband use some prophylactic measure. Throughout the chronicity (a salient characteristic of this malady in woman) of a long-drawn-out illness, such a course is a practical impossibility, and would certainly in the end destroy conjugal felicity almost as effectually as detection.

4th. Those cases in which the husband is not guilty of intentional wrongdoing—occurring in newly-married people. The man having considered himself cured of a former attack of the disease, and incapable of transferring the malady to his wife. In many instances these men have had the assurance of their physicians as to the safety of marriage.

I think it would be decidedly unwise to inject into an otherwise happy household the seeds of destruction.

In these cases the husband is in most instances merely the victim of his past follies, and is in this time of disaster not only desirous of protecting his wife, but, as the author of her misfortune, is assailed with a thousand regrets and enough mental anguish to render him a candidate for our commiseration and help. We should, however, with the utmost diplomacy and tact, lay before the woman the gravity of her malady in an effort to enlist her services in securing a permanent cure of the disease.

If we do not lay sufficient stress upon the necessity for absolute subservience to our professional dictates, we will lay at our doors an army of half-treated, half-cured gonorrhœics, carrying in their minds no respect for or fear of the supposed "leucorrhœa," which troubles them not and is often thought of so little importance as not to merit the services of a physician.

Suppose the infection be limited to the cervix uteri (and this is often the case in chronic cases), and again suppose that for years, through ignorance, the woman has been harboring this "lion in the lambskin" of "just a little discharge." We know certainly that gonorrhœal endocervicitis is merely a relative cause of sterility. If this woman should become pregnant, she has during the puerperium an excellent chance of developing a uterine, tubal and peritoneal extension of the disease. This may cost her her life, and will certainly destroy her health, to say nothing of the danger of opthalmia neonatorum in the child. Can one conceive a sadder birthright than blindness? And yet the asylums are crowded with the results of uncured gonorrhœa in the mother. Uncured in the vast majority of cases because the woman had no conception of the true nature of the condition or the dire results of pregnancy in association with it. Therefore, I think we may safely conclude that, except under special circumstances, it is our duty to inform female gonorrhœics of the existence of gonorrhœa. It is also our duty to dilate as forcefully as lies in our power upon the complications and seriousness of the disease, and to endeavor with every means at hand to impress upon the patient the necessity for thorough and radical elimination of the infection.

In this way, and in this way only, can we elicit the co-operation of the woman throughout that period of chronicity, so often barren of actual suffering, and yet so fraught with hidden danger. We must deplore always the methods of the "medical alarmist," but we must not, on the other hand, be over-zealous in suppressing information (unpleasant though it may be) which is essential to the radical cure of the disease.

Better a few tears in the beginning than the extirpation of adnexa as a grand final.

Better a little wholesome fear and mental disquiet than blind children.

II. The Treatment—Medical and Surgical.

The method of attack, of course, depends, first, upon the location of the lesions to be combatted; second, the duration of the malady.

In the acute, early stages of the disease we must not only consider the elimination of the malady as it exists, but must endeavor by the use of the most active measures at our command to prevent its spread to uninfected portions of the genital tract.

By far the two most frequent primary lesions of the disease are urethritis and endocervicitis. Primary vaginitis or vulvitis are rare except in those cases which place at the disposal of the organism in these localities a soil suitable to its development. It is unfortunate that this "structural adaptability," if I may term it such is found in the class of cases in which gonorrhœa finds its most terrible expression as a socio-sexual malady—i. e., in recent virgins and pregnant women.

Let us consider first a typical case occurring in a subject in whom the elements essential to a virulent development of the disease exist.

Here we may expect to encounter, even during the early stages of the malady, urethritis, vulvitis, vaginitis and endocervicitis.

In not a few cases enough general systemic reaction is induced to bring to our minds the necessity for "rest." As in all other acute infectious diseases, "rest in bed," if possible, is to be looked upon as an important aid. While this is not absolutely essential in all cases, it is, if possible, certainly desirable.

Fever, if it exists (and there is rarely enough to cause discomfort unless some pelvic involvement is present), may be relieved by cold sponges.

The bowels should be kept freely open, preferably with some saline purgative, and a simple nutritious diet ordered. We endeavor in this way to aid "tissue resistance" and enlist in our behalf the natural resisting powers of the individual toward infection.

Certainly we find in "proper elimination," "rest" and "nutrition" the essential elements for accomplishment of this purpose.

Far more important, however, are the local measures directed toward the destruction of the disease by direct attack upon the offending organism. Cleanliness is of the greatest importance, and by this means alone we may hope to accomplish much for the comfort of the patient. The discharges in acute gonorrhœa are, as a rule, intensely irritating, and if left long in contact with vulvar folds or the adjacent skin surfaces, will produce excoriation and even local ulceration, with accompanying œdema, pain and pruritis.

The vulva should be thoroughly bathed several times a day, each cleansing being followed by the free use of some bland, non-irritating, drying powder such as boric acid or equal parts of bismuth subnitrate and calomel.

Urethritis.

Urethritis, which is an almost if not quite inevitable complication in acute attacks of the disease, is best combatted with daily or bi-daily injections of argyrol 10 per cent., protargol 1 per cent., or albargin 1-1,000. The silver salts have been found especially active as gonococcicides, as is evidenced by their general employment in gonorrhœa.

In making urethral injections we must be careful not to carry the syringe further back than the sphincter or we may unwittingly convey the infection to the bladder. An ordinary eye-dropper answers every purpose as a syringe in this connection, the slender tip being easily and painlessly introduced into the urethra.

Micturition just before the injection thoroughly cleanses the canal and allows the full force of the medicament to fall on the diseased mucosa, unhindered by the presence of secretions on which it might otherwise expend at least part of its activity. Hexamethyltetramine in five-grain doses four times a day will render the urine antiseptic to a certain extent and discourage vesical invasion by the organism.

Urethral applications by means of cotton-tipped applicators are not only very painful, but are liable, even in skilled hands, to abrade the mucosa.

Cystitis.

If cystitis already exists, or if despite our efforts it becomes a later complication, bi-daily vesical irrigations with hot saturated boric acid solution will be found of great benefit. In addition, after each irrigation we may leave in the bladder four or five ounces of a 1-500 solution of argyrol or a 1-2,000 solution of albargin As the disease subsides the interval between irrigations may be lengthened, but not until the urine is absolutely clear should they be discontinued.

Internally hexamethyltetramine, as in urethritis, antiseptisizes the urine. In particularly malignant cystitis—and fortunately this is rare—absolute rest of the bladder by cystotomy—preferably vaginal—may be necessitated.

In chronic cystitis, which does not respond kindly to treatment, we may suspect ulceration of the mucosa. In these cases inspection of the bladder with the Kelly-Pawlik cystoscope and the direct application to the ulcerated urea of 5 per cent. nitrate of silver solution will often give gratifying results.

Vulvitis.

Vulvitis is best managed by removal of the exciting cause—discharge—and we may accomplish this by cleanliness and the free use of dusting powders previously mentioned.

Vaginitis.

Vaginitis usually runs, even if untreated, a short course, the thick vaginal mucosa being especially active and especially capable in its own defense.

Our treatment in this locality should be vigorous, as it is a prolific source of discharge and ulceration is particularly prone to occur in conjunction with the pockets of pus confined between

the rugae. The vagina should be thoroughly cleansed with a mild solution of mercuric bichloride (1-10,000), followed by the application to every crevice and fold of some active gonococcicide such as argyrol 25 per cent, silver nitrate 5 per cent or albargin 1-500. If silver nitrate is used, two treatments a week will only be advisible, as it is often intensely irritating. Argyrol, by reason of its non-irritant qualities, may be used daily. We should also prescribe hot bi-daily vaginal douches of 1-3,000 potass, permanganas or 1-20,000 bichloride. We may hope by these methods to speedily cause an abatement of the malady in this locality.

In ordering vaginal douches we should see that they are properly taken, and there is but one proper method. Have the patient lie down with the hips elevated. In this position the intestines fall backward and the entire vagina is ballooned out by a large column of water. Taken in the sitting posture they are much less efficacious and often only partially accomplish the desired end.

Bartholinitis.

Bartholinitis, or inflammation of Bartholin's glands, may be aborted in its early stages by the use of 50 per cent. ung. Ichthyol and the continuous application of heat or cold. If suppuration has occurred, the abscess should be at once incised and the diseased gland either curetted away or dissected out. After treatment in no way differs from that of abscesses in other localities.

In chronic bartholinitis without suppuration injection of the gland with a 2 per cent. solution of argyrol introduced through the duct with a hypodermic syringe carrying a blunt-pointed needle is found of benefit. If the orifice of the duct is so small as to prevent the insertion of the syringe tip, the opening may be enlarged by a slight incision.

Endocervicitis.

Endocervicitis is a frequent complication of vulvo-vaginitis and is often the primary infection.

The spread of the disease is in quite a few cases stopped by the constriction of the canal at the internal os, and we have a true endocervicitis without endometritis. The discharge from the cervix is muco-purulent from the uterus sero-purulent, and we may often by carefully observing the character of the secretions form an opinion as to the extent of the infection. If the disease is limited to the cervical canal, it would be decidedly unwise to tamper with the uterine cavity, and we should be especially careful not to penetrate the internal os in the treatment of these cases.

There are several modes of treatment. The first to be tried is as follows:

Thoroughly cleanse the cervical canal of discharge with a cotton-tipped applicator soaked in alcohol. Dry the mucosa and apply 50 per cent. argyrol, 5 per cent. nitrate of silver or 10 per cent. protargol. This may be done two or three times a week, and one should not feel discouraged if the disease responds but slowly to his efforts at eradication. In the deep-seated cervical glands the gonococcus becomes so securely intrenched that only by the most persistent effort can we destroy the nidus of infection.

Oedema of the cervix is not uncommon, especially in acute endocervicitis, and calls for the use of boroglyceride tampons. These will be found more efficacious if we use a 10 per cent. solution of Ichthyol in boroglycerin.

Hot vaginal douches by inducing cervical hyperemia are of much value.

If the disease is very resistent we may, as an accessory measure, resort to curettage of the cervical canal, preferably with a small, sharp bone curette, then applying pure carbolic, followed by alcohol.

In especially resistent lesions (and we may expect to ecounter cases in which the patience both of the gynecologist and the patient will be sorely tried) stellate incisions (4-5) of the cervix, extending into the canal with the Paquelin cautery will often effect a cure. An extensive slough occurs, but we need not fear cervical stenosis if we exercise discretion as to the extent of the cauterization. If, despite all our efforts the disease persists, we may feel justified in using as a "dernier resort" the radical operation of cervical amputation.

I think it well at this point to consider those cases in which the disease is limited to the urethra and vulva, with possibly beginning involvement of the vaginal mucosa. Such cases are seen at times, and if we can prevent cervical infection we will save the woman a train of ills which may, and often do, render her miserable for the rest of her days—not only through the medium of chronic disease, but as a psychical catastrophe in the destruction of woman's crowning attribute and primal purpose of existence—maternity.

I know of no one thing so pitiful as the mental anguish which often accompanies the realization

that "motherhood" is ever to be an unfulfilled hope.

The natural tendency of the disease is to extend upward toward the cervix by continuity of mucosa, and, though the prevention of cervical infection may look comparatively easy from a theoretical standpoint, we will find it in actual practice extremely difficult.

First and foremost, these cases should be exclusively treated by the gynecologist himself. Any manipulation by the woman should not only be discouraged, but absolutely prohibited.

Douches should never be employed. They are of doubtful value when the lesions are confined to the external genitalia, and may be the means of spreading infection. Bi-daily tamponning of the upper vagina with cotton soaked in 20 per cent. argyrol is, I think, the best means of accomplishing the end in view—in conjunction, of course, with energetic treatment of the existing foci of infection. Each morning and evening the cervix is carefully exposed with a Sims' or bivalve speculum and the tampons applied closely and tightly in the vaginal vault and as far down as the vaginal outlet. With the most careful technic we cannot hope to avoid carrying back organisms with our instrument, but they are at least free on the mucosa and easily destroyed by the drug. This should be continued throughout the course of the disease, or, at least, until cervical involvement does occur—and it often will despite our most earnest and conscientious efforts.

Endometritis.

In the treatment of this condition we must be careful to differentiate between the acute and chronic varieties. In acute endometritis curettage has been recommended by some gynecologists, but it is to say the least a dangerous procedure not infrequently followed by rapid tubal invasion by the gonococcus.

More conservative methods will, I think, give happier results, and should certainly be given a thorough trial.

Hot vaginal douches by causing uterine hyperemia will enable that organ to more successfully cope with the ailment. The principle being the same as that of hot applications largely employed in treating inflammation in other localities. Nature, the wisest of physicians, sees fit to increase the blood supply in infected areas, and we rarely go wrong when we follow her lead.

Direct treatment of the uterine mucosa is best carried out in the following manner:

Cleanse the vagina scrupulously with green soap and bichloride and free the cervical canal of discharge. Next expose the external os. with a speculum, preferably Sims', introduce a return flow catheter into the uterine cavity and thoroughly irrigate with a 1-2,000 potass, permanganate or 1-20,000 bichloride solution. This should be followed by the thorough application of a 25 per cent. solution argyrol on a cotton-tipped applicator—an applicator always with a roughened end, or we may have the unpleasant diversion of removing separately the dislodged piece of cotton. I think I can say that at times the hunt for the proverbial haystack needle is child's-play by comparison.

Applications should be made daily to the eudometrium until the disease shows improvement, when the interval may be lengthened.

Chronic endometritis is best treated by thorough curettage and the application of pure carbolic acid, followed by alcohol.

We may, of course, be able to effect a cure by the methods employed in the management of the acute variety, but as a rule chronicity is associated with deep-seated involvement of the uterine glandular system, which places the organism beyond the reach of the superficial attack.

In all endometritis we must ever bear in mind the possibility of conjoint tubal inflammation lest we neglect the treatment of this, the most important of all gonorrhœal lesions in the female.

Salpingitis.

Acute salpingitis is usually accompanied almost from its inception by more or less pelvic peritonitis. Peritonitis induced by the gonococcus is as a rule not markedly violent, and fortunately the rich lymphatic supply of the pelvic peritoneum enables it to combat the invasion with unusual vigor and success. As a rule there is an adhesive peritonitis, causing effectual "walling off" of the focus by intestine and omentum. It is only in those cases harboring a particularly virulent organism that we encounter true extra-tubal pelvic abscesses.

In acute salpingitis rest in bed is essential. Opinion is divided as to the use of cathartics, but I am inclined to think that absolute intestinal quietude as far as possible is the better course, at least during the very acute stage of the malady.

Ice caps over the lower abdomen in conjunction with frequent copious hot vaginal douches will be found of the greatest value. Morphia in small doses may be used to relieve pain, and fever may

be controlled with ice water and alcohol sponges.

Abdominal section is to be absolutely condemned, except in exceptional cases. Experience has proven that in nearly every instance the disease will gradually abate, and we will be able to attack during a period of quiescence the finished product.

To abort the malady during the acute stage would in nearly every instance, if we resorted to operation, mean salpingectomy, as we find in the tubes the focus of infection. Incision and drainage of the tubes has, it is true, been tried, but it is certainly a procedure of doubtful value. Acute salpingitis is in some cases entirely recovered from, at least symptomatically. Less frequently, however, is the process so evanescent as not to cause sterility by inversion and sealing up of the fimbriated extremity.

Chronic pyo-salpingitis is usually beyond the reach of conservative measures and calls for radical operation.

In tubal surgery we should always bear in mind the importance of conservatism, but, on the other hand, we should not let our better judgment go astray and foolishly endeavor to save hopelessly diseased structures.

As I have said before, true pelvic abscesses are not commonly encountered in association with gonorrhœa. They are much more frequent in puerperal infections. When of any size they usually "point" in the posterior fornix, and may be incised and drained by vaginal puncture.

CLINICAL TEACHING.

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Some of the things that I shall say are more or less radical, and before going on with this paper I wish to make myself perfectly clear on two points. First, I do not claim any originality regarding these remarks; and, second, I do not refer to the University of Maryland in these criticisms, but rather to the general question of medical teaching.

The text of this sermon is, "Back to Clinical Teaching." In the last fifteen years we have wandered far. We are prone to believe that without the microscope the blood counter, the x-ray, the blood pressure apparatus and other mechanical appliances requiring skilled manipulation we cannot make a diagnosis. We are apt to disregard many symptoms on the part of the patient, or rather to depend on certain "findings," microscopic or otherwise, in arriving at a diagnosis.

The practitioner of medicine, away from the hospital, must arrive at conclusions, state a prognosis and institute treatment largely on the result of an examination of his patient, and this is the sort of medicine we should teach. Not laboratory medicine, nor text-book medicine, but bedside medicine—study of the patient.

Do not misunderstand me. I think we should make use of every available means in getting at the trouble with our patients. It is not that I do not believe in all these things, because I do. But we should never let them take the place of the bedside study of patients, and this is the explanation of the remarkable astuteness of many of the old clinicals. They had made a careful study of many patients, and such elusive and fleeting symptoms as the condition of the skin, the odor of the breath and the facial expression were noticed and interpreted correctly.

We are squarely at the dividing of the ways in medical teaching. On one side are the scientific schools and on the other the clinical schools. A man has not time in four years to learn both. If he is to be educated as a scientist, then it must be done at the expense of clinical teaching. If he is to be a practitioner of medicine—to treat patients—then he had better, far better, spend his time learning something about patients at first hand, by watching patients, and not out of a book. What do we see now at the end of a medical student's fourth year? He is anxious to become a hospital resident and sacrifice another of his learning years to the further study of medicine. Why? Because he realizes, and realizes full well, that he is not equipped to practice medicine. He has a large fund of information, but a very small clinical experience.

A good example of the success of this method of teaching is seen here at the University, in the Department of Obstetrics. Every man sees and handles about 20 cases of obstetrics before he graduates. He not only hears about obstetrics, but he practices obstetrics; and consequently when he has his first labor cases he feels comfortable and sure, because he is already, in a measure, an obstetrician.

As to the microscope. I think every graduate of medicine should be able to handle his microscope in the study of bacteriology and clinical microscopy. He should be taught these two things thoroughly. It is very essential, for instance, to be able to recognize the gonococus and the bacillus of tuberculosis under the microscope; to know how to fix and shine microorganisms, and then to know what the different bacteria look like. It is very important to know how to look for the plasmodia of malaria, to know what casts look like in the urine, and many other things in bacteriology and clinical microscopy.

But I think it is a mistake to take so much of the student's time looking down a microscope in the study of pathology. This time could be spent to better advantage in other ways. Pathology is divided into three great subdivisions—etiology, morbid anatomy and morbid physiology—in other words, the causes of disease, the changes produced in the tissues by disease and the symptoms of disease. Now, do not think that I do not appreciate the importance of pathology. I understand that well enough. I know that the study of pathology is the foundation on which the proper understanding of disease rests, and that to treat dis ease properly we must understand the causes and processes of disease. The point I wish to make is this: that we are spending too much time with the microscope in teaching students pathology. The ability to make a diagnosis of any particular lesion by examining a bit of tissue under the microscopic lens is very important. On this alone much of the progress in medicine rests, but this ability belongs to the expert and not to the general practitioner. It requires special training and a great deal of it to make an opinion of any value. So difficult is it often that a pathologist gives his opinion only after very careful study, not only of the specimen, but of the patient's history as well. Still in teaching students the pathologist often expects them to make a diagnosis without special knowledge or training, and very often without any history of the patient. Morbid anatomy is one-third of pathology, and is divided into gross and minute, so that microscopic pathology occupies about one-sixth of pathology, and this, I think, is about the right proportion in teaching pathology.

Instead of teaching men so much minute pathology in proportion, it would be more to the purpose to teach them more fully the relationship between disease and its causes, the symptoms of disease and gross pathology—always gross pathology. Now every practitioner will be called upon to palpate a lump in the breast and to say whether it be benign or malignant. Very few will be called upon make a microscopical examination. Every man is called up sooner or later to differentiate sarcoma of the testicle from epidymitis clinically. Almost no one is called upon to do so microscopically. Every doctor again and again has to say to what particular disease a lump in the neck belongs. Only the expert in microscopic work is called upon to make a diagnosis by means of the cut and stained specimen.

So that while we need the pathologist, who is also a microscopist, he is a man with special training; he is a scientist; and this training is gotten after graduation, not before.

How many men, graduates in medicine—practitioners of medicine—cut and examine tissues? I am willing to say that not one doctor in this State outside of Baltimore does. Does any man present know of a general practitioner who uses the microscope personally in diagnosing disease by cutting and examining tissue? Many hundreds make use of this means, and more are doing so every day, but they always send their specimens to an expert for an opinion.

Why, then, compel the student to use up so much of his time in acquiring knowledge that he is not going to use? Why make a poor student of him when we could just as easily make a good clinician? Why not study the patient and not the bit of tissue? Why not spend more time in the ward? Why not teach him to feel the lump in the living tissues rather than to handle the formalin specimen?

In short, why not teach the man who is going to earn his livelihood by practicing medicine more of practical medicine?

Another matter that must soon come to the front and be settled is the manner of teaching the specialties to undergraduates. Each specialty has an expert in his line as its teacher, and this man naturally teaches his branch thoroughly. And with the multiplication of the specialties it is becoming more and more impossible for each man to learn even something of them all in the time allotted. The solution

offered is the grouping of the specialties and making them selective on the part of the student.

If a man's tendencies lead him to think that he is going to be interested in surgery, for instance, let him select for special study eye and ear, throat and nose, orthopedic, etc.

A better solution of this problem, I think, is to begin clinical teaching earlier in the course. It is notorious in all medical schools that the freshmen loaf and the seniors are crowded with work. Why not push back the teaching a half year? Require more of the freshman and get him into the habit of work. The first-year man usually gets an entirely wrong idea of medicine as a study. The first year is not difficult, and he thinks all the years are just the same. He works on this principle in his second year and fails a branch, and goes with conditions into his junior year. And here he comes in contact with a very hard year. He has contracted habits of idleness and he has conditions, and he finishes his junior year much crippled. Now what happens? He enters his senior year, and has to spend time in making up back work that should be spent in learning clinical medicine. He graduates, perhaps, with very defective clinical knowledge and blames his Alma Mater for not equipping him in a better manner. He forgets to apply to the student of medicine the old homely adage: "You may lead a horse to water, but you can't make him drink."

So why not give our freshmen more to do and begin our clinical teaching earlier? This will accomplish a double purpose.

Most men enter the medical schools with some knowledge of chemistry. Why not finish chemistry in the first year? A great deal is being done in this regard now, and here in the University a long step in the right direction has already been taken—the putting of bacteriology into the second year. Still there is no reason why the entire course, except the clinical specialties, should not be completed by the end of the third year. In this way the entire fourth year would be devoted to clinical work.

If possible clinical microscopy should be taught in the third year. It is a handicap to the fourth-year man not to know his clinical microscopy until the end of his year. He misses all opportunity to gain efficiency in this work by practice in the hospital wards, and if the microscope is to be of any practical value to him personally, as a practitioner of medicine, it is right here in this work. I think one reason why so few men follow up their work in clinical microscopy is because they get their course so near the end of their senior year that they get practically no opportunity to become more fully equipped by practice for doing this kind of work.

There is another matter that is claiming attention at the present time, and that is the drift toward therapeutic nihilism. Many physicians have become vastly skeptical regarding the action of drugs, and what is more important, they are using their unbelief as an excuse for their ignorance. This is largely the explanation of the appalling increase in patent medicines. So that men are openly prescribing ready-made preparations not found in the pharmacopœa, or they are removing the labels and prescribing them anyhow. Why? Because prescription writing has become a lost art. The student is taught the action of drugs—therapeutics—well enough, and he is taught preparations and doses also—materia medica—but we are so busy teaching symptoms and pathology and diagnosis that we often forget to teach treatment. I myself plead guilty to this charge that I am not definite and specific enough in explaining methods of treatment in the course in junior surgery.

This gap can be filled in by giving medical students a course in practical pharmacy. The teacher should be a pharmacist, and this would solve, in some measure, the present complaint against pharmacists as a class, substitution and adulteration. Physicians are often appallingly ignorant regarding drugs, their appearance, physical characteristics, incompatibilities, the appearance of different preparations; and this is a tremendous temptation to the unscrupulous druggist either to substitute or to adulterate, if he is fairly confident that the physician does not know the difference. I have no doubt that some of the present skepticism regarding drugs is due to the fact that the patient does not always get the drug prescribed, and consequently does not experience the proper result. There are lots of tricks in the drug business, and the doctor should know about them. A conscientious, able druggist could impart a great deal of very important in-

formation to the physician—information that would be of immense value to him in treating disease with drugs.

Princeton University is leading the way in a very important educational movement, and that is instructing men in small groups by lecturers, who get near to their students, and sooner or later we must follow their lead in medicine. The professors will always be the big men in their departments, and it is to them we must look for inspiration, guidance and discipline; but the heavy bulk of teaching should fall on the younger men, who teach in small sections, personal teaching, man to man, with a patient as the subject of the discourse.

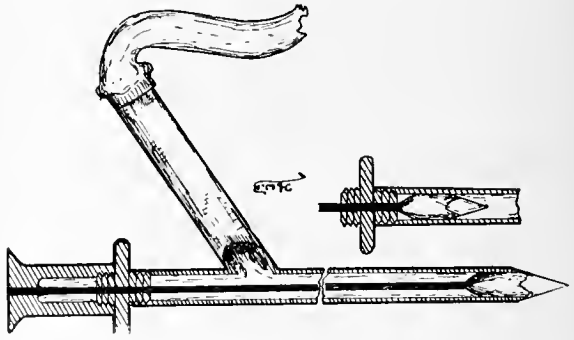
Original Article.

AN INSTRUMENT FOR TAPPING THE BOWEL IN INTESTINAL OBSTRUCTION.

By St. Clair Spruill, M. D.

A rather exhaustive review of the Literature on Intestinal Obstruction, coupled with certain observations made on a number of cases attended by marked ballooning of the bowel with stagnated feces and gases, has, in the mind of the author, satisfactorily established the fact upon which there is now a manifest harmony of opinion, that two of the most potent factors in producing discouraging results, after operation in such cases are first the maintenance of distention owing to the inability to get bowels freely moved, even after the obstruction is relieved, causing thereby more or less paralysis of the entire tract, with its incident auto-intoxication, as well as the absorption of toxins from the already accumulated intestinal and glandular secretions; and, secondly, the almost unavoidable rupture of an acutely distended and inflamed bowel by manipulation directed at locating the exact seat of obstruction, bringing its obvious peril.

This fact having been established, it becomes of paramount importance to quickly rid the bowel of its contents in such a manner as will most accurately conform to the customary rules of aseptic surgery, thus eliminating a large quantity of septic fluid as minimizing the danger of rupturing the bowel as the operator proceeds to isolate and relieve the obstruction. In the treatment of such cases in the University Hospital this has previously been accomplished, when deemed expedient, by the ordinary trocar and canula familiar to everyone. The danger of infection by contamination of the peritoneum in such a procedure is most evident. The following described instrument is offered to the profession with the hope that it may safeguard this most important step in the surgical treatment of Ileus.



Briefly described, the instrument consists of a canula having an exit by means of a tube entering it at an acute angle, to which a long piece of rubber tubing is attached, carrying its contents far away from the field of operation, and a trocar, upon which a movable shoulder is constructed having two sets of threads, as follows: One to screw into the distal end of the canula, which, when the trocar is drawn back after the bowel has been pierced, is completely closed off and is impervious to liquids coming from the bowel, owing to the fact that the proximal end of the trocar fits accurately in the lumen of the canula, acting thereby as a stopper when drawn to the distal end. It will be noted also that the trocar cannot be entirely withdrawn from the canula when in use unless the shoulder above mentioned is turned, which is never done only for purposes of cleaning. This fact prevents the accidental withdrawal of the trocar from the canula and the contamination of the peritoneal cavity which would follow.

The second set of threads upon the shoulder enables the operator to fix by a few turns the trocar in the canula. The instrument being now ready for use is thus prevented from slipping back in the canula when the puncture is made.

The accompanying illustrations show to better advantage the points in the instrument, for which I am indebted to Dr. H. W. Brent. In conclusion, acknowledgment is here given to the construction of the instrument in the shops of and under direction of Dr. Compton Riely, Instructor in Orthopedic Surgery in the University.

Prepared and read before the University of Maryland Medical Association by Dr. C. W. Roberts, Assistant to Author.

THE CLAIMS MADE BY THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF MARYLAND FOR STATE AID.

The Medical Department of the University of Maryland is asking the State of Maryland to appropriate $50,000 a year for two years for the completion of a new wing to the University Hospital, basing its claim upon the ground of merit.

The property controlled by the University of Maryland is under the charter of the University, owned by the State of Maryland, and whenever it ceases to be used for hospital and educational purposes reverts to the State.

Since the Medical Department of the University of Maryland was founded, one hundred years ago, the Faculty of Physic has invested from that time to the present over one-half million dollars in its plant.

The State has contributed to this investment less than one hundred thousand dollars in one hundred years, and yet the State holds the title to the property paid for by the Faculty of Physic. The University Hospital has cost the Faculty of Physic over $200,000. Of this sum there is a mortgage debt of $70,000, which the Faculty of Physic is paying off annually. Within the past ten years the Faculty of Physic has paid out of tuition fees over $80,000 in interest and sinking fund on this debt.

The University Hospital treats annually more State patients than any other hospital in the State. During the past year 16,322 days were occupied by State patients at a cost to the State of less than 50c. per day per patient, yet the expense of these same patients to the hospital was over $1 per day.

The University Hospital treated during the past year 3,100 indoor patients and over 29,000 outdoor patients, at a cost to the Hospital of $68,000, while the receipts from all resources were only $64,000, leaving a deficit of $4,000, which must be charged against the tuition fees belonging to the Faculty of Physic.

The Faculty of Physic is overburdened with the work the Hospital is doing, and is not financially able to meet the growing needs of the Hospital.

The present Hospital, though only ten years old, is overcrowded. A new wing is absolutely necessary to take care of the work coming to the Hospital. The institution is filling a great need in the State by the care it gives to the sick and poor of the State.

The University of Maryland is a State University. It has on its rolls over 1,000 students in all of its departments.

The interests of the people of Maryland have been promoted by the University in every way. The work the Medical Department is doing for the people of Maryland is as important as any which can be done by any institution in the State. This work is growing faster than the resources of the Faculty can meet, and this appropriation asked for is needed to meet the growing necessities of the Hospital.

The Faculty of Physic asks the State authorities to investigate the correctness of these statements. They ask a Committee from the General Assembly to visit the Hospital and see the ground on which this appeal for State aid is made. If it is not based upon justice, merit and necessity, then do not extend the aid sought. If the facts are as stated, we claim that the State should aid the University Hospital in enlarging its plant.

Prof. R. Dorsey Coale, Dean, and Prof. Randolph Winslow as representatives of the Faculty of Physic will attend the annual meeting of the Association of American Medical Colleges, which meets in Cleveland, Ohio, March 16th and 17th.

As members of this Association, the Medical Department of the University is greatly interested in its work and is annually represented at its meeting.

The power-house, electric light plant and nurses' dormitory building, connected with the University Hospital, now under construction, is so far completed as to be under roof. It is a very complete and substantial building, occupying ground on King street, in the rear of the buildings adjacent to the Hospital on Lombard street owned by the Faculty. The building is a three-story brick and concrete structure 50 by 70 feet, and when complete will cost about $50,000. It has been planned upon a scale sufficiently large to furnish heat and light for all the buildings connected with the University plant and to furnish rooms for fifty nurses. The lots in front of the building will be used for the new Lying-in addition to the Hospital.

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EDITORIAL.

PROGRESS IN EDUCATION.—The old adage, "it is easier to tear down than build up," is applicable to many forms of human endeavor. Notwithstanding this fact, progress has followed the march of human effort in every field of labor. Pessimism is the weapon which destructive criticism has used against every progressive and onward movement of civilization. The pessimist finds pleasure in opposition. He decries against any form of constructive policy which is not based upon an ultra conservatism and long-established precedent. To depress values, to obstruct enterprise, to hold back the spirit of adventure, are in his mind the only elements which stand for stability and right doing.

It is fortunate for human society that the spirit of optimism is more largely represented in human affairs than the spirit of pessimism. The latter spirit may have its value as a check upon the former. Beyond this value it retards growth in all forms of human activity. The progress of civilization demands a spirit of constructive and aggressive activity. Hope, faith, energy and adventure are the mental forces which work for the improvement and development of the human race. The world's civilization is moving with rapid strides because these forces rule the spirit of men who lead in human affairs. In science, government, law and religion men are working to discover facts and to improve conditions which will raise the human family to a higher plain. Education is the great prize which men are seeking. Knowledge only comes through education. Human society is only improved through moral and mental training. With a wider knowledge of the laws of nature and of the influences which uplift the natural man human society will continue to expand until the struggle of man with nature and of man with man will have reached its most rational and humane position.

Progress in education is the greatest of all the forces which lead up to this grand result. Education is a generic term which covers the widest scope of human activity. Its highest possibilities can only be reached through organized agencies. Government—national, state and municipal—religion through ecclesiastical organizations and individual co-operation must all bend their united efforts in behalf of established educational agencies if the highest results of education are to be reached. Recognizing the wide influence of education in the improvement of human society, how important is the responsibility which rests on society in the treatment of the agencies which have the direction of educational influences.

The many ways of directing these influences it is not necessary to state. The cause of education in general should appeal to every rational mind. The wide application of knowledge in the training of men and women for every duty which they owe to themselves and to society is restricted both by usage and precedent. The spirit of pessimism is ever at work creating barriers against educational progress. Old forms and methods are held in esteem and practice by those who would move slowly and who see only disaster in new and untried lines of progress. But for the restless spirit of optimism, the darkness of the Middle Ages would still hover over every form of human endeavor.

Governments—national, state and municipal—responsible for the growth of education among the people, undervalue the influence of education in the formation of material wealth, morals and citizenship. The demands which education makes upon the public treasury is regarded more as a burden upon legislation than an aid to stability and efficiency in government. Illiberality is the greatest foe which educational progress has to contend with. With the larger growth of knowledge will come a larger appreciation of all the influences which promote knowledge, hence education is directly making progress for itself by developing the agencies which make knowledge.

These suggestions have a practical interest at this time, when the Legislature of this state is being flooded with requests for aid for educational

institutions in the state. Whilst some of these applicants for state aid are more worthy than others, there is not an appeal for help which does not possess a claim to consideration. The state owes the greatest liberality to the educational institutions of the state. They are all working for the general improvement of the mental, moral and physical condition of the people of the state. The wealth of the state can in no way promote larger wealth for all of its citizens than through the liberal aid given to educational agencies of every character.

The Late Dr. I. R. Trimble.—In the death of Dr. Trimble the University of Maryland loses an alumnus who had achieved an honorable distinction and most useful position in his profession.

For some years after graduation Dr. Trimble was closely associated with the educational and clinical work of the University Hospital. It was during these years of service with his Alma Mater that he laid the foundation for the work which he subsequently performed with so much credit to himself and to other institutions, both as a teacher and as a surgeon.

His early training as a teacher was received in connection also with the Woman's Medical College in this city. About nine years ago he was elected professor of Anatomy and Clinical Surgery in the College of Physicians and Surgeons of Baltimore, and his work in this vigorous and progressive school was marked with that earnestness and industry which had always characterized his efforts.

Dr. Trimble possessed a most agreeable personality. He was at all times frank, cordial and cheery. Democratic in spirit, warm in friendship and devoted to his professional work, he drew around him a large clientele of patients. There were few men in the profession who could measure up to him in professional and personal popularity, or whose death will be more widely lamented. He leaves to his friends the memory of a lovable character and of a sweet and beautiful life. His influence and example will inspire all who knew him with the highest respect for high ideals and devotion to professional duty.

Fraternities at the University of Maryland.—The annual banquet of the Theta Nu Epsilon Fraternity, held at the Belvedere Hotel on the evening of March 5th, calls attention to the rapid growth in membership not only of this Fraternity, but of other Fraternities at the University. There were present at the banquet over sixty members, in addition to a number of invited guests, including members of several of the Faculties of the University. The Faculty of Physic was represented by seven of its members.

The occasion was not only an enjoyable one, but it expressed a very high standard of the refinement, culture, manly spirit and strength of the student body.

Judging the entire student body at the University of Maryland by the standard of the men who are connected with the T. N. Epsilon Fraternity, we doubt whether any institution of learning can present a higher type of young men under educational training. The age in which we live is one of organization and co-operation. The spirit of union for all purposes in life is the spirit which is lifting industrial, educational and social life to higher and higher planes of usefulness and achievement. To this spirit society must look for the promotion of the highest interests which influence mankind in the reach after higher standards of civilization. It argues well for the growth of this spirit when young men in the days of preparation for the afterwork of life can come together in fraternal organizations and strengthen all of the purposes of early manhood. College Fraternities are not simply social organizations to promote good cheer and friendship among members. They stand for far higher purposes in student life and make for standards which cannot fail to improve the intellectual and moral forces which go to make up the coming man. No one can doubt that the majority of students are made better students, and therefore become stronger characters in after life, through the influence which the Fraternity exercises over them. We recall the time when there were no Fraternity chapters at the University. Student life in those days had its compensations, but it lacked the spirit of unity and of class pride so noticeable at the present day. Since the Greek letter Fraternities began to organize chapters at the University class pride has been greatly stimulated and the student body has exercised a more commanding influence over the men enrolled in different classes and in different departments.

The men who are students today become alumni tomorrow. The loyalty which grows in the student is more fully developed in the alum-

nus. It is these men, whether students or graduates, that the University must work for and love if she wishes to receive their affection in return. There must be a common interest to bring out the best results between students and alma mater.

The Annual Meeting of the General Alumni Association of the University of Maryland.—The second annual meeting and banquet of the General Alumni Association of the University of Maryland, held at the Eutaw House on the evening of February 27th, was a most successful and enjoyable occasion. The attendance was large and represented all the departments of the University.

The committee in charge gave a feast which was abundantly satisfactory to both body and mind, and which added largely to the good cheer and happy flow of spirits of all present. The social features of the meeting were only excelled by the enthusiasm which was manifested in the growing sentiment in favor of a more complete and thorough affiliation of all of the departments of the University. The fact was clearly demonstrated that Alumni Associations connected with the several departments should abandon their organizations and transfer their membership to the General Association. It is manifest that one Alumni Association in connection with the University of Maryland is sufficient and that the General Association should receive the united support and co-operation of all the Alumni, irrespective of departments. When this condition is brought about the various departments of the University, through their Alumni, will be brought into closer relations and will work with one purpose and one spirit in the gradual upbuilding of a great State University. Each year the departments of the University have been brought into closer harmony, and the spirit of co-operation is being strengthened. This work must be pushed with an unselfish and intelligent purpose until the University of Maryland has been reorganized under a strong and efficient governing body which will be intrusted with the administration of the departments and control over all of the affairs of the University. When this plan of reorganization is fully perfected the University of Maryland will then assume the functions and influence of a great State educational plant, justly entitled to and fully receiving the financial assistance of the State.

The sentiment in favor of this movement for unity and consolidation of governmental power is rapidly growing. The reorganization is as sure to take place as the sun shines. It is only a question of time, expediency and wisdom in bringing about an adjustment of interests which have been disconnected by conditions which grew out of the early years of work in the departments.

When each department is brought to see that its financial condition and educational work can be improved by a merger of each department under a single administrative authority the merger will become effective. As much as this result is to be desired by those who have the future interests of the University at heart, it is fully realized that a radical change is not possible, nor is it desired, until adjustments of interests are brought about in a spirit of fairness and harmony. With a growing sentiment and favorable consideration of the advantages of the merger suggested it is believed that the day is not remote when conditions will open up a way for a reorganized State University.

ITEMS.

At the last regular monthly meeting of the Medical Association of the University of Maryland, held in the amphitheatre of the University Hospital, Tuesday, February 18, 1908, the program was as follows:

1. Some Suggested Changes in Medical Teachings.....Dr. A. M. Shipley
2. Exhibition of Surgical Cases, Dr. Randolph Winslow
3. Exhibition of Medical Cases, Dr. James M. Craighill
4. Demonstration on Tracheobronchoscopy, Dr. R. H. Johnston

Dr. Shipley's article appears elsewhere in this number, and calls attention to some of the numerous defects in the present method of teaching students. He directs especial attention to the method in vogue in some of the other colleges of the group method of instruction, and believes that this offers the only solution out of the present difficulty. He is also of the opinion that too much time is spent in the laboratories and too little in clinical work. He divides medical institutions into two great classes—the scientific or teaching and the clinical—and believes that in the latter the students should spend more time at the

sick-bed and less in the lecture hall than at present. Dr. Winslow exhibited a case, a colored man, from whose neck he had removed an enormous lympho-sarcoma.

Dr. Craighill brought before the society a case of pulmonary regurgitation and another of arterio-sclerosis in a girl 17 years of age. Dr. Johnston demonstrated upon a living subject the method of tracheobronchoscopy.

As mentioned from time to time in THE BULLETIN, these meetings are open to the general medical profession, and, as a cursory glance at the preceding program will show, are of a high degree of excellence. A visit will show that the Medical Department of the University of Maryland is not dead, but fully alive to the demands of the day.

Dr. Kivy Pearlstine, class 1906, writes under date of February 9, 1908:

"Please send my BULLETIN to 23 College street hereafter. I have left the Roper Hospital and am now practicing in Charleston, S. C.

Dr. Thomas Duncan, '06, also located here. He was until recently a member of the staff at Roper Hospital.

Dr. James S. Fox, '07, is resident surgeon at St. Francis Xavier's Infirmary here, having accepted the position January 1, 1908, until June 1. He is preparing to stand an examination for the army.

I was chief of the staff of Roper Hospital and Riverside Infirmary for six months, but resigned to locate here. With best wishes to U. of M. and BULLETIN. KIVY PEARLSTINE, M. D."

At a meeting of the Adjunct Faculty, held at the home of Dr. J. Gichner, the following officers were elected for the ensuing year: President, Dr. Joseph Gichner; vice-president, Dr. W. I. Messick; secretary-treasurer, Dr. Roscoe Metzel. After the business session the members were entertaind very handsomely by Dr. and Mrs. Gichner.

By virtue of his position as Governor of the State of Maryland, the Honorable Austin L. Crothers becomes for the period of his incumbency of office Chancellor of the Academic Council of the University of Maryland.

Dr. William Baltzell Burch, class of 1890, of Baltimore, has been appointed by the Governor of Maryland, His Excellency Austin L. Crothers, State vaccine agent.

Dr. William E. Wiegand, class of 1876, and Mrs. Wiegand, of Baltimore, are spending several weeks at Palm Beach, Fla., where they are registered at the Royal Ponciano.

Drs. Patrick W. Martin, class of 1900, and Silas Baldwin, class of 1867, of Baltimore, have been appointed coroners for Baltimore.

Governor Austin L. Crothers has appointed Dr. St. Clair Spruill a member of the State Board of Aid and Charities.

Dr. N. M. Owensby, class of 1905, was operated on at the University Hospital for appendicitis.

Governor A. L. Crothers will receive the degree of LL. D. from Loyola College at its commencement June 18, 1908.

Dr. A. D. McConachie, class of 1892, has been appointed by Governor Crothers a member of his staff, with the rank of surgeon-general.

Dr. Seymour, class of 1806, is ill at St. Joseph's Hospital, Baltimore.

Dr. J. D. Norris, class of 1878, of Baltimore, has been appointed a police examiner.

As only two months remain before the annual course of lectures for the session of 1907-8 will close, the student body is being pressed with work. The graduating class is now in training for the final examinations, which, in the special branches, will begin in a few weeks.

The work during the present session seems

to be up to the usual standard, though there has been some complaint upon the part of some of the teachers of an indifferent attendance upon the part of a few students. It may be proper for the BULLETIN to sound a warning to the derelicts and to remind them that absences are being noted and the day of reckoning is coming.

It has been given out unofficially that the annual commencement of the Departments of the University of Maryland will be held jointly on or about the evening of June 1st. A fuller notice of the Commencement will be given in a subsequent number of the BULLETIN.

The class of 1876 held a reunion recently at the Hotel Rennert, in this city, which was well attended. This class has the prize for holding reunions, and has shown a class spirit and comradeship which should be emulated by other classes.

The General Alumni Association of the University of Maryland held its annual banquet Thursday, February 27, 1908, at the Eutaw House, and about 100 graduates of the different departments were present. The large banquet hall was prettily decorated, and while the menu was being served selections were given by a string orchestra.

After cigars had been lighted Mr. Oregon Milton Dennis, chairman of the banquet committee, thanked the members for their cooperation in making the banquet a success, and then introduced Mr. J. Harry Tregoe, president of the association. Mr. Tregoe responded to the toast, "The Bond of Good-Fellowship," and introduced the other speakers. They were as follows:

"The Bond of Mutual Interests," Secretary of State N. Winslow Williams.

"The Bond of Affiliation," Dr. Thomas Fell, President of St. John's College, Annapolis.

"Bonds Statutory," Judge Henry Stockbridge.

"The Bond of Fraternity," Mayor's Secretary A. S. Goldsborough.

In responding to his toast Dr. Fell said: "Maryland hitherto has had no State university to crown the system of public education. The Johns Hopkins University maintains a foremost position among the educational institutions of the world, but cannot by its constitution ever be regarded as a State university.

"Now the State provides, with the full consent and approval of all, for partial education, and has of late years paid great attention to the establishment of excellent high schools throughout the State. Then why should not the masses have access to higher and professional education?

"They constitute the majority; they need it more urgently than the privileged classes; they pay a larger proportion of the taxes; they constitute the main support of the State in peace and war.

"In every Western State there is a State university. Every Southern State, except Maryland, has its State university. Yet all the elements exist in Maryland for a State university of the first rank.

"The schools now forming the University of Maryland are already receiving the support of the State in various degrees, and need only to be consolidated under proper government and direction to form the climax and complement of public education.

"This idea is gradually developing in the minds of men.

"At Annapolis there is a growing belief that the funds of the State have been distributed without due discrimination not only as regards the employes, but also as regards the charitable and educational benefactions of the State.

"Much of this could be remedied by concentrating the various recipients of the bounty of the State under central governing bodies according to these respective objects."

The following officers were elected:

President—Dr. B. Merrill Hopkinson.

Secretary and Treasurer—Dr. E. F. Cordell.

Executive Committee—Drs. Nathan Winslow, C. V. Matthews and Leroy Robinson, Ph. G.; Frank V. Rhodes and J. F. Adams, M. D.

Endowment Committee—Drs. E. F. Cordell and T. O. Heatwole, and Messrs. J. Harry Tregoe and E. F. Kelly, Phar. D.

Assistant Secretary and Treasurer—Mr. J. H. Skeen.

Mr. Dennis was assisted on the banquet committee by Drs. E. F. Cordell, Nathan Winslow, H. Hampson Biedler, Charles S. Grindall, Clyde V. Matthews and Thomas E. Latimer, and Messrs. James E. Carr, J. Leiper Winslow, John B. Thomas, S. Le Roy Robin-

son, Henry B. Hynson, Phar. D., and Louis H. Seth.

The following were elected honorary vice-presidents for the ensuing year:

B. Howard Haman, LL. B.; Wilmer Brinton, M. D.; O. M. Dennis, LL. B.; J. H. Tregoe, LL. B.; Thomas Fell, LL. D.; R. Winslow, M. D.; Wirt Randall, LL. B.; A. S. Crothers, LL. B.; J. C. Hemmeter, M. D.; R. T. Taylor, M. D.; B. V. Cecil, Chas. O'Donovan, M. D.

Among those present were:

Messrs. Dr. Eugene F. Cordell, S. Leroy Robinson, Henry P. Hynson, Dr. R. Dorsey Coale, Oregon Milton Dennis, James E. Carr, Jr., Dr. Clyde V. Matthews, J. Leiper Winslow, Louis H. Seth, Dr. John R. Winslow, Dr. C. V. Mace, Rossville, Md.; Dr. J. Dawson Reeder, David Ash, John Henry Skeen, Dr. Howard W. Jones, J. Harry Tregoe, T. A. Ashby, Dr. Holt, Washington, Dr. I. H. Davis, N. S. Dudley, Dr. O. P. Penning, Dr. S. Demarco, Dr. Frank O. Miller, Dr. J. Fred Adams, J. E. Hengst, C. H. Ware, W. N. Owings, Daniel Bare, Dr. Thomas Fell, Hon. H. L. D. Stanford, Charles B. Nicholson, E. W. Hodson, B. A. Lillich, Claude Hickman, O. C. Smith, Dr. J. F. Hancock, Lee Williamson, Dr. Harrower, Dr. Koehmer, Dr. T. O. Heatwole, Dr. J. Carlton Wolf, Dr. L. K. Hirshberg, J. W. Dickson, Joel J. Barnett, F. L. McCartney, Dr. J. H. Smith, Sr., Dr. R. C. Franklin, Dr. R. T. Taylor, Dr. W. H. Daniels, Prof. V. B. Cecil, Dr. Nathan Winslow, Dr. Charles S. Grindall, Dr. H. H. Biedler, Charles Caspari, Jr., F. J. S. Gorgas, John P. Poe, Dr. Thomas E. Latimer, John B. Thomas, William H. Lawrence, Dr. B. M. Hopkinson, Henry Stockbridge, J. E. Bond, John S. Donnet, Dr. Chas. E. Sadtler, Dr. G. Lane Taneyhill, Harry Adler, Dr. John C. Hemmeter, Dr. John C. Uhler, Dr. Valentine, A. M. Shipley, Dr. W. H. Smith, Dr. Randolph Winslow, Dr. John Houff, Dr. J. M. Hundley, Dr. Wren Howard, Washington; J. W. Westcott, Eugene A. DeReeves, Dr. E. Miller Reid, Hon. J. Frank Harper, A. S. Goldsborough, W. G. Horn, Oscar B. Thomas, D. R. Millard, Frank V. Rhodes, William M. Fouch, Van V. Dorr, Dr. Creet, Dr. Crowe, Dr. Freeman, G. A. Bunting, Benjamin Woolford, Leroy Oldham, Charles C. Neal, Nathan C. Mules, Wm. S. Robinson, Dr. J. H. Smith, Jr., Dr. J. Harry Farrow, Dr. Hildebrand and Dr. J. A. Wright.

DEATHS.

Dr. Isaac Ridgeway Trimble, class of 1884, a prominent surgeon of Baltimore, and Professor of Anatomy and Clinical Surgery in the College of Physicians and Surgeons, Baltimore, died Saturday, February 24, 1908, of Septicemia, aged 48.

Dr. Trimble's illness was brought about by an operation he performed Monday, February 10, 1908, at St. Joseph's Hospital on a patient suffering with an infected kidney. During the operation he nicked a finger of his left hand with his knife. Although feeling badly the next day, there were no definite symptoms to lead him to suspect that he was infected. By Wednesday, however, the veins in his arm showed evidence of being infected, consequently he went to St. Joseph's Hospital, and the following day underwent an operation, the infected veins and the axillary glands being removed. Immediately after the operation he showed signs of improvement, but on the following Monday had to undergo a second operation, owing to an extension of the process, from which day he gradually grew worse until the day of his death. The funeral, which took place Wednesday from Memorial Protestant Episcopal Church, of which he was a vestryman was attended by people of every walk of life, his tragic ending in the prime of life having aroused public sympathy. The pastor, Rev. William Page Dame, officiated at the services, which were very simple and beautiful.

Following the service at the church the body was taken to Union Station to be entrained for Easton, Talbot county, Md., where the body was interred Thursday in the family burying ground at Wye House. The services at the grave were conducted by Rev. W. Y. Beaven, rector of All Saints' Parish, Longwoods, of which Dr. Trimble was a member while a young man.

The active pall-bearers who had been ushers at Dr. Trimble's wedding were:

Mr. Alexander Brown, Gen. Lawrason Riggs, Mr. George S. Jackson, Mr. John C. Daves, Dr. Ridgely B. Warfield, Mr. John Redwood, Dr. Mactier Warfield, Mr. Edward Lloyd Winder and Dr. William S. Thayer.

The honorary pall-bearers, selected from among the surgeon's closest medical friends, in addition to two of his cousins, were:

Drs. Louis McLane Tiffany, Charles O'Donovan, Hiram Woods, Frank Martin, A. C. Harrison, J. Whitridge Williams, John Ruhrah, J. M. T. Finney, Summerfield Bond, Charles W. Mitchell, Henry M. Thomas, S. Griffith Davis, J. M. Lynch; Commander Edward Lloyd, U. S. N., and Mr. C. Howard Lloyd.

Dr. Trimble was of old Maryland stock and was descended from the most distinguished ancestry in the early annals of the State. He was a grandson of Gen. I. R. Trimble, a gallant

officer in the Confederate Army, for whom he was named, and was connected with the Lloyds, the Winders, the Howards and other famous families of the Eastern Shore.

His father was the late David C. Trimble, of Talbot county, and his mother, who survives him, was formerly Miss Sallie Lloyd, of Wye House, where the son was born in 1860. Wye Heights, where he spent his boyhood, was near Wye House, the home of the Lloyds for generations.

Dr. Trimble was educated at the old Shenandoah Valley Academy at Winchester, Va. Later Dr. Trimble attended the Johns Hopkins University. He studied medicine at the University of Maryland and was graduated in 1884. He was appointed to the staff of the hospital and for a number of years was assistant surgeon there. He was also at one time assistant surgeon at Bayview Asylum.

Dr. Trimble was surgeon-in-chief of the United Railways and was surgeon to the Baltimore and Ohio Railroad. In 1889 he was appointed assistant surgeon to the Fifth Regiment, M. N. G., in which capacity he served until 1899.

Besides his mother, he leaves a widow, who before her marriage was Miss Margaret Jones, of New York, and five children—Margaret, Ridgeway, David, Theodore and William Trimble.

While Dr. Trimble lost his life as a result of the infection received while operating on a patient at St. Joseph's Hospital, the patient is expected to recover.

Dr. H. Jermingham Boone, class of 1844, formerly of Frederick, died at the home of his daughter, Mrs. William F. Stonebraker, at Weverton, Md., Friday, February 21, 1908, aged 88 years. He was one of the oldest physicians in his community. After leaving Frederick he practiced at Buckeystown, and later moved to Weverton. He married Miss Mary Jane Eichelberger, who died some years ago. He is survived by three daughters—Mrs. Robert Padgett, Adamstown; Mrs. William F. Stonebraker, Weverton, and Miss Maggie Boone, of Baltimore. The funeral took place Monday, February 24, 1908, from St. John's Church, Frederick.

Mrs. Virginia Duvall Atkinson, widow of the late Dr. Isaac E. Atkinson, class of 1865, who was for many years a professor in the University of Maryland, and mother of Dr. A. Duvall Atkinson, class of 1894, clinical professor of medicine in the University of Maryland, died Thursday, February 20, 1908, at her residence, 609 Cathedral street, Baltimore, of acute Bright's disease. She survived her husband only 15 months. Mrs. Atkinson was the daughter of the late James Lingen Hawkins Duvall, of Frederick county, Maryland. She was married in 1867 at All Saints' Protestant Episcopal Church, Frederick. Mrs. Atkinson is survived by a son—Dr. A. Duvall Atkinson—and three daughters—Mrs. Philip Gardner, Mrs. John C. Rice and Mrs. Albert L. Nickerson, all of Boston, Mass.

Dr. James McDonald Josey, class of 1904, died at his home, near Hartsville, S. C., February 11, 1908, aged 28. A little over a year ago he went to Colorado for his health, but in November he began to fail so rapidly that he returned to his home. Death was due to tuberculosis.

CHANGE OF ADDRESS

Dr. C. J. B. Flowers has moved from Harrisburg, Pa., to Union Deposit, Pa.

Dr. Irvin H. Neff, of Pontiac, Mich., will, on April 1st, assume the superintendency of the Foxboro Hospital at Foxboro, Mass.

Dr. S. R. Clarke has changed his place of residence from Roland Park to 330 East Twenty-fifth street, Baltimore.

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SOME POST-OPERATIVE COMPLICATIONS OF PERITONITIS.*

BY RANDOLPH WINSLOW, A. M., M. D.,

Professor of Surgery in the University of Maryland.

One of the most notable advances in surgery of the past few years has been the treatment of suppurative peritonitis by the postural method, with drainage of the pelvic cavity. By this method a condition that was formerly followed by an enormous mortality has now been robbed of most of its terrors, and recovery after suppuration within the peritoneal sac is the rule rather than the exception. It is not my intention to discuss the treatment of acute suppurative peritonitis, but to call attention to some of the complications following operations for this condition, and to invite discussion as to the manner in which they may be prevented.

Adhesions—An inherent tendency in peritoneal irritation and inflammation is the production of plastic exudate in greater or less quantity upon the surfaces of the intestines, by means of which they become adherent to each other or to some contiguous structure, and in consequence of which in not a few instances there follows an angulation of the gut or a narrowing of its lumen to such a degree that intestinal obstruction is set up, with its dire train of symptoms, and its frequently fatal result. The unfortunate patient escapes Scilla indeed, but only to be wrecked upon the jagged rocks of Charybdis. When the abdominal cavity is opened and the viscera are handled, an additional traumatism is inflicted, and when tubes or gauze are placed within the peritoneal sac adhesions to a certain extent must occur. Fortunately these adhesions are not generally followed by bad results, but in the exceptional case serious complications occur.

Intestinal Obstruction.—Intestinal obstruction is the most frequent complication of peritonitis, whether due to the original infection, to the traumatism of the operation, to the irritation of foreign bodies introduced for drainage, or to intestinal paresis from sepsis. Intestinal paresis is a potent cause of obstruction, but is one that precedes rather than follows operations for the relief of peritonitis. Post operative obstruction is generally due to adhesions causing angulations or kinks in the gut, more frequently than actual contraction of its lumen. The patient who has been doing well is suddenly seized with cutting pains, tympanites and vomiting, and with an arrest of the downward passage of flatus and feces. When the abdomen is opened there will usually be found adhesions of the intestines at one or more points, sometimes slight in character and easily separated, at other times very extensive, and detached with great difficulty and often leaving raw surfaces, which it may be impossible to cover with peritoneum. Whilst in some cases there may be an actual constriction by a band with consequent strangulation, generally the bowel is distended and kinked, and the greater the distention, the more acute the kink. These adhesions may be due to the original infection, but are undoubtedly often provoked by the use of gauze and tubes for drainage.

Fowler Position.—Again is it not probable that the Fowler position favors adhesions and obstruction by causing too great a descensus of the intestines into the pelvic cavity? We indeed cure our patients of the peritonitis, but have them die of obstruction or save them by another operation, so as by fire.

Prevention.—How can we prevent obstruction in these cases? In my opinion, by handling the intestines as little as possible, by removing or repairing the original focus of infection, as a ruptured appendix or perforated viscus, and by avoiding the use of gauze in the peritoneal cavity, unless it is enclosed in tubes or rubber protective, and by removing the drains in a shorter

*Read before the Southern Surgical and Gynecological Association at its twentieth annual session, at New Orleans, on December 17th, 1907.

time than has been customary with some of us. The acutely inclined posture is invaluable and cannot be dispensed with, but I am inclined to think it may be maintained an unnecessarily long time, and that adhesions of the intestines will be lessened, if the patient is placed in the horizontal position at an early rather than a late period. Intestinal paresis favors adhesions, hence peristalsis should be encouraged by the use of appropriate measures as soon as the acuteness of the peritoneal inflammation has subsided. Intestinal peristalsis tends to prevent or limit the formation of adhesions, and to cause their attenuation or disappearance after they have formed.

Large Tubes.—I wish also to call attention to the danger of using large glass or rubber tubes within the abdominal cavity. In one personal case the small intestine in some manner became incarcerated in a large "lamp chimney" tube, causing a genuine strangulated hernia within the tube. This I was fortunately able to release and the patient recovered, but the same accident happened in the hands of a colleague, with a fatal result. Perforated tubes are also dangerous, if the fenestrae are large, as there is danger of prolapse of the intestine through these openings, especially if the tube is of large calibre. This accident happened to me in one case; the small intestine passing through two lateral fenestrae into a large sized rubber tube, and, though released, an intestinal obstruction resulted from the effects of which the patient died.

I think two or more moderate-sized rubber drainage tubes split or cut spirally and filled with gauze, and carried to the bottom of the pelvis, are preferable to the rigid glass tubes of large size; or wicks of gauze of any desired size, covered with rubber protective, may be used. One of my colleagues uses a condom with the end cut off, and filled with gauze, and finds it very efficacious for pelvic drainage.

Other Complications.—Of course, there are many other post operative complications of peritonitis, such as vomiting, tympanites, obstipation and pain, which are usually due to paresis from sepsis, or to obstruction from adhesions; in the first case requiring gastric lavage and rectal instillation of large quantities of salt solution, and possibly enterotomy; and in the latter event an early and intelligent interpretation of the symptoms and the release of the adhesions, or if this is impossible or inadvisable, the performance of an enterotomy or anastamosis to side track the obstructed area.

When the adhesions are extensive it will be better in some cases not to attempt to separate them, as this is often followed by profound shock, and frequently by a recurrence of the obstruction, but perform at once an anastamosis with a contiguous portion of the intestinal tract below the obstruction, or make a temporary fistula with drainage externally. Fecal fistula may also result from pressure of the drainage tubes or from necrosis of the bowel wall from obstruction of the circulation, and will require appropriate treatment, excision and suture of the opening, or resection of a portion of the gut with enterorrhaphy. In one case detailed herewith gangrene of a considerable area of the abdominal wall occurred, probably from infection following an enterotomy. In exemplification of the foregoing remarks, I beg to append a brief history of two cases that have occurred recently in my hands.

Case I.—Appendicitis and peritonitis, followed by intestinal obstruction from adhesions—Operation—Cure.

M. P., a fine, healthy-looking girl, 20 years of age, was admitted to University Hospital on June 25, 1907. Five days previously she was taken with acute pain in the right side, soon extending over the entire abdomen, attended with nausea and vomiting. When admitted she had an evident appendicitis with peritonitis, and was at once subjected to laparotomy, a vertical incision being made through the right rectus muscle. The appendix was ruptured and gangrenous and a large quantity of foul, greenish yellow, purulent fluid was found free in the peritoneal cavity. The appendix was removed and two split tubes filled with gauze were introduced into the pelvis, and a small quantity of unprotected gauze was also placed between the tubes. An examination of the pus showed it to contain streptococci in abundance. She was placed in the Fowler posture, with the head of the bed acutely elevated, the stomach washed out and rectal instillation practiced. At first she was very ill, but at the end of 48 hours there was a marked amelioration of her condition, and she made a satisfactory recovery, and was discharged on August 10th. She remained well four weeks, when she was taken with cramps in the belly, vomiting and inability to pass flatus or feces. She was readmitted to Hospital on Sep-

tember 6th, and immediate laparotomy done. There were some adhesions of the small intestine which were tied off and divided and she made a good recovery.

Case II. — Appendicitis and Peritonitis, followed by extensive adhesions, causing intestinal obstruction, enterotomy, followed by anastamosis, and subsequently by resection and enterrorrhaphy.

C. M., white male, aged 19 years, was admitted to University Hospital on August 5th, 1907. He was a healthy young fellow, an ironworker by trade. On July 29th he was taken with cramps all over his abdomen, with tenderness, nausea and vomiting. He did not enter hospital until a week later, when he had a markedly distended and rigid abdomen, especially in the appendical area, but without vomiting. Temperature 99 degrees; pulse, 78; respiration, 28. Ice bags were applied and the pain ceased. He was operated on on August 8th under ether. An incision through the right rectus muscle revealed an extensive peritonitis, with exudate on the intestines, and a large purulent collection within the peritoneal and pelvic cavity. The appendix was gangrenous and ruptured, and was removed, the pus partially evacuated and the pelvic cavity flushed with salt solution, and two large rubber tubes filled with gauze carried to the bottom of the pelvis and the external wound partially closed. He was placed in the Fowler position, and did well, there being free drainage, almost no elevation of temperature, notwithstanding the fact that he got up and went to the water closet on the third day, without permission, of course. He was apparently convalescent, with good appetite, no pain and bowels moving well, when, on August 29th, three weeks after the operation, he commenced to vomit and complained of severe abdominal pain, with some distention of the abdomen. Gastric lavage and rectal enemeta did not stop the vomiting, but did cause a bowel movement. On the 30th an enema of vinegar was given, which produced a fecal discharge 20 minutes later, but did not relieve the pain and vomiting, so on August 31st he was anesthetized and an incision five inches in length was made through the left rectus muscle, as it was thought the obstruction was situated on the left side. The intestines were distended, adherent to the abdominal wall, extensively matted together and densely adherent in the pelvis to the drainage tracks. Collections of pus were also found in the pelvis and about the cecum, and there was a glandular enlargement in the mesentery. It was necessary to puncture the gut and allow its contents to escape, and an accidental opening was also made in separating the adhesions; these openings were closed and the adhesions separated chiefly by means of gauze pressure. The intestines bled freely, and in some places were denuded of peritoneum extensively, which could not be replaced. The abscesses were drained, and the patient, now much shocked, was put to bed. The vomiting continued, but the pain ceased, and his condition improved, though neither feces nor flatus passed per anum. For some reason the whole area between the two abdominal incisions sloughed, leaving an oblong gap in the belly wall. This dead tissue was cut away and coils of intestines were found lying in the hiatus and adherent to the margins of the wound. The gut was punctured and a tube introduced and surrounded with a purse-string suture. This drained the bowel and the vomiting ceased at once, and never returned. An external fistula was thus established, and subsequently an additional opening formed spontaneously in the exposed intestines, and through these the whole intestinal discharge took place. The patient lost flesh rapidly and became almost a living skeleton; his skin became excoriated by the discharges and his life was very miserable. I tried to close the openings in the bowel, but without success. On September 27th he was anesthetized with ether, and I again opened his abdomen by an incision on the right side, and found the intra-abdominal condition better than I had expected. I was able to attach the small intestine to the transverse colon with a Murphy button, and then closed the fistulous openings. The intestines were still very adherent, and suppurating cavities still remained within the abdomen. He was now freely fed with milk and eggs, and improved some, but the fistula did not close, and, whilst he had bowel movements from the rectum, a large portion also came through the openings, and caused much distress. The open space in the abdominal wall gradually contracted, and the abscess cavities healed, and on November 15th I again opened his abdomen and found the adhesions largely absorbed, and I was able to loosen the intestines from each

other and the abdominal wall. During this procedure the intestine was torn, and I resected six or eight inches of small intestines and restored the continuity of the tube by a lateral anastamosis, and closed the other fistulous opening by suture. I was also able to close the gap in the abdominal wall without great tension. He had no unfavorable reaction from this operation, his highest temperature being about 99°; the sutured intestine united and his condition at once improved. Small quantities of albumen were allowed in 48 hours, and gradually increased. Milk, soft eggs and soft toast were soon added, and free alvine evacuations took place in a normal manner, and he began to put on flesh and to look less like a skeleton. He has since been able to return to his home in a very much improved condition.

EGYPTIAN CHLOROSIS.

By N. Kenawy, M. D.,
Class 1905, *Alexandria, Egypt.*

Synonyms.—Uncineriasis, Ankylostoma Duodenalis, Hookworm Disease and Miners' Disease.

My attention was attracted to this interesting disease by a case which I have seen diagnosed as Pernicious Anemia. The treatment was iron and bone-marrow. The patient, of course, did not improve. I was called to see the case; I made the same diagnosis and approved of the treatment. Two days later I met a country doctor, to whom I related the symptoms of the case. He at once called my attention to Ankylostoma Duodenalis; I previously knew but little of the disease due to this parasite. I at once put my patient on the Ankylostoma treatment; in consequence all the symptoms disappeared after two weeks. Since then I took great interest in the disease and began to study the subject thoroughly.

Definition—It is an insidious disease characterized by progressive anemia and by digestive and nervous disturbances, and it is caused by the presence in the duodenum and jejunum of a nematode worm.

History—Our earliest reference to this disease is contained in an old Egyptian medical papyrus about 3,500 years old. The next references occurred in the seventeenth and eighteenth centuries, from Brazil and the West Indies. In Europe the disease was discovered among the miners of Ansin in 1802. Dubini, of Milan, was the first to discover the Ankylostoma Duodenalis, in the year 1838. The disease is so common in Egypt that it is known as Egyptian Chlorosis. It affects the villages of both Upper and Lower Egypt, and is rare in the cities. The female worm is larger than the male.

The eggs of the female are laid in the intestines of the host and discharged with the feces. The eggs must develop outside the body, where they develop into embryos; these develop into larvae, which, when taken into the human body through the mouth or exposed skin, find their way to the duodenum and jejunum, where they develop into the mature parasites. There is a bad habit among some of the Egyptian poor to eat the mud of the Nile during the maximum height of its flood. This habit is due to a superstition that it is good for the system. It affects the Fellaheen (peasants) more than any other class, because they work barefooted and arms naked in the muddy water in the fields; they also drink out of this muddy water.

Symptoms—The presence of this worm is generally indicated by the usual signs of anemia. The patient usually comes with the hand over the abdomen complaining of constant colicy pain. The appetite is variably affected, with some it is ravenous, with others it is lost. Nausea and vomiting are rarely complained of. Constipation, alternating with diarrhœa, sets in, but generally the former predominates. Bloody stools are sometimes seen, but these are not characteristic of the disease. Pain in the knees, faintiness and headache, usually referred to the temples, are generally complained of. In severe acute cases pallor, general weakness, dyspnea, and sometimes dropsical effusion may occur. Palpitation of the heart and pulsation of the veins are seen in advanced cases. The area of apical cardiac dulness and impulse is increased. Organic and anemic murmurs may be heard; the pulmonic second sound may be accentuated. As to the state of blood, in this disease it closely resembles the anemia of chlorosis.

Diagnosis—The finding of the Ankylostoma worms in the feces, and the characteristic eggs under the microscope are the most important.

Prognosis—This depends on the general condition of the patient's health. Intense anemia, obstinate diarrhoea and general weakness constitute symptoms of grave import. If properly treated the prognosis is good.

Treatment—The native remedies for the disease are crude. Some of the patients are cauterized with red-hot iron on the epigastrium to relieve the constant colicy pains. Others have setons in the ears and over the stomach.

For the rational treatment of this disease two conditions are to be met with—the destruction of the parasite with its ejection from the body, and to assist nature to repair the damage done to the system. The Anthelmentics most commonly used are: Thymol, Santonine, Calomel and Male fern. Thymol is the one nearly specific.

The patient must take a purge in the evening and at 8 A. M. on the following morning takes two grammes of Thymol; the same dose may be repeated after two hours; this is to be followed by a dose of castor oil or magnesium sulphate. The patient must be kept on liquid diet. He should be under careful observation during the administration of Thymol for collapse.

Now the treatment generally used in the government hospitals, and which was found to be satisfactory, is as follows: At 6 P. M. patient takes a purge of magnesium sulph., fasts all evening and night. At 7 A. M. the following morning takes half of the following:

Eucalyptus Oil.....2.50 Gram.
Chloroform.....3.50 Gram.
Castor Oil.....40.00 Gram.

At 7:30 A. M. takes the other half of the above mixture. He then fasts till the bowels act. If any depression occurs the second half is to be omitted. If the patient is young or feeble, the following dosage is to be used and be divided into thirds and given at intervals of 20 minutes:

Eucalyptus Oil.....2.00 Grm.
Chloroform.....3.00 Grm.
Castor Oil.....40.00 Grm.

The resultant motions must be searched for the worms. The Anemia then is to be treated by preparations of iron. This treatment may be repeated in a week's time if necessary.

It might be interesting to review the symptomatology and treatment of the following two cases:

Case 1—T. D., male, 19 years old, a peasant. Duration of the disease was five months. Presented himself with colicy pains in the abdomen. Constipation alternated with diarrhoea. Had occasional bloody stools. He gave up his work because he got tired on the least exertion. He got shortness of breath, pain in the knees and temporal headache. Got faintness. Appetite was poor. He had no nausea and no vomiting. He was very anemic.

Heart had nothing abnormal. Spleen was very enlarged. He carried two setons on the abdomen with the idea of relieving the pain. I gave him four grammes of thymol in four equal doses at two hours' interval; this was followed by a dose of castor oil. Several Ankylostoma worms were found in the motions. I put him then on iron and quassia. After a week the same treatment was repeated. Patient resumed his work after a month, and he is in perfect health now.

Case 2—K. H., male, 29 years old, a peasant. Duration of the disease was two years. Complained of colicky pains in the abdomen and constipation. Gave up his work like the first case. Had pain in the knees, faintiness and temporal headache. Appetite was good. He got edema of face and legs. He was also very anemic.

Heart was dilated, systolic soft-blowing murmur was heard over apex and not transmitted. Anemic murmur was heard at the base. Pulsation of veins were seen round the neck. I put him on chloroform, eucalyptus oil and castor oil. This was followed by iron and quassia. Patient was perfectly recovered after 20 days.

Pharmacie du Phare, 11 Boulevard Ramleh.

REPORT OF CASE OF GONORRHOEAL ENDOCARDITIS.

By J. Bird, M. D., *Class of* 1907.

This particular case of Gonorrhoeal Urethritis, which has recently come under our observation at the University Hospital, has been selected as one to report, owing to its rare complications—that is, a Gonococcus Septicaemia, setting up an endocarditis, with later the development of a left hemiphlegia, probably due to lodging of embolusiin motor area of brain. The above statements are made rather positive, owing to fact that the Gonococcus has been isolated in pure culture from patients' blood, thus eliminating that form of endocarditis which might be due to the ordinary pyogenic organisms or any others which might be associated. We all know that the role which the gonococcus plays in human infection is an important one. By the laity gonorrhoea is generally considered as a mild and un-

important disease, but the physician who knows its complications and far-reaching consequences does not consider it so lightly. It is one of the oldest human diseases.

H. L. C., Hagerstown, Md. White male, age 20; single. Occupation, tanner.

Complaint—Bloody urine; pain in micturition and defecation.

T. H.—Maternal grandfather living, age 64; has had a cough and bronchitis for 2 years; has lost weight, blood in sputa. Maternal grandmother died of grippe; also had rheumatism.

Father living, age 74; has inflammation of bladder and has to be catheterized; has general anasarca; frequently falls unconscious and has convulsions; physicians say they do not know what his trouble is. Mother living, age 45; has heart trouble; ankles always swell during pregnancy. Has one sister who suffers with severe cough; sputa tinged with blood; has not lost weight.

Past History.—Whooping cough and measles in infancy; recovery complete. Had gonorrhoea February, 1907, existed until June. Inquinal Adenitis complicated this attack; recovery was apparently complete.

Present Illness.—Noticed urethral discharge with pain and burning sensations at meatus December 4, 1907, six days following sexual intercourse. First appeared as a whitish discharge from penis, which rapidly became profuse. This condition continued for two weeks. Since December 25, 1907, pain has been of an aching character and is situated more particularly in organ coming on after micturition. Since January 8 urine has been bloody and lessened in amount. Patient had three chills between December 25 and January 1, accompanied by fever and followed by profuse sweating; suffered with slight pain in knee joints, but there has been no swelling. Patient came to University Dispensary February 6, complaining of severe and constant pain in perinaeum. Was referred to Genito-Urinary department; was examined by Dr. Edmunds, who made diagnosis of acute Gonorrhoeal Prostatitis; admitted to ward for treatment. Gives history as stated above of some systemic envolvement manifested by chills, fever and painful but not swollen joints.

Upon admission following points were noted: Patient passes urine several times daily, found to be loaded with pus, epithelial cells and debris, sugar negative. Albumen positive. Passes urine more often at night; severe pain complained of before and after micturition, causing patient to double up in bed; when out of bed finds greatest comfort by squatting down. Has urethral discharge containing gonococci. Digital rectal examination showed an enlarged edematous prostate, very tender. External pressure on perinæum causes severe pain. Testicles and epydidimi normal. Along urethra, apparently beneath mucous membrane, small shot-like nontender masses can be felt. General examination of heart and lungs negative. Abdomen negative; vessels soft; joints normal. Diagnosis, gonorrhoeal prostatitis and crystitis complicating a urethritis.

This condition of affairs continued slightly improved with patient under treatment, with no further complications or untoward symptoms presenting themselves until March 7. For several days prior to this date patient complained of severe headache, to which little attention was paid; said that other than this felt perfectly well. On morning of above date, March 7th, at 9 o'clock, patient became paralyzed in left side—that is, left hemiphlegia developed, involving motor areas only, sensation being slightly impaired. This was preceded by a dizzy sensation and slight epistaxis; three minutes later had stiffness in leg and arm of affected side, with slight tingling of left side of face. Felt no throbbing in precordia. Motor paralysis of entire left side was absolute. Pupils equal and reacted normally to light and accommodation.

Physical examination of heart revealed following: P. M. C. I. in 5th interspace half an inch to outer side of nipple line palpable and visible; no thrill. At apex the first sound is replaced by a murmur rumbling in character and systolic in time; can be heard as far back as posterior axillary line. At base the first sound is not heard, but a still louder systolic murmur is heard in aortic region. Second sound at apex, accentuated less so at base.

Between and a little below nipple and sternum both sounds can be heard and a very soft diastolic murmur follows close to second sound. Dullness extends to nipple line on left and to right margin of sternum on right. There appears to be a cardiac hypertrophy and not a dilitation, compensation being well maintained.

Lungs normal. Blood examination positive. Gonoccoci isolated in pure culture. Up until this time patient had been up and walking about ward, feeling perfectly well. This existing endocarditis has evidently been present for some time, and this later and very rare co-existing condition of cerebral embolism is due to a washing off into blood current of a shread from endocardium. At present time paralysis has cleared up markedly and patient has fair amount of motion restored. General condition is excellent.

WHAT SHALL WE DO WITH THE UTERUS AFTER THE REMOVAL OF BOTH TUBES AND OVARIES?*

By Thomas A. Ashby, M. D.,

Professor of Diseases of Women, University of Maryland.

The pathology and treatment of intra-pelvic conditions have been so carefully and thoroughly discussed that one has little encouragement to enter this field with any hope of presenting new ideas for consideration. However, as the harvester can only recover a few grains of wheat by repeatedly going over the stubble field, so the worker in this field of clinical study can only hope to gather a few stray facts by drawing out the views and experiences of others who have given careful study to this subject.

The suggestions here offered are not presented in a dogmatic way. The question asked in the title of this paper is suggested for the purpose of gaining information, even though it assumes the form of an affirmation.

To obtain the information sought I shall present an argument in support of certain views with reference to the subject. If I set up a man of straw, I shall not feel humiliated if others knock him down. The convictions and opinions of one man are valuable only in so far as they are confirmed by the larger and wiser views of others who have given equal consideration to the subject under discussion. I ask the direct question, What shall we do with the uterus after the removal of both tubes and ovaries?

The internal organs of generation, uterus, tubes and ovaries, possess a joint function. They have need of each other. The uterus, bereft of the tubes and ovaries, becomes a useless and rudimentary structure. It has no functional value, and is about as useless as the fifth wheel to a wagon. If this be the case, why, then, leave it after robbing it of those organs which are essential to its functions?

The answer to this question will depend for its solution very largely upon habit, precedent, general custom and individual bias. There can be only one other logical answer—the additional risk of mortality from a hysterectomy superadded to an oophorectomy. This statement can only apply to that class of cases in which a simple oophorectomy has been done. Here it is admitted that the amputation of the uterus will add somewhat to the complication of the oophorectomy. Statistics are, however, not available to prove this assertion, and it must rest entirely upon circumstantial evidence.

In dealing with this simple class of uncomplicated cases of oophorectomy it will be conceded by many, no doubt, that the uterus may as well be left undisturbed. This is the present routine practice, seldom violated—a so-called unwritten law about which men may differ, but in regard to which almost all act in concert. So far is this practice employed, that in conditions of retro-displacements of the uterus it is the general practice to bring the uterus up and attach it to the abdominal wall, to reif the round or broad ligaments or to fix it in some false position for further distress to the patient. In this class of cases why employ such artificial aids to a useless organ? Would not the removal of the uterus by a supra-vaginal amputation be the least evil to follow in such conditions? Can experience and practice answer this question? My own cannot. I have been so far a slave to custom that I have not abandoned the irrational for that which is rational. Who has?

Passing from these simpler cases of oophorectomy, I come next to that class in which we have positive evidence of tubal and ovarian inflammation. Infection of both tubes, possibly of both ovaries, calls for ablation of these organs. The uterus may or may not be involved in the infective process. Most usually

*This paper was prepared some six years ago, but has never been published. Its contents have never been shown to Dr. Brent, and it has been offered now as it accords so well with Dr. Brent's observations.

it is more or less so. If not actively involved it is often arrested in its involution, burdened with a poor circulation and more or less a menace to health.

Its involution and circulation may improve after the removal of the diseased appendages, yet how often does it happen that it remains a permanent source of ill health to the woman. Of what use is it after passing through these changes? Would not its removal by high amputation be the least of the evils which are likely to follow after the removal of its appendages? Here the elements of increased danger from the additional procedure of high amputation may enter into consideration. Except in a few rare cases, is not this danger exaggerated? In my own personal experience such is the case. I have had no greater mortality following high amputation than in those cases in which the uterus was left behind.

In cases of pronounced uterine infection, where tubes, ovaries and uterus were all involved, high amputation has been the means of saving cases which, in my judgment, would have died had the infected uterus been left behind. There can be little discussion about this class of cases. High amputation is a conservative measure, and can only be disparaged on the ground that the condition of the patient at the time of operation may not warrant the danger of shock and hemorrhage, already extreme. Here we are sailing from Scylla to Charybdis. We leave behind an infection to avoid the danger of immediate death, to invite a death only a few hours later from sepsis. The wisdom of this line of action must be determined by the judgment of the operator and by the conditions present in the given case. No arbitrary rules can be established to govern such conditions, still individual experience must teach one what is best to do under such grave circumstances, and lead to measures more or less daring, according to his temperament and method of practice. I am firmly convinced that I have saved more patients by boldly going ahead in the face of grave shock and removing all sources of infection within sight—removing all the organs and tissues involved, even to the extent of resecting an infected ileum—covering in all exposed surfaces and hinging the result on the thoroughness of the procedure, than by compromising with the conditions through drainage and other artificial helps.

The improved mortality rate in inflammatory conditions within the pelvis is due more largely to careful dissections, thorough removal of semi-disorganized tissues and to covering in of exposed surfaces, than to any other factors, if we accept only the employment of aseptic principles. In the former we remove the danger of infection from within; by the latter we limit the danger of infection from without.

HYSTERECTOMY IN ASSOCIATION WITH BILATERAL SALPINGO-OÖPHORECTOMY.

By Hugh W. Brent, M. D.,

Instructor in Gynecology, University of Maryland.

The question as to the removal of the uterus in association with bilateral salpingo-oöphorectomy is of no small importance in many instances.

There are, of course, many arguments for and against this procedure, but in many instances a radical operation of this kind is absolutely indicated.

Simple bilateral salpingo-oöphorectomy may greatly alleviate the existing conditions, but we cannot hope for permanent and complete cure if we bow to the dictates of "routine" and fail to judge each case on its own merits. In these days, when the tendency is for each man to do his own surgery, possibly without the previous training and experience in this work which is so essential to success, we may expect to encounter cases in which incomplete and therefore only partially successful operations have been performed.

For some unknown reason gynecological operations seem to be those most fearlessly undertaken by physicians who are not only not surgeons, but are not gynecologists. We, of course, in this locality deal with diseases that are usually essentially chronic in character, and we know full well that the most fatal surgical ailments are those acute diseases which the body at the time of operation is fully occupied in combating, and can ill afford to bear the added burden of operative interference.

This explains to a certain extent the low mortality in pelvic surgery, though there are other

factors, such as the greater powers of resistence of the pelvic portion of the peritoneum and the minimum handling of intestines during these operations. This may explain to a certain extent the invasion of this field by men "untrained in the art," but aside from mortality the permanent cure of the patient is a consideration not to be lightly thought of by one who would do his whole duty. In no other specialty is special training, special experience and good judgment more desirable.

We are dealing with the very fountain of Life when we undertake to correct the varied maladies of the generative apparatus and are perverting more or less by surgery the functions of a system of organs so essential to the well being and happiness of the individual as to command something more than mere ability to do the mechanical part of the work.

The decadence of gynecology as a specialty is a thing frequently spoken of today, not by the gynecologists who recognize its value, but rather is it being forced upon them by the invasion of the pelvis by "almost every one else."

As the supply of pelves is limited and as the gynecologist in common with other people must earn his daily bread, one can hardly criticise him for excising an offending appendix or taking off a leg as the needs of the patient may require. I hope this digression from the subject under consideration will be pardoned; it is merely intended to point out the necessity for a careful and capable consideration as to the needs of each case, if we are to be rational and successful in its management.

Reference in this paper is to supra-vaginal hysterectomy, a much simpler procedure than total removal of the organ.

In the class of cases under discussion it is not necessary to remove the entire uterus, amputation at the internal os being quite sufficient.

Among the debatable points are:

1st—Operative Mortality.

This is practically the same. In uncomplicated cases hystero-salpingo-oophorectomy has no higher mortality than the less radical operation. If, however, the patient is already shocked by a prolonged operation, we will naturally hesitate as to the advisability of adding to the existing depression a factor which might swing the pendulum toward disaster. On the other hand, in association with the more serious pelvic ailments, notably inflammatory diseases, it is often simpler and easier to remove the entire mass, including the uterus, "in toto."

In shock where rapidity is of the utmost importance a hystero-salpingo-oophorectomy may be indicated as offering the patient a much better chance of recovery, aside from its possible importance in effecting a radical cure.

2d—The Value of the Uterus in Supporting the Pelvic Floor.

When the cervix is left this is a minor consideration The vesico-uterine attachment is undisturbed, there is no special tendency toward prolapse either of the rectum or bladder, and the cervical stump remains higher in the pelvis. Of course, there is a possbility of trouble of this kind, but it is decidedly remote unless there be some co-ordinate weakness of the pelvic floor. In fact, these patients, as a rule, suffer rather from atresia of the vagina, due to the resultant atrophy of the entire sexual system through the influence of an artificial menapause.

3d—Its Influence on Menstruation.

In a certain number of cases menstruation persists a few months or irregularly for a year or so after complete ablation of the ovaries. The exact cause is not known, but it is probably explained by "nervous habit," if I may term it such. That is, menstruation is so firmly fixed in some women as a physiological function that through the influence of some inherent nervous impulse it continues after the removal of the primary exciting cause—internal ovarian secretion. It may be argued that in these cases we find an indication for the less radical operations.

As the menapause (artificial) is inevitable, however, I can hardly consider any element likely to cause its prolongation either essential to health or in any way desirable. The sooner the cycle of changes recognized as an artificial menapause is completed the better it will be for the patient's health and mental happiness. Let us take up the reasons which justify us in deciding on the more radical operation. They far overshadow, I think, the mostly imaginary contra-indications.

We have already discussed two points in its favor. Its advantages in cases of shock where it can be performed with greater rapidity than simple bilateral salpingo-oophorectomy, and the celerity with which the artificial menapause is completed.

We find another in pelvic inflammatory disease. A large percentage of bilateral salpingo-oöphorectomies are done for pyo-salpingitis and we must not forget that this condition is associated in many instances with chronic inflammation not only of the endometrium, but of the uterine muscle itself.

In our efforts to conserve a useless and certainly functionless organ we may overlook the fact that we are leaving behind a pathological process, which may to a certain extent, and often does, mar an otherwise perfect result.

Sometimes, of course, the general atrophy of the uterus, including its glandular system, is accompanied by abatement of the endometric and uterine inflammation, but this is by no means always the case.

Another post-operative sequel of no mean importance is the so-called "apoplexia uteri." This fortunately, is not common; if it were, there would be no question as to the advisability of always performing hystero-salpingo-oophorectomy.

The vessels of the uterus in some cases become schlerotic and brittle after removal of the ovaries, and in these cases menstruation usually persists and is alarmingly profuse. Hemorrhage is of such long duration (10-15-20 days) and so much blood is lost that the general health of the patient often suffers.

In association with the menorrhagia, dysmenorrhoea is not uncommon and is usually severe in character.

In fact, the condition may be so unbearable as to convince the patient that she has not only been benefited by operation, but has been distinctly harmed by it, and in some instances she certainly has good reason for drawing this conclusion.

I think we may conclude, therefore, that when a functionless and therefore useless organ is capable of causing through its presence so much trouble, even though trouble be limited to a few cases, we are justified in its removal at the time of operation, unless some special contra-indication exists.

The Georges Creek Branch of the Allegany County Medical Association, in convention at the Frostburg Opera House, Maryland, March 21, 1908, elected the following alumnus an officer for the ensuing year: Treasurer, Dr. W. O. McLane, class of 1892, Frostburg; censor, Dr. W. O. McLane, Frostburg.

The Nu Sigma Nu Fraternity of the University of Maryland held its annual spring initiation March 21, 1908. The chapter house at 618 West Lombard street was beautifully decorated with palms and evergreens. Besides the student members of the fraternity, there were present Doctors J. C. Hemmeter, St. Clair Spruill, Hiram Woods, L. M. Allen, J. Mason Hundley, Joseph L. Hirsh, T. Harris Cannon, C. W. Roberts, Jacob W. Bird, J. B. Piggott, J. W. McConnell, R. W. Mitchell.

The Sigma Tau Chapter of the Theta Mu Epsilon Fraternity, of the University of Maryland, held their annual banquet at the Belvedere Hotel Thursday, March 5, 1908. Dr. Arthur M. Shipley was the toastmaster. Those who spoke were: Dr. H. P. Hill, Mr. J. L. Anderson, Mr. G. H. Richards, Mr. W. J. Coleman, Prof. C. W. Mitchell, Prof. Randolph Winslow, Prof. L. E. Neale, Mr. F. W. Rankin.

Dr. Frank Denton Gavin, class of 1874, resident physician and general superintendent of the Church Home and Infirmary, Baltimore, has resigned to take up the practice of medicine. Dr. Gavin has been associated with the institution for thirty-four years.

Dr. John H. Drach, class of 1880, of Butler, was thrown from his horse Saturday night, March 1, 1908, by a wire stretched across an open gateway through which he attempted to ride. Although severely injured, he insisted on paying the visit.

Dr. Thomas C. Baldwin, class of 1894, a former practicing physician of Whitehall, Md., but for the last four years a resident of York, Pa., has returned to Whitehall, where he will resume the practice of his profession.

The Baltimore and Ohio Railroad Company has designated Dr. Samuel Claggett, class of 1898, of Frederick county, as the company's surgeon at Knoxville, Md. This town is at the west end of the Brunswick yard.

Dr. C. W. Trader, class of 1878, is practicing his profession in Cuereo, New Mexico.

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EDITORIAL.

WHO OWNS THE PROPERTY OF THE UNIVERSITY OF MARYLAND?—The editor of *Old Maryland* takes the editor of the BULLETIN to task for making the statement in a recent issue that "The University of Maryland is a State University" and "that its property is owned by the State." The editor of the BULLETIN is so busily engaged in the work of trying to build up the interests of the Medical Department of the University that he has had no time to read the ancient history of the University or to study its charter. He may be technically in error in the statement he has made as to State ownership but from a practical standpoint he claims to be correct. If the property of the University is owned solely by the Board of Regents, it is held by the Regents in trust for the people of Maryland, and would revert to the State when it ceased to be used by the Regents for educational purposes. If the editor of *Old Maryland* can show where during the long life of the University the Regents have ever sold a dollar's worth of University property and converted the proceeds to their private uses, we would be glad to know the facts.

On the contrary, the BULLETIN can show where the Regents have expended thousands of dollars on the University from tuition fees which have added to the value of the property now held in trust by the Regents. We do not believe it would be possible under any circumstances for the Regents to sell the property of the University and to apply the proceeds to their personal use. To insinuate such a charge is to accuse the Board of Regents of dishonesty and breach of trust.

If the editor of *Old Maryland* will devote less criticism to the shortcomings of the Board of Regents and will offer some practical plan, will name some gifted Moses to lead the Regents, the reorganization of the University along the lines he so devoutly advocates may be made effective. The Board of Regents, as now composed, is made up of the members of the Faculties of the four Departments, with a probable representation of three members from St. John's College.

These gentlemen are alive to the interests of their respective departments. The growth of these departments is sufficient proof of their loyalty to the University. Under the conditions under which these departments have worked there is a divided opinion among the Regents over the suggestion of a plan of reorganization which will place the property interests and management of the departments under a single administrative authority.

Whilst the editor of the BULLETIN holds to the opinion that a reorganization under a wise and conservative policy would improve the educational and financial condition of all of the departments, he is not prepared to find fault with those members of the Board of Regents who do not hold to his views. The sentiment in favor of a reorganization is a growing one. When a plan is presented which will meet present as well as future conditions, a strong State University will be the result. Moreover, the property interests of the University will be so safeguarded as to remove all danger of their diversion to private uses.

MEETING OF THE UNIVERSITY OF MARYLAND MEDICAL ASSOCIATION, MARCH 17, 1908—EXHIBITION OF TWO DOGS WITH ACCESSORY OR PAWLOW STOMACHS — DEMONSTRATION OF TWO SINE SALIVARY DOGS — COMPARISON OF THE EFFECT OF THE GASTRIC JUICE OF NORMAL DOGS WITH THE GASTRIC JUICE OF DOGS WHOSE SALIVARY GLANDS HAD BEEN EXTIRPATED.

At the meeting of the University of Maryland Medical Association, on March 17th, the large clinical amphitheatre at the University Hospital was crowded to its utmost capacity. Dr. Thomas E. Satterthwaite, formerly President of the Medical Society of Greater New York and the distinguished heart specialist, was the guest of the Association, but the feature of the evening

was the demonstration of living animals who had successfully been nursed through very difficult surgical operations upon their stomachs, viz.: the preparation of an accessory stomach, and others had undergone complete extirpation of their salivary glands. These animals had been operated upon by Dr. Frank Martin, Dr. St. Clair Spruill and Dr. J. Mason Hundley and Professor Hemmeter. The two animals from whom the salivary glands had been completely removed were operated upon last July and August. The two animals who had successfully recovered from the operation providing them with an accessory stomach had been operated upon by Dr. St. Clair Spruill in November, 1907. Professor Hemmeter began his demonstration by saying that he disapproved of demonstrating living animals for the purpose of giving evidence of their varying gastric secretion, because such animals were, as a rule, extremely sensitive to psychic impressions and to the unavoidable confusion and excitement attending their transportation from the kennel or laboratory, and their exhibition before such a large audience at such a late hour of the evening, when their usual habit was to be quietly at rest or sleeping. Very frequently, he said, the unexpected happened during such a demonstration, the dogs sometimes doing exactly the opposite of what they are expected to do; but as the demonstration went on it was very evident that the demonstrator's apprehensions were unfounded, for these four animals gave evidence that the removal of the salivary glands decidedly reduces the amount of hydrochloric acid and the proteolytic and milk-curdling power of the gastric secretion.

The gastric juice was collected from two of the animals from a rubber tube inserted into a fistula through the abdominal wall directly into the experimental stomach; in other cases it was drawn by the stomach tube; both in sight of the audience.

Dr. E. Holland, Dr. J. Howard Iglehart and Dr. Charles C. Conser executed the quantitative titrations before the audience, for which an ample number of burettes, decinormal solutions of sodium hydroxide and numerous indicators for free and combined HCL had been provided.

The first animal exhibited was a large tan-colored dog, looking much like a Scotch bull terrier. He was carried in by the janitors, resting in a peculiar dog holder on bandages that supported him immediately behind the front legs and on the posterior part of the abdomen. The animal appeared to be comfortable and wagging his tail in a friendly way whilst reposing in this holder.

Dog No. 1.—Accessory stomach prepared according to the method of Dr. J. C. Hemmeter. This animal had not been fed since the previous day. His salivary glands were intact. Held up by his front feet in full view of the audience, the demonstrator introduced his finger through the abdominal fistulous opening into the accessory stomach. A rubber canula was exhibited presenting many perforations. This was introduced into the accessory stomach and held there by a rubber bandage encircling the animal's abdomen. A small Erlenmeyer flask was held to the end of this canula and the dog brought to a position of repose in the holder. Next this animal was shown some fresh-ground meat, but not allowed to eat any. This produced a psychic secretion. Within a few minutes clear gastric juice of the color of Rhine wine was observed dropping into the flask. When about 8 or 10 cc. had been collected, it was given to Dr. Conser, who demonstrated the presence of free HCL by the phloroglucin-vanillin test, and to some of it fibrin was added and given into the care of the analyst to report at the next meeting of the Society.

Dog No. 2.—This was a black female Mongrel Newfoundland with an accessory stomach, also operated on by Dr. St. Clair Spruill. This animal was given water to drink, and it was surprising to see that none of the water ran out through the fistula in the abdominal wall, but presently there was a feeble secretion of gastric juice, though not as strong as in dog No. 1. This is explained by the fact that the accessory stomach is separated from the principal stomach by a double layer of the mucosa. In order that the animal should not be subjected to too great a dilution of the stomach contents, only about 150 cc. of water was given, and this followed by 100 grams of beef, and the gastric juice titrated as in dog No. 1. Some of it was added to a weighed amount of Fibrin and boiled egg albumen. Mett tubes—5 cc. of milk were not curdled at the end of 45 minutes by this gastric juice.

Dog No. 3.—This was a fox terrier from whom the salivary glands had been completely removed six months previously. A test meal of bread

had been given three hours before he was exhibited to the audience, as Dr. C. C. Conser stated. This meal was drawn with remarkable facility, and whilst it gave no evidence of free HCL with congo, nor with tropaeolin, it gave indications of the presence of combined HCL. Some of the juice of this animal was also poured over glass tubes of 2 mm. diameter filled with boiled egg albumen (Mett tubes) and placed in charge of the analyst to report at the next meeting, because the demonstration of the proteolytic power of juices requires eight to ten hours. But the juice of the dog did not give the phloroglucin-vanillin reaction. It should be mentioned that the alcoholic solution of phloroglucin-vanillin when evaporated by itself gives a peculiar dark yellowish stain on white porcelain, which should not be confounded with the vermillion color produced by free HCL. The two should always be evaporated on the same dish; that is, the pure phloroglucin-vanillin alone, and then the same reagent to which the gastric juice has been added for comparison. The total acidity of this animal's gastric juice was equal to 150 11-10 norm NaOH.

Dog No 4.—This was also a female black dog from whom the salivary glands had been removed. This dog was formerly a typically Pawlow dog, but by a mistake of the janitor she had been fed with bones three weeks ago, which perforated the partition between the principal or large stomach and the accessory stomach. A second operation was then performed by Dr. Mason Hundley, in which an attempt was made to restore the perforated partition or septum, in which, however, the operator was not successful. So the dog was sewed up again, from which operation she recovered, and she was used at this demonstration by drawing the test meals with a stomach tube. The gastric juice of this animal gave evidence of free HCL to congo, but not to phloroglucin-vanillin and not to tropaeolin oo. As the total acidity of the gastric juice was only equal to 10 (one-tenth normal NaOH), using Phenol pthallein as an indicator, there could not have been a normal amount of HCL in it, because the gastric juice of normal dogs contains an amount of HCL equal to from 50 to 65, one-tenth normal NaOH. The proteolytic power was tested by the Mett method and left for the clinical chemist to report upon at a future meeting. One of the imperfections of such demonstrations was that the demonstration of the proteolytic power required so much time that it was impossible to give either a positive or negative evidence before the audience concerning this factor. The Surgeons of the University Hospital, Dr. F. Martin, Dr. St. Clair Spruill, Dr. Mason Hundley, are to be congratulated upon the success of their operations upon these animals, for such animals are extremely difficult to nurse through such operations.

The docility of these animals was also surprising during these demonstrations. Stomach tubes were repeatedly passed through the jaws of rather savage-looking dogs, who did not resent this annoyance in the least.

In concluding the demonstration, Dr. Hemmeter gave expression to his opinions concerning a probable internal secretion of the salivary glands. He holds that they secrete a chemical substance which passes into the blood during mastication and starts up the secretion of gastric juice; that the gastric juice is greatly reduced in its content of HCL, remin or chymosin, after the salivary glands are extirpated, and that this reduced proteolytic power can be restored by intravenous injection of salivary gland extracts. This partial restoration of the impaired gastric secretion by salivary gland extracts has been demonstrated repeatedly to the large class of medical and dental students attending the demonstrations on Physiology; but it was not attempted before this Medical Society on March 17th because it was first necessary to demonstrate that the dogs had suffered a manifest loss of the constituents of the gastric juice before any effort to restore it by intravenous injection of salivary gland extracts could logically be made. Such a demonstration was promised for a future meeting. Dr. Hemmeter has been at work on this problem for over five years, approaching it from the standpoint of clinical pathology, as well as from the aspect of comparative Biology and experimental Physiology; and from these demonstrations it appears that his deductions are supported by sound clinical and physiological evidences.

CORRESPONDENCE.

Baltimore, Md., *March* 1, 1908.

Mr. Editor:

Dear Sir—Having had some experience in the healing art, may I be permitted to express my views as to the present position assumed by

Christian Scientists. No one denies that some of the aforesaid people affirm that they are Christian Scientists healers. As a matter of fact, then, they therefore affirm that they heal *diseases*. This of necessity must be so, for the simple reason that if there were no disease healers would be useless. So said healers admit that there are diseases and that they can heal them. Very good. If a Christian Scientist healer believes this (and I have shown he says he does) in so far he has done no harm, and he has a right to his belief. Let us take a step further, however, and see what actually happens when the healer is called upon to put his belief into practice. He is summoned to heal a sick child. He cannot tell whether the child has diphtheria or a stone in the bladder. At some time, however, someone is going to ask the question, What is the matter with the child? And right here is where the healer goes to pieces. He cannot name the disease he is paid to heal! He, therefore, denies the existence of disease, and says it is "mortal mind." He does this not because he wants to, but because he has to. By "mortal mind" the healer states that the trouble is mental only. I say without fear of contradiction that this is a device by which a healer *may* hold cases, collect fees and make a living. The Christian Scientist says that he can heal without having studied anatomy. According to him it is useless to take a four years' course at a medical college, because Mrs. Mary Baker Eddy can teach anyone how to heal anything in four months. The healer cannot even afford to say that there are incurable diseases. If he does admit that some diseases are incurable, someone asks, What diseases can you cure? Here again he is up against it, and, as he cannot discriminate between stone in the bladder and appendicitis, he allows it to be understood that he can cure both. I repeat, then, the fact that the Christian Scientist says that he is acquainted with a system by which he can heal a disease without knowing its name. Is there any absurdity beyond this? This system gives results which might be expected from its absurdity, as the following illustration will show:

A certain healer was employed to heal a lady dying of tuberculosis. He said that he could cure her. He did treat her, received his fees, and she did die while under his care. This patient perished miserably of tubercular laryngitis without so much as an anodyne to relieve the excruciating pain. I was intimately acquainted with the healer and the patient, and can qualify to the above statement. Again, we find Christian Scientists turning loose children infected with diphtheria, scarlet fever, etc., etc., who in turn infect innocent members of the community, and the climax to this astounding proceeding is only reached when the healer demands a fee for such treatment. Anyone can verify these facts, and anyone can see that the healer officiates for a consideration, and not for the privilege of spreading his religious belief. This was made as clear as sunshine at Annapolis in both houses of the Legislature.

The Anti-Christian Science Bill made no objection to the Christian Scientist, or to his proclaiming his belief, but the bill did object to his charging a fee for so doing. Hence the bitter fight made by the "scientists." All objections here advanced apply equally to anyone attempting to heal diseases without a proper knowledge of anatomy and physiology.

Wm. P. Chunn, M. D., Class of 1881.

OLD BALTIMORE STREETS: THEIR ROLES IN HISTORY.

Lombard Street—The Ancient Highways of Baltimore—This Is One of a Desultory Series of Papers.

No description of Lombard street would be complete without mention of the University of Maryland, one of the finest, as well as one of the oldest, schools in the country.

The University of Maryland, whose beautiful buildings are located at Lombard and Greene streets, is one of the oldest chartered universities in America, being the eighth established. It is unique among modern universities, having a school of medicine as well as law. Many of our most prominent lawyers as well as physicians have studied here. Many from other states received their education at this university.

In 1800 Baltimore was very young and small in size compared with now, but it had the true, progressive spirit. The great men of those days decided that a university would fill a great want.

An act of Assembly authorizing a lottery for building the college was passed by the legislature on January 20, 1808. About 1810 a lot was purchased on the northeast corner of Lombard and

Greene streets from Col. John Eager Howard, at "a merely nominal sum." Ten thousand dollars was asked, but no security was taken, and there were no limitations of time for payment. Colonel Howard himself contributed $1,000.

Mr. R. Cary Long was the architect. His designs were in the style so popular at that time. Mr. Long selected the Pantheon of Rome for his model. The result has long been the pride of the city.

A few words about the architect might be of interest here. He was born in Maryland in 1772, and to him the city owes the introduction of gas and the honor of being second only to London in utilizing this method of illuminating.

The men appointed to conduct the lottery in 1808 were Col. John Eager Howard, James Calhoun, Charles Ridgely, of Hampton; Charles A. Warfield, John Crawford, W. M. Gwynn, John Comegys, Solomon Birckhead, John B. Dandidge and Ernal Martin. They were charged to secure not more than $40,000, but they made little progress, and later on Dr. Cooke and Professor Potter assumed charge. However, it was not until after the building had been completed, in 1812, that help was derived from the lottery.

The expenses of building were largely borne by the members of the faculty, who made themselves personally responsible for debts. Loans from banks and individuals were negotiated. Robert Gilmor, Jacob and David Hoffman and Colonel Howard gave both financial aid and time to the enterprise. The cornerstone was laid April 7, 1811.

Among the eminent men who have taught within its walls, and who have achieved world-wide reputation, are Granville Sharpe Pattison and Robley Dungleson.

To no individual is the school of medicine more indebted than to Dr. Nathan Ryno Smith, who was elected to the chair of surgery in 1827. His acceptance infused new energy in the institution. He was soon regarded as the most skilful surgeon in the country, and attracted students from all parts of the United States.

It would be quite impossible in the limited space of this article to mention all of the brilliant physicians and lawyers who received their education in or who taught at the university from the earliest days.

An old directory of 1842 says that the "Faculty of Physic" of the University was composed of Drs. Nathaniel Potter, Richard Wilmot Hall, Wm. E. A. Aiken, Nathan R. Smith, Joseph Rolfy and George W. Miltenberger. The dean was Samuel Chew." Ten years later we find added the names of Drs. William Power and Richard Thomas.

The law school has also played a most important part in the history of Baltimore. As early as 1831 there were 30 students at the college. In 1837 the members of the Faculty of Law were: David Hoffman, dean, and the Messrs. Meredith, Winchester, Mayer, Evans, Hall and Dobbin, professors. Others who received their education or taught in the university are John H. B. Latrobe, George William Brown, Bernard Carter, H. Clay Dallam, John P. Poe, Robert A. Martin, John A. Inglis, Alexander Handy, S. Teackle Wallis, Reverdy Johnson, Charles Marshall, Thomas W. Hall, John P. Kennedy and Judge Harlan.

This article appeared in the Baltimore *Sun* of March 22, 1908. It is reprinted because it shows the trend of the times. In other words, the University of Maryland is again attracting notice, and why shouldn't it? Our faculty and graduates compare favorably with those of any other school in the country.

ITEMS.

At the last regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, March 17, 1908, at 8:30 P. M., the program was as follows:

1. "Gonorrhoeal Endocarditis: Report of a Case," Dr. Jacob Bird.

2. "Cerebro-Spinal Meningitis: Therapy and Report of Cases," Doctors Bagley and Gichner.

3. Exhibition of Dogs with Accessory (Pawlow) Stomachs; Demonstration of Sine Salivary Dogs; Effect of Extirpation of Salivary Glands on Gastric Secretion, Dr. J. C. Hemmeter.

Dr. Bird's paper appears elsewhere in this number. Dr. Bagley read an extensive and exhaustive paper upon what is known of epidemic cerebro-spinal meningitis, and exhibited three patients upon whom the Flexner serum had been used. In each of these patients there is no doubt of the accuracy of the diagnosis, as the diplococci were demonstrated in the cerebro-spinal fluid. So far Dr. Bagley has only been able to test the efficacy of this serum upon the three cases presented to the society, with a

complete cure in each instance. As Dr. Hemmeter's work was of such a monumental character, I have deemed it worthy of as full a report as my meagre qualifications will permit, so present it to you as nearly verbatim as possible.

Prof. John C. Hemmeter, who holds the chair of Physiology and Clinical Medicine at the University of Maryland, has received official notification from Geheimre Medizinal Rath Ewald, who is professor at the University of Berlin, that he has been elected an honorary member of the Royal Society for Internal Medicine of Berlin (Kgl. Verein fur Innere Medicin). Professor Hemmeter's writings are known to occupy a very high rank in Germany, and his work on the Diseases of the Intestines is undergoing a translation into German under the editorship of Dr. H. Schorlemmor. Professor Hemmeter is already a member of the Imperial Society of Austrian Physicians in Vienna, and of a number of French scientific associations. He is an alumnus of the Baltimore City College, of the Royal Gymnasium at Wiesbaden, Germany, has the degree of Doctor of Medicine from the University of Maryland, of Doctor of Philosophy from Johns Hopkins University, and Doctor of Laws from St. John's College, Annapolis.

His articles that have been published in German journals are equal in number and merit to those published in America.

We are indebted to Dr. W. B. Warthen, of Bartow, Ga., for the following item of information:

At the regular monthly meeting of the Washington County Medical Society the following alumni were elected to office: Dr. Wm. Rawlings, class of 1875, re-elected delegate to State Convention; Dr. W. B. Warthen class of 1905, appointed censor. Owing to the expiration of their terms, the following retired from office: O. L. Rogers, class of 1897, president; D. L. Cheatham, class of 1874, censor.

The editors desire to publicly thank Dr. Warthen for this bit of information. It is just such news items that we desire, and our burden would be greatly ameliorated if our other alumni would occasionally send us some little information about themselves and their classmates and friends. Because you have left the portals of the old University is no reason for you to let your connection cease. Keep yourself in touch with the institution and your fellow-alumni by writing for the BULLETIN.

For the fourth time within the year Dr. Wm. D. Corse, class of 1887, of Gardenville, Md., has recently been confined to his home as the result of an accident. He was thrown from his buggy on Gay street, above North avenue, Baltimore, as a result of which he suffered severe contusions and lacerations of his head and body, as well as being considerably shocked.

Less than a year ago Dr. Corse was struck by lightning, from which he suffered considerably; some months later his horses ran away with him and he suffered a broken rib; not long after this accident he was thrown over an embankment with his carriage.

Dr. Howard D. Iglehart, class of 1903, and Mrs. Iglehart, before her marriage Miss Nancy Kinnirey, class of 1902, of the University Hospital Training School for Nurses, both now of Baltimore, are being congratulated upon the birth of a fine girl baby.

Dr. S. P. Latane, class of 1897, ex-medical superintendent of University Hospital, and now located at Winchester, Va., has been appointed a member of the Virginia State Board of Health, which was recently created by the General Assembly with an appropriation of $40,000 for its work. The appointment came to Dr. Latane unsolicited, and is a just recognition of his qualification for the position. Dr. Latane is rapidly coming to the front as one of the leading physicians of the state. His ability and training are of a high order and his success is assured. THE BULLETIN wishes him the very best in his field of work.

The class of 1876 of the University of Maryland held its thirty-second annual banquet at the Hotel Rennert, Baltimore, February 29, 1908. The reunion was attended by some of the most prominent physicians in the city. Dr. H. H. Biedler was the toastmaster. The toasts were responded to by Drs. Samuel C. Chew, Wilmer Brinton, Henry D. Fry, of Washington; W. A. B. Sellman, Harry Friedenwald, J.

L. Noble, of Preston; T. Chew Worthington, P. H. Latham, of Weatherly, and J. H. H .Gorsuch.

Dr. C. F. Bevan, class of 1871, professor of surgery in the College of Physicians and Surgeons, Baltimore, has been elected vice-president of the Association of American Medical Colleges.

At the meeting of the Baltimore County Medical Society, held March 19, 1908, at Towson, Md., Dr. Charles W. McElfresh read a paper on "Early Diagnosis of Abdominal Diseases."

Dr. A. C. Harrison, class of 1887, of Baltimore, has been appointed surgeon in chief of the United Railways Company, to succeed the late Dr. I. R. Trimble.

Owing to the recent burning of the Masonic Temple, the Geneva Lithia Water Co., of which Mr. Eugene F. La Porte is resident manager, is temporarily located at 16 Clay street. Upon the rebuilding of the Masonic Temple, which is in course of construction now, Mr. La Porte will occupy the same offices under the Masonic Temple as heretofore.

DEATHS.

Robert H. VanDyke, one of the best-known civil lawyers in lower or central Delaware, who succeeded to the practice of his father-in-law, J. Alexander Fulton, died Friday, March 13, 1908, of a peculiar stomach trouble which baffled his physicians.

Dr. Deever, of the German Hospital, Philadelphia, was several days ago brought into the case by Dr. Pressly S. Downes, the attending physician, and the doctors wanted to operate, but the patient asked for delay that a further diagnosis might be made.

Mr. VanDyke was also a physician, having graduated in medicine at the University of Maryland, class of 1884. He, at the instance of his father-in-law, ceased the practice of medicine and took a course in law. He was admitted to the Kent county bar in 1889, and at once became active in civil law.

Dr. VanDyke was born near VanDyke's Station, Maryland, where he still owned several fine farms at the time of his death. He took great delight in farming enterprises. During the recent local option campaign he was very active for the no-license forces, and Chairman Daily secured his services for a stumping tour. It was during this campaigning that he caught a severe cold, which in some way settled in the abdomen.

The deceased was an ardent Presbyterian, a trustee of Dover Presbyterian Church, leader of the choir and chorister of the Sunday School. He was an accomplished musician and could not only "sing his part" in the chorale, but could take his place at the pipe organ and play the entire service. His wife, formerly Miss Nan Fulton, survives him.

The funeral took place Monday afternoon at 1.30, under the direction of Rev. Joseph Brown Turner, his pastor, of Dover Presbyterian Church. Interment was made in the adjoining churchyard, a historic spot which Dr. Van Dyke and a committee of associate churchmen have beautified and made it one of the most interesting places in Dover. Delegations of the Kent county bar, members of the Legislature, a deputation from Diamond Lodge, A. O. U. W., of Dover, and other organizations attended the funeral.

Dr. E. Hall Richardson, class of 1891, one of the most prominent and influential physicians of Harford county, Md., died on the morning of March 7, 1908, at his home, in Belair, after a short illness of pneumonia. He contracted the disease as the result of exposure incident to his professional work. He was the son of the late Dr. William S. Richardson, and was forty years old. He was a great-grandson of Captain John Adams Webster, one of the defenders of Baltimore in the war of 1812. Dr. Richardson was a widower and is survived by one sister, Miss Bessie May Richardson, and one brother, John A. W. Richardson, of New York.

The death of Dr. I. R. Trimble at St. Joseph's Hospital of blood poisoning, in consequence of infection during a surgical operation, calls attention to the risks incurred by medical men in the practice of their profession. In the use of the knife their own life, as well as that of the patient, is at stake. Dr. Trimble's demise is specially regretted by reason of his eminent ability, his skill

and his possession of qualities of intellect and heart that endeared him to all who knew him. Socially and professionally he occupied a position of distinction, so that his death will be widely felt.

On February 10, in cutting about the kidneys of a patient, Dr. Trimble nicked with his knife two fingers of his left hand. The cuts were sterilized to destroy the bacteria that might have been communicated by the patient, and the incident was forgotten. The bacteria present in diseased tissue are sometimes extremely virulent, constituting a poison. Introduced under the skin of a healthy person they multiply rapidly in the blood, and, altering its character, interfere with all the processes of life. Cuts and abrasions incurred by surgeons in their operations are not all necessarily dangerous. The morbific bacteria are not always and everywhere present. But where there is internal disease attended by suppuration the risk is known to exist and care must be taken to avoid infection. When introduced beneath the skin the morbific bacteria are sometimes successfully destroyed by prompt cauterization, or other means, but the cases in which all effort to stay their growth has failed are fairly numerous. Many distinguished surgeons have succumbed to blood poisoning incurred in the discharge of their duty. In Dr. Trimble's case symptoms indicating the multiplication of bacteria soon appeared and heroic measures were taken to prevent the spread of the poison from the hand to the body. The veins of the hand and arm were emptied up to the armpit, but without effect, the removal being too late, or the bacteria being of extraordinary virulence.

It is stated that the patient upon whom Dr. Trimble was operating is improving and may recover. In other words, the patient had not taken the morbific bacteria into the circulation, or, if introduced, the bacteria by their growth had produced an anti-toxin which rendered him immune. A newer theory asserts the development in the blood of a substance, called opsonin, which renders the bacteria inert. Millions of the bacteria existed, doubtless, in the patient's diseased kidney, but nature had devised a means of isolating them, or of rendering them harmless. This ingenuity of the cells composing the human body is one of the marvels of science. Surgeons tell us that when they have opened the body and removed an important organ, it is the custom to pack the place it occupied with sterilized gauze, leaving some of the gauze protruding from the wound, so that drainage, if need be, may take place. No sooner is this done but nature goes to work to prevent blood poisoning by secreting material for a wall that will completely enclose the gauze. A temporary membrane impermeable to bacteria is built up all around, and the delicate organs of the interior of the body are protected from infection. Then when the internal cut surfaces have healed and the gauze has been pulled out, nature goes to work to remove the temporary membrane she had constructed. Bit by bit it is absorbed and taken away, with the result that no trace of it is left. The thing seems incredible! How can the cells of the tissues round about the inserted gauze, or round about the cut surfaces, know that an emergency has arisen? How can they act intelligently to achieve a definite result? And then, when healing has taken place, how can they have sense enough to perceive that it is up to them to remove the temporary wall?

One may say it is cellular wisdom or the wisdom of the molecules of which cells are composed, or of the atoms of which the molecules are composed. If so, the atoms, molecules or cells are excellent surgeons, and capable of varying their action to meet changing emergencies. They manifest intelligence. They do their best, and if conditions are not too unfavorable "win out" and cure the patient. If what they do seems too wonderful for mere animated matter, there remains the doctrine of a divine, omnipresent Power, who is all and does all that materialists ascribe to the inherent properties of atoms. Be the theory what it may, the fact remains that a patient may recover, though a diseased organ contains virulent bacteria enough to destroy, if introduced into the circulation, thousands of persons.—*The Sun Editorial, Feb. 25, '08.*

CHANGE OF ADDRESS.

Dr. R. B. Hayes has moved his place of residence to 2535 St. Paul street, Baltimore.

Dr. W. C. Gordon has moved from Wallum Lake, R. I., to 1285 Cranston street, Providence, R. I.

Dr. R. A. Wall has changed his residence from 526 North Fulton avenue to 4500 Pimlico Road, Baltimore.

Dr. R. C. Carnal has moved from Rheins, S. C., to Waverly Mills, S. C.

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TRAUMATIC ANEURYSM OF THE BRACHIAL ARTERY.

(Report of a case with ligation of the artery and its terminal branches.)

BY ROBINETTE B. HAYS, M. D.,

Ex-Resident Surgeon of the University Hospital, Baltimore, Md.

On March 4th, 1907, Henry R——, a muscular, well developed young negro, was admitted to the University Hospital as a patient of my chief, Prof. St. Clair Spruill, with a history of having six weeks previously accidentally stuck a penknife into his right arm just above the elbow. Immediately after the injury there was a profuse hemorrhage, which was checked by the application of a tourniquet.

A physician was summoned, and on his arrival removed the tourniquet, when it appeared that the hemorrhage had been permanently checked. The wound was cleansed and dressed and healed uneventfully.

About a week later, the arm having caused him no discomfort in the meantime, the patient attempted to cut some wood. The effort caused him pain, so he desisted.

Soon afterward he noticed a swelling at the point of injury. This increased in size and caused pain, which was always increased by any attempt to use the arm.

The swelling continued to slowly increase in size, the increase being attended by more or less pain, until the patient came to the hospital for relief.

On examination a tumor the size of a man's fist was found occupying the flexure of the right elbow, which was held in a position of semi-flexion. The most prominent portion was a point about 1½ inches above the elbow, on the anterior and slightly inner aspect of the arm. At this point could be seen the ciatrix of the punctured wound, which was the origin of the trouble.

Distinct fluctuation could be obtained here, but the rest was firm and only slight tenderness was elicited by pressure. There was little pain except when an effort was made to use the arm.

A comparison of the pulse in the radials of the two sides showed that on the injured side to be markedly weaker than on the opposite side and also somewhat retarded. There was no pulsation of the tumor and no bruit could be made out by auscultation over it. Examination of the heart and lungs was negative. Urinalysis, also negative.

Patient's entire condition, with the exception of the injured arm, was normal. Temperature on admission was 99.6° F. Diagnosis was made of Traumatic Aneurysm of the Brachial Artery.

On March 6th patient was operated upon by Prof. Spruill; was anesthetized with ether, the arm cleansed in the usual manner and an Esmarch tourniquet loosely applied above the tumor. A longitudinal incision, six inches long, was made over the course of the brachial artery, passing directly over the swelling and extending a couple of inches down the forearm.

There was found to be a partially organized blood-clot, which infiltrated the cellular tissue and extended between the various muscles and layers of fascia. It was densely adherent, and when an attempt was made to remove it, there was a gush of bright arterial blood. The tourniquet was tightened so as to control the hemorrhage, the coagulum removed and the vessels exposed.

There was seen in the brachial artery an elliptical opening the size of a grain of wheat, a portion of the vessel-wall having been completely removed. The basilic vein also was seen to be injured and was ligated with silk above and below the point of injury. The artery was separated from its sheath and ligated with silk on the proximal side of the opening. When an attempt was made to apply a ligature distal to the opening, it was found that this was so near the point of division of the artery as to necessitate

ligation of the radial and ulnar arteries just below their points of origin. This was done and the tourniquet somewhat loosened.

There was still a slight escape of blood from the opening in the artery. On searching for the origin of this hemorrhage, it was found that there was an anomalous origin of the interosseous artery, which arose in common with the radial and ulnar at the division of the brachial, instead of being as usual a branch of the ulnar. A ligature was placed around this, which completely controlled the hemorrhage.

The deep fascia was closed with interrupted sutures of chromicized cat gut, and the integument with a continuous, subcuticular suture of silver wire. The usual dressing was applied over the incision, the entire extremity was enveloped with non-absorbent cotton, and over this a plaster cast applied, the limb being put up in semiflexion.

At the close of the operation no radial pulse was perceptible. When the patient was returned to bed, the limb was kept slightly elevated. Warmth was maintained and circulation invited by the constant application of hot-water bottles.

The condition of the hand and forearm was kept under observation through a fenestra cut in the cast. For several days patient complained of numbness in the hand, but it was always warm. The fingers could be moved and sensation to touch was normal.

The day following the operation the patient's temperature reached 100° F., which was the highest point attained. On the fifth day after the operation it had returned to normal and continued so the remainder of his stay in the hospital.

The numbness gradually disappeared from the hand and sensation became normal, but it was not until March 15th that the radial pulse became perceptible. Then it was but the faintest flicker and lagged behind that of the opposite side.

The cast was removed and the arm examined on October 18th, and the wire suture was removed. Primary union had been secured. Lighter dressings were applied and the semiflexed position maintained, though the patient was allowed to make gentle movements at the elbows until October 30th, when he was discharged. The pulse at time of discharge was as strong and of as good volume as on admission, but was still somewhat retarded. All the movements, at the elbow, flexion, extension, pronation and supination could be accomplished without difficulty.

Of the vessels entering into the anastomosis by means of which circulation was re-established, according to Gray, by far the most important is the anastomotica magna. It, with the anterior-ulner recurrent, forming the anastomosis in front of the internal condyle of the humerus; with the posterior ulnar recurrent and posterior terminal branch of the inferior profunda, behind the internal condyle; with the interosseous recurrent and posterior terminal branch of the superior profunda behind the external condyle, not entering into the anastomosis in front of the external terminal branch of the superior profunda going to form this anastomosis.

The successful establishment of the collateral circulation, in this instance, was doubtless facilitated by the length of time intervening from the infliction of the injury until the ligation of the vessels.

During the greater part of this time there was a partial obstruction to the circulation in the main vessels, thus causing the accessory vessels to assist in maintaining the circulation of the forearm, partially preparing them for the greater effort they were called upon to make when by means of the ligatures the main vessels were completely occluded.

That there was at the time of operation a collateral circulation about the elbow was evidenced by the fact that, after the brachial artery had been ligated proximal to, and the radial and ulnar arteries distal to the point of injury, there was still some hemorrhage, which was checked by applying a ligature to the interosseous artery. This hemorrhage could have occurred only through the anastomosis of the interosseous recurrent behind the external condyle.

I have not the proper reference works, nor have I had opportunity to collect statistics as to the frequency of the above operation and the results obtained, but it is not one very commonly performed. Not infrequently there follows its performance gangrene of the extremity below the point of ligature, requiring amputation of the arm. Occasionally, when amputation has been deferred an unnecessarily long time, general sepsis and loss of life have been the consequences.

THE PHIPPS DISPENSARY.

By Eugene Kerr, M. D., (Class 1908),
Roland Park, Md.

The Phipps Dispensary is the division of the Johns Hopkins Hospital out-patient department devoted to the diagnosis and treatment of pulmonary tuberculosis.

Beginning its work in the spring of 1905, upon the completion of a building for which Mr. Henry Phipps, of Pittsburg, gave the sum of $20,000, it is now actively engaged in combating the ravages of consumption. Its staff, including laboratory workers, now comprises fourteen physicians and six nurses. The latter cover the entire city with their visits, as patients come to the dispensary from every section. The names of patients registered on the dispensary books up to the present time number more than 2,800, and are being added to at the rate of from five to ten a day. Although this department has a waiting-room which will accommodate about 40 people, it is frequently overcrowded.

Upon registration a history of the patient is taken, after which a physical examination is made. The patient is then informed of the diagnosis, and if it is definite, or even a suspicious case, he is instructed as to his mode of life, conduct toward others, etc. A tonic of gentian and nux vomica is commonly given, with possibly a cough sedative, as codein or heroin.

Any complicating symptoms would also receive appropriate treatment.

Particular stress is put on the destroying of sputum, and paper napkins are furnished to this end. Patients are requested to bring a sample of their sputum on their second visit, and suitable boxes are furnished for this purpose.

The name and address of the patient is given to the visiting nurse, who calls and inspects the sleeping apartment and impresses upon him and his family the importance of following out the proper rules of conduct; a tin sputum cup, with the accompanying cardboard lining, are furnished the patient by the nurse. The patient is requested to report at the dispensary from time to time for advice, medicine and to have his condition recorded.

Many patients make only a few visits, but the nurse is supposed to keep in touch with them until they are lost or die.

The Endowood Sanitarium is in close touch with the Phipps Dispensary, and receives many of its patients through it. Of course, it can receive only a very limited number of the incipient cases which present themselves.

Advanced cases with poor home surroundings are sent, if possible, to the Municipal Tuberculosis Hospital at Bay View.

A few suitable cases are referred to the charitable organizations of the city for food and care.

A certain number of early cases are taken into a "class," the members of which receive the tuberculin treatment, the tuberculin being administered hypodermically in graded doses, depending on various factors entering into the case. A careful personal supervision is exercised over these cases, and they are put under a strict regime of conduct.

In the past year Mr. Phipps has given more money to further the dispensary's work, and this has gone into fitting up the laboratory. Much experimental work is now being done in Germany and France on tuberculosis, and it is the aim of the laboratory here to keep in touch with the work being done abroad, and, if possible, add a mite to the knowledge on the subject.

Laboratory diagnostic methods are used in many cases as an auxiliary and for statistical purposes, as, for instance, Von Pirquet's cutaneous reaction and Calmette's ophthalmic reaction.

The Phipps Dispensary, as now organized and equipped under the supervision of Dr. Louis Hamman, is doing a work which, it is hoped, will in the near future show some results in the way of reducing the mortality in Baltimore of the widely disseminated white plague.

THE FREUND-WERTHEIM OPERATION FOR COMPLETE PROLAPSE OF THE UTERUS.

By J. M. Hundley, M. D.,
Clinical Professor Diseases of Women, University of Maryland

(An abstract.)

Before giving a description of the Freund-Wertheim operation Dr. Hundley reviewed some of the most important points in the mechanism of complete prolapse of the uterus, or procidentia. He also referred to the reasons for failure in the older operations. Loss of integrity of the pelvic floor is a potent factor in the production of procidentia, especially when associated with

a retroverted subinvoluted uterus. The uterus normally is placed at right angles to the vagina, and the vagina lies obliquely in the pelvis, and ends under the public arch in the axis of the outlet. So long as those two axes are maintained—that is, the axis of the pelvic inlet and that of the outlet—the uterus, bladder, rectum and post-vaginal wall retain their normal relations. When the pelvic floor becomes relaxed or torn, and is associated with subinvolution of the entire genital track, the lower extremity of the vagina falls away from the pelvic arch and becomes vertical. The upper end of the vagina, with the heavy retroverted uterus, now descends in the pelvis. The uterus is now no longer at right angles to the vagina. The axes have become coincident—that is, the uterus now lies in the axis of the vaginal outlet. The intra-abdominal pressure now falling upon the uterus, gradually forces it further and further into descensus with the production of cystocele, rectocele, and later complete prolapse. The pelvic fascia is one of the most important in the maintenance of a normal pelvic floor and a normal position of the bladder. When it is torn, or once stretched, prolapse of the pelvic organs will likely occur. It can be seen from what has been said as to the mechanism of procidentia that, whatever the operation, failure is inevitable unless the lower extremity of the vagina and posterior vaginal wall is lifted up under the pubic arch, establishing once again the axis of the vaginal outlet, and also that the uterus must be placed at right angles to the upper end of the vagina and maintained there. That is what the Freund-Wertheim operation does.

The older operations failed to cure procidentia because we failed to appreciate the fact that procidentia is hernia, and that it should be treated as any other hernia. Another reason why the older methods failed is that the position of the uterus was neglected and not taken into account. As said before, no operative method can succeed unless the uterus is placed at right angles to the vagina and kept there. The old way of operating was to make a superficial denudation on the anterior and posterior vaginal walls. The denuded one was extensive enough to take up the slack in the relaxed walls, so constricting the vagina as to offer a barrier to further descent of the uterus. It is needless to say that the uterus soon bored its way through the constricted vagina, and that the cystocele, rectocele and complete prolapse of the uterus soon recurred.

Striving to overcome the defects of the above methods, amputation of the cervix uteri was added, as also was suspensio-uteri. This was a distinct advance, but the fact that procidentia was hernia was not appreciated even at this time. The old way of denuding the tissues was adhered to. No one today would expect to cure an injured hernia by excising the redundant skin and then suturing the skin snugly over the hernial sac. That is about the way procidentia has been dealt with until recently. Dudley and Watkins, in this country, and Freund and Wertheim in Europe, have emphasized the necessity of using the fascia and parametridum in the cure of procidentia. It is strange that we have so long practiced the method of superficial denudation, uniting structures that could in no way give permanent strength to the prolapsed organs. Of equal importance to the utilization of the fascia and parametrium at the upper extremity of the vagina is the utilization of the levatorani muscle and fascia at its lower extremity, or on the posterior vaginal wall The old way of doing a perineorrhaphy was to denude the surfaces and then to co-optate the parts by through and through sutures. The newer and better method is after denudation to seek for, and, on finding the separated edges of the levatorani muscles, bring them together in the middle line by buried sutures of twenty-day chromicized catgut.

No mass sutures are used. The different planes of tissue are sutured separately. Buried catgut sutures give no trouble in this region. When an efficient operation is done on the posterior vaginal wall the perineum, vagina and rectum are tucked up under the pubic arch, re-establishing the axis of the vaginal outlet. This is one of the most important steps in the operation for the cure of procidentia. The levatorani muscle and pelvic fascia must be utilized, and it is important that muscle be sutured to muscle and fascia to fascia. The last step in this part of the operation is the approximation of the mucous and skin surfaces.

THE FREUND-WERTHEIM OPERATION.

The first step in the operation is to make a straight incision on the anterior vaginal wall, beginning at about the vesical end of the urethra, and ending at the cervix uteri. The incision extends through the entire thickness of the vaginal

wall down to the bladder The next incision is circular, and extends around the cervix, securing the attachment of the vagina to the cervix. The edges of the incised vaginal wall are now caught with forceps and held firmly in the left hand, while with the right the bladder is stripped away from the vagina as far up as its pubic attachment, and also from the cervix up to the utero- vesical peritoneum. The peritoneum is now opened and the retroverted uterus is delivered through the opening and the bladder is made to lie on top of and behind the uterus. In doing this the uterus is placed at right angles to the vagina and blocks up the cystocele. The bladder can in no way prolapse again and drag with it the uterus. The cervix uteri is next amputated, and as much of the redundant vaginal wall is removed as is needed. A vulsellum forceps is inserted into the fundus of the uterus for the purpose of keeping the uterus at the proper level while the sutures are being placed. The uterus is now fixed in its new position by buried sutures of chromicized catgut. The sutures first pass through the parametrium of one side, then through the anterior wall of the uterus, and finally through the parametrium of the opposite side, when they are tied. These sutures should be interrupted and not continuous. Five to six sutures are required for this part of the work. The round ligaments are not utilized in this operation. The fascia, called the parametrium, in this locality is the structure to be relied on to keep the uterus in anteflexion and at right angles to the vagina. The vaginal mucous membrane is now closed and the amputated cervix covered over with mucous membrane. Lastly, the operation on the posterior vaginal wall is done as previously described.

He has performed up to this time ten Freund-Wertheim operations, one case—and an extreme case it was—he examined the past week, and found the result perfect. The other nine cases he has heard from, and so far they are satisfactory. The time is too short in these ten cases since operation to speak with certainty as to the final results.

The operation should be done only on women past the child-bearing period, but, as 75 per cent. of all cases of procidentia occur in women past forty years of age, the operation has a wide field of usefulness.

Dr. F. J. Taussig, of St. Louis, referring to the Freund-Wertheim operation, said "that of 148 cases reported up to June, 1906, there was a return of the prolapse in five. This certainly speaks well for the operation. He believes it should receive more consideration at the hands of the American surgeons."

Dr. Hundley says he has gotten better results from this operation than from any other he has ever employed.

Summary—Freeing the bladder from the uterus and its elevation to a higher point, as is done in the Freund-Wertheim operation, is essential in any operation for the cure of procidentia. The uterus is placed at right angles to the vagina, and at its normal elevation in the pelvis, and is fixed in this position by being sutured to the fascia. In that way the upper extremity of the vagina and uterus are made to assume their normal axis in the pelvis

In amputating the cervix uteri the adjacent parametrium is shortened which pulls the cervix backward to the hollow of the sacrum. Lastly, and of the greatest importance, is an efficient operation on the posterior vaginal wall—muscle must be united to muscle, fascia to fascia.

REPORT OF THE UNIVERSITY HOSPITAL FROM JANUARY 1, 1907, TO JANUARY 1, 1908.

PREPARED BY A. M. SHIPLEY, M. D.,
Medical Superintendent.

	Recovered	Improved	Unimp.	Died
Abortions	20	5	..	2
Abscesses	7	19	3	1
Tubercular	2	7	3	..
Alcoholism	3	10	..	1
Appendicitis—				
Abscesses	36	5	0	2
Acute	52	6	1	2
Chronic	40	4	1	1
Peritonitis	16	2	0	4
Recurrent	12	0	0	0
Tubercular	1	0	0	0
Arteries and Veins	0	2	0	0
Aneurism	2	2	2	1
Arteritis	0	3	2	..
Phlebitis	0	3	0	0
Varicocele	10	0	0	0
Varicosity	6	6	2	0
Thrombosis	0	0	0	1
Benign Tumors	10	2	1	0
Bladder	0	2	4	1
Calculus	1	0	0	1
Cystitis	0	7	3	2
Diseases of Blood	1	2	2	2

	Recovered	Improved	Unimp.	Died
Bone—Diseases of	4	4	1	1
Acute Inflammations	10	14	3	0
Benign Growth	1	1	1	0
Carcinoma	0	2	0	0
Osteo-Sarcoma	0	1	3	0
Tuberculosis	0	25	6	0
Diseases of Breast	2	0	1	0
Abscess	1	3	0	0
Benign Tumors	6	1	0	0
Carcinoma	0	24	1	0
Inflammation	2	0	0	0
Burns	3	14	2	8
Cellulitis	12	14	1	0
Contusions and Lacerations	36	31	0	1
Deformities	6	8	2	0
Diabetis	0	3	1	0
Dislocations	10	6	0	1
Ear	8	14	1	0
Eye	14	15	1	0
Foreign Bodies	1	0	0	0
Fractures	53	45	7	6
Skull	12	2	0	10
Gangrene	3	6	1	..
Glands—				
Axillary	3	0	0	0
Carcinoma	0	3	2	0
Cervical Adenitis	3	6	3	0
Inguinal Adenitis	12	19	2	0
Sarcoma	0	3	1	0
Tuberculosis	3	8	2	0
Gun-shot and Stab Wounds—				
Abdomen	4	0	0	7
Brain	0	1	0	0
Chest	0	0	0	1
Miscellaneous	11	12	0	0
Habitue	1	2	0	0
Heart	3	53	10	12
Hemorrhage	4	2	0	0
Hernia	50	3	4	5
Inguinal	36	0	0	0
Femoral	4	0	0	0
Strangulated	8	0	0	4
Ventral	9	0	0	0
Acute Infectious Diseases—				
Erysipelis	1	0	1	1
Mumps	1	0	0	0
Rubeola	0	0	1	0
Tetanus	1	0	0	1
Varicella	0	1	0	0
Infections	13	14	0	3
Diseases of Intestines	10	10	1	1
Amebic Dysentery	0	1	0	1
Dysentery	0	2	0	0
Carcinoma	0	2	1	3
Colic	1	1	0	0
Constipation	0	5	1	0
Diarrhœa	2	2	1	0
Enteritis and Colitis	1	3	1	1
Intussusception	1	0	0	3
Obstruction	1	2	2	4

	Recovered	Improved	Unimp.	Died
Diseases of Intestines—				
Parasites	0	3	0	0
Ulcer	0	2	0	0
Joints—Diseases of	2	3	0	0
Ankylosis	0	3	0	0
Arthritis	0	2	1	0
Arthritis Gonorrhœa	1	4	2	..
Tuberculosis	2	7	2	1
Kidney—				
Anuria	0	1	0	0
Abscess	3	0	0	2
Calculus	3	4	1	0
Carcinoma	0	0	1	0
Nephritis, Acute	0	3	1	1
Nephritis, Chronic	2	29	6	15
Nephroptosis	7	0	1	0
Tuberculosis	1	1	0	0
Pyonephrosis	3	2	1	1
Renal Colic	2	2	1	0
Uremia	0	3	0	7
La Grippe	23	7	0	0
Liver and Gall Bladder—				
Carcinoma	0	0	0	1
Catarrhal Jaundice	2	0	0	0
Cholecystitis	9	0	1	0
Cholelithiasis	15	3	3	2
Cirrhosis	0	4	2	0
Laceration	0	0	0	1
Diseases of Lung and Pleura	1	3	0	0
Abscess	0	1	0	0
Asthma	1	1	1	0
Bronchitis	4	11	2	1
Emphysema	1	2	0	1
Empyema	4	4	1	0
Hydrothorax	0	2	0	0
Laceration	0	0	0	1
Pneumonia	26	8	0	13
Pleurisy	4	14	2	0
Tuberculosis	0	20	10	2
Malaria	30	8	1	0
Malignant Tumors, Miscellaneous	0	3	4	3
Mouth, Teeth and Tongue	3	3	0	0
Carcinoma	0	1	0	0
Muscles	4	11	0	0
Nervous System—				
Brain—				
Abscess	0	0	0	1
Concussion	3	0	0	0
Epilepsy	1	5	2	0
Hemiplegia	0	3	0	4
Hemorrhage	0	1	1	4
Meningitis	1	1	2	1
Syphilis	0	6	0	0
Thrombosis	0	1	1	1
Tumors	0	0	1	0
Functional Diseases—				
Chorea	0	1	2	0
Headache	0	1	0	0
Hysteria	1	8	2	0
Myasthema Gravis	0	0	1	0

	Recovered	Improved	Unimp.	Died
Mental Diseases	2	21	4	0
Alcoholic Insanity	1	0	0	0
Dementia	1	1	1	0
Mania	0	0	1	0
Melancholia	0	0	3	0
Paresis	0	0	1	0
Peripheral Nerves—				
Bell's Paralysis	0	1	9	9
Multiple Neuritis	0	2	0	0
Neuralgia	4	8	0	0
Neuritis	1	4	0	0
Spinal Cord—				
Locomotor Ataxia	0	1	0	2
Myelitis	0	2	2	0
Ovary—				
Diseases of Tubes and Ovaries—				
Benign Tumors	24	6	0	1
Carcinoma	0	1	0	0
Inflammation	38	11	3	3
Tuberculosis	1	1	0	1
Pancreas	1	1	0	0
Penis, Scrotum, Testicles	4	0	1	0
Chancroids	3	9	1	0
Epididymititis	4	9	0	0
Gonorrhœa	4	12	1	0
Hydrocele	6	3	2	0
Hypospadias	0	1	1	0
Orchitis	2	3	0	0
Phymosis	8	6	0	0
Stricture	6	5	1	0
Urethritis	3	6	0	0
Perineum	24	2	4	0
Diseases of Peritoneum—				
Peritonitis	1	0	0	5
Peritonitis-Tubercular	0	3	0	1
Poisons	10	7	1	1
Pregnancy	6	4	6	0
Eclamsia	1	0	0	0
Ectopic Gestation	7	3	0	1
Placenta Previa	1	1	0	0
Puerpal Infection	6	4	0	1
Prostrate—				
Diseases of Prostrate—				
Carcinoma	0	0	0	1
Hypertrophy	0	6	4	7
Postatitis	0	5	0	0
Rectum—Diseases of	0	3	1	0
Abscess	6	1	0	0
Benign Tumors	0	1	0	0
Carcinoma	0	0	2	0
Fistula	12	12	2	0
Hemorrhoids	18	6	3	0
Proctitis	0	0	1	0
Tuberculosis	0	0	1	0
Ulcers	1	3	0	0
Rheumatism	4	20	3	0
Salivary Glands	0	0	1	1
Senility	0	1	1	0
Shock	0	0	0	1
Skin—Diseases of	2	7	0	2
Spleen	0	3	0	2
Sprains	6	6	5	0
Stomach	0	9	5	0
Carcinoma	0	1	7	4
Dilated	1	6	3	0
Gastritis	5	15	3	1
Pyloric Stenosis	2	3	0	0
Ulcer	1	4	3	0
Syphilis	7	44	4	1
Thyroid	8	2	0	0
Tuberculosis—Miscellaneous	0	1	0	2
Typhoid	79	0	0	10
Throat and Nose—				
Carcinoma of Larynx	0	1	0	1
Deviated Nasal Septum	2	6	0	0
Diseases of Nose	6	9	1	0
Tonsils and Adenoids	51	0	0	0
Tonsillitis	7	7	1	0
Tubercular Laryngitis	0	1	0	0
Ulcer	1	5	4	0
Unclassified	12	10	7	2
Undiagnosed	0	7	24	2
Uterus—				
Benign Tumors	17	4	4	1
Carcinoma	4	9	5	1
Cervix Atresia	1	1	0	0
Cervix—Lacerations	9	3	0	0
Dysmenorrhœa	1	1	0	0
Endometritis	19	14	3	1
Placenta Mole	2	0	0	0
Prolapsus	2	0	0	0
Retroversion	20	5	7	0
Subinvolution	2	1	0	0
Tuberculosis	2	0	0	0
Vagina—				
Artesia	1	1	0	0
Carcinoma	1	1	0	0
Cyst	2	0	0	0
Fistula	2	0	0	0
Relaxed Vaginal Outlet	3	3	0	0
Double Vaginia	1	0	0	0
Vaginitis	2	2	1	0
Number of patients during year from January 1, 1907, to January 1, 1908				2,726
Number of operations during the year				1,850

DEMONSTRATION OF SINE SALIVARY DOGS BEFORE AND AFTER INTRA-PERITONEAL INJECTION OF SALIVARY GLAND EXTRACT.

Meeting of the University of Maryland Medical Association, Tuesday, April 21, 1908.

This meeting took place in the large amphitheatre of the University Hospital, and the principal papers were by Dr. J. Mason Hundley, who addressed the meeting on the "*Freund-Wertheim Operation.*" Thereafter Prof. L. E. Neale read a paper and exhibited a patient upon whom a sym-

physiotomy was performed. The child and mother being in excellent state of health at the time of this demonstration, but an important feature of the meeting was a demonstration by Prof. J. C. Hemmeter of *THE EFFECTS OF INTRAVENOUS AND INTRAPERITONEAL INJECTION OF EXTRACTS OF SALIVARY GLANDS ON THE GASTRIC SECRETION OF SINE SALIVARY DOGS.* The principal aim of the demonstration was:

First, to draw a test meal from the stomach of a sine salivary dog before the audience, filter it, and examine it for free HCL by the phloroglucin-vanillin test, the Boas resorcin test, and using at the same time auxiliary color tests, which, however, are not quite as reliable as the two mentioned; tropaeolin OO, congo red and dimethyl amido azo benzol were used for this purpose.

Secondly, when the gastric juice of this test meal had been determined, qualitatively and quantitatively, by Topher's method, the dog was given a second test meal, and thereafter an injection of salivary gland extract was made into the peritoneum. Thereafter the animal was allowed to rest for about an hour and one-half, during which time the other reporters delivered their addresses and the discussions on their papers took place. At the expiration of about an hour and a half, the animal was brought before the audience the second time and a second test meal drawn by a stomach tube, filtered and tested by the same acid indicators, and titrated by Topher's method. Any difference between the percentage contents of acid and ferments found between the first and second test meal must, of course, be due to the effect of the intraperitoneal injection of the extract of salivary glands.

The following were the results of the analysis of the first meal as determined by Dr. J. Howard Iglehart: Test meal of 150 grms. bread, reaction, acid; total acidity by phenolpthalein was 12; congo—negative; tropaeolin—negative; dimethyl amido benzol—positive; litmus—positive; phloroglucin-vanillin—negative. It was evident that this gastric juice, if it contained any HCL at all, it was far below that which should be present in the stomach contents of a normal dog.

The animal was then held up by the front legs, a small area of the abdominal surface was sterilized by absolute alcohol, and an injection of 5 cc. of salivary gland extract made into the peritoneum through the linea alba. With some care and experience, it is possible to make this injection into the peritoneum without injury to the intestine. Thereafter the animal was allowed to rest for about an hour and a half. After the expiration of this time, a second test meal was drawn by the stomach tube before the audience. The analysis made immediately after this meal was filtered gave the following result: Total acidity, 60; free HCL, 34; congo—positive; dimethyl amido benzol—positive; phloroglucin vanillin—positive; resorcin—positive. It should be stated that the first meal taken before the injection of salivary gland extract gave a faint biuret reaction, indicating that some degree of peptonization had taken place in this sine salivary dog, but the biuret reaction was much more pronounced in the second meal. Mett's method, which is the standard for determining the gastric proteolysis, could not be used because it requires too long to demonstrate it before a society, but on the day following the meeting the proteolytic power of the juice gained from the first meal was found to be one m. m. Mett; that of the second meal, taken after the intraperitoneal injection of salivary gland extract, was 3.5 m. m. Mett. It was not considered expedient to inject the salivary gland extract into a vein, for this would have necessitated the insertion of a canula, either into the jugular or femoral vein, and as Professor Hemmeter desired to keep these animals, he did not deem it wise to expose them to danger of infection.

In order to call attention to some of the many difficulties with which these demonstrations are encompassed, we have to say that one of the animals that was to be brought before the audience refused absolutely to take any kind of food on this particular evening, and for this reason no test meal was obtained. Another animal was exhibited with a perfectly healed abdominal fistula leading into an accessory stomach. This animal had been accidentally or carelessly fed with a piece of bone, which had perforated through the partition separating the accessory from the main stomach. This was proven by the fact that when the animal drank water it immediately ran out through the abdominal fistula, when for months preceding this accident the dog could drink water without losing it through the opening in the abdominal wall. He was thought to be useless for

any further experimentation, but was fed very carefully on nothing but milk. Three weeks after the careless feeding which had caused the accident, it was found that the dog could drink nearly 500 c. c. of milk and not lose any of it through the abdominal opening. The first idea was that the partition which had been broken through was again healed, but an exploration of the accessory stomach with a soft catheter proved this idea to be erroneous, for the catheter could, after some efforts, be introduced into the chief stomach, and milk drawn from the principal stomach, although none was found at first in the accessory stomach. It is believed that this dog has a valve-like flap, which closes the perforation in the septum so that food, semisolid and solid, under ordinary circumstances, could not get into the accessory stomach; yet at the same time it was possible, with a little manoeuvering, to pass a soft rubber tube from the accessory stomach into the principal stomach. So that in this animal it is possible to gain pure gastric juice from the accessory stomach and compare it with gastric juice gained from the food itself in the main stomach.

According to the demonstrator, the mechanism of gastric secretion reveals itself as a complex one. Pawlow, following the work of Bidder and Schmidt, had definitely established on a solid experimental basis the existence of a psychic secretion, pure and simple, brought about solely through nervous paths. Edkins had demonstrated the existence of a pyloric SECRETIN or HORMONE.

Tarulli and Pascucci in Luigi Luciana's Laboratory (PHYSIOLOGIE DES MENSCHEN LUCIANI, Bd. 2, p. 151) have conducted experiments demonstrating the existence of peptogenous substances that can be extracted from the spleen during the height of digestion.

The present series of experiments demonstrated to this Medical Society on March 17 and April 21, 1908, strongly suggest that the existence of a hormone capable of stimulating gastric secretion occurring in the salivary glands and acting by way of the blood stream. At the beginning of this series of experiments it was found that occasionally in animals that had been provided with accessory stomachs, and from whom the salivary glands had been removed, would show absolutely no gastric secretion whatever; and upon this phenomenon erroneous conclusions were based, which were stated in a preliminary communication which was published in *Science* October 11, 1907, p. 473, New York. It was there stated that in dogs with accessory stomachs removal of the salivary glands abolishes permanently all gastric secretion. This was observed to be true in three dogs operated in the manner described, but in two of these animals that were kept for six months after the operation a gradual and partial resumption of the gastric secretion was observed. The complete loss of the gastric secretion first observed after any severe operation upon the animal is due to the direct insults to the secretory apparatus caused by the operation itself, to traction upon the nerves, or due to reflex nerve influences, for Pawlow states (Work of the Digestive Glands) that a stimulation of the sciatic nerve a very few minutes, for example, may cause an arrest of gastric secretion for many hours, l. c., p. 69. It is, therefore, necessary in these experiments to observe the animals a long time to allow for complete recovery before the chemical studies of the gastric juice are undertaken. Contrary to the dog whose gastric secretion is immediately abolished after an operation, Dr. Hemmeter has occasionally come across an animal in which the gastric juice continued to be secreted after extirpation of the salivary glands. Whilst it was not secreted in the normal amounts, yet the diminution was not what was discovered to be the case on an average in the other animals. He believes this continuation of gastric secretion to be due to an abnormal condition of the glandular apparatus of the stomach of the dogs before the operations are undertaken. The pathologic condition of secretion which is very perplexing in this connection is hyperacidity and hypersecretion. Pawlow has already described a dog with hyperacidity, and M. Powsner (*Biochemische Zeitschrift*, Bd. 2, p. 344) gives a description of a dog suffering from hypersecretion. The most confusing abnormality, however, is a condition first described by Professor Hemmeter and termed "HETEROCHYLIA" by him. This is an alternating state of gastric secretion which expresses itself by marked excess of all constituents of the juice at one time, and complete cessation of the secretion at another time after the identical test meals. That this condition exists has been confirmed in the laboratory of Prof. I. Boas, of Berlin. (See

Archiv fur Verdauungskrankheiten, Bd. 8, s. 75.) The reporter stated that all such abnormalities of secretion render the animal unfit for this kind of experimentation.

It has been his experience that any long continuance of a normal gastric secretion after the removal of the salivary glands was due to either one of the following three factors: (a) that the lobules of the parotid glands had not been completely removed. This is surgically the most difficult gland to extirpate completely; (b) that the psychic secretion has not been thoroughly eliminated, which, if at all started up, will convert the food into peptogenous substances capable of stimulating the formation of the pyloric hormone or secretion, first described by Edkins; (c) that abnormalities of secretion existed similar to those described in the preceding.

The Reporter's Principal Conclusions after this demonstration were:

1. In dogs with simple gastric fistula the extirpation of all of the salivary glands produces a marked diminution in the gastric secretion. This is also evident in the analysis of test meals drawn by the test tube from animals with intact stomachs. *It is necessary to prevent psychic secretion in order to bring about the phenomenon described.*

2. Even in animals with intact vagi it may sometimes happen that the removal of all the salivary glands causes a decided impairment of gastric secretion. So that a causative relation between the loss of the salivary glands and the reduced proteolytic and milk coagulating power of the gastric juice appears certain, even in these cases.

3. In sine salivary dogs in whom the gastric secretion has been decidedly diminished, it is not restored to the normal by the feeding of food that has been well masticated and insalivated by other normal dogs.

4. When the gastric secretion is diminished, a temporary restoration may be brought about by intravenous or peritoneal injection of extracts made from the salivary glands of normal dogs.

5. This temporary restoration of gastric secretion takes place even when the stomach is isolated from the central nervous system.

6. The chemical co-ordination of the gastric secretion is effected by hormones that have different origins; some are contained in the food itself (Schiff, Bayliss and Starling), others originate in the pyloric mucosa, still others originate in the spleen (Luciana), and the present series of experiments indicate the existence of a HORMONE stimulating gastric secretion which is formed in the salivary glands. Salivary gland extract fed directly with the food or placed into the stomach directly is not capable of exciting gastric secretion. Ground up fresh salivary glands cause approximately the same gastric secretion as an equivalent amount of ground beef in these animals.

It is possible that these different chemical mechanisms exert different effects on the gastric secretion.

Professor Hemmeter promised that in a further communication to point out that the purely nervous or psychic secretion, and the gastric secretion which is kept up by chemical stimulation or hormones, although in the normal animal they act synergistically, have different objects; the psychic secretion effecting the primary phase of secretion—*i. e.,* the discharge of prozymogen granules and acid already in the secreting cells, and the chemical mechanisms controlling the secondary phase or the reconstruction of cytoplasm.

The previous experiments at extirpation of salivary glands, too much significance was attached to the fact that animals may live and digest fairly well without salivary glands. To this objection the reporters replied that animals may live and digest fairly well without spleens, or even after the entire stomach has been excised. As has been stated in the preceding, the co-operation of the salivary glands in the formation of pepsin and hydrochloric acid does not exclude the possibility that pepsin and hydrochloric acid can be formed in the absence of salivary glands. It has been demonstrated, for instance, that the spleen plays an important part in the formation of trypsin from its corresponding symogen (Luciani, L. C., p. 78). This was already suggested by M. Schiff in 1862, vis., that the congested spleen at the height of digestion gives off a substance into the blood which is utilized by the pancreas for the formation of trypsin, and although his results were received with scepticism, they were later confirmed by Herzen, Gachet and Pachon. Later on, H. F. Bellamy, working under Herzen in Germany, Mendel and Rettger, in this country, reached conclusions confirming the doctrine of Schiff, so that it is now accepted that the spleen is actively concerned in the formation of trypsin; but, nevertheless, it

has been found that the pancreas of animals that have undergone complete excision of the spleen may contain trypsin. This controversy on the relation of the spleen to the formation of trypsin is instructive as throwing light on the relation of the salivary glands to the stomach. The fact that pepsin and HCL can be formed in the absence of the salivary glands, according to Dr. Hemmeter, cannot be taken as proof that the salivary glands do not form a peptogeneous substance. The experiments described in the preceding lend sufficient proof to the doctrine that the salivary glands do exert an influence on the formation of gastric secretion.

At the regular monthly meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, April 21, 1908, at 8.30 P. M., the program was as follows:

1. The effect of intravenous and intraperitoneal injection of salivary glands in the gastric secretion of Sine Salivary dogs, Dr. J. C. Hemmeter.
2. The Freund-Wertheim Operation, Dr. J. M. Hundley.
3. Pubeotomy, Dr. E. L. Neale.

As in the meetings held heretofore this year, this meeting was very interesting as well as instructive. All of the addresses were much above the average in merit. Those present could not help going away with a better understanding of the subjects under discussion. The only drawback was the number of those present. This particular meeting being one of the smallest held in the near past.

Dr. Hemmeter's paper was extremely interesting, and the conclusions which he drew from his experiments were logical and reasonable. As in the previous meeting, he exhibited some dogs upon whom the salivary glands had been entirely extirpated. From these before the assembly he introduced a stomach tube and withdrew their stomach contents. The gastric secretion was filtered and tested for hydrochloric acid, which was entirely absent. He then injected into the peritoneal cavity a liquid extract of the salivary glands, and in a half hour again withdrew the stomach contents. This secretion was subjected to the usual reagents for the detection of hydrochloric acid, with the result of this time getting a marked reaction of acidity. Dr. Hemmeter merely by these experiments claims to establish the missing link in the action of the internal secretions of the higher parts of the gastro-intestinal tracts upon the lower, it having already been proven that any given portion of the intestinal tract exerts a definite relation upon the secretion of the next succeeding portion of this tube. A more complete report of this paper appears elsewhere in the BULLETIN. Dr. Hundley read a paper upon the recent improvements in the management of prolapsus uteri.

Dr. Neale exhibited a patient upon whom he had performed a pubeotomy in order to widen the parturient canal so that a child could be born by the natural route rather than subjecting the patient to an abdominal Caecarian section. This operation may be performed either by an open incision or subcutaneously. The advantages over symphysiotomy is that the wound is through bone, not through cartilage, consequently the resulting union is firmer. The only drawback of this operation is an occasional severe hemorrhage, which, however, is usually easily controlled by pressure. The bone is severed just internal to the spine of the pubis, either on the right or the left side, according to the position of the head of the child.

At the third annual meeting and banquet of the Baltimore Alumni of Haverford College, April 4, 1908, addresses were delivered by the following of our alumni: "The Haverfordian as an Athlete," Dr. H. M. Thomas, 1885; "Haverfordians on the Pacific Coast," Dr. Fitz Randolph Winslow, 1906. Dr. Randolph Winslow, class of 1873, presided in a most happy manner. The society was entertained by Mr. Richard J. White, 1124 St. Paul street.

At the recent annual meeting of the Medical and Chirurgical Faculty the following papers were read by our alumni: "Electrotherapy and the X-Ray in Its Relation to Medicine and Surgery," Dr. Howard E. Ashbury; "Radiotherapy," Dr. T. C. Gilchrist; "General Pathology," Dr. W. R. Stokes; "Incipient Tuberculosis of the Lungs," Dr. Gordon Wilson; paper, R. H. Johnston; paper, Dr. J. J. Carroll.

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EDITORIAL.

THE SESSION OF 1907-08 AT THE UNIVERSITY OF MARYLAND.—The session of 1907-08 in the Departments of the University of Maryland, now growing near its end, has been from every point of view one of the most successful in the long history of the University. Not only have the classes of students been upon the whole fully as large as in any previous year, but the character of the student body and the courses of instruction have been as satisfactory as it is possible to make them under conditions now surrounding the educational work of the University.

Whilst the University makes no claim to a standard only possible in a richly endowed school, she holds to lines of work and conduct which have given her graduates as good an equipment for the practical duties of their respective professions as can be had from any other institution of her class in this country. We make this claim advisedly, for the University points with pride to her alumni. Wherever found they take a high rank in professional work and in citizenship. As society is organized the private in the ranks has as important a duty to perform as the officer who directs his services. Though widely apart in station, they are necessary parts of an organization which can only be made effective through the faithful services of both. In the great army of graduates from the University the rank and file are both found at their posts of duty, bearing testimony to the faithful training under their Alma Mater. The best inheritance the University has is the high standard her alumni have attained in professional life. With each graduating class her students are sent out with a practical training which will guarantee them an honorable and useful position in the great battle field of labor and responsibility. Those who measure up to the duties and opportunities which come to them need have no fear of failure. Whilst the gifts of industry, of opportunity and of talent are not possessed in an equal degree by all men, it is often found that the men who make the best use of ordinary attainments do better than those who neglect the talents intrusted to them. The plodder is the man who usually wins. The men who least impress their fellow-students and teachers with winning qualifications not infrequently come to the front and take leading parts in the great drama of life. The student, whether industrious or negligent in his class work, must ever bear in mind the fact that a professional training has only a beginning when he receives his degree. His preparation will have a marked influence over his subsequent life's work, but the great fight has only begun when he leaves the halls of his Alma Mater. The real struggle for success begins when his educational training is put to a practical test and made to measure up to a level of efficiency.

Speaking for the Medical Department of the University, the BULLETIN claims that the clinical training of the medical student is the most important feature in his education. It is this training which makes the graduate in medicine from the University a well-equipped physician and gives him a foundation for success in clinical work. The BULLETIN has no doubt that in the other Departments of the University the practical side of professional education is fully insisted on.

The work of an unendowed University must be given in the largest measure to the preparation of the student for practical and efficient service to society as distinguished from the more brilliant and experimental lines of training. Both systems have advantages and merits. They meet at many points. When brought into association they can only be made to keep company upon a general understanding of the claims of each upon the interests and attention of those who seek to associate them in active co-operation. The experimental work of the laboratory differs in degree and kind from the work of observation and investigation in the clinical wards of the Hospital, but the habit of thought, the patient study and the methods of looking into things are the same. They both seek beneath the surface

for facts which explain nature's way of doing things. The physician who can associate in his work both the laboratory and clinical methods of study is thereby more thoroughly equipped for professional service. He is a fortunate man who can make each system pay a full measure of tribute to his attainments. A few men of this unusual type are now and then met with. To the average mind brilliant success in both fields is not attainable. There are limitations to every mental and physical exercise. He is a fortunate man who early recognizes these limitations and casts the lines of his life's work in waters which will not engulf him. The plans and purposes of life must harmonize with one's adaptability and power of doing well and efficiently what he undertakes, if the best results from his work are to be arrived at. To play a small part well rather than a large part indifferently represents the highest standard of conduct and efficiency. This should be the aim of all educational training.

ITEMS.

Dr. F. D. Chappelear, class of 1905, is located at Lewes, Delaware.

Dr. Taoufik T. Rasy, class of 1903, is serving as a lieutenant in the Medical Corps of the Egyptian Army and is stationed at Singa, Sudan.

Miss Laura H. Jessup has announced the engagement of her sister, Miriam Louise Jessup, class of 1907, of the University Training School for Nurses, to Dr. Frank Brown Hines, of Chestertown, Maryland.

Dr. Homer E .Clarke, class of 1901, is a resident interne at the Oak Grove Sanitarium, Flint, Michigan.

Mrs. George R. Parrott has announced the engagement of her daughter, Miss Emily May Parrott, a graduate of the University Hospital Training School for Nurses, class of 1904, to Mr. James Edward Hammond, of Pittsburg, Pennsylvania, formerly of Ellicott City, Maryland. The wedding is to take place during the latter part of June.

Miss Sarah Katherine Hall, of Covington, Kentucky, has announced the engagement of her sister, Miss Eudora Roberta Hall, to Dr. Robert O. Lyell, class of 1902, of Warsaw, Virginia. The wedding will take place the latter part of June. Miss Hall is the daughter of the late Prof. Carey Judson Hall, a prominent educator of Kentucky.

Dr. William Wirt Eichelberger, class of 1904, of Glenwood, Maryland, has been appointed acting assistant surgeon at the United States Marine Hospital, Portland, Maine.

Dr. and Mrs. Gordon T. Atkinson, of Crisfield, Maryland, have announced the engagement of their niece, Miss Lillian Horsey, to Dr. Rastus Ransom Norris, class of 1904, of 1309 North Charles street, Baltimore. The wedding will take place in June.

At the meeting of the Baltimore County Medical Association, held April 17, 1908, papers were read by Drs. Henry L. Naylor, class of 1860, and Josiah Bowen, class of 1903.

Dr. F. M. Chisolm ('89) has leased 816 Connecticut avenue, opposite The Rochambeau, Washington, and he and Dr. J. R. Winslow ('88) have moved their offices from 1424 K street to the new location. Dr. Chisolm will continue his office in Baltimore on three days in the week and by appointment.

The *University Orist*, issued April, 1908, has this to say concerning the amalgamation of the various alumni bodies of the University of Maryland:

"The General Alumni Association of the University of Maryland held its annual banquet on February 28, 1908, at the Eutaw House, covers being laid for about one hundred participants. This organization is of rather recent origin, and in some measure at least was a forerunner of the plans and purposes which brought about the addition of two new departments to the University just prior to the Centenary celebration.

"The underlying idea of the General Alumni Association is in thorough keeping with the broadened lines along which the University is now operating. Concentration is the watchword of present day success in any field of endeavor. A co-operative plan, where all the forces attainable are centered upon one particular end, gives promise of growth and sure progress, if it be possible of attainment under any condition.

"The Pharmaceutical Department, the youngest department of the University, has merged its Alumni Association with that of the General Association, and overtures are now being made to the other departments with a view of having them all come in.

"The Executive Committee of our Association has had the scheme under consideration, and will doubtless make some recommendations at the annual meeting to be held in the early part of June.

"There is argument in favor and against this proposition, but we are inclined to the opinion that, all things considered, the time has come for us to join forces with other interested parties in a united effort to aid in the work of maintaining a real university plan rather than to continue to contend for a condition while our work visibly shows a lack of unity."

In this connection the editors of the BULLETIN are glad to report that there has been a joint meeting of the executive committee of the Alumni Association and a committee appointed by the General Alumni Association, and at the present time the consummation of the union seems practically assured. We are even hopeful that this happy event will have taken place before the BULLETIN comes out of print. These various amalgamations augur well for the future. The idea of centralization seems to have made its appearance to stay. Indeed, we are of the opinion that nothing can turn it aside.

The Pennsylvania Branch of the General Alumni Association held its annual meeting and banquet at the Rittenhouse Hotel, Philadelphia, on March 25, 1908. Those present were: Doctors Noble, Clawson, West, Matthews, Pheneger, Minor, White and Beale, of Philadelphia; Dr. Elgin, of Glenolden; Dr. Ewens, of Atlantic City, N. J., and Mr. Haines, of York, Pa. The old officers were re-elected, viz.: President, Dr. Charles P. Noble; Secretary-Treasurer, J. C. C. Beale, D. D. S. Nine names have been added to the membership during the past year.

Hon. Austin L. Crothers, Chancellor of the University of Maryland and Governor of the State of Maryland, will receive the honorary degree of LL. B. at the coming commencement of Loyola College.

Dr. Alan G. Brooks, class of 1906, has returned from South America. He spent a day around the old University renewing past acquaintances.

The "Samuel Leon Frank Scholarship" for 1907 and 1908 has been conferred on Mr. Wm. Murray Hollyday, of Easton, Md., of the senior class.

Dr. James M. Craighill has been made Director of the Medical Staff of the University Hospital.

Dr. George G. Thomas, class of 1871, of Wilmington, N. C., President of the North Carolina State Board of Health and Chief Surgeon of the Atlantic Coast Line Railroad, will deliver the annual address before the Medical Department of the University of North Carolina, Chapel Hill, North Carolina.

Dr. John Whitridge Williams, class of 1888, of Baltimore, Md., has been elected President of the Johns Hopkins University Alumni Association.

Dr. Samuel A. Binion, class of 1886, is a resident of Key West, Florida.

Dr. Monte Griffith, class of 1896, of Washington, has been elected President of the District of Columbia Branch of the General Alumni Association for the ensuing year.

Dr. J. D. Norris, class of 1878, of Baltimore, has been elected president of the Board of Police Examiners of Baltimore.

The Board of Police Commissioners have elected the following of our alumni police surgeons: Dr. William S. Hall, class of 1899; Dr. R. R. Norris, class of 1904.

The new State Tuberculosis Sanitarium, located near Sabillasville, in the Blue Ridge Mountains, will be ready for occupancy about June, 1908. Dr. Guy Steele, class of 1897, of Cambridge, is one of the examining physicians for the Sanitarium.

Dr. Robert Randolph, class of 1884, exhibited some interesting cases at the May 5, 1908, meeting of the Johns Hopkins Hospital Medical Society.

At the State Conference of Charities and Correction, held at McCoy Hall, Baltimore, May 1, 1908, Dr. Guy Steele, class of 1897, of Cambridge, delivered an address on "The Care of Indigent Sick in the Counties." Dr. Louis B. Henkel, Jr., class of 1903, of Annapolis, opened the discussion.

At the closing session of the ninth annual meeting of the State Federation of Women's Clubs, Dr. John S. Fulton, class of 1881, spoke on the International Tuberculosis Congress to be held at Washington from September 21 to October 12, 1908.

Dr. Charles Bagley, Jr., class of 1904, superintendent of the Hebrew Hospital, Baltimore, recently spent a few days in Philadelphia, visiting hospitals.

At the annual meeting of the Montgomery County Medical Association, held at Rockville, April 21, 1908, our alumni were elected to the following offices for the ensuing year: Vice-President, Dr. O. M. Linthicum, class of 1890, of Rockville; Secretary-Treasurer, Dr. J. L. Lewis, class of 1888, of Bethesa; Censors, Dr. W. L. Lewis, class of 1892, of Kensington; Dr. O. M. Linthicum, class of 1890, of Rockville; Dr. H. B. Haddox, class of 1893, of Gaithersburg. Dr. James E. Deets, class of 1882, was chosen to represent the County Society at the annual meetings of the State Association for the next two years.

Dr. Thomas Allen Mann, class of 1903, of Durham, N. C., who was recently operated on at the University Hospital for appendicitis, is making a good recovery.

Dr. Henry C. Houck, class of 1905, of 1914 Pennsylvania avenue, Baltimore, is at the University Hospital with a bad infection of the right side of his nose and face.

At the annual meeting of the Medical and Chirurgical Faculty our alumni were elected to the following offices: Vice-President, Dr. D. W. Smith, class of 1884; Members of the State Board of Medical Examiners, Dr. W. W. Goldsborough, class of 1901, and Dr. H. Harlan, class of 1879.

The following of our alumni have been elected to the medical staff of Church Home and Infirmary: Drs. T. A. Ashby, class of 1873; L. McLane Tiffany, class of 1868; J. W. Williams, class of 1888; Mactier Warfield, class of 1884; C. W. Dobbin, class of 1894; A. D. McConachie, class of 1890; A. C. Harrison, class of 1887; R.

B. Warfield, class of 1884; A. D. Atkinson, class of 1894; C. B. Gamble, class of 1887; Nathan R. Gorter, class of 1879; George Hocking, class of 1879; L. Gibbon Porter, class of 1886; Henry B. Thomas, class of 1888; George Walker, class of 1888.

The annual meeting and banquet of the Alumni Association of the Medical Department of the University of Maryland will be held at the Eutaw House on Friday afternoon, May 29.

The annual commencement of all of the departments of the University of Maryland will be held at the Academy of Music on the evening of June 1st. The address will be delivered by Dr. George H. Read, president of Dickinson College.

Dr. C. J. B. Flowers, class 1908, who is located at Union Deposit, Pa., in a recent letter to the BULLETIN, writes as follows: "Have been here since February 8th, 1908. Appointed county physician March 1st, 1908. Appointed medical examiner for Knights of Maccabees in four townships and have a large and increasing practice."

The annual commencement of the Training School for Nurses connected with the University Hospital took place on Thursday afternoon, May 14th, in the Nurses' Hall. Prof. R. Winslow delivered the address to the graduating class. A further notice will appear in the next issue of the BULLEIN.

Dr. R. W. Crawford, former assistant resident physician at the University Hospital, but now surgeon to the Atlantic Coast Line Railroad, and in charge of its hospital at Rocky Mount, is now making a hurried visit to Baltimore to attend the nurses' commencement. Dr. Crawford is a very modest man, and has not betrayed any special symptoms of matrimonial attentions. The significance of his attendance upon the nurses' commencement may appear in evidence later.

Dr. Joseph W. Scannell, class of 1906, who is located at Lewiston, Me., writes to the BULLETIN: "It is a great pleasure for me to receive the BULLETIN monthly, as it keeps me in touch, so to speak, with my professors and classmates. I am located here in Lewiston, Me., and have built up a very large practice. I am the youngest man by quite a few years on the operating staff at the Central Maine General Hospital, and have lots of surgery with very good success. I am also surgeon for the Maine Central Railroad and the Grand Trunk Railroad in this district, and last spring I was appointed one of the attending physicians at the Poland Spring House. Please let my friends know I am doing well. I wish the dear old University and the BULLETIN the best of success."

The following of our alumni attended the banquet of the Medical and Chirurgical Faculty, held April 29, 1908, at the Hotel Stafford: Baltimore—Drs. T. C. Worthington, class of 1876; Charles O'Donovan, class of 1881; S. K. Merrick, class of 1872; J. J. Carroll, class of 1893; H. O. Reik, class of 1891; W. W. White, class of 1896; Herbert Harlan, class of 1879; F. R. Smith, class of 1891; T. M. Chaney, class of 1906; F. W. Janney, class of 1905; Hiram Woods, class of 1882; Compton Riely, class of 1897; L. M. Allen, class of 1896; S. T. Earle, class of 1870; H. L. Smith, class of 1894; J. D. Norris, class of 1878; A. H. Carroll, class of 1907; W. Guy Townsend, class of 1888; R. R. Norris, class of 1904; W. R. Stokes, class of 1891; H. H. Biedler, class of 1876; George Flemming, class of 1884; W. T. Watson, class of 1891; G. W. Dobbin, class of 1894. Cambridge—Guy Steele, class of 1897. Cumberland—C. R. Winterson, class of 1902. Greensboro—W. W. Goldsborough, class of 1901. Maryland—D. E. Stone, class of 1900, and Dr. Gordon Wilson, Associate Professor of Medicine.

MARRIAGES.

Dr. Sydenham Rush Clarke, class of 1905, of Baltimore, was married Wednesday evening, April 22, 1908, to Miss Louise Earle Topham, daughter of Mrs. Frances Rogers Topham, of Baltimore, Md., at Roland Park Presbyterian Church. The ceremony was performed by Rev. John W. Douglas, pastor of the church, and Rev. Dr. John R. Van Meter, dean of the Woman's College, Baltimore. Miss Elizabeth K. Boyd was maid of honor. Little Miss Dorothy Benson was flower girl. The best man was Mr. Lawrence Sangston Clarke, brother of the groom. The ushers were Messrs. Frank B. Fellows, of Washington, D. C.; Downing Clarke, a brother of the groom; Howard May and Edgar Legg. Immediately after the ceremony Dr. and Mrs. Clarke left on a bridal tour. After their return they will reside at 330 East Twenty-fifth street, where Mrs. Clarke will be at home after June 1, 1908.

Dr. James Madison Lynch, class of 1904, of Baltimore, was married April 17, 1908, at the home of Mrs. J. O. Sullivan, in East Nashville, Tenn., to Miss Anne Imboden Duff. The ceremony was performed by Rev. Charles E. Sullivan. Charles and Francis Sullivan were the ribbon bearers. The ring bearer was Miss Anna Katherine Reed. The maid of honor was Miss Frances Sullivan. The flower girls, nieces of the bride, were Misses Elizabeth Sullivan and Ruth Robinson. Immediately after the ceremony Dr. and Mrs. Lynch left for the Doctor's former home, Asheville, N. C. They will visit Norfolk and Washington, D. C., before returning to Baltimore. Dr. Lynch was formerly resident physician at St. Joseph's Hospital, Baltimore, and was an assistant to the late Dr. Isaac Ridgeway Trimble. Mrs. Lynch was at one time in training at the University Hospital Training School for Nurses, but resigned before she had completed the course.

Dr. Louis H. Limauro, class of 1906, to Miss Chiara Longobardi, at New Haven, Conn., February 17, 1908.

Dr. Henry C. Houck, class of 1905, of Baltimore, to Miss Ella May Thompson, of Glencoe, Md., at Ellicott City, Md., December 18, 1907.

DEATHS.

Dr. Harry C. Morrison, class of 1866, died February 7, 1908, at Kansas City, Mo., aged 63.

Dr. William J. Best, class of 1856, dropped dead at Brucetown, Frederick county, Va., on February 5, 1908, aged 75.

Dr. James C. Kinkle, class of 1847, for many years a practitioner of Still Water, Minn., died at his home, in St. Paul, Minn., January 19, 1908, aged 82.

Dr. N. K. Vance, class of 1882, formerly a surgeon in the United States Marine Corps, was found dead in his room at a hotel in Atlanta, Ga., April 1, 1908. Death was due to a pistol wound, which the authorities think was self-inflicted.

CHANGE OF ADDRESS.

Dr. R. W. Crawford has moved from the University Hospital, Baltimore, to his new residence, Rocky Mount, N. C.

Dr. J. R. Lowery has moved from Cool Springs, N. C., to Cooleemee, N. C.

Dr. W. L. Hart has changed his residence from the Army Medical School, Washington, D. C., to his former home, Yorkville, S. C.

Dr. Nathaniel Burwell has moved from Fire Creek, W. Va., to Mucklow, W. Va.

Directory of Living Alumni of Medical Department of the University of Maryland—Continued.

NORTH CAROLINA.

Headen, Wm. E., Morehead City, class 1891.
Ross, C. E., Morehead City, class 1889.
Wallace, J. Brown, Mount Holly, class 1897.
Steele, Wm. C., Mount Olive, class 1891.
King, Ed. S., Mount Pisgah, class 1889.
Battle, Jas. P., Nashville, class 1880.
Brooks, Baird U., Nashville, class 1905.
Duguid, Jos. W., New Bern, class 1893.
Jones, R. DuVal, New Bern, class 1896.
Bunting, R. C., New London, class 1899.
Everhart, W. H., Newton, class 1903.
Yount, J. H., Newton, class 1876.
Hatchcock, Thos. A., Norwood, class 1893.
Paddison, John R., Oak Ridge, class 1902.
Brooks, H. M., Olive Branch, class 1849.
Williams, J. Burton, Oxford, class 1906.
Everett, A. C., Peagues, class 1897.
Ward, W. H., Plymouth, N. C., class 1881.
Black, Jas. C., Pioneer Mills, class 1886.
Whitfield, Wm. C., Quinnerly, class 1884.
Lewis, Richard H., Raleigh, class 1871.
Tucker, H. McKee, Raleigh, class 1899.
McMillan, Benj. F., Red Springs, class 1882.
McMillan, John L., Red Springs, class 1881.
McGehee, John W., Reidsville, 1904.
Love, Bedford E., Ridgeville, class 1904.
Williams, Thomas B., Ridgeway, class 1877.
Hoyt, Augustus C., Roanoke Rapids, class 1900.
Garrett, F. J., Roberdell, class 1889.
Hargrove, Robert H., Robersonville, class 1877.
Garrett, Frank J., Rockingham, class 1889.
McPhail, L. D., Rockingham, class 1900.
Braswell, Mark R., Rocky Mount, class 1886.
Quillen, Emille B., Rocky Mount, class 1904.
Shubrick, J. T., Rocky Mount, class 1877.
Speight, Richard H., Jr., Rocky Mount, class 1901.
Whitehead, J. P., Rocky Mount, class 1899.
Whitehead, Wm. H., Rocky Mount, class 1870.
Wimberly, Geo. L., Rocky Mount, class 1882.
Sinclair, Duncan, Rowland, class 1855.
Bradsher, Wm. A., Roxboro, class 1904.
Northrop, T. McL., St. Paul, class 1897.
Heilig, Herman G., Salisbury, class 1899.
Stokes, James E., Salisbury, class 1892.
Monroe, Wm. A., Sanford, class 1886.
Barnes, B. F., Saratoga, class 1902.
Clarke, Henry J., Scotland Neck, class 1879.
Gibbs, N. M., Scranton, class 1896.
Stephenson, M. R., Seaboard, class 1881.
Sawyer, W. W., Shiloh, class 1903.
Patrick, G. R., South Point, class 1879.
Busby, Julien, Spencer, class 1904.
Young, James W., Spencer, class 1898.
Dew, Samuel B., Spring Hope, class 1885.
Linville, W. C., Sprucepine, class 1903.
Paul, Wm. T., Stacy, class 1869.
Shamsburger, John B., Star, class 1890.
Adams, M. R., Statesville, class 1878.
Campbell, Arch, Statesville, class 1889.
Hill, W. Junius, Statesville, class 1889.
Long, Henry F., Statesville, class 1892.
McLaughlin, John E., Statesville, class 1886.
Phifer, F. W., Statesville, class 1902.
Basnight, Thomas G., Stokes, class 1904.
Corbell, Edwin F., Sunbury, class 1886.
King, Ed. S., Sweet Home, class 1888.
Baker, Julien M., Tarboro, class 1879.
Harrell, Samuel N., Tarboro, class 1897.
Cheatham, Arch, Toxaway, class 1888.
Salley, E. M., Tyron, class 1905.
Cathell, J. E., Tyro Shops, class 1899.
Bennett, J. H., Wadesboro, class 1894.
McMillan, W. D., Warne, class 1869.
Williams, J. M., Warsaw, class 1902.
McCain, W. R., Waxhaw, class 1897.
Allen, Rufus L., Waynesville, class 1885.
Littlejohn, Richard N., Webster, class 1903.
Patterson, E. C., West Durham, class 1903.
Speight, Richard H., Whitakers, class 1870.
Maxwell, H. B., Whiteville, class 1902.
Bell, Charles D., Wilmington, class 1883.
Bullock, D. W., Wilmington, class 1873.
Green, Thomas M., Wilmington, class 1900.
Harper, Charles T., Wilmington, class 1894.
McMillan, Wm. D., Wilmington, class 1869.
Nixon, E. J., Wilmington, class 1899.
Russell, Frank H., Wilmington, class 1893.
Thomas, George L., Wilmington, class 1871.
Thomas, Pride J., Wilmington, class 1902.
Wessell, John C., Wilmington, class 1900.
Lewis, George W., Wilmington, class 1886.
Williams, Albert F., Wilmington, class 1901.
Copple, Thomas M., Wilmington, class 1898.
Fearrington, Jos. B., Wilmington, class 1887.
Summers, Charles L., Wilmington, class 1887.
Cox, B. Thaddeus, Winterville, class 1888.
Odend'hal, Edward P., Winton, class 1895.
Hanes, J. Lewis, Winston, class 1902.
Paul, Wm. T., Wit, class 1869.

OHIO.

Welsh, E. A., Cincinnati, class 1887.
Rowe, George T., Circleville, class 1877.
Howard, Wm. T., Jr., Cleveland, class 1889.
Richards, Harry P., Columbus, class 1889.
Hendricks, N. M., Dayton, class 1885.
Kochenderfer, Charles C., Galion, class 1875.
Day, Henry, Newark, class 1868.
Keller, Bayard T., Streetsboro, class 1871.

OKLAHOMA.

Trader, Charles W., Cache, class 1878.
Brown, Paul R., Jr., Guthrie, class 1901.

OREGON.

Taggert, Charles C., Marshfield, class 1887.

PENNSYLVANIA.

McGee, Thomas J., Alleghany, class 1880.
Ritter, Francis O., Allentown, class 1881.
Quail, Charles E., Auburn, class 1867.
Arthur, Walter C., Bellevue, class 1897.
Shaw, W. Potter, Berlin, class 1883.
Crist, Robert O., Boswell, class 1903.
Council, Malcolm S., Bryn Mawr, class 1896.
Donohoo, Harry C., Chester, class 1903.
Smith, John R., Christiana, class 1904.
Stemple, John H., Conshohocken, class 1901.
Lawson, Lemuel S., Dallastown, class 1867.
Smith, Gilbert T., Danville, class 1897.
Coble, Aaron C., Dauphin, class 1885.
Hocking, Wm. C., Duquesne, class 1890.
James, W. Dudley, East Brady, class 1881.
Moyer, Lewis W., East Mauch Chunk, class 1887.
Jenkins, Felix S., Jr., Edgegrove, class 1887.
Leh, Henry D., Egypt, class 1884.
Warren, Everard P., Etters, class 1868.
Wilson, Harry M., Evans City, class 1889.
Remsburg, Albert J., Franklin Mills, class 1874.
Myers, A. H., Freedom, class 1882.
O'Neal, John W., Gettysburg, class 1844.
O'Neal, W. H., Gettysburg, class 1871.
Elgin, Wm. F., Glen Olden, class 1887.
Crushore, Chas. C., Greensburg, class 1905.
Offutt, Lemuel, Greensburg, class 1876.
Everhart, Oliver T., Hanover, class 1856.
Russell, Roswell, Hanover, class 1882.
Hooven, H. Hewitt, Harford, class 1892.
Fishel, Henry W., Harrisburg, class 1886.
Mosier, J. Russell, Hayfield, class 1883.
Boggs, W. H., Huntingdon, class 1891.
Born, Charles E., Johnstown, class 1902.
Miller, Edward L., Johnstown, class 1884.

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THE CONDITIONS CONFRONTING THE COUNTRY PRACTITIONER.

By THOMAS M. CHANEY, M. D.,

(Class 1866), Chaney, Md.

Mr. President and Fellow-Alumni of the Medical School of the University of Maryland:

I find myself this evening in a position somewhat similar to that of Sam Weller in writing his first valentine to his lovely Mary. Sam wrote it with pen and ink, and corrected his mistakes by rubbing them over with his finger and writing over the blots. When Tony, his father, came in and found what Sam was doing, he was shocked, but said it might not result in matrimony or cause other very serious damage, as it was not written in poetry, and he consented to hear Sam read it. Sam read: "I am ashamed and circum—"a blot and a "D." The old man at once suggested that the word was intended for "circumvented," and that it was a very expressive word. But Sam said that would not be a proper word for a valentine, and that it must be "circumscribed." Now, friend Taneyhill has "circumscribed" me, and it may be also "circumvented" me, by confining me to a subject selected by himself. But, my friends, as my address is not in poetry, it will, I hope, do no serious damage.

I think we may get the best view of the conditions that confront the country practitioner by considering his obligations and his rewards.

The country physician is a general practitioner in the widest scope of these words. In taking his position in a community he assumes the obligation to practice medicine and surgery, and to some extent, in many places, dentistry. All diseases and injuries that man is subject to in the locality in which he lives he must expect to be called upon to treat. When he comes to a case, he knows that the whole responsibility of the diagnosis and the treatment rests upon him. However obscure the case may be, he must rely upon himself to institute the treatment. He cannot make a superficial examination and hurry his patient to a hospital, nor can he generally give a palliative and promise to return in a few hours, for usually his patients are too distant to be seen more than once a day; nor can he call in a specialist to assist in the diagnosis and treatment, and in many cases there is not time to call in a neighboring physician, if it is desirable to do so.

These are important obligations, weighing heavily upon the conscientious physician, and especially so upon the young man.

Again, as in the country there are no specialists, if a physician calls in another for consultation, by some this will be construed as showing a want of confidence in himself or as an admission of incompetency, unless it be in a surgical or an obstetrical case, where it is plain that two or more are required to do the work.

But there are emergencies in which, however plain it may be to anyone that help is needed, the country practitioner cannot get it. I recall such an experience in the early days of my practice, with three cases of labor in one night, two of them primiparal and one of these having eclampsia. The first was three miles from my home, the second five miles away, and the third—the case of eclampsia—two miles away, in an opposite direction. This last was a patron of an older and very able neighboring physician, who was too ill to leave his bed. My engagement with one of the other patients made me late in reaching this one, and she had, to the time of my arrival, had fifty-six convulsions. The nearest physician to be gotten to help me was seven miles away. The woman had not been conscious for more than five hours. She was restless, and with every pain there was a convulsion. My duty was plain. The woman was put to sleep with chloroform, which was entrusted to her mother, a very sensible woman, who said she would do just what I might direct her.

The child was high up and I expected much difficulty in applying the forceps. But the chlo-

roform brought such relaxation that the long Hodge forceps passed easily into position, and in less than ten minutes the child was delivered. There was no return of convulsions. The mother and child are living in this city now. The latter is herself the mother of a large family. This was in 1868. It was the first time I had applied the forceps and the first time they had been used in that part of the country. I felt that I did not deserve much credit for this, for I had to do it. There was no alternative, and it proved to be so easy a task after it was undertaken.

Let me recall a more recent emergency. This was in surgery, and occurred in 1898. A boy twelve years of age was accidentally shot in his right shoulder by his brother with a gun loaded with coarse shot, at a distance of ten feet. The load entered just below the clavicle, severing the axillary artery. A few shot passed through the scapula and rested under the skin. Another physician three miles away and myself, five miles distant, were sent for at the same time. I reached the patient first, and found him stretched upon a bed which was saturated with blood, which had gone through and made a stream across the room. There was no pulse to be felt at either wrist. The patient was unable to speak or to move, and with every expiration frothy blood came from his mouth. The finger, passed into the wound, came to the lacerated lung tissue, and beyond to a small, ragged opening in the scapula. A neighboring farmer who had come in was shown how to press against the proximal end of the artery to prevent hemorrhage. One-twentieth of a grain of strychnia was given hypodermically, and a quart of quite warm solution of chloride of sodium was forced into the wound with a syringe. In five minutes blood ceased to come from the mouth, and in half an hour the patient was able to speak. Then he was given a glass of hot milk. This was before it was known that the normal salt solution was so powerful an agent for good in hemorrhage and shock. I used it as a safe antiseptic to come into contact with the lung and to check the hemorrhage from that organ through the mouth. It must have gotten quickly into the circulation by absorption, and possibly by going directly into the severed vessels, for the improvement was immediate. The patient was too weak to be disturbed further then. The wound was packed to prevent hemorrhage during the night and the arm was wrapped in cotton wadding and heat applied to it.

Just as I was leaving the other physician came, and by agreement we met the next morning, completed the opening posteriorly through the soft tissues and the scapula, and cleaned the wound thoroughly.

As the severed artery was not accessible to ligate without further cutting, it was decided to make pressure on the proximal end by using gauze packing. Two neighboring farmers were instructed how to make pressure in case of hemorrhage. Except that there was some sloughing of the ends of the ring and little fingers, which after some days were amputated at the line of demarcation, and some paralysis affecting the arm and forearm, which passed off in twelve months, the case progressed most favorably. At no time did the temperature reach 100 degrees.

This young man is now a successful merchant. Here I had to make assistants of willing, sensible farmers. Waiting at that time for the help of another physician meant death to the boy.

I have no doubt many of you here from your country work have had such experiences as these in both obstetrics and surgery, and did better work than I did.

The country physician, whatever his tastes may be or his abilities in any kind of work of his profession, cannot afford to let it be known that he is a specialist, or that he prefers one line of work to another. It will be assumed that he is deficient in other branches.

I recall a young man of fair ability, a graduate of this school, who came into a neighborhood near me and announced that he would give special attention to the diseases of women and children. This was at the time that Dr. Miltenberger was doing an immense amount of work in this city. This young man also carried a magazine and read it while riding through the country. The heads of some of the respectable families said they wanted a physician who could attend them as well as their wives and children. The young man got no practice there. He moved to a distant neighborhood, withheld his specialty announcement, stopped reading magazines on the road and became successful—at least, to the extent of marrying a wealthy woman and not having to seek a practice.

The country physician has, too, obligations as a citizen which must be met. His conduct, aside from his professional work, will have quite as much weight in deciding his success as will his skill as a physician. Very soon after he enters a

neighborhood to practice he will be known by every resident and he will know all of them.

It is always assumed that a graduate in medicine has a fair rudimentary education, and that his association with educated fellow-students, and his intercourse with the teachers, have broadened his intelligence beyond that of the average country man. He is expected to discuss intelligently current events, and is generally, in his early years, made secretary of public meetings. If he is ignorant it will soon be known, and he loses all chance of being classed among the best physicians of his community or county.

Of greater importance still is it that he has the reputation of being honest and moral, and the reputation cannot be maintained unless he really develops such a character. His habits will be known to all his patrons, and must be above reproach. Otherwise he fails to get the practice of the best people, and others soon follow their example and discard him.

No other person outside of the family is brought into such intimate relations with its members as is the country physician with those among whom he practices. I believe that men of no other class, men of no other profession or calling, have so seldom betrayed the confidence reposed in them. An observant old gentleman whom I had not seen for many years called to see me last summer. Among other changes of the times that he mentioned, he said: "And you doctors are looked upon as the best people among us now. It used to be that the preachers were the first consulted in case of trouble, but now the first one called in in such cases is the doctor, and his advice governs everything."

Should it not be so? No other can know so well as the physician how business reverses, loss of friends and impaired health affect his patients, and no one else is so well prepared to give the needed help.

Christ was known as the Great Physician, and that seems to have been a more prized title than either that of preacher or teacher.

Dr. Forbes Winslow says: "The spirit of love, tender sympathy, Christian benevolence, unwearying kindness and warm affection should influence every thought, look and action of the physician engaged in his holy, honorable, sacred and responsible work." This, it seems to me, applies with great force to the country physician on account of his intimate relations to his patrons.

I will not dwell at length upon the long rides through heat and cold, rain and snow, that confront him. The labors of Dr. Weelum MacLure, so touchingly described by Ian Maclaren in "Beside the Bonnie Brier Bush," are paralleled by many country physicians. Rides of from ten to sixty miles a day are often made by them, and sometimes on horseback. I recall a ride of five miles in five hours. But these are simply physical labors, and rest restores the tired body. The telephone, the electric and steam railroads and the automobile are rapidly making this work easier.

While the duties of the country physician are exacting, laborious, often exhausting, there are few persons who have such opportunities for useful service, and this is what really decides the success of a life.

The work that he must do in emergencies makes him resourceful and independent and brings him reward.

Such work, either in country places or small towns where the work is that of the country practitioner, developed such men as Dr. Ephraim McDowell, Dr. J. Marion Sims, Dr. Nicholas Senn, and in my own county, and for the great benefit of this city and our alma mater, Dr. Samuel Chew, the father of our president.

Although all country physicians do not reach such eminence as these, he who applies himself earnestly to his work is sure of success in attaining a pecuniary competency for himself and his family, and is sure of being classed among the foremost men of his community. From the time he begins his work he can make a support. In this respect he has, in my opinion, great advantage. His expenses are not great, and in a few years his income from his practice will be from $1,000 to $2,500 a year. It is seldom he can do enough work to make it above the higher figure, and nearly always it is above the lower one. For his surplus, too, he has at hand investments which are secure and that are constantly under his observation. He can invest in farming lands and rent these for a share of the crops. It is true, as Mr. Greeley said, "the profits of farming are sure, but infinitely small." This element of certainty, though, is very important, as I learned, in company with some of you and other wise men of this city. I mean we have all gotten wise since we made that investment in the Baltimore Petroleum Company, which, with the Sand Fork Petroleum Company, the Sand Fork Extension,

etc., all became the National Consolidated Oil Company, with W. L. Russell president. I know some of you here have heard of this company, but you do not hear of it now. From my experience with them, the building associations and some other companies with headquarters in the cities are but little better.

Again, the country physician, according to his tastes, may indulge in recreations which are at the same time profitable. He may, if fond of horses, have a few well-bred ones to ride or to drive, to exhibit at fairs, and perhaps to sell at a good profit. He may find enjoyment, wholesome food for himself and his family and considerable profit in cultivating fruits and nuts.

But not the least important of his rewards is the good health which his out-of-door life, with pure air, pure water and pure food, brings to himself and family. In my opinion the life of the country physician, located in a village or small town on a steam or electric road, as many now are, with telephone and frequent mails, may be made the ideal life. In such places a man with a family knows that he is raising his children under the most favorable conditions to be found. We know that many of our most successful men and women have come from such surroundings, and that a large per cent. of these are the sons and daughters of country physicians.

The obligations of the country physician are as important as those of any other men. His reward may be only a consciousness of useful service which will never be recorded or recognized by the public, or it may be such development and education of the faculties that will lead to renown, perhaps to wealth. However this may be, it is his duty, as that of his city brother, to aim to give his patrons the best service to which medical science has opened the way.

The pleasure of the pursuit of knowledge and the preparation for duty are always the best rewards; the renown and wealth that follow are accidents.

AMERICA'S FOREMOST HEALTH RESORT.

W. Turner Wooton, M. D., '99.

Hot Springs, Arkansas.

The writer was influenced to adopt the above caption for an article to appear in the Bulletin by the many erroneous ideas of this resort expressed by the alumni at the "Centennial Celebration."

It behooves the well-posted physician of today to know something of the greatest health-giving springs in the world, and be cognizant of their surroundings, that he may intelligently advise those patients contemplating a trip to them, for, whether he advises it or not, there will be those of his clientele making the trip.

I will forego the desire to delve into the many beautiful traditions in which the early history of the springs abound, and endeavor to give some idea of the conditions as existing today.

The city of Hot Springs, with a resident population of 16,000 and 150,000 annual transients, is about in the geographical center of the state, having an altitude of six hundred feet. The climate is mild in the winter and tempered with cooling breezes during the summer, the nights being always cool and conducive to slumber.

The city is laid out in the shape of a dumbbell, the one street running north and south between the two mountains and connecting the two ends, which spread out as soon as the confines of the mountains allow, may be likened to the handle of the dumbbell. From each side of this street rise majestically the mountains to a height of 1,300 feet. From one on the east flows the hot water, and at its base are the bathhouses, while on the opposite mountain are no hot springs, and business houses line the street at its base, a great deal of which has been dug away in order to procure room sufficient for building.

Hot Springs is often referred to as a city of hotels and bathhouses, being so thoroughly equipped to care for pleasure and health seekers. Hotels, large and small, to the number of five hundred, can house twenty thousand visitors, while the twenty-four bathhouses, in 1907, furnished about 850,000 baths.

Scattered through the valley are twenty churches, sixteen schools, four banks, four hospitals, five theaters, twelve livery stables, three parks, all easy of access by the electric street railway. All the fraternal orders are represented by lodges, and the twenty-four drug stores claim the patronage of the hundred and fifty physicians. Golf links, beautiful drives and bridle paths furnish outdoor exercise for those who delight to bask in the glorious sunshine

Among the points of interest are the ostrich farm, alligator farm, dog kennels, whetstone

quarries, fullers' earth mines, quarries of the Hot Springs Pottery Company, pottery plant, Thousand Dripping Springs, Cave Spring, Snow Spring, Ouachita River and Hell's Half Acre.

Surrounding resorts, with hotel accommodations, ranging in distance from five to twelve miles, are Potash Sulphur Springs, White Sulphur Springs, Ozark Lithia Springs, Spring Lake and Mountain Valley Springs. Driving parties and tally-hos take crowds out to these points daily for dinners, card parties and dancing.

The United States Reservation embraces about a thousand acres, and was set apart in 1832 as "a national sanitarium for all time," and the general scheme for beautifying has been going on since. The mountainsides have been parked, while shrubbery, climbing vines and flowers have been planted in profusion. The system of twenty miles of walks and driveways on the mountains, which wind around the sides by easy grades to the summit, are a never-ending source of delight to the pedestrian and equestrian. The views of the peaks and valleys of the Ozarks that unfold before one are not surpassed in beauty and variety by those far more famed.

These improvements are maintained by the rental of the hot-water leases to the bathhouses. A superintendent is in charge to see that all rules and regulations as promulgated by the Honorable Secretary of the Interior (by sanction of Congress) are observed. In 1904 the state legislature granted the Federal Government exclusive jurisdiction over the reservation, since which time the Department of the Interior has been all-powerful and the Secretary has made rules and regulations governing the bathhouses and specifying certain requirements for those physicians desiring their patients to use the water. He has seen fit to appoint a commission, composed of two physicians and a lawyer, to judge of the qualifications of those physicians practicing here and using the hot water. It is the duty of this board to examine all physicians who may apply as to their professional attainments; to hear all evidence when unethical conduct is charged, making such recommendations to the Honorable Secretary as deemed advisable in the premises, who may then allow or discontinue the further privilege of the hot water to such physicians.

There are forty-seven hot springs on the reservation, with a total flow of a million gallons daily, at an average temperature of 135 degrees F. (1). This water is collected in large reservoirs and then apportioned to the different bathhouses, thus insuring the public the water will be the same in all bathhouses.

During the year 1904 the United States government commissioned Prof. Bertram B. Boltwood, of Yale, "to make a scientific test of the waters of the hot springs of Arkansas for the presence of the mineral radium." He completed his work and reported back to the Interior Department within the year. His conclusions were:

"1. The waters of the springs of Hot Springs Reservation are all radio-active to a marked degree.

"2. The radio-activity of the waters is due to a dissolved radium emanation (a gas, and not to the presence of radium or other radio-active solids."

This theory is in keeping with all the experimentation that has been done, it being a well-known fact that the water, once cooled, no longer possesses the therapeutical value it primarily possessed. Also, it was known long before radium was heard of that there was some element about the water that could not be defined, but variously referred to as magnetic, electro-magnetic, etc.

Years ago it was determined that the effects produced by bathing in the water were entirely dissimilar to those of an ordinary hot bath, as it was shown that the patient's temperature would rise from one to six degrees when immersed in the water at a temperature slightly below that of the normal person, the pulse rate being proportionately increased.

To this property—be it radio-active or what you will—does it owe its value as an agent in combatting pathological conditions, and to this property is due the credit for the thousands of cures effected in the past, and will claim homage from the legions to come in the future.

It has been said of this, as well as most resorts, that the chief virtue lay in the fact that persons sojourning for their health devote their entire time to the business of getting well, take their medicine, eat, sleep and exercise with due regularity and pay the strictest attention to hygienic surroundings and existence, which conditions are impossible while a person is at home with business or household cares, social obligations and other incumbrances encountered by the practitioner.

No one can gainsay the fact that these attained conditions are of inestimable help to the resort

physician (and should be reason enough for sending patients away from home when necessary), but it would be impossible to return the vast army of invalids that have sought relief here back to their homes in a happy physical and mental state if this was the sole aid awarded. Be it borne in mind that a great many invalids come here after all other succor has availed them naught—and not in vain.

Contrary to the usual expectation, the hot water is very palatable, and does not cause nausea, as an artificially heated water does, therefore large quantities can be drunk with impunity. It readily passes from the stomach to the duodenum, from whence it is very rapidly absorbed, and, unless quantities are imbibed, is apt to cause constipation, not by slowing of peristalsis or decreasing the amount of glandular secretion in the bowel, but by the increased absorption of the fluid in the small intestine there remains little to pass into the large, the foecal mass becomes dry and hard, with consequent decreased motility as it reaches the colon. This condition is usually obviated by increasing the amount of water the patient drinks between meals.

The action of the water internally is that of a cool spring water, sans minerals, plus the proper temperature at which it can pass from the stomach ready for absorption, plus a slight stimulating effect on mucous membranes and plus a vehicle for the immediate absorption of the other contents of the stomach and small intestines.

Externally the water has a very stimulating effect on the entire system, as is shown by the general cell activity, as evinced by a gradual increase in pulse rate and rise of temperature when a person is immersed in the water at a temperature not to exceed that of the normal body. This influence, which is not adduced by prolonged bathing in ordinary hot water, can be taken advantage of in varying degrees to accomplish different results, just as we employ different dosage for ipecac, for instance, where directly opposite results are to be had by the minute and full doses.

In consequence of this dosage I have attempted to arrange into groups the various effects produced and the diseases chiefly benefited by each according to the result desired. Of course, personal equation has to be dealt with, and no fast rules can be laid down governing the administration of the baths, the effect having to be watched just as when any other medicine is administered; (2) and just here I wish to divert long enough to say the physicians of this resort do not expect the water alone to cure any and all diseases, but also depend on the materia medica very extensively. To the cripple or invalid the water is one crutch and the materia medica the other. They act beautifully and harmoniously together, and the patient can hobble along quite rapidly, whereas with one crutch only he goes more slowly, except in those cases where the injury or disease is slight and there is no need for more than the one, there being a good leg opposite.

The classification I have seen fit to use is as follows:

1. Tonic bath.
2. Stimulative bath.
3. Sedative bath.
4. Mildly eliminative bath.
5. General eliminative or sudorific bath.

The tonic effect produced by immersing the patient in the water at a temperature of 92 degrees F., and gradually raising to 97 degrees, allowing him to remain to the point of reaction only where the temperature begins to rise. The patient is then removed to the cooling room, which is kept at a temperature of 80 degrees, placed in the recumbent position for half an hour or more. About six ounces of the hot water is taken internally just after getting into the tub, and again before being removed.

The conditions chiefly benefited by this bath are:

Convalescence from all specific infectious diseases except tuberculosis and syphilis.

Convalescence from surgical procedures.

Malnutrition, nervous prostration, acute eczema, hyperidrosis, lupus and pemphigus.

The stimulative effect is produced by a bath at 96 to 98 degrees, the patient remaining until slight rise of temperature—2 degrees—takes place; then remove to the cooling room until the patient recovers from the reaction. One-half to one pint of the hot water is drunken while the patient is in the tub.

The conditions especially applicable here are:

Chronic catarrh of all mucous membranes, buccal, nasal, laryngeal, bronchial, gastric, biliary, enteric (including catarrhal appendicitis, colitis, diarrhoea, dysenteric and constipation), cystic and urethral.

Anaemia, leukaemia, chronic Bright's, arterio-schlerosis, diabetes, dermatitis, sub-acute eczema,

furunculosis, herpes, pityriasis, schleroderma and scrofuloderma.

The sedative is procured at a temperature of 95 to 97 degrees, allowing the patient to remain for a rise of from 1 to 2 degrees, then remove to the pack room (temperature 98 to 100 degrees) and wrap in sheet until a mild sweat takes place. A needle and shower spray at 80 degrees for a minute, then put the patient to bed for several hours. One pint of hot water is drunken during the bath.

The diseases most benefited by this bath are:

Heart—Chronic valvular disease hypertrophy, dilatation, neuroses (palpitation, arythmia, tachycardia, bradycardia and angina pectoris).

Nervous System—Acute delerium, chorea, hysteria, neurasthenia, insomnia and exopthalmic goitre.

Skin Diseases—Herpes zoster, hyperasthesia, pemphigus, pruritis and urticaria.

The mildly eliminative and reconstructive bath is given at a temperature of 98 degrees until a reaction of 3 degrees is attained. The patient is then placed on a cot in the pack room, wrapped in blankets and sheets and the sweat is continued for twelve or fifteen minutes; then he is removed to the cooling room for half an hour, after which a cool shower is taken. One to two pints of hot water are drunken.

This bath lists the following:

Uraemia and other deficiencies in urinary secretion, locomotor ataxia, muscular atrophy, chronic malaria, chronic poisoning (alcohol opium, tobacco, metallic).

The general eliminative or sudorific for a general cell cavity, engorgement of superficial capillaries, solvent, absorptive and eliminative effect is produced at a temperature of 98 to 100 degrees (the latter rarely necessary, remaining in the bath until a reaction of 3 to 4 degrees takes place. A vapor of two or three minutes or dry hot air (140 degrees) for ten to twenty minutes after which a fifteen-minute pack; then to the cooling room until reaction is over and the patient entirely recovers Two to three pints of hot water are drunken during this time (4).

The diseases most applicable to this course are:

Arthritis, chronic rheumatism, muscular rheumatism, gout, obesity, hay fever, sciatica, neuralgia, migrane, dermatitis, chronic eczema and prurigo.

It will be noticed that a few diseases are listed under two or more headings, as it often becomes necessary to change from one to another. It also becomes apparent that the one disease more treated here than any other is not listed, and this purposely, so that it may receive special consideration.

Syphilis, having so many phases, must needs be given consideration in each and every one, and the following is my method of reckoning with it:

In the primary stage, before treatment is begun (where suspicions have not been confirmed) the tonic bath is given, and after treatment is inaugurated the stimulative is substituted.

The secondary, with either the early or late skin lesions, warrants the mildly eliminative .

In the tertiary, with skin lesions, the sudorific; with gummata, or ataxia, the mildly eliminative.

After the medical treatment has been thorough the sudorific is substituted for the mildly eliminative.

In those persons who return here in after years with no lesion or trace of the disease apparent, but who want to take what we call "an insurance course" (taking no chances), the stimulating is used in connection with mercurial inunctions; when the latter is continued the sudorific is advised for a week.

The effect of giving the baths according to classes 4 and 5 in syphilitic persons who may be undergoing mercurial treatment is identical with the effect that Dr. Robinson (Medical Record, June 15, 1907) is now claiming for pilocarpine, hypodermically injected, with none of the disadvantages or dangers possessed by his method. This accounts for the rapidity with which stubborn secondary and tertiary skin lesions heal here after resisting all efforts at home.

In conclusion I would say the sooner the profession at large recognizes the fact that the water of the Hot Springs of Arkansas has a specific effect, and is not to be likened unto any hot bath taken at home, the sooner will their "chronic" patients lose their "chronicity" and gain greater respect for their physicians.

(1) The temperature of some of the springs is as low as 115 degrees, ranging up to 165 degrees, the hottest.

(2) The time one person may have to remain in the bath to get one degree reaction may be sufficient to give another 6 degrees and prostrate him.

(3) For the same reason that other diseases are benefited, tubercular conditions—save lupus

—are made worse, and consequently phthisical patients are advised not to bathe in the hot water.

(4) It is at once apparent that only a strong person can take the bath as outlined, but by modifying it to suit the individual we have no trouble in producing the desired effect. In fact, it is often necessary to blend one class into another in order to meet individual requirements.

AN ADDRESS TO THE GRADUATING CLASS OF NURSES.

By Randolph Winslow, M D.,
Professor of Surgery, University of Maryland.

Young Ladies, Graduates of the Training School for Nurses: May is the month when nature seems to awaken from her winter's sleep, and to deck herself in gorgeous raiment, and to laugh aloud and shout for joy. The birds fill the air with music, the flowers bloom and shed loveliness and fragrance upon our paths, and the hillsides and dales are carpeted with velvety green, whilst the trees in their new foliage delight us with their stately beauty and spread umbrageous canopies to protect us from the too ardent embraces of the radiant sun. The wintry storms are past, and the cold and sleet and hyperborean blasts are forgotten, and we are joyful because it is good to live and to participate in the awakening of nature. In May the skies take on a lovelier hue, and the azure of the vaulted heavens entrances us and fills our souls with delight. The spring is here, the spring is here.

"In the spring a fuller crimson comes upon the robin's breast;
In the spring the wanton lapwing gets himself another crest;
In the spring a livelier iris changes on the burnished dove;
In the spring a young man's fancy lightly turns to thoughts of love."

The springtime of youth comes but once, and is soon over, and it is also a time for rejoicing and mirth, as well as for preparation for the serious affairs of life. Rejoice, therefore, in the days of your youth and be glad, for

"All things rejoice in youth and love,
The fullness of their first delight;
And learn from the soft heavens above
The melting tenderness of the night.
Maiden, that read'st this simple rhyme,
Enjoy thy youth, it will not stay;
Enjoy the fragrance of thy prime,
For O, it is not always May."

It is a propitious circumstance, therefore, young ladies, that at this springtime of life, as well as of nature, you have finished your period of probation and preparation and are now about to assume the duties and responsibilities of your calling. The bonds that have hitherto held you are now about to be loosed, but before the ties that have linked us together as teacher and pupils are finally severed I desire to be the first to congratulate you upon the completion of the arduous years of training and of tasks well performed. In the name of the Faculty of Physic of the University of Maryland, and of the officers and teachers of the Training School for Nurses, I stand before you as their spokesman, and extend to you their heartfelt felicitations and best wishes for an useful, happy and successful career. None know better than we the self-denial and abnegation you have undergone; the long hours of service, the broken sleep, the tired bodies and the exhausted minds; the harrowing scenes, the desperate and often futile struggle with disease and death. Well may you exclaim:

"O how could I serve in the wards if the hope of the world were a lie?
How could I bear with the sights and the loathsome smells of disease
But that He said: 'Ye do it to me when ye do it to these'?"

You have chosen an honorable and useful, and it may be a saintly and holy, calling. Your professional work will demand of you a vast sacrifice of ease and pleasure, and possibly even of health and life. By day and by night you must keep vigil with an eye single to the welfare of the sick and suffering who are entrusted to your care. Your devotion to duty will bring you in contact with diseases of a contagious character, and it may be that some of you will contract these pestilential diseases, but you are enlisted for the war, and cannot shirk the dangers of the battle, even though you fall in the fray. I here desire to lay a tribute of remembrance upon the tomb of one of our most esteemed graduates, Mrs. Annie Georgianna Truitt, of the class of 1906, who died on October 26th, 1907, at the Peninsular General Hospital, Salisbury, Md., of typhoid fever, contracted in the line of duty. She was faithful unto death.

You will be brought in association with all kinds of people; some of them will be considerate and appreciative of your services, others will be ungracious and churlish. To each class you must

be kind and patient and gentle, remembering that you see them when they are brought low by sickness and distress or misfortune, at a time when they may not be entirely responsible for their words and actions. Unfortunately, you will too frequently be called on to minister to those who are passing through the valley of the shadow of death, and the opportunity and the duty will be presented not only to alleviate their physical pain and discomfort, but at times to speak words of comfort and hope, that you alone may be able to utter. This is a service which makes of you "ministering angels," and your vocation an holy calling.

If pestilence should stalk through the land, or war, with its terrors, overtake us, the nurse will always be found at her post of duty, and her ministrations will soothe the anguish of the afflicted and comfort the last moments of those who are crossing the great divide. The graduates of the University of Maryland have ever been ready to sacrifice themselves on the altar of duty as they have apprehended it. Less than ten years ago Jas. Carroll, a graduate of the Medical School in 1891, was sent by the Surgeon General of the United States Army to Cuba to investigate the cause and prevention of yellow fever. He discovered that yellow fever was propagated by the bite of a special variety of mosquito, and that it could be prevented by killing the insects, and especially by destroying their breeding places. His discovery was made certain by an heroic act—that of voluntarily submitting his own arm to the bite of an infected mosquito. He contracted the dread disease, and, whilst he escaped with his life, his health was shattered and he paid the extreme penalty less than a year ago. By this discovery he has already saved thousands of lives and millions of money, and he has become one of the greatest beacons of medical history, which will shine brighter and brighter as the years slip by. When this country was threatened with cholera, about fifteen years ago, several of the graduates of this Training School promptly volunteered their services to the government, and reported for duty on the hospital ship stationed at the mouth of the Chesapeake Bay. Fortunately, the epidemic was averted, but all honor is due to these, your fellow alumnae, who, knowing the danger confronting them, like good soldiers pressed to the front. To them and to you comes the encouraging assurance, whether in private or public service engaged: "Thou shalt not be afraid for the terror by night, nor for the arrow that flieth by day; nor for the pestilence that walketh in darkness; nor for the destruction that wasteth at noonday." To each of you I say, set before yourselves high ideals, and place a broad Christian charity as the ruling principle of your lives rather than mere pleasure or sordid gain. Be true to yourselves, first as women, then as nurses. Remember that you are not absolved from the ordinary refinements and duties of womankind in general by the special obligations and exactions of your professional calling. A modest mien, a soft speech and kindly manner will commend you to those into whose houses you may enter fully as much as your skill in caring for the sick and suffering. Try to adapt yourselves to the conditions of those who may employ you, and make as little confusion and trouble as possible in the household. This advice may appear to you to be trite and unnecessary, but there are many nurses who need to be reminded that illness adds largely to the domestic and financial burdens of their patrons, whilst it diminishes or destroys their ability to bear these burdens. Whilst, therefore, maintaining your personal and professional respect and dignity, avoid all unnecessary interference with the domestic routine and lend a helping hand. Tact is an important attribute for a nurse as well as for a physician. Be cheery, soothing and kind, and avoid idle tattle and scandal. Discourage social calls from your friends and admirers upon you at the homes of your patrons, and do not keep the telephone wires overheated in sending or receiving your personal messages. In addition to your general education, the special training you have received has been of itself a schooling of no small value. You owe it to yourself, as well as to your alma mater, to continue to study and to keep abreast the advances in the art of nursing, as well as to constantly extend the boundaries of your general culture. Remember that any derogatory act or professional misconduct reflects not only on yourselves, but leaves a stigma on your calling and on the school which has sent you forth with its diploma.

The nurse is, or may be, a most important ally and aide to the physician, but she must not for a moment suppose that she is the physician herself, or that she can usurp the functions and duties of the physician. Her duty is to carry

out the instructions of the doctor loyally, to inspire confidence and not distrust in his judgment, and to do nothing that will undermine him in the estimation of his patients. This is an important rule, and one that is frequently transgressd. You may have a great admiration for Dr. A., or supreme confidence in the skill of Professor B., but when you are employed by Dr. C. it not only will not be your duty to make invidious comparisons, but you are obligated morally and professionally to abstain from anything that will destroy or diminish the esteem in which he is held. Any other course of conduct will be ruinous to you, and will sooner or later leave you stranded high and dry.

Many years ago I was attending a young man ill with typhoid fever, but who was doing perfectly well. He was being nursed by an English woman who had come to Baltimore in expectation of getting a position in the Johns Hopkins Hospital when it should be opened. For some reason she took a notion that he was not being properly treated, and went to the family and said she wished to retire from the case, as she was unwilling to be responsible for his care, as she had "knowledge and was as competent to treat a case of typhoid as any physician, and did not approve the treatment." Fortunately, the people were not easily upset, the nurse was released, others less highly trained, whose knowledge and assurance were not so great, were secured, and the patient recovered and is alive and well at this time. The English lady did not receive an appointment at the Johns Hopkins Hospital, and soon left the city.

If you cannot conscientiously carry out the instructions of the medical attendant, retire from the case as quietly as possible, and not with the blare of trumpets.

The last words written by that great surgeon and remarkable man, the late Dr. Nicholas Senn, of Chicago, and communicated in an address to the Cook County Hospital Alumni Association since his death, are as applicable to nurses as to internes, and I will transmit them to you: "Bemerke, hoere, schweige, urteile wenig, frage viel." Observe, listen, be silent, judge but little, question much.

I have already briefly called attention to some of the ways in which your profession may be made an honorable and a useful calling, and I now desire to say a few words in regard to another part of the well wishes of your teachers, that for a happy and successful career. Success and happiness go hand in hand. You can scarcely have a successful career unless you are happy in that career. The first essential for success, therefore, is a love for the work. You must not only be content with your work, but you must have an enjoyment and satisfaction in the performance of your duties, and this is near akin to happiness. Success is a relative term, and people apply it differently. To some it means lucrative employment and the acquisition of gain, and this is certainly an important feature of a successful calling, but it is not the most important. To my mind success means the opportunity to do good, and to excel in that which we undertake; to live up to the full measure of our opportunities. In this broad sense, as well as in the more restricted one of financial profit, we again wish you success and happiness.

I once asked a little girl what she expected to do when she grew up, and she promptly replied that she was going to be a stenographer and marry her employer. We know that the fair stenographer is pretty successful in this portion of her professional duties, and that she lives fully up to the measure of her opportunities in this regard. Likewise, the trained nurse is not aware of her qualifications in this matter, and she sometimes lands her millionaire patient, more frequently one whose bank account is not expressed in so many figures, and most often her catch is only a poor, impecunious doctor. In any and all of the relations in life she makes good, and her graduation from the calling of a nurse to that of a wife is effected easily, naturally and gracefully. A distinguished clergyman has recently expressed the opinion that there would be fewer mismated and unhappy marriages if custom permitted the woman to do the proposing. Poor Queen Victoria had to make the proposal to Prince Albert, and the little Queen of Holland to her consort, and I do not see why our American queens cannot do the same. It would save a great deal of trouble and mental distress to bashful swains. I am interested from the standpoint of the bashful lover. I was once there myself. Sometimes in our trepidation we cannot muster courage to know our fate

face to face, but must rely upon the help of the friendly postman.

"Where is another sweet as my sweet,
Fine of the fine and shy of the shy?
Fine little hands, fine little feet.
Dewy blue eye.

Shall I write to her? Shall I go?
Ask her to marry me by and by?
Somebody said that she'll say no;
Somebody knows that she'll say ay!

Ay or no, if I ask'd to her face?
Ay or no, from shy of the shy?
Go, little letter, apace, apace,
Fly.

Fly to the light in the valley below;
Tell my wish to her dewy blue eye;
Somebody said that she'll say no;
Somebody knows that she'll say ay!"

The confidence expressed in the last line does not appear to have been germane, however, as we find the bashful and shy lover awaiting her answer with a palpitating heart. Even nature seems to have been in a melancholy mood, and to have sympathized with him in his dolorous plaint, as he exclaims:

The wind and the wet, the wind and the wet!
Wet west wind, how you blow, you blow!
And never a line from my lady yet!
Is it ay or no? Is it ay or no?
Blow, then, blow, and when I am gone,
The wet west wind and the world may go on."

But all things have an end. The postman knocks and the answer is delivered, and with a faint heart the letter is opened. It is ay.

"Cuckoo! Cuckoo! Was ever a May so fine?
Why?
For it is easy to find a rhyme.
O merry the linnet and dove.
And swallow and sparrow and throstle, and have your desire!
O merry my heart, you have gotten the wings of love,
And flit like the king of the wrens with a crown of fire.
Why?
For it is ay, ay, ay, ay!"

Doubtless this anxiety would have been unnecessary had the sweet one with the dewy blue eyes been permitted to have the first word. As the custom is fixed, in this country, at least, that the man proposes, it is fortunate that the woman disposes, and that a marriage cannot be forced on her without her consent, hence the vital necessity of considering carefully this important step in life. If this were done more frequently there would be less inequality and incompatibility in the lives of married couples, and a less frequent resort to the divorce court as a remedy for these inequalities. Remember that "pearls should not be cast before swine, lest they trample them under their feet, and turn again and rend you."

May it never be said of you:

"Yet it shall be; thou shalt lower to his level day by day,
What is fine within thee growing coarse to sympathize with clay.

As the husband is the wife is: Thou art mated with a clown,
And the grossness of his nature will have weight to draw thee down.

He will hold thee, when his passion shall have spent its novel force,
Something better than his dog, a little dearer than his horse."

On the contrary, may the springtime of young love ever remain green in your experience, as is expressed by the poet Schiller in "The Song of the Ball:

"O Dass sie ewig gruenen bliebe,
Dis schoene Zeit der yungen Liebe!"

My pleasant task is completed. Why should I detain you longer? Your friends and admirers are anxious to grasp you by the hand and to extend their congratulations, and perhaps to whisper messages that I am not permitted to deliver for them. Standing on the threshold of your new life, I bid you welcome.

"An usher, standing at the door,
I saw my white rosette;
A smile of welcome, nothing more,
Will pay my trifling debt;
Why should I bid you idly wait
Like lovers at the swinging gate?"

But in bidding you welcome into the sisterhood of nurses I take leave of you as pupils of the University, and in concluding I beg to commend to you the sentiment embodied in the following lines:

"He prayeth well who loveth well
Both man and bird and beast.

He prayeth best who loveth best
All things, both great and small;
For the dear God who loveth us,
He made and loveth all."

Farewell!

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BALTIMORE, MD., JUNE 15, 1908

EDITORIAL.

THE GENERAL ALUMNI ASSOCIATION.—In the last issue of the HOSPITAL BULLETIN there was a notice that the Executive Committee of the Alumni Association and the Committee of Amalgamation of the General Alumni Association had had a meeting in order to formulate plans for a consolidation of these bodies. The BULLETIN also went so far as to state that it thought it would be able to announce its consummation. The BULLETIN is sorry to announce that it is unable to report its fruition. It can announce, however, that the terms upon which the Alumni Association of the Dental Department is willing to join its forces with those of the General Alumni Association have been drawn up and presented to the Executive Committee of the General Alumni Association, which body has decided to report the terms as set forth favorably to the General Alumni Association, which body will, without doubt, act favorably upon them. These are the conditions under which the Alumni Association of the Dental Department of the University of Maryland agrees to merge with the General Alumni Association of the University of Maryland:

First—A full list of our membership will be placed in the hands of the Secretary of the General Alumni Association.

Second—This Association will obligate itself to combine with the General Alumni Association free of debt, and will turn into the treasury of the General Association the sum of twenty-five dollars.

Third—All graduates of the Dental Department shall be eligible for election to membership in the General Alumni Association.

Fourth—For the unexpired part of the fiscal year of the General Alumni Association the Dental members will be carried free of charge, and dues for membership paid at the time of transfer shall carry them to the end of the succeeding fiscal year.

Fifth—We agree to observe all the rules and regulations, not herein excepted, now or hereafter governing the General Alumni Association, and shall claim equal rights and privileges with all other members of the Association.

The BULLETIN congratulates the Dental Alumni Association for this act of self-denial. It is, indeed, an unselfish act, for this Association has been in existence a number of years, and now that it is in a flourishing condition, it is an heroic act to merge its identity and aspirations with those of the General Alumni Association. It is this unselfishness of the University authorities in general that is gradually forcing the University of Maryland, our dear old Alma Mater, out of its lethargy into an active career. The amalgamation of the various alumni associations is merely an indication of the times. The University is taking on new life. Its aspirations are becoming higher. We are beginning to comprehend that more can be accomplished if the forces of the University are centralized; that heretofore there has been too much dissociation of effort, and that the day is past when strong and flourishing departments can hold themselves aloof from their weak and struggling associates. The signs are, indeed, hopeful. A University spirit has been aroused, and the General Alumni Association can say, without fear of contradiction, that it has been a great factor in this renovation. Do not despair, our fellow alumni, better days are surely in sight. Lend a helping hand and they will materialize the sooner. Do not think you can hasten them by carping criticism, but encourage the authorities in what they are attempting to do.

While on this subject we will say that there are indications, and rumors, that the Medical Alumni Association now sees its way clear to merge with the other alumni bodies. This subject may be taken up at the coming meeting of the Medical Alumni Association. It is too much to hope that the happy event can be accomplished at this meeting, but the editors of the BULLETIN hope to be able to announce be-

fore a year rolls round that there is only one Alumni body at the University of Maryland.

If any of our readers have any suggestions or criticisms to make upon this subject, the editors wish to assure them that the pages of the BULLETIN are at their service. Indeed, we will be more than pleased to hear what they have to say, and we have no doubts that our readers will be equally interested.

Old Maryland has this to say: "It seems that the Scriptural prophecy—the last shall be first and the first last—is to be verified in regard to the alumni and the General Alumni Association. The first to move in the amalgamation were the pharmacy men, and their example has been now imitated by the dental men, leaving the medical men to act later. Whilst the way had already been paved for them by the action of the pharmacists, the dentists deserve no little credit for their spirited action, which was foreshadowed and doubtless more or less influenced by the excellent editorial in the *Orist*. We welcome them to our membership and to our hearts, and we hope that their union with us may make it still more apparent that what a University needs is one great and powerful and all-embracing organization of its alumni, and not several small and impotent departmental ones. Let us sum up in conclusion some of the things which may be credited to the General Alumni Association. It represents the first effort to bring all alumni into one body; it founded the University endowment and Charles Frick Research Funds; it secured a charter for itself and brought about the legislative chartering of the Board of Endowment Trustees; it adopted the University button and ode, and secured the adoption of the University colors by the Regents; to it we owe the first University banquets ever held; to it directly or indirectly are due the great University Centennial, the University stir and sentiment, the new hope and aspirations for a greater University."

THE CLASS OF 1908.—The Class of 1908 began its fourth year with over 90 members. The degree of M. D. was conferred upon 73 graduates. Upon the whole, the class measured up to the standard of previous classes. It numbered some exceptionally good students, who promise well for the future in professional work. In the great struggle which an earnest professional life imposes upon the practitioner of medicine the race is not always with those who lead in class standing and who enter upon work with the most brilliant promises. These men, although starting out with brighter prospects, may not always have the staying qualities, the force of character or the opportunities which are possessed by others of apparently less intellectual industry. The qualifications which go to make the successful physician only show up as the man progresses in his life's work. It is the man who grows, who toils and who molds his character from day to day by hard experience and earnest purpose, who finally reaches the high rank and dignity of his calling.

The man who begins well must hold on to the task he has undertaken. The man who has been less fortunate in class standing may yet hope to rise higher and higher in his professional life by making the best use of time and opportunity as he works in the future. The profession of medicine is a jealous taskmaster. No man who assumes to work in the ranks of the medical profession can hope for permanent or honorable success who does not live up to the high standards which are expected of him.

To take rank and position in a profession which numbers men of the highest intelligence, distinction and honor the young physician must be an industrious student, a careful observer and a man of the highest character and honor. He may achieve notoriety and pecuniary success by short cuts, shrewd methods and tricks of trade. He can never win a position of honorable distinction, of professional esteem or of permanent usefulness unless his work is built on merit, conscientiousness and efficiency. Whatever may be his intellectual ability, he must have moral stamina, strength of purpose and forceful character to support his intellectual equipment

INTERNES AT THE UNIVERSITY HOSPITAL.—With the completion of the dormitory over the new power-house connected with the University Hospital there will be rooms provided for the housing of twenty-seven internes. With this additional room for the student the Faculty has decided to increase the number of internes to fifty-five. The BULLETIN regards this increase of students in hospital work one of the most important movements the Faculty has made recently. The interneship at the University Hospital has been one of the best assets the Faculty has had in its clinical work. The position of interne has been eagerly sought, and it has done

more to train students in clinical medicines than any other feature. There is the greatest abundance of clinical material in the indoor and outdoor work of the hospital. This work should be fully utilized by the students. If it were possible every student of the fourth-year class should be required to serve one year as as interne. Whilst this is not now possible, the increase of the number of internes to fifty-five will provide for over half of the present fourth-year class. No student should let the opportunity pass to reside in the Hospital for one year before graduating. It is in the Hospital he will receive his best training in practical medicine.

The Annual Address to the Graduating Classes.—The annual address delivered to the graduating classes at the commencement exercises by President George E. Reed, of Dickinson College, was well received by the audience and elicited well-merited attention and applause. The speaker was fortunate in the selection of his subject and presented it in a most happy and pleasing style of delivery. Much sound and practical advice was given, not only to graduates, but to the audience. The earnest words of the speaker gave a true ring to his subject when he urged the claims of a high and noble manhood upon the young men who were just entering upon life's work in their respective professions. What is needed today in all professions and in every walk of life is manliness and men—manliness to stand for the best type of citizenship, for high principles and true ideals; men who dare to do the world's work in the right way, and who hold character and moral force in higher esteem than worldly success purchased by a commercial spirit rather than by a commercial probity, justice and honor.

MANY DOCTORS AT DINNER

Alumni of Maryland University Choose Dr. Chaney President.

The Alumni Association of the University of Maryland School of Medicine held its annual meeting and banquet at the Eutaw House, Friday, May 29, 1908.

The meeting preceded the dinner, officers being elected. The annual oration was delivered by Dr. Thomas M. Chaney, of the class of 1866, who spoke on "The Conditions Confronting a Country Practitioner," which appears elsewhere in the Bulletin.

The alumni elected Dr. Chaney president.

Speakers at the dinner were Dr. Thomas Fell, president of St. John's College, Annapolis, who spoke on the history of the college and its amalgamation with the University of Maryland; Judge Henry Stockbridge, who spoke on behalf of the law department of the University; Prof. Samuel C. Chew, the retiring president, who told of the Centennial of 1907, and Mr. S. C. LaBarre, president of the senior class.

The subscribers were:

Drs. H. C. Algire, T. A. Ashby, A. D. Atkinson, H. E. Ames, J. S. Bowen, J. H. Billingslea, A. K. Bond, M. R. Bruin, W. H. Baltzell, Wilmer Brinton, S. B. Bond, E. M. Bush, Joseph Blum, Geo. H. Cairnes, M. J. Cromwell, J. C. Clarke, Lee Cohen, Hubert Clayton, H. F. Cassiday, A. T. Chambers, F. M. Chisolm, Theo. Cooke, Jr., James J. Carroll, Samuel C. Chew, C. C. Conser, J. M. Craighill, T. H. Cannon, T. M. Chaney, R. P. Carman, N. H. D. Cox, E. F. Cordell, P. G. Dausch, N. L. Dashiell, N. S. Dudley, I. H. Davis, John Dickson, S. Demarco, John Davis, H. C. Davis, F. C. Eldred, W. W. Eichelberger, S. T. Earle, Jr., W. H. Feddeman, Charles R. Foutz, George A. Fleming, F. V. Fowlkes, J. W. Funck, C. W. Famous, Charles Getz, George R. Graham, Joseph E. Gately, Harry Gross, H. H. Goodman, F. J. S. Gorgas, T. O. Heatwole, Geo. H. Hocking, Geo. E. H. Harman, B. M. Hopkinson, C. W. Himmler, H. T. Harrison, W. H. Houston, H. C. Hyde, J. M. Hundley, L. B. Henkel, Jr., C. W. Heffenger, C. B. Henkel, R. Lee Hall, A. L. Hodgdon, J. C. Hemmeter, John Houff, Joseph S. Horner, Jose L. Hirsh, N. F. Hill, R. F. Hardesty, H. C. Houck, R. B. Hayes, Geo. W. Hemmeter, Howard Iglehart, Felix Jenkins, James H. Jarrett, R. H. Johnston, Howard W. Jones, Charles J. Keller, John T. King, N. G. Keirle, Howard Kahn, W. B. Kirk, Thomas A. R. Keech, Eugene Kerr, G. S. M. Kieffer, J. W. Linthicum, T. W. Linthicum, Richard Lewis, W. T. Lilly, Charles W. Larned, Howard D. Lewis, Wm. S. Love, J. Whann McSherry, W. H. Marsh, Frank Martin, J. Charles Macgill, Wm. S. Maxwell, Chas. M. Morfit, R. C. Massenburg, H. C. McSherry, W. P. Morgan, A. D. McConachie, J. N. Morris, George W. Mitchell, H. J. Maldeis, W. H. Mayhew, H. D. McCarthy, L. E. Neale, V. L. Norwood, C. P. Noble, H. L. Naylor, H. A. Naylor, H. C. Ohle, W. G. Porter, John I. Pennington, A. C. Pole, M. L. Price, W. H. Pearce, Wm. J. Pillsbury, Charles H. Riley, H. O. Reik, W. W. Requard, J. H. Rehberger, Charles E. Roop, John A. Robb, Jr., J. Dawson Reeder, James L. Ridgely, S. W. Seldner, St. Clair Srpuill, W. A. B. Sellman, Frank R. Smith, I. S. Stone, Charles E. Sadtler, Joseph F. Smith, E. L. Sensindiver, Guy Steel, H. M. Simmons, W. I. Skilling, J. Tyler Smith, H. C. Silver, A. Trego Shertzer, Stephen S. Stone, Richard Sappington, G. Lane Taneyhill, L. J. Turlington,

L. McL. Tiffany, John Turner, E. M. Wise, C. R. Winterson, Nathan Winslow, Hiram Woods, Wm. Whitridge, Randolph Winslow, James H. Wilson, John R. Winslow, R. T. Wilson, C. S. Woodruff, W. T. Watson, W. E. Wiegand, S. R. Waters, Marshall B. West, Joseph C. Wunder, J. A. Zepp, H. E. Zepp.

Dr. B. Merrill Hopkinson sang several songs.

The retiring officers are: President, Samuel C. Chew; Vice-Presidents, Eugene F. Cordell, N. L. Dashiel, W. G. Porter; Recording Secretary, C. E. Sadtler; Assistant Recording Secretary, J. A. Zepp; Corresponding Secretary, G. H. Hocking; Treasurer, G. Lane Taneyhill; Executive Committee, B. Merrill Hopkinson, S. B. Bond, S. T. Earle, Jr., Joseph Blum, John Hough.

A partial list of the new officers is as follows: President, T. M. Chaney, class of 1866; Vice-Presidents, J. M. Craighill, John Houff; Treasurer, G. L. Taneyhill; Recording Secretary, C. E. Sadtler; Corresponding Secretary, Guy Steele, of Cambridge; Executive Committee, A. D. McConachie, W. Wiegand, C. R. Winterson.

During the business meeting a resolution was adopted empowering the Executive Committee to draw up conditions looking toward the federation of the Medical Alumni Association with the General Alumni Association, which recommendations are to be referred back to the Alumni Association at their next annual meeting. As matters now stand, everything seems favorable towards the early consummation of the amalgamation.

CORRESPONDENCE.

BALTIMORE, May 13, 1908.

To the Editors of the Hospital Bulletin:

GENTLEMEN: In the April number of the HOSPITAL BULLETIN I noticed an article from an old Directory of 1842 to the effect that the Faculty of Physic was composed of Drs. Nathaniel Potter, Richard Wilmot Hall, Wm. E. A. Akin, Nathan R. Smith, Joseph Rolfy and George W. Miltenberger. The Dean was Samuel Chew.

Joseph Rolfy is (I think) a misprint and ought to have been Joseph Roby. The article further states "that ten years later we find added the names of William Power and Richard H. Thomas, also a mistake.

As a member of the class of 1846-7 and '47-8, the Faculty of '46-47 was composed of Drs. Nathan R. Smith, Surgery; William E. A. Akin, Chemistry (Dean); Samuel Chew, Materia Medica, and Therapeutics; William Power, Theory and Practice; Joseph Roby, Anatomy; Richard Wilmot Hall, Obstetrics; George W. Miltenberger, Demonstrator of Anatomy.

Richard Wilmot Hall died in 1847, and Richard H. Thomas was called to the Chair of Obstetrics in 1847-8. Respectfully,

JOHN I. R. CROZER, M. D.,
Of the Class of 1848.

ITEMS.

The Annual Commencement of the University of Maryland was held at the Academy of Music Monday evening, the 1st of June, 1908, at 8.15 o'clock. The candidates for the various degrees and the members of the several Faculties assembled in the Concert Hall, whence they marched to their allotted places in the main hall. Owing to the number of the candidates—249—there was not room for them on the stage, so they were seated in front of the audience.

After the 249 young men had received their degrees an address was made to them by Dr. George Edward Reed, president of Dickinson College. To the young doctors of medicine Dr. Reed declared that the possibilities of further discoveries and development in medicine and surgery were unlimited; to the young lawyers he urged following in the footsteps of Severn Teackle Wallis and of Roger B. Taney, and to the dentists he declared that there were many possibilities in their chosen profession.

Following the address the prizes for excellence in the various professions were awarded, the deans announcing the winners and Provost Carter presenting the prizes.

In the medical class the University prize, a gold medal, was awarded to Dr. David Franklin, and certificates of honor were conferred upon Drs. William Murray Hollyday, Solomon L. Cherry, Lawrence Kolb, Henry Lyon Sinskey and Louis Hamilton Seth.

Cash prizes were awarded members of the Law class for excellence. Mr. Poe announced that two students had so closely paralleled each other in proficiency that two cash prizes of $100 each, instead of the usual single one, had to be conferred, the winners having been Messrs. William Conwell Smith and Reginald Stevenson Opie. The winner of the prize for the best thesis, the judges having been Prof. W. W. Willoughby, of

the Johns Hopkins University; Mr. Francis K. Carey and Mr. J. Walter Lord, were Messrs. Charles Alexander Marshall, and Henry Findlay French. (Honorable mention was accorded Messrs. Samuel Want, William Harkinson Hudgins, William Henry Klinesmith, William Henry Maltbie and Charles A. Marshall.)

The faculty gold medal in dentistry was awarded Dr. Eugene B. Howle, and Dr. Raymond Smyser Nieman won honorable mention.

In the Pharmacy class the gold medal for general excellence was awarded Dr. Clemens A. Balmert, and certificates of honor were given Drs. Frank L. A. Haelbig, Charles N. J. Gwinn and Charles W. Rauschenbach.

In the special prizes the gold medal for excellence in practical pharmacy was won by Dr. Frank L. A. Haelbig; the Simon medal for excellence in practical chemistry was awarded Dr. Charles W. Rauschenbach; the alumni medal for excellence in vegetable histology went to Dr. Charles N. J. Gwinn, and the Junior class prize for general excellence was won by Mr. Robert Lee Swain of Delaware.

Honorable mention was given Messrs. Henry E. Wich, of Maryland; Jaroslav J. Toula, of Bohemia; George H. Hinton, of Virginia; Edwards F. Winslow, of Maryland, and Leland McD. Kennedy, of South Carolina.

Candidates for the Degree "Doctor of Medicine"—Charles Rhodes Anderson, Virginia; James Leland Anderson, South Carolina; Jas. Hugh Bay, Maryland; Joseph Francis Barry, New York; Thomas Malcolm Bizzell, North Carolina; Grover Cleveland Bolin, South Carolina; Morris Ramsay Bowie, New Mexico; William Lawrence Burns, Maryland; R. Starke Carey, Virginia; William Underdown Charlton, Pennsylvania; Solomon L. Cherry, Maryland; William Joseph Coleman, Connecticut; Platt Walker Covington, South Carolina; Frank Garnett Cowherd, Maryland; James Alexander Craig, Pennsylvania; W. Cole Davis, Virginia; G. L. Dougherty, Delaware; Slocomb Rupert Edwards, North Carolina; Wm. A. Ellingwood, Massachusetts; Oscar W. Fletcher, Virginia; David Franklin, Maryland; George W. Hafele, Maryland; Wm. D. Hammond, Maryland; Emil Heller Henning, Maryland; David Ernest Hoag, Missouri; J. Howard Hodges, West Virginia; William Murray Hollyday, Maryland; J. Knox Insley, Maryland; Joseph Connor Joyce, Maryland; John Daniel Kerr, North Carolina; Lawrence Kolb, Maryland; Louis Charles LaBarre, Pennsylvania; Paul P. Lane, North Carolina; Charles Evans McBrayer, North Carolina; John J. McGarrell, Virginia; Allen McLean, North Carolina; John Evans Mackall, Maryland; Joaquin S. Miranda y Castillo, Cuba; Elias Nathanson, New York; Verlin Nolt, Indiana; Lester Dimmitt Norris, Maryland; Frederick James Pate, North Carolina; Roy Clifford Potter, Connecticut; Jaroslav Radda, New York; Russell Wesley Raynor, Maryland; David Samuel Rhone, New Jersey; Granville Hampton Richards, Maryland; Luther Allen Riser, South Carolina; Ramon Luis Rodriguez Porto Rico; Herbert Jerome Rosenberg, South Carolina; Adin Adam Rucker, North Carolina; Louis Hamilton Seth, Maryland; Leo George Scheurich, Maryland; Amzi Bedell Shoemaker, New Jersey; Henry Lyon Sinskey, Maryland; Frederick Snyder, New York; Arthur Ogburn Spoon, North Carolina; Leo Fleischer Steindler, Maryland; D. Hoster Swengel, Maryland; James Thomas Taylor, North Carolina; Horace B. Titlow, Maryland; Homer Ulric Todd, Maryland; Charles Manly Walters, North Carolina; Frederick Chauncey Warring, New York; Henry Harry Weinberger, New York; T. Marshall West, Maryland; Edgar Harold Willard, Maryland; Philip R. Williams, West Virginia; Franklin Davis Wilson, Virginia; Cato Franklin Winslow, North Carolina; Arthur Leon Wright, Maryland; Arturo Zelaya, Honduras; John Edward Berridge Ziegler, Maryland.

The passage by the United States Senate of the special bill granting a pension to the widow of Major James Carroll calls attention to the fate of a physician who died as the result of his work in investigating yellow fever in Cuba.

Major Carroll was the first man to voluntarily submit to the bite of an infected mosquito, as the result of which was the first experimental case of yellow fever. Although he recovered, he was ever afterwards an invalid. The inoculation occurred August 27, 1900, and he died September 16, 1907, his death being due indirectly to the weakened condition in which his heart was left.

Major Carroll was and still is the greatest alumnus of the University of Maryland. In recognition of the invaluable work done by him in behalf of suffering humanity the Board of Regents during the centennial celebrations bestowed upon him the degree of doctor of laws. Every alumnus of the University of Maryland must take great pride in the fact that such a man was the product of their Alma Mater, and great pleasure in hearing that his widow has been provided for by the national government.

The annual commencement of the University Hospital Training School for Nurses was held in the Nurses' Parlor at the University Hospital Thursday, May 14, 1908. R. Dorsey Coale, Ph. D., Dean of the Faculty of Physic, conferred the diplomas upon the graduates, and Dr. Randolph Winslow, professor of surgery in the University of Maryland, delivered the address, which appears elsewhere in the BULLETIN in full. The customary dance given by the graduates to their friends was held the same night in the Nurses' Parlor. The graduates were: Martha Reamey Hamlin, North Carolina; Clyde Clayton Dawson, North Carolina; Henrietta Ashcom Gourley, Maryland; Augusta Cassandrà Russell, Maryland; Ethel Palmatry Cunningham, Massachusetts; Minnie Bond Anderson, Maryland; Mary Gavin, Washington State; Susannah Aneta Hostrawser, Canada; Rose Wilson, Maryland; Charlotte Agnes Cox, West Virginia; Mary Emma Wright, Maryland; Lulu Arters Price, Maryland; Maude Fowble Smith, Maryland; Mary Virginia Hamlin, Virginia; Harriet Juliet Parsons, Maryland.

Dr. James F. H. Gorsuch, class of 1876, of Fork, Md., has been appointed local health officer of the county by the County Commissioners. The position is a new one and was created by the last legislature. District health officers were appointed as follows: First, Dr. Arthur H. Mann, class of 1890; Third, Dr. Harry A. Naylor, class of 1900; Fourth, Dr. Harry M. Slade, class of 1884; Fifth, Dr. Benjamin F. Price, class of 1857; Sixth, Dr. John B. Norris, class of 1866; Seventh, Dr. Eugene W. Heyde, class of 1892; Ninth, Dr. R. C. Massenburg, class of 1884; Tenth, Dr. J. T. Payne, class of 1862; Eleventh, Dr. J. F. H. Gorsuch, class of 1876; Twelfth, Dr. W. E. McClanahan, class of 1902.

Dr. St. Clair Spruill, clinical professor of surgery in the University of Maryland; Dr. Page Edmunds, instructor in genito-urinary diseases in the University of Maryland, and Dr. A. C. Harrison, class of 1887, demonstrator of anatomy at the College of Physicians and Surgeons, Baltimore, have been appointed directors of the relief and hospital work of the Baltimore and Ohio Railroad in the place of the late Dr. I. R. Trimble, class of 1884.

The trustees of the Washington County Hospital, Hagerstown, Md., have appointed the following of our alumni upon their consulting staff: Dr. Frank Martin, Dr. Charles W. Mitchell, Dr. Thomas A. Ashby, Dr. Hiram Woods, Dr. Herbert Harlan, Dr. Thomas C. Gilchrist, Dr. John N. McKenzie.

Dr. R. C. Massenburg, class of 1884, of Towson, Maryland, has been appointed a member of a society which has for its object the establishment of a National Health Bureau in Washington, D. C.

Dr. Albert H. Carroll, class of 1907, of Baltimore, has left for the headwaters of the Amazon, in Brazil, where he has accepted a position on the medical staff of the Madeira Mamore Railway Company.

Dr. J. P. LaBarre, class of 1901, has moved from Baltimore to Watersburg, Pa., where he intends to pursue his profession. Dr. LaBarre has been very successful in Baltimore, but was forced to move owing to bad health.

Dr. J. W. Hering, class of 1855, of Westminster, Md., presided at the sessions of the General Conference of the Methodist Protestant Church, which are being held at Pittsburg, Pa.

Dr. Charles O'Donovan, class of 1881, delivered the graduation address to the graduates of St. Joseph's Hospital Training School for Nurses.

Dr. George A. Fleming, class of 1884, and Mrs. Fleming have returned to the city after a few days' stay at Old Point Comfort, Va.

Dr. Joseph R. Owens, class of 1859, treasurer of the Maryland Agricultural College, has been elected mayor of Hyattsville for the third successive term.

The Carroll County Commissioners, Maryland, have appointed Dr. Charles R. Foutz, class of 1897, of Westminster, general health officer for the county.

Dr. C. U. Smith, class of 1889, and Mrs. Smith have left for Europe, where Dr. Smith intends to visit the different clinics.

Dr. Daniel St. T. Jenifer, class of 1904, of Loch Raven, has left for Atlantic City, where he will engage in his profession.

WEDDINGS.

Miss Louise Tremlett Walker, a graduate of the University Hospital Training School for Nurses, was married June 17, 1908, to Mr. Harrison Cassard, of Baltimore, at Christ Church, Winchester, Va.

Miss Miriam Louise Jessop, class of 1907, of the University Hospital Training School for Nurses, was married during the early part of May to Dr. Frank Brown Hines, of Chestertown, Md. Rev. Peregrine Wroth, rector of the Protestant Episcopal Church of the Messiah, officiated at the ceremony. After a honeymoon spent in the North, Dr. and Mrs. Hines will make their home in Chestertown.

Dr. J. Emory Rawlings, class of 1904, of Daytona, Fla., was married Tuesday, June 2, 1908, by Rev. Harris E. Kirk, of Franklin Street Presbyterian Church, in the parlors of the Rennert Hotel, to Miss Lelia K. Blunden, of Northumberland county, Va. Dr. and Mrs. Rawlings left soon after the ceremony for their future home, in Daytona.

DEATHS.

Dr. J. W. C. Cuddy, class of 1863, of 937 Madison avenue, Baltimore, Md., died May 14, 1908, at the Biedler-Sellman Sanitarium, after a short illness.

For a number of years Dr. Cuddy lectured on the theory and practice of medicine at the Baltimore University. His first medical training was obtained in the office of Dr. Nathan R. Smith. He was a member of Veteran Post, Grand Army of the Republic.

Dr. Cuddy was twice married. His first wife died in 1894. In January, 1900, he surprised his friends by marrying Mrs. Bessie Cromwell, who died two years ago. He is survived by one son, who lives in New York. The funeral took place the succeeding Monday. Services were conducted by Rev. C. W. Baldwin and Rev. E. L. Watson, of Strawbridge Methodist Episcopal Church, and Rev. J. F. Heise, presiding elder of the West Baltimore district. Among the honorary pallbearers were: Drs. E. Miller Reid, W. A. B. Sellman, H. H. Biedler, G. Lane Taneyhill. Burial was in Loudon Park Cemetery.

James T. Holley, class of 1881, of Port Bolivar, Texas, at Galveston, Texas, April 22, aged 49.

NOTICE.

The BULLETIN is in receipt of $1.00 for subscription from May, 1907, to May, 1908, on a return order blank which the BULLETIN has recently been sending to its subscribers. The party sending the money failed to give his name and address. That a proper credit may be given this party, the BULLETIN would like to find out the name, if possible.

CHANGE OF ADDRESS.

Dr. J. C. Kenton has moved from Damascus, Ga., to Quincy, Fla.

Dr. E. C. McEachern has moved from Cardova, N. C., to Rockingham, N. C.

Dr. H. G. Righton has changed his residence from Hebrew Hospital, Baltimore, to 410 Taylor street, Savannah, Ga.

Dr. A. D. Tuttle has moved from Fort Des Moines, Ia., to Fort Thomas, Ky.

Dr. Francis M. Chisholm has moved from 114 West Franklin street, Baltimore, to 816 Connecticut avenue, Washington, D. C.

Dr. S. B. Sherard has moved from Iva, S. C., to Gaffney, S. C.

THE HOSPITAL BULLETIN

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Original Paper.

PSYCHOTHERAPY.

By JOSEPH T. SMITH, M. D., *Class* 1872, *Associate Professor of Hygiene, University of Maryland.*

The influence of the intangible MIND over the tangible MATTER of our bodies is one of the vital topics under discussion at this time; what is it and how far can it be availed of in the treatment of disease? The subject is an old one, but it comes to us today with a more vitalizing interest than ever before. Strong minds and weak ones have always existed as they do now; there are those mentally vigorous who can control the matter of which their bodies are composed much more efficiently than those we call weak-minded.

Two problems are before us for solution in this connection—what is MIND and what factor or factors is it that determines the quality and power of mental activity. We are handicapped because we are unable to explain what we mean by MIND; the word conveys but a vague and indefinite idea, we know nothing about it except the effect it produces upon matter. We know our neighbor has a mind and we can estimate its quality and strength only by noting the activities it calls forth. It becomes a necessity and our first duty to study the Brain and Cord and find out as far as we may whether in any given diseased condition of the nervous system the trouble is not with the matter through which the mind acts before we speculate about the mind itself, we should not attempt to explain any effect as due to the mind until we have exhausted every means in our power to determine whether or not the matter has been changed and how. This is being done to a greater extent now than ever before, much that was formerly unknown or guessed at has been made clear, and what in times past was spoken of simply as mental failure or weakness is known to be caused in great part, if not altogether, by alterations in or destruction of matter; the Golgi method of staining will serve as an illustration as showing the effects of certain conditions upon the nervous matter. No doubt the future has in store some methods that will be brought out and by which we will be allowed to read the secrets of that matter through which the mind must act, together with the effects upon such matter of the activities set up.

The second point noted was what constitutes the difference between a vigorous mind and a weak one. Is the strong mind due to a greater thickness of grey matter, to a more equable distribution of the cells on and between the convolutions, to the amount and quality of the contents of the nerve cells, or substances in the blood which influence cell action. These and other theories are suggestive, and we may be able to solve the problem in some of these ways. Investigations are now in progress to determine the chemical and other changes which take place in the nerve cells. That exercise has a powerful influence in strengthening mental activities is well recognized, but what changes take place as the result of the stimulation—who can tell?

May the activity of the nerve cells not be dependent upon some internal secretion, just as we know other parts of the body depend for their integrity and activity upon the Thyroid Gland or Pituitary Body, and this would seem to have force added to it by the recent cancer investigations. Dr. Crile in his address on Surgery at the recent meeting of the American Medical Association says: "The biologic characteristic of the cancer cell is its power of limitless division. * * * It seems probable that cancer may multiply indefinitely, and may, possibly, like the ameba, prove to be immortal." If now we take this statement in connection with the reports of Drs. Gaylor and Clowes from the Cancer Laboratory of the New York Department of Health, in which

they furnish evidence "that the malignant growth can be resisted by the organism under certain circumstances. In other cases an arrest of the growth occurs. The experiments seem to indicate that the immunity is secured by the development of some immunizing substance in the body of the affected animal (editorial, Journal American Medical Association, April 11, 1908); that is to say, in those bodies which do not succumb to cancerous affections even after persistent exposure, as in the case of surgeons, there is a resistance and in the light of our knowledge there is presumably in the blood a something which limits cell growth, prevents the endless multiplication of cells; even in the normal body some force is at work constantly to prevent the overgrowth of cells in each and every part of the body. What, then, we are pleased to style the MIND in some instances at least may be nothing more than cell activity due to an internal secretion, or that the secretion, failing the cells, are unable to respond to stimuli. Until we have exhausted every means to discover the secrets of nervous matter and have thoroughly investigated the changes that are impressed upon it as the result of its activities, we are not at liberty to speculate in regard to the mind.

That the action of certain nerve cells, however brought about, influence the body, we have abundant evidence, notably the secretions, especially those of the bowels and kidneys. We are at a loss to know just how far certain bodily states are controlled by the inherent powers of the nervous system, as in the case of the hysterical, and again there are certain bodily conditions which we know cannot be controlled by the nervous system, the MIND, if you will, such are fractures or destruction of the soft tissues, as in certain diseases of the kidneys, liver and lungs.

The subject is one of great difficulty, the most difficult because so complex, of any we are called upon to deal, and partly for the reason that we have not been able to solve many of the problems which present themselves, and partly for the reason that its inherent difficulties are so great, we have neglected to give the matter sufficient attention, many cults have arisen pretending to deal successfully with the influence of mind over matter. Dr. Weir Mitchell, in an article just published, says: "There are, I find, not less than seven of these cults. They are alike in despising every other. * * * A vast mist of lies and suppressions of failures surrounds these people. Some of these means of influentially capturing belief and dollars appeal to my sense of the humorous. One is known as 'soul massage.'"

Few are able to master what is known, one works in a small portion of the great field, and another in another, and it may be that is the only way the conditions will ever be able to be dealt with.

We have thought it well to call attention once again to the difficulties of Pschotherapy; it is only as we have a realizing sense of the difficulties of the problem that is calling so loudly for a solution that we can take heart and labor zealously and with painstaking investigations in each case of those mentally diseased and not be discouraged if we do not gather all the fruit we think our work entitles us to.

The call comes to the medical profession from all quarters to work harder and try and solve this problem of the influence of mind over matter, and to do all in our power to keep the unfortunate subjects of mental infirmities from "the varieties of creeds, well baited for the credulous." "It is a time-consuming business."

CLINICAL PSYCHIATRY—DISPENSARY DEMONSTRATIONS.

By N. M. Owensby, M. D., *Class of* 1904.

There is no other diseased condition which necessitates as early recognition to effect a cure as does the various forms of insanity, and yet the majority of medical schools in past years have ignored the subject entirely in the preparation of their curriculums. The result of this is obvious to anyone who will take the trouble to visit an institution for the treatment of the insane and note the crowded wards filled with demented patients, many of whom may have become useful citizens had the attending physician been properly trained and recognized their malady in the incipient stage, but are now hopelessly imbecile and will continue to be burdens to their families or the com-

munity in which they reside until death overtakes them. That a large percentage of insanity can be prevented there can be no doubt, inasmuch as the majority of cases are due to drug or alcoholic addictions and syphilis. Alcolhol alone is estimated as being the direct cause of from ten to thirty per cent. of the admissions to asylums. Out of 1,373 admissions to the psychiatric clinic in Munich in 1905, Kraepelin found 30 per cent. of the males were suffering from insanity due directly to alcohol, and that in 61.8 per cent. of cases not due to alcohol, it was an important factor in the production.

Cotton,2 in reviewing the statistics of the Danvers (Mass.) Insane Asylum for 1906, states that 25.6 per cent. of the male patients admitted alcohol was the direct cause, and should statistics be furnished by the other institutions in the United States, it would be found that the psychoses due to alcohol, syphilis and other preventable causes would predominate.

This knowledge, coupled with the fact that there seems to be a general awakening to the importance of an early recognition by the physician to the various mental disturbances, has furnished inspiration to report some of the cases seen in the out-patient department of the University of Maryland Hospital and present them in such a way that the general practitioner will have no difficulty in making an early diagnosis of similar cases which may come under his care, and thus prevent them reaching the incurable stage.

In this and the reports to follow I shall try and omit all technical appellations used by the psychiatrist as far as permissible, and will refrain from presenting any theories except those given by standard works on the subject.

The first patient to whom I shall call your attention is a white female, aet 34, who gives her occupation as laundress and charwoman. She is very untidy in appearance, her clothing soiled and in tatters, her hair disarranged, face bloated, eyes reddened, and upon closer examination you notice that she has a fine tremor of her tongue and fingers. She entered the room with a firm step and head erect and went directly to the physician to present her card.

Upon questioning, she states that she was reared on a farm in one of the Western States by fairly prosperous parents, and as a child was healthy and no different from the average girl until she was about seventeen, when she begun having attacks of despondency, during which she was nervous, sleepless, uneasy, irritable and restless, and would have to resort to sedatives and rest in bed in order to gain any relief. These attacks would occur about once a month and last two or three days.

About two years later, while on a visit to relatives in a city, she was given whiskey during one of these attacks of despondency, and "it seemed that she could not get enough until the spell passed away." After this she secured a position in the city "where she could quench her thirst when a spell came on," but soon lost it on account of her intemperate habits, and a month or so later went to live with a man as his common-law wife. Since then she has been drifting from one town to another, and landed in Baltimore about two years ago. The attacks come on about once a week now, and the money she earns for washing and scrubbing all goes for drink. She has no delusions, hallucinations, etc., and is perfectly oriented, but states that she is afraid she will have delerium tremens if she does not stop drinking, and it is for the purpose of consulting a physician regarding her habits that she visits the dispensary. She wants to stop drinking, but when one of the attacks referred to comes on, "the Devil must get her, for she cannot help drinking." As soon as the attack passes away she loses all desire for drink and does not touch it until another comes on.

As you have doubtless already noted, this patient is not suffering with ordinary drunkenness, which requires the services of the social reformer rather than the physician, but is suffering with Dipsomania, or thirst madness, a distinctly diseased condition, which requires a considerable degree of tact and skill to treat successfully. The periodicity in which the attacks occur, the loss of control over themselves during an attack, the prodromal symptoms of headache, uneasiness, restlessness, etc., the absence of desire for drink between attacks, all point to the fact that it is a mental disease, and have lead many authors, and notably Kraepelin,3 to classify it among the "manifold varieties of epilepsy." Of the treatment I shall have more to say at another time.

An entirely different picture is presented by the chambermaid, aet 37 years, who is next to enter the room. You notice that she appears frightened and hesitates in going to the physician. She has an anxious expression and her eyes fill with tears as she begins to speak. At first she seems suspicious of the examiner, and her replies are low and in monosyllables, but soon she apparently places confidence in him and makes the following statement:

"Her parents are dead, both were intemperate, she was healthy as a child, menstruated at the age of 15 years, married at the age of 22 years, had four children, the oldest is fourteen years and healthy, the remaining three had spasms during infancy and are of a nervous temperament, separated from her husband two years ago and has since been employed in one of the smaller hotels as chambermaid; begun the use of alcohol after the birth of her first child and has continued its use up to the present time; at first drank beer, but during the past two years has been drinking whiskey as well. For the past ten days she has been on a spree, and during that time has partaken of very little food. Two nights ago she awoke from her sleep with a start, a feeling of uneasiness crept over her and she imagined she could hear the voice of some one in the next room who was planning to do her bodily harm; the bed seemed to move up and down, and she jumped out, but became so nervous that she sank to the floor and screamed for help; a neighbor came in and she was quiet the remainder of the night, but the next day she became frightened at voices which seemed to emanate from the ceiling and which warned her of harm that was about to befall her. The night following some one came into her bedroom and attempted to drag her away; she could feel their hands upon her and see other people hiding behind her furniture; they then discussed the best way to dispose of her, and the bodies of her children, whom they had already slain. When she arose this morning she could not eat, the food tasted so peculiar that she imagined that it was poisoned. On her way to the dispensary some people followed her, while those on the streets looked at her in a significant manner and spoke disparingly of her. She realizes that she is not like her former self, but cannot account for the strange voices she hears and the objects moving around in her room, and does not think that it is due wholly to her imagination. On other subjects the patient reasons well and converses intelligently, but she believes in her delusions and hallucinations, and this fact alone makes these the most troublesome patients with which we have to deal, as they frequently commit suicide in order to escape their tormenters, or else injure some innocent person whom they imagine to be one of their chief persecutors and who is constantly speaking of them in a depreciatory manner. Male patients often imagine their wives are unfaithful, and even think they see them meeting other men in the bedroom while they are present; others imagine their wives are poisoning them in order to secure the insurance and elope with their lovers. Indeed, hardly a day passes without a notice appearing in the newspapers where some unfortunate has murdered his wife or mistress, followed by his suicide, without any apparent cause, except that he has been drinking rather heavily. What a wonderful amount of information the last sentence conveys to the initiated, when between the lines he reads delusions of infidelity caused by alcoholic poisoning!

This patient is suffering with what is known as Acute Alcoholic Hallucinosis, a disease whose etiology is supposed to be identical with that of delerium tremens, but why one person should have the one disease, while a second has the other, is not clearly understood. She should recover from the present attack within the next two or three weeks, but will probably have more, since her will power is materially weakened and will soon drift back into her old habits again. After passing through one or two more attacks, whose duration will be longer than the preceding one, she will then present a picture similar to the laborer who is just entering the room. He has just been released from the city jail, where he was confined four months on a charge of disorderly conduct and assaulting his wife, and comes here to be treated for his "nerves." He states that his mind is perfectly clear, but after considerable questioning we find that he has been drinking heavily for the past twenty years, and during that time has had two attacks of delirium tremens, and was confined to an

asylum on account of his "nerves" for a period of two or three months; he cannot recall the date or name of the institution at present. He has had constant ringing in his ears for two years and frequently hears voices calling his name, which is evidenced by the way he suddenly turns his head and looks behind while he is being questioned. Hot and cold flushes run up and down his spine, and "rheumatic" pains affect his legs. He states that his wife was the cause of his arrest; she had been placing poison in his food which made him impotent, and when he upbraided her for it she swore that he was beating her and had him arrested. Later he acknowledged that he struck her "one time" and swore a "little." While in jail his life was made miserable by his fellow-prisoners throwing filth at him and calling him vile names. On several occasions the Lord visited him at night in his cell and told him that he was going to be released, and that he must lead a religious life. The patient displays no emotion while speaking of his persecutions and seems to be more or less exalted, but grows irritable when told that he has imagined all of the above story. His memory is poor and he has difficulty in recalling what he had for breakfast, and on the whole we would say there is a considerable degree of mental deterioration. This condition we know as Alcoholic Hallucinatory Dementia, and is the result of long-continued abuse of alcohol. The prognosis is unfavorable, and should the hallucinations and delusions subside, the patient would still show a marked degree of mental weakness.

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(To be continued.)

GUN SHOT WOUNDS OF THE BLADDER.

By Charles L. Jennings, M. D.,
Surgeon to Duval County Hospital, Jacksonville, Fla.

The bladder being a pelvic organ, well protected by the bones of the pelvis, is seldom injured by gunshot. When distended it becomes partly an abdomal organ; then it is more often injured. Some writers say: "In about one-half of one per cent. of all gunshot wounds of the abdomen the bladder is injured." This important viscus may be injured intra or extraperitoneal. When wounded extraperitoneal it is in the space of retzius, this space being anterior to the reflected peritoneum.

Diagnosis—The diagnosis of gunshot wound of the bladder is readily made. The history, presence of external wound, with blood in the urine, readily leads to the diagnosis.

Prognosis—Without surgical treatment the mortality is very high. When the wound is intraperitoneal the patient dies of peritonitis. In extraperitoneal wounds the danger is infiltration and cellulitis. With surgical treatment, if the urine is sterile and the operation done soon after the injury is received, the death rate is reduced to about 40-60 per cent. in intraperitoneal and 30-40 per cent. in extraperitoneal wounds.

Treatment—The treatment is surgical. The earlier the better are our results.

Case—W. J., colored male, 35 years of age, driver, while resisting arrest was shot at close range with a 38-caliber Winchester rifle. Patient was sent to the County Hospital, where I was called to see him.

Physical Examination—Well developed, muscular negro; clothing from waist down well saturated with blood; pulse 90, good volume and regular; temperature 98°. On exposing the abdomen find it very rigid and somewhat distended in its lower part. A wound situated one inch above Pouparts ligaments and two inches to the left of the median line was abscessed with blood escaping freely. On percussion the lower fourth of the abdomen found dull, the line of dullness following an arch, with the convexity up. A catheter was inserted into the bladder and eight ounces of blood stained urine withdrawn; the dullness then became less marked in the median line. The diagnosis of extraperitoneal wound of the bladder was made and immediate operation advised. The patient readily accepted.

Operation—Within two hours after receiving the wound the operation was begun. An incision to the right of the median line, extending from above, about one-half inch below the upper limits of the line of dullness, well down to the symphysis pubis. The structure of the abdominal wall being divided, the bladder was observed

much distended, the peritoneum being above the upper limit of the incision. Considerable blood and urine were observed outside of and around the bladder, this viscus presenting to the left of the median line a wound which would readily admit two fingers. The bladder was washed out with hot saline solution, considerable clotted blood being removed. The inner walls of the organ were then explored. On the antero lateral wall of the right side the wound of exit, somewhat larger than the wound of entrance, was found. Passing the finger into this wound, it was found to pass out through the obturator foramen, the horizontal ramus of the os pubis forming the upper part of the circumference of this foramen, was somewhat shattered by the bullet, several small pieces of bone being removed with the examining fingers. No further search was made for the bullet. The bladder was next stripped from its antero-lateral attachments, so as to get at the wound outside of the organ. With considerable difficulty a purse-string suture of chronic catgut was introduced and the wound closed. The bladder and perivesicle space were again cleansed with hot saline solution. The anterior wound in the bladder was then closed with two rows of chronic catgut. Gauze drains were next placed in all directions around the bladder and brought out just over the symphysis pubis. The abdominal wound was then closed with interrupted through and through silk worm gut, leaving sufficient opening for the exit of the drains. A large, soft rubber catheter was introduced into the bladder through the urethra, and held in place by adhesive straps.

Result—Patient recovered from the anesthetic without any bad symptoms; was given fluids freely as soon as he could swallow. Hexamethylenamia, gr. iii., was given every three hours for three days, then gr. v. t. i. d. for twelve days. Bowels moved freely with mag. sulph. as often as condition required.

At the end of twenty-four hours the temperature was 100°, pulse 86; abdomen still rigid, but within the second twenty-four hours the temperature came down to normal, the abdomen losing its rigidity. Free drainage of bloody urine continued through the catheter for five days, the urine becoming almost clear on the sixth day. On the tenth day the catheter was removed and used every three hours for two days, then every six hours for three days. On the seventeenth day patient voided urine, but the use of the catheter was continued until the twenty-first day. During the first twenty-four hours quite free drainage occurred from the drains above the pubis. At end of four weeks the abdomina wound had closed. The patient was made to assume the Fowler position until the seventh day. He has perfect control of his bladder and is able to be at work, his only trouble being some pain in his right hip when he sits down. I intend locating the bullet by means of the X-ray and removing it soon.

Summary—1st. Gunshot wounds of the bladder are rare, occurring only when this organ is distended.

2nd. The organ having been penetrated by the bullet in two places without opening the general peritoneal cavity.

3d. The rapid recovery, with complete control.

CORRESPONDENCE.

MACON, MO., *June* 17, 1908.

To the Editor of the Hospital Bulletin.

DEAR SIR:—The American Medical Association met at Chicago June 2d, 3d and 4th, and the evening of the 2d of June was given up entirely to section dinners and alumni reunions. Alumni headquarters was established in Suite 126 of the Auditorium, and there were registered in the University of Maryland box seventeen graduates. A reunion and smoker of these alumni occurred at the Hotel Victoria at 8:30 P. M. The meeting was called to order and Dr. L. D. Gorgas, 1883, was elected chairman, Dr. E. S. Smith, 1900, secretary. The chairman read a letter from Prof. Hemmeter calling attention to the centennial memorial volume. Dr. Smith suggested that the organization of the alumni who were present be made permanent, and that a president and secretary be elected, and that the secretary be instructed to notify all alumni of the University of the existence of this organization, and Dr. Fry, 1876, and Dr. Cook, 1869, of Washington, thought that the members residing at the point of the next meeting should be requested to make all arrangements for the banquet and reunion of that year. Dr. Young, 1887, moved that the chair appoint a committee of five, chairman to be ex-officio a member. Dr. Cook moved an amendment that the president, vice president and secre-

tary be constituted an executive committee to arrange matters for the next meeting and future meetings. Dr. Young accepted the amendment and the motion was carried. Dr. Taneyhill, 1865, Baltimore, was elected vice president. These offices are to be held one year. The executive committee was authorized to get into communication with the local alumni in Atlantic City (for instance) and to make any local arrangement or appoint any local committees that may be necessary to get the reunion located for the following year. Dr. Warner, 1885, moved that the organization be called the American Medical Association Alumni of the University of Maryland. Seconded and carried. It was the consensus of opinion that there should be no unwieldy constitution, by-laws or other machinery to interfere with the flow of good spirits; that the organization was simply brought into being for the purpose of assuring the alumni of the University that on the first evening of every national convention of the A. M. A. in the years to come there would be a stated and arranged reunion of the loyal alumni, and that the evening would be given over to a social session and such refreshments as the local committee deemed suitable.

All the members present were called on to relate some story incident to their student days, and after a most enjoyable evening, and after a vote of thanks had been tendered the local alumni of Chicago for their thoughtfulness and their generous hospitality, we adjourned.

It is the desire of the charter members of this association that every alumnus should understand that this is formed simply for the renewal of the social relations of Maryland men who may be attending the annual conventions of the A. M. A. There were present, in the order of signing, the following: L. D. Gorgas, 1889, Chicago; G. Lane Taneyhill, 1865, Baltimore; D. Salinger, 1894, Chicago; Wm. H. Burr, 1884, Gallup, N. M.; E. S. Smith, 1900, Macon, Mo.; Frederic Schultz, 1902, Waltham, Minn.; Henry D. Fry, 1876, Washington, D. C.; Isaac S. Stone, 1872, Washington, D. C.; George Wythe Cook, 1869, Washington, D. C.; George B. McClellan Bower, 1887, Fort Wayne, Ind.; Edgar T. Duke, 1891, Cumberland, Md.; John H. Chew, 1863, Chicago; Marshall Compton Price, 1902, Baltimore; O. Tydings, 1877, Chicago; Anthony F. Warner, 1885, Chicago; G. B. Young, 1887; P. H. and M. H. S. W. Morrell, 1887, Chicago; Alexander C. McConachie, 1890, Baltimore.

Very respectfully,

E. S. Smith, *Secretary.*

P. S.—The health of the organization was drunk with appolinaris. E. S. S.

The Alumni Association, University of Maryland, School of Medicine—Its Proposed Coalition With the General Alumni Association.

Baltimore, *June 27*, 1908.

Dear Mr. Editor:—Since my return from Chicago I observe on page 287 of your edition of June 15th, 1908, you invite suggestions and criticisms on the subject of the merging of the Medical Alumni Association with the General Association. A year or so since you were kind enough to refer to me as having personally contributed to the success of the Medical Alumni Association, and this emboldens me, at the risk of incurring criticism for the egotism necessarily involved, to refer to the proceedings of our last meeting and banquet, May 29th, and particularly to the scheme to induce the members of the Alumni Association of the School of Medicine to join the General Alumni Association.

For twenty-six consecutive years as treasurer of the Medical Department Alumni Association, on account of my loyalty to and love for my alma mater, I have administered the office in its many vexatious and minute details. About a dozen years ago, with a view of increasing the membership, at a meeting at which there were only eleven members of the association I proposed that power be given the executive committee to issue a *free banquet ticket* to all who shall have paid dues in full each year. By close collections, especially from out-of-town members, we have been enabled to give a $2.00 banquet for the $1.00 dues paid annually for the last twelve years, and had a balance of about $200 each year—in fact, one year paid $100 to the endowment fund of the University. The membership increased each year, and now 1908 numbers 236, and we have about $140 in the treasury after paying all bills. So much for the business-like manner of conducting the Medical Alumni Association.

With an effort to please certain members I introduced the following preamble and resolutions at our last meeting, considering that this would be the only equitable manner in which to decide

the question. They were referred to the new executive committee with power to act:

WHEREAS, The question of disbanding this association has been recommended, with a view of merging its membership into the *General* Alumni Association as far as possible; and

WHEREAS, The surplus in the treasury is the property of all the members in good standing, who should, in equity, be informed of any contemplated disposition of the same, in order that they might vote their wishes in the premises; and

WHEREAS, Amendments and changes in the constitution require a certain constitutional majority, so this absolute probable abrogation of the constitution inferentially would require the same constitutional majority; therefore, with this in view, notice is hereby given of such contemplated action, and the following resolutions are offered:

Resolved, That the incoming executive committee be and are hereby directed to arrange in sending out notices of the next meeting of this association to inform each member that the question of disbandment of this association will be acted upon, and that each member in good standing (those who have paid their dues in full) will be entitled to vote on the question of said meeting.

Resolved, That if the treasurer discovers that there be sufficient funds in the treasury in the coming year to meet the expenses of the banquet of 1909 without collecting dues for that year from those members who have paid up in full for the year ending March 1, 1908, that he so notify the executive committee, and on their order he may refrain from mailing bills except to the new members elected in 1908, thus compensating the members for the omission of the banquet of 1907.

Resolved, That, as it has been the custom for the treasurer to mail banquet tickets *only* to those members who have paid in full, that this order be continued in 1909, and that the treasurer be so directed.

Thus, you will observe, we will settle the question in 1909. The future will determine the expediency, justifiability and wisdom of the movement.

As you failed to publish a correct and complete list of the officers for 1908-9, I enclose herewith an authentic copy: President, Thomas M. Chaney; vice presidents, Isaac S. Stone, John Houff and T. O. Heatwole; recording secretary, Chas. E. Sadter; assistant recording secretary, Jas. M. Craighill; corresponding secretary, Guy Steel; treasurer, G. Lane Taneyhill; executive committee, A. D. McConachie, John I. Pennington, Wm. H. Pearce, Wm. E. Wiegand and C. R. Winterson.

As a matter of history, which can be substantiated by the minutes, the Medical Alumni Association adopted a "button" with the Geneva cross on it before the subject was considered by the General Alumni. It displayed the "colors" before the regents took any action, and *three years* before the centennial the treasurer introduced resolutions looking to the celebration of that function, thus anticipating the action of the General Alumni Association, to which *Old Maryland,* as quoted by you, gives credit. Fraternaly yours,

G. LANE TANEYHILL, of '65.

The seventeenth meeting and smoker of the General Alumni Association of the University of Maryland was held in the main Lecture Hall of the Law Building on Thursday, June 11, 1908. Mr. Edward Otto, LL. B., read some of his poems. The amalgamation of the Dental Alumni Association with the General Alumni Association was formally ratified. The executive committee recommended that there be an active vice-president from each of the departments, which resolution was adopted. The following were elected:

First—Charles Caspari, Pharmacy. Second—I. H. Davis, Dental. Third—Edward Otto, Law. Fourth—A. L. Wilkinson, Arts and Sciences. Fifth—A. M. Shipley, Medical.

The office of secretary-treasurer was separated and Dr. G. Lane Taneyhill was elected to fill the office of treasurer. Upon recommendation of the Executive Committee, rules were adopted for the founding of branch alumni associations in any State, section of the country or foreign country. A petition to form a branch must be signed by at least five alumni residing in the locality specified, and the authorization shall be given in writing, signed by the officers of the General Alumni Association. It shall be explicitly understood that membership shall be open to the alumni of all departments of the University—i. e., to all who have attended one full course in the University.

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BALTIMORE, MD., JULY 15, 1908

EDITORIAL.

THE REPORTS OF THE EXAMINING BOARDS FOR 1907.—"Statistics," wrote the great surgeon Billroth, may be "either a wife of the purest virtue or a most meretricious whore."

The Council on Medical Education of the American Medical Association have collated the results of the examinations for license to practice in the various states for 1907, and have presented their annual report to the Association. Whilst there are many opportunities for error in the tabulation of these results, and doubtless many errors have occurred, yet on the whole the statistics are approximately correct, and give us a fair basis upon which to base our views as to the standing of the various medical schools in this country. We believe the Council on Medical Education to be actuated with the desire to do justice, and not injustice, to the colleges of the country, though its membership is drawn almost entirely from the large and highly endowed schools, and naturally they view medical education from a standpoint different from those who are connected with less favored institutions. The Council very properly emphasizes the fact that the results of the examinations before the various examining boards is not the whole truth as to the qualification of those who apply for examination, since the "character of the boards making the examination and the methods employed by them are important factors to be considered, since some boards mark severely, whilst others, which is especially true of partisan boards, may be most lenient. Finally, in this connection it should be stated that the character of the license examination, as usually conducted at the present time, is such that graduates of colleges operated largely in quiz-class methods may be most successful in passing them. Therefore, the statistics herewith presented should be taken only as a part of our investigation of medical schools, although it is an important part."

As might be expected, those schools that have large endowments, or are supported by state appropriations, show to great advantage in these statistics, and it is due to the fact that they have a better educated class of students to deal with.

Unfortunately, the University of Maryland is not in this category, and our results as tabulated do not appear to advantage. We are striving mightily to weed out bad material and to turn out well-equipped graduates, and, notwithstanding the poor showing recorded, we are doing it. We aim to teach by practical methods, and not by "quiz-class methods," though probably we might make more use of this class of teaching with advantage. The class of 1907 consisted of 98 members, of which number 62 graduated, and of these about 19 per cent. failed to pass at their first examination before the various boards. It is useless to attempt to apologize for or to try to explain away these figures. It is true that the Maryland Board is a hard board to pass, and that we have more candidates to appear before it than any other school, but this does not excuse known errors in the tabulation of the Maryland records, the percentage of failures of those applying for examination for the first time was 17 per cent. One man who failed had a combined average for the four years at the University of 86 per cent. He was a good student, and we cannot but be surprised at his failure. Another man, who was a foreigner, and did not express himself well in English, was a person of remarkable lingualistic culture, who brought certificates of the highest character from the University of Rome, and who was most excellent in his theoretical and practical work. We have no hesitation in expressing the opinion that he failed to pass his examination for license on account of his handicap in lack of ability to write and express himself well in the English language. We do not wish to criticise the Maryland Examining Board, and believe those who failed did so because they did not answer the questions correctly, but the thought arises whether the questions propounded were such as

to test fairly the fitness of candidates to practice medicine, and we are constrained to say they were not. The lack of reciprocity was the occasion of the failure of several graduates who had passed their own examining boards, and failed to pass those of the states to which they had moved, and yet we know they were exceptionally qualified to practice in any state. We live and learn—in fact, live to learn. Let us learn by our errors and shortcomings of the past, and press forward. In the recent examination held in North Carolina twenty University of Maryland graduates appeared before the board, and nineteen of them passed. All of those of the class of 1908 who were examined passed the board.

Changes in the University Hospital Staff.—With the beginning of the fiscal year, July 1st, a number of changes take place in the hospital staff at the University.

Dr. A. M. Shipley, who has been medical superintendent of the Hospital for the past four years, retires from the position he has filled so acceptably to the Faculty and with such credit to himself to engage in private practice in this city. During his long connection with the Hospital Dr. Shipley has discharged his duties with marked ability and faithfulness. He severs his official relations with the Hospital carrying with him the esteem and confidence of all who have worked under him, and meriting the thanks of the Faculty he has served so faithfully. With the large experience he has had in hospital work he has made a foundation for brilliant success in his professional life.

Dr. R. P. Bay, assistant medical superintendent of the Hospital two years ago, and during the past year resident physician to Bay View Hospital, succeeds Dr. Shipley. Dr. Bay brings to the work of medical superintendent a large experience in hospital management and a splendid equipment in clinical medicine and surgery. He is a young man of a genial and commanding personality, of industry and force of character, fully trained for the responsible position he has been called to.

Of the staff of assistant resident physicians of last year, Dr. Bird and Dr. Lynn are the only two who hold over. Drs. Perkins, Franklin, Billups, Glidden and Roberts have retired from hospital work to engage in private practice. They have been industrious and useful men, and with the year's training in the Hospital are well prepared to enter the field of private practice. The Bulletin predicts for all of these young men a distinguished career in medicine.

Miss Nettie Flannagan, who for the past four years has been superintendent of the Training School for Nurses, has resigned this position to engage in private work. Miss Flannagan is a graduate nurse of the University School, and has made a most efficient and popular superintendent. At all times faithful and attentive to her duties, she has commanded the esteem and respect of all who have been brought in contact with her in her responsible work.

Miss Flannagan's successor has not yet been chosen. The Training School for Nurses is the most important department of the hospital work. The position of superintendent is a most difficult one to fill. Unusual combinations of character, attainments and of technical training are required in the superintendent of some sixty young women under training for the duties of a nurse. The University Training School has reached a high standard of efficiency, and its nurses are always in demand. In this work alone the University has made a record of which all should feel proud who have her interests at heart.

The young men who come in as assistant resident physicians have been selected with care from the graduating class. They have presented to them the very best fields for clinical work and for the future development of their professional interests. Those who measure up to the duties required of them need have no apprehension of failure in their respective positions.

With the advent of the new interne the hospital machine for a time works with some slight friction. From day to day, as the machine becomes somewhat worn by use, the friction disappears and the work moves along with satisfaction. In this manner the routine work of a great institution is constantly adjusting itself to new conditions and new experiences. Men come and go on the stage, but institutions live and grow through the vitalizing forces which come to them through the generations of men who govern their affairs, as it were, in the interim. In this way institutions outlive and are stronger than individuals. With the beginning of a new fiscal year at the University the constructive work is made more apparent to those who have her present interests most at heart. At no time in her

history have her affairs been under more favorable auspices than at the present. There is nothing sensational or startling in her progress. It is the slow but hardy growth which indicates stability and permanence, a living up to traditions and ideals, a gradual adjustment of her policies to conditions which are moving the educational world along lines of constructive and conservative development.

Loyal Alumni.—Nothing can show more strikingly the loyalty of the alumni of the Medical Department of the University than the recent gathering of these old graduates, scattered far and wide, upon the occasion of the fall meeting of the American Medical Association in Chicago.

In a communication found in the present number from Dr. Smith, of Mexico, Mo., an account is given of a most enjoyable alumni reunion, and of the purpose to hold at future meetings of the American Medical Association similar meetings. The purpose set forth and the spirit manifested are most gratifying to the Faculty of Physic and to the friends of the University. Nothing draws an alumnus so close to his fellow alumni and to his alma mater as an occasional meeting and social entertainment. In such reunions friendships are made and strengthened, loyalty and affection for alma mater are rekindled, and the interests of the old University are greatly promoted.

The Bulletin was established with the chief aim of promoting closer relations between the University and her alumni. It is with deepest satisfaction that we are able to record a gradual growth of these ties of affection and of mutual interest. At no time in her history have the alumni of the University been more interested in the welfare of their alma mater than at the present. From all over our land and from far-distant countries The Bulletin is receiving constant proof of an affection and loyalty upon the part of the alumni which gives assurance of better things in future. The spirit of loyalty is the spirit of helpfulness to those in present charge of the interests of the University. This spirit should manifest itself in many ways. The Faculty of Physic not only needs encouragement and helpful suggestion in the conduct of its work, but it would receive with favor helpful criticism from the alumni, who have the best interests of the University at heart. The policy of the Faculty is to live up to their responsibilities as best they can under existing circumstances, and to push forward the educational work under their charge as present conditions will admit. If the work the Medical Department is doing is investigated by unprejudiced minds, we believe no just ground for dissatisfaction will be found.

Whatever progress the old alma mater is making, it is reflected in the work of her graduates. Viewing the work of these men from various points of view, it is manifest that the Faculty has no occasion to complain of the work it has done in training students.

It is earnestly hoped that the alumni of the Medical Department will both in spirit and act use whatever influence they can command to advance the growth and usefulness of their old alma mater. It makes no difference whether an alumnus has a direct or indirect interest in his alma mater. Her success and renown add to his advantage, while his own distinction is an honor to his alma mater. Loyalty is the noblest of Nature's gifts of heart. Like charity, it suffers long and is kind.

The New Student Dormitory.—The new dormitory being erected by the Faculty of Physic is in connection with the electric light and heating plant for the general use of the Hospital and University buildings is so far completed that it will be opened for the accommodation of students by August 1st. The building is being constructed at a cost of over $60,000, and when completed will be one of the most substantial and well-equipped building owned by the University.

It will provide room for 27 students and internes. The accommodations are of the most comfortable character, up-to-date in every feature and arrangement.

This building is a part of the general plan designed for the enlargement of the University Hospital now contemplated by the Faculty.

THE CLASS OF 1888.

Through the courtesy of Dr. W. M. Lewis, of this city, a member of the class, The Bulletin is able to publish the order of exercises at the graduation of this class, twenty years ago.

In looking over the names of the graduates the percentage of men who have achieved honorable distinction in their profession will be found to be unusually large. If it were possible The Bulletin would be glad to publish the present location of all of the living graduates and to say something

about those who have died since graduation. It will be noticed that the Hon. S. Teackle Wallis was at that time Provost of the University.

Of the members of the Faculty in 1888 only Prof. Chew and Prof. Coale are now connected with the Faculty. With the exception of Prof. Tiffany, the other members have joined the silent majority and rest from their labors. It is surprising to note the many changes which have taken place at the University in the past 20 years.

UNIVERSITY OF MARYLAND,

Faculty of Physic.

EIGHTY-FIRST ANNUAL COMMENCEMENT,

Academy of Music,

Tuesday, April 17th, 1888.

Class Officers.

Wirt Adams Duvall, Md.....President
G. Franklin Baker, Md.....Vice President
C. W. R. Crum, Md.....Secretary
Robert F. Porter, Va.....Treasurer

Executive Committee.

Chairman, Aristides S. Harrison.....North Carolina
John Hack Ayres.....Virginia
Jenness Morrill.....North Carolina
Maxey Gregg Lee.....South Carolina

ORDER OF EXERCISES.

Music by Prof. Wm. F. Thiede's Orchestra.

Prayer.

By Rev. C. R. Hains, D. D.

Music.

Reading of Mandamus by the Dean of the Faculty.

Music.

Conferring of Degrees and Award of Prizes.
By Hon. S. Teackle Wallis, LL. D.,
Provost of the University.

Music.

Oration by Rev. Julius E. Grammer.

Music.

Benediction.

Music.

Graduates, 1888.

John Hack Ayres, Virginia; Frederick B. Baker, Connecticut; G. Franklin Becker, Maryland; J. D. Bissell, South Carolina; William Sinclair Bowen, Maryland; Jacob L. Bowers, South Carolina; Harry Boyd, Maryland; Thomas H. Buckler, Maryland; Arch. Cheatham, North Carolina; Wm. F. Chenault, North Carolina; Francis J. Cooke, Texas; B. Thaddeus Cox, North Carolina; A. C. Crothers, Maryland; C. W. R. Crum, Maryland; Charles F. Davidson, Maryland.

Pinkney L. Davis, Maryland; George T. Dent, Maryland; W. Walter Dodson, South Carolina; Albert M. Drought, Maryland; Wirt Adams Duvall, Maryland; J. H. T. Earhart, Maryland; Wm. H. Feddeman, Virginia; Sam Victor Fiery, West Virginia; J. William Funck, Maryland; Frank H. Garverich, Pennsylvania; R. L. Gattis, North Carolina; Wm. E. Gaver, Maryland; A. B. Glascock, West Virginia; Wm. S. Gorsuch, Maryland; Thomas W. Greenly, Maryland; Franklin W. Hains, Virginia.

Aristides S. Harrison, North Carolina; Horace Bruce Hetrick, Pennsylvania; August Horn, Maryland; Charles M. Iddings, Maryland; J. Sothoron Keech, Maryland; J. Purd Kerr, Pennsylvania; Edwin H. Kuykendall, West Virginia; Martin Lappe, Jr., Ph. G., Pennsylvania; Arthur E. Ledbetter, North Carolina; Maxey Gregg Lee, South Carolina; John Latane Lewis, Virginia; W. Milton Lewis, Ohio; Preston B. Loftin, North Carolina; Charles H. T. Lowndes, Maryland; Wilson Prestman Malone, Virginia; Henry Wheeler McComas, Maryland.

A. M. Dupuy McCormick, Virginia; John M. McGlaughlin, West Virginia; John Bruce Moorman, Virginia; Jenness Morrill, North Carolina; Charles W. Morrow, Maryland; Charles L. Myers, Pennsylvania; Jere Robert Pearsall, North Carolina; Samuel Pennington, Tennessee; A. L. Porter, Maryland; Robert F. Porter, Virginia; Joseph C. B. Ray, Kentucky; H. N. Rickards, Maryland; James L. Ridgely, Maryland; Ezra B. Sharp, New Jersey; Edward M. Singewald, Maryland; Howard C. Silver, Maryland.

Charles A. Sinsel, Maryland; Edmund W. Slaymaker, Virginia; Benj. Moseby Smith, Virginia; G. E. Milton Smith, Maryland; Charles Moore Strong, North Carolina; Henry Briscoe Thomas, Maryland; W. Guy Townsend, Maryland; George Walker, South Carolina; Wm. C. Wheeler, Maryland; Edmund Gover Wicks, Maryland; Elias Morton, Virginia; J. Whitridge Williams, Maryland; H. N. Willis, Maryland; E. B. Wilmoth, West Virginia; John R. Winslow, Maryland; William Edward Wright, Virginia; C. D. Wyche, North Carolina; Elkanah Zion, Tennessee.

Prizemen.

1. University Prize, gold medal, J. Whitridge Williams, Maryland.

2. Miltenberger Prize, instruments. J. Whitridge Williams, Maryland; William Sinclair Bowen, Maryland.

3. Chisolm Prize, opthalmoscope, J. William Funck, Maryland.

4. Surgical Prize, instruments, Henry Briscoe Thomas, Maryland.

5. McKew Memorial Prize, gold medal, E. Gover Wicks, Maryland.

UNIVERSITY OF MARYLAND.

Faculty.

Wm. E. A. Aiken. M. D., LL. D., Emeritus Professor of Chemistry.

George W. Miltenberger, M.D., Profesor of Obstetrics.

Samuel C. Chew. Professor of Principles and Practice of Medicine and Hygiene.

Christopher Johnston, M.D. Emeritus Professor of Surgery.

Frank Donaldson, M.D., Clinical Professor of Diseases of the Throat and Chest.

Wm. T. Howard, M.D., Professor of Diseases of Women and Children, and Clinical Medicine.

Julian J. Chisolm, M.D., Professor of Eye and Ear Diseases.

Francis T. Miles, M.D., Professor of Physiology and Clinical Professor of Diseases of the Nervous System.

L. McLane Tiffany, M.D., Professor of Surgery.

J. Edwin Michael, M.D., Professor of Anatomy and Clinical Surgery.

I. Edmondson Atkinson, M.D., Professor of Materia Medica and Terapeutics, Clinical, Medicine and Dermatology.

R. Dorsey Coale. Ph. D., Professor of Chemistry and Toxicology.

ITEMS.

Dr. J. Herbert Bates, '07, who was appointed first assistant resident physician, and Dr. Wm. M. Hollyday, '08, who was appointed second assistant resident physician to the Church Home and Infirmary, started in on their new duties on July 1st.

On Thursday, May 21, 1908, at 8.30 P. M., a new and somewhat novel feature was added to the concluding exercises of the scholastic year, namely, a buffet luncheon and smoker in the main hall of the Law Building, a parting token of their good will and affection by the adjunct faculty of the Medical Department to the members of the senior medical class.

This function inaugurated a new custom, which we sincerely desire will be continued in the future. The affair was entirely informal and those present listened to good words of advice, cheer and encouragement from members of the Faculty, Adjunct Faculty and the student body. During the pauses in the speech-making music was rendered by a negro minstrel troupe, which added greatly to the entertainment and conviviality of the evening. Everybody was in a good humor and thoroughly enjoyed himself. Nothing but good can accrue from such a gathering. The student meets his instructor on the same level, learning to appreciate him better and appreciates that there is no broad gulf between the teaching and the student bodies. Dr. Messick, the vice-president of the Adjunct Faculty, in the absence of Dr. Gichner, the president, called the meeting to order, and, with a few appropriate words of welcome and felicitation over the hard year's work just completed, bade those present enjoy themselves to their hearts' content. After the luncheon Dr. Gichner, who had in the meantime arrived, called on Drs. Ashby, Coale, Hemmeter, Hirsch, Wilson, Allen, Craighill and Mr. Coleman, of the senior class, for words of encouragement and advice.

The burden of the speeches was the oft-repeated though never wearisome tale that the members of the Faculty, one and all, take especial delight and pride in the success of our alumni, among whom are some of the foremost educators in this country.

This class must not think for one little moment because its four hard years of preparation for the Doctor's Degree have been completed that its association with the old University has been severed. Indeed, it ought to consider itself in closer relationship than ever, by the time these words appear in print being alumni, children, and may one and all of you always conduct yourself as children to your adopted mother.

All of the speeches breathed messages of love, of sympathy, of encouragement, thus enhancing the spirit of good-fellowship which permeated the guests of the evening.

Too much praise cannot be given Drs. Abercrombie, Scott and Shipley, the committee in charge, for the excellent collation served and the thoroughness and evenness with which the pro-

gram was executed. May this entertainment be an annual affair.

The recent annual banquet of the Baltimore County Medical Society, held at the Stafford Hotel, was addressed by Dr. A. D. McConachie. Dr. J. S. Bowen, class of 1903, of Mount Washington, also spoke.

Among the officers of the organization are: Dr. J. S. Bowen, vice-president; Dr. R. C. Massenburg, corresponding secretary.

Among those present were: Drs. N. D. Cox, class of 1902; George H. Hocking, class of 1879; Marshall B. West, class of 1901; John Turner, class of 1892; B. B. Browne, class of 1867; Herbert Harlan, class of 1879; Marshall L. Price, class of 1902; W. P. E. Wyse, class of 1886; M. G. Porter, class of 1886; Henry A. Naylor, class of 1900; Charles O'Donovan, class of 1881; H. Louis Naylor, class of 1860; J. M. Hundley, class of 1882; J. C. Monmonier, class of 1886; J. H. Jarrett, class of 1852; Bennett F. Bussey, class of 1885; Wilmer Brinton, class of 1876.

Dr. G. Lane Taneyhill and Mrs. Taneyhill, each of whom is a child of a Methodist minister, have been keeping open house for their many friends attending the General Conference of the Methodist Episcopal Church.

Dr. Henry C. Houck, class of 1905, who has been ill at the University Hospital with septicemia, has so far recovered as to leave for his home, 1914 Pennsylvania avenue, Baltimore, Md.

Dr. James Robinson Bishop, class of 1904, formerly of Nanticoke, Md., has removed to Park Heights and Oread avenue, Baltimore.

Dr. T. C. Gilchrist, Clinical Professor of Diseases of the Skin, has left for a short stay at Hot Springs, Va.

The students of the College of Physicians and Surgeons, Baltimore, recently presented a picture of the late Dr. I. R. Trimble to their Faculty.

At a special meeting of the Baltimore City Medical Society, held for the purpose of discussing typhoid fever, Dr. Wm. Royal Stokes spoke on the bacteriological examination of drinking water.

Terra Mariae, the students' year-book for 1908, is out of press. It measures fully up to the standard of those of former years. This year the volume is dedicated to Prof. John P. Poe, Dean of the Faculty of Law. Besides containing the usual features of the books of former years, it for the first time has included the Department of Arts and Sciences, as well as the University Hospital Training School for Nurses. Terra Mariae began as a modest volume known as Bones, Molars and Briefs, in the year 1897, since which time it has been expanding and each year waxing more and more pretentious. In 1905, owing to the addition of the Department of Pharmacy, the name of the book was changed to Terra Mariae, by which it is still called.

Dr. John R. Abercrombie is dean of the Woman's Medical College, Baltimore.

Dr. John C. Hemmeter made the address at the recent commencement exercises of the Woman's Medical College, Baltimore. He spoke on the higher education of women.

The following of our alumni are on the visiting staff of St. Joseph's Hospital Baltimore:

Physician—Charles O'Donovan, class of 1881. Surgeons—L. M. Tiffany, class of 1868; F. J. Kirby, class of 1892; Frank Martin, class of 1886. Gynecologist—L. E. Neale, class of 1881. Oculist and Aurist—J. J. Carroll, class of 1893. Rectal Surgeon—S. T. Earle, class of 1870. Radiographer—H. E. Ashbury, class of 1903.

Those on the consulting staff are: Physician—C. H. Riley, class of 1880. Oculists and Aurists—Herbert Harlan, class of 1879; J. F. Crouch, class of 1890. Neurologist—H. J. Berkeley, class of 1881.

Those on the Dispensary staff: Surgical Department—J. E. Gately, class of 1902; J. M. Lynch, class of 1905. Eye, Ear and Throat Department—J. J. Carroll, class of 1893; F. E.

Brown, class of 1893. Gynecological and Obstetrical Department—L. E. Neale, class of 1881.

The following have been resident physicians: J. C. Monmonier, Alan Murray, Charles Scott, Craig Barrow, W. S. Hall, F. O. Rogers, Thos. M. Green, William E. Kurtz, T. J. O'Donnell, G. C. Lochard, J. M. Lynch, W. H. Hopkins, S. R. Clarke, H. C. Irwin, Charles L. Jennings, N. W. Hershner, J. B. Piggett and H. Y. Righton.

The Memorial Volume, commemorating the Centennial Celebration of the University of Maryland, has made its appearance. The front piece is the Exterior of the Old University Building as it appeared on the Opening Day of the Centennial, May 30, 1907. Among the other cuts are portraits of Ex-Governor Warfield, by virtue of his position of chief executive of the State of Maryland and Chancellor of the University, group photographs of the Regents' Committee and the Executive Committee, as well as a cut of Bernard Carter, Provost of the University of Maryland, and of the celebrated alumnus, James Carroll, the yellow fever martyr. The preface is addressed to the Honorable Board of Regents of the University of Maryland.

GENTLEMEN: In compliance with your recommendations of May, 1907, for the publication of the ceremonies, events and transactions, etc., of the Centennial Celebration of this University, May 30 to June 2, 1907, inclusive, the undersigned have the honor to present this volume, during the editing of which they have endeavored to be guided by the motto of our University, *"Omnia autem probate, quod bonum est tenete."*

Respectfully,

JOHN C. HEMMETER, M. D., Ph. D., LL. D.,
Editor.

SAMUEL CLAGGETT CHEW, M. A., M. D., LL. D.,
JOHN PRENTISS POE, LL. D.,
ISAAC H. DAVIS, M. D., D. D. S.,
CHARLES CASPARI, JR., Phar. D.,
THOMAS FELL, Ph. D., LL. D.,
Committee.

The volume contains a complete description of the events leading up to and occurring during the Centennial Celebration, the program, the lists of the graduates of the various departments, the honorary degrees bestowed, an account of the grand banquet and other functions, the members of the various committees; in fact, everything of interest concerning this memorable occasion.

This volume sells at $2. Everybody who had anything to do with the celebration ought to acquire one.

Ex-Governor Frank Brown, a warm friend of the state charity institutions, has this to say in their behalf:

"When I went into office I was very much opposed to the idea of the state contributing money to institutions that it did not own and control absolutely. My term of office converted me in this respect. I found that semi-private institutions returned to the state many fold the money it contribued. Work in these institutions is done for the most part free of cost from a sense of religious duty or a desire to promote the general welfare of mankind. Many dollars are collected and put by the side of the dollars contributed by the state, and the result is greater than it is possible to achieve when the state contributes all the money and pays people to spend it.

These institutions have directors just as the state institutions, but the people who attend the directors' meeting go carrying a basket on their arm instead of expecting a magnificent dinner at the expense of the state. The needy have to be looked after. If the state had more of these semi-private institutions and fewer public ones it would be better off."

The editors of THE BULLETIN are in absolute accord with the expressions of the above utterances of our ex-Governor.

Dr. Luther Allen Riser, class of 1908, who has been suffering with typhoid fever at the University Hospital, has sufficiently regained his health to leave the institution.

Dr. Gordon Wilson, associate professor of medicine in the University of Maryland, has recently been ill at the University Hospital.

Dr. G. R. Meyers, class of 1902, is a patient in the University Hospital. He has been suffering with attacks of renal calculus.

The following alumni passed the recent State Board of North Carolina medical examination: Drs. Arthur Ogburn Spoon, of Haw River; Cato F. Winslow, of Hobbsville; S. R. Edwards, of Silver City; T. M. Bizzell, of Goldsboro; Allen McLean, of Laurinburg; James E. Mann, of Lake Landing; Hammond Carson Irwin, of Roanoke Rapids; P. W. Covington, of Wadesboro; A. A. Rucker, of Rutherfordton; Charles M. Walters, of Burlington; T. M. Chaney, of Old Fort; J. T. Taylor, of Raleigh; F. J. Pate, of Gibson; J. D. Kerr, Jr., of Clinton; P. P. Lane, of Wilson; J. W. McConnell, of McConnellsville, S. C.; Ralph E. Dees, of Grant's Falls; John S. McKee, of Raleigh.

Dr. John C. Hemmeter, Professor of Physiology in the University of Maryland, is spending a part of his summer vacation at Hot Springs, Va. He will spend July and August at Cape May.

Dr. Benjamin R. Benson, Jr., of Columbus Hospital, N. Y., is spending a few weeks with his parents, Dr. Benjamin R. Benson, class of 1873, and Mrs. Benson, of Cockeysville, Md.

A memorial tablet to the memory of the late Major James Carroll, class of 1891, the yellow fever martyr, has been hung in the College building. It will be unveiled with appropriate exercises in the fall.

Dr. James H. Bay, class of 1908, of the house staff of the University Hospital, was operated on recently for appendicitis. He is reported to be doing well.

The Woods Club of the University Hospital, a new organization, originated and founded by Dr. A. M. Shipley, is an outing society, which has for its purpose a cultivation of the love for the big outdoors, which will relieve us occasionally from the cares of life. The initial meeting was held several weeks ago in Harford county, where the club was entertained at dinner by Prof. J. Holmes Smith, Sr., at the San Domingo Club on the Middle River. The second outing took place last week, the members going to Anne Arundel county, where they were entertained by Dr. Shipley at his home at Millersville, near Academy Junction.

In the thirtieth annual report of the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore we note a large number of our graduates: Governors—Dr. George A. Fleming, class of 1884; Dr. J. R. Winslow, class of 1886; Dr. Hiram Woods, class of 1882. Executive Surgeon—Dr. Herbert Harlan, class of 1879. Consultants—Dr. Henry B. Thomas, class of 1888; Dr. H. M. Thomas, class of 1885; Dr. C. W. Mitchell, class of 1881. Surgeons comprising the Medical Board — Dr. Herbert Harlan, class of 1879; Dr. Hiram Woods, class of 1882; Dr. J. Frank Crouch, class of 1890; Dr. R. H. Johnston, class of 1894; Dr. John R. Winslow, class of 1886. Assistant Surgeons—Dr. C. F. Nolen, class of 1890; Dr. G. A. Fleming, class of 1884; Dr. E. E. Gibbons, class of 1895; Dr. Wm. Tarun, class of 1900; Dr. G. S. M. Kiffer, class of 1903; Dr. H. C. Davis, class of 1903; Dr. J. P. LaBarre, class of 1901; Dr. F. W. Janney, class of 1905; Dr. L. J. Goldbach, class of 1905; Dr. W. E. McClanahan, class of 1902. Resident Physician—Dr. John W. MacConnell, class of 1907. Pathologist—Dr. R. H. Johnston, class of 1894. Head Nurse—Miss Mary C. Miller, class of 1903, of the University Training School for Nurses.

Dr. Marshall B. West, class of 1901, of Catonsville, Md., and Mrs. West recently entertained a number of their friends at the Pot and Kettle Club, Dunmore, on the Frederick road, Catonsville.

Dr. Joshua W. Hering, class of 1855, of Westminster, Md., state comptroller and president of the board of trustees of Western Maryland College, was entertained at a banquet by his fellow-trustees and the faculty of the college June 17, 1908. As a further mark of their appreciation of

his devotion to the interests of the college, a picture of him by Oscar Halwig, the Baltimort artist, was unveiled.

Dr. W. H. Bates, class of 1907, and for the past year a resident physician at Bay View, has been appointed first assistant resident physician at the Church Home and Infirmary.

Dr. Wm. H. Hollyday, class of 1908, has been appointed second assistant resident physician at the same institution.

D. Arthur M. Shipley, class of 1902, superintendent of the University Hospital, has resigned to enter upon the practice of medicine in Baltimore. He has been appointed first assistant surgeon on the Baltimore, Washington and Annapolis Electric Line. The other assistants are Drs. J. F. Hawkins, class of 1906, and R. B. Hayes, class of 1906. Dr. St. Clair Spruill, class of 1890, is chief surgen.

Dr. Shipley will be succeeded as superintendent of the University Hospital by Dr. R. P. Bay, class of 1905. Dr. C. W. Roberts, class of 1906; Dr. E. W. Glidden, class of 1907; Dr. R. C. Franklin, class of 1907, have resigned to engage in their profession in Georgia. Dr. G. W. Billups, class of 1906, has been appointed resident physician at the Woman's Hospital, Baltimore. Drs. J. W. Bird and Frank S. Lynn, both of the class of 1907, have been reappointed. The former has been appointed to assistant superintendent. Those appointed to positions in the University Hospital from the present graduating class are: Assistant surgeons, Drs. G. H. Richards, T. M. West; assistant physicians, Drs. L. Kelb, L. H. Seth; assistant gynecologists, Drs. W. D. Hammond, J. E. Mackall; assistant obstetricians, Drs. J. H. Bay, D. S. Rhone; resident pathologist, Dr. J. L. Anderson.

Dr. J. B. Piggott, class of 1907, formerly of the resident staff of St. Joseph's Hospital, Baltimore, has also received an appointment to the resident staff of the University Hospital. Dr. J. T. Taylor, of the present graduating class, has resigned his residency at the University Hospital.

Drs. E. H. Henning, L. G. Scheurich and Arthur L. Wright, of the class of 1908, have been appointed assistant resident physicians at Bay View.

Dr. Wm. A. Ellingwood, class of 1908, has been appointed resident physician at the Presbyterian Eye, Ear and Throat Hospital, Baltimore.

Dr. E. S. Perkins, of the class of 1907, for the past year a resident in the University Hospital, will engage in the practice of medicine in Baltimore.

Dr. Charles Bagley, class of 1904, has been reappointed superintendent of the Hebrew Hospital, Baltmore, and Drs. L. F. Steindler and J. E. B. Zeigler, of the class of 1908, assistants in the same institution.

Dr. L. C. LaBarre, of the class of 1908, has received an appointment to St. Luke's Hospital, New York.

Drs. W. L. Burns and W. C. Davis, class of 1908, have been appointed resident physicians at St. Joseph's Hospital, Baltimore.

Dr. Samuel Theobald, class of 1867, and Mrs. Theobald are spending the summer at their cottage at Ocean City, Md.

Dr. Hiram Woods, Professor of the Diseases of the Eye and Ear in the University of Maryland, and Mrs. Woods have announced the engagement of their daughter, Miss Mary R. Woods, to Mr. Hugh Fernandis Watts, of Baltimore.

Prof. William Z. Holliday, class of 1882, has resigned his chair in the Medical Faculty of the University of Georgia. He has been honored with the title of Emeritus Professor.

Dr. A. R. Shands, class of 1884, has been elected vice-president of the Medical Society of Northern Virginia.

Dr. Harry C. Algire, class of 1895, of Baltimore, was a delegate to the Republican Convention recently held in Chicago.

Dr. Henry M. Thomas, class of 1885, has been elected a councilor of the American Neurological Society.

Dr. E. V. Nolt, class of 1908, has received an appointment in the Lutheran Hospital at Fort Wayne, Ind.

Judge Conway W. Sams, Henry P. Hynson, Phar. D., and Dr. B. Merrill Hopkinson have been elected to the vacancies upon the Board of Trustees of the endowment fund to fill the vacancies caused by the resignations of Messrs. Allen McSherry, Clayton C. Hall and Joshua W. Hering.

In a game of baseball between the physicians and lawyers of Frederick, Dr. Frank Hedges, class of 1898, played first base.

Dr. A. M. Shipley has just returned from the North Carolina State Medical Society meeting.

Dr. R. P. Bay, the new medical superintendent of the University Hospital, has assumed the duties of his office.

Dr. Frank Martin will leave for Europe during the early part of August.

MARRIAGES.

Dr. Rastus Ranson Norris, class of 1904, of Baltimore, formerly a resident physician at Provident Hospital, Washington, District of Columbia, and late medical superintendent of Bay View Asylum Hospital, Baltimore, was married Wednesday, June 24, 1908, at the home of the bride's aunt, Mrs. Gordon Thomas Atkinson, in Crisfield, to Miss Lillian Horsey. Miss Horsey is the daughter of Mr. William P. Horsey, of Crisfield. Her mother was Miss Clara L. Roach, daughter of the late William H. Roach, of Somerset county. Dr. Norris is the son of Hon. James L. Norris, of Washington. After their honeymoon Dr. and Mrs. Norris will reside at 1309 North Charles street, Baltimore, Md.

Dr. Thomas Howard Phillips, class of 1907, a former assistant resident physician at Bay View Hospital, was married Wednesday, June 17, 1908, to Miss Eunice Nicholson Coulbourne. Dr. and Mrs. Phillips will make their home at 1500 West Fourth street, Wilmington, Del.

Dr. William Fletcher Hall, class of 1885, of Crisfield, Md., was married at Wilmington, Del., June 17, 1908, to Mrs. Clara J. Benson. They will spend their honeymoon in the North. They will reside at Crisfield. Mrs. Hall was the widow of Nathaniel R. Benson, Jr., ex-president of the Wilmington City Council. Rev. Dr. Kellogg, of Grace Methodist Church, officiated.

Dr. Robert M. Dawson, class of 1869, of Wittman, Md., and Miss Agnes B. Battee, of Royal Oak, were married Wednesday evening, June 10, 1908, at the residence of Col. S. S. Thompson. The groom is the youngest son of the late Major John Dawson, of Royal Oak. He practiced medicine at Bayside and married for his first wife Miss Mary Kemp, and lived at the old Kemp home, Bolton, which he inherited. Miss Bates is a member of one of the oldest families of Talbot. Dr. and Mrs. Dawson will reside at Bolton.

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SOME CASES ILLUSTRATIVE OF THE IMPORTANCE OF ROUTINE PATHOLOGICAL EXAMINATION OF NASAL AND POST-NASAL TUMORS.

By JOHN R. WINSLOW, B.A., M.D.,

Clinical Professor of Nose and Throat Diseases in the University of Maryland; Laryngologist to the University Hospital, Baltimore, Md.

Although attention has been quite recently directed to this matter (Rosenheim, *Johns Hopkins Bulletin, June*, 1906), its importance cannot be over-emphasized.

While relatively rare, the frequency of malignant nasal growths is undoubtedly greater than the collated statistics would indicate, inasmuch as many cases have escaped detection from omission of systematic pathologic examination.

In the early stages the characteristic distinctive symptoms are lacking, and resort must be made to the microscope for diagnosis.

Early diagnosis is of the utmost importance, since when small, these growths can and ought to be removed by rhinological methods, whereas extensive growths are incurable even by the most radical external surgery.

In this respect rhinologists have been reproached by the general surgeon with neglect of duty, and I must admit with some justice.

Case of Epithelioma and Sarcoma of left nostril, diagnosed and treated as mucous polypi by a general practitioner.

Michael L., white, aged 58 (Presbyterian Eye, Ear and Throat Hospital No. 2299—1907), complains of obstruction of left side of nose for six (6) months past. Seven (7) months ago had polypi removed by a general practitioner. No headache, pain nor hemorrhage. Deaf in left ear. Examination revealed multiple mucous polypi on left side, an elongated growth of peculiar appearance along the floor of the left nostril, extending to the nasopharynx; also a retro-nasal tumor. Septum deviated to the left. March 7th, 1907, I removed multiple polypi with snare and Luc's forceps, also the mass on the nasal floor, remarking to my class at the University of Maryland, before whom I operated, upon its suspicious nodulated appearance. Subsequently the retro-nasal mass was removed through the nose with cutting forceps. Pathologic examination by Dr. Levy, of the University of Maryland, declared the anterior growth to be an epithelioma and the posterior a sarcoma. Radical endo-nasal operation was determined upon, and on June 12th, 1907, the left inferior and middle turbinals were removed, the ethmoidal cells exsected and the sphenoid curetted. Unfortunately much valuable time had been lost, and multiple lymphadenitis followed by marked constitutional cachexia ensued. A recurrent mass was removed within a week, and also on several subsequent occasions by myself or my assistant, Dr. H. C. Davis, and the patient finally succumbed to general infection the latter part of August, 1907.

Case of Epithelioma of right nostril, probably hereditary, resembling a mucous polypus.

Miss C. B., white, aged 18 years, private patient, consulted me for obstructed right nostril, which she stated was due to a tumor visible to herself and which had increased in size lately. She is subject to moderate nose-bleed at times, and dull headache over right eye. Sense of smell bad. Had an abscess of right ear about one (1) year ago, in the winter. There is a small red area on skin of right side of nose, over nasal process. Her father died of endo-nasal cancer, which is said to have extended from the outside of nose. Examination revealed a spherical tumor the size of a hickory nut, resembling a mucous polypus, and attached above the anterior third of the inferior turbinated body. This tumor was removed April 15th, 1908, with a snare, without pain or hemorrhage, and the base cauterized with lunar caustic. It could then be seen that the septum was markedly deviated to the right, terminating in a sharp bony crest. Pathological examination by Professor Hirsh, of the University of Maryland, proved the tumor to be an

epithelioma. May 9th, 1908, I curetted the base of the growth and the adjacent nasal process thoroughly with a bone spoon. June 4th, the wound was healed with a smooth cicatrix. It is to be hoped that early diagnosis, radical operation and continuous supervision will save this patient.

Case of Sarcoma of naso-pharynx, resembling a cyst.

Mrs. N. T., white, aged 50, private patient, complaining of bilateral nasal obstruction for four (4) months, steadily increasing and now absolute. No pain, no hemorrhage, no adenitis. Examination with post-nasal mirror showed an ovoidal tumor in naso-pharynx, of grey color, close against choanae and apparently attached to the roof of naso-pharynx—compressible on palpation. The condition was diagnosed as a cyst. April 30th, 1907, an endeavor was made to remove the growth through the mouth with a post-nasal snare, but examination of the specimen showed only adenoid tissue. October 19th, 1907, I compressed the growth with my finger and by massage forced it into the left naris. I could not, however, pass the snare around it. The sensation imparted was that of grape pulp, and the manipulation caused some pain and free bleeding. November 5th, 1907, after subsidence of reaction, I succeeded in passing a snare through the naris, with the end of my finger in naso-pharynx, around the base of the growth and removed same with little pain or hemorrhage, under cocaine-adrenalin anesthesia. Pathologic examination of growth by Professor Hirsh revealed a Sarcoma. The patient was well several months after operation, but has since moved from the city and observation.

Case of Lympho-sarcoma (?) of the naso-pharynx with symptoms of adenoids.

Edith O., white child, aged about 6-7 years, private patient, with symptoms of nasal obstruction. Blonde coloring and lymphatic type. November 4th, 1900, I performed adenoidectomy and tonsillectomy (punch) under Schleich's general anesthesia. April, 1904, the patient returned with a recurrence of the adenoid and the right tonsil. Removal under general anesthesia. Owing to fact of recurrence and the constitutional type of the patient, I had the adenoid tissue examined by a pathologist, who reported it a lympho-sarcoma. The patient has been kept under observation and repeatedly re-examined. No recurrence has taken place and she is in good health. There was either an error in diagnosis or the growth was eradicated by operation. This case exemplifies the importance of early and thorough removal of adenoid growths with pathologic examination of specimen, especially in cases of a suspicious constitutional type.

While it is true that many doubts have been raised by competent authorities as to the transformation of benign into malignant growths, without entering into the merits of the controversy, I think that we may now claim an affirmative solution of the question. We have the evidence of such authorities as Virchow, Senn and Welch that such transformation is a pathologic possibility, and there is abundant clinical evidence in favor of it. This takes place not only in lymphoid tissue, but mucous polypi are particularly prone to undergo such malignant degeneration (sarcoma, epithelioma and mixed). There is reason to believe that this degeneration is facilitated by constant irritation. Hence such measures as repeated cauterizations, blind fishing in the dark with forceps or snare, repeated inadequate operations, etc., should be avoided in the treatment of these growths.

114 *West Franklin Street.*

CLINICAL PSYCHIATRY — DISPENSARY DEMONSTRATIONS—*(Continued.)*

By N. M. Owensby, M. D., *Class* 1904.

The pathological changes we would expect to find in these patients will be proportionate to the length of time they have abused the use of alcohol and to that of the intellectual enfeeblement; therefore I will speak only of the changes that are usually found in cases similar to the last patient who entered the room.

Upon removing the skull cap the dura is found to be thickened and adherent, milky arachnoid and thickened pia, which in extreme cases is adherent to the convolutions. The blood vessels are tortuous and show a considerable amount of sclerosis. When we remove the brain we notice that it is markedly atrophied and that the arteries at its base show evidences of atheromatous degeneration, some of the capillaries being completely occluded. The ventricles may or may not have a granular lining. Should we continue the "autopsy" and examine the organs of the vegetative functions, we would doubtless find a myo-

carditis, chronic gastritis, fatty degeneration of the liver and an interstitial nephritis.

Upon making a microscopical examination of the brain we should, according to the teachings of Clouston, (1) Bevan Lewis (2) and Hyslop (3), make the following observations: The pia is thickened. Amyloid bodies are seen in the epicerebral space. In the periphery of the cortex, just below the pia, are numerous scavenger cells. There is an increased vascularity with enlargement of the cortical vessels and their coats show fatty and atheromatous changes. The nuclei of the adventitia have proliferated freely and the protoplasm of the cells have undergone a fatty degeneration. Occasional minute aneurysmal dilations of the capillaries, most marked in the white matter, are observed, and there seems to be small extravisations of blood. Here and there are small fatty embolisms. The large moter cells in the fifth layer of the cortex and the spindle cells lying immediately beneath show fatty changes and seem to be undergong absorption. There is also an overgrowth of the neuroglia and a granular degeneration of the ordinary pyramidal cells.

Now, since we have in a general way dispensed with the gross and microscopic pathological findings, we will take up the treatment of these unfortunate persons. The treatment of alcoholism is a subject which has given the medical profession no little concern for many years in the past, and while the problem is by no means solved, it is nearer solution at the present time than ever before. Numerous societies have been formed among the laity for the study and prevention of inebriety, many good laws have been enacted in behalf of the intemperate, and lastly but of not least importance, there is a general acknowledgement on the part of the physician that inebriety is a disease that requires rational treatment.

It would require several volumes to chronical the fights which have been made and the methods used to enlighten the world of the evils resulting from the abuse of alcohol. The advice Paul gave Timothy, "Drink no longer water, but use a little wine for thy stomach's and thine often infirmities," has been religiously followed by many men who were ignorant of the fact that they were borrowing from a source a hundred times more exacting than Shylock, and whose demand in return has frequently been a shattered physical and nervous system, which has resulted in their spending the remainder of their days in an institution for the treatment of the insane.

The percentage of asylum inmates who first began the use of stimulants for social reasons is small; it is those who resorted to the use on the account of some physical discomfort, imaginary or real, that form the majority. The first patient we saw began the use of alcohol on the account of an intense nervous depression, and we must bear this in mind in the treatment prescribed for her.

The history given by her is practically the same of all patients suffering with dipsomania. They all have fits of despondency and nervous depression, and during one of these attacks their desire for alcoholic beverages is incontrollable; pride, honor and self-respect all fade away in their mad desire for drink. They differ from the other alcoholic cases in that the dipsomaniac "is alienated before beginning to drink, and the other becomes alienated because of his drinking" (Magnan) 4. The attacks vary in frequency and in some cases occur only once a year. During the intermission between attacks they have no desire for drink, and have even been known to become active temperance workers, but upon a return of the symptoms they forget all of their teachings and enter another state of intoxication. Many begin taking some of the so-called cures at the close of an attack, and it is to this class of patients that "quack" remedies are often indebted for their testimonials. The intermissions gradually become shorter and the attacks last longer until finally they present all the symptoms of an alcoholic dementia.

The other class of patients usually give poor health, financial or family troubles, as the cause of their intemperance, or else advance similar excuses for the continuance. I will not attempt to discuss the cause for their intemperance other than reiterate what I have already said concerning physical discomfort and mention that a very large percentage have a hereditary taint or predisposition on account of intemperate parents, but will state that the family or financial troubles given as excuses for the continued indulgence, when not imaginary, are often due to the fact that when under the influence of alcohol they mistreat their families and neglect their business, and that the real cause is a weakened will

power, which continues to become weaker as long as they abuse the use of alcohol.

The inability of these patients to resist temptation and the danger of their injuring themselves or others make it imperative that they should be watched at all times, and to do this successfully they should be placed in an institution for the treatment of this class of patients. There they will have all alcoholic stimulants withdrawn and a general tonic and hygienic treatment substituted.

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THE FAMILY PHYSICIAN AND UTERINE CANCER.

By Hugh W. Brent, M. D.,

Instructor in Gynecology, University of Maryland.

Carcinoma of the cervix uteri is written in the history of medicine as one of its saddest pages. It is essentially a disease of the mothers of the nation, finding in motherhood one of its most essential etiologic factors (cervical laceration), and occurring at that time of life when "mother" finds its tenderest expressions in the hearts of a new generation. Just at that period when woman has completed her life work—for I think in maternity we find the life work of woman—and may justly claim her reward in the affection of those whose existence she has made possible. To rob her of this through the agency of so terrible an ailment seems an incredibly cruel stroke on the part of fate, one which not only as physicians, but as men, with the milk of human kindness in our breasts, we should combat with every force at our command.

It is one of the most insidious of diseases, born in darkness and carrying on its deadly work during the curable period under the mask of that cloudy process, the so-called "change of life." I say cloudy process, I think with reason, for in no other natural function does the race allow so much of the unnatural to exist without heed, without fear and without protest.

Ignorance in women in regard to this inevitable cycle of changes, and especially in regard to perversion of it through disease, is one of the things to be fought for only in those cases in which the subtle warnings of the enemy are promptly and properly interpreted. Can we hope through the means at hand to accomplish a radical cure?

The burden of prophylaxis and early recognition falls most heavily on the shoulders of the family physician, if indeed even he be consulted before the malady has ceased to be curable.

Metrorragia and menorrhagia are unnatural at any time during menstrual life; they in themselves constitute no specific disease, being merely one of the symptoms of some genital or constitutional pathologic process. In the majority of cases some local cause for their existence is discoverable, and the folly of attempting treatment without local examinations must be evident to any one of even ordinary intelligence. A gynecologist would never have such faith in his personal diagnostic acuteness as to render an opinion or hazard treatment without something more tangible than the rambling, indefinite statements of the patient. If one specially trained hesitates, it is evident that the general practitioner assumes a grave responsibility when he essays to correct a symptom without some definite knowledge of the cause.

The innate modesty of woman is, of course, ever opposed to gynecologic exposure; but when we consider the importance of the procedure in its relation to the welfare of the patient, we must realize that by its omission we rob her of any sincere and intelligent effort on our own part to properly interpret the existing disease.

If the situation be tactfully and delicately explained, the average woman will at least recognize the necessity for thorough investigation, and should she then demur, the physician will make no mistake in refusing to undertake treatment. Failure to be firm in this regard often reaps disaster. This is notably the case in cancer, for it is in the stage of incipience, revealable only through thorough and painstaking examination that radical operation can be undertaken with any hope of success.

Uterine hemorrhage other than *normal* menstruation is to be regarded with suspicion in women over thirty; it is often the earliest sign of malignancy, and should be looked upon by

the family physician as a sign of such importance as to merit his best efforts in the determination of its pathologic significance.

Another sign which may antedate hemorrhage is a peculiar thin, watery discharge, the product of the growth itself, and not to be confounded with the corrosive, foul flow encountered in the stage of ulceration.

We will take, for example, the following case: The patient a healthy, robust woman of forty, mother of several children, gives the following history:

"For several weeks I have noticed after coitus or unusual exertion a slight bloody vaginal discharge, which only causes me worry through the fact that I feel it to be unnatural. Menstruation is regular, but has lately been more profuse than usual. For years I have had slight leucorrhoea, but knowing this to be a common ailment in married women, I have given it no special attention other than the ordinary douches. Recently, however, I have noticed that it has slightly increased in amount. My general health is excellent. I suffer no pain and suspect, doctor, you will consider it foolish that I consult you in regard to such minor ailments."

Foolish? Would that every woman were as sensible. True, they may be the symptoms of a minor ailment (endocervicitis will cause them), but to the alert, conscientious physician comes the hint in these subtle warnings—possible malignancy. And if he be alert and conscientious, he insists on a thorough local examination, firmly refusing to be "bullied" or "teased" into submerging his better judgement and honesty to such an extent as to adopt methods bearing a charming similarity to those of Mrs. Pinkham's and others of her ilk who combat disease through the perusal (?) of lists of symptoms and send to the luckless victim a "pill or two" to "regulate the womb"—whatever that is.

Unfortunately we cannot always "see" or "feel" cancer, but we can at least in suspicious cases excise under cocaine a wedge of tissue for examination by a competent pathologist.

Uterine cancer is such an insidious disease that it often advances beyond the curable stage before any definite manifestations of its existence becomes apparent. Pain and cachexia practically inevitably indicate its extension to periuterine structures, and he who awaits the development of such symptoms before making a definite diagnosis is guilty of inexcusable procrastination.

Cancer is so frequent in parous women and so infrequent in virgins that we must look upon cervical laceration as a factor of prime importance in its etiology. The prolonged irritation, associated with infected, infiltrated cervical tears, seems to be almost essential to the development of the disease. The general practitioner, realizing the dangers of this precancerous period, should always advise the repair of these injuries. We know so little of value in the prophylaxis of cancer that we can ill afford to neglect an element of such importance in the development of malignancy.

THE DISPENSARY OF THE UNIVERSITY HOSPITAL.

By A. M. Shipley, M. D.

The growth of hospitals in our American cities has been phenomenal in recent years. Everywhere they are being built, and hospital equipment, and hospital management, and many other phases of hospital work are occupying the minds of many people. So important is it that there is now a large association—the Association of Hospital Superintendents—who meet yearly and discuss for several days all those manifold questions having to do with hospital management.

The growth of the Free Dispensary has been only a little less noticeable than that of hospitals. Indeed, it has been truly almost unparalleled. Our cities are growing at a rapid rate. Millions of aliens are landing yearly on our shores, and comparatively few of these go to the country. Not only this, but the drift away from the farm toward the city of our American-born youth is a serious menace to us in many ways. This, added to the increase in population from births, is swelling the size of our cities at a rapid rate.

During good times, when work is plentiful and wages high, there is little trouble. The average man will pay as he goes, if he has money with which to pay. But, unfortunately, a large percent of our city population are laborers—unskilled for the most part—and when supply exceeds demand and retrenchment becomes necessary, these men are thrown out of work. Then what happens? Usually nothing has been laid by for dark days, or even if there has been, this

is soon exhausted and the family becomes an object of charity. Now this is a very weak place in our American institutions. It is absolutely wrong to pauperize a man unnecessarily. This is being overcome in some countries by a government insurance for the unemployed. A man is taxed according to his income during working times, and thereby has a compulsory savings bank account, so to speak, from which he can live during days of enforced idleness.

The worst phase of this temporary need for charity is this: A man finds out how easy it is to get something for nothing, and he continues to get it long after the necessity has ceased. By so doing he loses some of his self-respect. So that we are slowly but gradually ruining our laboring classes by too much misdirected charity, too much coddling, too much politics, too much catering to this thing or to that.

As an example of this, witness with what utter lack of forethought many a man of this class marries. He often does not appreciate the solemn obligation he is taking upon himself. Why? Because he knows that the maternity hospitals will look after his wife if she be pregnant, and if the responsibility of children becomes irksome, the asylums will look after them.

A dispensary serves four purposes: first, and by far and away most important, it provides medical advice and medicines to those who could not get them in any other way; second, it acts as a feeding ground for hospital wards, sending in many cases which require ward attention; third, it provides a tremendous wealth of material for the teaching of students of medicine; and, fourth, it is the great schoolroom for the post-graduate who is trying to fit himself to do some particular work in a manner a little better than the general man.

The abuses of the dispensary are mainly twofold: first, that many patients pauperize themselves unnecessarily; and, second, this condition removes a source of livelihood, in part at least, from many sincere and capable physicians. However, the dispensary is a mighty educative factor, and it is a powerful stimulant to the practitioner of medicine who might otherwise become careless in treating his patients. Competition with the dispensary makes a better man of him, because dispensary workers are usually capable men and bring to their work more or less special training.

What can be done with the Dispensary of the University of Maryland? Nearly thirty thousand visits yearly. What a wealth of material! Already a great deal is being done, but the end is not yet. What a large laboratory this is for the teaching of clinical medicine! and the conditions for teaching are nearly ideal. We are teaching men who are going to practice medicine, who are going to see patients, and treat them, and try to cure them. Here we have the patient and the student and the other thing needed is the teacher. We do not need more patients in the University Dispensary; there is a wealth of patients. What we need is to get the student in contact with the patient; and one other thing we need, and that is the keynote of the entire thing. Our dispensary workers should be teachers. Teachers in the best and highest sense; not only men who point the way, but men who lead the way; men who are earnest in acquiring all the knowledge possible of their branch, and are then enthusiastic in imparting that knowledge to others.

We should face the question squarely. Dodging will do no good. The teaching of medicine by didactic methods is dead. It belongs to a past regime. The University has always been a pioneer and opportunity is spelled here for us in large letters. Not laboratories are needed, not rich equipment but only two things: patients with symptoms, and pathology, and men who understand how to interpret what they see, and who will then teach students of medicine; teach them at first hand how to examine a patient, how to read correctly what they see and hear, and then with these things as a basis, how to cure disease wherever cure is possible; for unless these things be our reward, "much study is a weariness of the flesh."

PANCREATIC AFFECTIONS.

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

This is the most deeply placed organ of the abdominal cavity. It is situated post-peritoneal and lies transversely on a level with the second lumbar vertebra. Fortunately, it is not the seat of pathological conditions so frequently as some of the other organs. If the opening of the common bile duct is obstructed at the papilla of

Vater, there is a damming of the bile along the duct of Wirsung, which starts up a chronic pancreatitis.

Cysts of the Pancreas.—Retention cysts, due to the obstruction of the duct, owing to some infection, are rare. They do not give rise to any definite symptoms. A cystic swelling is found in the middle line or left of the abdomen, between the stomach and transverse colon. It is rounded, tense and elastic, and gives rise to a dull percussion note. Resonance ought to be obtained above and below the cyst, owing to the stomach and colon being respectively located above and below this tumor. The cyst is due to the retention of the secretions of the gland. It is covered by two layers of the great omentum, and the posterior layer of the peritoneum. Fatty stools, due to the absence of the pancreatic juice in the intestines, are not of an uncommon occurrence. Owing to the obliteration of the islands of Langerhaus, sugar makes its appearance in the urine.

Treatment.—An incision is made in the middle line or through the left rectus. After gaining an entrance into the peritoneal cavity, tear through the great omentum and expose the cyst. After carefully packing off the abdominal cavity so as to prevent the digestion of the tissues, aspirate the cyst. It is the better plan, however, to pack and wait for several days and then open the cyst. Insert a drain after opening and allow the wound to heal from the bottom by granulation. The cyst may be opened at once if the sac can be pulled into the wound and aspirated extra abdominally. It often leaves a fistula, which takes some time, but eventually heals. As the secretion of the cyst causes an excoriation of the skin, the epidermis should be protected by some ointment.

Acute Pancreatitis.—Pancreatitis is subdivided into the two great subdivisions, acute and chronic. Acute pancreatitis may be further subdivided into the following varieties: Hemorrhagic, suppurative and necrotic.

This affection is more prevalent than was generally supposed, and is extremely common in alcoholics. A combination of the hemorrhagic and the necrotic is the form most met with. In this case there will be a parenchymatous hemorrhage as well as sloughing of the pancreatic tissues. It is due to an infection traveling up the pancreatic duct. The bacillus coli communis and the pus organisms are the germs most frequently cultivated.

Symptoms.—The onset is sudden, the patient is in extreme collapse, and experiences cramp like epigastric pains, which are not relieved by vomiting. The temperature is irregular and the abdomen is greatly distended.

Mayo remarks that it may follow injury with most acute sudden pain in the epigastric region, with profound collapse, and the abdomen is at once distended. Nausea, vomiting, "nervous unrest," lividity, hiccough, repeated attacks of collapse and fat necrosis are prominent symptoms.

Suppurative Pancreatitis.—Suppurative pancreatitis usually occurs in alcoholics and obese individuals. There will be severe pain in the epigastrium, as well as a rigidity, tenderness and distention of the upper abdomen. This distention is located either in the epigastric or left hypochondriac region. Nausea, vomiting, and sometimes jaundice will be present. The pulse is rapid, ranging from 100 to 140, and the temperature is somewhat raised, reaching from 100 to 103 degrees. A leucocytosis is present.

Treatment.—This condition calls for an operation. The incision is made through the left rectus muscle, or, if the surgeon prefers, from behind on the left side, as recommended by Robson. In some instances the best results accrue from leaving both the incisions open, thus draining from the front and back at one and the same time. No matter if the front incision is employed, the posterior, or the two combined, the wound must be left open and thoroughly drained.

Acute Hemorrhagic Pancreatitis.—Acute hemorrhagic pancreatitis may follow injury, but ordinarily it depends upon an infection. The onset is sudden, and so intense as to throw the individual into extreme collapse, with all its associated symptoms, such as rapid pulse, quickened respirations, etc. The pain in the abdomen is so intense that the patient is thrown into profound shock. This pain is located in the epigastrium. The abdomen is greatly distended. Nausea and vomiting are persistent, and do not relieve the abdominal distress. Owing to the persistent con-

stipation, combined with the other abdominal symptoms, this affection greatly similates intestinal obstruction. With the administration of a purgative this condition will be eliminated, as there will be a free movement of the bowels. Among the other important symptoms may be mentioned "nervous unrest," lividity, hiccough, recurrent attacks of collapse, etc. When opened areas of whitish or brownish fat necrosis of the omentum or mesentery attract our attention. Often there will be encountered sloughs of the pancreas. Fat will be found in the stools, owing to the absence of pancreatic juice in the intestinal contents. There are blood clots in and about the pancreas. It is an extremely fatal disease. The temperature is irregular. So it can be seen that in any case of acute pancreatitis there will be a sudden onset, associated with cramps like pains of the epigastrium, which are not relieved by nausea and vomiting. About the same time the abdomen will begin to swell enormously—so much so that, with persistent constipation, one is likely to think he is dealing with intestinal obstruction. Combined with all these symptoms there is profound collapse.

Treatment.—Perform a prompt laparotomy, remove the blood clots and insert a drain, but as a rule all treatment is of no avail.

Chronic Pancreatitis.—Chronic pancreatitis is commonly due to obstruction of the common bile duct below the entrance of the duct of Wirsung with a gall stone; alcohol and syphilis are also important factors in the production of this pathological condition. As a rule jaundice will be present. The pancreas is indurated—so much so that we may think we are dealing with carcinoma. There are chronic digestive disturbances present. The disease is not suspected, and frequently only diagnosed during an operation for the removal of the biliary calculi.

Treatment.—Remove the gall stones and drain the bladder and there will frequently be complete recovery.

Tumors of the Pancreas.—The pancreas is not so susceptible to tumors as the other organs. When such do occur they are usually malignant, and when discovered it is too late to resort to operative procedures for their removal. If the tail is the only part of the gland involved, it may be possible to remove the growth.

FOR DR. TRIMBLE'S PLACE.

A subject now exciting considerable interest and speculation among officers of the Maryland National Guard is that of the appointment of a chief surgeon of the First Brigade to succeed the late Dr. Isaac Ridgeway Trimble, whose rank was that of colonel.

The appointment of chief surgeon lies in the power of Brig.-Gen. Lawrason Riggs, commanding the First Brigade. His choice would be subject to the approval of the Adjutant-General of the State.

Although General Riggs has not chosen any medical officer for the place on the brigade staff, those officers who are interested expect he will appoint Major W. Guy Townsend, medical department, attached to the Fourth Infantry. Major Townsend is second in seniority of the medical officers of the State troops.

The senior major of the medical department is Major W. C. Claude, of Annapolis, with the First Infantry, but Major Townsend's friends say that, although Major Claude is senior to Major Townsend, the fact that the latter lives in Baltimore, which is the headquarters of the First Brigade, and that almost all of the State troops are stationed in the city, entitles him to the position.

All the State's medical stores are kept, too, in the military storehouse in the Fifth Regiment Armory, and requisitions for hospital and medical supplies are honored only by the chief surgeon. It is pointed out by Major Townsend's supporters that this fact alone should influence the appointment of a Baltimore surgeon.

Major Townsend has been in the military service of the State since 1900, when he was made captain and assistant surgeon in the Fourth Infantry.

He is a graduate of the School of Medicine of the University of Maryland, having received his degree in 1888.

It is probable that in the fall the hospital corps of the Maryland National Guard will be established on a new basis, in conformation to the present organization of the Hospital Corps of the United States Army, as provided for in the Militia bill passed by the last Legislature.

At present each regiment has its own hospital corps, separate and distinct from the hospital corps of other regiments. Under the reorganization the entire hospital establishment will be combined into one body, so that when the brigade goes into the field, instead of each regiment having its own hospital corps, there will be a field hospital, fully equipped and manned by nearly all the surgeons and hospital men in the brigade.

To each regiment in the field will be assigned a surgeon and a detail of men for work on the firing line when the troops are in action and to man a small regimental hospital in camp to care for minor cases.—*Baltimore Sun.*

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EDITORIAL.

POST-GRADUATE WORK AT THE UNIVERSITY OF MARYLAND.—So many inquiries have come to the Medical Department of the University in one way or another, regarding the opportunity for doing post-graduate work, that the Faculty and Adjunct Faculty have organized a post-graduate course.

This course will begin May 15, 1909, and continue for six weeks until July 1, and will include medicine and surgery, the specialative and laboratory methods. The cost for the entire course will be $60; individual courses, $25.

The arrangement of the course of instruction is as follows:

MEDICINE—

Clinical Medicine, instruction for examination in Life Insurance.

Practical Therapeutics and Hydrotheraphy.

Clinical Medicine with especial reference to cardio-vascular diseases and Diseases of the Blood.

Diagnosis of Abdominal Diseases.

Diagnosis and treatment of Pulmonary Tuberculosis and Diseases of the Chest.

A special course in physical diagnosis will be arranged for those who desire the course.

Diseases of Children—Infant feeding, home modification of milk, ward and dispensary instruction in the various diseases of childhood.

Diseases of the Nervous System—A course in nervous and mental diseases, including electrotherapeutics and diagnosis, will be given. Clinical material in the University Hospital, Bay View Asylum, City Insane Asylum and the Maryland School for the Feeble-Minded will be used for teaching purposes.

Digestion and Metabolism—Diseases of the Stomach and Intestines, Oesophagoscopy and Gastroscopy, Physiology of Digestion, the study of Food and Metabolism.

Histology and Embryology—Study of the normal organs and tissues and their development, with demonstrations of microscopical technique.

Pathology and Bacteriology—Gross and microscopic pathology, making of media and study of important pathogenic organisms, post-mortem demonstrations.

Clinical Microscopy—Examination of blood, urine, sputum, stomach contents and farces.

Obstetrics—All obstetrical operations on the manakin, classes in palpation and pelvinetry on the living patient, study of the puerpera, care of the new born, attendance on the melvae and outpatient clinic.

Gynaecology—Operations daily at the University Hospital. Gynaecological examinations, non-operative treatment of gynaecological cases. Dispensary instruction in diagnosis and treatment.

Surgery—Clinical and operative surgery; operations daily at University Hospital; ward rounds; treatment of fractures and dislocations after treatment of operative cases.

Surgical Pathology and Diagnosis—Gross surgical pathology, diagnosis and treatment of surgical diseases.

Anaesthesia—Practical demonstrations and instructions as to method of administering anaesthetic. Local anaesthesia.

Clinical and Practical Anatomy—Practical teaching by demonstration on human cadaver. The course will include practical anatomy, topographical and applied clinical anatomy.

Skiagraphy and Radio-Therapeutics—The use of the X-ray in the diagnosis and treatment of disease.

Orthopedic Surgery—Operative, didactic and bedside instruction at the Hospital for Crippled Children; methods employed in the outdoor treatment of tuberculous bone diseases at the Mountain Hospital. Dispensary instruction at the University Hospital.

Diseases of the Eye and Ear—Dispensary instruction daily and operative opthalmology at the University Hospital. Surgery of the Ear and Mastoid. Instruction daily in eye and ear diseases at the Presbyterian Eye, Ear and Throat Hospital.

Diseases of the Throat and Nose—Dispensary instruction daily and operations on throat and nose at the University Hospital and the Presbyterian Eye, Ear and Throat Hospital.

Diseases of the Skin—This course will include lectures and dispensary instruction in diagnosis and treatment, with microscopical demonstrations of pathological conditions of the skin.

Genitro-Urinary Surgery and Venereal Diseases—Demonstrations in cystoscopy, urethral catheterization and endoscopy. Dispensary instruction in genitro-urinary diseases daily.

The Memorial Volume of the Centennial Celebration.—The editorial committee has recently presented to the profession and public the memorial volume of the Centennial Celebration of the Foundation of the University of Maryland, a book of 267 printed pages, handsomely illustrated and bound.

The work contains all the matter relating to the Centennial, giving a complete description of the events, ceremonies and transactions leading up to and connected with the four days devoted to the celebration. These ceremonies, now fresh in the minds of those who were so fortunate as to witness them, have been preserved in this memorial volume to be handed down to coming generations. The first one hundred years of life of the old University, so crowded with important and historic events, have been recorded and related in this volume of transactions in a form which will give to future generations a clear picture of the work which the University has done for the State and Nation. This memorial volume has been edited with great care and labor. It is a work of patriotism and devotion to the best interests of the University and of her alumni. It should be found in the library of every alumnus of the University.

Annual Announcement of the Department of Medicine of the University of Maryland.—The 102d Annual Catalogue of the Department of Medicine of the University for the session of 1908-09 has recently been issued from the Dean's office. This catalogue contains nothing sensational or startling. It is a simple report of the work done during the past session and a statement of the work cut out for the coming session. The story of what the Faculty of Physic is doing in the educational world is told in plain but earnest language. There is no effort made to drag in students by loud and boastful promises. A bid is made for patronage on the ground of an honest endeavor to give to each student an equivalent for his time and money. The course of instruction is only modified from year to year, as experience suggests. Such changes as are made are designed to meet the requirements of the present growth of education as it is being inaugurated by the leading medical schools of our country. The Faculty of Physic is keeping pace with the enlightened thought of the profession and is aiming to give to the students of the University equal opportunities and advantages offered by medical schools of its class. Holding to the opinion that the best equipped man for the practice of medicine is the man who has had a thorough training in clinical work, the course of clinical instruction at the University is being more largely used and insisted upon. The indoor and outdoor service at the University Hospital is a vast mine for clinical study. The amount and variety of material presented to the student by the University Hospital is sufficient for every practical purpose in the study of disease. The student who takes advantage of the opportunities presented to him by the various clinical teachers will go away from the University with a thorough education in practical work and will be fully qualified to practice his profession. To provide for a larger number of Hospital internes the Faculty of Physic has during the present year made provision for the accommodation of fifty internes, thus increasing the number by fifteen.

This arrangement provides for a training in interne work of over half of the fourth year class. There are few medical schools in this country which can offer to their graduating class as large opportunities for indoor hospital work as does the University. By the systematic use of both indoor and outdoor service every interne is provided with abundant material for study. It is up to the student to make use of the opportunities presented to him.

RABIES IN THE DISPENSARY.

By Herbert Schoenrich, Phr. D., M. D.,
Class 1907.

This case is of interest on account of the unusual rapidity of its course. The patient, a colored boy of eleven years, was accompanied by his mother, who gave the following history: About two weeks ago the boy was playing at his home in the country with his pet dog, when the animal suddenly bit him on his left cheek. The wound, being superficial in character, attracted no more than ordinary attention, and in the course of a few days the incident was forgotten. His father immediately killed the beast. Since then the lad showed absolutely no symptoms nor signs of disease; he showed no signs of indifference or apathy, nor did his actions in any way reveal a suspicion of sickness. On the contrary, he invariably seemed bright and active, playing with his comrades as usual, until this morning, when he had peculiar spasms of short duration, limited mostly to his throat. He is thus brought to the dispensary for treatment. In giving this history the mother thought her son was suffering with throat trouble, almost neglecting the fact that he was bitten by a cur. The attitude of the child was characteristic; he sat closely to his mother's side, with an expression of anxiety, impending evil and fright; his eyes were widely dilated and glary; with his right hand he firmly held his neck, suggesting throat trouble. He was quiet until I brought him a tumbler of water, when he showed peculiar spasms, largely intermingled by hysteria. In attempting to speak he uttered a harsh cry and was hardly able to walk or even stand; he made efforts to vomit, but only froth appeared around his lips, which he expectorated. It was, indeed, a pitiful sight. He was immediately transferred to the Pasteur Institute, where the unfortunate lad succumbed to this treacherous malady in the course of a few hours.

The extremes of incubation in hydrophobia recorded range from two weeks to two years and over; the average is estimated to be *20 to 60 days*. Prodromes are frequently characterized by thirst, with a disinclination to swallow, marked depression, interrupted slumbers, often stinging sensations of the wound. These symptoms merge into the more severe manifestations, namely, convulsive seizures resembling tatanus, excitation of the mechanism of swallowing by attempting to relieve thirst are followed by spasms of the glottis, neck and jaw muscles. This, according to Allbutt, may be the very first symptom, and it is interesting to note that this corresponds to the case above. Fright, barking and biting, with greater or less hyteria, desire to be alone, accumulation of mucus in the mouth, the convulsive seizures mentioned above, and lastly paralysis and possibly asphyxia and death, constitute the final stages, which generally last from *2 to 5 days* or more.

DISPENSARY PHYSICIANS and CHIEFS OF CLINICS AT THE UNIVERSITY HOSPITAL.

Arthur M. Shipley, M. D., Chief of Out-Patient Department.

John Houff, M. D., Dispensary Physician.

W. H. Smith, M. D., H. J. Maldeis, M. D., J. F. O'Mara, M. D., G. C. Lockard, M. D., and H. D. McCarty, M. D., Chiefs of Clinics to the Professor of Medicine. R. C. Metzel, M. D., R. B. Hayes, M. D., H. W. Jones, M. D., G. S. Kieffer, M. D., W. K. White, M. D., J. F. Adams, M. D., and E. S. Perkins, M. D., Assistants.

John G. Jay, M. D., Chief of Clinic to the Professor of Surgery. M. J. Cromwell, M. D., John A. Tompkins, Jr., M. D., J. Fred. Adams, M. D., J. Holmes Smith, Jr., M. D., Assistants.

L. M. Allen, M. D., Chief of Clinic to the Professor of Obstetrics.

A. B. Lennan, M. D., H. J. Maldeis, M. D., Chiefs of Clinics to the Professor of Diseases of Children. W. C. Lyon, M. D., H. Schoenrich, M. D., Assistants.

W. K. White, M. D., and H. W. Brent, M. D., Chiefs of Clinic to the Professor of Diseases of Woman. R. L. Mitchell, M. D., and E. S. Perkins, M. D., Assistants.

E. E. Gibbons, M. D., and Wm. Tarun, M. D., Chiefs of Clinic to the Professor of Eye and Ear Diseases.

J. R. Abercrombie, M. D., Chief of Clinic to the Professor of Dermatology.

J. H. Iglehart, M. D., Chief of Clinic to the Professor of Diseases of the Stomach. R. A. Warner, M. D., Assistant.

H. C. Davis, M. D., Chief of Clinic to the Professor of Diseases of the Throat and Nose. F. J. Wilkens, M. D., Assistant.

Howard E. Ashbury, M. D., Chief of Clinic to the Professor of Orthopedic Surgery.

Wm. D. Scott, Jr., M. D., Chief of Clinic of Genito-urinary Diseases.

J. F. Hawkins, M. D., Chief of Clinic to the Lecturer on Diseases of the Nervous System. F. J. Wilkens, M. D., and N. M. Owensby, M. D., Assistants.

John G. Jay, M. D., Associate Professor of Clinical Surgery.

Harry Adler, B. A., M. D., Associate Professor of Diseases of the Stomach and Director of the Clinical Laboratory.

Arthur M. Shipley, M. D., Associate Professor of Surgery.

Gordon Wilson, M. D., Associate Professor of Practice of Medicine.

F. M. Chisolm, M. D., Associate Professor of Ophthalmology.

J. W. Holland, M. D., Demonstrator of Anatomy and Lecturer on Clinical Surgery.

W. I. Messick, M. D., Lecturer on Clinical Medicine.

H. C. Hyde, M. D., Lecturer on Pathology and Bacteriology.

R. H. Johnston, A. B., M. D., Lecturer on Diseases of the Throat and Nose.

W. H. Mayhew, M. D., Lecturer on Histology and Embryology.

Irving J. Spear, M. D., Lecturer on Neurology and Psychiatry.

Henry L. Whittle, Phar. D., M. D., Lecturer on Physiological Chemistry.

E. E. Gibbons, M. D., Demonstrator of Ophthalmology.

G. A. Fleming, M. D., Demonstrator of Ophthalmology.

C. C. Couser, M. D., Demonstrator of Physiology.

G. S. M. Kieffer, M. D., Demonstrator of Histology and Embryology.

John A. Tompkins, Jr., M. D., Instructor in Minor Surgery and Bandaging

Page Edmunds, M. D., Instructor in Cystoscopy.

Compton Riely, M. D., Instructor in Surgery.
Nathan Winslow, B. A., M. D., Instructor in Surgery.

J. D. Reeder, M. D., J. W. Pierson, M. D., Instructors in Osteology.

H. W. Brent, M. D., Instructor in Gynecology.

M. J. Cromwell, M. D., Instructor in Clinical Surgery.

Wm. H. Smith, M. D., Instructor in Clinical Medicine.

S. Demarco, M. D., G. C. Lockard, M. D., R. C. Metzel, M. D., Assistants in Pathology and Bacteriology.

Leo Karlinsky, M. D., J. F. Hawkins, M. D., Assistants in Histology and Embryology.

Nathan Winslow, M. D., J. F. Hawkins, M. D., J. Holmes Smith, Jr., M. D., R. L. Mitchell, M. D., Assistant Demonstrators of Anatomy.

G. W. Hemmeter, M. D., Assistant Demonstator of Physiology.

R. B. Hayes, M. D., E. L. Bowlus, M. D., Assistants in Clinical Pathology.

J. Holmes Smith, Jr., M. D., Prosector to the Professor of Anatomy.

HOSPITAL STAFF OF THE UNIVERSITY OF MARYLAND FOR SESSION 1908-09.

Robert P. Bay, M. D., Medical Superintendent.

J. W. Bird, M. D., Frank S. Lynn, M. D., T. Marshall West, M. D., Granville H. Richards, M. D., Assistant Resident Surgeons.

Jas. L. Anderson, M. D., Resident Pathologist.

J. B. Piggott, M. D., Lawrence Kolb, M. D., Louis Hamilton Seth, M. D., Assistant Resident Physicians.

John Evans Mackall, M. D., W. D. Hammond, M. D., Assistant Resident Gynecologists.

FACULTY HOSPITAL STAFF.

Attending Physicians.

Prof. S. C. Chew, M. D., Prof. C. W. Mitchell, M. D., Prof. J. C. Hemmeter, M. D., Prof. J. E. Gichner, M. D., Prof. J. M. Craighill, M. D., Prof. A. D. Atkinson, M. D., Prof. C. W. McElfresh, M. D., Prof. Gordon Wilson, M. D.

Attending Surgeons.

Prof. R. Winslow, M. D., Prof. T. A. Ashby, M. D., Prof. J. Holmes Smith, M. D., Prof. J. M. Hundley, M. D., Prof. Hiram Woods, M. D., Prof. Frank Martin, M. D., Prof. St. Clair Spruill, M. D., Prof. John R. Winslow, M. D.

CLINICAL ASSISTANTS FOR 1908—1909.

J. B. Baldwin, Kentucky; G. E. Bennett, Ohio; N. I. Broadwater, Maryland; P. Brown, South Carolina; M. A. Buch, Cuba; A. E. Cannon, South Carolina; J. Costas, Porto Rico; A. L. Fehsenfeld, Maryland; H. B. Gantt, Maryland; R. H. Gantt, Georgia; B. H. Gibson, Georgia; W. T. Gibson, South Carolina; J. M. Gillespie, Virginia; M. B. Green, Maryland; J. Y. de Guzman, Porto Rico; S. W. Hill, West Virginia; J. W. Hooper, Maryland; E. Iseman, South Carolina; A. S. Kepple, Pennsylvania; E. M. Long, North Carolina; S. H. Long, Maryland; J. F. Magraw, Maryland; J. B. Parramore, Florida; T. A. Patrick, North Carolina; S. J. Price, California; W. M. Priest, Maryland; W. G. Queen, Maryland; F. W. Rankin, North Carolina; J. W. Robertson, Virginia; A. Santaella, Porto Rico; A. J. Shakashiri, Syria; R. A. Shankwiler, Maryland; C. C. Smink, Maryland; I. Stein, Maryland; N. S. Stirewalt, North Carolina; A. Thurston, North Carolina; A. C. Trull, Massachusetts; F. H. Vinup, Maryland; W. F. Weber, Maryland; E. B. Wright, Virginia.

The total number of patients treated in the Hospital during the year 1907-1908 was 4,786.

THE UNIVERSITY TRAINING SCHOOL FOR NURSES.

Under the guidance of the Superintendent, the pupils of this School are instructed in all that pertains to Scientific Nursing. Lectures are also delivered to them by the members of the Faculty of Physic on Elementary Anatomy, Physiology, Materia Medica, Chemistry, Antiseptics and Hygiene, as well as upon Nursing in special practice. The Nursing in the Hospital is thus conducted on the most approved plan, and its large material is invaluable to the pupils of the School.

For circulars and information about the Training School, address

THE SUPERINTENDENT OF NURSES,
Hospital of the University of Maryland,
Baltimore, Md.

MATERNITY HOSPITAL OF THE UNIVERSITY OF MARYLAND.

Prof. L. E. Neale, M. D., Director.
L. M. Allen, M. D., Chief of Clinic.
D. S. Rhone, M. D., J. H. Bay, M. D., Resident Physicians.

Synopsis of the Report of the Resident Physicians for the Year Ending May 1, 1908.

Number of Confinements in Hospital.....234
Number of Confinements in Out-door Department 405

Total 639

Average number of cases seen by each student of the graduating class, 22.

TEXT-BOOKS.

Anatomy—Piersol, Gray, Cunningham.

Surgery—Fowler's Surgery; Da Costa; American Text-Book; Wharton and Curtis; Bickham's Operative Surgery; Brewer; Park.

Chemistry—Remsen; Witthaus; Holland; Simon.

Obstetrics—William's Obstetrics; Hirst, American Text-Book of Obstetrics.

Principles and Practice of Medicine—Anders; Edwards; Hare; Osler; Thomson; Tyson.

Materia Medica and Therapeutics—Culbreth's Materia Medica; Wood's Therapeutics (1 vol.); Cushny; Hare.

Physiology—Halliburton; Hall; Howell; Brubaker; Tigerstedt.

Diseases of Women—Ashby; Ashton; Montgomery; Webster.

Diseases of the Eye—Fuchs, 1908 Edition; De Schweinitz; May.

Diseases of the Ear—Politizer (last edition); Deuch; Bezold.

Diseases of the Throat and Nose—Elementary, Ballenger; J. J. Kyle, Gleason. *Advanced*, B. Kyle; Coakley; Grunewald's Atlas.

Orthopedic Surgery—Taylor's Notes on Orthopedic Surgery.

Pathology—Delafield and Prudden; Stengel; Macfarland; Abbott's Basterogy. Histology—Ferguson. Embryology—McMurrich; Heisler.

Medical Jurisprudence—Chapman; Draper; Taylor (Clark Bell).

Hygiene—Egbert; Harrington; Parke; Bergey.

Diseases of Nervous System—Starr; Church and Peterson; Gowers; Dana.

Mental Diseases—Kraepelin; Defendorf.

UNIVERSITY SCHOLARSHIPS.

The Dr. Samuel Leon Frank Scholarship.

This scholarship, established by Mrs. Bertha Rayner Frank as a memorial of the late Dr. Samuel Leon Frank, an alumnus of this University, entitles the holder to exemption from the payment of the tuition fee of that year.

It is awarded by the Trustees of the Endowment Fund of the University in each year upon nomination of the Faculty of Physic, "to a medical student of the University of Maryland who, in the judgment of said Faculty, is of good character and in need of pecuniary assistance to continue his medical course."

This schlarship is awarded to a second, third or fourth year student only who has successfully completed one year's work in the medical course, and no man may hold such scholarship for more than two years.

The Charles M. Hitchcock Scholarships.

From a bequest to the School of Medicine by the late Charles M. Hitchcock, M. D., an alumnus of the University, two scholarships have been established which entitle the holders to exemption from payment of tuition fees for the year.

These scholarships are awarded annually by the Faculty of Physic to students who have meritoriously completed the work of at least the first year of the course in medicine, and who present to the Faculty satisfactory evidence of good moral character and of ability to continue the course without pecuniary assistance.

BAYVIEW HOSPITAL.

The clinical advantages of the University of Maryland have been largely increased by the liberal decision of the Board of Supervisors of City Charities to allow the immense material of Bayview Hospital of 2,000 beds to be used for the purpose of medical education. There are daily visits and clinics by the teachers of the University in medicine and surgery at that institution, and the dead-house furnishes a great abundance and variety of pathological material, which is used for demonstration. The Insane Department contains 250 beds. Three resident physicians from among the graduates of the school are annually appointed by the Trustees upon the recommendation of the Faculty. The medical staff representing the University at the hospital is as follows:

Physicians—C. W. McElfresh, M. D.; W. I. Messick, M. D.; W. H. Smith, M. D.

Surgeons—John G. Jay, M. D.; J. W. Holland, M. D.; M. J. Cromwell, M. D.; N. Winslow, M. D.

Ophthalmologist—Lee Cohen, M. D.

Laryngologist—H. C. Davis, M. D.

Resident Physicians—E. H. Henning, M. D.; L. G. Scheurich, M. D.; A. L. Wright, M. D.

THE LIBRARY OF THE UNIVERSITY.

The Library, founded in 1813, now contains 8,225 volumes, and is open daily during the year for the use of the members of the Faculty, students and the profession generally. During the past year 1,825 volumes were added, and the Library has been transferred to more commodious quarters in the newly acquired Davidge Hall.

It is well stocked with recent literature, and forty-six journals are regularly received. The pamphlets number 4,500.

CORRESPONDENCE.

A Trip to Guatemala to Attend the Fifth Pan-American Medical Congress.

NEW ORLEANS, LA., *July 29th*, 1908.

To the Hospital Bulletin—On May 30th I received an especial invitation to attend the fifth Pan-American Medical Congress to be held at Guatemala City from the 5th to 10th of August, proximo, and to read a paper at that time. After some consideration I concluded to comply with the request, and after having taken an extra accident insurance to guard against contingencies, I have arrived this far on my journay. I left Baltimore on Monday night, and notwithstanding doleful prognostications in regard to the intense heat of travel at this time, and the danger to life and limb on the Southern railroad, I had a very pleasant journey, and the train arrived on time. I leave for Guatemala tomorrow morning on the United Fruit Company's steamer Preston. This is a small steamship, the smallest I have ever trusted my valuable self to on the vasty deep, and I do not like her appearance. I only wish I had my old traveling companion, Dr. Hundley, to share the discomforts and dangers and to cheer me up with his optimistic views. There will be quite a number of physicians going on this steamer, but I have only met one, Dr. Garcia Leao, of Brazil, who is a good-looking and pleasant gentleman. We go from here to Puerto Barrios by ship, then by train to Guatemala City, and it will take five days to get there. The government of Guatemala requires you to have a passport from the Guatemalan consul here, otherwise you don't get in, or, if you do, it may be unhealthy for you. Now I have told you all I know about Guatemala, and must refer you for further information to my next letter, which will probably be forthcoming if the whales don't get me, or if I am not shot or hung in Guatemala. My military bearing and the subject of my paper, "Penetrating Wounds of the Abdomen," may make me a marked person in that country, and who can tell what may happen, notwithstanding my new passport, which certifies for the reasonable sum of one dollar, that I am as harmless as a kitten. The United Fruit Company runs steamers to various parts of Central and South America from New Orleans. The steamship Cartago has just arrived here from Glasgow, and will leave in a few days on her first trip to Panama. She is just off the ways, and is the most beautiful boat of her size in this country, I expect. Her staterooms are very commodious, and are kept cool by electric fans, the windows and portholes are screened to keep out mosquitoes, and the larger staterooms have bath and toilet rooms. The saloon, ladies' room, smoking room and all the staterooms are elaborately equipped and furnished. She is about 5,000 tons displacement, and I have never been on a ship that compares with her as a passenger boat, though of course I have sailed on others that were much larger. Her sister ship sailed from Glasgow today and another will leave shortly. When the three are in service, passengers for Panama will have the most up-to-date methods of reaching their destination. To return to things I know more about. I am told it has rained here 23 days this month, and it has rained pitchforks today. Whilst in Maryland we have been burned up by the drought, here the crops have been destroyed or greatly damaged by the deluge, and there is a great danger of a very short cotton crop. Financial matters in New Orleans are worse than with us; the general financial stringency felt all over the country, has fallen with equal or greater weight here, in addition to which a "moral wave," as a friend of mine expressed it, has swept the state and caused the suppression of Horse Racing, with great loss to local interests. The longshoremen have also been on two strikes, so that cotton could not be shipped, and even the cotton grown in the state is transported to Galveston or other ports for exportation. The water front is pretty well deserted, and no river craft with cotton are in sight at this time. In addition to the Central American steamers, fine ships ply between here and Havana and New York, so there are quite a number of seagoing lines from here, and for those who like sea life, there are ample opportunities for gratifying their desire. Railroads are good enough for me, and I only go to sea when I cannot go by land, and because aerial navigation is as yet rather uncertain.

RANDOLPH WINSLOW.

ITEMS.

Reprints of papers published by the Alumni of the University of Maryland have recently been received by THE BULLETIN, as follows:

Direct Laryngoscopy, Tracheo-Bronschoscopy, Esophagoscopy, Gastroscopy, by Richard H. Johnston, M. D. From the Lancet Clinic, July 4th, 1908.

Nitroglycerine in the Treatment of Neuritis, by H. Burton Stevenson, M. D., Rider, Md. From Medical Record.

Ocular Neurasthenia, by Hiram Woods, M. D. From Journal American Medical Association, July 20th, 1907.

Ocular Complications of Pregnancy, by Hiram Woods, M. D. Journal American Medical Association, July 18, 1908.

The following of our Alumni are upon the staff of the Baltimore Medical College: Emeritus Professor of Obstetrics, Dr. Wilmer Brinton; Emeritus Professor of Physiology and Diseases of the Rectum, Dr. S. T. Earle, Jr.; Professor of Anatomy, Dr. A. C. Pole; Professor of Diseases of Nose, Throat and Chest, Dr. S. K. Merrick; Professor of Materia Medica, Opthalmology and Otology, Dr. J. Frank Crouch; Professor of Therapeutics and Diseases of Children, Dr. Charles O'Donovan; Professor of Biology, Histology and Bacteriology, Dr. Tilghman B. Marden; Professor of Clinical Pathology, Dr. Chas. E. Simon; Professor of Hygiene and Public Health, Dr. W. T. Watson; Associate Professor of Anatomy, Dr. R. B. Warfield; Associate Professor of Psychiatry, Dr. J. Clement Clark; Lecturer on Surgical Pathology, Dr. F. J. Kirby; Lecturer on Nervous and Mental Diseases, Dr. W. A. Duvall; Lecturer on Nervous and Mental Diseases and Medical Ethics, Dr. W. P. E. Wyse; Demonstrator of Diseases of Children, Dr. P. F. Martin.

Prof. Randolph Winslow has left on another one of his exploring jaunts. Several summers ago he thought he would like to investigate the climate and topography of Alaska and the great Northwest. Being noted for his predilection for hot weather, one could not presume that he would select the North this time. His new field of observation includes a visit to Guatemala City, in the Republic of Guatemala, where he will attend the Fifth Pan-American Medical Congress. On his return trip he expects to visit the city of Mexico, as well as other cities in the Republic of Mexico, and perhaps Havana, Cuba.

The month of August is the month of the year for the city physician's outing. The University Hospital Staff is largely reduced by absentees on vacation. The surgical work is running lighter than for months past. The medical wards are full and typhoid cases begin to be in evidence.

Dr. Peter W. Hawkins, class of 1852, a prominent physician in Charles county, is seriously ill with stomach trouble at his home, near La Plata. He is now in his seventy-eighth year. Dr. Hawkins is one of the few of our alumni of the early fifties living, and we sincerely hope that the attack will not prove fatal.

Dr. Wm. H. Smith, class of 1900, for several years an interne at the University Hospital, and later superintendent of Bay View Hospital for two years and of the Hebrew Hospital for one year, has been confined to his home with an attack of Bell's paralysis.

John M. Stevenson, the 11-year-old son of Dr. H. Burton Stevenson, class of 1892, of Sherwood, who was run over by an automobile, is out of danger. He is at his home, and is being attended by his father. Four of his ribs are broken. It is not known to whom the automobile belonged.

The following of our alumni have been selected to serve on a local committee to co-operate with the Washington Committee of the International Congress on Tuberculosis: Drs. M. L. Price, C. W. Mitchell, Charles O'Donovan, W. R. Stokes, Hiram Woods.

Dr. Vance McGougan, an alumnus of the University, now one of the leading physicians of Fayetteville, N. C., made a recent hurried visit to the University Hospital with a patient.

Dr. Cary B. Gamble, class of 1887, a member of the Faculty of the College of Physicians and Surgeons of Baltimore, has been appointed by His Honor Mayor Mahool a member of the Supervisors of City Charities.

Dr. Benjamin R. Benson, Jr., class of 1907, of Columbus Hospital, New York, who spent sometime with his parents, Dr. and Mrs. B. R. Benson, of Cockeysville, Md., has returned to his duties at the hospital.

Dr. Harry Young Righton, class of 1907, of Savannah, Ga., late of the resident staff of St. Joseph's Hospital, Baltimore, has left for Germany, where he will take a special course in surgery.

The following of our alumni are on the staff of the Maryland General Hospital:

Medical—Dr. S. K. Merrick, Dr. A. C. Pole, Dr. Charles O'Donovan, Dr. W. T. Watson. Surgical—Dr. J. F. Crouch, Dr. R. B. Warfield.

Dr. Cooper R. Drewry, class of 1902, and Mrs. Drewry entertained a number of friends July 15, 1908, at the Pot and Kettle Club, on the Frederick road, Catonsville, at dinner.

Dr. Herbert Schoenrich, class of 1907, has located at 1013 S. Clinton street, Canton. He is connected with the Children's Out-Patient Department, University Hospital Dispensary.

Dr. Wm. B. Corse, class of 1877, of Gardenville, who has been ill for six weeks, is convalescing at Cape May.

Dr. John Turner, class 1892, of Baltimore, has returned to his home after a month's vacation, spent at Atlantic City.

Dr. H. W. Kennard, class of 1899, has been appointed resident physician at Bedford Springs, Pa.

Dr. James H. Bay, class of 1908, is at his home recuperating from an operation for appendicitis.

Dr. S. T. Earle, class of 1870, of Baltimore, has returned home from a prolonged stay at Atlantic City.

Dr. Edgar Shirley Perkins, class of 1907, has located at the Hotel Rochambeau, Franklin and Charles streets, Baltimore, Md.

Dr. Cooper R. Drewry, class of 1903, has gone to the Adirondack Mountains to spend several weeks.

Dr. St. Clair Spruill has returned from his summer vacation, which he spent at Atlantic City.

Dr. C. W. McElfresh will spend the early part of August in Boston visiting the various hospitals.

Dr. Salvador Guilliani has returned to his home, Viengues, Porto Rico, where he will engage in the practice of medicine.

Dr. C. R. Franklin, class of 1907, has left for his home, in Georgia.

Dr. H. D. Fry, class of 1876, of Washington, D. C., sailed for Europe July 25, 1908.

Dr. E. W. Glidden, Jr., class of 1907, has located at 1416 Abercorn street, Savannah, Ga.

Dr. C. W. Roberts, class of 1906, has located at Nichols, Ga.

Dr. Ira Burns, class of 1905, is located at Oil City, Pa.

Dr. B. Merrill Hopkinson is at the Hotel Chickley, Prout's Neck, Me.

Dr. M. A. O'Neil, class of 1900, of Baltimore, is at Creagerstown, Md.

Dr. W. V. S. Levy, class of 1904, is spending the summer at Atlantic City, N. J.

Dr. John A. Tompkins, class of 1898, will spend the month of August at Bar Harbor.

Dr. John R. Winslow will spend his summer vacation in Maine.

Dr. W. E. Wiegand spent the month of July at the Hotel Stockton, Cape May, N. J.

MARRIAGES.

Dr. Allen Kerr Bond, class of 1882, of Baltimore, was married the 2nd day of August, 1908, to Miss Louise Birckhead Gambrall, daughter of the late Rev. Theodore Charles Gambrall and Susan Birkhead Gambrall. The marriage took place at Memorial Protestant Episcopal Church, Baltimore. Rev. Wm. M. Dame, rector of the church, performed the ceremony. Miss Emily B. Owings was maid of honor, and Dr. Summerfield Bond, cousin of the groom, best man. After a honeymoon spent in the North, Dr. and Mrs. Bond will reside at 949 Park avenue, Baltimore.

Dr. Gilbert Tyson Smith, class of 1897, formerly of Baltimore, but now of Stamford, Ct., was married at Stamford July 15, 1908, to Miss Olive Shaeffer.

DEATHS.

Dr. J. G. Ireland, class of 1852, formerly of Baltimore, died Thursday, July 9, 1908, after a long illness, at the home of his daughter, Mrs. William Spignull, in Washington.

Dr. Ireland was born in Calvert county, and was 77 years old. He was a graduate of the medical department of the University of Maryland, and for many years practiced medicine in Calvert county. For some time he was in the Internal Revenue Service in Baltimore. About a year ago he suffered several strokes of paralysis. Dr. Ireland leaves a brother, Mr. C. W. Ireland, who resides at 230 N. Howard street, Baltimore, Md.

Dr. Charles Winter Trader, class of 1878, formerly of Somerset county, Md., died in Suervo, New Mexico, of heart failure, July 15, 1908. Dr. Trader was a graduate of the Medical Department of the University of Maryland, and had lived in the Southwest since his graduation. He was prominent as a physician and surgeon in Texas and Oklahoma. His father was the late Levin White Trader, of Somerset county, and his mother was Matilda Horsey, sister of the late Dr. W. O. Horsey, of Accomac county, Va.

Dr. Trader married Miss May Hilliard, daughter of Dr. Robert Carter Hilliard, of Louisiana. His two daughters (Mrs. John L. S. Sneed and Miss Custis Winter Trader), a brother (Mr. John A. E. Trader, of Mountain Park, Oklahoma) and a sister (Miss M. Louise Trader, of Oak Half, Accomac county, Va.) survive him. Burial was in the family lot at Fairlawn Cemetery, Oklahoma City.

Mrs. Kate E. L. Virdin, widow of Dr. W. W. Virdin, class of 1866, died at her late home, Brightwater, near Lapidum, this morning, after a lingering illness, of stomach trouble. She was in her seventy-ninth year.

THE HOSPITAL BULLETIN

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PENETRATING WOUNDS OF THE ABDOMEN.

By RANDOLPH WINSLOW, A. M., M. D.,
Baltimore, U. S. A.

Notwithstanding the effort to lessen the frequency of war, by the establishment of an International Court of Arbitration at The Hague, and the Central American Court at Cartago, Costa Rica, the fulfilment of the ancient phophecy does not appear to be near at hand, when "nation shall not lift up sword against nation, neither shall they learn war any more." It is not probable, then, that "man's inhumanity to man" will cease in the near future to such a degree that a brief consideration of the injuries inflicted by individuals upon their fellows may not be held with propriety and profit. I am, therefore, emboldened to present for discussion upon this occasion the subject of penetrating wounds of the abdomen, having nothing of startling novelty to bring before you, but only the results of a considerable personal experience with this class of injuries acquired in civil practice in a metropolitan city. Although one might legitimately think this subject would be presented by one connected with the military service, with an experience gained in actual warfare, I am of the opinion that it is the civil surgeon who is most frequently called on to treat these cases at a time when operative measures may be undertaken with some degree of success, whilst the military surgeon does not frequently come in contact with such cases at a time when, and place where operations may be performed to advantage.

Penetrating wounds may involve the abdominal parietes only, without inflicting lesions on the viscera within the abdominal cavity, and, indeed, a considerable proportion of cases are of this character. When the intra-abdominal viscera are injured, a perforating wound is said to have been sustained. Penetrating wounds are usually those resulting from gunshots, or from stabs, though at times injuries are received by impalement, as by falling on pointed stakes or spikes, or by goring with the horns of cattle. Our consideration of the subject will be limited to those injuries inflicted by bullets or shot discharged from pistols, rifles or shotguns, and stab wounds from knives, scissors and similar sharp-pointed objects. Owing to the enormous fatality of these injuries when treated expectantly, it was confidently hoped that a great lessening of mortality would follow their operative treatment in time of war, but this expectation does not seem to have been realized, owing to conditions that prevail at such times.

In civil practice these injuries are usually seen early, and are taken promptly to hospitals or places where appropriate measures can be applied under favorable conditions, and there can be no doubt of the propriety of performing laparotomy for the joint purpose of ascertaining the extent of the damage sustained, and of repairing, if possible, the lesions.

Symptoms and Diagnosis.—The first requisite for correct treatment is correct diagnosis. The most important point to be ascertained is whether the peritoneal cavity has been invaded, and if so, what traumatisms have been inflicted? A consideration of the symptoms presented will often elucidate the fact that penetration has occurred, and that lesions of the viscera have been sustained, but the nature and extent of these lesions can only be determined by an exploratory laparotomy. Frequently there are no diagnostic signs present, and the diagnosis must be made by opening the abdomen. The most evident sign is the presence of a wound in the abdominal wall, and when this is situated on the anterior aspect of the abdomen, it is reasonable to suppose that penetration has taken place; but when the wound of entrance is on the back, chest or pelvis, there may be grave doubt whether the abdominal cavity has been entered. In many such cases there is penetration of the abdomen, with visceral or vascular lesions. When the intestines, or omentum, or feces, bile or urine escape from the

wound, it is manifest that a penetrating injury has been sustained, but it is only exceptionally that this occurs. Shock is often severe, and it may be due to hemorrhage, or it may be neurotic in character, and as a rule does not give us any valuable information as to the extent or nature of the trouble within. Often with severe lesions there is no shock present. Vomiting of blood would indicate the probability of a lesion of the stomach, as would the passage of bloody stools render an injury of the intestines probable, and the occurrence of bloody urine suggests a lesion of the bladder or kidney. The occurrence of a tympanitic distension of the abdominal parietes might be due to escape of intestinal gases into the peritoneal cavity, causing an obliteration or lessening of the normal liver dullness. The occurrence of free fluid in the abdominal cavity would suggest severe hemorrhage. These and other symptoms are suggestive of penetration of the abdominal cavity with lesions of the viscera, but when in doubt we must incise the track of the bullet or stab, and follow it until we ascertain whether it leads into the peritoneal sac or not. The ubiquitous newspaper reporter in the profundity of his wisdom frequently announces that the doctors are going to probe for the ball, or that they have performed that marvelous feat, but it is unnecessary to say that the day of probing for the ball is past, and that one should incise the bullet or stab track instead. Sometimes there will be both a wound of entrance and one of exit, or the bullet may be felt under the skin, but in most instances the missiles lodge in the body and cannot be felt, and often they are not discovered even after laparotomy has been performed. In some cases there may be more than one wound of entrance, as well as of exit, if several shots have been received.

Stab wounds are more local in their effects than gunshots, and are less likely to produce intra abdominal injury, but if they are situated in such a position that visceral lesions are at all probable, they should be enlarged sufficiently to permit of exploration. No exploration of a bullet or stab wound should be undertaken until the patient has been removed to a hospital or to his home, and then only after every preparation has been made for an aseptic operation. Wounds of the thorax as high as the fifth rib frequently penetrate the peritoneal cavity and produce visceral lesions, and should always be considered as potential wounds of the abdomen, and in many cases treated as such. They frequently produce many and complicated lesions, and are attended with a high death rate.

Prognosis. — The prognosis in penetrating wounds of the abdomen is always grave, and depends upon many conditions, such as nature of the organs and structures injured, the character of the traumatism, the fullness or emptiness of the viscera at the time of the injury, and the presence or absence of hemorrhage. Wounds above the umbilicus are not so fatal as those below that point, and at times a bullet may traverse the abdominal cavity in this region without inflicting visceral lesions. Perforating wounds of the hollow viscera when unoperated on are usually followed by death, though small wounds of the stomach may not always be fatal. Wounds of the small intestine are very fatal; those of the large gut less so. Wounds of the solid viscera are frequently recovered from, if they are limited in extent. Gunshot wounds of the abdomen traversing the cavity obliquely or transversely produce many lesions, and are very fatal, whether operated on or not. Stab wounds are followed by more hemorrhage than gunshot wounds, but are more local in their effects, and do not usually produce as much damage, and the injuries can be repaired more easily and with less shock to the patient. Gunshot wounds of the pelvis are likely to injure the bladder, rectum or other structures within the pelvic cavity, and are attended with a high mortality.

Reports from the military surgeons engaged in recent campaigns seem to indicate that penetrating lesions produced by the modern, small, nickel jacketed bullets, propelled at a high velocity, are much less fatal than similar injuries caused by the slower-moving leaden bullets of pistols used in civil strife. Since the introduction of exploration and repair of the injuries produced by penetrating wounds the mortality of these cases in civil practice has been markedly diminished, and if seen early and treated efficiently, 60 to 75 per cent. of all cases ought to recover. Without operation 80 per cent. or more will terminate fatally.

Treatment.—The last word has not been said in regard to the treatment of pentrating wounds of the abdomen, especially those due to gunshot, but as far as concerns these injuries in civil life it may be laid down as an axiom that they should

be subjected to operative treatment. In military practice the small, high-velocity projectile often produces injuries that are recovered from without operation, and as the exigencies of military service are such as to preclude prompt aseptic operations, it is still a question as to the best method of procedure in such cases. The experience of the surgeons during the Spanish-American and Boer wars was not favorable to operative treatment. According to the report of the Surgeon General of the United States Army for 1899, fourty-four pentrating wounds occurred during the Spanish and Philippine wars, of which thirty died, a mortality of 68.2 per cent., whilst those who were subjected to laparotomy all died, with perhaps one exception. Nevertheless, if the cases of undoubted penetrating wounds, with probable injuries to the viscera, especially the alimentary tract, are seen within a few hours, and the patient can be taken to a properly equipped hospital, I am of the opinion that laparotomy should be done. Of course, if, as was the case in South Africa, there is an insufficient supply of water, a dusty and germ-laden atmosphere, flies in large numbers and imperfect facilities for abdominal work, it will be the part of wisdom to refrain from meddling in such cases and leave them to nature.

In civil life the projectiles are usually discharged from pistols, though sometimes from rifles or shot guns, and are soft, round or conical shaped, and move with a comparatively low velocity, hence are not aseptic in character, and produce extensive laceration of the viscera, with speedy infection of the peritoneum and death.

I wish, therefore, to again insist that the principle of operative treatment has been fully established in this class of cases, and that one who does not give his patients the benefit of an operation is liable to be under the necessity of defending himself, not only from an accusing conscience, but before a court of law.

What is the duty of the physician who first is called to a case of stab or gunshot wound, which probably enters the peritoneal cavity? It is to resist the temptation to introduce a finger or probe into the wound, and, instead, to place a piece of gauze or clean cloth over the wound until the patient can be removed to a hospital or to whatever place he is to remain. If he is shocked he may have judicious stimulation, but as shock may be due to hemorrhage, no time should be lost in getting him to a surgeon. Do not wait for symptoms of visceral injury to occur, but operate as soon as possible. Every hour's delay is fraught with increased danger, and but few of those operated on after the lapse of twenty-four hours recover. As the result of injury the intestines are temporarily paralyzed, and there is but slight extravasation of feces, but if the operation is delayed, the intestines recover their peristalsis and an extensive escape of intestinal contents is bound to occur. The abdominal incision is usually best made in the median line, and of sufficient length to permit a satisfactory exploration of the abdominal cavity, and especially the intestinal tract, but sometimes it will be best to incise the site of the bullet or stab wound, or to make a lateral incision, if the projectile is known to have traversed only a small portion of the peritoneal cavity. After opening the abdomen, the first duty of the operator will be to search for and arrest any active bleeding that may be going on. Gunshots as a rule do not cause a great deal of hemorrhage unless a very large vessel has been injured, but stabs are frequently attended with violent hemorrhage. In some cases the bleeding cannot be arrested until the aorta or vena cava has been seized with the fingers and strongly compressed. Having arrested the bleeding, a careful search for perforations of the hollow organs should be made, and they should be closed by sutures, or in some cases a resection of the intestine may be necessitated. The search for perforations should be systematic and thorough, but with as little handling and dragging on the intestines as possible. Of course when it is known that only a limited area has been injured, this extensive search may not be necessary, but in most instances it will be safer to make a thorough examination. Many of these cases occur at night and immediate treatment is imperative, and is carried out under difficulties, with perhaps insufficient light and assistance, and under such circumstances it will be easy to overlook a perforation, especially if it is situated at a distance from the initial point of injury to the abdomen. I believe it is better when the hollow organs, and especially the intestines, have been wounded, to provide drainage by tube or gauze, and if peritonitis is present, or is likely to occur, to place the patient in the Fowler position, with a drainage tube in the pelvis.

If there has been any soiling of the peritoneum,

there should be a free flushing of the cavity with hot normal salt solution. No food should be given by the mouth for nearly a week, but nutritive enemata may be employed. In some cases the instillation of salt solution in a very small, continuous stream into the rectum lessens thirst, stimulates the heart and flushes the kidneys.

Wounds of the Stomach.—The stomach fills a large portion of the epigastric and left hypochrondriac regions, and when distended extends into other zones and is liable to be injured when gunshot or stab wounds are received in either the lower thoracic or upper abdominal regions. Unfortunately wounds of the stomach are frequently complicated with other serious injuries, such as perforation of the pleura, lungs, diaphragm, liver, spleen, kidneys, gall bladder, duodenum, intestines and great vessels, with hemorrhage, hence these complicated injuries are very difficult to repair, are attended with great shock and are followed by a high mortality. Ordinarily it will be best to make an incision in or near the middle line above the umbilicus in order to explore and remedy the traumatisms inflicted, but at times it may be necessary to make a left lateral incision. Usually both walls of the stomach are perforated, and it is always necessary to explore both surfaces of this viscus, unless the bullet can be felt lodged within its cavity. The posterior surface of the stomach can be explored by tearing through the great omentum, or by making an opening in the transverse meso-colon and pushing the stomach through it, as in posterior gastro-enterostomy. It is generally easy to suture perforations on the anterior surface of the stomach, but when they are situated high up towards the oesophagus, or at the extreme left, it may be necessary to make another incision, or to divide one or more ribs, in order to get at the injuries. A perforation on the posterior wall situated high up may be inaccessible for suturing, and gauze packing must be used instead. If the stomach is full when wounded, there will be an escape of its contents into the greater and lesser peritoneal cavities. The contamination of the lesser peritoneal cavity is especially serious, as it is difficult to properly clense it. This should be done by tearing through the greater and lesser omenta and thoroughly mopping and irrigating this space and establishing free gauze drainage.

Wounds of the stomach are not always fatal, even when unoperated on, as its walls are thick, and when the perforation is small the mucous membrane may evert into the opening and plug it up, and thus prevent an escape of its contents.

The mortality is, however, very great when the stomach is perforated, and as one can never tell what lesions have been inflicted unless there are marked contra-indications present, laparotomy should be performed and the traumatisms remedied. In my service at the University Hospital, Baltimore, ten perforating wounds of the stomach have been operated on, with five recoveries and five deaths. Three stab wounds and two gunshot wounds of the stomach recovered, whilst one stab with severe hemorrhage and four gunshot wounds, complicated with injuries to the spleen, chest, lungs, diaphragm and liver, with hemorrhage and shock, died.

Wounds of the Intestines.—By far the greater part of the abdominal cavity is occupied by the large and small intestines, and it is difficult to understand how a bullet can traverse this cavity from before backwards below the umbilicus without perforating some portion of the intestinal tract, yet this is sometimes done. More frequently the intestinal coils are penetrated in a number of places, and when the missile traverses the cavity in a transverse or oblique direction, there may be many perforations situated in various and widely separated regions. A single bullet may make as many as a dozen perforations, but usually from one to six openings are found. A discharge from a shotgun, if received at a short range, will extensively lacerate the abdominal walls and the underlying organs, but at a greater range there may be many perforations of both the parietes and intestines. In a case of shotgun injury under the care of my colleague, Prof. J. Holmes Smith, fourteen perforations of the intestines were found and sutured and the patient recovered.

Stab wounds will not produce as many perforations as those due to gunshot, but the incisions in the organs are liable to be extensive and the hemorrhage severe; the lesions, however, will be confined to the location of the stab, and it will not be necessary to make such an extensive search for perforations.

If possible, the relative position of the patient to his assailant at the time of the assault, or accident, should be ascertained, in order to enable us to judge as to the course of the bullet and aid us

in determining the best point at which to make the laparotomy incision. After the arrest of hemorrhage, if any is present, a careful search must be made for perforations of the intestines, bladder and other organs. Small perforations of the intestines may be inverted with one or two purse-string sutures; larger openings must be closed with some of the various forms of intestinal suturing, usually two rows of sutures being placed. When the openings are large they should be sutured transversely to the lumen of the gut, in order to prevent the formation of a stricture. When several perforations are in close proximity, or the rent is extensive, or the mesentery is much lacerated, a resection of the intestine must be done, with end to end or lateral enterorrhaphy. Fortunately, this is not often required. Care should be taken to prevent undue exposure of the viscera, and if the intestines are removed from the abdominal cavity, they should be enveloped in hot cloths. The intestines should be passed between the fingers and both sides of the gut examined. After the intestines have been penetrated, contamination of the peritoneum is almost sure to have occurred; hence a careful toilet of the peritoneum should be made, foreign matter and blood removed, and the exposed parts washed off with normal salt solution. If there has been extensive soiling of the peritoneal cavity, it should be freely flushed with sterile water, a tube placed in the pelvic excavation, and the patient placed in the elevated posture, or the head of the bed raised to facilitate drainage into the pelvis. Fifteen cases of perforating wounds of the intestines have occurred in my service, and have been submitted to laparotomy, of which seven recovered and eight died, and several other cases where there was no actual perforation, but contusions or partial laceration of the intestinal walls, all recovered. Of twenty-five cases of perforating wounds of the stomach and intestines, twelve recovered and thirteen died. This is not a brilliant record, but a true one. Some of these cases were already in an almost hopeless condition, and with complications of a most extensive character. In two perforations were overlooked. One died of post-operative pneumonia. Several died from shock due to the injury and hemorrhage, and the rest of peritonitis.

Wounds of the Urinary Bladder.—The bladder is liable to be wounded when a ball penetrates the pelvis, or when the bladder is distended and rises into the general peritoneal cavity. The bullet may lodge within the bladder, or it may make wounds of entrance and exit, either extra or intraperitoneally. The injury may be suspected from the location of the external wound, or from the withdrawal of bloody urine, or from the proximity of lesions to neighboring organs. It is a serious injury and demands immediate operation. If the ball is lodged in the bladder, it must be removed, the wounds closed and the peritoneum thoroughly cleansed and drained. During the war with Spain in 1898, I saw a soldier at Fort Monroe who had been shot in the back, the bullet perforating and lodging in the bladder. This was removed, the pelvis cleaned and drained and the man recovered. In extraperitoneal injuries an incision must be made into the space of Retzius and the case treated as a supra pubic cystotomy. As I write a report has just reached me from a former pupil, of a rifle wound of the bladder, causing two perforations extra-peritoneally. He was at once operated on, the perforations sutured, the space of Retzius drained, and a prompt recovery ensued. The bladder is said to be injured in only one-half per cent. of all cases of gunshot wounds of the abdomen, and in thirty-seven personal cases of abdominal wounds there has been but one case of wound of the bladder, which was complicated with perforations of the small intestines and rectum.

Wounds of the Gall Bladder.—This organ is occasionally injured, usually in conjunction with other traumatisms. Bile escapes into the peritoneal cavity, and will cause peritonitis if it is at all infected, though uninfected bile may be absorbed. I saw a case in which there was a perforation of the gall bladder in association with injuries to other organs, in consultation with a colleague, but have had no similar case in my own series. Suture of the perforation in the gall bladder, or cholecystectomy, may be done, depending on the extent of the injury.

Wounds of the Ureters.—The ureters are seldom injured in gunshot or stab wounds, though it is not probable that an injury of these tubes would be ascertained sufficiently early for the application of effective treatment. If it should occur, and the laceration of the ureter be recognized, an attempt should be made to make an ureteral anastomosis; or if that should be impossible, a nephrectomy should be performed. I have not recognized any uretral injury in the

cases that have come under my care, nor do I think any such injuries have occurred.

Wounds of the Solid Organs.—It is seldom that wounds of the liver and spleen occur without other traumatisms, but this occasionally happens. The chief danger in these cases is hemorrhage, which may be very profuse, but is by no means always so. When either of these organs is perforated by a bullet, or penetrated by a stab, the bleeding can usually be controlled by gauze packing or by deep sutures, and in the event of extensive laceration of the spleen, it may be removed.

A case of gunshot of the liver has recently come under my care; the bullet entered posteriorly, about the ninth intercostal space, and passing forwards, escaped above the left costal arch. She was brought to the University Hospital, a distance of fifty miles, some hours later, and laparotomy was performed at once. A hole was found extending through a large portion of the liver, but with no injury to other viscera, and with only a moderate amount of hemorrhage. The anterior opening was sutured, the upper part of the abdomen drained with gauze, and the nine-year-old child recovered after an attack of pneumonia and the transdiaphragmatic opening of a large abscess, which discharged pus mixed with bile.

At the same time a case of pistol shot of the left side was admitted to my service, and on opening the belly the spleen was found to be perforated, but without any other visceral injuries, and but little bleeding. The peritoneum was cleansed, gauze packed against the spleen, and after a rather stormy time, the man recovered. I have seen other cases of injury of the spleen that did not terminate so favorably.

The pancreas is but seldom injured, owing to its deep location at the back part of the abdominal cavity, but traumatic lesions of this organ are very dangerous. The case of the late President McKinley is illustrative of this fact. One case of gunshot of the stomach in my service was complicated with an injury to the pancreas, which was sutured, and the man recovered.

The kidneys are sometimes injured by both gunshots and stabs, which may be extraperitoneal or may penetrate the peritoneal cavity. The location of the external wound and the presence of bloody urine will call attention to the necessity for an exploration of the loin with packing, suturing or nephrectomy, as the exigencies of the case requires.

Hemorrhage.—All penetrating wounds of the abdomen are attended with some degree of bleeding; this may be slight or it may be profuse in character. The mesenteric vessels are the ones usually lacerated or cut, but sometimes the great vessels, as the renal, the portal vein, vena cava, or aorta are divided; in which case the hemorrhage is usually very great. Many years ago a case of pistol wound of the epigastrium came under my care. No operation was done, and the patient lived five days and two hours. At the autopsy it was found that there were no visceral lesions, but the bullet had passed through the aorta and lodged in the body of the second lumbar vertebra. There was some free blood in the peritoneal cavity, but there was an immense hematoma behind the peritoneum. It was remarkable that a person could live five days with two large holes in the abdominal aorta.

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AN INTERESTING CASE OF RECURRENT ITEUS.

By J. Holmes Smith, Jr., M. D.,
Class 1906, Baltimore, Md.

This case is of particular interest, because of the recurrent attacks, and because, in the later ones, there appears to be a neurotic element.

The attack always comes on when patient is at home, and quickly subsides after several days' rest in the hospital ward. At no time has an attack come on while patient was in the hospital.

Case:—A. S., 5 years of age, white, female. Very precocious and nervous in temperament and always nervous and restless during attacks. First admitted to the hospital on March 21, 1907, in the service of Professor Smith. She gave the history of having been taken acutely ill on March 18, 1907, with severe pains in the abdomen and a blackish vomit. Purgatives and enemas being ineffectual, with her condition becoming steadily worse, she was brought to the hospital. Upon admission, examination showed her to be fairly well nourished, but the general appearance was that of a very ill child. The face was somewhat drawn; eyes sunken, with black rings around

them; tongue coated and child very restless. Temperature subnormal; pulse between 120 and 135 and weak; respiration, 30. Leucocyte count, 30,000. Abdomen was somewhat sunken, but examination failed to elicit any tenderness, tympanites or palpable lump. There was frequent vomiting of a blackish vomitus.

An enema, administered shortly after she was taken to the ward, being ineffectual, a laparotomy was deemed necessary, and about three hours after admission the abdomen was opened by Professor J. Holmes Smith.

A small intussusception was found involving the Ileum, about 12 inches from the ileocaecal valve. There was no exudate and no adhesion between edges of peritoneum. Slight traction reduced the invagination, and no apparent damage to the parts could be found. The remainder of the intestines, peritoneum and other viscera appeared normal, except for the presence of several round worms, discovered in the intestinal canal. Abdomen was then closed and the patient made an uneventful recovery, except for an attack of tonsilitis, and also the discomfort incident to the administration of a vermifuge. Discharged on April 7, 1907, in good condition.

After leaving the hospital she complained frequently of some pain at the seat of operation, and because of a chronic constipation it was necessary to give her a cathartic about twice a week.

On the 26th of June, 1907, she was again brought to the hospital, with symptoms very similar to those noted upon her first visit. This time she entered the service of Professor Martin. Upon getting the history, it was found that two days previous to her second admission, she was seized with sudden and violent pain at the seat of operation, accompanied by frequent vomiting of a mucous-like material, which was streaked with green. The pain and vomiting were accompanied by great restlessness, requiring morphia to quiet her, and these conditions continued until she was brought to the hospital. No history of injury could be obtained. Examination showed about the same symptoms as on the previous occasion: Pains in abdomen, stercoraceous vomit, constipation and very restless. Abdomen flat and nothing discovered upon percussion or palpation. Temperature, between 99 and 100 degrees. Pulse, 145. Respiration, 25 to 40. Leucocyte count, 21,800.

A recurrence of her former condition being feared, her abdomen was opened by Professor Martin. Upon exposure of the abdominal viscera, a condition was found which at first was thought to be a thrombosis of the mesenteric vessels, but in reality was a large, irregular, flattened mass, filling up a considerable portion of the mesentery and apparently composed of extravasated blood. It was definitely confined, like a haematoma.

That portion of the intestine whose mesentery contained the clot was contracted down to about the size of a lead pencil and appeared like a thick, irregular cord. There was no evidence of any gangrenous gut. Peritoneum was smooth and glistening. No round worms present. A few slight adhesions were found and broken up, after which the abdomen was closed, without anything further being done. Patient was then returned to bed, and it was thought that she could not recover. The head of her bed was elevated, everything by mouth discontinued and a slow, continuous rectal injection of normal salt solution administered.

For several days her condition remained about the same, but after this she began gradually to improve, and in about one week her general condition was very good. Discharged on August 4, 1907, cured.

Since the second attack she has returned five times, after varying intervals of time, and been under the care also of Professor Winslow and Professor Spruill. On each occasion the principal symptoms have been pain in the abdomen, vomiting and constipation, accompanied by more or less shock. Only once was there pain in the abdomen—*upon pressure* or tympanites—and these were during the course of an attack, following a blow on the abdomen, while she was at play. The temperature has always been low, but the pulse rate and respirations have been increased. Leucocyte count was high on the two occasions when taken, but there is no record of it in the later attacks. Other symptoms of shock have varied with the severity of the attack.

The treatment since the second operation has always been the same: As nearly absolute rest in bed as possible; nothing by the mouth and normal salt enemata. In the course of from a few hours to twenty-four the symptoms have gradually subsided. Generally, after two or three days, she has been apparently as well as ever and able to run around the ward without any inconvenience.

SUBPARIETAL INJURIES OF THE KIDNEY, WITH REPORT OF A CASE REQUIRING IMMEDIATE NEPHRECTOMY.

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It would seem from the study of this subject that there are two principal reasons for the comparatively low proportion of injuries to the kidney when contrasted with that of other abdominal viscera. Hidden deeply in the recesses of the abdomen the kidney is protected from traumatism, which anatomic reason is reinforced by the fact that the organ lies deeply imbedded in a large quantity of loose fatty tissue, acting as a buffer against blows upon the loin or ileo-costal region. Thus in a report of two thousand six hundred and ten deaths from injury recorded by one investigator, there were thirteen instances of injured kidneys.

The kidney suffers injury from direct and indirect violence, constituting the class of cases generally spoken of as subparietal. In this class the soft parts, or abdominal parietes, escape laceration, the damage resulting from crushes and blows upon the kidney region (direct violence) or from indirect violence as in falls from a height accompanied by sudden bending of the trunk at the time of alighting, crushing the kidney between the costal margin and the iliac crest. Another class of injuries to this organ are designated penetrating, embodying all those resulting from wounds extending through the soft parts to the kidney seen most often in military practice. By far the most frequent variety, however, is the former seen in civil practice, and not unfamiliar to the majority of physicians who have labored for a few years in the application of our art. Subparietal injuries of this organ vary from slight contusions to rupture or even pulpefaction. Lacerations may be single or multiple, in the most cases the rent being transverse. Severe cases often show complete separation into an upper and lower portion. It has been observed that when numerous superficial lacerations exist, there are usually adjacent organs involved which must receive consideration. Such injuries to the kidney, notwithstanding, are not nearly so serious as rupture of intraperitoneal organs owing to the fact that its interior surface only is covered by peritoneum. We are able thus to explain why the majority of cases reported show extravasation of blood and urine outside the peritoneal cavity, a fact unfortunately not borne out in the one to be considered, and which complication when it does exist renders the case of the most serious nature, placing it as regards prognosis in the category of injury to intraperitoneal organs.

Symptoms.—The symptoms which a given case would present will depend, as is evident, upon the degree of damage sustained by the kidney substance. There is always a history of injury of more or less severity. If there is present simply pain and tenderness with frequent micturition and a slight haematuria without the rapid formation of a tumor about the injured organ, or the superaddition of signs of shock, the case may be put down as belonging to the more frequent variety of simple injury. If, however, added to the preceding symptoms the patient developes the familiar signs of shock and hemorrhage, i. e., depression in force of heart beat followed by increased rapidity, paleness of the skin, subnormal temperature, incessant nausea, vomiting, thirst, air, hunger, restlessness, etc., the surgeon must recognize that he has to deal with the more serious type of kidney traumatism.

Haematuria, although the most constant symptoms of renal injury, cannot be relied upon as an index to the severity, or pathognomonic, of such injury. While it is always present in some degree, when there has been laceration of tissue, or even following severe contusion without actual separation of continuity of parts, taken alone it is misleading. Thus, in a given case there may be persistent extravasation of blood and haematuria accompanying a slight contusion or laceration, while again the most severe disorganization will not manifest itself by this symptom. It behooves us, therefore, in reaching a decision as to the proper course to pursue in the treatment of these as well as all other maladies to which the human flesh is heir, to consider the signs and symptoms as a whole with special emphasis upon none, but due regard to all.

Complications.—Unless a fatal termination quickly ensues from hemorrhage or collapse certain complications soon arise, bringing additional symptoms to be met. A very common one is cystitis, seen in neglected cases of persistent

haematuria. Clots of blood have been allowed to remain in the bladder for weeks, setting up a troublesome inflammation of its walls and in a few cases reported, causing ascending infection of sound kidney followed by anuria and death. Moreover, perinephritic abscess results from extravasation of blood and urine. The presence of a large quantity of fat surrounding the kidney predisposes to this complication since its blood supply is limited. Unless free incision established without delay furnishes drainage, this condition may become widespread, finally exhausting the patient from local absorption or more general toxemia. When less happily the rent in the kidney extends through the peritoneal covering on its anterior surface, a very dangerous complication ensues precipitated by the ready entrance into the abdominal cavity of blood and urine establishing the much dreaded and fatal peritonitis.

Diagnosis.—As has been stated previously, there is no pathognomonic symptom of subparietal injury to the kidney. Given the history of a fall or blow sufficient to produce deepseated injury, with pain following down the ureter, tenderness on palpation over renal area, haematuria that persists after the bladder has been well washed out in an individual whose past history is negative, we are justified in giving treatment directed at such a lesion. If, in addition to these symptoms the patient rapidly developes signs of shock and hemorrhage with the rapid formation of a tumor about the injured kidney, a positive diagnosis may be ventured.

Prognosis.—The prognosis likewise will depend upon the given case. Authors generally have been led to suppose that this class of injuries are fraught with more danger than the work of more recent investigators would confirm. In simple contusions and lacerations the prognosis is favorable. In the class attended by severe shock, hemorrhage, widespread infection, anuria, an unfavorable termination is seen in more than fifty per cent. of cases, although subjected to the most appropriate means of relief.

Treatment.—Bearing in mind that hemorrhage and extravasation of urine in and around the kidney, offers the principle obstacle to be combatted as well as inaugurating the complications mentioned above, the question of treatment resolves itself into the successful management of this one exigency. Hence, in simple cases, absolute rest in bed, strapping of affected side, application of ice caps, morphia and ergot hypodermically, the avoidance of purgation and vomiting, all directed at controlling hemorrhage should be at once instituted. As prophylactic measure against cystitis the bladder should be frequently washed out with normal saline solution. Little, other than this, need be done unless the case prove from the first to be of the most severe type. If collapse from hemorrhage or peritonitis seems evident, nothing short of surgical interference will give satisfactory results, and a free incision down to the bleeding tissues should be made at once, the hemorrhage controlled or kidney resected as is found necessary. If the peritoneal cavity has been contaminated with blood and urine the abdomen must be opened, thoroughly washed out and a short drainage established. When surgical treatment is indicated it would appear from a careful study of case reports that the best results are gotten in those where early interference has been resorted to, drainage being afforded ere perinephritic or peritoneal inflammation has begun. If, notwithstanding your efforts to prevent it, retained coagula with chronic cystitis develops, resort must be had to some form of lithotomy for removal and drainage. Immediately following the injury, if shock and collapse is present, various supporting measures should be used, such as strychnia, atropine, whiskey and heat. These must be discontinued, however, as soon as the condition requiring them has been somewhat overcome, as they favor hemorrhage. It may become necessary to use some form of diuretic, in which case the refrigerant, or irritating drugs, would be preferred, but even these should be avoided if possible. Since the injured kidney is incapable of performing its normal functions, placing upon one organ the work of two, the diet should be carefully watched, consisting principally of liquids until the efficiency of the remaining organ has been well proven.

The following case, requiring immediate operation, came under my observation June 28th, 1908:

Patient—J. M. C.; age forty-six; farmer. Injured 5 P. M. above date. Past History—Was born in Georgia, reared upon a farm, and has always been in good health, being noted as one of the strongest men of the county. Some

twelve years ago, while walking through the woods with an axe upon his shoulder, a falling limb from the top of a tree under which he was passing struck the axe, driving it forcibly against the right occipital region, producing a fissure fracture of the vault, accompanied by considerable concussion of the brain. After some weeks' confinement to the house, during which time patient gradually recovered from what at first appeared to be a very serious brain injury, he again assumed the duties of his farm, having made complete recovery. Operative measures were not indicated, the expectant plan having been pursued. Health at time of injury was good; had been well for many years, with exception of slight disturbance of digestion. Weight, one hundred and sixty-five pounds. Height, five feet seven inches.

History of Injury.—About 5 P. M. June 28th, 1908, patient was riding a bare-backed horse at full speed down a hard lane, trying to round up a calf.

On making a right-angled turn he was thrown with terrific force against the ground, the body being doubled upon itself upon alighting. An attempt was made to get up, but soon abandoned. Later, by the help of two of his children, he managed to get to his house, some hundred yards distant. I was then summoned.

Upon arrival, some twenty minutes after injury, patient was rolling from side to side of his bed, extremely restless, very pale, extremities cold and bathed in perspiration, complaining of feeling chilly. The pulse was at first imperceptible, but soon became evident, observed to be weak, of very feeble tone, and about eighty-five per minute. Respiration caused pain, and was, therefore, jerky and restrained. Nausea and vomiting quickly ensued; patient complained of marked pain about the junction of eleventh and twelfth ribs with spinal column, and from thence to the iliac crest on right side. All over the right kidney region palpation was very painful and the tissues boardlike. The right hypochondrium was also resistant and painful to the palpating hand. The skin was not bruised, not even an abrasion to be seen, save on right side of face over malar bone, where an area size of the half-palm was noted. The left wrist was slightly sprained. Further than this nothing was made out worthy of notice. Morphia and strychnia were administered hypodermically to control pain and quiet the patient. There was no desire to urinate immediately after injury, but later patient called for urinal, only to strain without voiding.

One hour after arival, patient's pulse was ninety-six, more feeble, vomiting was persistent, expression bad, collapse more marked. A catheter was now introduced into the bladder, when bright-red blood escaped in large quantity. The bladder was next dilated and found to hold water. The kidney region was more resistant by this time, the hardness extending over the whole right abdomen. Patient complained of inability to get breath and great thirst. A diagnosis of ruptured kidney with intraperitoneal hemorrhage was now made and steps looking towards surgical help were taken. Being more than twenty-four hours removed from well-equipped hospitals, in addition to the precarious condition of the patient, which was hourly becoming worse, it was determined to operate upon him in his home with whatever aid could be summoned.

It was noon the following day before all preparations were ready. Every hour had witnessed the rapid sinking of the patient; haematuria had continued well marked. A tumor was easily made out about injured kidney. The abdomen was dull to percussion, painful all over to palpation. Patient was semi-comatose; pulse, one hundred and forty; respiration, ten (due to morphia); temperature, one hundred and three-fifths. Vomiting had become more frequent; collapse well marked.

Operation.—After a distinctly rural operating-room and equipment had been prepared, there being marked abbreviation, both in quality and quantity of instruments and dressings, with the aid of three other physicians, two or three laymen acting as nurse, the patient, now moribund, was placed upon the table. The right kidney was hastily exposed by the ordinary lumbar incision. It was found imbedded in and surrounded by blood, its capsule being stripped off by its extravisation. A rent partially dividing the kidney into two halves, extending into the kidney pelvis, was made out by the palpating hand. The patient's condition being such as to demand the quickest disposition of the condition at hand, it being necessary already to heroically stimulate by strychnia and whiskey, hypodermically as well as normal salt intravenously, clamps were placed on the renal vessels, the ureter severed and the

kidney removed. The clots of blood surrounding the kidney having been removed, the cavity was packed with gauze and the wound partially sewed up. As an index to the degree of exsanguination present, I need simply mention that it was unnecessary to ligate or clamp a single vessel save the renals.

Now the patient was hastily turned on his back and the abdomen opened. The peritoneal cavity contained several hundred cubic centimeters of blood fluid, which was washed out with normal saline solution.

Drainage wicks were again placed, and both wounds dressed. After some twenty minutes' work, directed at overcoming the shock, which was now alarming in the extreme, the patient was removed to his bed, showing signs of slight reaction.

After Treatment and Convalescence.—Stimulation was kept up and pushed to point of intollerance. Repeated infusions were given. Slowly response became evident, the pulse gained in tone and rythm. Urine was soon voided and contained only a trace of blood. No post-operative vomiting. The day following operation found the patient in an encouraging condition. Mentally good, urine voided in sufficient quantities, no further signs of bleeding. Pulse fairly strong, regular and running about one hundred to the minute. Wounds draining nicely. No evidence of peritoneal inflammation.

On the third day the wounds were dressed, clamps removed and the cavities repacked. Convalescence was at this time well established. The daily output of urine was normal in amount and constituents, save a decided ring of albumin, which was explained as a "Congestive Albuminuria," and which soon disappeared. Patient began eating, the nourishment confined altogether to liquids. Bowels moved normally, pulse came down to eighty-five; temperature remained around normal, reaching one hundred only twice or three times during convalescence. Patient was urged from the first to drink large quantities of water. Notwithstanding this and the preliminary bladder irrigation, a mild degree of cystitis developed about the tenth day, causing considerable temporary trouble, but was quickly controlled by the use of twenty grains of hexamethylinamine per day, gradually decreased. This, a slight annoyance, was the only complication noted during the eight weeks' indoors. Following this, his recovery was uninterrupted, and at present almost complete. Daily dressings of wounds witnessed rapid healing. Patient was kept in bed five weeks, then allowed in a reclining chair. At the end of six weeks was put on his feet.

At present patient is going about his farm free from pain or inconvenience, save slight weakness of right side, from which he is daily recovering. A small sinus still remains at seat of incision in lumbar region, but is rapidly healing. Abdominal wound is well. Now, eight weeks since the injury, patient presents a most gratifying appearance, his mode of life a little changed from that preceding the fall, save the inability, of course, of performing manual duties.

I want especially to invite attention to the following facts concerning this case:

First—The severity of the lesion found, there being no adjacent structures involved.

Second—The apparent absolute indication for operation at once under rural handicap, it being considered impossible to transport the patient alive to the nearest hospital.

Third—The absence of infection, although the perinephritic space and peritoneal cavity were both contaminated with urine, to be explained, perhaps, by the early establishment of drainage.

Fourth—The marked albuminuria which developed early after operation, only to gradually disappear as the compensatory action of the sound kidney was established.

Finally, I wish to acknowledge my indebtedness to Dr. A. C. Hoyt, of Waycross, and to Drs. D. H. Meek and S. L. Vinson, of Nicholls, Ga., for most valuable assistance, without whose cooperation in this emergency little worthy of note could have been accomplished.

*Read before the Coffee County Medical Society, Douglas, Georgia, in Regular Session, September 1st, 1908.

A CASE OF GENERAL PERITONITIS, FOLLOWING ABORTION, WITHOUT UTERINE INFECTION.

By Hugh W. Brent, M. D.,
Instructor in Gynecology, University of Maryland

So frequent is the induction of abortion that it is, indeed, wonderful that so few cases come to our professional notice as the result of serious complication. The total disregard of asepsis and

the crudity of method with which the average abortion is accomplished would lead one to expect a high percentage of septic infection. The fact remains, however, that infection is rather uncommon, and when it does occur, is usually found in association with a very frequent complication—incomplete expulsion of the products of conception. The resisting powers of the uterus in this regard have surely been underestimated. In spite of the fact that it offers an almost ideal culture medium for the growth of organisms, it is as a rule fully able to successfully cope with bacterial invasion when not handicapped by the presence of susceptible nonresistent placental debris. Conservatism in the management of incomplete abortion is dangerous. Aseptic curettage, *gently* and properly performed, is a faultless surgical conception of the proper course to be pursued. The procedure is without danger and removes *at once* an element which Nature, ever alert in her own behalf, is vainly endeavoring to eliminate. The case considered in this paper is of interest for several reasons. First, the abortion was absolutely complete, the 2½ months' foetus, membranes and placenta being expelled *en masse*, in toto. Second, the cause of abortion, if true, is rather unique, so unique that one accepts it—*cum grano salis*. Third, uterine infection was not clinically evident—if it did exist in a mild form, it was seemingly of secondary importance. Fourth, it aptly illustrates traumatic uterine perforation and the possible serious result of such injury.

Gynecological No. 1678, University Hospital, was seen in consultation with Dr. W. W. White a few hours after complete abortion. She presented the following picture: Facies anxious, respiration entirely thoracic, knees drawn up, diffuse abdominal pain, general abdominal tenderness, entire musculature rigid, pulse 130, temperature 101 degrees. She had been awakened during the night by lancinating abdominal pain, followed in a few hours by expulsion of the foetus. Peritoneal symptoms developed coincidently with the labor. Two days previously she had been taken sick with a chill; temperature 100 degrees; some nausea, slight jaundice and general muscular aching. She had at this time no abdominal symptoms, nor did careful examination of the abdomen reveal anything of moment. She was given calomel and quinine, and improved to such an extent that the next day she wanted to get up to do her work, but was advised to remain in bed. Early the next morning the abortion occurred, much to the "patient's surprise," as she was nursing a child and "had no idea she was pregnant."

She was removed to the University Hospital. Her condition on arrival being such as to contraindicate immediate operation, she was treated after the method of Ochsner. Improvement was steady and on the tenth day the peritonitis had distinctly localized in the left iliac fossa. Laparotomy revealed the following condition: Perforation in the fundus uteri, the uterus being adherent at this point to the anterior abdominal wall. With the exception of the perforation, the uterus was apparently normal, firm in consistency and only slightly larger than usual. Recent intestinal and omental adhesions walled off two definite abscesses, one in Douglas' cul de sac and one in front of the uterus on top of the bladder; the left tube and ovary were infiltrated and densely adherent. Left salpingo-oophorectomy was performed and the abdomen drained, suprapubically with iodoform gauze, vaginally with rubber tube. There was immediate subsidence of all symptoms, followed by uneventful recovery. When told of the perforation the patient immediately attributed it to a vaginal douche, taken a few hours before the first symptoms made their appearance. Though it is hard to believe that the uterus was perforated in this way, it comes within the range of possibility.

According to the 102d annual announcement of the School of Medicine of the University of Maryland, the Honorable J. Wirt Randall, Philemon H. Tuck and Thomas Fell, Ph. D., LL. D., D. C. L., have been elected to the Board of Regents of the University of Maryland as representatives of St. John's College, School of Arts and Sciences. We also note that as Chancellor, Hon. Austin L. Crothers, LL. D., Governor of Maryland.

Dr. Charles Bagley, Jr., class of 1904, superintendent of the Hebrew Hospital, East Monument street, Baltimore, has returned to the hospital, after spending two weeks in New York. While in New York Dr. Bagley inspected several hospitals to gain ideas for the new addition to the Hebrew Hospital.

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EDITORIAL.

THE WORK OF THE HOSPITAL IN CONNECTION WITH THE CARE OF THE SICK POOR OF THE CITY. —There is scarcely a public hospital in any of our larger or smaller cities which does not care for large numbers of the sick poor of these cities. The work which these institutions are doing for suffering humanity is not fully understood and is poorly appreciated. The city authorities and the public know but little of the extent and value of this work, and are fully contented when they have paid to these institutions small annual appropriations to assist in their maintenance. The burden and responsibility of caring for the city poor falls upon the hospital management. Many worthy institutions are kept poor through their efforts to care for the unfortunate cases which are assigned to them by the city authorities. The few institutions which have endowments are able to escape the burden which is imposed by necessity upon the unendowed hospitals. In the case of the latter class of institutions even the small appropriations made by the city authorities are necessary to their support. They must exist or go out of business. The measure of existence is determined by the question of management. In the most frugal way they carry on their work at all times, doing their best to care for their dependent inmates.

It is well known to all hospital managers that the expense of caring for the sick has increased from 25 to 50 per cent. per capita per day during the past few years. The single item of surgical treatment and supplies has added over 50 per cent. to the cost of maintenance of surgical cases. It is through surgical work that humanity has been most profitably benefited. Lives are now saved which only a few years back were lost; invalidism is removed in many cases and health restored to those who in former years were not only sufferers, but who were dependents upon charity for means of living. The financial side of hospital work is seldom viewed from the standpoint of public investment. This humane work is only regarded as a public burden and necessity.

Notwithstanding the fact that the hospital is doing a noble, unselfish work in the interest of the public, that the expense of this work is adding more and more to its poverty and burdens, in but few instances have these facts been recognized by the authorities who govern our municipalities. Here in Baltimore the same allowance per diem for the care of the city poor in the hospitals which receive this class of patients is made today as was made five or ten years ago, and the increase in the allowance is only twenty-five cents a week more than it was thirty years ago.

There is not a hospital in this city which is not losing in dollars and cents as much per diem as it is receiving from the city. The institutions could not exist but for the fact that the most rigid economy prevails in management and the returns from private cases made to equalize the loss on the city poor. The pay patient and the attending surgeon and physician are charged with the expense of maintenance, which properly and more generously should be borne by the taxpayers, who are responsible to society for the proper care of the sick poor.

In this connection the BULLETIN quotes from the *National Hospital Record* (August, 1908), which presents this question in a fair and frank light:

"At various times in the past *The Record* has called attention to the spirit of unfairness shown by cities to hospitals in connection with the care of the city sick poor. The topic is well worth referring to again. Public sentiment demands the admission of the sick poor to the hospitals, and the compliance with the demand largely increases the hospital's needs. In many instances the hospital must bear the burden entirely unaided by the city funds. Is it right that this condition of affairs continue? Ought not a city and its citizens be liberal with its hospitals and pay them a fair remuneration for the care of its sick

poor? No such institutions should be compelled to use their own earnings to defray expenses of this kind. Money should come to them freely. All hospitals are so useful if properly managed that they plead their own merits more eloquently than words can speak for them. The men and women who have found them citadels of defense in time of peril are an ever-growing army of witnesses to their usefulness and their claim upon public-spirited citizens. It is better understood now than it was years ago that there is no place within the reach of the average sufferer from disease or accident which affords such opportunities for quick and sure recovery as a good hospital. There nurses and physicians are always ready for emergencies. There the best appliances are kept in the best condition for immediate use. Hospital needs are manifold, especially those institutions that are run in a public-spirited and humane way—not for money-making—but to use its resources to the utmost in doing good and relieving the sufferings of the sick. Such institutions should receive liberal treatment by city and citizens, for the larger their income the more good they can do. The more they are given the better they serve the communities which support them."

Session of 1908-09 at the University.—Before another issue of the Bulletin has made an appearance the Session of 1908-09 at the University of Maryland will be well under way. We learn from the Dean's office that the inquiry for catalogues and information, the correspondence of the office and the advance guard of students are all larger than for any previous year. All the indications point to larger classes of medical students for the coming session. The work of preparation for these students is well in hand, and the machinery, when it begins to move, will, we believe, work without friction.

The Bulletin takes this opportunity to make a few suggestions, which will be received, it trusts, in the spirit in which they are given. What is needed around the old University is a spirit of optimism, of unselfishness and of energetic loyalty. The teaching body needs the stimulus of unity of purpose and of closer co-operation in its work. In the lecture hall, laboratory and clinic many old methods and ways of teaching should be cut out. The course of instruction should be modified and so condensed as to eliminate much that is parallel. The aim of each teacher should be to get at the practical and useful, to lay aside the matter which belongs to the junk shop. To make good students the teacher must arouse an interest in the subject taught. Sleepy heads and empty benches will always be in evidence when the teacher is not wide awake himself. Sensation and fake have never had any standing at the University. They are not wanted now. What is wanted is an energetic, earnest, wide-awake presentation of subjects taught, a direct and practical method of imparting knowledge. It is not the ultra-scientific formula, the latest idea or the newest creed that meets the needs of the student. The good old things which lay at the foundation of the students life's work, the training of his faculties of observation, of reasoning and of thought, the creation of an abiding interest in his work—these are the daily lessons which the teacher should impart.

It would greatly aid the work of the teacher if he could be brought into personal contact with the student. While this is not possible in all cases, it is not impossible for every teacher to see and know more about the work and habits of the student. Medicine in the future must be taught in a more personal way. In the laboratory, lecture-room and clinic the student and teacher must be brought to see the same thing at the same time. The direct way of imparting knowledge must enforce the direct reception and understanding of facts and principles taught. To see, feel and handle stimulate every sense. The modern system of instruction in medicine and surgery must follow the practical and direct system which is now in force in the treatment of all forms of disease. The complicated machine which we call the human body has many parts and functions. To understand its many parts, to know its complicated functions, is a practical, not a theoretical study. The correction of defective parts of the machine, or the understanding of its discordant functions are practical subjects for study. The teacher must bring to the mind of the student a thorough understanding of the parts of this machine and its functions in its normal as well as abnormal conditions. This knowledge must be imparted in the laboratory, in the lecture hall and in the clinic. The treatment of this machine in its abnormal condition is the aim and end of medicine and surgery. The clinic is then the place of chief importance, of

last resort in the education of the medical student. His observation and studies at the operating table, at the bedside and in the autopsy-room go to complete his equipment for the practical work of his profession. Here he stands or falls in his work of conquest with disease. It is in the clinical work of his profession that his educational training is subjected to its most rigid test.

The great aim of the Medical Department of the University of Maryland is to make skillful practitioners of medicine and surgery. It is in this field that the University most excels. Her facilities for clinical instruction are as good as the best. It is up to her clinical teachers to make use of these resources and to equip her students for the responsible duties of the practitioner of medicine and surgery.

The relation of the student to his teacher and to his fellow-student is a very important one. The teacher owes much to the student. The student owes something to his teacher. Unless the two are in accord the best results are not secured. The closer the contact between the two the better the results through association and friendly ties.

The relation of the student to his fellow-student is a most potent factor for good or evil in the student's life. The early associations and habits formed at the beginning of a medical career mean much to the young man removed from the influences of home and thrown into the excitement and novelty of the campus and classroom.

The character of the individual student will soon assert itself. Props placed under him at this time of life may render a most valuable service. The promise of student life is in the cultivation of class spirit and class pride. A well-organized student body, under strong and earnest leadership, should be the aim and purpose of every institution of learning. When men are brought in line and are fired with resolution and high ideals of student life, there are but few who will resist the influences for good presented to them. The University must look to her teaching body first, to her student body next, for the rank she will take in the educational world

Amalgamation of Alumni Associations.—The Bulletin is glad to announce the amalgamation of the General Alumni Association and the Dental Alumni Association. Last June there were four distinct and separate alumni bodies in the University, and if St. John's Alumni Association is included, five independent bodies. Today this number has been reduced to three, *i. e.*—the Medical Alumni Association, St. John's Alumni Association and the General Alumni Association, the reduction having occurred through the consolidation of the Pharmaceutical and Dental Alumni Associations with the General Alumni Association. This fusion of the interests of the alumni bodies merely marks the general trend of events at the University, and is, we think, the forerunner of the amalgamation eventually of the separate schools comprising the University of Maryland under a central governing body. It is the earnest desire of those who are engineering the consolidation of the alumni bodies to be able to report in the near future the union of the Medical Alumni Association with the General Alumni Association. Indeed, it is our fondest hope that the Alumni Association of St. John's College, Department of Arts and Sciences, University of Maryland, will eventually join their forces with the other alumni bodies. There have been great difficulties overcome in this welding of forces, but insurmountable as they appeared in the beginning of the undertaking, a common ground has at last been found, and the union, we are sure, redounds to the credit of all concerned in bringing it about.

There are no tenable grounds for the Medical Alumni Association holding itself aloof from the movement. If it refuses to consolidate with the other associations, how can the members of that body hope to see the welding of the forces of the University under a central management? Remember the old axiom, "In unity there is strength." This applies to alumni bodies as well as to educational bodies.

Consolidated Medical Colleges.—Eighteen months ago Louisville had five regular medical colleges—The Hospital College of Medicine, the Kentucky University Medical Department, the Louisville Medical College, the Kentucky School of Medicine and the University of Louisville Medical Department. A year ago the Kentucky University Medical Department merged into the University of Louisville, and a little later the Louisville Medical College and the Hospital College of Medicine merged under the name of the Louisville and Hospital Medical

College. Thus there remained three colleges, which have since merged, retaining the name of the University of Louisville Medical Department. Here in Baltimore there are more medical schools than necessary. If the University of Maryland Medical Department, the Baltimore Medical College and the College of Physicians and Surgeons could find a way to consolidate their interests, great progress would be made in the simplification of the Maryland medical muddle. Among the benefits to accrue from such a consolidation would be the raising of the requirements for graduation, better equipped laboratories, the cutting down of the running expenses, that is, it would cost less to run the three schools as one than as independent schools. The calibre of the students would be better, because there would be more to pick from, and the flotsam and jetsam could be eliminated. Moreover, such a school would wield more influence in the community and would tend to bring their alumni together, a fact which we are beginning to realize more and more. In the educational world, as in the business, there has been in recent years a tendency to centralize their endeavors under a strong central head. They realize that more can be accomplished by a strong corporation than by a number of weak ones, floundering here and there in their endeavors to gain a livelihood. The same argument holds true as regards the three medical schools just cited. They could accomplish more united, would be under less expense, would give better returns to the student for his money, would exert a greater influence in the community, and would make as powerful a medical combination as any in the country. Amalgamation is the order of the day. Why not here?

CORRESPONDENCE.

FROM NEW ORLEANS TO GUATEMALA CITY.

GUATEMALA CITY, REPUBLIC OF GUATEMALA,
August 14th, 1908.

To the Hospital Bulletin:

Our steamer was scheduled to leave New Orleans at 10 A. M., but did not get off until 8 P. M., hence the trip down the Mississippi River was made at night and we could see nothing of the scenery, or the historic points of interest, or of the jetties at the mouth of the river. When we awoke we were out of sight of land and were dancing a jig on the Gulf of Mexico. A number of people concluded they did not want breakfast, and I did not feel hungry myself. The water grew calmer and it was very pleasant on shipboard for those who liked a seafaring life and a heavy diet. On Sunday we sighted the coast of Yucatan, which added zest to the voyage, and early the next morning we dropped anchor in the harbor of Belize, British Honduras. The weather had been fine and the voyage pleasant, notwithstanding we were in the tropics. Belize appeared very attractive as seen from the ship a mile or more from shore, with its white houses surrounded with the deep green of the tropical vegetation, with the water of the bay clear as crystal and a beautiful green. Soon we were surrounded by sail boats and motor launches, and whilst the cargo was being discharged we were allowed to stretch ourselves on shore. The town is really quite attractive, but its population is of various shades of black, the negroes being at least 100 to each white person. It is a British colony and seemed to be quite a bustling place, with good stores, schools and other concomitants of civilization. The vertical rays of the sun beat down pretty fiercely, but in the shade it was pleasant. Weighing anchor about 4 o'clock, the next morning early we were opposite Puerto Barrios, Guatemala, and soon were tied to the wharf. There were eight representatives from the United States en route to the fifth Pan-American Medical Congress, besides other passengers. Even before we reached the shore we received a message of welcome from the President of the Republic, and a special parlor car was placed at our disposal, and we were furnished free transportation to the capital. The country on the coast is hot and there is a dense tropical vegetation of cocoanuts, bamboos, palms and other growths, and the only cultivated areas seen were the banana plantations belonging to the United Fruit Company. The inhabitants are Indians in varying stages of admixture with the whites. They are mostly small, swarthy or yellow and not much for looks. They live in small houses, made of bamboo or split cane, with thatched roofs, and with little furniture, except hammocks for sleeping purposes. It is an ideal country in which to live, as it costs nothing to build one of these thatched houses, and five dollars would supply clothing for a family for a long time. A cotton shirt for a man, a pair of pantaloons of

similar goods and a coarse straw hat is proper costume for state occasions; on less ceremonious occasions the shirt is often dispensed with, and frequently the hat is the only article of apparel worn, except a big cigar. The native woman's costume is also very much abbreviated at both ends, and is sometimes conspicuous by its absence. As our train passed along the women could be seen standing in the streams, more or less in a state of nature, and doing the week's washing of clothes. The railroad has only been extended to Guatemala City for four months, and the ascent over the mountains is very precipitous, hence the trains do not make the entire distance in one day, but lay over at Zacapa for the night and finish the journey the next day. The trip across the mountains is very picturesque and beautiful, and we then reach the high platau on which the city is situated. This is nearly five thousand feet above sea level, and is always pleasantly cool and bracing, ranging from 65 to 70 degrees Fahrenheit, summer and winter. The soil is of wonderful fertility and will produce three crops a year with almost no tilling. The resources of Guatemala are enormous, and are still largely undeveloped. Bananas, coffee and corn are the chief products of the soil, though almost any kind of grain, fruit or vegetable will grow luxuriantly. Horses and cattle are raised in large numbers, as well as the other domestic animals.

Guatemala City is a town with about 80,000 inhabitants, and it is sometimes called the Paris of Central America. It does not resemble Paris in the least, however, but is a typical Spanish city, with low buildings of one and two stories height, with heavily barred windows and very plain exteriors. The houses are tinted in many colors, pink, blue, yellow, green and, in fact, in almost all the colors of the rainbow, which gives considerable variety and a pleasing effect. They are built around a patio, or court, which is open to the sky, and generally has a fountain and flowers or trees in it, and the rooms of the house are entered from a gallery or portico opening upon this court. On the inside the houses are spacious and comfortable. The streets are generally narrow and badly paved, though in the newer parts of the city wide and handsome avenues have been laid out. Little mule cars are in use, but most of the travel is done on horseback or in carriages. The natives take the place of the beasts of burden, and it is surprising to see the heavy loads carried on the backs of both men and women. The mountain Indians are very small and come from long distances into the city, carrying marketing and merchandise. They always go in a trot, and it is not uncommon for a little woman with a heavy load on her back and a baby on the load to trot along briskly, sometimes knitting or plaiting mats as she goes. They all go barefooted and wear scanty clothes, the skirt, which is a piece of cloth wrapped around them, barely reaching to the knees. Little donkeys and mules also are much used as beasts of burden, and droves of them are driven into the city bearing large loads of marketing and merchandise. The conditions of life are very different from those in the United States, and any one who desires change and recreation at a moderate expense is advised to make a trip to Central America, where he will find much to interest him.

RANDOLPH WINSLOW.

ITEMS.

Prof. Randolph Winslow has returned from his visit to the 5th Pan-American Medical Congress, held at Guatemala City, Republic of Guatemala. He went by way of New Orleans, the Gulf of Mexco and Puerto Barrios, and returned by way of the Pacific Ocean, Salina Cruz, Mexico City, Republic of Mexico and Laredo. He was away all told nearly five weeks and enjoyed his vacation immensely, the mode and conditions of life being entirely different from what he had ever seen. He has been kind enough to give us a series of papers of his former experiences in foreign climes, which have added to the value and popularity of the BULLETIN, and commencing last month is giving the readers of the BULLETIN an insight into the life, conditions and aspects of the Republics of Mexico and Guatemala as he was able to see them. The editors of the BULLETIN desire to extend their thanks to Professor Winslow for these articles and to assure him that they are greatly appreciated by its readers.

Dr. Henry Chandlee, class of 1882, of 742 West North avenue, Baltimore, is spending his vacation in Canada.

Dr. Thomas Edwin Latimer, class of 1907, is ill with typhoid fever.

Dr. Walter H. Mayhew, class of 1901, and Mrs. Mayhew have returned from their wedding trip and will reside at 1718 West Lafayette avenue, Baltimore, Md.

Dr. Dempsey William Snuffer, class of 1906, was a recent visitor to the University Hospital.

Dr. J. Knox Insley, class of 1907, was a recent visitor to the University Hospital.

Dr. George R. Sledge, class of 1903, was a recent visitor to the University Hospital.

Dr. C. W. Roberts, class of 1906, has located at Nicholls, Ga.

Among the recent visitors at the University Hospital were: Dr. William F. Sappington, class of 1901; Dr. S. B. Sherard, class of 1905; Dr. R. C. Carnall, class of 1905.

Dr. George W. Lewis, class of 1886, has been elected secretary of the Montgomery Country Club. He has also been appointed on the Board of Governors.

Dr. C. Urban Smith, class of 1889, has returned from his European tour.

Dr. Patrick F. Martin, class of 1900, has been elected president of the Ancient Order of Hibernians.

Dr. Henry M. Fitzhugh, class of 1896, of Westminster, Md., was a recent visitor to the University Hospital.

Dr. John Houff, class of 1900, has been visiting friends on the Eastern Shore of Maryland.

Dr. W. F. Curran, class of 1904, is an interne in the Colon Hospital, Canal Zone, Panama.

Dr. Charles Hardwicke, class of 1904, is located at Santiago, Dominican Republic, West Indies.

Dr. J. Clement Clark, class of 1880, has been re-elected superintendent of Springfield State Hospital for the Insane, Sykesville, Md.

Dr. John R. Winslow, class of 1888, is registered at Oak Grove House, Booth Bay, Me.

Dr. J. Frank Crouch, class of 1890, is at the Hotel Frontenac, Quebec, Canada.

Dr. Louis C. Skinner, class of 1901, is in New York, attending the Polyclinic Post Graduate School. Dr. Skinner is located at Greenville, North Carolina.

Dr. Oliver P. Penning, class of 1897, is spending three weeks at Rochester, Minn., following the work of the Drs. Mayo.

Dr. C. W. McElfresh, 1889, of Baltimore, is spending his vacation in Chicago.

Dr. R. H. P. Ellis, class of 1877, is at Ocean Hotel, Asbury Park, N. J.

Dr. Page Edmunds, class of 1898, of Baltimore, has returned home after a two-weeks' stay at the Ebbitt House, New York.

Dr. S. Lee Magness, class of 1902, of Baltimore, has returned home after an extended stay at Cockeysville, Md.

Dr. Henry M. Thomas, class of 1885, is at North Hadley, Canada, for the summer.

MARRIAGES.

Dr. Walter H. Mayhew, class of 1901, of Baltimore, was married Wednesday, August 5, 1908, to Miss Tillie E. Seipp, daughter of Mr. and Mrs. Frederick Seipp, of 1718 West Lafayette avenue, Baltimore. Dr. and Mrs. Mayhew will reside at 1718 West Lafayette avenue upon their return from their wedding trip.

Dr. Thomas Pugh McCormick, class of 1877, of 1421 Eutaw place, Baltimore, was married August 5, 1908, in New York City, to Miss Leonora C. Franklin, of San Antonio, Texas. Dr. McCormick has been married twice before. They were married at the Chapel of Grace Church, Rev. Mr. Edwards officiating.

Dr. Solomon C. Katzoff, class of 1904, of 116 Aisquith street, Baltimore, was married Tuesday, August 18, 1908, to Miss Yetta Berman, of Lancaster, Pa. The wedding took place at the home of the bride, Roosemore Hall, in Lancaster. Miss Berman is the daughter of Mr. and Mrs. H. Berman, of Lancaster. Dr. Katzoff is a graduate of the University of Maryland, Medical Department, class of 1904. The year following his graduation he was an assistant resident physician at the Hebrew Hospital, Baltimore.

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THE HISTORY OF SURGERY—AN INTRODUCTORY LECTURE TO THE COURSE IN JUNIOR SURGERY.

By Arthur M. Shipley, M. D.

The history of surgery is the biography of surgeons.

Ever since the existence of mankind on the earth there must have been some attempt at the practice of surgery. Accidents were possible in those far-distant days, and the women of the race surely made some effort to restore the members of their community to a condition of health. Be this as it may, the first records that we have of surgery as an art are found among Egyptian inscriptions. There are Egyptian records dating from about the sixteenth century, B. C., and much of the learning therein depicted had been traditional for centuries.

The Jews learned much of their surgical knowledge from the Egyptians, and as remote as the time of Moses, about 1500 B. C., records already existed showing some skill in a very crude surgery.

So for nearly a thousand years the Egyptians were the famous surgeons of the world. They traveled much and practiced on Arabians, Assyrians, Persians and Greeks. The Greeks during all these years were gathering the strength and culture that was to enable them to supplant Egypt as the leaders of thought and progress in the world. "They were the Yankees of that far-away ancient world," restless, roving and yearning after a more full and complete knowledge. So as time passed the center of surgical skill was transferred from Egypt to Greece. This was before the days of Hippocrates. Surgeons were valued because the Greeks were war-like, and he who healed a wound was honored among them.

This brings us down to the time of Hippocrates. Here lived a great man. His native place was Cos, near the coast of Asia Minor. He lived during the golden years of Grecian greatness. The battle of Volomis was fought about ten years before his birth, and the sixty years following this are spoken of as the Age of Pericles. He came of a family of physicians who maintained the best medical traditions of their time. They had absorbed all of the Egyptian knowledge of surgery of the thousand years preceding this, and this was considerable. "The Egyptians trepaned the skull, they performed circumcision, they removed superficial tumors, and they set broken bones." The Greeks added to this much that they themselves had learned. Now Hippocrates is thought of as a great physician, but he was a great surgeon as well, and a large portion of his works is given up to a description of surgical conditions and their treatment. This treatment was often surprisingly rational and reads very like a modern treatise at times.

Hippocrates was a great traveler and was familiar with the best surgical knowledge of his time. He was the first to accurately describe what he saw and to honestly report the results of his treatment. There was much surgical knowledge before his time, but he it was who first gave it form. He was a great clinical surgeon and a great surgical authority; so much so that his word was law until the time of Galen, five hundred years later. What man in these last five hundred years has had his statements unrefuted or his authority unquestioned? Not one; not even the great immortals.

After Hippocrates the next great milestone in surgical progress was the Alexandrian school. Here lived and taught Herophilus, he who named the torcular Herophili. The Alexandrians were famous anatomists, and after the decline of this school practically no further progress was made in anatomy until the time of Vesalius, nearly a thousand years later.

Half a millenium separted Hippocrates and Galen. What had happened during this time? Although surgery as a science made practically no progress, the world had been moving on.

Greece had lost her supremacy, Alexander had moved like a meteor across the world. Egypt had shown some repetition of her old-time greatness, but had again decayed, and a new center had developed in the west which was destined to be one of the mighty facts of history—the rise of the Roman Republic, which had already given place to the Roman Empire. The Jews had been scattered after the destruction of Jerusalem and a new and mighty moral factor had entered the world, for Christ had lived and died, and Christianity was already becoming a world question.

It was with this stage setting that Galen made his entrance. Here was another giant. He controlled medical thought for thirteen hundred years, until Vesalius dared to question his authority. He was the accomplished son of an accomplished father, and was by birth and training a Greek; for, be it remembered, that although the Greeks had long since lost their world supremacy in politics and war, they were still the leaders of thought. The Romans were too busy at this time conquering the world to have much time for science. Marcus Aurelius was Emperor, and knew and appreciated Galen. Medical ethics were bad in Rome at this time, and Galen's life was far from a quiet one. He was a great physician and surgeon and was a great physiologist as well. He almost made the discovery that placed Harvey among the immortals. He noted that the arteries contain blood and not air, and wrote that "the arteries and veins anastomose with each other throughout the whole body and exchange with each other blood and spirits by certain invisible and exceedingly minute passages." Even the great Harvey, fifteen hundred years later, did not know about this anastomosis. He knew and practiced the ligation of arteries, although it remained for Paré to apply this to vessels in amputation stumps.

Soon after Galen's death surgery languished. True, there are some famous names in the two centuries following him, but dark days were waiting for the world. Drunk with wealth and success, the Romans lost their sturdiness and the old tragedy of history was repeated. Licentiousness, ease and love of luxury had sapped the mighty Roman lion and the dark shadow of the northern hordes was hovering over the civilized world, and when the storm broke everything went down before it, the good with the bad.

"The rough, wild, clean-bodied barbarians had to be turned loose for centuries over the earth to sweep it clean, else had mankind expired of very rottenness."

After this came the long night of the Dark Ages, with some precious remnants of the old world kept and carefully guarded in the monastaries, and whatever our attitude of mind toward this wonderful church, nothing but deep thankfulness should be felt that so much was saved from the wreck and ruin brought by the Northmen. Then came the awakening, the Renissance, and Vesalius was a product of this time. He is a heroic and romantic figure in the history of surgery. Born in Brussels of good parentage, he was educated in the University of Louvain. He went up to Paris and became a pupil of Sylvius. Four years later he went to Italy, and soon after this when only twenty-two years old, he was given the chair of surgery and anatomy in the University of Padua. Here he worked industriously and became a great anatomist. He broke away from the teaching of Galen and found out things for himself, and immediately met with the most stubborn opposition. He published his *Structure of the Human Body* in 1543, and was so violently opposed that he gave up his chair and became court physician to Charles V. Many years later he went on a pilgrimage to Jerusalem, and died before his return at the age of fifty.

There was in him a perfect passion for dissecting, and it is told that when he went up to Paris to become a pupil of Sylvius he found him sitting and reading out of Galen with his students around, while one or two clumsy barber assistants laid bare certain structures in a rude way at his direction. Now Vesalius had a fair knowledge of anatomy at this time and had dissected many animals, and was so exasperated at the lack of skill on the part of the assistants that he took the scalpel and showed them how it should be done. He was a brilliant student, educated and a scientist. He had all the advantages of training, but he was not a clinician, and in this respect he differed widely from the great Ambroise Paré, who was four years his senior. Paré began his surgical life as a barber surgeon, a surgeon of the "short robe," the lowliest of the lowly among those who followed medicine as a vocation. That was his beginning. How about

the end? He died when he was eighty years old, the greatest clinical surgeon since Hippocrates and the best-loved man in France.

Vesalius and Paré saw something of each other, and they probably consulted over the deathbed of Henry II. of France. Sylvius taught them both. Paré was twenty-three when he went to Paris, where the plague was then raging, and he was almost immediately appointed resident in the Hotel Dieu, a hospital famous then as now and already nine hundred years old. The tale of Paré's life is an attractive one. He established himself in Paris, but spent a large part of his time at the wars. These were stirring times. He lived during the reign of five kings of France, saw the Massacre of St. Bartholomew and lived to see the Bourbon King, Henry IV., sometimes called Navarre, ascend the throne after Ivey. He had a tremendous influence on the clinical surgery of his day, and was a clear-headed, practical surgeon, who followed rational lines. He revolutionized the treatment of wounds. He possessed a wonderfully attractive personality, and was the friend and adviser of kings and generals, and at the same time the idol of the soldiers. "He loved the common people, but did not hate their rulers."

The great men in surgery have, in a measure, been the product of the dominating race at their particular time. First Egypt, then Greece, then Rome, and, after the long night, France, and now the balance of power was shifting to the little island in the North Sea, which was destined to be the birthplace of as mighty and powerful a race as the world has ever seen. So John Hunter lived and taught in London. He was born a Scot, and had few advantages of education when a boy. He was rough, rugged and intolerant. His youth had not always been spent to the best advantage. He had an older brother, William, ten years his senior, who was established and successful in London, and John, when he was twenty, went to London and became an assistant in his brother's dissecting-room. Here he worked and laid the foundation for his remarkable knowledge of human and comparative anatomy. He became a pupil of Percival Pott and was appointed house surgeon at St. George's in 1756. His brother entered him at Oxford in 1755, but he did no university work. Years after, when Jessie Foot attacked him for his lack of knowledge of the classics, Hunter said: "Jessie Foot accuses me of not understanding the dead languages; but I could teach him that on the dead body, which he never knew in any language dead or living."

All this brings us up to the time when he was thirty-one, when his health broke down. He went with the troops to the wars, and returned to London when he was thirty-five to establish himself. He possessed a short allowance, but splendid courage. He proposed to make surgery his life work, and began by teaching anatomy and surgery to private classes. He was probably most at home in this work. He did not like formal lecturing, and began each lecture with embarrassment.

Scant practice did not leave him idle, as he went on at once with his studies in comparative anatomy, and the work he did in this line alone would have made him famous. At his death his museum contained 10,563 specimens, illustrative of human and comparative anatomy, pathology and natural history. Soon after his death it was purchased by the government for $75,000 and presented to the Royal College of Surgeons in London.

John Hunter was one of the great creative geniuses of medicine. Fundamental work was his forte. "He saw the meaning of science more clearly than any man who had lived." He was a man of great industry and the boldest and best operator of his day. He was the greatest anatomist of his age, and a great biologist as well. The work done by this man is almost past belief. He was a pioneer in many fields. Lectures, essays, letters, reports and descriptions of original work flowed from him all these years.

Probably his greatest fame as a surgeon rests on his ligations of arteries proximal to the heart for the cure of aneurism, and he came upon this discovery directly as a result of animal experimentation. He had had a buck caught, and tied one of the external carotids to see what would happen to the antlers on that side. He found that the wound healed and the antler remained warm and alive. He thought the ligature must have slipped, so he killed the animal in order to find out what had happened. To his surprise the blood had gone around by anastamosis. Soon after a patient came in St. George's suffering from aneurism of the popliteal artery. At that time one of two things

was done—either the vessel was tied above and below and the sac dissolved out or the leg was amputated. Hunter tied the femoral artery in the canal since called Hunter's, and the patient got well.

He was possessed of an irascible temper, and during his last years was in ill health as the result of a body drawn to the very brink by an overwhelming will. The manner of his death makes a tragic and pathetic scene. A rule passed by the governors of the hospital seemed to be aimed at him, and he went to a meeting of the board on the 16th of October, 1793. It is told as follows: "Arrived at the hospital, he found the board already assembled, and, entering the room, presented the memorial of the young men and proceeded to urge the propriety of their being admitted. In the course of his remarks he made some obervations which one of his colleagues thought it necessary instantly and flatly to contradict. Hunter immediately ceased speaking, retired from the table, and, struggling to suppress the tumult of his passion, hurried into the adjoining room, where, with a deep groan, he fell lifeless." So died in this tragic manner the first, and, up to his time, the "greatest English-speaking exponent of proper scientific research. He is the father of us all, physicians, surgeons, laboratory students, for he wrought mightily in many fields."

This brings us to the beginning of the nineteenth century and almost down to our own time. One lesson is taught us by all these mighty men, and that is the lesson which teaches the value of work. Not one of them reached the success he attained except through the medium of hard and well-sustained effort. Their lives are still another proof of the truth of the definition of genius sometimes given: "That genius is the ability to take infinite pains."

INCUBATORS AND INCUBATOR CHILDREN.

By James A. Hughes, M. D.,
Assistant Resident Physician, Maternity Hospital, University of Maryland.

Improvised incubators have been in existence for many years, but about the first to do good work was opened and operated at the Victoria Era Exposition in 1897. These were operated by the same people who are operating in the different summer resorts at the present time with so much success. They had a fair amount of success at this first hospital. The first successful incubator hospital opened in the United States was operated at the Omaha Exposition. They have been improving their hospitals until they have a number of large and very well-equipped hospitals throughout the country. One of the very good things about these hospitals is that they do not charge any fee for the rearing of these children. But I am sorry to say that, in order to keep these institutions in good running order, admission is charged to visitors. The majority of people think that the incubator does all of the work toward the rearing of children prematurely and weakly born. This is far from being true, for the temperature, moisture and pure air must be regulated. In order to have good success in rearing these children the institution should have a well-equipped nursery, where the child can be attended to in the proper manner. A well-equipped nursery should consist of a well-kept linen cabinet, usually made of glass or metal; a large, softly padded table for attending the infants, a small metal bathtub and a very delicate scales. No nursery is complete without a good set of scales. A wet nurse should always be kept near the nursery, so that the child can be fed at the proper time. Everything that is used should be kept clean, and if possible in glass cabinets. There should be experienced people in attendance at all times. Hospitals, as a rule, may not have the success that private institutions have in rearing these children, because they do not have the proper facilities. An incubator can be made very cheaply, and will do as good service as a very high-priced apparatus. They are usually made of nickel-plated iron, glass or tin. Glass is without a doubt the best material, on account of being the best to clean, and not having many crevices for the lodgment of bacteria. A regulation size incubator should be about 26 inches in height, 24 inches in depth and 22 inches in width. Some of the most important features of an incubator are the regulation of temperature, the supplying, filtering and purifying, as nearly as possible, of the outside air. The heat is supplied by the hot-water system, coils of pipe being placed in the lower part of the incubator, and leading to

a boiler which is attached to the outside of the apparatus. These boilers are usually lined by fire clay. An ordinary Bunsen burner is sufficient to heat the water. A gas heater or a kerosene lamp may be used.

The temperature is regulated by a very delicate thermostat on the inside of the incubator.

In order that an attendant may regulate accurately the temperature of the inside chamber, the thermometer should be conveniently arranged. The supply of air is brought from the outside and forced through large pipes by a fan. Before the air enters the incubator it passes into a small, square metal box, which is attached to the side of the apparatus. In this box the air is filtered by passing through cotton and gauze, and it is purified to a certain extent by passing over an antiseptic solution. It is then ready to pass into the lower part of the incubator, where it strikes a flange and the cool air is spread over the hot pipes in all directions, thus making the air warm before it reaches the subject, which is lying on a wire frame bed above these water pipes. The air then passes through an outlet pipe, which is on the top of the incubator.

On the top of this outlet pipe there is a small whirligig, which is continually forced around as long as there is a complete circulation of air. This is an index of good air circulation. The moisture is also an important feature. There should be a tray of water in the bottom of the incubator at all times in order to help keep the moisture of the apparatus as nearly normal as possible.

The Preparation of Baby for Incubator.

One of the first things that should be done to the child when brought to the incubator department is to bathe it thoroughly, being very careful that the water is warm enough not to lower the temperature of the child. He should then be prepared as all children are. After he is dressed in regulation clothes he should be fed by mother's milk. If he cannot retain mother's milk, brandy water is very good for a few feedings. He is then placed in an incubator at a temperature of 90° F. The temperature of the apparatus is then regulated to keep the temperature of child as nearly normal as possible.

Feeding of the Infant.

The feeding of a premature baby is without a doubt the hardest battle that the physician and the nurse has to fight. Premature children should be regulated as to the quantity of milk just as any other baby.

If the baby be very weak, a drop or two of brandy at each feeding is very helpful. When a baby is to be taken out of an incubator he should be carefully wrapped in a blanket while yet in the incubator. The room in which he is fed and attended to should be so arranged that there will be no draught. At each feeding the clothes should be changed, if necessary. To feed a baby properly they should be weighed before and after being put to the breast, as this is the only sure way of knowing how much milk a child receives at each feeding. The child should be fed every second hour in the day and every third hour at night. All children should be attended to and dressed on softly padded tables, as it is much easier to handle a child and there is no danger of injuring his delicate framework. An incubator child should not be bundled with a whole lot of superfluous clothes.

In regard to rubbing children with oil, it may be all right for children who do not get sufficient nourishment from milk, but for the ordinary premature infant the cleaner he is kept the healthier he will be.

Bathing.

There is a wide difference of opinion as regards bathing of children. We have had good results with our babies, and every one, regardless of age or period of gestation, have been bathed every morning. The temperature of the water used has ranged from 98° to 100° F., all depending upon the vitality of the subject to be bathed.

Results.

During the past ten months we have had some very interesting cases, sixteen in all, and we have saved 66 2-3 per cent. of these cases.

The following is the gestation period, weight and result, with remarks:

Gestation period.	Weight.	Result.	Remarks.
36 weeks	2230 Gms.	Lived	Delivered.
32 weeks	2100 Gms.	Lived	Normal delivery.
37 weeks	2330 Gms.	Lived	Normal delivery.
28 weeks	1480 Gms.	Died 2d day.	Precipitate labor.
31 weeks	1440 Gms.	Lived	Breech presentation.
36 weeks	2200 Gms.	Lived	Normal delivery.
40 weeks	1820 Gms.	Lived	Induction of labor—Eclampsia.
32 weeks	2220 Gms.	Lived	Induction of labor—Toxemia of Pyung.
32 weeks	1410 Gms.	Lived	Normal labor caused by fright.

28 weeks	1310 Gms.	Died in 24 hours, caused by injury.
24 weeks	900 Gms.	Died in five hours. Induction of labor toxezing.
31 weeks	1920 Gms.	Lived Normal delivery.
35 weeks	2200 Gms.	Lived Normal delivery.
30 weeks	1500 Gms.	Died in the 40th day. Septic infection.
30 weeks	1900 Gms.	Died in 24 hours. Eclampsia.
26 weeks	1115 Gms.	Died 3rd hour. Eclampsia.

In the comparison with the results of large incubator hospitals with which I am familiar we have as good a per cent. of recovery as they.

Some Interesting Cases.

Baby No. 1—One interesting case which we have in the hospital at the present time was delivered at about a gestation period of 32 weeks, weighing 1,500 grams. It was brought to the hospital on the day after the delivery in a chilled condition. The baby was immediately placed in hot water, 100° F., until it was thoroughly warmed and the circulation in fair condition. It was then placed in incubator, the temperature being 90° F. The child was fed on mother's milk, but could not retain it. The mother's milk was then diluted with four parts water, but the stomach of the child seemed to be in too weak a condition to retain it. It was finally fed on sterile water, two or three drops at a time, with the nasal spoon, and was able to retain this. The child, however, lost 282 grammes in 16 days. He then kept the same weight for four days. Mother's milk was gradually substituted for the water. The quantity of milk has been increased from two drachms each two hours to ten drachms each two hours. The baby is now 81 days old and weighs 2,190 grammes.

Baby No. 2—Was delivered by pubiotomy at 36 weeks gestation period and weighed 2,230 grammes. His stomach was in a very weak condition, and, as in the majority of cases, it could not retain mother's milk. He was fed through the nose with the nasal spoon one drachm of sterile water with two drops of brandy. He was gradually able to retain small portions of diluted milk. He finally retained and digested mother's milk, on which he gained rapidly.

Baby No. 3—This case labor was induced on account of loxemia of pregnancy. It was 32 weeks intrauterine gestation and weighed 2,220 grammes. She was placed in the incubator at a temperature of 90° F. and fed on mother's milk. Did not gain for a week, but after that she gained in weight very rapidly. She is now four months old and weighs 14 lbs.

Baby No. 4—One of the most difficult cases I have ever seen, was a little colored baby, born in the hospital by breech presentation. He was 31 weeks intrauterine gestation, and weighed 1,440 grammes. As soon as the child was delivered he was resuscitated by the hot and cold water method. This child immediately developed convulsions. When he was in fair condition he was prepared for the incubator. He was fed on mother's milk and did very nicely till the fourth day, when he had 15 convulsions. He was kept in hot water almost continually. These convulsions lasted for three days at different intervals. He was finally taken home with the mother in fair condition, and at that time he had gained about 200 grammes.

SOME INTERESTING THROAT CASES.

By Richard H. Johnston, M. D.,
Lecturer on Diseases of the Throat and Nose, University of Maryland, Surgeon to the Presbyterian Hospital.

Case I.—A Large Calculus from Wharton's Duct. During the past summer I was consulted by Mr. O. H. C. for a swelling in the right floor of the mouth, which he had discovered accidentally a few days before. He complained of no pain. On examination a hard, elongated mass was found extending from the submaxillary gland along Wharton's duct. The opposite side was normal. The submaxillary gland was slightly sensitive to pressure, as was the hard mass in the floor of the mouth. There were no other symptoms. From the location and the consistency there was no doubt as to the diagnosis of calculus in Wharton's duct. In order to remove the stone an unusually long incision had to be made. As is usually the case, it was intimately adherent to the walls of the duct and had to be dug out with a curette. The calculus measured ⅞x⅝x⅜ of an inch and weighed 28 grains. It seems remarkable that such a large stone could remain in the duct for any length of time without causing symptoms.

Case II.—Tumor of the Larynx removed by Direct Laryngoscopy. Mr. M. G. B., lawyer, 50 years old, had suffered from hoarseness for three years, which, at first a mere huskiness of the voice, had gradually grown worse until he was

forced to give up practice in the courthouse. From time to time he had consulted specialists, who made different diagnoses as to the cause of his trouble. In Atlanta he was given sixty treatments with the X-ray, with no benefit. Being a man of more than ordinary intelligence, he had gotten it into his head that he was suffering from Sarcoma of the larynx. He had read several medical works on tumors of the larynx, and could discuss benign and malignant growths intelligently. Before coming to Baltimore he had been told that any operation on his throat would be most formidable and bloody. When the patient came into my charge he was in such a condition from a prolonged debauch that careful treatment for four days was necessary to quiet his nerves and to get him in condition for examination. The appearance of the larynx was as follows: The posterior wall was thickened by epithelial proliferation; both cords were red and thickened and in the anterior subglottic space a tumor could be seen extending backward for about a quarter of an inch. The growth was so close to the left cord that in phonation it did not reach its normal position in the middle line.

The epiglottis was low and broad, making the examination difficult. In view of the facts that the epiglottis was in an unfavorable position, that the patient was nervous and that the tumor was below the cords, it was decided to try to remove it by direct laryngoscopy. Though the patient had a short, thick neck, the middle incisors were small and he was able to extend his head well. After a course of bromides and morphia-atropia hypodermically, the throat was cocainized and a good view of the larynx obtained. With Pfau's universal handle and cutting tips the growth was successfully removed, as was the thickening on the posterior wall. Twenty-four hours later the voice was better and the larynx, aside from the chronic inflammation, looked well.

Case III.—A Laryngeal Tumor removed in the left lateral position. In the month of July of this year a girl, 21 years old, came to the Presbyterian Hospital complaining of hoarseness of several months' duration. Five years before a papilloma had been removed from the anterior part of the larynx. In June two attempts at removal at another hospital were only partially successful. A piece of the growth was removed at the first sitting with Krause's forceps. The patient then became so nervous that a second and third attempt with the mirror were not productive of any results. Direct laryngoscopy was then tried with no success. Having just gotten a set of Mosher's instruments, I proposed that we try to remove the growth under ether anesthesia. Her consent was readily obtained. She was anesthetized, the head turned to the left, the chin flexed and the instrument introduced. The larynx was soon brought into view and the growth removed.

Case IV.—C. B., 69 years old, was referred to me with the diagnosis of impermeable stricture of the œsophagus. Attempts to pass the smallest bougie by the old method had not succeeded. The patient was a most unfavorable one for examination. He was markedly round-shouldered and the anterior muscles of the neck were contracted so that it was impossible for him to extend the head sufficiently to bring the mouth and the œsophagus in the same straight line. Morphia and cocaine were used and Jackson's separable speculum introduced until its entire length of eight inches was below the teeth. Force had to be used to pull the cricoid forward. At the lower end of the speculum we saw the œsophagus completely filled with a new growth, through which a fine probe finally passed. Dilatation with Bunt's bougies followed. With this treatment the patient was able to swallow until his death, some months later.

On October 8, 1908, the new Frank Memorial Hospital, of East Monument street, Baltimore, was formally opened. Dr. Frank, to whose memory the Hospital is dedicated, was a graduate of the University of Maryland, class of 1862. The key of the new building was handed Dr. Adler, class of 1895, by representatives of Mrs. Bertha Rayner Frank, through whose generosity the hospital was made possible. There was music and other exercises appropriate to the occasion. On the Thursday, Saturday and Sunday following the formal opening the hospital was thrown open to the public for inspection. Dr. Charles Bagley, class of 1904, superintendent of the Hebrew Hospital and Asylum, is working energetically to have the new building completed and ready for use after the inaugural exercises. Dr. Harry Adler is chairman of the board of directors. A number of our alumni are on the visiting staff of the hospital.

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EDITORIAL.

BACK TO WORK.—On the first day of the present month the 102nd regular session in the Medical Department of the University began work. A number of familiar faces about the campus and in the lecture halls give evidence of the return of former students bent upon new performances. After some three months of outing, the student body puts on its harness and gets down to work. The freshman class this year at the University promises to be one of the largest first-year classes for some years back. These young candidates for the healing art have received the usual form of introduction to their more advanced comrades. The spirit of comradeship at the Old University is a most genial and healthy one. Formal introductions are not attended with unkind or brutal ceremonies. Acquaintances are made and friendships established which soon bind the classes into well-organized bodies, with a proud class spirit and generous rivalry for class honors and privileges.

The class spirit at any institution of learning is a most potent one for good or evil to the student body. Where high standards are set both of morals and of student work, much good may be expected for each individual student who is brought under the influence of his class. The BULLETIN is glad to see the spirit of organization of the student body at the University so active and so loyal to every phase of student life. The fraternities, the class organizations, the Y. M. C. A. and the athletic teams are all doing a valuable service in bringing the student into closer relations and in strengthening the best purposes of a university life. Among these bodies the best types of student character are brought out and the men who lead and the men who follow are brought to see and know what is best in endeavor and in performance. Men unconsciously appropriate the influences of environment, hence association is the best form under which character and intelligence are strengthened in youth. There are few young men who will depart from the better influences of a college life. Many will fall away from a high standard when the lower one is made more attractive to him. The importance and value of the student organization will depend upon the standard and purpose it sets up for its membership. Where the standard is high, as the BULLETIN believes it is, at the University, too much encouragement cannot be given to all the class organizations connected with the several departments. It is a great service to any institution of learning to have its classes of students aroused with a spirit of class pride and of loyalty. When both student and teacher are working for the good of an institution, its progress is assured.

TO THE FRIENDS OF THE BULLETIN.—The BULLETIN has always hesitated to use its reading columns for business purposes, and it now regrets the necessity of having to do so. Facts are very impressive necessities at times. It is always embarrassing for a physician to have to ask the payment of a professional account. He much prefers that the patient should recognize the obligation or mail a check in response to a bill than to be the aggressor and urge his claim in a personal way. Some physicians who combine good business attainments with professional service know how to collect money for services rendered. The vast majority of physicians are poor business men and so neglectful or sensitive about asking payment for their services that they work hard and remain poor after many years of care and toil. There is a proper medium to be followed in the conduct of every business. He is a fortunate man who combines the ability to render good service and to secure a proper consideration for the service rendered. His sense of proportions is correct when he places a just value on his work and then quietly enforces payment for the same. The BULLETIN is led to these reflections by its own experiences. It has been in active publication now going on four years.

During this time it has added a large number of names to its subscription list. A number of its subscribers have paid their subscriptions regularly when bills for the same have been mailed to them. A few have run over one or two years and then remitted, whilst the larger number, it is sad to say, have paid no attention to the bills sent to them and are now in arrears for two or three years. Whilst the BULLETIN has made repeated requests, few responses have been made. If this failure to pay is due to carelessness or oversight, there may be a pardonable excuse, but if it is due to design and a purpose to receive the BULLETIN as a free offering, whilst others bear the burdens of its publication, there is a petty meanness in accepting its monthly visits in this way. The business necessities of the BULLETIN are such that it can only prosper through the generous support of its friends. He who would not give this support, but prefers to accept its monthly visits gratuitously, is retarding the progress of a publication which is trying to render a useful service to the University and to afford some degree of satisfaction to the alumni. The BULLETIN requests such subscribers who do not intend to pay their subscription to send a notice to that effect. This is the only business way to signify one's wishes.

CONSTRUCTIVE AND DESTRUCTIVE CRITICISM.—Everyone knows how much easier it is to tear down than to build up. The toil and labor of years may be completely overthrown in the twinkling of an eye by some great catastrophe of nature or by human instrumentality. Institutions as well as individuals may labor for years to build up a character or to establish a useful work, only to see both blighted by malicious criticism and unfounded suspicion. The most destructive critics are often those who make their attacks under the guise of friendship. Assuming that they are right and others are wrong, they inject poison as the only remedy that will correct conditions which they attack. The University of Maryland has many warm and loyal friends who are ever ready to say a kind word or to lend a helping hand to those who are directing her policies and laboring to upbuild her great work. She has a few bitter enemies who have the good sense to say little and keep at a distance. She has some so-called friends who are ever at work throwing mud at her, and in their professed zeal to render her a friendly service are doing all in their power to oppose every policy which does not measure up to the standard they have arbitrarily erected. In their estimation the present Board of Regents is made up of a lot of old fossils and back numbers who govern their own departments for purely selfish interests, and who have no concern for the general good of the University. Were these opinions founded on any reasonable or just ground, the remedies proposed for their correction are irrational and impracticable. Reforms are seldom brought about by misrepresentation or destructive criticism. Constructive criticism is the only healthy and efficient agency in any true reform. If the critics of the University desire to improve conditions which underlie the betterment of the institution, they must come forward with helpful hands, with loyal hearts and with a spirit of toleration. These forces count, and in due course of time they bring about practical results. It is not contended by those in present charge of the policies of the University that her governing body is doing all that might be done for the more rapid growth of the University. It is simply contended that they are doing what present conditions seem to indicate as the proper lines to follow in the more gradual and conservative development of a University system. No one who has watched the growth of the different departments of the University within the past decade can fail to observe the sure and substantial improvement which has been made in every department. This is shown not so strikingly in the size of the student body as in its character and in the gradual raising of the educational standard. The property interests of the University have improved in the same period of time in an equally creditable manner. In this respect the University is willing to stand in contrast with the other unendowed schools of the country.

It is idle nonsense to be carping over minor incidents which apply in equal degree to almost every institution in the land and to lose sight of a genuine and substantial growth, which the University is making from year to year.

The University of Maryland welcomes any friendly criticism which will build up her work. She repudiates the attacks which are designed to prejudice her work in the minds of those who will not take the pains to examine results and who are ever ready to listen to the malicious critic.

CORRESPONDENCE.

A TRIP TO GUATEMALA—THE FIFTH PAN-AMERICAN MEDICAL CONGRESS.

CITY OF GUATEMALA, *August 5 to 10, 1908.*

The Spanish-American peoples are very formal in their etiquette. We had scarcely arrived at our hotel when we were informed that the American minister would call for us in two hours to present us to the President of the Republic, and that it would be proper form to wear frock coats, high hats and gloves. Unfortunately, these articles of adornment had been left at home by all of us, and we not only had to wear our ordinary summer suits, but some of the party did not have time to put on clean linen. We were a rather sorry looking crowd to be calling on dignitaries, but we faced the music and put on a brave front. We did not speak Spanish, except Dr. Gregory Guiteras, who is a Cuban, and the President did not speak English, hence the conversation was not very animated, but the champagne and cigars were of excellent quality and of sufficient quantity to fill in the gaps, and all went well. The formal opening of the Congress took place on the morning of the 6th and was a very solemn occasion. Etiquette prescribed swallow-tailed coats, plug hats and white gloves. I had the spiked-tailed coat, but I had to purchase an opera hat, which I suspect was a second-hand one, for which I paid $30 in Guatemalan shin plasters, which is the equivalent of $2 of Uncle Sam's money. We were conveyed in carriages, at the expense of the government, to the School of Medicine, where we met cabinet officers, officials, representatives of foreign countries and the high military officers in gorgeous uniforms. We then marched to the magnificent new hall, especially fitted for this occasion, where the sessions of the Congress were held. Dr. Juan J. Ortega, of Guatemala City, was the president of the Congress, but the greetings of the President of the Republic were read by Senor Barrios, the Minister of Foreign Affairs. The large hall was well filled with a brilliant assembly, the sombre hue of the costumes of the civilians being enlivened by the gaudy raiment of generals and diplomats. There were delegates from 19 American countries, those from the United States being only eight in number, but more than those from any other outside country, San Salvador with six being next. The President of Guatemala had an effective way of securing the attendance of the physicians of his own country, by notifying them that he would cancel their licenses if they did not attend. They attended all right. The addresses made were responded to by the official delegates from the countries represented, and as each one finished, a full military band played the national anthem of his country. The scientific sessions were held in the afternoon, and in accordance with Spanish customs. Most of the papers were sent by persons who did not come, and they were read in abstract or by title, and there was very little discussion. An amusing episode was an address by the delegate from Brazil, who spoke in Portugese, and not a soul except himself knew what he was talking about. This was no great loss, however, as he was an homeopath, and was supposed to have been discussing homeopathy. I cannot say very much as to the value of the Congress from a scientific standpoint, as I could not understand the papers that were read in Spanish, and but few of the Spanish-Americans could understand those written in English, hence we did not profit vastly by each other's productions. Not all the papers of value, however, came from the United States, as there were many contributions from the Spanish-speaking countries that appeared to be excellent, if one can judge from their titles. Amongst these I note, "Resection of Both Maxillae," by Dr. F. Zumbado, Costa Rica; "New Procedure for the Restoration of the Urethra," by Dr. G. Cano, El Salvador; "Resection of Both Maxillae," by Dr. Juan J. Ortega, Guatemala; "Myxoedema and Cretanism Amongst the Mountain Guatemalans," by Dr. Pastor Guerrero, Guatemala.

Unfortunately, I was not able to understand the papers and could not discuss them, so I did not attend the sessions very closely. The Central and South American physicians were a good-looking and intelligent set of men, and as far as I was able to judge, they were well versed in their profession. The School of Medicine in whose halls the Congress met is a large two-storied building, with very handsome assembly rooms and offices. There are about 250 students in attendance. Formerly it was the only medical school in Central America, but now there are others. In close proximity to the school is the General Hospital, which is said to contain 500

beds, and certainly covers a large area. Its wards were large, well ventilated and clean, but did not contain very many patients when I visited the institution. A new operating pavilion had been erected, which is up to the requirements of the times in its arrangements. There is also a large military hospital in the city, which is under strict military discipline. A handsome convalescent hospital is about completed, with ample grounds, as well as a handsome lying-in hospital. In fact, the President of Guatemala and the medical profession are fully alive to the importance of modern medical institutions, and I believe the meeting of the fifth Pan-American Medical Congress in this city will be an epoch in the medical, social and possibly political history of the country. A beautiful vaccine institute has just been completed, a national disinfectorium and a splendid laboratory for the students of the Practical School, which was well equipped with chemical and physical apparatus. There are departments of Pharmacy and Dentistry in connection with the Medical School, and a School of Law. Whatever may have been the merits or demerits of the Congress from a scientific point of view, it was a huge success from an official and social standpoint. Before landing the welcome of the President was conveyed to us, and a special car, free transportation and an absence of all customs inspection ordered for us. At Zacapa the Commandant of the District called on us and offered his services. At the capital we were met by a committee and conveyed to our hotels, and almost immediately, before we had time to properly remove the soil of travel, were received informally by the President and his Cabinet. Each day subsequently we were flooded with invitations to receptions, banquets, the opera, concerts and entertainments of various kinds. On August 7th we were formally received by the President at the Palace, which is a very handsome building, and is always strongly guarded. In fact, no one is allowed to walk on the same side of the street as that on which the Palace is situated, as there have been several attempts to kill the President. An unusual entertainment for medical men was a sham battle, in which we had an opportunity to see several thousands of troops of all arms. The officers were very gay in their showy uniforms and the soldiers were well drilled and active, even if they were barefooted. They were well equipped with the most modern guns and artillery and smokeless powder, and would doubtless acquit themselves creditably in battle. The bane of these Central American countries is their large military establishments, for which there should be absolutely no use. Guatemala claims to be able to put 60,000 men fully equipped in the field within two weeks, and 100,000 in four weeks. The total population of the country is about 2,000,000 and the people are mostly Indians or mixed, and very poor. A very enjoyable entertainment was an open-air banquet or picnic at Aurora, the country place, or national farm, for the use of the President. This was an elaborate dinner, at which there were many ladies, where we had an opportunity to observe the fair sex close at hand. Champagne and other liquids were on tap without stint, as was the case wherever we went. A splendid banquet was also tendered the Congress and other guests by the officers of the army, the special feature of which was the superb music by two full military bands. The Opera House is a very handsome structure, and a fine Italian company was playing there during our visit. Sunday is not much observed in Guatemala; most of those who go to church are women; the men prefer to go elsewhere. There were two sessions of the Congress and a great ball at the Guatemala Club at night. I did not like to go to a ball on Sunday night, but concluded I might as well do as the others did, and I went. There was a great crowd; some of the ladies were very handsome, but I hardly thought they equaled the American girls in beauty. They were dressed magnificently in Parisian gowns and were covered with jewels, and danced well. I found it difficult to carry on a conversation at the supper table with my young lady neighbor, who did not understand anything I said. I left early, but those who were devoted to Terpsichore did not seek their couches until Aurora had dispersed the shades of night with her rosy rays. The Congress adjourned on Monday, the 10th, after farewell speeches by various delegates, but in the evening a very elaborate banquet was given by President Cabrera at the Presidential Palace, at which he made an address. Everything was very ceremonious; when the President rises, the guests stand; when he sits down, they follow suit. At the close of this reception and banquet the fifth Pan-American Medical Congress was a matter of history, and early the next morning half of our party left for home.

RANDOLPH WINSLOW.

SOME IMPRESSIONS OF A RECENT TRIP TO ROCHESTER, MINN.

I left Baltimore Monday, September 14, 1908, at 7.05 P. M., on the Chicago Limited via Harrisburg. The Pennsylvania ticket office was able to furnish through transportation to Rochester, together with transfer from the Pennsylvania Station in Chicago to the Chicago and Northwestern Depot, thus obviating the necessity of worrying about getting across the city. The trip out consumed thirty-six hours, the only break occurring at Chicago, where there is a wait of four hours, the Chicago and Northwestern train bound for Rochester not leaving until 8.04 P. M., whereas the Pennsylvania train arrived at 4 P. M.

Much of my travel was done at night, in consequence of which a great deal of beautiful scenery was lost. The Alleghenies were passed through at night, as well as the beautiful Wisconsin Lake country.

When I awoke the next morning I was at Alliance, Ohio. From there to Chicago the country is flat, and only here and there is the monotony broken by a slight rise in the land. Corn appeared to be the staple crop. Owing to the prolonged drought, however, it was parched and rivers were very low and the whole country was dry and did not look very flourishing. All of the in the hands of a severe drought. In Ohio, Indiana, Illinois and Wisconsin I passed through many good-sized and flourishing manufacturing towns, namely: Canton, Lima, Alliance, Gary, Fort Wayne, Lacrosse, Madison, etc. The second stage of the journey, as the first, was made at night, and when I awoke the next morning a goodly portion of Illinois and Wisconsin had been left in the rear. Here the land seemed to be more fertile than that of Indiana or Ohio and the vegetation was not so parched and dry. The country is hillier and the scenery more pleasing to the eye. Our train arrived at Rochester, a town of some 7,000 inhabitants, surrounded by hills and a rather pretty place, on time. Besides myself there were nearly a dozen other physicians on the train bound to see the Mayo brothers, amongst whom was Mr. Lane, of London, England. Every train brings its quota of visiting physicians and patients. The conductor had previously told me I would see an unloading of the train when it reached Rochester. Such was the case. A bus conveyed me from the train to Cook's Hotel. As I had heard the Drs. Mayo began to operate at 8 A. M., I merely registered, then took another bus for St. Mary's Hospital, which is about a mile from the hotel. By the time I arrived, about 10 A. M., Dr. W. J. Mayo had already done a number of operations, among which may be mentioned a radical cure for umbilical hernia, cholecysduodenostomy, two other operations upon the gall bladder and a resection of the ascending and a portion of the transverse colon for malignancy. I saw him do that day a nephrotomy for stone in the kidney, a radical cure for ventral hernia, an appendectomy with drainage and several other interesting cases. Dr. W. J. Mayo talks as he operates. Although Dr. C. H. Mayo did not begin to operate until 10 A. M., he removed two goitres, two breasts and an appendix by 1 o'clock.

There were twenty-four operations posted on September 17th, including a partial gastrectomy, an appendectomy with drainage, an anterior gastro-enterostomy by Dr. W. J. Mayo; ligation of both superior thyroid arteries for exopthalmic goitre, removal of multilocular cyst from the thyroid, extirpation of one-half of the thyroid, three appendectomies, internal Alexander's operation, varicose veins, by Dr. C. H. Mayo. I remained until the 24th and every day there were from 20 to 25 major operations. Dr. William J. Mayo limits his work almost entirely to the abdomen, whilst Dr. C. H. Mayo is the general surgeon. Dr. W. J. is famous for his cancer work in the abdomen, and Dr. C. H. for his goitre work, having done since the first of last January more than 300, with only two or three deaths.

One cannot help but be struck with the thoroughness each case is worked up before operation and the wonderful system of the whole institution. It is, indeed, an unique institution, there being no other of a like character in the world. The patients come from all over the United States and Canada. They are coming in faster than they can be accommodated in the hospital, as a result of which a new addition is being added to the hospital.

The offices are not located at the hospital, but in the centre of the town. They occupy the entire ground floor of the Masonic Building. Here from 2 to 5 P. M. a procession is continually pouring in and out, anywhere from 125 to 175 patients being seen during the course of the afternoon, and the operative cases being culled from the medical and unoperative. Before

a patient gets to see the Drs. Mayo he passes through the hands of a number of assistants, and if he is not deemed a suitable case he may, indeed, never get to see them.

NATHAN WINSLOW.

ITEMS.

Dr. A. A. Matthews, class of 1900, of Spokane, Washington State, has returned to his home from a visit to the Yellowstone Park and other points of interests in the vicinity. During his absence his practice was looked after by his brother, Dr. James G. Matthews, class of 1905, of Spokane, Wash., formerly of Baltimore.

Dr. E. K. Ballard, class of 1887, of 1622 Mount Royal avenue, Baltimore, has returned to his home from Charles Town, W. Va.

Dr. William Whitridge, class of 1862, has gone to Portsmouth, N. H., where he will spend the late summer.

Dr. John T. King, class of 1866, is at Narragansett Pier, R. I.

Dr. A. G. Rytina, class of 1905, of Baltimore, is at Atlantic City, N. J.

Dr. Nathan Gorter, class of 1879, of Baltimore, is at White Sulphur Springs for a fortnight.

Dr. James G. Linthicum, class of 1859, of Baltimore, who was recently appointed police surgeon, was recently severely hurt by being thrown out of his carriage. Dr. Linthicum was driving across the Edmondson avenue car tracks when a car of that line struck his carriage.

Dr. John T. King, class of 1866, of Baltimore, has returned home after spending some weeks in the White Mountains and vicinity.

Dr. Frank Martin will not return from his vacation until the 1st of October.

Dr. William H. Baltzell is at Elm Bank, Wellesley, Mass.

Dr. Eugene Lee Crutchfield, class of 1887, of Baltimore, is seriously ill with appendicitis.

Mr. M. Cabell Woodward, of Roland Park, announces the engagement of his daughter, Miss Ella Louise Woodward, to Dr. William Kelso White, class of 1902, of North Charles street, Baltimore. The wedding will take place on October 21, 1908. Dr. White is the son of the late Dr. W. W. White, class of 1870, and Mrs. W. W. White.

Dr. T. C. Routson, class of 1899, was a member of the committee of arrangements of the first joint meeting of the Frederick and Washington County Medical Societies, held at Frederick, Md., August 22, 1908.

Dr. J. W. Holland announces the removal of his office from 1530 Linden avenue to 1624 Linden avenue, Baltimore.

The arrangements for the post-graduate course which is to be given at the University of Maryland have been definitely decided upon. The course will be inaugurated on May 15, 1909, and will extend over a period of six weeks. The course is in medicine and surgery, including the specialties and laboratory methods, and is given by the faculty and adjunct faculty of the Medical Department. The matriculates will have the advantages of the clinical material at the University Hospital, Bayview Asylum, City Insane Asylum, the Maryland School for the Feeble-Minded and others.

The departments are as follows: Medicine, Diseases of Children, Diseases of the Nervous System, including a course in nervous and mental diseases, with the use of the clinical material of the various hospitals; Preventive Medicine and Sanitation, Digestion and Metabolism, Histology and Embryology, Pathology and Bacteriology, Clinical Microscopy, Obstetrics, Gynecology, Surgery, Clinical and Operative; Surgical Pathology and Diagnosis, Anasthesia, Clinical and Practical Anatomy, Skiography and Radiotherapy, Orthopedic Surgery, Diseases of the Eye and Ear, Diseases of the Throat and Nose, Diseases of the Skin.

Dr. John R. Winslow, class of 1888, clinical professor of the diseases of the nose and throat in the University of Maryland, has returned to his home, at Roland Park, after an extended vacation spent at Booth Bay Harbor, Me.

Many of our alumni were present at the semi-annual meeting of the Medical and Chirurgical Faculty, held at Ocean City, Md., September 17-18. Those present unanimously indorsed the action of the faculty urging the State to care for its indigent insane. The faculty is now solidly behind the movement for humanely caring for the insane.

Dr. A. C. Harrison, class of 1887, presented by proxy a paper on "Acute Pancreatis." Dr. Allen, associate professor of obstetrics in the University of Maryland, read a paper on "Cesarian Section," in which he urged more frequent recourse to this method of procedure.

Dr. C. F. Davidson, class of 1888, spoke on "Conditions Necessary for Successful Surgical Work," and described some interesting cases. Dr. William Royal Stokes, class of 1891, had as the subject of his address "Bacteriological Facts." Dr. Marshall L. Price, class of 1902, secretary of the State Board of Health, spoke on the "Coming International Tuberculosis Congress in Washington," and Dr. Herbert Harlan, class of 1879, of "The Activity of the Society in Prosecuting Unregistered Physicians."

The second day of the meeting, as on the first, our alumni took a prominent part in the discussions. The second day was given over to the discussion of state care for the insane. Strong and eloquent pleas were made on behalf of the state caring for its indigent insane. Amongst our alumni to make addresses on this subject was Dr. J. Clement Clark, class of 1880, superintendent of the Springfield Hospital for the Insane, Sykesville, Md. The institution is now being run by the State, and Dr. Clark explained how well the system works there. He gave a most interesting description of "the Open-Door Treatment of the Insane," as practiced at Springfield. He said, in part:

"Since Phillips Pinel, in 1792, at Bicetre, France, substituted compassion, kindness and justice for chains and cells, the pendulum has been swinging more and more toward non-restraint in the treatment of the insane, until the present age finds us treating them even with open doors. Maryland has been in the advance guard in the cause.

"The late Dr. Richard Gundry, at Spring Grove, in 1878, introduced many reforms in this direction, and abandoned the use of wristlets, strait-jackets, handcuffs, hobbles, leather muff and shut-up cribs and underground cells. Patients at that time were kept locked in jail-like wards, the quiet as well as the unruly, and exercised only in courts with high, tight board walls.

"It remained, however, for the late Dr. Geo. H. Rohe to inaugurate a system and to build a hospital in which not only cells, shuttered rooms and window guards are unknown, but also with open doors and without locks. What a transition from the massive, prison-like building and barred windows and a cell for nearly every inmate, as of yore!

"At Springfield none of the doors have locks, reliance being placed upon the attendant to watch the doors to the day room, and the night watch is stationed at the doorway in the dormitory, where he can see every patient.

"Dr. Rohe, in his second annual report after the completion of the first group of buildings, says: 'I congratulate the board of managers upon having given to the people of the State of Maryland the most perfect and consistent example of the "open-door" hospital for the insane in the world.'

"Another factor is the employment of all able-bodied patients in out-of-door occupation, whether maniac, melancholiac, paranoiac, imbecile or terminal dement.

"Occupation is now recognized as an important method, if not the most important method, of treating the insane. It is surprising what good effect a few hours' work out of doors will have upon a restless patient. The motor excitement and restlessness seem to find outlet thereby, and the mind and body act together. The exercise in the open air is beneficial, increasing the appetite, promoting digestion and often relieving insomnia. Medicine can do no more; besides, the constant use of medicine is more or less harmful.

"The mental effect of work is also beneficial, helping the patient to fix his attention, aiding memory and creating a healthy interest in his surroundings, thereby making him forget his delusions, or, if a melancholiac, his unpardonable sin.

"From a humanitarian standpoint the open-door system, therefore, stands for all that is good. Patients are treated as sick people, and not as criminals, and are shown every consid-

eration. The largest liberty possible is given them, often at a personal risk to the patients and to the reputation of the hospital, it being a well-known fact that the less the insane are restrained and their desires interfered with the better. The fact that so much confidence is reposed in them as regards behavior and control, insanity being largely loss of control, has a salutary effect upon the average case, and they exercise their self-control.

"The watchful eye of the trained attendant, trained in the modern training school, has taken the place of locks, bars and cells. Of course, it requires a greater number of attendants in a system like this than in a locked and barred establishment, but who is the man that would deny this, the most unfortunate class of God's creatures, all that is necessary for their comfort and welfare?"

Among those present at the Ocean City meeting were the following:

From Baltimore—Drs. Herbert Harlan, class of 1879; Wm. T. Watson, class of 1891; E. M. Wise, class of 1877; F. J. Kirby, class of 1892; L. M. Allen, class of 1896; A. D. Atkinson, class of 1894; H. O. Reik, class of 1891; Marshall L. Price, class of 1902; R. H. Johnston, class of 1894.

Pocomoke—R. Lee Hall, class of 1901.

Crisfield—J. F. Sommers, class of 1885.

Bryantown—L. C. Carrico, class of 1885.

Clarksburg—J. E. Deets, class of 1882.

Pikesville—H. Louis Naylor, class of 1860.

Sykesville—J. Clement Clark, class of 1880.

Easton—Philip Travers, class of 1902; C. F. Davidson.

Dr. Carey Gamble, class of 1887, has returned to his residence, after spending a fortnight at North Hatley, Canada.

Dr. Charles W. Mitchell spent his summer vacation in the Blue Ridge Mountains.

Dr. Nathan Winslow, class of 1901, has returned to his home, 3112 West North avenue, Baltimore, after a week spent at Rochester, Minn., where he was a visitor to the clinic of the Mayo brothers.

Dr. Joseph Hering, class of 1885, has returned from the Blue Ridge, where he has been camping for some time.

Dr. William Royal Stokes has closed his cottage, at Sudbrook Park, and reopened his city home.

Dr. Walter Van S. Levy, class of 1904, has taken apartments at the Walbert, Baltimore, for the winter.

Dr. Henry B. Thomas, class of 1888, who has been summering at Blue Ridge Summit, has returned and reopened his home, 1007 Cathedral street.

Dr. Wm. E. P. Wyse, class of 1886, and Mrs. Wyse, of Pikesville, Md., are being congratulated upon the arrival of a new son.

Prof. R. Tunstall Taylor has closed his cottage, at Blue Ridge Summit, and reopened his home on Maryland avenue, Baltimore.

Dr. Mactier Warfield, class of 1884, spent his summer vacation at Bass Harbor, Maine.

Dr. C. W. McElfresh, clinical professor of medicine in the University of Maryland, has returned from Fairmont, W. Va., where he has been in attendance on Dr. Cook, who has been suffering from blood poisoning.

Dr. Fitz R. Winslow, class of 1906, has returned from a visit to the Luray Caves, Virginia.

Prof. Randolph Winslow, class of 1873, has returned from Fairmont, W. Va., where he was called in consultation upon Dr. Cook.

Dr. Lee S. Magness, class of 1902, has received an appointment in the department of physical diagnosis, Atlantic Medical College, Baltimore.

Dr. G. Lane Taneyhill, class of 1865, of Baltimore, was elected Surgeon-in-Chief of the Grand Army of the Republic at its recent reunion.

Dr. Robert P. Bay, class of 1905, superintendent of the University Hospital, has returned to the Hospital after a week's stay in Harford county.

Announcement has been made of the engagement of Miss Elizabeth Olyvia Talbott, daughter of Mrs. Etta P. Talbott, of Chaneyville, Talbott county, to Dr. Irving D. Chaney, class of 1906. The wedding will take place next month at Hampton, the bride's home, near Chaneyville. Miss Talbott is a daughter of the late State Senator J. Frank Talbott, of Calvert county, who died in the early nineties. Dr. Chaney is at present located at Connellsville, in the medical department of the Baltimore an Ohio Railroad. He was formerly located at Pittsburg.

Dr. Louis M. Allen, associate professor of obstetrics, has returned from Berryville, Va.

Dr. James Bordley, class of 1868, a prominent physician of Centreville, Md., is in a critical condition. He was born in Centreville, March 14, 1846. He studied medicine at the University of Maryland, and after his graduation in 1868 he returned to this place, where he has since engaged in practice. He is a member of the State Board of Medical Examiners, of which he was president from 1893 to 1896.

The new three-story building in the rear of the University Hospital is to be used to house the nurses. It is expected that it will provide for a substantial increase in the number of nurses, as there are quarters for fifty persons in the building. It is nearing completion and will be opened in the near future.

Dr. C. W. Roberts, class of 1906, together with Drs. W. F. Sibbett and W. A. Sibbett, have established the Douglas Surgical Institute and Infirmary. Dr. Roberts was born and reared in Coffee county, Ga. He received his preliminary education at the Southern Normal Institute, now the Georgia Normal College and Business Institute, from which he graduated in 1902. He then entered the medical department of the University of Maryland, where he was graduated with the class of 1906. After graduating he was appointed an assistant resident surgeon in the University Hospital, which position he held for two years. He left the hospital this summer, and has located at Douglas, Ga.

Dr. St. Clair Spruill, clinical professor of surgery, has returned from a short visit to Atlantic City.

The following of our alumni hold commissions in the medical corps in the Maryland National Guard: Major W. Clement Claude, class of 1875; Major W. Guy Townsend, class of 1883; Major S. Griffith Davis, class of 1893; Capt. J. Wright Downey, class of 1869; Capt. Thaddeus W. Clarke, class of 1880; Capt. Edward R. Trippe, class of 1862. Capt. Joseph T. Hering, class of 1885; Capt. Wirt A. Duvall, class of 1888; Capt. Gordon Wilson, associate professor of medicine in the University of Maryland.

At the recent session of the American Association of Obstetricians and Gynecologists, held at the Belvedere Hotel, Dr. W. A. B. Sellman, class of 1872, was elected a member of the executive council. Dr. Wilmer Brinton, class of 1876, responded to the toast "The City of Baltimore."

Dr. Cooper Drewry, class of 1902, of Catonsville, Md., has returned to his home after a summer's vacation spent at Eaglesmere, Pa.

Dr. J. Frank Crouch, class of 1890, of Baltimore, has given up his apartments at the Washington and will reside at 1125 North Charles street.

Dr. Louis McLane Tiffany, formerly professor of surgery in the University of Maryland, has returned to his home, on Park avenue, Baltimore, after spending the summer in the Bretton Woods.

Dr. C. W. Roberts, class of 1906, ex-resident surgeon in the University Hospital, Baltimore, has moved to Douglas, Ga. He has returned to his home after visiting Mr. and Mrs. A. H. Porter, of Augusta, Ga.

Dr. Nathan E. B. Iglehart was operated on recently for stomach trouble. It is reported that Dr. Iglehart is making satisfactory progress.

Dr. Daniel Jenifer, class of 1904, of Atlantic City, is visiting his father at Loch Raven, Md.

Dr. T. C. Gilchrist, clinical professor of dermatology in the University of Maryland, has been elected president of the American Dermatological Association at their recent convention held at Annapolis.

Dr. Alexander D. McConachie, class of 1890, of Baltimore, who has been touring the country in his motor car, has returned to his home, 805 North Charles street.

Dr. Marshall B. West, class of 1901, of Catonsville, Md., is spending several weeks at Atlantic City.

Dr. Robert P. Bay, medical superintendent of the University Hospital, is spending a week at his home, in Harford county, Md.

Dr. George W. Hemmeter, class of 1901, of 800 Harlem avenue, has been appointed an assistant in physiology in the Woman's Medical College, Baltimore.

Dr. A. M. Rossette, class of 1903, is located at Savannah, Ga.

Dr. N. E. B. Iglehart, class of 1889, of Baltimore, who was operated upon recently for appendicitis, has left for Atlantic City, N. J. He expects to return home about October 15.

The Medical Department of the University of Maryland was formally opened Thursday, October 1, 1908. The enrollment is considerably larger than last year.

Governor Crothers has appointed Dr. James F. H. Gorsuch, class of 1876, health officer of Baltimore county, a delegate to the Tuberculosis Congress to be held in Washington, D. C., September 21 to October 12.

Dr. H. O. Reik, class of 1891, of Baltimore, has returned from Canada.

Dr. William Royal Stokes, class of 1891, of Baltimore, has returned from Winnipeg, Manitoba, where he attended the Congress of the American Health Association. On his way home Dr. Stokes stopped in St. Paul and Chicago, where he inspected the health departments.

Dr. Mactier Warfield, class of 1884, of Baltimore, has returned from a six weeks' trip to the coast of Maine.

Dr. Joseph W. Holland, class of 1896, of 1624 Linden avenue, Baltimore, has returned from a month's stay at Atlantic City.

Dr. Frank Martin, Clinical Professor of Surgery, has returned home after a two months' stay at the Mount Pleasant, Bretton Woods.

Dr. J. Burch Joyce, class of 1894, of 1800 West North avenue, Baltimore, spent the month of August at Ocean Grove, N. J.

Dr. J. Carroll Monmonier, class of 1897, of Dickeyville, Baltimore county, Md., has returned from Toronto, Canada, where he attened the meeting of the American Hospital Association, of which he is a member. He says the meeting was largely attended and many important subjects were discussed.

Dr. Joseph Slicer Bowen, class of 1903, of Mount Washington, Md., is seriously ill.

Prof. Randolph Winslow and Dr. Charles W. McElfresh were recently summoned to Fairmount, W. Va., to see Dr. John R. Cook, who was desperately ill with streptococcus infection. Dr. Cook, who is a very prominent surgeon, punctured his finger whilst operating, in consequence of which a virulent septic infection occurred. We are glad to learn that Dr. Cook is improving, and it is thought he will recover.

In the October issue of *Old Maryland*, a journal supposed to be an official organ of the University of Maryland, is a statement to the effect that at the last examination held in June, 1908, twenty-two graduates of this school passed and eighteen failed. This absolutely erroneous statement can do the University no good, and is capable of doing great and unmerited injury, and whilst we cannot at this writing give the exact figures, as we have not yet received a reply from the secretary of the Examining Board, we take this opportunity to protest against the issuance of such an unwarranted and fallacious report.

WEDDINGS.

Dr. J. Oliver Purvis, class of 1904, of Annapolis, was married September 21, 1908, to Miss Louise Sommers, third daughter of Mr. and Mrs. Robert E. Sommers, of Annapolis. The ceremony was performed at the residence of the bride's parents, on Prince George street, by Rev. Joseph P. McComas, of St. Anne's Church. The best man was Dr. Charles Bagley, class of 1904, of Baltimore. Dr. and Mrs. Purvis will spend their honeymoon touring the North. After their return they will reside at 191 Green street, Annapolis, Md.

Dr. Walter F. Sowers, class of 1906, of Baltimore, was married September 9, 1908, to Miss Clara J. Margaret Ellinghaus. After their wedding trip they will make their home at 2311 Edmondson avenue. Mrs. Sowers is a daughter of Mr. Frederick W. Ellinghaus.

Dr. Henry D. Fry, class of 1876, of Washington, D. C., was married September 17, 1908, to Mrs. Addison Atkins, at the rectory of Christ Protestant Church, 1014 St. Paul street, Baltimore, by the rector, Rev. Edwin B. Niver. Dr. Fry was a widower, and is one of our most prominent alumni in Washington. Mrs. Fry was the widow of Addison Atkins, who was connected with the *Brooklyn Eagle*, and was one of the most prominent newspaper men of Brooklyn. Immediately after the ceremony Dr. and Mrs. Fry left on their honeymoon.

DEATHS.

Dr. Peter Wood Hawkins, class of 1852, one of the oldest residents of Charles county, Md., died at his home, near La Plata, Md., September 17, 1908. He was a member of the well-known Hawkins family, and was born in Charles county in 1830.

Dr. Hawkins married Rebecca Morton, and on November 12, 1907, celebrated his golden wedding. Besides his widow, he is survived by two daughters and two sons—Mrs. E. Gill Bowling, Miss Florence Hawkins, H. Holland Hawkins and W. Pinkney Hawkins, all of Charles county.

Dr. Hawkins practiced medicine in Charles county for over fifty years. Under the administration of the late Governor Hamilton he held the position of tobacco inspector, and under Internal Revenue Inspector Vandiver he was appointed a storekeeper in the Internal Revenue Service.

Dr. James Stevens Chaplain, class of 1854, one of the most prominent and successful physicians of Talbot county, Md., died at his residence, in Trappe, September 12, 1908, after an illness of several weeks, of cancer of the stomach, in his eighty-second year. His ancestors settled in Talbot county about 1660. Dr. Chaplain was the second child of James and Eliza (Stevens) Chaplain, and was born in Trappe May 5, 1827. His early education was received in the public schools of Trappe. After graduating from the high school he entered the drug store of Richard F. Homsley, in Easton, in 1843. At the end of three years he removed to Baltimore and accepted a position as chief clerk in Littlefield's drug store, on North Charles street, where he remained for six years. During this time he studied medicine under Dr. Thomas H. Buckler, class of 1835, and Prof. George W. Miltenberger, and also attended lectures at the University of Maryland, from which he graduated in 1854. On November 9, 1854, he married Evelina, daughter of Samuel T. Kemp, who survives him. He was a Mason, having been at one time junior warden of the Grand Lodge of Maryland, and a member of the Methodist Episcopal Church South.

The funeral of Dr. William Brounley Bowen, who died suddenly at Front Royal, Va., during the early part of September, was one of the largest ever seen in Moorefield, W. Va. He was a Virginia Military Institute student, and was in the battle of New Market, fought under Mosby and was at Appomattox. He was only nineteen years old when Lee surrendered. He practiced medicine in Washington and Virginia. He is survived by a widow and seven children. He was graduated from the University of Maryland with the class of 1871.

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REPORT OF CASE OF TRANSVERSE MYELITIS IN WOMAN FIVE MONTHS PREGNANT, FOLLOWED BY VERY EASY LABOR.

IRVING J. SPEAR, M. D.

The fact that the uterine muscle is capable of expelling the full term foetus independent of the assisting force of the abdominal muscles, or even after its nerves are completely separated from the spinal cord, has been proven by many reported cases. Williams (1), "Action of the abdominal muscles is not necessary to bring about the expulsion of the foetus."

Edgar (2), Jewette (3) and Rein (4), in experiments on rabbits, have proven that the uterus can expel its contents after the complete separation of its nervous connection with the spinal cord. Routh (4), Benicke (4), Lusk (4), report cases in which labor proceeded after the uterus is entirely isolated from the cerebro-spinal system. In fact, Jewette (3), Dorland (5) and others (6) make the assertion that labor in paraplegic women is, as a rule, much less difficult and painful than in those that are in full control of their voluntary muscles. In the literature of the accidents, injuries and complications of pregnancy, we see evidence of the remarkable resisting power of the pregnant women, and of the marvelous provisions of nature for the retention of the uterine contents until such a time as the foetus is capable of independent existence, and the bringing about of expulsion of its contents without other help than that of the uterine muscle itself.

The following is the history of a case examplifying the fact that the uterus unassisted is able to retain and expel its contents after a destruction of the spinal cord above the uterine center.

The following is the history of the case of Mrs. M. A., a patient at the University Hospital in the later part of the year 1907. Mrs. M. A. entered hospital complaining of paralysis of the lower part of her stomach, her lower extremities and inability to control her vesical reflexes. Shortly after her entrance she was referred by Professor Craighill to me for examination, and with the assistance of Dr. Glidden, the physician in charge, the following notes were made:

Mrs. M. A., age 39, married, white, female, occupation housework, German. Complaint, paralysis in lower abdomen and legs, trouble with bladder. Family history, consumption in family of paternal grandparents; father a chronic alcoholic; died with paralysis; no other history obtainable of paternal relatives. Maternal grandparents both died with paralysis; mother also died with paralysis, age not stated; mother had eight children, no miscarriages; all normal labours. No other family history obtainable.

Past History—Scarlet fever as baby; measles age 9 years; pertusis age 12 years; malaria age 16 years; for several years during winter had attacks of rheumatism in hands lasting several months, with severe pain.

Menses—Age 17 years; always normal; no history of night sweats, cough, etc.; always very constipated; appetite and digestion good.

Habits—Drinks two cups of strong coffee at each meal; does not use alcohol or drugs; subject to attacks of dizziness of very short duration; no history of venereal diseases.

Disposition—Has always been rather excitable and quick tempered. Married age 24 years, and during the past 15 years has had 13 pregnancies—seven boys, four girls and two miscarriages; labours were all long and difficult, but no instruments were ever used.

Infants were not breast fed, but were brought up on cows and condensed milk. Six of these children died before the sixth month of "summer complaint." The remaining children are well and show no nervous taint, etc.

First miscarriage occurred about five years ago and the second about two years later. Was curretted after the second miscarriage. She thinks both miscarriages were brought on by overwork and poor food. Has always been

abused physically by her husband, and generally improperly fed and clothed.

Present Illness—Patient became pregnant about middle of January, 1907. About middle of May she was kicked over lower lumbar region by her husband, which caused her much pain, and compelled her to walk stooped over for about two weeks. About this time her husband drove her out of house at 2 A. M. on a cool, rainy night. She had to walk four miles to obtain shelter. A few days later the patient was confined to bed with dull, aching pains deep in upper half of right thigh. She crawled down stairs without assistance; had sensation as if falling forward. Pain continued and involved the left thigh; then left leg and foot; then the right leg and foot. Legs became useless and unable to control rectal and vesical reflexes.

She says she was all right from the waist up, otherwise helpless. In about three days she was able to move the legs, but not stand on them. Pain continued for about two months, when it was replaced by sensation of burning in affected regions, which at times was intense. This stopped on September 30th, when her child was born.

When she stands there is always a flow of urine. When asleep both defecation and urination become involuntary.

On September 30th, 1907, she gave birth to a healthy child, and she says that this was the easiest labour she had ever had, as well as the shortest. Labour did not increase the symptoms, but since then she thinks she has gotten better.

Physical Examination—Fairly well nourished white woman of medium stature, large scar over sacrum, the result of recent bed sores; otherwise the skin is fairly clear. She has very few teeth left, and those are in bad condition; mucous membranes are healthy in appearance. Speech is slow but distinct. Intelligence is rather below the normal.

The examination of her cranial nerves, with exception of an old strabismus and a catarrhal deafness, is negative. The examination of her thorax and upper abdomen also yields negative results.

Examination of the Nervous System.

Motor Function.—Upper Extremities—Muscular development and nutrition good; no atrophies; strength of flexors and extensors is good. No abnormal movements, and the co-ordination is good.

Trunk—The muscles above, the costal margins, anteriorly and posteriorly, are normal in development and strength. The abdominal muscles are relaxed and atrophied and show a marked decrease in their power.

Lower Extremities—Muscular development poor, nutrition poor, atrophy of the anterior tibial groups, perineal groups, the posterior muscles of the leg and the anterior and posterior muscles of the thigh. There are no abnormal movements or spastic contractions; patient has double foot-drop, marked weakness of the flexors and extensors of the legs and of the thighs.

Reflexes—Periosteal radial, triceps and biceps normal; petella and tendo-achilles markedly increased.

Planter exaggerated, abdominal present.

Koernig's sign negative; Babinsky's sign negative.

Rectal and Vesical Reflexes—Patient is unable to control bowel, frequently defecating while asleep, and not recognizing the fact until her attention is called to it. Altogether unable to control the vesical spincter, passing urine unconsciously whenever she assumes an upright position; also during sleep and when sitting in a chair.

Sensory Functions—Examination made eight months after commencement of her disease. There is a general hyperasthesia over the entire body. Tactile pain and temperature senses are correctly interpreted. Muscular sense is disturbed in lower extremities (feet). No girdle sensation.

Parasthesias—At present patient still complains of a slight burning of the outer sides of both legs and a numbness and tingling in her feet. It is impossible to test for Romberges sign, as the patient is unable to stand without external support.

Cranial Nerves—Are all normal with the exception of a slight congenital internal strabismus, and the eight, where we have slight catarrhal deafness.

Vasomotor and Trophic Disturbances—Temperature of both lower extremities is slightly below that of the body. The lower extremities are generally moist, and upon the slightest excitement of the patient they are covered with profuse perspiration. Scars, due to old bed sores, are still visible over the buttocks and sarcum.

Electrical Reactions—Are normal in the upper extremities and qualitatively unchanged in the lower extremities, but require much stronger

currents than normal to bring about contractions of the muscles.

Conclusions—This case we had inflammatory disease in the lower dorsal region of the cord. This was followed by certain permanent destructive changes, which interfered with the corticospinal tracts that transmitted voluntary impulses to the vesical center, the rectal center, uterine center, the spinal cells that control the movements of the lower extremities and the lower abdominal muscles.

The predisposing causes were insufficient food, poor hygienic surroundings and trauma. The exciting cause was exposure. That the uterine muscle was able to expel the full term foetus without help from any of the voluntary muscles. That, the corticle influences being cut off from the lower segments of the cord, labour was more rapid and less painful than normal.

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HEMORRHAGE IN NEW BORN.

By Nathan Winslow, M. D.

Owing to the frequency, complications and often fatal results of hemorrhage in the new born, it is of great importance for the practitioner not only to know its cause, but also its treatment. There are several physiological conditions in the infant which predisposes to hemorrhage, the extreme thinness and friability of the blood vessels, the comparative noncoagulability of the blood, and the transition of the circulation from intra-uterine to extra-uterine life, and it is often associated with many of the diseases of early life, such as syphilis and sepsis. So it behooves the obstetrician in any case of labor, but especially in protracted and artificial, to be on watch for this complication. The prognosis will depend upon the locality of the lesion. If it occurs within the brain it is serious as regards life. If the child should happen to live, we are almost certain to have paralysis or some other remote effect. In the case of surface hemorrhage, such as cephalhematoma, or hemorrhage between the cranial bones and the periosteum, the prognosis is good.

From the above statements it can be seen that hemorrhage of the new born naturally falls under one of the two following classifications: (1) Traumatic, which depends upon causes connected with delivery; (2) Spontaneous.

Traumatic.

Traumatic hemorrhages are mainly due to pressure in natural labor, or to the means employed in artificial delivery. They are more frequent in large children, malpositions, dystocia, and where the body of the child has been subjected to undue pressure during parturition. The most important of these are cephalhematoma and certain of the visceral hemorrhages—i. e., intracranial, thoracic and abdominal.

Cephalhematoma.

This is a rare tumor containing blood, situated upon the head, most frequently over one of the parietal bones, and tending to spontaneous disappearance by absorption. It is usually due to some trauma during either natural or artificial labor, but may be of spontaneous origin. Owing to the attachment of the periosteum along the sutures, the exudation is limited to one bone, and never crosses the sutures or fontanelles. The bloody mass is found between the bones of the skull and the periosteum; and in recent cases the blood is fluid; later it becomes coagulated. There is often developed about the clot a bony ridge, formed by the deposition in the blood of some bony elements. It is entirely benign and does not affect either the life or the health.

The tumor is usually noticed from the second to fourth day after birth. In the average case the growth is about the size of a hen's egg, and is oval in form. To the touch it is soft, elastic and fluctuating. It does not increase with the cough or cry, nor does it pulsate. Very soon the tumor is surrounded by a marginal ridge, which is at first due to coagulation of the blood; later to bony deposits, which may lend to the exudate the appearance of a fracture. As a rule the cases go on to recovery and the complete disappearance of the tumor may be expected in two months.

Do not confound this condition with encephalocele, a congenital malformation in which there is a protrusion of a portion of the brain substance through an opening in the skull. Encephalocele occurs along the line of the sutures or at the fontanelles, is partly reducible, and pulsates during respiratory movements and crying. In hydrocephalus we encounter a symmetrical enlargement of the head, and the fontanelles and sutures are open. Caput succedaneum, which occurs about in the same position as cephalhematoma, is an edematous, not a fluctuating tumor. It is not circumscribed, and begins to disappear in two or three days. In a depressed fracture of the skull there is a depression and not a raised tumor.

As it tends to spontaneously disappear in the great majority of cases, there is no need of either local or general treatment. Proceed, however, according to symptoms. If suppuration sets in, operative procedures become necessary.

Visceral Hemorrhages.

Visceral hemorrhages occur most frequently in large children and difficult labors, but may occur in small children and easy confinements. Intra-cranial hemorrhage follows the application of forceps, but may occur in natural labor. It may occur even in breech presentations; but here we are more liable to be confronted with the other visceral hemorrhages. If we have a large hemorrhage into the lung, we have practically the same pathological conditions existing as in atelectasis, for the blood not only fills the air vesicles, but also the smaller bronchi, and in some cases even the larger ones. The abdominal viscera, owing to their imperfect protection from pressure, are often the seat of hemorrhages. Except in the intra-cranial variety, the visceral hemorrhages excite but few symptoms, and a large proportion of the cases are undiagnosed. In the case of hemorrhage into the lungs, we may, upon physical examination, elicit the signs of consolidation, and in rare cases we may even have hemoptysis.

The prognosis depends upon the extent and location of the hemorrhage. These hemorrhages are not amenable to treatment.

Spontaneous Hemorrhage.

A disposition in the first few days of life to bleeding is associated with many diseases, especially congenital syphilis and pyemia. There is, however, a class of cases in which hemorrhages are not associated with any other known process, and in which the oozing of the blood from the capillaries is the essential pathological lesion. In these cases the bleeding is much more extensive than in the traumatic. These hemorrhages are characterized by the fact that they are spontaneous in origin, multiple in location, and, while influenced by treatment, they tend to cease spontaneously. They are most often from the stomach, and are exceedingly prone to occur beneath the skin, but may be from almost any organ of the body or mucous surface.

We have been unable so far to determine definitely what causes these hemorrhages, but we believe them to be due to either changes in the blood vessels, or in the blood, or possibly in both. They are slightly more prevalent in the male than in the female. The hemorrhagic diathesis is self limited, and runs a definite course to recovery or to death. The tendency to bleed does not extend beyond a few weeks, and often lasts but a few days. Hereditary syphilis is associated with a small proportion of the cases, but a more frequent association with sepsis has been observed. It is supposed by some authorities to be due to a bacterial infection, but this theory has not as yet been definitely settled.

In many of the cases the autopsy shows nothing except the hemorrhages in various situations and blanching of the organs due to the loss of blood. The hemorrhages of the brain are usually meningeal and diffuse. In the lungs there are small extravasations into its substance or ecchymoses here and there on its mucous membrane. Small extravasations may at times be seen either on the surface or into the substance of the liver, spleen and kidneys. The stomach and the intestines may contain a considerable amount of disorganized blood. Some authorities claim to have found evidences of endarteritis in some of the specific cases. The changes in the blood in this disease have been but imperfectly studied.

The time of beginning is usually during the first week of life, rarely after the 12th day. As a rule the hemorrhages from the stomach and intestines occur earlier than those from

the skin and navel. At times nothing is noticed until the hemorrhage begins. The first bleeding noticed may be from the stomach, intestines, or from any of the mucous surfaces, beneath the skin or from the umbilicus. There is merely a continuous oozing and the loss of blood as a rule is not great. The amount of blood lost varies from a few drachms to several ounces. The skin is pale, pulse feeble, and the patient is in a state of complete prostration. There is a rapid loss of weight; the temperature may be normal, subnormal or elevated. We frequently notice that the child has diarrhoea. Convulsions often occur at the close of the disease. When the case tends to recovery the attack is only of one or two days' duration. Death may occur as soon as the first day, but the child usually survives for a few days.

Umbilical Hemorrhage.

A slight oozing from the umbilicus not infrequently follows the improper application of the ligature. In some cases, even when the cord has been properly ligated, the ligature slips, due to shrinkage of the funis, and an oozing sets up. These conditions may usually be controlled by simple surgical remedies, but spontaneous hemorrhage from this locality is of much greater import, owing to its tendency to terminate fatally. As a rule it occurs later than bleeding from the mucous surfaces, commencing generally on the fourth or fifth day. A slight stain on the dressings is generally the first indication of trouble, but this disease may start with a gush of blood from the cut end of the cord. Occasionally we are able to check the hemorrhage, but it tends to recur. In case there is an exceedingly great loss of blood, we will have the general symptoms of hemorrhage added to the above local signs. If the patient is going to recover, the bleeding in three or four days tends to spontaneously cease.

Hemorrhage from the Stomach and Intestines.

It occurs much less frequently from the stomach than from the intestines. Here, as in umbilical bleeding, we have the hemorrhage to commence as a rule on the third or fourth day, and in no instance has it been reported to have occurred later than the twelfth day after birth. The color of the vomitus depends upon the length of time the blood has been retained in the stomach. In some rare cases blood arterial in color has been vomited. It is not great in amount, and with the exception of the above-mentioned instance occurs in dark-brown masses. The quantity varies from a few drops to an ounce. Vomiting is very apt to be set up by nursing. When the blood is discharged from the bowels we call it melena. The stool is intimately mixed with the blood and is very black in color. We will not in this case find any blood clots. You can in gastro-intestinal hemorrhage confirm your diagnosis either by using the microscopical or the tincture guiacum test for blood.

The spontaneous hemorrhages which occur from such surfaces as the mouth, trachea, bronchi, nose, kidneys, are not of such great importance as those just treated, for they do not tend to produce death; so we will not give a detailed account of their symptoms.

As we are very likely to have some surface manifestations of these hemorrhages, the diagnosis very seldom gives us any trouble, but in cases of concealed hemorrhages the doctor may slip up in his diagnosis. Bleeding from the nose usually indicates a case of syphilis.

The prognosis is grave in all these cases. The mortality ranges from 50 to 75 per cent. In general it may be said to depend upon the vitality of the child, the location and the amount of the hemorrhage. As long as the child lives do not give up hope, for the most desperate cases sometimes make a good recovery.

Drugs exert no specific influence upon this disease. The best we can hope for is to maintain life by judicious stimulation, nutritious feeding and by maintaining the animal heat. When the hemorrhage is within reach, silver nitrate fused on a probe may be applied to the hemorrhagic area. Any other astringent will do about as well. The actual cautery may be given a trial, yet the bleeding is likely to recur when the wound sloughs. Internally astringents have been tried, but nothing seems of much avail in hemorrhage of the gastro-intestinal tract. We place most reliance upon such stimulants as strychnine and whiskey, aided by the child's vitality, to pull it through the attack.

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BALTIMORE, MD., NOVEMBER 15, 1908

EDITORIAL.

THE CLINICAL STUDY OF MEDICINE.—As important as is the study of anatomy, physiology, chemistry and pathology, the study of clinical medicine is the foundation which underlies the work of the medical practitioner. No practitioner can succeed in his contest with disease if he is lacking in knowledge and experience of the essential principles which underlie his clinical work. He may meet with a fair degree of success with a small knowledge of the fundamental branches of medical science, but he is a signal failure as a practitioner of medicine, or of surgery, either in general or special lines of work, if he be an ignoramus or charlatan as a clinician. The importance, then, of a thorough clinical study of medicine and surgery is of such magnitude that no medical school can measure up to its highest duties to its students which does not supply the material and insist upon its thorough study. Hospitals and dispensaries with an abundance of clinical material must not only be provided for the instruction of the student, but the use of this material in the most careful and systematic manner must be made by a well-trained corps of clinical lecturers and demonstrators who are engaged in the work of training the student how to practice his profession. The University of Maryland has prided herself on the abundance of the material which she brings before her student body. In clinical instruction her record has been a most creditable one. She has made good use of the material at her disposal, and her graduates have profited in their professional work by the careful clinical instruction given to them when students. While this may be said in all fairness, it must be borne in mind that medicine and surgery, both general and special, have made rapid advances in recent years; that the clinical study of these branches has greatly widened, and that the needs of the student of today for a more accurate and intimate clinical knowledge are greater than ever before. The old-fashioned amphitheater clinic, the ward class and the dispensary clinic are giving away to better systems and methods of instruction. This is an age of demonstration, of personal contact and of closer investigation of disease in its physical aspects. The student's needs will not be met by a clinical talk or by the mere sight of a brilliant operation. He must not only see, but must handle the patient, dress wounds, give anaesthetics, and in a personal way go over the various symptoms and physical conditions presented by the patient. This opportunity can only come in a large way to the exceptional student who enjoys an Interne service. In a general way it should come to every man who presents himself for his medical degree. THE BULLETIN can suggest only one plan which will take in every fourth-year student. That plan makes use of every phase of section work—a systematic drill in sections by demonstrators and clinical instructors who work with the student and force upon his attention the most important clinical facts presented by the patient under study.

THE SATTERTHWAITE LECTURES.—At the invitation of the Faculty of Physic of the University of Maryland, Dr. Thos. E. Satterthwaite, of New York, delivered a special course of four lectures, one each day, on October 26th, 27th, 28th and 29th, at 1 o'clock P. M., in the Clinical Amphitheater at the University Hospital, to the students, faculty and invited guests.

Dr. Satterthwaite is one of the most distinguished specialist in cardiac diseases in the world, and the subjects of his lectures were the study of the heart and its diseases. His presentation of the various subjects discussed was an able and interesting one, and was most favorably received by the large audience in daily attendance.

In establishing a special course of lectures to be given by distinguished specialists, the Faculty recognizes that much good can come to the students and teachers connected with the University through this medium of public instruction.

It is announced that this course of lectures will

be repeated another year by some distinguished surgeon yet to be selected. The precedent is a good one, and should be repeated many times.

THE CORRECT RESULT OF THE MARYLAND STATE BOARD EXAMINATION, HELD IN JUNE, 1908.—We have received the list of those who appeared before the Maryland State Examining Board last June, and can now give the exact results of those examinations.

In the list as published in the Maryland Medical Journal in September, fifty-seven men are accredited to the University of Maryland, but one of those, number 162 in the list, who passed a successful examination, was not a graduate of this school. Two others who applied for examination did not appear; one of these, number 8 on the list, graduated in 1891, and we do not know why he did not appear for examination. The other, number 103 on the list, is one of the residents at the University Hospital at this time, and was sick, and, indeed, was operated on for appendicitis about that time. This leaves 54 who actually were examined; of these eighteen were second-year students and thirty-six were graduates. Of the eighteen second-year students, eleven passed on all branches, six passed on all but one subject, and one failed miserably on all but one subject. On the whole, these second-year students did very well. We now come to the thirty-six graduates; of these twenty-seven passed and received their licenses, and nine failed, or 25 per cent. of failures, instead of twenty-two passed and eighteen failed, as published in the September issue of "Old Maryland." Of the class of 1908, twenty-seven were examined and twenty-one passed and six failed, or 22¼ per cent. of failures. Of those taking re-examinations six passed and three failed. Now these results are not good, and the writer is not trying to apologize for them or to explain them away, but simply to present an absolutely correct statement to those who are entitled to know how our men stand before our own examining board. No one is as much interested in the results of the State Board examinations as the Faculty of the University, and no one feels so keenly as it the stigma of any poor showing made by our graduates. A very large proportion of our graduates remain in Maryland, and come before our Examining Board. Great stress seems to be placed on chemistry and pathology, more so than in many other states, and examination in these two branches is conducted by the same examiner, and it is in these two subjects that our men most frequently fail. Strenuous efforts are being made to strengthen our weak places, and whilst we cannot do as some of the highly endowed schools can, we know that we are instructing our men better, and turning out better physicians than the vast majority of the schools of this country.

CORRESPONDENCE.

SPOKANE, WASH., *Oct.* 16, 1908.

Editors Bulletin:

DEAR SIRS: After seeing Portland one cannot help but saying it is the ideal Northwest town for the retired man. They have the most beautiful roses practically the whole year, and it is spoken of as the Rose City. Although they have rain for four months or more, it is not severe, and one becomes accustomed to it, and some carry an umbrella as religiously as you would wear a hat. They are near enough the coast to get the effects of the Japan current, and consequently never have snow.

The town is divided by the Columbia River, and this is spanned by four large draw bridges and numerous ferries, constantly carrying the traffic. There are numerous salmon canneries all along the river, and one wonders where so many fish come from. Thousands and thousands of these slimy fighting inhabitants of the waters are dragged to the shore by the seiners and allowed to flop away their lives. And there elapses but a short time ere they are canned and shipped East.

The harbor is filled with ocean-faring sailboats, but few steamers. Now and then a tug is seen bearing in tow huge logs, bound together, having a serpentine appearance, for often they string out three-quarters to a mile in length. These are towed to the numerous saw mills along the river. The tides are very high, necessitating high piles for the wharfs.

The town itself shows evidences of rapid growth and the bungalow home predominates. Property has increased two to three times its value during the last few years.

The old Fair Grounds are still to be seen with its dilapidated buildings. Some still show what they were during the fair; most have gone to ruin. The Forester Building is kept by the government, and should be seen by all who visit the town. On the hills about the town are seen some perfectly beautiful homes. Many of the most artistic bungalows are to be seen here. The architecture of these homes is entirely different from the East, and I must say it is beautiful. A trip up Council Cliff gives one an opportunity to see many of the pretty places.

Council Cliff is just back of the town and gives a beautiful view of the surrounding country. The Columbia River can be seen for miles up and down the valley. To the south the town spreads out gracefully to the foothills on the far side of the river. Beyond the mountains rise and the peaks are lost in the clouds. To the west mountains alone are to be seen. To the east quite a number of small towns are seen in the valleys. Following the course of the river east, we see the wide expanse of bad lands, so spoken of because they are swamps and not what the Westerner generally means by bad lands. To the north are seen numerous valleys and tier above tier of beautiful mountains. Between these mountains there is the richest farm land in the country and numerous villages are seen. On the sides of these rugged mountains are large prune orchards. These trees average 12 feet high, of a light color. They are very knotty and ugly.

Portland has very nice hotels, especially The Portland. There are numerous new office buildings, many very pretty. The town, like all Western cities, is full of strangers. With all its beauty and resources the town fared badly during the flurry, some of the banks going down.

We left this town at 7.40 P. M. over the Southern Pacific over the Mt. Schaster route. In the morning we were in a valley, where the sun was warm and was pleasant on the observation car. The snow-capped mountains on either side of the valley were beautiful. The soil in the valley was black and rich, with numerous small towns to be seen. We soon started up the mountains again, and in half an hour we were in a snow storm.

We saw the mountain on which the Indians made their last stand. It was as though the top of a mountain had been cut off, leaving this level plateau. There is but one road which leads to the plateau. About the rest was a drop of from one to two hundred feet. And this natural barrier the Indians took advantage of; and it was only after big losses on both sides that the Indians gave up. It necessitated three engines to get us up these mountains (the Siskeyon Mountains), two pulling and one pushing. At 11 A. M. we saw in the far distance Mount Schaster.

At noon we reached 4,125 feet altitude. Everything was covered with snow. All the trees are laden with mistletoe to such an extent that the deciduous trees look green as though in foliage. Many trees even break under the weight. The mistletoe is even found on the fruit trees in the valleys.

All during the afternoon we could see Mount Schaster standing out before us in its majestic beauty and the sun's rays being reflected by its snow-white cap. Passing through beautiful, green, summer-like valleys and, looking up, see this huge mountain of snow, is quite a contrast. We traveled all day in valleys and over mountains and did not reach the foot of Mount Schaster until 6.30 P. M., when we came to the famous Mount Schaster Springs. The hotel is built right at the foot of the mountain by the railroad. There is a large stream of water dashing down the mountain over rocks and boulders, and this is most beautifully illuminated by electric lights way up the side of the mountain, presenting a most spectacular appearance.

The water is very good, but owing to the large amount of minerals the taste is not pleasant at first. While traveling over these mountains you could not exactly talk to the engineer from the observation, but we could look down and see the tracks over which we had just passed. Upon awakening in the morning we were in a flat valley, bordered by high, barren mountains, which do not look a bit like the California we read of. We soon passed out of the valley and ran along the foot of low hills, and below us lots of low, swampy land and in the distance the river. The train was put on a ferry and carried across the river, and we went on to Sacramento. There we got off and took the ferry across the bay to San Francisco.

This town did not present the appearance of the Golden City of the West that we had read so much of. The down town streets were hor-

ribly cut up and muddy; but one was impressed by the great progress being made in the reconstruction of the burnt district—many of the old buildings rebuilt and many new buildings. The most striking sight was to see a large reinforced concrete building being covered with a dark, glazed tiling for the first two floors, and the rest of a pale green color, thus giving the building a tropical, brilliant appearance.

Chinatown was completely rebuilt. Knob Hill ceases to be the home of the wealthy. The only thing that still stands is the magnificent hotel Fairmount. The old inhabitants of this hill have moved to the towns along the bay. The ruins of these handsome mansions remain untouched.

From this hill you command a wonderful view of the bay and surrounding country. The Golden Gate Park is as beautiful as ever, but shows great needs of attention. The tropical plants are magnificent, the huge lakes and ponds with beautiful swan and Japanese ducks floating gracefully about. The Musical Conservatory is beautiful, with seats arranged for thousands, all in the open air. The Museum is a creation of Greek architecture. Inside you see art, sculpture, relics, etc.—everything you can possibly imagine. Mummies dating back 1,000 B. C. in their coffins all carved in Greek figures, the bodies completely wrapped in linen and spices many thicknesses deep.

In this wonderful park, with its beautiful drives, the machines never blow their horns, but speed gracefully along.

After a beautiful ride along the water front we came to the famous private park—Sutro's Park. Once within the gate, you are impressed by the numerous pieces of statuary all through the grounds. A deer here, a soldier there, a nude figure here, a goat on the hillside there; a hunchback somewhere else. Thus you pass through the beautiful walks and meet with surprises on all sides. An artificial fort is seen on one bluff. Between each cannon a beautiful piece of statuary and urns of flowers. Down the slope one sees here and there a mountain goat. Below this there is a walk which leads around the bluff and overlooks the water, and the huge waves roll in to the shore 40 to 50 feet below you. You can see the strong forts on both sides of the channel, and to the left a beautiful stretch of beach, where the soldiers can be seen riding their horses in the surf, and an unexpected wave almost covers them. To the right is seen the Seal Rock and the sight of the Cliff House.

Going to the old site, we could easily see the huge seals basking on the rocks and the waves dashing over them. Below this are the Sutro's Baths and Museum. The swimming pools are large and most beautifully arranged. There is seating capacity for thousands, and from these tiers of seats the audiences watch the sports, after which the wonderful collection of curios are looked over. To see everything necessitates several trips, for there are millions which come from all parts of the world.

The following day we took an early boat for Sonciliato, which is quite a distance, and you pass close by Prisoners' Island, where Uncle Sam keeps misbehaving soldiers prisoners. In crossing the bay you cannot help being impressed by the enormous number of "Harbor Scavengers"—the sea gulls. It is quite safe to say there are more than in any other harbor in the United States. They follow the boats back an forth across the bay, and anything thrown overboard never touches the water, for one of these graceful birds has caught it and gone with numerous others in close pursuit. These birds are so tame you can almost reach out and touch them as they glide gracefully along beside the ship, looking at you in a beseaching and longing manner. The more you throw things to them, the nearer your hand they come. Sancilator is a small but pretty town. Many very pretty homes are to be seen.

Here we took a train up Mill Valley, which took but a short time, for the train was very fast. In this pretty, quiet valley are numerous lovely cottages and artistic bungalows. Here we changed trains and took the Mount Tamalpais car. This railroad is the most crooked in the world; there is no part of the track over 100 feet that is straight. This railroad winds its tortuous way up this mountain in a most marvelous manner. At one place a double bow knot is formed by the track. This can be seen after you reach the top and look down on the road.

On this trip up the mountain is the only place I saw the famous redwood forests, and yet I traveled from the north to the south of the State. The forests are almost impassible, due to the dense underbrush, and the houses are com-

pletely hidden by the dense foliage. The engines used on this road are very novel. The steam chests are perpendicular to the ground, as are the piston rods. The shafts are not one continuous piece of steel, but have several joints, to allow the twisting and turning of short corners, and there is always a constant stream of water flowing on the drive wheels. The rails are smooth, as are the wheels, but the wheels are faced by cogs on their sides. This road carried us to the tavern, about 200 feet from the top of the peak. From the top of the peak you can see to the west the low mountains, beyond which you see the angry Pacific Ocean rolling and tossing in the high wind, dashing against its restraining shores.

Looking south you see the beautiful bay, spread serenely out before San Francisco, and the boats gliding gracefully upon its surface. To the east and southeast you see several towns, most of them having good-sized hotels. San Raphael and San Quentin are the largest, beyond which the mountains rise gracefully, cutting off all other view.

There is a large expansion of surface, perfectly level, with numerous tortuous, snake-like streams passing through it, which is known as the flats, and in high tide are submerged. Nothing can be seen to the north save mountains, mountains and mountains. The panoramic view from this peak is wonderful, and one should not miss visiting this point of interest.

A delicious dinner is served at the tavern for reasonable rates. This is the only place about San Francisco where snow ever is seen. When snow begins to fall the city is notified by wireless telegraph, and people flock there by thousands, many never having seen it before. They go wild over the sight, and roll over and over in it as a child would on the grass on a spring day. They bring baskets and boxes and try to carry it back to the city. With but one or two exceptions this has never been done. Ere they reach Mill Valley or Sansiliata the snow has melted, and they only take home wet clothes and a gratified curiosity.

We left San Francisco at 8 P. M., taking the coast trip to Los Angeles. As we were running along the coast a storm was raging and the waves were immense, rolling in over the shore. We soon ran out of the storm, and for the next 100 miles or two stayed close to the shore. The country was beautiful and green. There were immense orchards of English walnuts, but no orange groves. Numbers of enormous eucalyptus trees are to be seen everywhere.

I met an old gentleman who had traveled over the world, and, by the way, knew Baltimore well and every nook in the Chesapeake Bay. He said Santa Barbara was the garden spot of the world, and there he would spend the rest of his days.

"There is no place where you will find uniform temperature the year around, the ocean at your feet, five or ten miles of orange groves, and then the snow-capped mountains, thus affording one any kind of climate and any kind of diversion at any time of the year."

We reached this town before noon, and it was exactly as he had said. There is a beautiful hotel—The Potter—and its enormous beds of calla lilies in full bloom, and this was February! There is no doubt about it, this town won my heart. Everything so peaceful and tropical palms were beautiful—everyone enjoying themselves. Here and there groups of beautiful women basking in the sun, numerous riding parties, well mounted, and the only thing to mar the beautiful place was the clang-clang of the lunch gong, which is to be heard at every station on the coast.

The old mission was beautiful, as were some of the modern churches.

Before we reached Santa Barbara the ocean had become calm, and only gradual swells were to be seen.

The old mariner said the Atlantic was twice as rough and treacherous as the Pacific, and he always went out in a catboat on the ocean.

After a short run below Santa Barbara you leave the coast and approach nearer the mountains, which are snow-capped and very rugged. The land is of little value. The cactus thrives, as does the sage brush.

The last 100 miles before reaching Los Angeles you pass through a beautiful, narrow valley. There are large vineyards here, and the vines are kept cut close to the ground, not over 12 or 18 inches long, and each year the new branches are cut off. Numerous oil wells are seen along the coast near Los Angeles, and many even in the town; yes, and on the lawns of homes. The most remarkable are those out in the ocean, 400 to 500 feet from shore, and all active. Just before we reach Los Angeles

Dr. Eugene Kerr, class of 1905, and Leo Karlinski, class of 1906, are on the Dispensary Staff of the Phipps Institute.

The local chapter of the Nu Sigma Nu fraternity held a housewarming at the chapter house on West Lombard street during the early part of the month. Among the invited guests were: William Lee Hart, class of 1906; T. Marshall West, class of 1908; A. D. Tuttle, class of 1906; Robert L. Mitchell, class of 1905; W. M. Hollyday, class of 1908; J. B. Piggott, class of 1908; Jacob Bird, class of 1907; W. Cole Davis, class of 1908. The members of the fraternity present were: Messrs. J. B. Parramore, R. N. Knowles, H. S. Anderson, I. R. Robertson, I. G. Glover, D. J. Rivers, C. I. Joslyn, H. A. Coddington, W. T. Gibson, C. L. Strohmeyer, W. J. Rickets, George Walter, N. T. Kirk, W. V. V. Parramore, G. D. Townsend, H. B. Athey.

Dr. E. C. Kefauver, class of 1891, of Thurmont, was toastmaster at a banquet held to celebrate the opening of the section of the Washington, Frederick and Gettysburg Electric Railway, between Frederick and Thurmont. The banquet took place October 10, 1908. Dr. M. A. Birely, class of 1894, of Thurmont, was one of the committee in charge of the reception.

Dr. Robert L. Mitchell, class of 1905, has removed his office and residence from 2321 Maryland to 2112 Maryland avenue.

Dr. Wm. D. Scott, class of 1904, has moved his office to 1024 Madison avenue.

Dr. J. Marshall Price, class of 1890, of Frostburg, Md., has resigned from the Democratic State Central Committee.

Dr. W. W. Riha, class of 1905, has located at Durham, in the Catskill Mountains, of New York, where he will practice his profession.

Dr. Oliver J. Gray, class of 1902, of Wilmington, Del., was severely injured at Quantico, Md., by the premature explosion of a shotgun. The injury necessitated the amputation of the left leg above the ankle.

Dr. H. Y. Righton, class of 1907, of Savannah, Ga., is in Europe.

Dr. James Edwin Harris, class of 1886, a son of Prof. James H. Harris, sailed for Bremen from the port of Baltimore during the latter part of August.

The University of Maryland was represented at Washington during the International Congress on Tuberculosis with a small but excellent collection of specimens.

Dr. Richard H. Lewis, class of 1871, resides at Raleigh, N. C. He is one of the best-known and most representative members of the medical profession in the State of North Carolina. He is an honor to his alma mater. He presided at the meetings of the American Public Health Association, held at Winnipeg, Manitoba.

The Interurban Orthopedic Club, as its name indicates, composed of members from the several cities of the United States, met in the Nurses' Home, University Hospital, Friday, October 23, 1908. Dr. Compton Riely showed them a number of interesting cases. One of the patients was suffering from a fractured spinal column. He had had a laminectomy done for relief of pressure upon his spinal cord and a plaster cast applied. Although his lower extremities were completely paralyzed at the time of the injury, under his treatment he had somewhat improved. There were two other cases of fractured spinal columns exhibited, both of whom were improving under treatment.

Dr. Riely also showed and fully explained an instrument invented by him for the forcible correction of latteral curvature of the spine, and several others of his inventions. The display seemed to make a favorable impression upon the visitors. The University of Maryland has too long been hiding its light under a bushel. Our men are all the time doing something worthy of bringing to the attention of the medical profession, but they are too diffident and modest. We must stop our hibernating and thrust ourselves to the forefront. Prof. Randolph Winslow showed to the society a little girl patient upon whom he had operated to release the upper thighs from each other. They were united by a kind of a false web, which resulted from severe burns and improper after treatment. The external urinary meatus and the vagina were situated posterior to the apron.

Prof. Thomas E. Satterthwaite, professor of medicine in the New York Post Graduate School, delivered a series of four lectures upon the heart to the students and faculty at the University Hospital from October 26 to 29, inclusive, in the amphitheatre of the University Hospital. We are all greatly indebted to Dr. Satterthwaite for the course and the interest he manifested in the University of Maryland. We think, perhaps, of more import than his lectures were the kind words of encouragement he gave to the directors of the destinies of the old University. He said the University had had a glorious past, but that the University was to be a great university in the near future. He also mentioned George Washington's desire that the University of Maryland be one of the greatest universities in the world.

As regards the lectures, they were concise and embraced our latest known means of diagnosticating and treating the various forms of heart affections. He called special attention to the fact that the myocardial affections should be more thoroughly studied and should be sooner diagnosed. The condition of the myocardium is of vastly more importance than the condition of the endocardium. He also graphically illustrated his resistance exercises for heart affections.

The Nu Sigma Nu, the Chi Zeta Chi and the Psi Omega Fraternities occupied boxes at Ford's Opera House October 2, 1908, and enjoyed a benefit performance of "Mary's Lamb" by Richard Carle and his company. The benefit was for the Athletic Association of the University of Maryland.

Drs. Marshall L. Price, class of 1902, Secretary of the State Board of Health, and J. F. H. Gorsuch, class of 1876, recently addressed the Hamilton Improvement Association on "Sanitation."

Dr. Harry Adler, in his speech of acceptation of the Frank Memorial Hospital by the trustees of the Hebrew Hospital and Asylum, said:

"In 1868, with it in the capacity of visiting physician, which position he held until 1873, when he went to Europe to pursue special studies. On his return he was elected a consulting physician. In 1897 he became a member of the Board of Directors and inaugurated the medical advisory committee, of which he was chairman until elected president in 1905. This memorial is, however, not simply a monument to him; it stands forever a testimonial to her whose benevolence bid it rise, and its dedication would be incomplete without a recognition of that generosity which even in this Jewish community, justly noted for its philanthropy, is without a peer. As distasteful as I know any public reference of Mrs. Bertha Rayner Frank is to her, I cannot forego what is at once a duty and a pleasure—gratefully to acknowledge our debt to her, who, reared in affluence, denies to herself many of the material pleasures of life in order that the bulk of her means may be devoted to her fellow-man.

"Messrs. Louis Sigmund and Simon Kahn have erected a children's ward in memory of their late parents as a tribute of their filial love. Nothing could have been more opportune than this gift, as without it we should have been unable to provide accommodations for sick children, which is so important."

Dr. Harry Adler, class of 1895, Associate Professor of the Diseases of the Stomach, University of Maryland, is president of the Board of Trustees of the Hebrew Hospital.

Dr. Charles Bagley, class of 1904, is medical superintendent of the Hospital.

Dr. Frank, in whose memory the Hospital was erected, is a graduate of the University of Maryland, class of 1862.

Mrs. Frank, through whose benevolence the Hospital was made possible, has founded two scholarships in the University of Maryland for needy students.

Dr. B. Merrill Hopkinson, class of 1885, led the choir at the dedication.

Dr. Arturo Zelaya, who was graduated from the University of Maryland with the class of 1908, has sailed for his native land, Honduras, where he intends to enter upon the practice of his profession. Dr. Zelaya is a native of Tegucigalpa.

Dr. Josiah S. Bowen, class of 1903, of Mount Washington, Md., who has been seriously ill from an attack of pneumonia, is reported to be making a good recovery.

The recent meeting of the Baltimore County Medical Society was entertained by interesting addresses by Dr. Marshall Price, class of 1902, secretary of the State Board of Health, and Dr. James F. H. Gorsuch, class of 1876, health officer of Baltimore county. Dr. Price said, in part: "In the counties the County Commissioners do not take sufficient interest in the health of the counties. They cannot be much blamed for this, as there is a lack of good county government throughout the State. The district plan of handling the sanitation question is the best, and I think Baltimore county is rapidly meeting the requirement of a good county government. The people will do well to awaken on the sanitary subject."

Dr. Henry A. Naylor, class of 1900, of Pikesville, was appointed secretary of the society.

Among those present were: Drs. J. H. Jarrett, class of 1852, of Towson; H. L. Naylor, class of 1860, of Pikesville; J. T. Payne, class of 1862; R. C. Massenburg, class of 1884, of Towson; James F. H. Gorsuch, class of 1876, of Fork; H. A. Naylor, class of 1900, of Pikesville; J. Royston Green, class of 1899, of Towson; B. F. Bussey, class of 1885; A. C. Smink, class of 1896, of Dickeyville; J. H. Drach, class of 1880; M. L. Price, class of 1902; N. H. D. Cox, class of 1902, of Pimlico.

At the last meeting of the General Alumni Association of the University of Maryland, held in Davidge Hall, Wednesday, October 21, 1908, Alfred M. Quick, Water Engineer of Baltimore City, gave an address on the "History of the Water System of Baltimore." In his address Mr. Quick briefly sketched the history of the water system of Baltimore from its inception in 1797 to the present system and plans.

The Committee on Program was: Dr. T. O. Heatwole; Oregon Milton Dennis, LL. B.; Eugene Hodson, Phar. D.

The General Alumni Association was founded and incorporated in 1903. At that time there were three separate and distinct alumni bodies at the University, none of which represented the University as a whole. They were simply departmental associations. The requirement for membership therein was that the applicant should be a graduate of the department which the association represented. So it occurred to Dr. E. F. Cordell that this was an anomalous state of affairs, a great University having only departmental alumni bodies. Consequently he called together a few of the representative alumni of the various departments of the University of Maryland and discussed the advisability of forming an association whose membership should not be limited to any one department, but was to be open to lawyer, dentist, pharmacist, doctor, et al, alike. As there was no alumni association of the Law Department, the graduates of that school who wished to continue their connection with their Alma Mater could now do so. I am glad to report a number have availed themselves of this privilege, and among our most respected, active and honored members are some from this department. If it were not for the General Alumni Association their services would be lost to the University. By this service alone the General Alumni Association justifies its existence. Evolution is slow; the General Alumni Association was nearly an hundred years a coming, but we are glad to say is now so solidly entrenched that it is certain to survive. With a humble membership at the beginning of not more than 10, today there are 498 names upon its roll. By this time next year this should be increased to 700, as there will be a consolidation of the General Alumni Association with the Medical Alumni Association. The General Alumni Association will then be the only Alumni Association in the University of Maryland, as the Dental and Pharmaceutical Alumni Associations have already consolidated with the General Alumni Association. This will mark an important epoch in the history of the University of Maryland, as it is surely the beginning of the centralization of the management of the departments themselves. Three years ago it would have been impossible to bring about an union of the Alumni Associations. Indeed, the scheme was broached at that time, and was scouted as impossible. Time has wrought great changes, and greater changes are in store in the near future. The Alumni Association is going to play its part in these changes. The day is past when the governing body of an institution can afford to be deaf to the appeals of its alumni. In fact, many of the institutions

of this country have recognized this fact, and have admitted alumni representatives to their governing boards. Such a move by the Board of Regents of the University of Maryland would be popular amongst its alumni, and would tend to bring the governing and alumni bodies into closer and a kindlier relationship. Such an appointment need not be a life tenure. It need be only a yearly appointment or longer, if thought desirable. As regards a precedent for this radical departure, mention need only be made of the fact that neither Mr. Wirt R. Randall or Mr. Philemon Tuck is a member of the Faculty of St. John's College, still they are representatives of that College upon the Board of Regents of the University of Maryland.

MARRIAGES.

On Wednesday, October 28, 1908, at high noon, at Hampton, Chaneyville, Calvert county, Dr. Irving Drury Chaney, class of 1906, was married to Miss Elizabeth Olivia Talbott, daughter of Mrs. E. P. Talbott and the late State Senator J. Frank Talbott.

The bridesmaids were Misses Nellie W. Chaney, of Bristol, sister of the bridegroom; Margaret Hamilton, of La Plata; Carrye Hardesty and Mabel Drury, of Chaney; Mary Lowndes Owens, of Baltimore, and Florence Van Devender, of Leesburg, Va. The maid of honor was Miss Roberta Andrew, daughter of Rev. and Mrs. J. R. Andrew, of Salem, Va. Isabelle Talbott, daughter of Dr. and Mrs. Erlie Talbott, of Washington, and niece of the bride, was flower girl. The ring-bearer was Virginia Talbott, daughter of Dr. and Mrs. Russell Talbott, also a niece of the bride.

The bride was given away by her youngest brother, Mr. Francis Boswell Talbott. The best man was Mr. Joseph Chaney, the groom's brother. The ceremony was performed by Rev. W. H. Sanders. Miss Maude Smith, of Baltimore, played the wedding march. Dr. and Mrs. Chaney, after a honeymoon spent in the North, will make their home in Baltimore.

Dr. Charles Richardson, class of 1903, of Belair, Md., son of Mr. and Mrs. John S. Richardson, of Belair, and Miss Cornelia Trimble Munnikhuysen, daughter of the late Dr. Wakeman B. and Mrs. Munnikhuysen, were married October 10, 1908. The ceremony took place at St. Mary's Protestant Episcopal Church, near Emmorton. The Rev. Dr. William L. Glenn, the rector of the church, was the officiating clergyman. After the ceremony Dr. and Mrs. Richardson left on a wedding tour.

Dr. Wilbur Pledge Stubbs, class of 1902, of Baltimore, was married Thursday evening, November 5, 1908, at Grace M. E. Church, Baltimore, to Miss Ellen Louise Marshall, daughter of Mrs. Emma V. Marshall, of Baltimore.

Dr. William Kelso White, class of 1902, of Baltimore, was married Wednesday, October 25, 1908, to Miss Ella Louise Woodward, daughter of Mr. and Mrs. M. Cabell Woodward, at the home of the bride, 2108 Maryland avenue, Baltimore, Md., by Rev. John Roach Straton, pastor of the Seventh Baptist Church, Baltimore. Dr. White is the son of the late Dr. Walter W. White, class of 1870, and a brother of Dr. Walter W. White, Jr., class of 1896, of Baltimore. He graduated from the Medical Department of the University of Maryland in 1902. After graduation he was for one year a resident physician in the maternity department, and for another year a resident in the gynecological department of the University Hospital, since which time he has maintained his connection with the University of Maryland in the outpatient gynecological department. Dr. Arthur M. Shipley, class of 1902, ex-superintendent of the University Hospital, associate professor of surgery in the University of Maryland and a classmate of the groom, was the best man. Miss Virginia Johnson was maid of honor. The ushers were Drs. Hugh Brent, class of 1903; Robert L. Mitchell, class of 1905, and W. W. White, Jr., class of 1896, all of Baltimore, and Mr. George P. Bagby. Dr. and Mrs. White spent their honeymoon in the North. After their return they will reside at 1818 North Charles street, Baltimore, Md. Dr. H. Walton Wood, class of 1902, of Fairhaven, Mass., attended the wedding.

DEATHS.

Dr. Maxey G. Lee, class of 1888, died recently at Hartsville, S. C.

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REPORT OF A CASE OF HYPERNEPHROMA.

WALTER VAN S. LEVY, P. D., M. D.,
of Baltimore, Class of '04.

Before reporting this case of hypernephroma I think it well to say a few words regarding the etiology and structure of these tumors. There have been a good many papers written on the subject, among them one by Drs. Keen, Phaler and Ellis, while not quite up to date as regards statistics, still a very comprehensive article, and from which I obtained a good deal of the following:

Keen says: "The term hypernephroma is so recent that it does not even appear in Morris' "Surgical Diseases of the Kidney and Ureter," the preface of which is dated May, 1901. It was first employed by Birch Hirschfeld in 1896. The term is applied to tumors of the supra-renal gland and is derived from a Greek form of the Latin name of the supra-renal gland. The Greek form is adopted in order to correspond etymologically with the Greek termination "oma," meaning tumor. Kuster uses the name "Epinephroma," a term similar in origin.

Hypernephromas are tumors, benign or malignant, arising from the supra-renal gland, either in its normal position or as accessory glands or aberrant rests, the malignant forms showing in the metastases more or less the normal structure of the supra-renal.

Ellis says: "The frequency of ectopic adrenals is placed by some writers as surprisingly high. Imbert says they are found in 92% of all bodies coming to autopsy, and in the kidney in 6-8% cases. Holmes places the number at 90% of all autopsies. McFarland does not believe they are so frequent in man as in cattle. He has made an examination in more than 1,000 autopsies, and has never seen a distinct supernumerary adrenal.

Various writers have found them in the following locations: In and upon the adrenal, liver and kidneys, in the perirenal tissue, solar and renal plexuses, mesentery, in the region of the internal abdominal ring, upon the spermatic cord, between the epididymis and testes, in the broad ligament and in the fundus of the uterus. The tendency of adrenal, itself of abnormal development, is shown by Flint, who speaks of finding islands of the cortical substance in the medulla, and vice versa. Dr. Ellis gives the following general description of such tumors:

"In the kidney hypernephromas are usually single, but not rarely multiple, and have been found in both organs. Regarding the side, they occur indiscriminately. Of the cases in his series, the tumor was in the left side 57 times, in the right 55. As to sex, 71 were males, 45 females. The tumors are situated beneath the capsule of the kidney, and vary in size from a pinhead to that of a pea, in what may be called strictly benign growths, and from this to the size of a child's head in the frankly malignant ones. When small they are most always confined to the renal cortex, but may be in the medulla. When large, they project from the surface of the organ and also extend inward at the expense of renal tissues until they reach the pelvis, which may be obliterated by pressure, but is seldom actually penetrated. Either pole or the middle of the kidney may be involved. The external surface of the tumor is lobulated by depressed bands of the capsule. The color is usually grayish red or yellow, the latter predominating, but often they are brown or bluish, or even black areas, due to hemorrhage. The tumor may be firm, but in many of the larger growths the projecting masses are softened, and in some case cyst-like in consistency. The tumor is generally sharply outlined from any remaining renal structure by a distinct band of fibrous tissue.

Microscopically—

The tumors reproduce more or less perfectly the structure of the adrenal, usually one or more layers of the cortex, rarely the medulla. They possess a fibrous capsule, but this may be penetrated, and even partially destroyed, by rapidly growing tumors. The two pronounced features are the stroma and the cells. The stroma may consist of bands of fibrous tissue, but commonly consists of capillaries with endothelial walls only. In the larger growths both types are often represented, vascular fibrous bands dividing the tumor into lobules or alveoli, which in turn contain a capillary network. The relative large cells of the tumor are round, polygonal, or even columnar in type; usually they rest on the stroma or the endothelium of the capillaries, but often become detached and lie free in the large spaces. The cytoplasm is scanty and granular and contains numerous vacuoles, the former site of dissolved fat. The nucleus stains deeply and nucleolus is generally conspicuous. By some considerable diagnostic value is placed on the fact that the nucleus and nucleolus stain dissimilarly. Glycogen can usually be demonstrated in these cells. Giant cells not infrequently occur. Kelly ascribes diagnostic importance to the presence of intensely black pigment, similar to those normally found in the adrenal cortex. In all tumors of any considerable size degenerative changes are a prominent feature. Hemorrhages are often conspicuous, and are largely responsible for the variations in color seen in many of these tumors.

This case I am reporting came to our notice at Bayview Hospital this spring. The following history and physical examination were made by Dr. Robert P. Bay:

A. M. F., white male, aged 54; occupation, proofreader; admitted to asylum September 21, 1907; admitted to hospital February 16, 1908; died March 28, 1908.

Patient entered hospital with a lump about size of a walnut in his left axilla, two smaller ones further down on left side, one in his groin and a small one over the eighth rib, in the mid-axillary line (right side). Patient first noticed present condition about a week ago, but for some time before that had suffered with cough and gradual weakness. Previous to this had been healthy. First visible trouble started as a lump in left axilla about size of a walnut; came on suddenly; hard and painful only by pressure on surrounding tissues. Following this noticed several similar lumps scattered over chest and abdomen. At the end of first week had at least six to eight, and suffered slight pain in splenic region. At present suffers from vomiting on taking food into the stomach. Bowels move freely; no blood or mucus.

On examination patient is a fairly well developed man, showing marked evidence of loss of flesh. Eyes prominent and conjunctiva very pale; sclera of a bluish tinge; nose and ears normal. On both sides of neck several small scars noted, the result of tubercular adenitis 25 years ago. Chest is slightly barrel shaped, expansion good, equal on both sides, slightly hyper-resonant throughout. Above mentioned lumps noted. Abdomen rather prominent, but not distended. Liver palpable about two fingers' breath below costal margin. In left hypercondriac region a large mass is made out, which moves slightly during respiration and is painful on pressure; apparently both kidney and spleen are involved in mass; the right kidney is also palpable and tender. Lower extremities apparently normal.

Patient's temperature on admission was 100° F.; was taken every four hours. In the evening temperature would go to 102°, or a little more, on one occasion going as high as 103°; in the morning it would go down to normal, or about 99°, gradually rising again, and by noon would usually be about 100; this continued until within a few days before death, when temperature came down, often being subnormal.

The pulse rate was fast throughout, the first week he was in the hospital running from 80 to 100, varying somewhat from time to time. After the first week the pulse was nearly always over 100, and continued so until death. Respiration was about normal, never going faster than 24 to minute. Frequent examinations of the urine showed blood and mucus at intervals. Albumin was also present.

Examination of the sputum for T. B. was negative. Blood examination showed the hemaglobin to be 45 per cent., red corpuscles 3362400, white corpuscles 25000 per cubic mm. Stained smears showed a few poikilocytes, many erythrocytes, showing pale central depressions and the average size of the cells smaller than normal. On March 16th, about

one month after admission to hospital, the following note was made concerning the lumps: In the left clavicular fossa is noted a lump about the size of a hen's egg, hard and irregular, but surface is smooth, only slightly movable, not painful and skin not involved. Scattered over the body are similar lumps, varying in size from a pea to a baseball, the largest one seen in left axilla. These lumps seem to show a predilection for the sides of the body. From axilla to crest of ilium they are 12-14 in number, while in the midline they are not seen. During last few days they have been noticed on lower extremities, deeply situated. Only one enlargement noted in inguinal region, and that on left side about size of hickory nut. They are also more numerous over the chest, and seem to be adherent to the intercostal muscles.

Patient's condition is gradually getting worse and he is becoming weaker and weaker.

This note shows the rapid metastasis and the rapid enlargement of the lumps before mentioned.

The patient died March 28th, 1908, and the following report was obtained from Dr. Winternitz, who performed the autopsy:

Bay View.

Autopsy No. 3035—Dr. Winternitz.

Anatomical Diagnosis. — Hypernephroma (left); general metastasis to the lymphatic glands; metastasis to the right adrenal; chronic diffuse nephritis; pulmonary emphysema; healed fibrous nodules (bilateral); fatty degeneration of the liver; emaciation; anaemia, prostatic hypertrophy; dilatation of the bladder; atrophy of the left testicle.

Body.—Is that of a rather emaciated white man, 166 cms. in length. Rigor mortis is marked. Pupils dilated and equal, measuring 7 mm. in diameter. Over the anterior surface of the body there are large masses varying in size from 1 cm. to 10 cm. in diameter. The largest of these is in the left axilla. It measures 18x10 cms. The skin is freely movable over its surface. It is slightly lobulated, but for the most part seems to be one mass. The lobulations are more marked at the lower pole, where distinct oval masses are felt, partly attached to the larger mass. Similar masses are felt in the right axilla above the left clavicle, in the anterior axillary line, attached to the ribs, down to the tenth, over the entire anterior abdominal wall. These latter, however, are somewhat smaller. In both inguinal regions and in Scarpa's triangles similar masses are to be felt, as well as over the head of the right radius, the middle portion of the left radius. In the postcervical region and over the back only a few small nodules are to be made out. There is a small bed sore over the sacrum. There is an excoriation in the posterior folds of the buttocks, where the epithelium is lacking and tissues are reddened. There are a few external haemorrhoids. These nodules all seem quite movable, have a peculiar elasticity, and the tissues about them do not seem to be indurated. The abdominal fat is rather scant and of a pale yellow color. The muscles are pale and delicate. The abdominal cavity contains no excess of fluid. The anterior abdominal wall is studded with nodules measuring 2 cms. in diameter. These are freely movable and for the most part covered with peritoneum, but in some places, where they have become larger, the peritoneum is lacking, and they stand out as grayish white opaque nodules. On section of one of these nodules, it is seen to be composed of two rather distinct masses of tissue. One smaller area, which is gray, opaque and firm, and a larger area surrounding this, which is soft, yellow and necrotic in appearance. Just at the ensiform cartilage a large mass is seen, which on section is somewhat similar to the one described above, the grayish firmer tissue predominating. Many of the nodules in the peritoneum, on section, seem grayish and quite soft, scraping off as a semi-fluid like mass. The omentum is bound down to the parietal peritoneum by numerous fibrous adhesions. The mesenteric glands are much enlarged and are of the same general characteristics as those described in the sub-peritoneal tissue. There is a mass about the size of a child's head in the left epigastrium and hypochondrium, and this is nodular, the nodules having the characteristics of those described above, the largest ones having a distinct fluctuation. The spleen is apparently free from this mass. The splenic flexure of the colon passes over the top of the mass and is quite firmly adherent to it. The left kidney cannot be felt. The right kidney can be made out lying in its normal position, covered over its entire peritoneal surface by small nodules. The liver extends about 10 cms. below the ensiform cartilage, and the mass of glands, as removed from the left axilla, measures 16x12x5½ cms. These were removed

with some difficulty. In places it is quite soft. On section its central area is softened and honeycombed in appearance, and of a deep yellow opaque color, while the outer zone is mottled, the basement being formed by red, muscle-like tissue, everywhere being marked with lines similar in appearance to the center. The mass removed from the right axilla measures 11½x6½x3 cms., which is everywhere similar to that removed from the left. The lungs meet in the midline, covering the pericardial sac completely. There is a gland 2 cms. in diameter just to the right of the mid line of the sternum over the fourth rib, which is freely movable and similar to those before described. This has pressed on the right lung and left a distinct depression. The inner surface of the right pleural cavity is lined by similar nodules, and the apex of the lung is bound down by old fibrous adhesions. The left pleural cavity likewise has similar nodules. There is no excess of fluid in either cavity. There are a few small tumor masses in the anterior mediastinum over the aorta. The pericardial cavity contains no excess of fluid and the walls are smooth throughout.

Heart.—Is normal in size. The epicardial surfaces are everywhere smooth. The coronary arteries are tortuous and there are some semi-transparent oedematous adipose tissue about them. The right auricle is normal in size and appearance. The tricuspid orifice admits the tips of three fingers. The tricuspid valve is slightly thickened at the attachment of the chorda tendinea, but otherwise appears normal. The right ventricle contains some post-mortem clot. It is normal in size and appearance. The pulmonary valves are delicate. The left auricle is apparently normal except for a few light yellow subintimal thickenings. The aortic cusp of the mitral valve shows similar thickenings, but otherwise appears normal. The aortic valves are slightly thickened throughout, especially at the attachment, but seem competent. The base of the aorta is covered by numerous yellowish subintimal thickenings. The coronary arteries are delicate. The heart muscle is very pale and of a honeycomb light brown appearance.

Lungs.—The *left lung* is very voluminous and shows a fibrous scar at the posterior lateral margin of the upper lobe. It is of a pale gray color, not very elastic and everywhere air containing with loud crackles. The lower lobe is slightly firmer. The glands at the hilum are small, black and soft. The bronchi are pale and contain a small amount of serous fluid. On section, the lung is of a homogeneous pinkish gray color, everywhere air containing, rather dry and rather black. The right lung shows numerous scars and fibrous tags over the apex. It is somewhat more moist and the lower lobe is congested more in areas, but no areas of consolidation are to be made out. Otherwise it resembles the left lung in every respect.

Spleen.—Measures 12½x8x2½ cms. The capsule is delicate. The internal posterior surface is attached to the large mass above described, and was slightly torn in removal. On section the tissue is of a dark maroon color and the finer architecture is made out.

Pancreas.—Is normal.

Liver.—Measures 29x23x7 cms. The capsule is smooth throughout. On section the liver is pale. The peri-portal spaces are markedly yellow and elevated, while the tissue about the central vein is still reddish brown in color. The liver has a marked lardaceous fluid.

Kidneys.—The *left kidney* and adrenal were removed en masse. This formed a tumor, measuring 27x13x12 cms. Numerous adhesions bound it to the parietal wall of the spleen above and to the transverse and descending colon. The mass at this posterior pole has a definite fluctuating feel. On section two distinct portions can be made out. The lower portion is composed of kidney, and measures 13½x9½x7 cms. The upper pole, which is composed of a yellowish gray opaque mass, its center being honeycomb and showing extensive degeneration. This tissue is rather firmer at the periphery, but the solid wall measures only about 2 cms. in the thickest portion, the entire center being made up of a very friable tissue, which has in general the characteristic of the metastasis above described. In the center of the kidney there is a tumor mass which measures 7½x7 cms., which has spread the kidney tissue about its periphery. The tumor has the characteristic of those above described. The kidney, where it is still to be made out, is soft and grayish in appearance. The striations and cortex are made out with difficulty. The pyramids are slightly more congested and of a light brown color. The *right kidney* measures 12x6x3½ cms. The capsule strips easily, leaving a pale surface. On section the cortex of the kidney is pale and

the striations are slightly irregular. The cortex is uneven, averaging about 5 mm. in thickness. There are several small retention cysts in the kidney. At the pelvis of the kidney is a tumor mass similar to those described. The *right adrenal* contains a similar tumor mass, which involves one-half of the gland.

Rectum.—Is slightly congested.

Bladder.—Is contracted and its mucous membrane is pale and normal. The lateral lobes and intervesicular portion of the *prostate* is enlarged.

Stomach.—The mucosa of the stomach is pale gray in color and shows here and there a few small submucous haemorrhages. The glands along the external portion of the colon, rectum and small intestine are markedly enlarged, with little similar nodules to those described. The intestine is quite normal except for some areas of congestion. The *œsophagus* is slightly discolored by a few distinct veins, but is otherwise apparently normal.

Larynx, Trachea.—Are apparently normal.

Glands.—The sub-maxillary lymph glands show involvement by tumor growths. The thyroid shows a few diluted acini, but otherwise appears normal.

Aorta.—Is normal.

The microscopic appearance of the tumor is as follows:

Portion of the tumor which is best preserved, with low-power section shows areas of well-preserved cellular tissue lying between large areas in varying stages of degeneration. These degenerated areas show all stages, from complete necrosis to areas where a faint blue staining nucleus can be made out in cells with pale violet protoplasm, the limits of which are no longer definite. In the well-preserved areas one sees with the high-power cells of varying sizes, the nuclei of which are in general pale and versicular, but which are not at all uniform, and show many stages of a typical division. The cells are not arranged in any definite columnar order, for the most part, but one can make out definite columns of cells lining capillary spaces. These capillary spaces show their normal endothelium and contain blood. In some of these capillary spaces one can see occasional tumor cells. Giant cells are seen in some of the sections, usually showing more than one nucleus, and undergoing degeneration, as is shown by the way they take the stain.

A CASE OF LARYNGEAL DYSPNOEA DUE TO WHOOPING-COUGH.

By Nathan Winslow, M. D.,

Of Baltimore.

W. W., age 6 years, of New Windsor, Md., came under my care during the early part of November, suffering with an extreme degree of laryngeal obstruction. The patient was referred to my father, Dr. Randolph Winslow, by Drs. Hoff and Brown, of New Windsor. As my father was out of the city, I was called to see the child, and found him gasping for air. The history of the case as given by the parents, who accompanied the child, was that he had been sick two weeks; that the difficult breathing had commenced a week after the onset of the disease, and had been becoming gradually worse. He started out as a typical case of whooping-cough, having the characteristic whoop, and vomiting after the coughing spells. In between the paroxysms he was apparently as well as before he was taken sick. Three other children were suffering with typical cases of whooping-cough.

As the breathing of the child became more and more labored, his physicians believed he was suffering with laryngeal croup, the parents stated, so anti-toxin, 8000 units, were administered, and the child sent to Baltimore for further treatment. It was at this time that I saw the patient. He was experiencing considerable respiratory embarrassment. His face was of a leaden hue and he could only speak in a whisper. The pulse was slightly increased, but of good tone. The respirations were increased and shallow. I immediately did an intubation, which at once relieved the dyspnoea, after which the child said he felt well. At this time I had no culture of the throat made, which leaves a point of attack as regards the cause of the labored breathing, but I think it a reasonable supposition, considering the condition of the pulse and the absence of fever. The tube remained in his larynx about thirty-six hours, when it was expelled during a coughing paroxysm. This time it was replaced in about six hours by Dr. Randolph Winslow. After a lapse of eight days from the original insertion of the tube it was removed by me, but in less than eight hours I was recalled by the parents to reinsert the tube, as the breathing of the patient had again become very difficult. This time the tube was allowed to remain in the throat a week before it was removed, since which respiration has

been normal. At this time a culture was taken from his throat as well as from his parents. There were no diphtheria organisms grown.

Having received the history that the child had been sleeping with his brothers, who had whooping-cough, and that none of the others had had anything similating fauceal or laryngeal diphtheria, the embarrassed respiration of this case must undoubtedly be attributed to an ordinary catarrhal laryngitis complicating pertussis. It is rather unusual that a pure and simple case of whooping-cough requires an intubation; it is for this reason that the case was reported.

REPORT OF ACADEMIC DAY AT THE UNIVERSITY OF MARYLAND.

"Academic Day," the first celebrated by the University of Maryland, which took place Wednesday morning, November 11, 1908, at Westminster Presbyterian Church, was a notable, interesting and impressive event, as the day marked the one hundred and nineteenth anniversary of the opening of St. John's College, Annapolis, which embodies the departments of sciences and arts of the university.

Being, as the name indicates, a day set apart for the bringing together of members of all departments of a great university, it was only fitting that an elaborate program should have been prepared—a program which was carried out with all the dignity identified with one of the oldest institutions of learning in a city famed far and near as an intellectual center.

In the impressive academic procession which assembled in the various buildings of the university there marched representatives of each department student body—the St. John's men in their smart uniforms of gray and black and headed by their band; the high officials, regents, members of the faculty and others in the distinctive caps and gowns authorized by their academic degrees; guests and alumni.

Among those in satin and velvet were college presidents, noted instructors and men prominent throughout the land as leaders in the foremost ranks of their individual professions, authorities upon the law, eminent judges and practicing attorneys, famous physicians and medical investigators and masters of other professions and arts.

The entrance to the historic old church was made in the following order, while Mr. Robert Leroy Haslup, of Brown Memorial Presbyterian Church, played Wagner's triumphal entry march from "Rienzi":

Students of the department of arts and sciences, St. John's College.

Students of the department of medicine, freshmen, sophomores, juniors and seniors.

Students of the department of law.

Students of the department of pharmacology.

Students of the department of dentistry.

The chancellor, provost and regents of the University of Maryland, faculties and adjunct faculties.

Orators and guests of the University of Maryland.

Alumni of the University of Maryland.

Drs. Arthur M. Shipley, class of 1902, and H. W. Brent, class of 1903, were the marshals.

The students remained standing until Mr. Bernard Carter, pro-chancellor and provost, who presided in the absence of the chancellor; Governor Crothers, the regents and guests reached the platform. Rev. Thomas Grier Koontz then delivered the invocation, and a vocal quartet, composed of Messrs. Frederick H. Weber, H. Rea Fitch, B. Merrill Hopkinson and Harry M. Smith, sang the one hundred and thirty-third Psalm, beginning "Behold how good and pleasant it is for brethren to dwell together in unity."

Other distinctive features of the exercises were the address by Dr. Charles W. Needham, president of George Washington University, who, in speaking upon "Efficient Men, the Aim of University Training," compared "memory mongers," mental charlatans and fakirs to the men of true merit and worth; the unveiling of a memorial tablet to Major James Carroll and Dr. Wm. H. Welch's address upon his heroic work on the Army Yellow Fever Commission, and the conferring of the honorary degree of doctor of laws upon Dr. Thomas Edward Satterthwaite, of New York.

Coincident with the celebration a bronze memorial tablet to Dr. James Carroll, a graduate of the university, who died more than a year ago a martyr to science and medicine, was unveiled in the medical building. An important part of the celebration was the tribute paid to Dr. Carroll for the experiment he underwent in demonstrating that the mosquito conveys the yellow fever germ.

Upon the tablet to Major Carroll is the following inscription:

JAMES CARROLL,
M. D. 1891 and LL. D. 1907.
Major and Surgeon U. S. Army.
Born in Woolwich, England, June 5, 1854.
Died in Washington, D. C., September 16, 1907.

As a member of the Army Commission, which succeeded in demonstrating the mode of conveyance of yellow fever, he became an eminent contributor to science by his investigation, and a heroic benefactor of his country and of mankind by voluntary submission to the bite of an infected mosquito, whereby he suffered from a severe attack of yellow fever, produced for the first time by experiment.

Greater love hath no man than this, that a man lay down his life for his friends.

Erected by the regents of the University of Maryland.

Mr. Carter explained the significance of the day, in that it served to bring into closer association the component parts of the university. He gave a historical sketch of the institution.

Speaking of the day, he said:

"It seemed appropriate that we should select the day which is also the one hundred and nineteenth anniversary of the opening of St. John's College, which antedates the foundation of the university itself; and also that we should have this, the first of our academic celebrations, in this old edifice, the history of which is known to all."

Dr. Welch told how, as a member of the Army Yellow Fever Commission, Major Carroll, who was graduated from the university in 1901, allowed himself to be bitten by a mosquito previously inoculated with germs of yellow fever, so that it might decide conclusively the method of transmitting the dread disease, which had baffled investigators for years. Major Carroll contracted the disease, and it was his action which has resulted in the recent effectual fight against the fever in tropical countries, particularly Cuba and the Canal Zone.

Dr. Welch called Dr. Carroll the most distinguished graduate of the University of Maryland, if distinction can be estimated by service and sacrifice for the welfare of mankind.

"Major Carroll, a man of lovable character and modest demeanor, has conferred one of the greatest benefits ever given to mankind by his unflinching heroism, and it is a source of pride to us that his name is linked with the University of Maryland."

Long cheers greeted Dr. Welch's every mention of the name of Major Carroll. After the final outburst Dr. Warner Holt, of Washington, D. C., arose and asked to be allowed to respond for Mrs. Carroll, who wished to express her appreciation for the tribute paid by tablet and eulogy to her husband.

He said: "I must confess my appreciation of the opportunity to appear at this time and in this place as the representative of Mrs. Carroll, who has honored us by her presence. It is a most fitting and graceful act upon the part of the University of Maryland to commemorate in a beautiful bronze tablet the distinguished Major Carroll. I know of and hereby voice Mrs. Carroll's profound gratitude and high regard to and for the regents of this university."

Major Carroll's widow was present, and was escorted by Dr. D. M. R. Culbreth.

Dr. G. Lane Taneyhill arose and said:

"As an alumnus I move, sir, that we recognize Mrs. Carroll's presence by a rising vote of thanks to her."

All stood.

Dr. Needham, in describing the modern needs of efficiency in educational training, said in part:

"We live in a practical, strenuous age that determines the value of men and things by their usefulness. The man who serves much in such times must have decided intellectual and moral attainments. Life today is a deep, irresistible flood tide. A man must not only be powerful and strong, but he must be quick and alert. The young man who has entered the race has little time to make the preparations which he should have made before entering the lists. He will find a world quick to recognize talent and quality, but slow to forgive mistakes and errors.

"Education is not simply the acquirement of facts or knowledge any more than eating food is gaining strength. Growth and development, whether physical or mental, depend upon assimilation. The undigested food is a cause of weakness.

"We are blessed with a faculty called memory that holds for a time the things we see, hear or read. It is the storehouse of learning from which we draw our raw material for consumption. It gives entertainment and grace to conversations, but it does not give intellectual power and strength. There are plenty of men with monstrous memories, but when we know them thoroughly we never think of trusting their judgment or discretion. The world never calls upon them to settle its problems. They are 'memory

mongers,' with odd lots for sale, but wholly lacking in spiritual force—capacity to create, to reason.

"Efficiency consists in having an intellectual constitution and being able to use this power to advantage upon every problem and in every struggle in life."

Dr. Needham also advocated cultivation of personality and allowing students intellectual freedom.

In introducing Dr. Satterthwaite, an eminent heart specialist and author of note, Dr. Hemmeter said:

"The students of the medical department of the university have been so fortunate as to have had an opportunity to listen to the teachings of a specialist on diseases of the heart several times which gave evidence of such admirable mastery of the subjects that the regents have decided upon the recommendation of the faculty of physic to present the name of this distinguished clinician for special academic honors. Mr. Provost, I have the honor to introduce Thomas Edward Satterthwaite, and recommend that he be admitted to the degree of doctor of laws."

Mr. Carter presented the degree.

After the exercises the regents, faculty members and guests were entertained at luncheon at the Germania Club, and the St. John's College students were similarly entertained at the nurses' parlor of the University Hospital, the Ladies' Auxiliary Association of the hospital, of which Mrs. Helene E. M. Hemmeter is chairman, acting as hostesses.

At the Germania luncheon toast responses were made by Dr. Needham, Judge Henry Stockbridge, Drs. Welch, Hemmeter and Satterthwaite and Mr. Philemon H. Tuck.

Among those present were:

Messrs. Judge Henry Harlan, Dr. Randolph Winslow, Dr. R. Dorsey Coale, Dr. H. P. Hynson, Prof. C. W. Mitchell, Prof. Thos. A. Ashby, Prof. Samuel C. Chew, John R. Randall, Dr. Thomas Fell, Dr. L. E. Neale, Dr. Hiram Woods, Prof. F. J. S. Gorgas, Prof. D. R. M. Culbreth, John P. Poe, Dr. Chas. Caspari, General Oberavzt Oscar Schneider, Wiesbaden, Germany; Dr. Joseph E. Gichner, Dr. T. O. Heatwole, Dr. L. M. Allen, Dr. J. M. Craighill.

THE IMPORTANCE OF EXAMINATION OF THE UPPER END OF THE ESOPHAGUS.

By Richard H. Johnston, M. D.,

Lecturer on Diseases of the Nose and Throat in the University of Maryland; Surgeon to the Presbyterian Eye, Ear and Throat Hospital.

Read Before the Baltimore City Medical Society Section on Medicine and Surgery, November 6, 1908.

That the examination of the upper end of the esophagus is of some importance is shown by the fact that during the past year four patients have been examined at the Presbyterian Hospital in whom the pathological lesion was found within two inches of the cricoid cartilage. In two patients examined at other hospitals the stricture was found above the cricoid in one and on a level with the cartilage in the other. The method of examination is simple. In adults, after a hypodermic injection of morphia and atropia, the pharynx and upper end of the esophagus are swabbed with a cocaine solution (20% solution). After waiting a few minutes, the patient extends the head and the examiner passes Jackson's laryngeal speculum down to the larynx. When the arytenoid cartilages come into view the spatula end of the speculum is passed down behind them and the cricoid cartilage gently pulled forward. By careful manipulation the spatula end can be introduced about two inches below the cricoid, thus giving a clear view for diagnosis and treatment. Through the speculum pieces of tissue can be removed with cutting forceps and strictures dilated with absolute precision. Thus far I have succeeded in examining all adult patients under local anesthesia. In a very nervous individual it might be necessary to use ether, and in such a case the best instrument, in my opinion, is that devised by Dr. Mosher, of Boston, which gives a wonderful view of the pyriform sinuses and the upper end of the esophagus. In examining with his spatula the patient's head rests on the table in the left lateral position. In children general anesthesia is necessary. If Jackson's instrument is used, the head must be extended over the edge of the table and held by an assistant; with Mosher's instrument the left lateral position is employed.

The most interesting cases were the following: C. B., 69 years old, was referred to me with the diagnosis of impermeable stricture of the esophagus. Attempts to pass the smallest bougie by the old method had not succeeded. The case was a most unfavorable one for examination with the speculum; the patient was markedly round-shouldered and the anterior muscles of the neck were contracted so that it was impossible to extend the head sufficiently to get the mouth and the esophagus in the same straight line. Morphia and cocaine were used and the speculum introduced until its entire length of eight inches was below the teeth. Force had to be used to pull the cricoid forward. At the end of the speculum we saw the esophagus completely filled with a new growth, through which a fine probe finally passed. Dilatation with Bunt's bougies followed. Pieces were removed and given to Dr. J. L. Hirsh for microscopic examination. The tissue forming the stricture was hard and the appearance of the esophagus suggested epithelioma, which, however, was not confirmed by the microscope. Dr. Hirsh found nothing malignant in the sections. The patient was successfully dilated until his death, the latter part of September. Two weeks before dissolution he began to decline so rapidly that metastasis in some other organ was suggested as the direct cause of death. The patient swallowed liquids in sufficient quantity to sustain life until his death.

M. E., 24 years old, came to the Presbyterian Hospital complaining of difficult deglutition, which had steadily grown worse for a week. The speculum showed a large, red mass just below the cricoid. Bougies were passed around the growth, with the result that the patient swallowed better. The age of the patient and the rapid increase in symptoms seemed to indicate that the mass was syphilitic, though she denied infection. Treatment consisted in dilatation and increasing doses of potassium iodide. The prompt improvement proved that we were dealing with a gumma of the esophagus. The patient in a short time was able to eat solid food. She then disappeared and has not been seen since.

A little boy, 14 months old, swallowed lye when he was twelve months old. Deglutition became more difficult until he was brought to the city for treatment. The child was able to take milk. For the examination there anesthesia was used. A stricture was located just at the cricoid cartilage, and was successfully dilated. The little patient was under ether about ten minutes. The next afternoon his temperature rose and the morning after pneumonia was diagnosed. He was at no time seriously ill. Ten days after the onset of the disease the temperature fell to normal. Two days later the temperature again went up, and pus was found in the thorax, which was promptly drained. One morning when we were congratulating ourselves that he was well on the road to recovery, and that we would soon be able to resume treatment of the stricture, there was a sudden gush of blood from the mouth and the little patient was soon dead. Had pneumonia not developed the stricture could have been successfully dilated through the speculum.

After a limited experience with the examination of the upper end of the esophagus, I have concluded:

The examination is of great help in diagnosis and treatment.

Upper esophagoscopy is harmless.

It can be done in most cases under cocaine anesthesia.

It is not difficult of accomplishment.

It should be used oftener in the removal of foreign bodies and in symptoms of obstruction.

Among those who attended the meeting for the formation of the Maryland Psychiatric Society at the Sheppard-Pratt Asylum were the following of our alumni: Dr. Frank Flannery, class of 1880, of Mount Hope Asylum; Dr. Henry M. Thomas, class of 1885; Dr. N. M. Owensby, class of 1904; Dr. W. H. Twigg, class of 1883, of Sylvan Retreat, Cumberland, Md.; Dr. Henry J. Berkley, class of 1881; Dr. Frank Keating, class of 1896; Dr. Horace Simmons, class of 1881; Dr. J. Clement Clark, class of 1880.

The Ladies' Auxiliary Board of the University Hospital have elected the following officers for the ensuing year: President, Mrs. Hamilton Easter; Secretary, Mrs. Frederick Tyson; Corresponding Secretary, Miss Lucy Marshall; Treasurer, Mrs. Samuel J. Hough; Vice-Presidents, Mrs. Samuel C. Chew, Mrs. Joseph T. Smith, Mrs. William T. Howard, Mrs. L. B. Purnell, Miss Anna Chew, Mrs. Alcaeus Hooper, Miss Livezey, Mrs. Frances E. Waters, Mrs. Franklin Levering, Mrs. John T. King, Miss E. J. Chisolm, Mrs. James McElroy.

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EDITORIAL.

ACADEMIC DAY AT THE UNIVERSITY OF MARYLAND.—The selection of the 11th day of November, the one hundred and nineteenth anniversary of the founding of St. John's College, now the Department of Arts and Sciences of the University, as Academic Day, was most appropriate, and inaugurated a custom which for all time to come, we trust, will be observed by the University. The occasion was celebrated in the most imposing manner and in every respect in keeping with the purpose had in view—a bringing together of all of the departments of the University in a celebration of the founding of its oldest department and the upbuilding of a university spirit.

The regents, faculties, students and invited guests were assembled in Westminster Church to hear addresses from distinguished speakers, and to celebrate with appropriate exercises the respect and pride which the University feels for the memory and work of one of her most distinguished graduates, the immortal James Carroll. Seldom has such an impressive occasion been witnessed in Baltimore; seldom has the memory of any hero been honored with such genuine and noble tribute. The address delivered by Prof. W. H. Welch, of the Johns Hopkins University, on the life and work of Dr. James Carroll, was an eloquent tribute to Dr. Carroll and a comprehensive statement of his services to science and humanity.

Dr. Welch described the work of the Yellow Fever Commission, of which Dr. Carroll was the most conspicuous member, and related the incidents which led Dr. Carroll to submit his person to the infection of a mosquito which had previously bitten a subject ill with yellow fever. Through this voluntary inoculation Dr. Carroll contracted the disease, which came near destroying his life at the time, and which laid the foundation for the disease from which he died over one year ago. The experiment proved the correctness of the theory upon which Dr. Carroll was working, and established the doctrine now universally accepted, that yellow fever owes its propagation to the bite of the infected mosquito.

This work of Dr. Carroll was so revolutionary and so heroic that it has given him one of the most distinguished positions in the annals of the heroes of the world. Dr. Carroll graduated from the University of Maryland in the class of 1891. Just prior to his death the University conferred upon him the honorary degree of LL. D., in recognition of his valuable services to humanity. The tablet to Dr. Carroll erected by the regents of the University of Maryland was unveiled on Academic Day, and commemorates in brass the debt which alma mater owes to one of her most distinguished sons.

A marked feature of Academic Day was an address delivered by Dr. Chas. W. Needham, president of George Washington University, on "Efficient Men the Aim of University Training."

Seldom has an audience been treated to a more eloquent and interesting discourse. The speaker defined the true aim of university training. The filling of the mind with facts or knowledge will not accomplish a full purpose if unassimilated and undigested. The purpose of all training is to create, to do. Efficiency depends upon the use of these powers; knowledge and wisdom may be so far apart as to have no connection. The possession of knowledge must be supplemented by a wisdom which enforces its best use. In a practical and strenuous age Dr. Needham asserts that the value of men and of things must be determined by their usefulness.

Taking this, the first Academic Day in the long life of the University, as a model for the future, but little can be said by way of suggestion. In every respect the celebration was worthy of the University. It exemplified most fully the growth of the university spirit, which now animates every department, and the greater need of an administrative head to direct the affairs of a larger university, now made necessary by this celebration of Academic Day.

It is apparent to all true friends of the University that a closer union must take place between its departments, and that a great state university must arise from that union of now seemingly independent schools designated as departments.

CORRESPONDENCE.

A TRIP TO GUATEMALA—THE CITY OF MEXICO, AND HOMEWARD JOURNEY.

August 22d to 30th, 1908.

The present City of Mexico stands practically on the site of the ancient Aztec city, Tenochtitlan. In the time of Cortes the city stood upon an island in Lake Texcoco, connected with the mainland by causeways. This body of water is still in existence, but has been reduced to a comparatively small area by drainage, and the city is situated on a broad plateau 7,600 feet above sea level. Notwithstanding its altitude, the soil is marshy and water is encountered at the depth of a few inches or feet, as in New Orleans. It is thought that a subterranean lake or river underlies a portion of the city, as some buildings have sunken to such an extent as to be dangerous. The city is handsome, with beautifully paved streets, though the sidewalks are rather narrow. The houses are mostly rather low, though many of the stores are four stories high. The Postoffice is a splendid building, and beautifully equipped, much larger and handsomer than ours in Baltimore. There are apparently innumerable churches of all sizes and generally handsomely adorned. The Cathedral is the largest and finest church edifice in America, and is built upon the site of the Aztec teocalli or temple. Many of the pillars and stones of this ancient temple have been preserved and are now in the National Museum, and they show the native population to have been in many ways far advanced in civilization, though in other respects they were barbarians or savages. In all the Mexican and Central American cities there is a central plaza, around which are grouped the principal buildings. Here in Mexico we find the Cathedral on one side, the National Palace, which is said to be located on the site of the Palace of Montezuma, on another side, and various handsome stores, including the National Pawnshop, on the other sides, and all the trolley lines in the city have their terminus at the Plaza. The trolley system is most excellent, the cars are commodious and comfortable, and the roads traverse the city in all directions and extend far into the country to various suburban towns and villages. The streets are lively with the vari-colored and peculiarly robed population, many of whom go barefooted or wear bull-hide sandals. Hacks and cabs are numerous and cheap, and are drawn by good horses. On Sunday afternoon there is a great parade of people riding up and down the principal street from the Plaza out towards Chapultepec. Everybody who owns an equipage or who can hire or borrow one is to be seen in the line of this beauty and fashion show. The police are numerous and well equipped, and compare favorably with our own. The infantry soldiers are dressed generally in drab cotton uniforms, with sandals, but the cavalry is handsomely equipped. The officers are almost as gaudy as those of Gautemala.

The people are largely Indian or Mestizo, and are swarthy and often nearly black. I saw almost no negroes in either Mexico or Guatemala. The white population is mostly of Spanish descent, though there are many American, English and German people living in the City of Mexico and elsewhere in the country. The climate of the city is rather chilly, and at night one needs a light overcoat. Mountains surround the plain on which the city is situated, and on a clear day the towering mass of Popocatepetl with its snow mantle can be seen, as well as the less lofty Ixtacchihuatl, also covered with a snow cap of large dimensions. Sunday is not much observed as a day for worship, but is a holiday on which bull fights and other mild and pleasant diversions are enjoyed. As has been said, the electric cars are run out to various suburban villages and resorts, and the most important of these towns is Guadalope, a few miles distant, where there is a magnificant church dedicated to "Our Lady of Guadalope." The Virgin is supposed to have appeared to a native Indian priest at Guadalope in the 16th century, and this church commemorates that event. All the banisters, balustrades and fittings of this church are of solid silver, and are said to weigh 26 tons. There is kept here in a steel safe a magnifi-

cent gold crown studded with precious stones, a sceptre of gold with jewels, a gold vase, gold screens, and other costly articles, which are placed on the image of the Virgin on her feast days. Most of those superb ornaments have been presented by the wife of President Diaz, who has also built a handsome little chapel for her own use, and has adorned many other churches. On the top of a hill is a handsome cemetery, where I saw the tomb of our old enemy, General Santa Anna. He gave us some trouble in the forties, but he is very quiet in his marble home now. The same custom prevails here as in Central America in regard to a last resting place, as the lots are only bought or rented for a period of seven years, and if you do not pay up by the end of that time, out you go, and some other more profitable tenant takes your place. Churubusco is a town a short distance outside the City of Mexico, where one of the fiercest fights of the Mexican War occurred, and where the United States still has a national cemetery, though the American flag is not raised as in the national cemeteries at home. There are a large number of Americans in the City of Mexico, and one hears English spoken almost everywhere, and there is a distinct portion of the city known as the American colony. Other portions are known as the German and Italian colonies. These different parts of the city are built in a style of architecture more or less resembling that of the nationality of the individual colony. One of the most interesting places to visit is the National Museum, where is collected a great many relics of the Aztecs, Toltecs and other ancient native races, such as sacrificial stones, vessels, altars and utensils, all carved with much skill, reminding one of ancient Egyptian sculptures. They had no iron instruments, and this work was done with stone or copper tools. At the time of the conquest a lofty teocalli or pyramidal structure stood upon the site of the present Cathedral, and this was subsequently levelled by the Spaniards and the Christian church erected. Many pillars and stones from this teocalli are now preserved in the Museum. Chapultepec, situated on the outskirts of the city at the end of the fine avenue of the Reforma, is the residence of the President, and is also the Military Academy of Mexico. The Castle is situated on a high and precipitous elevation, and was the scene of the last fight of General Scott's troops, who stormed it in September, 1847, and then entered the city in triumph. A notable park is located here and a good zoological garden. At Guadalope I saw people, men and women, sleeping on the stone pavement outside a church, and I asked the guide what they were doing there. He said they came here to pray to the Virgin, but they got drunk on pulque instead. Pulque is the national drink; it is a milky fluid made from the maguey plant, and when unfermented is an insipid and harmless drink, but when it ferments it is worse than hard cider. I did not try any of it, but the smell of the shops in which it was sold was vile enough to nearly knock one down. Mexico is a republic, but it is a very different kind of a republic from ours. President Diaz has been in office for more than thirty years, and he is now over 80 years of age and wished to retire, but the people want him to remain at the head of the government. He is a ruler of great ability and has tranquilized the country until rebellions have ceased, and the country is in most parts as safe as in corresponding portions of the United States. Diaz, like his predecessor, Juarez, is said to be a pure-blood Indian.

I left the City of Mexico at 8.15 P. M., August 25th, on a well-appointed train with Pullman cars. When I awoke we were in a barren country with bare rocks and cacti, which became worse and worse, and the air almost stifling with dust, so it was necessary to keep the windows of the car closed. We stopped for breakfast at San Luis Potosi, then traveled all day through a desert land, with no vegetation except cacti and stunted palms, with dust and rocks, almost no water courses or pools, and with here and there miserable-looking villages of adobe huts. Considerable droves of horses and cattle were seen, but I did not see how they found enough water to quench their thirst. Had supper at Satillo, which seemed to be a thriving town. Another night on the train, and in the morning at 7 o'clock we reached the Rio Grande at Nuevo Laredo. Here we were inspected by the Mexican officials to see that we did not carry out any bullion, and then we started across the bridge to Laredo, in Texas, where we were

subjected to both a quarantine and customs investigation. I was disappointed in the Rio Grande, which was much narrower than I had supposed. It was a dirty, yellow stream, of no great width, flowing between lofty banks. From Laredo to San Antonio, 154 miles, the country is a desert, but is rather better looking than on the Mexican side. San Antonio is quite an attractive-looking city as seen from the train. From here the country improves and large areas of growing cotton are to be seen everywhere, with cotton ginning and baling plants in abundance. The country is flat, but fertile, and well cultivated, though foliage was scant. It took 24 hours to cross Texas from Laredo to Texarkana, where we arrived the next morning. We traversed Arkansas from southwest to northeast, passing through Little Rock, and reached the Missouri line late in the afternoon. Arkansas as seen from the train was rather flat, but well watered, timbered and cultivated, whilst Missouri is rather hilly and picturesque looking. We reached St. Louis on time, at 10.30 P. M., Friday, August 28th, three days and three nights from the City of Mexico, the distance being about 1,850 miles, having traveled the whole distance in the same Pullman car. Here I changed to the Pennsylvania Railroad, and in a short time was en route for Baltimore, which was reached 36 hours later. The distance from the City of Mexico to Baltimore is about 2,825 miles, and the time of transit four days and five nights, with only one change of cars. It is not a hard trip, nor is it very expensive, and I strongly recommend those who are considering how they may spend an agreeable and profitable vacation to go to Mexico, and if they have time and opportunity to visit Central America and Panama.

RANDOLPH WINSLOW.

ITEMS.

To Dr. John S. Fulton, class of 1881, of Baltimore, and professor of state medicine in the University of Maryland, who has labored earnestly as secretary general, was the success of the International Convention on Tuberculosis, held at Washington, D. C., September 21 to October 4, 1908, largely due. The burden of the preliminary work and organization fell upon the shoulders of Dr. Fulton, the former secretary of the State Board of Health of Maryland, with what success is now history. There were many interesting models of buildings, sanotaria, photographs and instruments. The meetings of the convention were held in the new National Museum, the entire second floor of which was given over to exhibition purposes.

Governor Crothers appointed the following of our alumni as delegates to the convention: Drs. S. S. Hedges, class of 1881, Brunswick, Md.; H. H. Hopkins, class of 1869, Newmarket, Md.; J. W. Downey, class of 1869, Newmarket, Md.; Charles Kefauver, class of 1891, Thurmont, Md.; D. Stone, class of 1900, Emmitsburg, Md.; John Mace, class of 1887, Cambridge, Md.; Victor Carroll, class of 1906, Church Creek, Md.; B. L. Smith, class of 1858, Madison, Md.; Lee Hall, class of 1901, Pocomoke City, Md.; R. P. Collins, class of 1890, Bishopsville, Md.; C. C. Laws, class of 1895, Chesapeake City, Md.; E. C. Kefauver, class of 1891, Thurmont, Md.; C. W. W. Wells, class of 1892, Hampstead, Md.; George Brown, class of 1864, New Windsor, Md.; W. D. Brown, class of 1894, Union Bridge, Md.; H. M. Fitzhugh, class of 1897, Westminster, Md.; Thos. J. Coonan, class of 1891, Westminster, Md.; John S. Matthias, class of 1879, Westminster, Md.; James H. Billingslea, class of 1864, Westminster, Md.; W. F. Tayley, class of 1884, Laurel, Md.; C. P. Carrico, class of 1898, Cherry Hill, Md.; Harry Cantwell, class of 1906, North East, Md.; S. G. Fisher, class of 1890, Port Deposit, Md.; H. E. Clemson, class of 1894, Port Deposit, Md.; Wm. D. Cawley, class of 1902, Elkton, Md.; John H. Jenness, class of 1887, Rising Sun, Md.; J. J. Murphy, class of 1896, Annapolis, Md.; Charles H. Brooke, class of 1891, Brooklyn, Md.; Arthur H. Mann, Jr., class of 1890, Catonsville, Md.; H. A. Naylor, class of 1900, Pikesville, Md.; Harry M. Slade, class of 1884, Reisterstown, Md.; B. F. Price, class of 1857, Mount Carmel, Md.; John B. Norris, class of 1866, Beckleysville, Md.; E. W. Hyde, class of 1892, Parkton, Md.; R. C. Massenberg, class of 1884, Towson, Md.; Wm. L. Lewis, class of 1892, Kensington, Md.; J. Marshall Price, class of 1890, Frostburg, Md.; Philip L. Travers, class of 1902, Easton, Md.; J. F. H. Gorsuch, class of 1876, Fork, Md.; W.

C. McClanahan, class of 1902, Highlandtown, Md.; Enoch George, class of 1872, Denton, Md.; Luther Kemp, class of 1887, Uniontown, Md.; Levin Wirst, class of 1886, Brunswick, Md.; Charles R. Kriete, class of 1895, Aberdeen, Md.; J. B. F. Weaver, class of 1864, Manchester, Md.; Charles R. Foutz, class of 1897, Westminster, Md.; Richard B. Richards, class of 1867, Hampstead, Md.; Edwin D. Cronk, class of 1884, Winfield, Md.; Geo. H. Brown, class of 1864, New Windsor, Md.; James Watt, class of 1863, Union Bridge, Md.; Wm. E. Gaver, class of 1888, Mount Airy, Md.; Guy Steele, class of 1897, Cambridge, Md.; H. W. McComas, class of 1888, Oakland, Md.; W. B. Kirk, class of 1893, Darlington, Md.; Charles R. Truitt, class of 1891, Salisbury, Md.; J. E. Pitsnogle, class of 1889, Hagerstown, Md.; E. R. Trippe, class of 1862, Easton, Md.; A. E. Landers, class of 1907, Crumpton, Md.; E. A. Scott, class of 1886, Kent county, Md.; J. R. Latimer, class of 1881, Kent county, Md.; Wm. Maxwell, class of 1873, Still Pond, Kent county, Md.; Louis B. Henkel, Jr., class of 1903, Annapolis, Md.; Eugene Kerr, class of 1905, Roland Park, Md.; John L. Lewis, class of 1888, Bethesda, Md.; Thomas S. Chaney, class of 1866, Chaney, Md.; George W. Todd, class of 1885, Salisbury, Md.; Guy W. Latimer, class of 1901, Hyattsville, Md.; Wm. E. Eareckson, class of 1890, Elkridge, Md.; Harry C. Algire, class of 1895, Baltimore, Md.; Lee Cohen, class of 1895, Baltimore, Md.; Charles O'Donovan, class of 1881, Baltimore, Md.; Frank R. Smith, class of 1891, Baltimore, Md.; W. H. Smith, class of 1900, Baltimore, Md.; Henry M. Thomas, class of 1885, Baltimore, Md.; Wm. Dulaney Thomas, class of 1887, Baltimore, Md.; Wm. T. Watson, class of 1891, Baltimore, Md.; Wm. R. Stokes, class of 1891, Baltimore, Md.; F. J. Kirby, class of 1892, Baltimore, Md.; C. W. Lanned, class of 1893, Baltimore, Md.; T. C. Worthington, class of 1876, Baltimore, Md.; J. C. Hemmeter, class of 1884, Baltimore, Md.; J. T. King, class of 1866, Baltimore, Md.; A. C. Pole, class of 1876, Baltimore, Md.; J. N. Reik, class of 1900, Baltimore, Md.; T. J. Talbott, class of 1895, Baltimore, Md.; H. O. Reik, class of 1891, Baltimore, Md.; R. T. Taylor, clinical professor of orthopedic surgery.

Dr. Frank J. Flannery, class of 1880, and Mrs. Flannery celebrated their silver wedding anniversary recently at their home, on Mount Hope avenue. Dr. Flannery married Miss Ella Brannon, of Weston, W. Va., the daughter of Judge Henry Brannon. The Doctor has been connected with prominent institutions of the city and state, and has been for many years the chief resident physician of Mount Hope Retreat.

The University of Maryland Branch of the Young Men's Christian Association held its opening reception on the evening of October 8, 1908, in the lower portion of Davidge Hall. The room was tastefully decorated and there were more than 400 guests. Dr. Samuel C. Chew made the opening address. The rest of the program consisted of speeches by Professors Hynson, Heatwole and Hundley, solo by Mrs. Miner, duet by the Misses Lemmerman and refreshments. The outlook, both as regards increased membership and finances, is better than it has ever been since the organization of the association. President, C. A. Shreve, 1909, dental, Maryland; vice-president, D. C. Abshire, 1909, medical, North Carolina; secretary, H. M. Robinson, 1909, medical, New York; treasurer, C. F. Strosnider; chairman membership committee, C. C. Abshire; chairman reception committee, H. M. Robinson; chairman missions committee, C. Spoore.

The last regular meeting of the University of Maryland Medical Association was held in the amphitheatre of the University Hospital, Tuesday, November 17, 1908. The program was as follows: 1. Pregnancy Complicated by Tuberculosis, Dr. L. M. Allen. 2. History of Case, Mr. Joseph W. Hooper, class of 1909. 3. Discussion, Dr. L. E. Neale, Dr. J. L. Hirsh, Dr. Gordon Wilson. Dr. A. M. Shipley, the president of the society, presided, and Dr. John T. O'Mara was the secretary.

At a meeting of the Athletic Association, November 16, 1908, it was decided to disband the football team. Nearly all present agreed that, while there is plenty of good material in the University, it is impossible to get it out, owing to the poor facilities for practice and the short time allowed for recreation. The efforts of Manager Vinup and Coach Willse were commended. Mr. J. O'Neil, of the Dental School, was elected manager of next spring's baseball team.

Dr. Joseph R. Owens, class of 1859, Mayor of Hyattsville, and treasurer of the Maryland Agricultural College, is seriously ill. He has been unwell since June last, and lately has been disturbed by loss of rest. He has been going regularly to his work at the college, although against the advice of his physicians. Dr. Owens is about 70 years of age. He is a remarkably well-preserved man.

At the fall meeting of the Harford County Medical Society, held at Havre de Grace, Dr. Charles O'Donovan delivered an address on the advisability of organizing a medical society at Havre de Grace. Dr. R. H. Smith, class of 1875, read a paper on "Intestinal Perforation in Typhoid Fever."

The junior class of the University of Maryland School of Medicine has elected the following officers for the ensuing year: President, R. P. Truitt, Maryland; vice-president, G. W. Shipp, North Carolina; secretary, J. M. Blodgett, New Hampshire; treasurer, F. P. Firey, Tennessee; historian, N. T. Kirk, Maryland; sergeant-at-arms, M. J. Firey, Maryland.

Dr. Thomas H. Buckler, class of 1888, and wife have returned to their home, St. Paul and Biddle streets, after spending the summer touring in their motor car. With their headquarters at Narragansett Pier, they made many trips, and in all covered about 3,000 miles. He said when you tour over the roads of New England, especially those of Massachusetts and Rhode Island, you know that the roads in our state are indescribably bad.

Dr. Marshall Price, class of 1902, secretary of the Maryland State Board of Health, was one of the principal speakers at the conference of charities of New York, held at Elmira. Dr. Price will talk on the subject "Operation of the Tuberculosis Law of Maryland."

The condition of Dr. George R. Graham, class of 1883, past department commander of the Grand Army of the Republic, and one of the best-known Union veterans and physicians in the city, who has been critically ill at his home, 725 Columbia avenue, is reported to be slightly better.

The following graduates received their licenses from the Maryland Examining Board as the result of the examinations held in June, 1908:

Benjamin R. Benson, W. L. Burns, Solomon L. Cherry, Frank G. Cowherd, Wm. C. Davis, David Franklin, A. R. Giampietro, George W. Hafele, Wm. D. Hammond, Wm. M. Hollyday, Francis E. Jameson, Herbert L. Kneisley, Lawrence Kolb, John E. Mackall, Lester D. Norris, James K. Insley, Russell W. Raynor, G. H. Richards, Ernest H. Rowe, George G. Scheurich, Louis H. Seth, Henry L. Sinsky, J. G. Fowble Smith, Leo F. C. Steindler, Homer W. Todd, Arthur L. Wright, John E. B. Ziegler.

Capt. Frank W. Weed, class of 1903, United States Army Medical Corps, has been relieved from duty at Plattsburg Barracks, N. Y., and has been ordered to report at Fort Totten, N. Y., for duty.

Dr. George W. Dobbin, class of 1894, was chairman of his class supper during the recent reunion of the Hopkins graduates.

Dr. J. Whitridge Williams, class of 1888, is president of the Johns Hopkins Alumni Association. He took a prominent part in their recent reunion and delivered one of the many addresses.

At the last regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, October 20, 1908, the program was:

1. "Demonstration of Opsonin Treatment," Dr. J. L. Hirsh. 2. "A Case of Muscular Dystrophy," Dr. I. J. Spear. Dr. A. M. Shipley was elected president for the ensuing year; Dr. I. J. Spear, vice-president, and Dr. John T. O'Mara, secretary.

Dr. B. R. Benson, class of 1873, and Mrs. Benson, of Cockeysville, have been visiting their daughter, Mrs. Beulah M. Koontz, at Thurmont.

Dr. Henry Lee Smith, class of 1894, and Mrs. Smith are receiving congratulations upon the birth of a son.

Dr. I. J. Spear, class of 1900, has been elected secretary of the Section on Neurology of the Baltimore City Society. At the last meeting of this section Dr. Walter Carswell, class of 1895, was appointed one of a committee to work in conjunction with the newly-formed Society for the Investigation of Mental Disorders.

Dr. Oscar von Schneider, ex-surgeon general of the Prussian Army, has been visiting the University Hospital. He is the guest of Prof. John C. Hemmeter. Dr. von Schneider came to America primarily to attend the Congress on Tuberculosis.

The Chi Zeta Chi Fraternity of the Medical Department of the University of Maryland has opened a fraternity house at 309 North Paca street. There was a housewarming to celebrate the opening of their home, at which were present members of the fraternity and some of the members of the faculty.

Dr. Henry McK. Tucker, class of 1899, and Mrs. Tucker are being congratulated upon the birth of a daughter.

At the annual election of the Frederick County Medical Society, among the officers chosen for the ensuing year are the following: President, Dr. T. C. Routson, class of 1899, of Buckeystown; Vice-President, Dr. H. S. Hedges, class of 1883, of Brunswick.

Dr. Eugene Kerr, class of 1905, has returned to the Hotel Sherwood, after having spent the autumn at Roland Park.

Dr. W. D. Scott, class of 1904, has been elected vice-president of the Baltimore Branch of the Alumni Association of the Virginia Military Institute.

Dr. Theodore Cooke, Sr., has been elected second vice-president of the Association of Physicians and Surgeons of the American Prison Association.

The following attended the recent reunion of the Alumni of Loyola College: Drs. Claude Van Bibber, class of 1877; F. J. Kirby, class of 1892; Charles O'Donovan, class of 1881; Geo. V. Milholland, class of 1895; Edward F. Milholland, class of 1858; B. B. Browne, class of 1867.

Dr. John S. Fulton, class of 1881, secretary-general of the Congress of Tuberculosis, spoke at the fourth post session of the International Congress on Tuberculosis. The session was known as the religious societies day.

Several members of the families of Dr. Theodore Cooke, Sr., class of 1859, and Dr. Theodore Cooke, Jr., class of 1891, were injured in a collision between a railway car and a wagon in which they were riding. None was injured seriously.

Dr. Benjamin R. Benson, class of 1873, of Cockeysville, Md., spent several days in New York, where he visited his son, Dr. Benjamin R. Benson, Jr., class of 1907.

Dr. Nathaniel G. Keirle, class of 1858, of Baltimore, addressed the Maryland State Association of Graduate Nurses November 5, 1908, at the City Hospital, on his work, the Pasteur treatment.

Dr. M. A. O'Neill, class of 1900, of 108 North Fulton avenue, Baltimore, who has been seriously ill with typhoid fever for several weeks, is rapidly convalescing.

Dr. Robert Crawford, class of 1906, recently registered at the Hospital. Dr. Crawford is superintendent of the Atlantic Coast Line's Hospital at Rocky Mount, N. C.

Dr. J. W. Hering, class of 1855, of Westminster, Comptroller of the State, addressed the Sunday School Convention at Brantly Church, Baltimore, the middle of October.

Dr. J. Edward Benson, class of 1884, of Cockeysville, and Mrs. Benson entertained the Ladies' Aid Society of Jessop Methodist Episcopal Church, Cockeysville.

Bishop Luther B. Wilson, class of 1877, of the Methodist Episcopal Church, formerly of Baltimore, has taken up a residence in Philadelphia.

Dr. Ross Halford Miner, class of 1901, of Oklahoma, has been spending several weeks attending the clinics at the hospital.

Dr. H. D. Purdum, class of 1902, of Traverse City, Mich., is visiting his two brothers at Hamilton.

Dr. B. Merrill Hopkinson, class of 1885, has gone to New York for a few days, and is staying at the Hotel Astor.

Dr. Norman Dudley, class of 1901, of Church Hill, Md., recently paid a hurried call to the hospital.

Dr. George R. Graham, class of 1883, a prominent physician and Union veteran of Southwest Baltimore, is critically ill at his home with pneumonia.

Dr. and Mrs. J. W. Holland have returned to Baltimore and have taken for the winter the house at 1624 Linden avenue.

Dr. William Whitridge is at Adamsville, Rhode Island, where he has been spending several weeks.

Dr. Frank O. Rogers, class of 1901, of Concord, N. C., was in Baltimore recently.

Dr. W. H. Coulbourn, class of 1901, recently spent several days around the hospital.

Dr. E. Quillen, class of 1904, of Wilmington, N. C., recently paid the hospital a hurried visit.

Dr. W. Stubbs, class of 1902, who has been a patient at the University Hospital, has returned to his home.

Dr. W. E. McClanahan, class of 1902, is health officer of Highlandtown, Md.

Dr. Marshall L. Price, class of 1902, is Secretary to the State Board of Health, Maryland.

Dr. Hiram Woods, class of 1882, and Mrs. Woods have reopened their town house.

Dr. Harry N. Richards, class of 1888, is located at Ridgely, Md.

MARRIAGES.

Dr. John L. Riley, class of 1905, of Snow Hill, Md., was married November 11, 1908, to Miss Beulah Vincent, daughter of Mr. and Mrs. Clarence I. Vincent, of Snow Hill. The ceremony was performed in Makemie Memorial Presbyterian Church, Rev. J. B. North, the pastor, officiating. Miss Martha Toadvine, of Salisbury, was maid of honor. The bridesmaids were Misses Eleanora Hargis, Helen Moore, Mary Townsend and Viola Smith. Mr. C. V. White, of Topsoil, was best man.

Dr. Elijah Wooton White, class of 1906, of Poolesville, Md., was married November 18, 1908, to Miss Florence Helen Pyles, daughter of Mr. M. Thomas Pyles, of Rockville, Md. The ceremony was performed by Rev. Walter Williams and Rev. Walter P. Griggs in St. Peter's Episcopal Church. The bride was attended by her cousin, Miss Jane Williams.

The best man was Mr. Benjamin White, brother of the bridegroom.

Dr. White was well and favorably known around the University Hospital, where he was an assistant resident physician. The BULLETIN extends its best wishes to the young couple.

DEATHS.

Dr. George W. Norris, class of 1872, of 1402 Harlem avenue, Baltimore, died suddenly at his home Friday, November 20, 1908. Dr. Norris was one of the most prominent medical practitioners of Baltimore, and especially of its Northwestern section.

Dr. Norris was a native of White Hall, Md., where he was born on his father's farm 64 years ago. He lived on the farm until he reached manhood, when he decided to enter upon the study of medicine. He graduated from the medical department of the University of Maryland with the class of 1872. Dr. Norris was a member of the Masonic Order. Besides a son, Mr. Harry C. Norris, Dr. Norris is survived by his widow, who was Miss Elizabeth L. Carmichael, daughter of William Carmichael, of Baltimore county, and two brothers, Dr. J. B. Norris, class of 1866, of Beckleysville, Md., and Mr. Wm. H. Norris, of White Hall. Interment was in Loudon Park Cemetery.

Dr. J. Edward Tompkins, class of 1891, one of the most prominent physicians of Fredericksburg, Va., died Wednesday, November 18, 1908. Dr. Tompkins was 41 years of age, and a graduate of Richmond College and the medical department of the University of Maryland. Death followed an operation, from which he never regained consciousness.

Dr. John Hood Owings, class of 1861, of Livingston, Montana, and for many years a practitioner of Deer Lodge, Montana, died at St. Paul, Minn., September 26, 1908, while on his way home from Rochester, where he had undergone an operation, aged 66.

Dr. Richard T. Gott, class of 1868, one of the best-known citizens of Poolesville, Md., died November 26, 1908, at his home, in Poolesville, after a long and lingering illness.

The Gott family was established in this country at an early day. Dr. Gott has been a resident of Poolesville practically all his life. Dr. Gott was in his sixty-fourth year. Interment was in Monocacy Cemetery, Beallsville.

Dr. George R. Graham, class of 1883, of 725 Columbia avenue, Baltimore, and one of the most prominent physicians in that section of the city, died Thursday, November 19, 1908, of diabetes and pneumonia. Dr. Graham was born on Constitution street, near Monument, on June 28, 1844. In September, 1861, he enlisted in Company E, Fifth Maryland Volunteer Infantry. He was promoted successively until he reached the grade of first lieutenant. He was wounded in the battle of Fair Oaks, on October 27, 1864, and was mustered out with his regiment on September 1, 1865. On June 20, 1883, Dr. Graham was mustered into the Grand Army of the Republic, and on February 22, 1890, was elected department commander. He was also a member of the Grand Army Club of Maryland. For several years he was a member of the Union Veteran Association of Maryland. He was also a member of the Military Order of the Loyal Legion of the United States, and for several years a member and secretary of the Pension Examining Board, No. 2. Dr. Graham was only 17 years old when he entered the Union Army. After the war he spent several years at sea. Dr. Graham is survived by a widow and two sisters—Mrs. Marion Boss and Miss Laura Graham—and one brother—Mr. William Graham. Interment was in Loudon Park Cemetery. Members of Dushane Post had charge of the services.

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TUBERCULOSIS AND PREGNANCY.

By L. M. ALLEN, M. D.

Read before the University of Maryland Medical Society Nov. 15th, 1908.

A sort of traditional view still exists in the mind of the layman, and even some medical men, that pregnancy may have a beneficial effect upon consumption, and sometimes may even arrest its development.

In looking over the literature it is noticed that only the comparatively recent text-books deal with the subject to any extent, and even these seem to pass it by rather lightly as if it were a matter of very little importance. For example, one of the most complete considerations I have been able to find in any of the text-books occupies in all a space of about three pages, and the same author devotes sixteen pages to a consideration of the various forms of destructive instruments, many of which at the present time are obsolete. To one who has had a fair amount of experience with such cases it is difficult to understand how such a serious condition can be passed by so briefly. My idea in presenting this paper is to bring this subject more prominently before the profession. By adding a little to the already accumulating evidence points out the fact that, as a rule, the gravid condition exerts a decidedly harmful effect upon tuberculosis when already present, and may probably act as a predisposing cause in those women who are looked upon as receptive candidates. According to Lancereaux, statistics appear to show that a considerable number of cases of tuberculosis develop solely as a result of pregnancy. The morbific action of the bacillus is not discredited by this statement, which simply means that a certain number of women have become tuberculous who had no family history of the disease, were not of the scrofulous or tuberculous habit, had never been exposed to the hazard of contagion, and were living at the time of the infection in a good sanitary environment. Assuming, as every one does, that the bacillus is omnipresent, he concludes that pregnancy alone can render a healthy individual tuberculizable. If pregnancy can thus effect the healthy, how much more likely would it be for the disease to assert itself in a woman who is a fit subject for it, or in one who is actually consumptive.

Several cases which have been under my care recently seem applicable to the subject, a brief report of which may prove interesting.

Mrs. S., aged 26; pregnant for the third time. The first pregnancy was terminated about the fifth month by accident; the second was a full-term delivery; and the third was interrupted about the thirty-eighth week on account of her condition, which will be explained below.

History of the present pregnancy. Between the fourth and fifth month patient had contracted cold and began to cough, which had continued up to the present time, gradually getting worse. During all this time she had been under the care of a general practitioner, who had given her a great deal of medicine and repeatedly told her family that it was only a simple cough, that would get well as soon as the confinement occurred. She was placed under my care because I was going to attend her in the coming confinement, not because of any alarm concerning her condition.

Condition. Quite weak and appeared careworn, coughing a great deal and expectorating large quantities of thick, purulent material. Morning temperature nomal, pulse 110 to 120. Examination of chest showed the entire left lung to be involved with a considerable area of consolidation, about the middle one-third and the right apex suspicious. Palpation of abdomen revealed the fact that the pregnancy was advanced about thirty-seven weeks. Child alive. Immediate termination of pregnancy was advised, but, as is the rule in such cases, the matter had to be discussed with the entire family, and consequently much time lost. Each day I was more and more confirmed in my opinion and impressed

upon the family the gravity of the case. Finally consent was given and at 10 A. M. August 7th the membranes were ruptured, the uterus actively kneaded for five or ten minutes and quinine, grains 5, strychnine, grain 1-40, given every four hours. At 7 P. M. I was called and found the first stage of labor progressing favorably. Child born alive and in good condition at 5 A. M. August 8th. Except for considerable post partum hemorrhage labor was uneventful and likewise the puerperium. Evening rise of temperature from 99 to 100, which has continued up to nearly the present time. As soon as possible she was sent to the country and given instructions about fresh air and exercise. She did not follow these out, taking too much exercise and not enough fresh air, and during the latter part of September had a severe bronchial hemorrhage. When seen the following day her pulse was 150, and she looked as if death might occur at any time. She was put to bed in a room with all windows removed, given nux vomica and syrup of wild cherry with codeia for her cough, and is still in bed. Clinical condition is somewhat improved, although examination of lungs shows about the same condition. So far as I can find out this woman has always been healthy and comes from a healthy family and had been living with good surroundings. The prognosis in this case is extremely bad, death being almost certain in a comparatively short time, and there is very little doubt but that she could have been saved had the pregnancy been terminated when the disease was in its incipiency.

Case number 2 differs from the above in that she has a bad family history, but had been healthy until after marriage. Her mother died of tuberculosis following her fifth confinement, and her sister five weeks after her first. This woman has had two children, having been attended by me in each. During the first she did well, but was unable to nurse the child longer than two months; during the second she developed a cough, but no lesion of the lung could be recognized. Notwithstanding this fact she became so weak and run down that I interrupted the pregnancy at the thirty-ninth week. This time she was unable to nurse the child at all and was a long time regaining her strength, although she had an easy labor and normal puerperium. She is at the present time pregnant four and one-half to five months. On October 20th I was called to see her for a severe pain in the chest. Examination revealed nothing definite, but a suspicious roughness in the left apex, pulse ranging from 96 to 100, temperature normal and a return of the old cough. I feel certain that this woman has tuberculosis, and only a short time will elapse before it will be recognizable.

Case 3. Mrs. C. Seen in consultation with Dr. Dickson; pregnancy six and one-half months advanced. Apices of both lungs involved. Evening temperature 99½ to 100, pulse 90 to 100. Weak and losing ground, although she had been under treatment for some time, having been given fresh air and forced feeding. I advised the termination of pregnancy at once, which was accepted. Labor was induced as above on Feb. 4th, 1907. Pains began evening of the 5th and labor was terminated spontaneously on the 6th. Child was alive, but on account of prematurity died in a few hours. The patient was sent to the mountains and when last heard from was doing well. This case was probably seen in time and we hope for recovery.

Case 4 came to me for treatment Oct. 1st, 1908, giving the following history: Mother died of heart disease, father of asthma, probably tuberculous; no brothers or sisters; has three children, six, four and two years old, respectively. At present time is five and one-half to six months pregnant. Has had a cough for several months and has been losing weight. Examination of chest reveals rales in apices of both lungs. Woman advised to have the pregnancy terminated at once, but on account of her religion refuses. Seen again Nov. 12th. Patient shows evidence of rapid progress of the disease, having been in bed for several days on account of weakness. Pulse 108, and has fever every evening. Still refuses to have pregnancy terminated. This patient will most probably succumb rapidly following her confinement.

There seem to be a few cases on record where tuberculosis was already present when conception took place, in which the pregnancy has apparently exerted a beneficial effect upon the disease, but these have been very few, and should never be hoped for, as in most of the reported cases the benefit has been apparent rather than real. As a rule signs of the disease are first noticeable about the fifth month of pregnancy, at a time when development of the fetus begins to act as a drain on the maternal system. The

first pregnancy and confinement may not have any bad result, but the second and still more certainly the third, especially if they have occurred in rapid succession, are apt to prove serious. In reference to this phase of the subject Dubois makes the following statement:

If a woman threatened with Phthisis marries, she may bear one accouchement well, a second with difficulty, and a third never. There may be exceptions to this rule, but generally speaking it is true. In a certain number of these cases the disease seems to be held somewhat in abeyance during pregnancy, but advances by very rapid stages following confinement, terminating frequently in acute general tuberculosis or acute tuberculous pneumonia. The real explanation of the fatality through which pregnancy and parturition lead to Phthisis is not entirely understood, but most probably is the result of lowered resisting power. The severe strain of pregnancy is not so noticeable in a strong, healthy woman, but one who is already weak is apt to be made weaker, and when there is added the labor with its shock and fatigue, followed often by loss of blood, the story is told. My own experience leads me to believe that the most rapid cases of tuberculosis are those following confinement. Three such cases especially I recall, in whom death occurred on the sixteenth day, fifth week, and end of second month, respectively. In two of these cases the diagnosis was confirmed by autopsy, in one of which there was acute tuberculous pneumonia and the other acute general initiary tuberculosis.

Another case which I have recently seen was one in whom the disease apparently was held in abeyance during pregnancy, but immediately following delivery showed evidences of activity. This patient, whose chart I show you, had a certain amount of cough during the latter weeks of her pregnancy, but apparently had had no fever or any signs of activity of the disease, which was only manifested immediately following delivery. She was advised to go to the country and was given instructions as to treatment, but refused, and is now a servant in a family in this city. Her present conditions, while not extreme, is far from satisfactory, and most probably she will before very long succumb.

The views of some of those who have made tuberculosis a special study may help to confirm what has been said. Laurason Brown (Osler's Modern Medicine) makes the following statement:

The effects of pregnancy and parturition upon pulmonary tuberculosis are to be separated. Pregnancy (including labor) may awaken old quiescent lesions and incite fresh ones to renewed activity. In advanced cases pregnancy is always serious, and when laryngeal lesions are present the mortality is said to be 61 per cent. (Fulner).

In a few cases the disease is apparently arrested and the nutrition and general and local condition of the patient is much improved during the pregnancy. The effects of parturition, although it lasts but five or six hours, is always to be regarded seriously.

Bonney (Text-book on Pulmonary Tuberculosis and Its Complications) says that nearly all clinicians agree that the combined effect of pregnancy, the puerperium and lactations constitute a tremendous tax upon the physical energies of the consumptive, and directly lower the powers of resistance. In view of the clinical observation as to the frequent increased activity of the tuberculous process after childbirth, with a progressive subsequent decline, pregnancy has come to be generally regarded as a factor of grave prognostic importance among such patients. Instances of actual improvement in the condition of the tuberculous lungs as a result of concurring pregnancy rarely have been recorded. It is but natural, therefore, that pulmonary invalids should have been instructed as to the advisability of marriage, the imperative avoidance of conception, and even the expediency of a speedy termination of pregnancy. He continues, however, with the statement that the effect of pregnancy upon the general health and the course of the pulmonary involvement, may be decidedly favorable in a few instances. Two of such cases are reported by him to substantiate this view.

While the title of this paper is pregnancy and tuberculosis, I do not feel that the subject would be complete without some reference to the offspring of tuberculous parents. In taking up this subject we must consider the possibility of the transmission of bacteria through the placenta. Out of the large number of tuberculous women who are confined every year, Hauser in 1898 was able to collect only 18 who have given birth to children or a placenta which gave evidence of the disease. Birch, Hirschfeld, Schmorl, Leh-

mann and others have described tuberculosis of the fetal portion of the placenta and occasionally cases of congenital tuberculosis.

In "Noth Nogle's Encyclopædia of Practical Medicine," the author quotes from the most reliable pathologists, including Virchow, whose experience extended over decades, and who never saw a genuine case of congenital tuberculosis: or they designate such a case as a rarity, which has only occurred in connection with uterine tuberculosis in the mother. He continues with the assertion that if we consider the two questions, first, whether placental transmission is possible, and, second, whether it occurs so frequently as to constitute the principal cause of dissemination in tuberculosis, we must answer the former unconditionally in the affirmative, but the latter absolutely in the negative.

Further argument against the frequency of the placental transmission of tubercular bacilli is offered by the pathological findings as presented by the same author. Thus, according to the law of localization we see the first and most advanced changes at the place where the tubercle bacilli enter the organism; that is, in the nearest lymph glands. Accordingly, in intra-uterine transmission, the liver being the inlet for the blood infected by the maternal circulation, should show the first and most important changes. As a matter of fact it has been found that in all incontestably congenital cases the liver and abdominal viscera are principally involved, whereas in the preponderating majority of tuberculous children it is not the liver, but, just as in adults, the lungs and the bronchial glands which are chiefly infected.

According to Biederts Compilation in 1,346 bodies of tuberculous children the organs were affected in the following ratio:

The lung in 79.6%, the intestine in 31.6%, the lymph glands in 88.0%, the peritoneum in 18.3%.

Concerning the effect upon the child at birth, a study of the literature reveals rather conflicting statements. Thus, in one text-book the statement is made that children of tuberculous women are usually well developed, while in another which is equally well known it is stated that the offspring of these women are usually delicate, undersized and after developing the so-called strumous diathesis have tended to fall a prey to the disease. My own experience agrees with the first of these.

Leaving aside the condition of the child at birth, we will review briefly the effect of the disease upon its early life. The researches of Von Behring and Calmette are gradually turning the trend of modern medical thought toward an interpretation of the term predisposition as a susceptibility of the patients dependent on antecedent infection.

According to Cornet, the extent to which hereditary disposition is responsible for development of the disease can never be determined until the factor of infection is completely eliminated.

This subject has been considered quite thoroughly by Dr. Theodore Sachs, of Chicago, in volume 17 of the Journal of the American Medical Association, 1908, and I will quote briefly from his article.

His investigation was undertaken with the object of determining, if possible, a prevalence of tuberculosis among children of tuberculous parentage. With this in view 146 families, with one or both parents known to be tuberculous, were selected from the records of the Chicago Tuberculosis Institute and the Visiting Nurses' Association. Fifty per cent. of all deaths from tuberculosis among the parents occurred within one year preceding the investigation; 79 per cent. within two years. The result of the investigation was as follows:

Total number of families, 146; born before parents became tuberculous, 458; of these 93, or 20 per cent., died. Of those living 230 were examined and of these 126 were tuberculous. Born after parent became tuberculous, 155; of these 41, or 26 per cent., died. This left 114 living, and of these 92 were examined, 45 of whom were tuberculous.

It is evident that these figures show that a very large percentage of children of tuberculous parents suffer from tuberculosis, and eliminating a small possibility of placental transmission, it must be concluded that a child of tuberculous parentage is born with a predisposition to the disease, although this cannot be positively proven until infection during long infancy is eliminated.

Treatment.—If a woman has a bad family history and is not robust and strong, but what might be considered delicate, she should be advised against marriage. If she is already tuberculous, marriage should be legally prohibited. If she becomes tuberculous after marriage she should be

warned against the occurrence of conception. If conception does occur she should be watched very carefully, and as soon as any activity of the disease is noted the uterus should be empted as carefully and conservatively as possible, and the woman put under most favorable conditions for recovery. If the pregnancy should continue to full term, the mother should not be allowed to nurse the child, nor should she have any part in caring for it, as it is undoubtedly these two drains on the maternal system that ofttimes causes a fatal termination. Personally I disagree with those who, for the sake of the offspring, would allow a pregnancy to continue while an active lesion is present in the lung. I would not hesitate a single moment to interrupt a pregnancy at any time, if the disease were definitely proven. Recently in conversation with a lady who has been a patient of Dr. Trandeau's at Saranac Lake she remarked that one of the most pathetic features of the sanatorium was the number of women under treatment who were grieving for their young babies at home. She could not understand why so many of them had young babies, never having known that Phthisis is more apt to occur at such time.

In the case of a woman who has had tuberculosis and recovers completely, I will quote from the advice given one of my patients by Dr. Trudeau: She might be allowed to marry after three years of good health, but must be watched carefully. As long as good health is retained she may be allowed to give birth every three years.

Conclusions—That a woman, although she has a good family history, may, because of lowered resisting power, the result of pregnancy and confinement, especially if these be repeated in rapid succession, be more susceptible to tuberculous infection.

That if she has the disposition, the disease is more apt to come on during pregnancy or following confinement than at other times.

If she already have the disease, although it may be only in mild form, it will be aggravated by pregnancy and the puerperium.

That marriage should be discouraged in those who are tuberculous, but if this advice is not taken and pregnancy ensues, it should be interrupted at any time in the presence of any activity of the disease.

Since this report Case No. 4 in the above series has died, the disease having progressed even more rapidly than I had thought. She was delivered of a premature infant Nov. 20th, the labor having been brought on most probably by the fever. She became rapidly worse and died Dec. 1st, 1908. When seen on Oct. 1st, even if labor had been induced, she could hardly have been saved, but she would have been given the only possible chance.

THE EAR POLYP: ITS CLINICAL AND PATHOLOGICAL MANIFESTATIONS.

L. J. Goldbach, B. S., M. D.,
Baltimore, Md.

These pedunculated connective tissue growths arise more frequently from the mucous membrane of the middle ear than from the external auditory canal or the tympanic membrane. These aural polyps are visible, more or less, as pearlish gray rounded masses lying in the external auditory canal.

Their development is brought about by a purulent discharge from the middle ear (acute or chronic in character)—in the most instances by a chronic supurative otitis media. At intervals a polyp may be seen on the walls of the external auditory canal. While it is not definitely proved that the aural polyps are directly due to an otorrhea, it, nevertheless, appears to be always a secondary condition of a purulent inflammation with caries of the bone in the immediate neighborhood. A pre-existing inflammation of the aural mucosa, pus and moisture, passive congestion starts a polyp growth. It is also significant that the pus has a rancid odor in which the polyp lies imbedded. The scantier the discharge and drier the parts, the smaller and tardier the growth.

When the polyp forms within the middle ear it is usually situated on the inner and inferior walls; they may also form on the ossicles or in the attic. When in or near the attic wall I have noted pressure symptoms, a disturbed equilibrium and faintness. Such polyps are usually fraught with danger on their removal, for they are usually attached to a necrosed attic wall, held by bands of fibrous tissue going into the polyp. Gentle manipulation and extreme care should be used in their removal and better performed by section removal.

In the external auditory canal the polyp is usually situated close to the rupture in the membrana tympani, around the posterior superior

wall. Its origin is brought about by an exfoliation of the epidermic lining of the canal walls, the polyp beginning from the superficial layers of the cutis. To arise from the deeper layers there must be a marked exfoliation, and a canal that has long been subject to a chronic otorrhea. The size of the polyp varies with the conditions present within the middle ear. A long standing otorrhea with profuse granular tissue may so rapidly stimulate the polyp that in the space of a few weeks it may extend to the opening of the auditory canal. A poor drainage and filthy condition of parts, the more probability of a larger growth. When a polyp forms on the membrana tympani it is usually small and resembles a papular eruption of the drum. With such a polyp formation the middle ear has more of a latent purulent inflammation.

The location of the polyp, the amount of discharge, the hole in the drum, the virulence of the organism and the constitutional condition of the patient all play part as to the size; this may vary from that of an ordinary green pea to a date kernel. The surface may be smooth, rough or lobulated—all depending on the condition of the epithelium of the middle ear and the external auditory canal.

Of the various aural polyps examined, macroscopically and microscopically, I find that the aural polyp resembles very much in its construction a benign tumor. It is a granular tissue collection undergoing metamophoric changes being partially brought about as a by-product of an inflammatory reaction. This granular tissue abnormally increased acts as foreign matter, causing a stimulus to a cellular and fibrous collection, the latter holding within its meshes epithelial disintegration and exfoliations of the middle ear, erythrocytes, leucocytes (principally the polymorphonuclear), broken down cells, round and spindle cells, loosely scattered or tightly packed, all depending upon the amount of fibrous tissue present. The normally ciliated cylindrical and squamous cells found within the middle ear and seldom found within the polyp, is accounted for by the round and spindle cell invasion, the partial hyperplasia of the infiltrated mucous membrane; so, practically, the normal contour of the membrane of the middle ear is destroyed before the polyp begins to form. The mucous membrane that remains may "become thickened either through the excessive growth of the mucous membrane layer with or without the formation of cysts, or through a general papillary or polypoid hypertrophy of the cutis layer."

A discharging ear does not necessarily mean a polyp growth, however, in the most instances unless the ear is cleansed by some antiseptic solution and the surrounding parts kept dry, the possibilities are that a polyp will form eventually. This does not mean that a polyp may not form though the ear is constantly cleansed. At times it is far better to apply the dry treatment by means of some astringent and mild antiseptic powders, the astringents shrinking the granular tissue and the powders absorbing the moisture.

In children more of a papillary excrescence is seen than a true polyp formation. Perhaps the predisposition of the mucous membrane of the child to papillary growths. The author has frequently found not only pedunculated papillary excrescences, but ridgy and combllke elevations on the mucous membrane of the middle ear.

In the young polyp we have more of an intravascular than a superficial blood supply. The older the polyp the more superficial is the distribution of its vessels, owing to the larger fibrous bands within its meshes cutting off the deep supply of blood. The older the polyp the more this condition is seen, particularly on its outer extremity. Within the polyp minute cavities, varying in size, are seen, cystic in their appearance. These spaces are probably caused by a collection of fluid in the connective tissue, with a subsequent enlargement, and at times fusion of the spaces. In some cases these cavities are lined with a flat tened connective tissue, though the walls of these cysts may vary in their nature, according to surrounding conditions. It may be an independent formation with no endothelial lining. Indentations on the surface caused by adhesions with a secondary epithelial lining brings about cavities. The contents of these spaces usually contain a liquid, gelatinous mucoid or pultacious matter. They may be superficially or deeply placed. In the polyp that contains a predominance of fibrous tissue very few, if any, cysts are seen. The polyp without a marked epithelial covering should be classed as an immature type. This lack of epithelium may be partly caused by a scanty epithelial covering of the middle ear, or the purulent discharge may have destroyed the epithelium before the polyp had a good chance to form. The ear polyp is found then to consist of disin-

tegrated blood, fibrin, red and white cells, cast off epithelium, cells passing through a transitional stage, granular and fibrous tissue, the latter either forming in bands or minutely divided through the polyp. The aural polyp containing large sections of fibrin may be possibly styled a fibromata; it grows very slowly; the round cell infiltrated polyp grows quite rapidly.

Our method of treating the aural polyps at the Presbyterian Eye, Ear and Throat Hospital is by 10% formalin irrigations (10 gtts. to a half tumbler of warm water). It is surprising to see how the soft polyp will disappear under this treatment. For the more persistent ones we add compound tincture of benzoin, with avulsion by means of the wire snare, and cauterization of its base with cromic acid infused on the end of a probe. Local anasthesia with a 4% Sol. Alypin and 1-2000 adrenalin chloride injected into the polyp answers admirably well.

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THE BRONCHOSCOPE AS A MEANS OF DIAGNOSIS AND TREATMENT.

By Richard H. Johnston, M. D.

Surgeon to the Presbyterian Eye, Ear and Throat Hospital; Lecturer on Diseases of the Nose and Throat in the University of Maryland, Baltimore.

Tracheo-bronschoscopy has revolutionized the methods of removing foreign bodies from the air passages. Instead of groping in the dark with forceps, which are apt to seize the mucous membrane, the bronchoscope enables us to see the foreign body and in many cases to remove it promptly. So wonderful have been the results in this class of cases, many medical men believe that the usefulness of the bronchoscope ends here. This, however, is not the case, as workers in this comparatively new field of medicine know. In every large city of this and other countries there will be found one or more men who are striving to give bronchoscopy its proper place in the diagnosis and treatment of disease. The work is discouraging in that it is always difficult to convince the profession generally that there can be any good in a medical innovation: it is encouraging to the worker himself who sees into a region of the body hitherto unexplored during life. As one becomes more expert in the passage of the tubes the pathology of the trachea and the bronchi unfolds itself in a manner impossible by other methods of examination. Von Schroetter in Europe and Jackson in this country have led the way in the diagnosis and treatment of diseased conditions in the respiratory tubes; they have shown that not only the simpler lesions, such inflammations and ulcers, may be successfully treated, but also lesions that are directly dangerous to life, as syphilomata, tuberculomata, etc., may be reached locally. Von Schroetter has treated stenosis of the trachea and the bronchi by inserting into the stricture and leaving in situ for variable periods of time a hollow aluminum tube, which dilates gradually. After remaining in for the required length of time, it is pulled out by a string attached to the upper end. In treating diseases of the trachea and bronchi through the bronchoscope it must be remembered that remedies cannot be used in the same strength as in the upper part of the respiratory tract. The solutions generally applied are nitrate of silver (2-3% solution) and argyrol (20% solution); with these drugs we can accomplish all that it is possible to do except in syphilitic lesions, in which chromic acid will probably do as much good as in ulcers seated higher up. In examining pathological conditions in the trachea and bronchi one is struck with the tendency of inflammations to limit themselves to certain areas. We may, for instance, find the disease in the trachea with no extension to the bronchi or vice versa; or we may see a circumscribed tracheal inflammation, which is usually located about two inches below the larynx, and which often follows "Grip" and gives rise to an obstinate, hacking cough. I believe that many post-grippal coughs can be traced to this "Grip" area and some can be cured by appropriate local treatment through the bronchoscope. During the past year I have had occasion to examine quite a number of patients complaining of cough or soreness or both symptoms in the region of the trachea. In some of these definite lesions were discovered through the bronchoscope and to two of them I wish to call particular attention. In January, 1908, I was consulted by Miss E. W. for troublesome cough of about five months' duration. In September, 1907, she contracted a cold which terminated in the cough. She consulted her family physician, who gave her several remedies, which did not cure. Examination of the sputum was negative. She left the city for a time; dur-

ing her absence the cough improved, but on her return became worse again. The paroxysms at night interfered with sleep. Under local anesthesia the bronchoscope was passed with the patient in the sitting position. The larynx and upper part of the trachea appeared normal; approaching gradually the bifurcation and about two inches above it, thick, tenacious muco-pus was encountered. Upon wiping out the secretion an area of what might be termed local inflammation was found. The mucous membrane was reddened and in the center of the area could be seen a small, well-defined ulcer, the edges of which were well marked and round. The bronchial tubes were slightly red, but otherwise showed nothing abnormal. The patient had located a "sore spot" in the chest at about the bifurcation. Treatment was begun at the first sitting with the direct application of nitrate of silver. The immediate effect of each treatment was to increase the cough for a few days. The applications were repeated every week or ten days, gradually increasing the strength of the silver solution, until six had been made. The cough had improved so much that further bronchoscopic treatment was considered unnecessary. At the fifth sitting the ulcer had practically healed. When the diagnosis of ulcer was made we feared that it might be tubercular, but the rapid healing under treatment proved otherwise. In April, 1908, Miss M. F. consulted me for a cough and a sensation of tracheal soreness of nearly a year's duration. Expectoration was slight, but the cough made the soreness more pronounced. The patient had been treated through the winter with various cough syrups and sprays locally with no benefit. She was greatly discouraged and the fear of Tuberculosis was ever before her. A bronschoscopic examination showed thick, tenacious secretion clinging to the tracheal walls; after its removal the mucous membrane appeared red and thickened. The bronchi were normal. A diagnosis of tracheitis was made and treatment with nitrate of silver was begun. The bronchoscope was passed eight times. The patient left the city practically well and has remained so.

These cases prove that tracheo-bronchoscopy is useful and practicable in the diagnosis and treatment of disease. Dr. Chevalier Jackson, whose experience has been much greater than mine, reports many cases in which the diagnosis could not have been made with any degree of certainty without the aid of the bronchoscope.

From my limited experience with tracheo-bronchoscopy I have drawn the following conclusions: With practice the introduction of a rigid tube into the trachea and bronchi is not very difficult.

The bronchoscope can be introduced in nearly every adult case under cocaine anesthesia.

The hypodermic injection of morphia and atropia is a sine qua non for successful manipulation of the tubes and for drying up secretion. The mucous membrane of the trachea and the bronchi is seen as clearly as is the membranes of the nose and throat with the head mirror. In none of my cases has a bad result followed; we may say that the method under proper antiseptic precautions is free of danger.

Tracheo-bronchoscopy is just as valuable in the diagnosis and treatment of diseased conditions as in the removal of foreign bodies. The tertiary bronchi can be seen with a good light.

A SERIES OF GYNECOLOGICAL CASES: FROM THE DEPARTMENT OF GYNECOLOGY IN UNIVERSITY HOSPITAL.

By W. D. Hammond, M. D., *Class* 1908.

Assistant Resident Gynecologist, University Hospital.

Case 1.—Ovarian Sarcoma. Miss C. H.; Social condition, single; age, 18; occupation, Schoolgirl. Patient entered hospital, July 7th, 1908. Complaint: "Abdominal Enlargement."

History of Present Illness.—Attention was first called to increase in the size of the abdomen on June 20th, about 17 days ago. This was seen to be pogressive and five days since patient went to bed.

There were no subjective symptoms, save a general weakness; local pain was absent.

Past History.—General health has been good. Has had measles and chicken-pox; these when very young. Also what was diagnosed as a slight attack of Typhoid Fever at the age of five.

Patient has led an indoor life, not being particularly robust. Sight is bad, glasses having been required at the 12th year. Appetite is always good; bowels fairly regular.

Menstrual History.—Menses began at 15. Has been regular every four weeks until past May,

when flow did not appear until about seven weeks late, or during the first week of June. At this time there was a slight hemorrhage, lasting two days. Has had none since. Some slight pain and discomfort were experienced when period was missed.

Family History.—Rather unsatisfactory and incomplete. Mother is living and in good health. Also three sisters and two brothers; none are dead. Father died three years ago of "stomach trouble." There is no tubercular history.

Note.—Father died at age of 63, evidently of malignant disease, most probably carcinoma of pylorus.

The family history was unilluminative, save as to the cause of death in the father. The fact mentioned in the note, as to probable malignancy, was only brought out subsequent to operative diagnosis. Whether in this instance heredity was a factor or the two cases merely coincidental would certainly be very hard to say. The diagnosis lay between malignancy and benign ovarian cyst, with the odds heavily in favor of the former; the patient, however, was given the benefit of the doubt.

Another point was the general aspect of the patient. Although distinctly anemic, she did not present the peculiar cachectia here generally looked upon as diagnostic. Her color was such as might be attributed to an ordinary chlorotic condition of some severity, dependent upon age and sex and the sedentary, indoor life to which she was accustomed. In fact, the family accounted for the general unsatisfactory condition of her health as being due to overstudy during the preceding winter.

Physical examination of the abdomen and pelvis was not particularly enlightening, the regular outline and absence of nodulation simulating simple ovarian cyst of benign nature.

Physical Examination. — Subject is a pale, anemic-looking girl, small for her age and poorly nourished. Complexion is very light and colorless. Mucous membranes not abnormal. Wears glasses; myopia apparently severe. No enlarged glands about neck. Lungs normal. Heart sounds distinct, but not loud. Pulse regular in rhythm and force; accentuated beat—105 to the minute. Temperature 99 3-5°.

The abdomen is sure to be enlarged uniformly—to about the size of a pregnancy advanced to the sixth month. The skin is normal in appearance. Maximum of distension two inches below the umbilicus, shading off to either side and above.

Palpation shows abdominal walls tense; smooth and regular in outline; underlying structures resistant to the touch; some slight pain is complained of on firm pressure.

The percussion note is uniformly dull over entire abdomen and in flanks.

Lower limbs are normal; no oedema or swelling.

Urinary Analysis.—Negative findings as to sugar and albumen. Amount slightly above usual output; color very light; S. G. 1010; reaction acid; sediment scanty, with triple phosphate crystals and disquamated cells.

Haemoglobin estimate 75%.

Leucocyte count, 15,733.

Operation.—July 10, 1908, a medium incision was made, extending downward from the umbilicus for about five inches. An enormous malignant process was disclosed, which occupied the entire pelvis and extended generally throughout the lower abdomen. The pelvic and abdominal viscera were all involved and intimately incorporated in the growth; it being practically impossible to differentiate them.

A portion of the tumor mass was removed in two sections, one the size of a quart measure, the other about that of a walnut.

Hemorrhage was considerable, due to persistent oozing, which could be controlled only by pressure.

A portion of the left tube and broad ligament were recognized and excised.

Five gauze tucks were inserted to control bleeding and the abdomen closed.

The condition of the patient was rather extreme, 700 cc. of normal salt solution being given as an infusion during the operation.

Subsequent History.—Patient rallied from the operation, which was rather a trying one, remarkably well; pulse was regular at 120. The temperature dropped to 97° on the second day, rising to 92° on the third. Little or no pain was complained of; general condition was seemingly no worse than before. On the fourth day patient was removed to her home.

Two subsequent attempts were made to remove the gauze packing, but the hemorrhage resulting was so alarming that the effort was abandoned.

The further course of the disease was uneventful-

ful, the patient gradually weakening, until death occurred in the third week of September, about seventy days after the operation, or ninety days subsequent to the first appreciable manifestation.

The foregoing case presents several unique features, which are of considerable interest, due to the infrequency with which such cases come under observation.

Regarding the occurrence of ovarian sarcoma, it appears that the disease is more prevalent than might be supposed.

According to Sutton, the majority of tumors that were formerly classified as fibromata, myomata or fibromyomata, were in reality sarcomatous in character. However, in a series of cases collected by Stander in Germany, in one hospital the percentage of sarcomatous growths was rather small, the occurrence being about one in 15, or 6.7 per cent.

Sixty per cent. of the cases are unilateral. Ascites is usually present, and sometimes hydrothorax.

The several varieties give rise to tumor formations, each one peculiar to its kind. The round-celled sarcomata, of which the foregoing was an example, are soft and brain-like, sometimes figmented, and show on section hemorrhages into the tissues and areas of softening. They are very malignant, rapidly cause metastasis, and in general arise early in life. They are said to constitute about thirty per cent. of all ovarian tumors, occurring in girls under fifteen, although the spindle-called type are also found. This latter variety, however, is usually met with in other subjects. The development of metastatic nodules simultaneously in other organs is rare. The extension to the adjacent pelvic viscera is by continuity, and not due to metastasis.

Among the singular and misleading features of the case under observation may be mentioned, first, the complete absence of pain. One would suppose that in such an extensive destructive process this would be a leading symptom. Many cancers affecting internal organs are, however, unaccompanied by it.

An attempt to judge the extent of the growth by external manifestations was entirely futile.

The past history gave no clue. That the appetite remained good might be attributed to the fact that the organisms, being continually called upon to support and maintain the excessive new growth required an abundancy of material.

On the other hand, how it were possible for the intestines and other accessory digestive organs to function as regularly and efficiently as they did, being involved to such an extent, is not so readily understood.

The presence of the menstrual flow at such a late stage in the course of the disease is explained by the fact that so long as the least bit of ovarian tissue remains intact the function will be kept up.

The absence of ascites rendered the diagnosis especially difficult, since most authorities agree that this sign is uniformly present.

The haemoglobin estimate and leucocyte count should have been considered, and a differential red cell estimate would have been of interest.

The operation, while holding out the only hope, was seen to be absolutely useless immediately upon opening the peritonium. Whether the removal of a portion of the tumor mass had any bearing upon the subsequent outcome is a question of no moment.

The most remarkable feature of all, however, was the wonderfully slight effect which operative interference seemed to have upon the patient's general condition, and the length of time elapsing between those measures and the ultimate outcome.

(To be continued.)

At the last regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, Tuesday, December 15, 1908, the program was as follows: "Classification of Joint Diseases," Mr. Strosnider, class of 1909; "Bone and Joint Tuberculosis with Especial Reference to Tuberculine in Diagnosis and Treatment," Dr. R. Tunstall Taylor: "Pathology and Diagnosis of Diseases of Joints," Dr. C. W. McElfresh; "Diseases, Treatment of Joint," Dr. A. D. Atkinson; "Surgical Treatment of Joint Diseases," Dr. J. W. Holland.

We are glad to report that the members of the fourth year class are taking an especial interest in these meetings, and, as noted above, are being encouraged in their participation by asking a member at each meeting to read a paper. As has been frequently reiterated, these meetings are primarily for the students, and we are glad they are responding so heartily.

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EDITORIAL.

THE NEW YEAR.—Entering upon the new year, THE BULLETIN extends cordial greetings to the Alumni of the University of Maryland. THE BULLETIN offers hearty congratulations to alma mater on the substantial progress she has made during the year which has passed. Whilst nothing sensational or startling has occurred in the work of the University, a healthy and satisfactory growth has marked her educational policies and her business operations. Her property interests are in good condition, her curriculum of study is constantly widening to keep pace with the educational progress of the day, and the university spirit, which is drawing all of her departments into closer co-operation, is more in evidence than at any time in her long and eventful history. Indeed, at no time in the life of the old University have influences for her development and field of usefulness been more real and substantial. THE BULLETIN can with perfect sincerity say, God has blessed dear old alma mater during the past year. At this season of the year it is profitable to individuals, as well as institutions, to take an inventory of assets and liabilities, to sum up gains and losses, that one may see the results of the year's work. Such an inventory, however made, will show satisfaction or regret. It will indicate whether one is going ahead, standing still or falling behind in his work and efforts. Whatever conclusions one may reach, there is only one practical and philosophical thought for reflection. The wise thinker will cast his mind back over the past with the solemn resolve to make good in the future the results of the past, to profit equally by success or failure, and to take a new hold on the problems which ever press upon his intelligence and consideration. There is only one solid ground upon which an individual or an institution can stand. Each must recognize the fundamental principles which underlie every achievement in life. There can be no permanent success in any field of work unless achieved by efficient service. No service can be efficient unless it is based upon meritorious effort. Results only can be reached through agencies and actions which follow the law of cause and effect. This law demands progress as the essential condition of success. One must go back or go forward in the world's work. To stand still is slow decay—it is retarded action which defeats every high and useful purpose. The race is to the swift and strong. At no time in the history of the world were the standards of endeavor higher than today. A strenuous age calls for strenuous men and for strenuous institutions. Strenuosity should not be confused with noise, fuss and boastful action. Quite the contrary, the most strenuous work is the quiet, calm labor of the unobserved and patient laborer. To use a common expression, the man who gets there and stays there is, in the vast majority of instances, the plodder. The plodder does the vast bulk of the world's work. He is ever holding on to his task, and but for his toil the moving forces of human activity would come to a standstill.

This restless age is running wild after money, fame, power and self-seeking advantage. Commercialism has laid hands on the very highest spirit of human motive and ambition. It has brought danger to many individuals and to many institutions working for the betterment of the race. Every individual should stop in the pace he makes to consider the drift of his own hopes and actions. Is he drifting with the current, resisting it, or is he stranded in an eddy? An answer to this question demands an intelligent consideration. A responsibility is involved in every human action. No serious-minded man can treat his convictions with levity. He must make them good or confess his shortcomings. This method of stock taking, of balancing accounts, of debits and credits, cannot fail to benefit the individual who places a proper estimate upon his services to his race and to himself. It shows just where he stands and what he stands for. He is brought face to face with his motives and acts. He must confess to himself, if not to others, the weakness

of his own character, the faults of his life, and the purpose which influences his pride. Having charged up his failures and faults, it is but just to himself to weigh the credits which go to balance the account. Every individual should find something in his character and life to arouse pride and self-esteem. He should never admit that he is bankrupt in mental, moral or physical capital, but with hope in despair cling to ideals and seek after methods that will bring out all that is worth saving in his character.

The new year invites such reflections as THE BULLETIN has expressed. They are but stray thoughts which are cast like bread upon the waters. If the ideals THE BULLETIN stands for are worth treasuring they will not be lost. If during the coming year it can bring pleasure and brotherly love into the hearts of its readers, it will greatly rejoice. If it can in any way be helpful to Alumni and to alma mater, it will be exceeding glad.

THE POST-GRADUATE COURSE OF THE UNIVERSITY OF MARYLAND.—In the present issue of THE BULLETIN will be found the program of the post-graduate course of instruction, which will be given by the Faculty and Adjunct Faculty of the University, beginning May 15th and lasting six weeks. The object of this course is to give to the Alumni and students, and medical practitioners in general, an opportunity to study in the laboratories and clinics of the University such branches as they may elect at a season of the year when the regular courses of instruction in medical schools have suspended.

The immense amount of clinical material in the University Hospital can be used to great advantage, and, the laboratories being less crowded with students, will offer better facilities for individual instruction.

It is believed that this post-graduate course will fill a place in the educational work at the University that is greatly needed. The course cannot fail to be of great advantage to graduates and to students who seek instructions along lines not fully established in the regular course. It will prove of special service to the teaching staff by way of training for work which must be done in the subsequent courses. Both teacher and student need the training which post-graduate work most readily enforces.

For some years past there has been a demand for this post-graduate work at the University, and THE BULLETIN wishes the present effort abundant success.

POST-GRADUATE COURSE OF UNIVERSITY OF MARYLAND.

The Faculty and adjunct Faculty of the Medical Department of the University of Maryland will begin a post-graduate course May 15, 1909, which will continue six weeks until July 1, 1909. This course will include medicine, surgery, the specialties and laboratory work in pathology, bacteriology, clinical microscopy, histology and anatomy.

The cost for the entire course will be sixty dollars; individual courses, twenty-five dollars.

MEDICINE.

Medical Clinic, Tuesday 1 P. M. Prof. Chew, Prof. Craighill.

Clinical Medicine, Instruction for examination for life insurance Wednesday 10 A. M. Prof. Craighill, Dr. W. H. Smith.

Practical Therapeutics and Hydrotherapy Tuesday 10 A. M. Prof. Gichner, Dr. Lockard.

Clinical medicine with especial reference to cardio-vascular disease and diseases of the blood, Thursday 10 A. M. Prof. Atkinson, Dr. Metzel.

Diagnosis of Abdominal Diseases, Monday 10 A. M. Prof. McElfresh, Dr. Messick, Dr. O'Mara.

Pulmonary Tuberculosis. Diagnosis and treatment. University Hospital, Monday and Friday 12 M. Bayview, Thursday 4-5 P. M. Prof. Wilson, Dr. McCarthy.

Dispensary instruction daily from 12-1. Diagnosis and treatment—general medicine. Chiefs of clinic, Drs. W. H. Smith, Maldies, O'Mara, Lockard, Metzel; assistants, Drs. White, Adams, Perkins, Todd, Sinskey, Todd.

A special course in physical diagnosis will be arranged if a sufficient number of men desire the course.

MENTAL AND NERVOUS DISEASES.

Anatomy and Physiology of the Nervous System, Tuesdays and Fridays 9-10 A. M. Dr. Spear.

Dispensary instruction daily. University Hospital 12-1 P. M. Drs. Spear, Hawkins, Wilkins, Hafele, Owensby, Settle.

Mental Diseases. Diagnosis and treatment, Saturday 4-5 P. M. Bayview Asylum and Maryland School for Feeble-Minded. Dr. Spear.

DISEASES OF CHILDREN.

Clinic. Diseases of Children. Special reference to infant feeding and diseases of the gastro-intestinal canal. Home modification of milk, Wednesday 1 P. M., Prof. Mitchell.

Ward and dispensary instruction daily 12-1 P. M. Drs. Lennan, Maldeis, Schoenrich and Pierson.

Special course in intubation on the cadaver. Dr. Shipley.

DIGESTION AND METABOLISM.

Clinic — Diseases of Stomach and Intestines, Friday 11 A. M. Prof. Hemmeter.

Oesophogoscopy, gastroscopy, use of stomach tube, gastric lavage, examination of gastric contents and faeces after test meals. Prof. Hemmeter, Dr. Adler.

Ward rounds, instruction in diseases of stomach and intestines, gastric inflation. Dr. Adler.

Dispensary instruction daily at 12 M. Drs. Iglehart and Warner.

PATHOLOGY AND BACTERIOLOGY.

Gross and microscopic pathology, making of media and study of important organisms. Post-mortem demonstrations. Pathological Laboratory, Mondays, Wednesdays and Fridays 2-4 P. M. Prof. Hirsh, Drs. Hyde, Lockard, Metzel.

CHEMICAL MICROSCOPY.

Examination of blood, urine, sputum, stomach contents and faeces, Tuesday and Thursday 2-4 P. M. Prof. Adler, Dr. Hayes.

HISTOLOGY AND EMBRYOLOGY.

Study of the normal organs and tissues and their development, with demonstration of microscopical technique. Drs. Mayhew, Maldeis, Sowers, Kieffer, Karlinsky and Mitchell.

SURGERY.

Surgical Clinic, Monday 1-2 P. M. Clinical amphitheatre. Prof. Winslow.

Clinical Surgery. Operations daily, University Hospital, ward rounds, after treatment of operative cases. Treatment of fractures and dislocations, 11-12 A. M. Profs. Winslow Smith, Martin, Spruill.

SURGICAL DIAGNOSIS AND PATHOLOGY.

Gross surgical pathology, diagnosis and treatment of surgical diseases. Clinical amphitheatre. Monday and Thursday 9-10 A. M. Dr. Shipley.

Anæsthesia. Practical demonstration and instruction as to method of administering anæsthetic, local anaesthesia, daily 11-12 A. M. Dr. Bay.

Dispensary Instruction in General Surgery, daily 12-1 P. M. Drs. Jay, Cromwell, Tompkins, Adams, Smith and Hayes.

SKIOGRAPHY AND RADIO THERAPY.

The use of the x ray in the diagnosis and treatment of disease. The taking, developing and interpretation of x ray pictures. University Hospital, 11-12 M. Dr. Ashbury, Dr. Levy.

OPERATIVE SURGERY.

Anatomical Laboratory; Operations on Cadaver. Mondays, Wednesdays and Fridays 4-6 P. M. Prof. Martin, Spruill, Dr. N. Winslow.

CLINICAL AND PRACTICAL ANATOMY.

Practical teaching by demonstration on human cadaver. This course will embrace practical anatomy, topographical and applied clinical anatomy, Tuesday, Thursday and Saturday 4-6 P. M. Drs. Holland, N. Winslow, Hawkins, Smith and Mitchell.

ORTHOPEDIC SURGERY.

Clinic, Wednesday 3-4 P. M. Clinical amphitheatre, University Hospital. Bedside and practical instruction, operative, mechanical, gymnastic and plaster work, Tuesday, Thursday and Saturday 11 A. M. to 1 P. M. Hospital for Crippled Children, 2000 N. Charles St. After June 15 instruction will be given in out-of-door treatment of surgical tuberculosis at the Mountain Hospital, Blue Ridge Summit, Pa. Prof. Taylor, Dr. Ashbury.

Dispensary instruction every Tuesday and Thursday at 2.30 P. M. in orthopedic surgery. Dr. Reily, Dr. Demarco.

Ward rounds and operations in orthopedic surgery, Monday, Wednesday, Friday and Saturday 2.30 P. M. Dr. Reily.

OBSTETRICS.

OBSTETRICAL CONFERENCE.

Demonstrations on Manakin, Anatomical Hall, 9 A. M. Wednesday. Prof. Neale.

Instruction in palpation and bedside teaching, pelvimetry, study of puerpera, care of infant, 10 A. M. Friday and Saturday. Dr. Allen.

Attendance on operative cases in indoor and outpatient departments, subject to call. Prof. Neale, Dr. Allen.

GYNAECOLOGY.

Operative gynaecology, clinic, Thursday 1 P. M. Prof. Ashby.

Operative gynaecology, clinic, Saturday 10 A. M. Prof. Hundley.

Operative gynaecology, daily, University Hospital. Dispensary instruction daily 12-1 P. M. Diagnosis and treatment of non-operative cases. Drs. White, Brent, Mitchell and Perkins.

GENITO-URINARY SURGERY AND VENEREAL DISEASES

Anatomy and physiology of the male genito-urinary organs, genito-urinary clinic, Friday 3 P. M. Cystoscopy, ureteral catheterization and endoscopy. Dr. Edmunds.

Dispensary instruction in diagnosis and treatment of genito-urinary diseases daily 12-1 P. M. Dr. Scott.

DISEASES OF SKIN.

Lectures and dispensary instructions in diagnosis and treatment; with microscopical demonstrations of pathological conditions of the skin. University Hospital, Monday, Wednesday and Friday at 2.30 P. M. Dr. Abercrombie.

DISEASES OF THE EYE AND EAR.

Instruction in optholmology and otology under Prof. Woods and Drs. Gibbons, Tarum, Fleming and Goldbach.

Didactic lecture, Monday 4 P. M. Clinic, Friday 1 P. M. Prof. Woods.

Dispensary instruction daily at University Hospital 12 P. M. Drs. Gibbons and Tarun.

Daily clinic at 2 P. M. at the Presbyterian Eye, Ear and Throat Charity Hospital, 1007 E. Baltimore St., the students being assigned for special instruction in clinical otology, clinical opthalmology and refraction work.

Opthalmoscopy. Dr. Chisolm.

DISEASES OF THROAT AND NOSE.

Clinic, Thursday 3 P. M., University Hospital. Prof. John Winslow.

Bronchoscopy, Laryngoscopy, Intubation. Dr. John Winslow, Dr. R. H. Johnson, Dr. H. C. Davis.

Dispensary instruction daily at University Hospital, 2.30-3.30 P. M. Drs. Johnson, Davis and Goldbach.

Presbyterian Eye, Ear and Throat Charity Hospital daily 2-3 P. M. Drs. Johnson, Davis and Goldbach.

MINOR SURGERY AND BANDAGING.

Application of bandages and splints, Saturday 9 A. M. Dr. Tompkins.

MONDAY.

Surgical Pathology
and
Diagnosis.
Diagnosis of
Abdominal Diseases.
Clinical Surgery and
Gynaecology.
Instruction in Anaesthetics.
Pulmonary Tuberculosis.
Dispensary
Instruction.
Surgical Clinic.
Pathological
Laboratory.
Lecture—Eye and
Ear 4-5 P. M.
Operative Surgery 5-6 P. M.

TUESDAY.

Anatomy and Physiology of
the Nervous System.
Practical Therapeutics
and
Hydrotherapy.
Clinical Surgery
And Gynaecology.
Instruction in Anaesthetics.
Dispensary
Instruction.
Medical Clinic.
Clinical Microscopy.
Clinical and Practical
Anatomy.

WEDNESDAY.

Obstetrical Conference.
Clinical Medicine.
Clinical Surgery
And Gynaecology.
Instruction in Anaesthetics.
Dispensary
Instruction.
Children's Clinic.
Pathological Laboratory
2 to 3 P. M.
Orthopedic Clinic, 3-4 P. M.
Operative Surgery.

THURSDAY.

Surgical Pathology
and
Diagnosis.
Clinical Medicine, with especial reference to cardio-vascular diseases and diseases of the blood.
Clinical Surgery
And Gynaecology.
Instruction in Anaesthetics.
Dispensary
Instruction.
Gynecological Clinic.
Clinical Microscopy,
2-3 P. M.
Clinic—Diseases of Throat and
Nose, 3-4 P. M.
Pulmonary Tuberculosis at
Bay View, 4-5 P. M.
Clinical and Practical Anatomy.

FRIDAY.

Anatomy and Physiology of
the Nervous System.
Instruction in Palpation.
Bedside Teaching.
Study of Puerpera.
Clinic.
Diseases of Stomach and
Intestines.
Pulmonary Tuberculosis.
Dispensary
Instruction.
Eye and Ear
Clinic.
Pathological Laboratory,
2-3 P. M.
Operative Surgery.

SATURDAY.

Minor Surgery and
Bandaging.
Application of Splints.
Instruction in Palpation.
Bedside Teaching.
Study of Puerpera.
Clinical Surgery
and
Gynaecology.
Instruction in Anaesthetics.
Dispensary
Instruction.
Genito Urinary
Clinic.
Histology and
Embryology.
Mental Diseases.
Bay View, 4-5 P. M..
Clinical and Practical Anatomy.

For further information apply to Arthur M. Shipley, M. D., 1024 Madison Ave., Baltimore.

ITEMS.

Dr. W. K. Robinson, class of 1893, and Mrs. Robinson, of Los Angeles, California, are spending a few days in Baltimore. They are registered at the Hotel Sherwood.

Dr. John Drach, class of 1880, of Butler, and Mrs. Drach and sons, spent Christmas with their son and daughter-in-law, Mr. and Mrs. Homer Drach, on the Old York road, Baltimore.

Dr. J. Horace Jenkins, class of 1901, of Elkton, Md., has entered suit in the Circuit Court of Elkton against Joseph Hinchliffe. The suit arose over the biting of Dr. Jenkins' young son, Horace, by a dog owned by Mr. Hinchliffe.

Dr. and Mrs. Theodore Cooke, Sr., have announced the engagement of their daughter, Mrs. Sophie Cook Waters, to Dr. N. Moreland Owensby, class of 1904, of Baltimore. Dr. Owensby was formerly superintendent of the insane department of Bay View Hospital, and at present is connected with the neurological department of the University of Maryland.

Dr. B. Merrill Hopkinson presided at the recent banquet of the Baltimore Athletic Club commemorating its thirtieth birthday.

Dr. Albert H. Carroll, class of 1907, has returned to his home, Evergreen, Hampden, after visiting his brother, Mr. Walter C. Carroll, in St. Louis.

Dr. William Corse, of Lauraville, has returned to his home after three months' confinement in a hospital, greatly benefited in health.

Dr. George W. Hemmeter, class of 1901, attended the banquet tendered Dr. James Bosley by the physicians and officials of the Health Department. Dr. W. R. Stokes, City Bacteriologist, was also present.

Dr. Samuel Theobald, class of 1867, read a paper on "Careless Refraction Work on the Part of the Oculist" before the Section on Opthalmology and Otology, Thursday, January 14, 1908, at the Baltimore Eye, Ear and Throat Hospital.

At the joint meeting of the Section on Clinical Medicine and Surgery and the Section on Gynecology and Obstetrics, Friday, January 15, Dr. L. M. Allen read a paper on "Full Term Ectopic Pregnancy Complicated by Fibroid Tumor of the Uterus," and Dr. Jose Hirsh, "Abscess of the Brain Complicating Typhoid Fever."

At the meeting of the Section on Laryngology and Rhinology, to be held January 22, 1909, will be reported an unusual case of post-operative tonsillar bleeding, and Dr. S. K. Merrick, a case of laryngeal tumor, growing from epiglottic fold, removed by means of snare.

The engagement of Miss Elizabeth Preston Elliott, youngest daughter of Mrs. Warren G. Elliott, of this city, to Dr. Gordon Wilson, 806 Cathedral street, has been announced. Dr. Wilson is Associate Professor of Medicine in the University of Maryland and a graduate of the Medical Department of Virginia.

Dr. Fairfax G. Wright, formerly assistant resident surgeon in the University Hospital, and now a resident and practitioner of Chambersburg, Pa., has been spending a few days with Dr. Arthur M. Shipley.

Dr. and Mrs. J. Fred Adams have closed their country home, on the Rolling road, near Catonsville, and are spending the winter at their city residence, 1314 North Charles street.

Dr. L. M. Allen addressed the recent meeting of the Baltimore County Medical Society, held last Thursday at 847 North Eutaw street.

Dr. and Mrs. J. Frank Crouch, of 1125 North Charles street, entertained their friends at a dinner December 28, 1908.

At the last meeting of the Adjunct Faculty, held December 15, 1908, in the amphitheatre of the University Hospital immediately after adjournment of the Medical Society, the following officers were elected for the ensuing year: President, Dr. J. W. Holland; vice-president, Dr. A. D. Atkinson; secretary, Dr. R. C. Metzel; corresponding secretary, Dr. A. M. Shipley.

At the quarterly meeting of the Nurses' Alumnae Association of the University of Maryland, held at 21 N. Carey street, Baltimore, December 7, 1908, the following officers were elected: President, Miss Bradbury; first vice-president, Miss Read; second vice-president, Miss Bell; secretary, Miss Grimes; treasurer, Mrs. Nathan Winslow; membership committee, Miss Robey, Miss Daniel.

Mr. and Mrs. Charles B. Hopkins, of Seattle, Wash., have announced the engagement of their daughter, Eva, to Dr. A. Aldridge Matthews, class of 1900, of Spokane, Wash. Dr. Matthews is the oldest son of Mr. and Mrs. D. M. Matthews, of Baltimore, Md. After graduating from the University of Maryland with the class of 1900, he was appointed assistant resident surgeon, and was successively assistant superintendent and superintendent of the University Hospital. He then went West and was appointed superintendent of St. Luke's Hospital, Spokane, Wash. For some years he has been engaged in the practice of his profession in Spokane.

Dr. William Whitridge, class of 1862, of Baltimore, is ill at his home, Charles and Reade streets. He is suffering from an attack of acute indigestion. It is reported that he will be out in a few days.

Dr. Louis Seth, class of 1908, assistant resident physician in the University Hospital, owing to ill health has been compelled to resign his position. He has left for Sabillasville for treatment. Dr. Seth was very popular with the resident as well as the visiting staff of the University Hospital, and he has their sincere wishes for a quick recovery.

Dr. T. Marshall West, class of 1908, a member of the resident surgical staff of the University Hospital, is recovering from an infected hand.

Dr. Henry M. Weinberger, class of 1908, of New York, has been appointed resident physician at the Maryland Homeopathic Hospital, North Mount street, Baltimore. Since his graduation Dr. Weinberger has been located at the Good Samaritan Dispensary, in New York.

Drs. George A. Flemming, B. Merrill Hopkinson, A. D. McConachie, Wilmer Brinton, Joseph T. Smith, John R. Winslow, Hiram Woods and H. M. Simmons attended the banquet of the Presbyterian Union, held December 8, 1908, at the Belvedere Hotel, Baltimore.

Dr. Charles Hardwicke, class of 1904, of Santiago de los Caballeros, Republica Dominicana, writes to Professor Randolph Winslow that he hears there is a school paper being published. If such a paper exists he would like to subscribe to it, as he has heard nothing from the University since he left. He says that he feels very much sidetracked from civilization in Santo Domingo, and the little news which filters through is very meagre. He expresses an abundance of faith in the Spanish American countries, and cannot understand why so many graduates remain in the States for a bare living, when South and Central America, with the exception of the larger cities, are in need of physicians, who would do well from the very outset.

Dr. George S. Hanna, class of 1901, writes to Professor Randolph Winslow that he is so glad his brother Michel is one of the University boys. Among other things, he expresses the hope that his brother will one day be honored with a diploma from the old University. He says THE HOSPITAL BULLETIN keeps him in touch with the dear University. He longs to visit the States again, and is anxiously awaiting the graduation and return of his brother, so that he can leave his practice and return to this country. He mentions that it has been bitterly cold in Egypt for a few days, a very unusual event in that country. According to him, the climate in Egypt has changed markedly in the past few years, both summer and winter. He attributes it to the installation of the irrigation system. Thousands and thousands of acres of land which were waste land are now irrigated and bearing abundantly. As compared to former years, very little of the water of the Nile reaches the sea. He mentions that Egyptian opthalmia is on the decrease, and attributes the decrease to better sanitary arrangements of the country.

Dr. H. V. Harbaugh, class of 1907, of East Newmarket, Md., has been visting Dr. Joseph L. Valentini, class of 1907, of 16 South Broadway, Baltimore.

Dr. J. C. Hemmeter, professor of physiology, recently addressed the Society for Experimental Medicine and Biology of New York at the Rockefeller Institute. While in New York he was the guest of Prof. and Mrs. Thomas E. Satterthwaite.

The annual business meeting of the Dorchester County Medical Society was held in Cambridge, December 8, 1908. The following of our alumni were elected to office for the ensuing year: President, Dr. Eldridge E. Wolff, class of 1899, of Cambridge; vice-president, Dr. Victor Carroll, class of 1906, of Church Creek; secretary-treaurer, Dr. W. H. Houston, class of 1899, of Fishing Creek; censor, for two years, Dr. G. Roger Myers, class of 1902; censor, for one year, Dr. Guy Steele, class of 1897, of Cambridge.

The Howard County Medical Society held its regular monthly meeting at the Howard House, Ellicott City, Md., Tuesday, December 8, 1908. Dr. Gambrill, class of 1876, read a paper on "Cirrhosis of the Liver." The following of our alumni were present: Dr. Ereckson, class of 1890; Dr. Gambrill, class of 1876; Dr. F. O. Miller, class of 1902. Dr. F. O. Miller, class of 1902, of Ellicott City, is secretary to this society.

The Prince George County Medical Society met at Queen's, Washington, D. C., Saturday, December 12, 1908. The following of our alumni were present: Dr. Cronmiller, class of 1856; Dr. G. W. Latimer, class of 1901; Dr. Harry Nally, class of 1900. Dr. Harry Nally, class of 1900, was elected vice-president, and Dr. G. W. Latimer censor, for the ensuing year.

Dr. Irving J. Spear, class of 1900, read a paper before the Section on Neurology and Psychiatry of the Baltimore City Medical Society Friday, January 8, 1909, on "Complete Transverse Destruction of the Spinal Cord with Increase of the Reflexes Below."

At the meeting of the Anne Arundel County Medical Society, held at Carval Hall, Annapolis, Tuesday, Jan. 12, 1909, our alumni took the following part in the proceedings: Address, Dr. H. B. Gantt, class of 1880; "Treatment of Pneumonia," Dr. Chas. O'Donovan, class of 1881; "Direct Laryngo-Tracheo-Bronchoscopy," Dr. H. C. Davis, class of 1902. Dr. H. B. Gantt, class of 1880, of Millersville, is president of this society.

At the annual meeting of the Baltimore City Society, held in the Medico and Chirurgical Building, December 1, 1908, Dr. H. O. Reik, class of 1891, read a paper on "What Should Be Our Attitude Toward Proprietary Medicines?" Dr. Wilmer Brinton, class of 1876, of Baltimore, is president of this society.

The Calvert County Medical Society met in Prince Fredericktown on Tuesday, December 8, 1908, and elected Dr. Chaney, class of 1866, president for the ensuing year. Dr. W. H. Talbott, class of 1904, was secretary of the meeting. Dr. T. M. Chaney, class of 1866, read a paper, "Some of the Reasons for Maintaining a Medical Society in Calvert County. Dr. Compton Wilson, class of 1894, was elected a member of the society.

The fourth quarterly meeting for 1908 of the Caroline County Medical Society was held Thursday, December 10, 1908, in the Court House, Denton. Dr. J. L. Noble, class of 1876, of Preston, was elected president; Dr. S. S. Stone, class of 1894, of Ridgely, vice-president, and Dr. J. R. Downes, class of 1904, of Preston, secretary-treasurer.

The Carroll County Medical Society met at the Westminster Hotel, Westminster, Md., Wednesday, December 16, 1908. The following of our alumni were present: Dr. Charles R. Foutz, class of 1897, secretary- treasurer; Dr. J. Sterling Geatty, class of 1906; Dr. H. M. Fitzhugh, class of 1897; Dr. S. L. Bare, class of 1905; Dr. Frank T. Shaw, class of 1864; Dr. James H. Billingslea, class of 1864; Dr. George H. Brown, class of 1864; Dr. C. H. Diller, class of 1872. Dr. H. M. Fitzhugh read a paper on "Sanitary and Hygienic Treatment of Tuberculosis;" Dr. G. H. Brown, "Medicinal Treatment of Tuberculosis."

Dr. Ridgely B. Warfield, class of 1884, of Baltimore, has been elected to the chair of surgery, Baltimore Medical College, vice Dr. Robert W.

Johnson, retired. Dr. Warfield, after graduating, was for a number of years connected with the University of Maryland in one position or another. At the time of his resignation from this institution he was demonstrator of anatomy. He has been a member of the Faculty of the Baltimore Medical College since 1895.

Dr. E. H. Roe, class of 1906, is superintendent of the Baltimore Eye, Ear and Throat Hospital, on West Franklin street. For a number of years he was a member of the house staff at Bay View.

Members of the Phi Sigma Kappa Fraternity gave a reception at their fraternity house, 1004 McCulloh street, December 11, 1908. This reception is an annual fixture.

Dr. E. G. Ballenger, class of 1901, of Atlanta, Ga., has written a book on "Genito-Urinary Diseases and Syphilis." Dr. Ballenger is lecturer on genito-urinary diseases, syphilis and urinalysis in the Atlanta School of Medicine. The book has been highly complimented by the reviewers.

The Xi Psi Phi Fraternity of the University of Maryland has opened its new home, 734 West Fayette street.

MARRIAGES.

Dr. Walter Forman Wickes, class of 1900, of Chicago, formerly of Baltimore, was married Wednesday, December 16, 1907, to Mrs. Catherine Young Hobart, a daughter of the late multimillionaire, Otto Young, of Chicago. Dr. Wickes is the youngest son of former Judge Pere L. Wickes, of the Supreme Bench of Baltimore, and is a graduate of the medical department of the University of Maryland. He practiced his profession for two or three years in this city, after which he went West and engaged in the brokerage business in Chicago, where he has been located for the past five years. He is thirty-one years of age and was very popular with his classmates. Dr. and Mrs. Wickes will spend their honeymoon in the East, after which they will take up their residence in Chicago.

Dr. Arthur Dunning Mansfield, class of 1890, of Baltimore, and Miss Elizabeth Ball, granddaughter of Dr. J. T. Twilley, of Chestertown, were married at the home of the bride's grandparents, on High street, Chestertown, at noon, December 30, 1908. Rev. W. L. White performed the ceremony.

DEATHS.

Dr. Charles William Bailey, class of 1889, a member of the Amerian Medical Association, and for fourteen years in the United States Public Health and Marine Hospital Service, died at his home, in Georgetown, S. C., November 24, 1908, aged 39.

Dr. Richard Thomas Gott, class of 1868, subregistrar of the State Board of Health, died at his home, in Poolesville, Md., November 26, 1908, from nephritis, aged 64.

Dr. Jeremiah Johnson, a member of the class of 1852, died November 30, 1908, at the home of his son-in-law, Capt. Edward W. Burns, in Hagerstown, from paralysis, aged 79. Dr. Johnson was born at Clear Spring, Frederick county, received his medical education at the University of Maryland, and was engaged actively in the practice of medicine for 58 years, thirty of which he was located at Parkersburg, W. Va. He retired from practice four years ago. Dr. Johnson was a member of the Masonic Order and is survived by a widow and four children.

Dr. Joseph F. Perkins, class of 1875, of New York, died at Baltimore, December 9, 1908. Dr. Perkins was a graduate of the medical department of the University of Maryland. He received his literary education at Princeton University, from which institution he received his literary degree. More than twenty years ago Dr. Perkins left this city and went to New York, where he engaged in the practice of medicine, with diseases of the throat as his specialty. He was unmarried.

On December 2, 1908, Mrs. Bessie Talbott, wife of Dr. Thomas J. Talbott, class of 1895.

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GONORRHEAL ARTHRITIS.

A Lecture Delivered at the University of Maryland.

By WILLIAM D. SCOTT, M. D.,
Chief of Clinic, Genito-Urinary Department.

The term gonorrheal rheumatism as applied to this condition is a misnomer, since it represents metastases in the eye, fasciae, the synovial membranes, of the joints, the bursae, muscle and tendinous sheaths, muscles, pleurae, cardiac valves, nerves, meninges, conjunctivae of the eyes, the veins and periosteum.

Gonorrheal Arthritis or Synovitis is a more accurate and definite term, and means an articular inflammation caused by the presence in the lymph or blood streams of the gonococcus or its toxines, and the deposit of the same in the joints.

As yet it has not been made definitely clear and demonstrated that the gonococci enter the lymphatics, but they have been found in the venous capillaries in the vicinity of an area of gonorrheal infection in the genitro-urinary tract, and at the same time the diplococci were demonstrated in the synovial membranes of a joint of same individual.

Gonorrheal Arthritis has long been recognized. In 1781, Salle described an inflammatory infection of the joints associated with gonorrhea, which was unquestionably gonorrheal arthritis.

Occurrence.—It occurs in 2 per cent. of the cases in some form.

Time of Onset.—Generally during the subacute stage, but it may occur at any time while gonorrheal suppuration is present in the genito-urinary tract.

The disease is not dependent upon exposure, moisture, fatigue, etc. The presence of the gonococcus is all that is required.

Women are relatively immune to this condition, but pregnancy, labor and the puerperium predisposes them, if they are harboring the causative micro-organism.

Recurrence.—Often recurs with every new attack or exacerbation of an old gonorrheal infection.

This, however, is not the rule, since many individuals have gonorrheal arthritis with their first infection, and never have a relapse with successive attacks.

What the exact etiological factor may be which predisposes one to systematic invasion of this infection, and its reappearance in subsequent infections in some patients, is undetermined, but that there is a susceptibility in certain patients is an observed and undisputed fact.

Discharge.—May become profuse, diminish, remain stationary, or almost cease. Generally is not much modified. In a few days any apparent subsidence may be due to corrected hygienic and enforced rest incident to the oftimes urgent symptoms of the onset of the synovitis.

Joints Affected.—(Larger ones, mostly the knee, ankle, wrist, elbow, shoulder or hip), and less frequently some of the smaller joints. The knee joint is most frequently involved in men and the wrist in women.

Pathology.—From the transmission to and deposit in the articulation of the micro-organisms or their toxtines, or both, an inflammation of the synovial membrane is the resultant, and an exudate is poured out in maximum or minimum quantity within the joint cavity. A simple excess of serum only may be thrown out, or we may have a sero-purulent, sero-fibrinous, or sero-haemorrhagic exudate.

The purely serous variety is due to the deposit of the gonococci or their toxines alone. The phlegmonous type is due to a mixed infection.

Pus examined from such a joint may be "sterile pus," the gonococci having died after causing the inflammation. A striking parallel to this may be seen in the sterile pus derived from many chronic pus tubes and pelvic abscesses, the aftermath of former gonorrheal infections in the female.

Clinically there are three forms. (*a*) Hydrarthrosis (hydrops) is usually confined to a single

joint (monarticular), which is generally the knee. *(b)* This form resembles rheumatic fever. *(c)* Synovial sheaths of tendons and muscles, and the bursae are attacked and become the seat of chronic inflammatory changes. (The joints may be involved at the same time or may escape.)

(a) This form is most common and generally attacks the knee, sometimes the ankle, elbow or wrist, and is mostly monarticular. Onset may be insidious, or very rapid development. Hydrops (or effusion) slow or rapid.

Pain may be the only symptoms for a long while, increased by motion. Discomfort may be ignored and there may be no constitutional symptoms. It pursues a chronic course and tends to recur. Fever, if high at first, often drops rapidly when the joint is immobilized.

The Suppurative type is very resistant, and may cause abscesses or may be accompanied by peri-articular inflammation. In one or two months swelling and pain subside. The muscles atrophy, contracture of the joint occurs, often anchylosis caused by contracture of the peri and para-articular tissues and adhesions within the joint. At first there may be fibrous anchylosis, and later, after destruction of the cartilages, we may have bony anchylosis and partial or complete obliteration of the joint cavity.

The second form is poly-articular as a rule, and its symptoms resemble those of rheumatic fever, only less acute, and frequently there is also often an implication of the tendons, the eyes (ritis choroiditis), etc. Pain, at the onset severe, is ameliorated by rest more than in rheumatic fever.

Fever, generally moderate, lessens after a variable time, while local symptoms continue. One important diagnostic point is the difference between the systematic and local symptoms.

One joint, or several consecutively, may be involved, but never so general as in rheumatic fever. It is more stationary than in the latter condition. Upon involvement of a new joint its predecessors continue to suffer. Resolution is more tardy. A second hydrarthrosis is not uncommon, sweats are unusual and of short duration. The urine shows no increase of acids or urates. The blood shows no excess of fibrin. Any one joint may be severely inflamed after subsidence of inflammation in the other joints.

Slow resolution is the rule in this form.

The third form is very vague and persistent; joints (knee, wrist, shoulder, foot, jaw), which show apparently no structural alteration, with undisturbed function, manifest pain varying in degree.

This is the sole symptom, is very resistent to treatment, and tends to recur if any cause tends to increase the urethral discharge.

The synovial sheaths of the tendons of the extremities may be inflamed with or without the joints; notably the extensors of hands and fingers, dorsal flexors of toes and the flexor pollicis, sheaths of biceps, brachii, and the tendo-achilles.

Special mention should be made of the involvement of the ligaments supporting the arch of the foot, since if not recognized and the patient allowed to walk, the arch may break down and permanent Pes Planus results.

Bursae.—The two most vulnerable are, viz., the one between the tendo-achilles and os calcis and the other beneath the inferior tuberosity of the os calcis. Symptom—Pain in the heel.

The bursae of the wrist, ankle, patella, and tuberosity of the ischium are the next most commonly involved. This inflammation of the bursae may be acute, subacute and chronic.

Gonorrheal synovitis of the temporo-maxillary or sterno-clavicular articulation, although uncommon, is at times seen, is generally monarticular, and is characterized by persistent pain in the joint affected.

Sequelae.—These are contractures, anchylosis, subluxations (from overstretching of the joint ligaments), persistent pain and stiffness, chronic hydrarthrosis, suppuration and disintegration of the joint, especially in lymphatic, tuberculous and debilitated subjects.

Gonorrheal synovitis of the spine is not infrequently accompanied by destruction of the intervertebral cartilages with the articulating surfaces of the vertebrae, and is followed by bony union with complete anchylosis of the part affected.

Diagnosis.—The presence of gonorrhea or the history of a recent case will suggest a diagnosis. Predilection for certain joints, a single joint, hydrarthrosis, coincident involvement of the tendon sheaths, fasciae and bursae, with maybe certain eye complications, are important points in diagnosis. There are relatively mild systemic symptoms with very urgent local manifestations. The prostatic secretions generally and the joint exudate often show gonococci.

Differential Diagnosis.—The following tabulation from (White & Martin) is very serviceable:

Rheumatic Fever.	Chronic Rheumatism.	Gout.	Gonorrheal Arthritis.
Most frequent in young adults.	Most frequent in older persons.	Most frequent in older persons.	Most frequent in young adults.
URETHRAL DISCHARGE COMPARATIVELY RARE AND GONOCOCCI NOT PRESENT.			Gonococci present.
Family history, positive.	Family history, often positive.	Family history, usually positive.	Family history, negative.
Etiologic relationship to cold and damp.	Symptoms distinctly influenced by weather.	Symptoms related to diet.	Primary relationship urethra.
Onset, Sudden.	Insidious.	Sudden, with often prodromes.	Sudden and with no prodromes.
Constitutional phenomena, severe high fever and often chill.	Absent.	Mild.	Mild and transient.
Polyarticular always and wandering from joint to joint.	Usually polyarticular.	Usually monarticular.	Nearly always monarticular.
Large joints a number at a time.	Large joints.	Great toe.	Knee most frequently, other joints one at a time.
Rarely hydrarthosis persists.	Rarely hydrarthosis.	Never Hydrarthrosis.	Usually hydrarthrosis.
No tophaceus deposits.	No true tophaceous deposits.	Always tophi in joints or ears.	Absent.
Sweats.	Less marked.	Not so conspicuous.	Never present for any length of time.
Cardiac complications frequent.	Less frequent.	Myocarditis and arterio-sclerosis.	Cardiac complications rare.
Urine acid.	Less so.	Acid.	Not acid and shreds.
EYE, TENDONS AND BURSAE USUALLY ESCAPE IN THE THREE ABOVE.			Frequent eye complications, bursitis and tenosynovitis.
RELAPSES FREQUENT, AND MAY OR MAY NOT BE ASSOCIATED WITH RECURRENCE OF URETHRAL DISCHARGE.			Relapses more or less dependent upon condition of the urethra.
Disease cured by salicylats.	Useful here.	Dietetic, hygienic and medical treatment.	Internal remedies are not curative and urethritis must be cured by local treatment.

Gonorrheal arthritis should further be differentiated from:

(A) Tuberculous Arthritis.—This disease generally has a most insiduous onset. Is often attributed to a fall or injury of some kind. The pain in this condition is often referred to some joint other than the one diseased. The carriage of the body is changed and generally a characteristic limp is observed, if the lower extremity is affected. Rigidity and atropy of the muscles, night cries, flexions, and the temperature chart are distinctive. Finally a positive tuberculin reaction is reasonably corroborative, and an absolute diagnosis can usually be established by the X-ray, since tuberculosis of the joints practically always begins in the epiphyses of the long bones.

(B) Syphilitic Arthritis.—Syphilis, the greatest disease imitator, may simulate any of the various forms of gonorrheal joint infection.

Keyes has very aptly tabulated the special characteristics of syphilitic arthralgia, viz.:

(1) There is no discoverable lesion sufficient to account for the pain.

(2) Nocturnal exacerbation and relief by exercise.

(3) Frequent in larger joints (shoulder, knee, elbow), rare in smaller ones; if polyarticular, one joint is usually much more painful than any other.

(4) Common with first onset of secondary symptoms, rare later.

(5) Unaffected by mercury; promptly relieved by small doses of iodid.

Levin has described a class of case of syphilitic synovitis, appearing in the knee joint late in life, apparently as the result of syphilis innocently acquired through a wet nurse. Here the nocturnal exacerbation of pain with the therapeutic test will suggest the true etiology. The "Wasserman reaction" is said to be a very valuable diagnostic adjunct, especially in the tertiary and quaternary stages.

(C) Rheumatoid Arthritis.—Is distinguished by being most common in young women. The muscles of the extremities waste and are affected with most painful spasms, and the joints often give a grating, crackling sound. The pulse is soft and compressible, rate one hundred to one hundred and twenty or more, even though the patient is afebrile. The soft and often much freckled skin is characteristic. It most frequently begins in the hands, and is symmetrical and bilateral. Numbness and tingling are often observed, and there may be painful neuritis independent of the joint lesion, or it may precede the arthritis.

Characteristic deformities of especially the hands, feet, fingers and toes are frequently found.

(D) Pneumococcic Arthritis.—This type of arthritis is generally coincident with or follows an attack of pneumonia, but it may occur from some other mode of entry. Its onset and course is rapid, symptoms severe, temperature very high, and in the majority of cases is followed by a fatal termination.

Pneumococci, as a rule, can be found free in the fluid.

(E) Acute Osteomyelitis.—Although the primary area of infection in this disease is generally in the medullary canal of the diaphysis of the long bones near the epiphyseal line, however, in some cases, the primary focus of the osteomyelitis starts in the epiphysis, and thus may strikingly resemble gonorrheal synovitis.

It is characterized by a sudden and severe onset, may be accompanied by a chill, parched and furrowed tongue, fascies pinched and anxious, most excruciating pain, high temperature, 103° F.-105° F., and accelerated pulse, and a very high leukocytosis.

At the onset, movement of the joint is not painful, but percussion will elicit intense pain.

Nichols in Keen's Surgery mentions a very valuable diagnostic point, observed by making gentle but continuous pressure over the shaft of the bone at some distance from the point of maximum constant pain. In the beginning no reaction is noticed, but shortly, very suddenly, the agony is very intense, and the subject will suddenly cry out or sit up.

Treatment.—First and most important, the lesion in the genito-urinary tract must be localized and receive appropriate treatment. Any form of treatment without strict observance of this premise will be attended by very unsatisfactory results.

Generally a posterior urethritis, with or without a well-defined prostatitis, will be noted, and proper treatment should be instituted.

General Measures.—These must be regulated according to the clinical picture which invites our attention.

The fulminating cases require absolute rest, liquid diet, cold sponging, packs or baths, careful and frequent examinations of the heart, and appropriate remedies applied when indicated.

The chronic cases should be treated, as is usual in all debilitating diseases, with rest, fresh air, and an abundance of nourishing food. They should avoid violent exertion and exposure to wet and cold.

Medicinal Treatment.—(a) Local, (b) Internal.

(a) Locally we may employ cloths saturated with Oil of Eucalyptus, Ointment of Lanolin or Goose Grease, with Methyl Salicylate or Guaiacol or any of the various liniments for their counter-irritant and analgesic effect.

(b) The internal administration of drugs to combat this malady is not rational, but symptomatic and empirical. From a careful consideration of the pathology of this affection, one necessarily sees that this is true. For other than their analgesic, hypnotic and genito-urinary antiseptic effect, drugs up to the present time have proved almost valueless. Nevertheless, the patient should be given the benefit of the doubt, since some cases are apparently ameliorated and at times benefited by their employment.

Some of the coal-tar derivatives are often useful, notably Sodium Salicylate, Acetphenetidin, Salol and Aspirin. Aspirin—gr. 5 to 10, with Codeiagis ¼, in combination with Quinine Hydrochloride, grs. ii to iii (if the temperature is high), have been found very useful in the acute stages.

Hexamethylentetraminae is indicated during any stage of the disease, in combination or alone.

Oil of Wintergreen, gtts. 5 to gtts. 20, three times a day, is often beneficial.

The use of Morphine, Veronal or Hyoscyamine, becomes imperative in some cases, but even the use of these powerful hypnotics often fail to relieve the patient, except in dangerously large doses.

X-Ray Treatment.—This form of treatment has its advocates, but it has not met with universal acceptance, and is of doubtful utility.

Immobilization.—Absolute and immediate rest of the joint by means of splints or plaster of paris has been generally adopted by the majority of physicians. When the hip joint is affected, combine immobilization with extension.

The disadvantages with this method of treatment is the greater tendency to deformity and stiffness of the joint afterwards. Nevertheless, when the proper environments for other forms of treatment do not obtain, immobilization in the acute cases must be instituted.

Bier's Treatment.—In the treatment of acute and subacute gonorrhoeal arthritis this method is especially applicable.

Many of the cases accompanied by most intense pain, notes even within an hour, marked diminution in their agony from the analgesic effect of the stasis hyperemia. Under its influence passive movements can be made without injury or discomfort to the patient.

The stasis bandage in many cases has proved to be the best hypnotic we have at our disposal, when worn during the night, and has invited slumber when our most powerful narcotics had been of no avail. The rubber bandage should be applied above the joint to be rendered hyperaemics, in several turns covering each other, tight enough to compress the thin walled veins, but not the stronger ones of the arteries.

The location of the bandage should be changed with each application to obviate any undue pressure effects. The duration of the applications and the intervals vary with the requirements of the case. The bandage may be worn from ten to twenty-two hours a day. When worn during the night, it should be carefully watched, and it should be applied at least an hour before bedtime, to be sure it is producing the desired effect. The stasis to be effectual must be vigorous, and the pain *must be diminished.* If the pain is not ameliorated, or is increased, our technique is faulty and the bandage should be reapplied.

Next commence passive motions very cautiously, and as soon as possible order active movements. Splints are used only during the intervals when the bandage is not applied or during the night when the pain is still intense.

The active or arterial hyperemia, as produced by the hot-air bath, applied to this disease, is inferior to the stasis hyperemia. It can be used though in regions where it is impossible to employ the stasis bandage.

Antitoxin and Vaccine Treatment.—During the last few years the attention of the medical profession has been directed to this practical application of "Wright's Opsonic Theory" in the treatment of gonorrheal infections. In a review of the literature upon this subject, one is confronted with very many optimistic reports of cases apparently successfully treated by this method, many pessimistic reports of cases which gave no response to this method, and an enormous amount of discussion as to the relative value of "personal or autogenous" versus "stock" vaccines.

The employment of autogenous vaccines is hardly feasible for the general practitioner, unless he has at hand laboratory facilities and is a trained bacteriologist. I think the general concensus of opinion of the most prominent urologists today is that results from this method of treatment have been exaggerated, and its field of usefulness *at present* is limited. All agree that it is worthy of trial in gonorrheal arthritis, since sometimes it does produce brilliant results. I have recently apparently cured a case of gonorrhoeal arthritis of the knee, having a duration of seven months, by the use of "Neisser-Bacterin," using in this case eight injections.

Surgical Treatment.—If suppuration occurs, the joint should be freely incised, irrigated and drained. When Hydrathosis is established and threatens to become chronic, the best treatment according to "*Keys,*" is irrigation of the joint with hot bichlorid of mercury solution at a strength of 1-5,000 to 1-1,000. He says:

"I used this many years ago upon the knee-joint, making two punctures with rather large trocais, one on each side of the joint, and first thoroughly washing the joint cavity with prolonged hot salt irrigation, and then with two

quarts of a bichorid solution, and putting it up under moderate pressure, later using blisters on the Paquelin cautery, and finally elastic pressure."

Treatment of Sequelae.—These should be treated according to general orthopedic principles. The procedures generally adopted are manual passive movements, correction under an anaesthetic, tenotomy, tendon and nerve transplantation, osteotomy and resection of the joint.

A CAMP IN THE JUNGLE

CORRESPONDENCE.

SOME EXPERIENCES IN THE VALLEY OF THE AMAZON.

BALTIMORE, *January* 25, 1909.

"All suffered with fits of fever, which, though subdued, were not cured by repeated doses of quinine so long as we continued to be exposed to the same pernicious influences."

Such was part of a report of Franz Kellar, a German engineer, commissioned by the Brazilian Government to survey the obstructed portion of the Madeira and Mamore Rivers with a view to their improvement. This was some years ago. The object at that time was the same as at present. That is, to build a railroad around the 240 miles of falls and rapids, and in this way afford an outlet for the exports of that most isolated of nations—Bolivia. This vastly rich country is as yet almost undeveloped. And why? It is cut off from the Pacific by the Andes. The exports and imports have to be carried by pack mules over a pass the altitude of which is 15,000 feet, or else be brought down one of the mighty branches of the Amazon River and by canoe carried through the rapids of the Madeira and portaged around its 19 falls, and then on nearly 2,000 miles to Para on the Atlantic Coast.

The largest canoes are manned by sixteen men. Nothing heavier than this number of men can lift can be brought into or taken out of the country. The mineral wealth is almost beyond conception, but without heavy machinery it is only possible to handle it in an obsolete and primitive fashion.

Bolivia produces great quantities of rubber, cinchona bark, sugar cane, cotton, dye woods and hard woods. Gold can be panned from al-

most any stream, but to live and get food into the more remote parts of the country is the great drawback to individual effort. Even a can of salmon will cost on the Bolivian border where the Madeira River crosses it $2.20 gold. But this is anticipating. Enough is said when some vague idea of the wealth and size of Bolivia can be gained from the following:

The area of the country prior to the war with Chili in 1882 was 597,271 square miles. Its population about two and one-half millions, one-half being savage and domestic Indians. In the 16th century there were 1,000 open silver mines, and those at Potosi alone are authoritatively reported to have produced to date the fabulous sum of $2,919,889,400. (Ency. Brit.)

Numerous revolutions, indolence, ignorance and the almost impossible barriers to the transportation of machinery have combined to render Bolivia's natural resources unavailable. The mines in our own country are profitable when assaying $10 or even less per ton. The ores of Potosi often yield $200 per ton, using the most primitive methods.

It appears to be an impossibility to build a railroad over any Andean pass known at present. The only other available outlet is by way of the Amazon around the 240 miles of the rapids of the Madeira and then on down to Para. The building of the railroad around these falls has been undertaken. It should and probably will be completed. Neither money nor engineering skill are lacking.

But the opening sentence of this article offers some idea of why failure may be met with. It represents health conditions just as I found them when I was acting a few months ago as physician to the Preliminary Surveying Party. This phase to the situation is the greatest block to the completion of a project which, if successful, will open up a country of marvelous wealth and natural resorces.

It is a great and interesting country, and space alone prevents giving a short history of its growth, its revolutions and the doings of its past presidents.

Castro, enlightened and smart as he is, would hang his head in shame if some instances of recent Bolivian history were charged against him. For example, not many years ago Great Britain was compelled to sever all consular relations.

John Bull's representative, being a man with ideas of decency and morals, was grossly insulted in private by the President referred to, and was placed face backward on a mule and escorted in this way out of the capital. Why? He neglected to attend a reception given in honor of a concubine then in favor at the palace. Later the President called for official maps, and on inspecting them learned that a big ocean lay between his country and England, so he gave up the idea of an invasion and scratched Great Britain off the map with many strokes of the pen, saying: "Now I blot you from the face of the earth." Quite recently British consular service has been re-established. The present executive is highly spoken of and Bolivia is well on the road to becoming a properly behaved little South American sister.

And right here I might tell you a recent interesting incident concerning three brothers. A few years ago they were the heads of one of the largest rubber exporting concerns in the country, with prosperous American and European offices. Their combined wealth was estimated at $60,000,000. Close to 7,000 peons gathered rubber in the jungle for them. One of their trading stations is only 200 miles above San Antonio. These brothers wished to develop a new rubber territory in Bolivia near the border of Brazil, and the youngest one of the three set out to make friends with the supposedly tame Indians of that district. He was killed by them. Soon after, in revenge, one of the two remaining brothers visited the same place, with clothing and food as presents and much drink for a feast. The liquor contained poison, and 50 Indians passed in their checks. He returned up the river, and within the last twelve months he was murdered by two of his house servants, who decided that it was better to kill him than to receive 500 lashes for a minor offense. The last one has lost his nerve and is now negotiating the sale of his vast interests.

And what did the Bolivian Government do in the way of punishment for the poisoning of the fifty Indians? A prominent general with a hundred soldiers came all the way down the river to take captive the great man. But the great man was a friend of the general's. They wined and dined on the best the district afforded, and the general went back to headquarters, reporting that his man was nowhere to be found. Merely an incident, but it may serve to give some sort

of idea of law and justice in the region I am writing about. I am coming to the health conditions later—in fact, I may touch on them now. From the Rio Bene to San Antonio the Madeira makes a great drop; 19 falls and numerous rapids intervene. And this district has long had the reputation of being deadly even to supposed immunes from farther up and lower down the river. Just why this particular stretch of the Amazon Valley, a space of little more than 200 miles, should bear such a just reputation for malignancy I am at a loss to explain. The whole great valley of the Amazon and its tributaries is flat. The soil and vegetation don't differ for hundreds of miles. The country is one vast jungle with an appalling sameness. One hundred or one thousand miles from its mouth the banks present the same picture—great trees are laced together with parasitical vines. It is one mass of impenetrable vegetation, which extends on both sides of the river, how far, no one knows. It reminds you of a great neglected, overgrown conservatory, with monkeys and birds and beasts let loose. And the animals sit and gaze at you, awaiting a second shot. They have not yet learned to fear man.

At many places the river divides into two or more streams, and these are connected by cross channels, the result being numberless islands. You may well compare the river to a reservoir, reaching from the ocean to the Andes, which at high water varies in width from 5 to 400 miles. Think of a river being navigable 2,300 miles for vessels of 14-ft. draft; 970 miles above Para the Madeira empties into the Amazon, and 633 miles up the Madeira is the town of San Antonio. This is near where the new railway has its headquarters. But to give some idea of the magnitude of this Amazon, the greatness of the river may be gained from Kellar's report, that the Madeira alone empties 1,212,286 cubic feet per second into the Amazon, which is nearly equal to the greatest recorded discharge of the Mississippi at Fulton, Tennessee. And this volume goes over the Madeira-Mamora Falls. Imagine, if you can, over 200 miles of river which is almost one continuous mass of boiling water, whirlpools and falls.

But how do you reach this region? A few extracts from my diary telling about the ocean and river trip to this region may be of some interest.

STEAMSHIP RAGELSTON, HAVANA,
May 21st, 1908.

We left port today at 8.30 for the more than two thousand miles run to Para, and, although the Ravelston is a new and sturdy boat of about three thousand five hundred tons, she will not make much more than nine knots per hour. There are other ways of reaching Para. The Booth Line, from New York, is fairly regular in its sailings and goes up the river as far as Manaos. This ship has been chartered to carry supplies as far as Serpa, and she put into Havana to complete her cargo with a large quantity of lumber. The captain, Mr. MacGregor, comes from near Edinburgh. He met us on board and welcomed us most cordially as his guests. My cabin is just below the bridge and is well ventilated, having two port holes. It is remarkable how much comfort in the way of deck and cabin space these newly built British tramp steamers have. I imagine the table will be fairly acceptable, for the lunch today was quite nice. The captain was relieved, I think, when he discovered that the staterooms, the ship and the food were to our liking. Several hours' run brought us down the Savannah River to the ocean, where the pilot left us.

This being a freighter, it was necessary to sign articles—a mere matter of form—which made myself an employe of the company. There is not the least danger of being asked to scrub decks, although I am now an "assistant steward." I am only afraid the captain may go out of his way to make us comfortable, judging of what I can gather from this first day's experience.

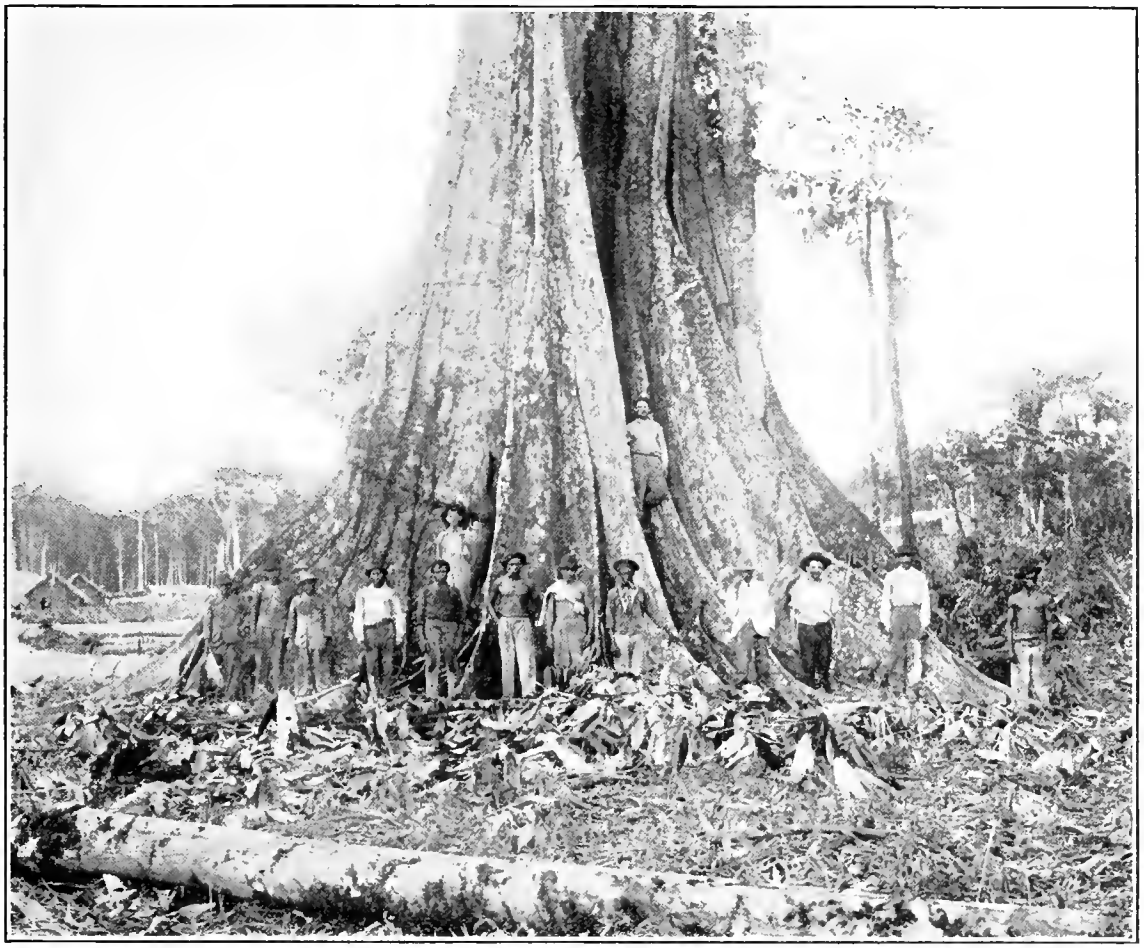
May 22d.

It has been quite calm all day and, outside of some reading, I have merely killed time. These are wonderfully sturdy little ships, but we have on such a heavy cargo that I am sure if we strike good head seas we will be washed stem to stern. A strong wind is blowing now, but the boat is a steady one, and quite as comfortable, as far as motion goes, as the great "Celtic" I crossed on a few years ago. Being British built, she only cost 2,700 pounds sterling. The same craft would cost 110 pounds if turned out in this country, so the captain told me today. For real comfort in sea travel this way of doing it is delightful. No crowded deck or unpleasant kitchen odors. Then one has access to all parts of the

boat and the bridge is to be a favorite camping spot, I think. The books brought along on Tropical Diseases are very good and will be much read. Manson's work is very complete, and a book by Stevens, principally on the malarial mosquito, is also up to date. Then I have some books of reference on Bacteriology and Pathology, which I have brought along, and these also bear constant reviewing.

warm sunshine between. Already we are far enough south to notice the approaching tropics. Venus is so bright tonight that she casts a good strong reflection on the water—almost as bright as a half-obscured moon does.

The engineer is a bit of a musician and one of the deck boys has a really fine voice; quite good in tone qualities, volume and intonation. The captain had them come up and play and sing to-



GREAT TREES ARE FOUND IN BRAZIL AS WELL AS IN CALIFORNIA

If you look on a map you may wonder why this ship goes to Para first. Well, she must go there to "clear," as it is called, and later will go on as far as Serpa. There the Madeira and Mamora agent will meet us. We have on board many thousand dollars' worth of new machinery, cars and lumber.

May 23d.

Today has been just the same as yesterday, except for a number of showers, with bright,

night. Some of the Scotch songs were very entertaining and the evening passed rapidly. Three of the crew have ventured as far as the cabin door to receive medical advice. I think that two at least of them merely wanted to look around and see what three doctors looked like. Before this trip only one other passenger was berthed, and the three of us, all M. D.'s, are interesting them.

Today we put up a target and practiced shooting. You see the opportunity for hunting should

be almost unequalled where we are going, and I regret I did not double my stock of ammunition, although it can be had at advanced prices in Para.

May 24th.

This is one of the most glorious tropical nights and the ocean is lighted with myriads of little phosphorescent particles. The Southern Cross is already visible above the horizon. We are now in the latitude of Cuba, but far east of the West Indies. The sun today has been hot and the mercury hangs around ninety. Don't be shocked, but yesterday I went around all day in my bare feet, and today I have had on only what the law demands.

There is no amusement except reading, and I do eight or nine hours a day of it. Manson on Tropical Diseases is invaluable; I am starting the second reading. The ship has good awnings and I crawl up in a canvas-covered boat and read myself to sleep every afternoon.

Today I saw an inventory of the goods our ship is taking down. It includes almost everything from mosquito nets to railroad cars, lumber in quantity, flush closets for the hospital, sewer pipes, and so on, for the camps at and above San Antonio. The cargo is valued at more than $250,000.

May 25th.

Today's breakfast was a rare treat. Flying fish often fall on board, and last night a deck hand gathered up nearly a dozen. They were served this morning, and were delicious. All today and yesterday also we have seen great quantities of seaweed. Now we are where the Saragossa Sea is reported by sensational story writers to be. The captain and his first officer both say there is no such place of calm, desolation and derelicts, and, moreover, the ship's charts, even the ones giving the depth, currents, prevailing winds, and so on, do not show any such mythological place. I for one had fully believed in such a sea of calm when younger. There is an area where seaweed in great quantities collects. But, although it is a region of comparative calm, the marine vegetation is not dense enough at any time or place to obstruct navigation. The great Equatorial current moves west, and the Gulf Stream, flowing in an easterly direction, imparts to this area a circular motion, and flotsam and jetsam are naturally attracted to it. But the stories which crop up every now and then about derelicts and so on are pure fiction. There is another such area in the Indian Ocean and one in the Pacific. I have crossed all three of them, but I saw no abandoned vessels, only great stretches of seaweed. For that matter, I remember quite well noticing just off the coast of Iceland, a little over a year ago, seaweed in almost as great quantities.

The ship's carpenter finished today a collapsible frame mosquito-proof house for me. It has a canvas floor and roof and will be used on deck after reaching the mouth of the Amazon, and later in the jungle. There is but little in the way of sailing craft to be seen so far. We have sighted but two ships since leaving. The balmy air, the fresh constant trade wind, water as blue as indigo and the most comfortable boat have made today as peaceful and enjoyable as any of those gone before.

Every morning at 6.30 the hose is put on to wash down the decks, and it is novel and good to go out and have it squirted on you from the deck above. Freighters don't have such necessary luxuries as bathrooms as a rule. Fresh meat is a thing of the past. The last chicken has been killed. (No ice water on board a British tramp.)

May 26th.

I fear that most Americans are as ignorant of this country I am on my way into as many otherwise well-grounded Continentals are about the States. Get in touch with some of Rand & McNally's maps. There you will find about ten degrees south of the Equator and far in the interior of Brazil a place called San Antonio. It is near San Antonio that the railroad has established its headquarters.

June *1st. Lat.* 12-43 *N., Long.* 50-41 *W.*

We are driving along in a strong wind in a southeasterly direction. The boat is steady as to vibration, but she pitches terribly. Yesterday she made only one hundred and fifty-two miles in twenty-four hours. Now we are as far south as the north coast of South America and the days are beginning to drag.

Today's reading was about Brazil, and I was surprised to learn of the vast trade of the Amazon River and of the size of several places on its banks. Para has a population of one hundred and forty thousand. Manaos, on the Rio Negro,

is a city of forty thousand, with electric lights, an ice plant, street cars and a cable to Para. Manaos is about a thousand miles up the river from the coast. As yet we don't know just where we will be located. It may be that the chief camp is at San Antonio or near there, and I believe there will be several other smaller camps stretching far from there into the interior.

Now we are approaching the coast of Brazil, and proper steps have been taken to avoid any infection from mosquito bites. The ship's carpenter has made me screen doors for my stateroom. In passing, I might also mention that a microscopic examination of the ship's drinking water, made two days after leaving Savannah, showed motile organisms in great numbers. We have naturally only used boiled water since then. We have not seen a ship for eight days. Para should be reached by June 6th.

PARA, BRAZIL, *June 7*, 1908.

Perhaps you would like to hear a little about Para (our first stop). It is the capital of the State of Para, and was founded in 1616, and has a population of nearly 140,000. It is situated on an elevated point of land on the right bank of the Para estuary and eastern arm of the Amazon, and is about 70 miles from its mouth.

There are the usual public squares, with royal palms and beds of flowers geometrically planted, which are always to be found in Spanish-American cities. In many ways Para reminds me of Havana, Cuba, after the Americans had cleaned it up a bit. The Cathedral is very good and other public buildings are rather more substantial than I expected to find them. Externally the hospitals are excellent in architecture and in location. The American Consul, a charming man, Mr. Pickerei, told me, however, today that their methods were hardly up to date. Unfortunately, I was unable to personally inspect them all. The Don Louis the 1st is the best and cleanest, and charges two dollars a day for treating the poorer classes. Some of the cases seen were very interesting and instructive, but I am sure, from the reports I hear, that up country, where I am bound, I will have plenty of opportunity to familiarize myself with about all the ills that flesh is heir to in Brazil.

I am glad I started prophylactic doses of quinine, as there seems to be a sort of feeling of terror here in Para about the health conditions far up the river. Five grains a day should help.

There are some very pretty walks in this city, and one of the most complete Zoolgical Gardens I have ever visited. I think that there must be a specimen of every bird and beast to be found in the Valley of the Amazon represented here. Just beyond the city limits there is a Botanical Garden which is in every way a wonder. No expense has been spared to make it perfect. In one of the long walks, which really is more like a tunnel, so completely overhung is it with vegetation, parrots of wonderful plumage are hung at short intervals, and then there are many rustic bridges spanning clear streams, which are fairly alive with fish of every color of the rainbow; and there is a grotto and a pavilion where you can have the most delicious coffee, such as you get nowhere else in the world, for about ten cents a cup. But go a bit beyond this garden, and you are in the jungle, and I hear that this jungle extends north and south and west many hundreds of miles, without any break, except where the numerous branches of the Amazon bisect it. It is impenetrable, and a person is just as liable to find big game two miles from the city limits as he is one thousand miles up the river, so Mr. Pickerel, the American Consul, tells me.

There are numerous lines of steamers plying up the river and several regular sailings for New York and Hamburg about every fortnight. A cable runs to Pernambuco, and thence to Europe by way of Cape Bear Islands, and to New York via the Antilles. Telegraphic communications can be had with Serpa. The United States has a Consul there, as well as at Manaos and Mara.

Most of my fears about an unbearable temperature have so far proved groundless, for 90 degress was about the maximum while on the ship coming down, and the temperature seldom goes above 94 here at Para. Naturally it will be much warmer inland, but I have never been in better shape and have no fear that with care during the hot part of the day and more care not to get chilled at night, I will come along in fine order.

We are going up the river at the tail end of the rainy season, when it is a usual thing to encounter tropical storms of great intensity. I know, from reading about them, that they are very frequent, very electrical and very awe-inspiring. It is said the sky becomes pitchy black and lightning flashes are continuous. Strange to say, little damage is done. The one thing the

pilots dread is getting afoul of floating trees and even islands of floating tropical growth which are detached from the river bank when the water is at its height. These floating islands are very remarkable. A man can get off the ship and walk all about on one, and yet they are only large masses of floating matted vegetation. Twice a day the ship is steered into one of these islands and men climb over the bow to cut fodder for our cattle which the boat is carrying up to the front. Rich as the country is in tropical vegetation nothing grows in a jungle which will serve as food for man. Wild pigs can be shot, and I hear monkey meat is not to be despised at times. Even fodder for cattle is brought from the coast and nearly all foodstuffs are imported even at Para. I learned later that the crying need of the Amazon Valley is food.

Just before sunset tonight we heard a high-pitched, screeching sound far off. Later on, turning a bend in the river, a strange sight was seen. It is not an exaggeration to say that no less than 100,000 small parrots and dozens of great, big, long-tailed ones were having a battle royal high up in the air. We steamed directly under them, and many little and one big fellow dropped near our boat before we left them behind us. Their cries could be heard for a full fourth hour after we had passed.

"It's a good thing cows don't fly!"

All night long strange sounds reach us from the jungle. It sort of takes one's nerve to anticipate sleeping off there in that dense, damp, matted mass of vegetation, where the animal life is probably as diversified as is the flora.

Don't you envy me the experience? Think of the vegetation, the orchids alone, for instance, and imagine, if possible, the trip up the Amazon with the moon brighter than any you ever saw elsewhere—no doubt there will be many trying hours, or even weeks, perhaps, but I shall not borrow trouble. My outfit is fairly complete. My literature on the diseases of the kind I am liable to encounter is the very latest. If nothing more, I will have seen the country, saved some money and will surely return with a broader knowledge of tropical diseases than I ever could get from text-books alone plus local experience.

LATER.

The steamer at times goes very close to the banks of the river and there are rare opportunities offered for shooting wild game. We had seen many birds, great, big pink cranes, and white ones also, but the most interesting of all are the aigrettes. Aigrette feathers are very valuable, and forty dollars an ounce is not too much to pay for them. They are hard to get even at that price. The female bird moults her head plumage as soon as her eggs are laid, so that I cannot see that there is very much harm in gathering the feathers, notwithstanding all the Audubon people have to say in the matter. The river is alive with fish. One is much like our porpoise, only its belly is pink. A hard creature to catch, but rather good food. So quickly does it disappear after a jump into the air that it is almost impossible to get a shot at one. The native Indians in dug-out canoes go after them with nine-foot bows and long arrows. They are wonderfully expert and seem intuitively to know just when a fish is about to rise out of the muddy water. They rarely miss a trial. And then there are alligators, bunches of them. At almost any time during the day you could see them, and they afforded good targets for the practice of marksmanship.

Tonight several lightning bugs paid a visit to the boat. They are the big tropical kind, with two green headlights, which only work when they crawl, and one bright-red light under the body, which is only exhibited when flying. They have hard, beetle-like wings, and when you place one on its back, it gives a quick snap, throwing itself into the air several inches, in order to regain its feet.

We have now left Serpa and are well on our way up the river. Serpa is hardly worth mentioning, although on any map you will find it marked in as heavy ink as is Para. It is just a miserable dirty little town, with about four hundred inhabitants, and since the river rises and falls anywhere from forty-five to sixty feet between dry and rainy seasons, the railway company has established there the hull of an old steamer, which serves admirably as a storehouse and floating dock for supplies, which later are to be sent up the river in smaller boats.

A Mr. Peterson was in charge at Serpa. His pay is $12,000 a year merely for seeing that cargoes are discharged properly and honestly. A large salary, but honesty and the ability to stand the climate are valuable assets to the company in this land of graft. His assistant, a Mr. Anderson, is quite bad off with fever and has been for some months, but he sticks to his post. He told me that everyone gets the fever; that it is useless to take quinine as a preventative, or to drink boiled water. He has been running a fever himself of 100 to 101 every day for a long time, and yet he is able to do a fair amount of work.

I went ashore for a few hours while at Serpa and found it most uninteresting. About the only thing worth mentioning was an effort to imitate Valenciennes lace. They use a much coarser thread, but really turned out a very pretty piece of work, making it with bobbin on a cushion in about the same way that Venetian lace is made. On my way down the river I shall buy some of it and bring it home as a souvenir of this part of the country.

ALBERT H. CARROLL, M. D.,
Class 1906.

[To be continued in next number.]

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BALTIMORE, MD., FEBRUARY 15, 1909

EDITORIAL.

A PRESIDENT FOR THE UNIVERSITY OF MARYLAND.—THE BULLETIN publishes in another column the report of a committee of the Regents on the election of a President of the University. This report gives the many reasons why an active administrative officer is needed to direct the management of the different departments and to unify the government of the University.

The sentiment in favor of this movement has grown rapidly during the past year, and the time has now come when a complete reorganization of the University along the lines indicated by the committee of the Regents is demanded.

When the Regents can secure an active President, who will devote his entire time and energy to the constructive work of the University, then we may look for a great state institution which will be not only a university in name, but one in fact and in authority.

With such an administrative head as President Read, of Dickinson College; President Remsen, of the Hopkins University; President Needham, of the George Washington University, or a dozen others directing the larger institutions of this country, the University of Maryland would soon step into the front rank among the state universities, and wield an influence not possible under her present organization. The welding together of the departments under an administrative officer would not only improve the work of each department, but it would make possible the growth of a large institution with the functions and character of a true university. At the present time each department of the University is responsible to no single authority. Each department makes its own regulations and works out its own policy. The Board of Regents nominally directs along very liberal lines, seldom interfering in the affairs of any department. So long as each department is satisfied with its own progress, it is let alone to develop its own interests.

There may be some advantages in a system which allows such an independent course of action in its general purposes, but to say the least the system is antiquated and un-American. It cannot give the best results. It lacks in strength and unity of purpose, and can never raise the University of Maryland to the level of other state universities.

Under the present system the Provost of the University simply presides at the meetings of the Board of Regents, officiates on public occasions and gives his signature to diplomas and official papers. His position is simply one of honor and dignity, and exercises but little authority in the management of the affairs of the departments.

The present Provost of the University is a gentleman of highest character and distinction. He is the recognized leader of the bar of this state and one of our foremost citizens. No one could fill the position of Provost with more dignity and grace. During his lifetime no attempt will be made to disturb him in the relations which he now bears towards the Board of Regents. THE BULLETIN is of the opinion that it is entirely within the power of the Board of Regents to elect an active president of the University with functions that will not trespass upon those of the Provost. If such be the case, why delay any longer a course of action so clearly demanded by opinion and necessity? THE BULLETIN believes that the increase in revenue from an efficient administrative officer will be more than sufficient to pay the expenses of a president and his office staff. Now is the time to act. The report of the committee, we trust, will be adopted by the Regents.

REPORT TO THE REGENTS OF THE UNIVERSITY OF MARYLAND AT THE MEETING OF WEDNESDAY, DECEMBER 30, RECOMMENDING THE ELECTION OF A PRESIDENT OF THE BOARD OF REGENTS, AND CONSEQUENTLY OF THE U. OF M., AT A FIXED SALARY, AND THE ESTABLISHMENT OF A BOARD OF TRUSTEES INDEPENDENT OF THE TEACHING FACULTY.

Some of the reasons why these administrative personages should become integral parts of the University management have already been set forth in the Centennial Volume, pages 31-34. It is much easier to give reasons why these administrative reasons should be taken up at once than to offer excuses and apologies explaining why they have not existed long ago. The following are some of the main reasons:

First. The U. of Md. at present has no real university administration, because a university must have a responsible leader or representative under affixed salary, whose duties are mainly twofold, exterior and interior. Exteriorly he represents the university to the outer world, seeks to keep it represented in all academic and educational movements of the country, presents and represents its claims to acknowledgment by all organized endowment and by the government

of the state, who must seek to interest private citizens of means in the affairs of this institution of learning; who must seek to grapple the alumni of all departments to their alma mater with hooks of steel; who must arrange all academic meetings and have a bureau equipped with the proper machinery, clerical and otherwise, for the accomplishment of these purposes. The next provost of the U. of Md., it is desired by all of our alumni, many of whom in different cities have taken official action on this subject, should be a salaried officer in daily attendance at the University. The first thing for the present regents to do is to discuss the feasibility and expediency of the proposition; secondly, to agree upon a plan to accomplish it; thirdly, to agree upon the person to be selected; fourth, to define his duties and work; fifth, to determine the amount of his salary, and, what is the most important, how this salary is to be produced.

The justification for considering these matters at present are the following:

1. All of our alumni desire it, those in Washington, Pennsylvania and Chicago having sent written resolutions recommending it.

2. Every professor who has resigned and every emeritus professor has recommended the plan, they being less embarrassed in their judgments by concomitant conditions than the professors still active in the faculty.

3. The work of teaching in the various departments is more than sufficient for the professors; they should be spared the administrative, financial and academic management.

4. By continuing in the simultaneous function of administrators and teachers the various faculties are in the disadvantageous position before the alumni, rival institutions, legislators and public benefactors to have to defend themselves against the allegation that they are managing the financial affairs of the University to their personal interest exclusively.

5. Having no university management which is accepted as such by the Rockefeller General Education Board, and by the Carnegie Foundation, we are, in their opinion, not entitled to the benefits of these great endowments. Under the present system of management our University will not be classed among those whose superannuated teachers are entitled to the benefits of the Carnegie Foundation.

6. There may be added the principle that with increasing age of an institution there must be a corresponding improvement of organization and executive. Such an improvement, in fact, is necessary. It means academic reform that is indispensable wherever the principle of adaptation to the spirit of the time and the principle of the survival of the fittest is believed in. The people of this state and its many thousands of alumni throughout the country desire that this University shall be maintained not simply as it has been, but more and more like a modern university. The reasons for its continued existence have been sufficiently set forth, perhaps, in the Centennial Volume, but it has not been sufficiently emphasized that similarly, as the right of self-government, the people have a right to have a voice in the educational question, and this should be the aim of the University of Maryland—that it more closely represents the culture of the sons of the soil of Maryland than any other institution.

ITEMS.

Dr. Wm. H. Davis, class of 1902, of Brooklyn, N. Y., received an appointment as consulting gastro-entomologist to St. Mary's Hospital, Jamaica, in December, and sailed on the Minneapolis January 30, 1909, for post-graduate work in London, Edinburgh and Berlin.

The following University of Maryland men are on the dispensary staff of the new Hebrew Hospital, on Monument street, near Broadway: A. B. Lennan and S. C. Katsoff, surgery; F. H. Hermann and E. Kerr, medicine; H. W. Brent and M. W. Aaronson, gynecology. The building was only finished last October, and consequently the dispensary is the most modern in the city. It is well lighted and finely equipped. Its popularity is evinced by the great increase of outpatients over those handled by the old dispensary. It is now too small to properly accommodate the applicants. From 40 to 70 patients a day attend the medical clinic alone.

Dr. Ejnar Hansen writes: "I wrote you in October that I had moved my office, but noticed a delay in getting my BULLETIN on account of it going to my old address. Please correct my address in your books. I am now living in a very central part of town and have an office with a young Dr. E. W. Pinkham, associated professor in gynecology at Post-Graduate Medical School, and also junior professor at Woman's Hospital, a very clever and bright young doctor, and it is greatly to my advantage to live with him, and I see a deal of hospital work, and good work, too. Wishing you a good and prosperous new year, I am, as always, one of the old boys from the University of Maryland."

Dr. Wilmer Brinton, class of 1876, of Baltimore, formerly a member of the faculty of the

Baltimore Medical College and ex-vice president of the Medical and Chirurgical Faculty, as well as a loyal supporter of his alma mater, was born in Oxford, Chester county, Pennsylvania, March 15, 1854. He is a son of Alban Harney Brinton and Mary Elizabeth Crouch, his wife. Dr. Brinton was educated in the public schools of Cecil county, Maryland, and at Lamb's High School, in Baltimore. He was educated in medicine at the University of Maryland, graduating from there in 1876 with the degree of M. D. Since that time he has engaged in general practice in the city of Baltimore. At one time he was professor of obstetrics in the Baltimore Medical College, was president of the Baltimore Medical and Surgical Association, twice vice president of the Medical and Chirurgical Faculty, and president of the General Alumni Association of the University of Maryland. On May 10, 1892, Dr. Brinton married Katherine Watson Buck, of Port Gibson, Mississippi, by whom he has three children.

Dr. William Edward Wiegand, class of 1876, of Baltimore, was born in Baltimore, April 25, 1853. Dr. Wiegand received his earlier education in the public schools, St. Timothy's Hall and Pembroke School, Baltimore, and his higher education in the University of Maryland School of Arts and Sciences. After leaving the University he went abroad and continued his studies in a private school in Paris, France, and still later was a cadet at the Virginia Military Institute, Lexington, Virginia. He also took a course at the Bryant, Stratton & Sadler International Business College, in Baltimore. He was educated for the medical profession at the University of Maryland and received his degree with the class of 1876. On April 25, 1882, Dr. Wiegand married Miss Florence Green, of Baltimore, and has three children.

Dr. Henry McKee Tucker, class of 1899, of Raleigh, North Carolina, was in Baltimore recently. Since locating at Raleigh Dr. Tucker has built up a lucrative practice, and is held in high esteem both by the laity and the profession.

Dr. John G. Hollyday, class of 1868, of Baltimore, in general practice nearly forty years, was born in Hagerstown, Maryland, May 10, 1845. He is a son of Richard T. Hollyday and Susie Ragan, his wife, and grandson on the maternal side of Colonel Ragan, of Hagerstown, a patriot and soldier of the War of 1812.

He was educated in private schools and at the Hagerstown Academy, and after the Civil War, during which he served for two years in Brown's First Maryland Cavalry, Confederate States Army, he entered the medical department of the University of Maryland, completed the prescribed course and graduated in 1868 with the degree of M. D. His preceptor in medicine was Dr. Chas. Smith, of Frederick. For one year Dr. Hollyday was a resident student in the University Hospital. After receiving his degree he served for six months as a member of the medical staff of Bay View Hospital. Dr. Hollyday has practiced medicine in Baltimore and its vicinity almost forty years. He married Virginia Lannay, by whom he has two daughters and one son.

Dr. John Brooke Boyle, class of 1869, of Baltimore, has been a general practitioner in this city for nearly forty years. He was born in Frederick county, Maryland, and is a son of John Brooke and Elizabeth Key Boyle. His literary education was obtained at Calvert College, Maryland, and his medical education at the University of Maryland, whence he graduated in 1869. The first six months thereafter he was a resident physician at Bay View Hospital. Since then he has been actively engaged in general practice in Baltimore. He was physician to the Maryland Penitentiary from 1874 to 1880, and was for twenty-three years physician to the institution of the Little Sisters of the Poor. He was a member of the First Branch of the City Council from 1886 to 1887.

Dr. Frank Denton Gavin, class of 1874, of Baltimore, formerly general superintendent of Church Home and Infirmary, is a native of Canada. He was born in 1854, and is a son of Daniel and Lucy Cornelia Gavin. At present he is engaged in the practice of his profession in Baltimore.

In making his annual report Dr. Harry Adler says: "Too much praise cannot be given to our medical superintendent, Dr. Charles Bagley, Jr., for his efforts in achieving these results," i. e., betterment of the management of the Hebrew Hospital.

Dr. Joseph A. Seligman, class of 1892, is supervisor of the dispensary of the Hebrew Hospital.

Dr. Jose L. Hirsh is visiting pediatrist to the Hebrew Hospital.

Dr. Harry Adler is president of the Hebrew Hospital and Asylum Association.

Dr. Harry Adler has been appointed a director of the Jewish Home for Consumptives.

Dr. J. E. Gichner has been appointed a member of the board of directors of the Jewish Home for Consumptives.

The board of trustees of the permanent endowment fund of the University of Maryland, a fund established by the General Alumni Association of the University under a charter from the legislature, recently held its annual meeting at the office of the president of the board, Judge Henry Stockbridge, in the Gunther Building. The following officers were elected: President, Judge Stockbridge; secretary-treasurer, Mr. J. Harry Tregoe; executive committee, Judge Stockbridge, Mr. Tregoe, Dr. S. C. Chew and Judge Conway W. Sams.

The treasurer reported the value of investments and cash to be $18,635.74, distributed as follows: Medical School fund, $9,046.17; general university fund, $4,239.48; Dr. Samuel Leon Frank fund, $2,548; Hemmeter chair fund, $2,245.12; Charles Frick research fund, $535.81; Law School fund, $21.16.

The receipts from subscriptions during the year were $1,208; the interest and profit from reinvestment were $866.67. The fund is invested in railroad and other bonds bearing 5 per cent. interest mostly. The interest from the Dr. Samuel Leon Frank fund is appropriated to the support of a scholarship in the Department of Medicine; otherwise, the fund is for the present allowed to accumulate.

The following of our alumni were successful in the fall examination of the Maryland State Medical Examining Board, and have received their licenses to practice:

Dr. Emil H. Henning, class of 1908; Dr. Jos. B. Hodges, class of 1908; Dr. Joseph C. Joyce, class of 1908; Dr. Thomas H. West, class of 1908; Dr. Edgar H. Willard, class of 1908.

The following of our alumni attended the Democratic harmony banquet:

Dr. Silas Baldwin, class of 1867; Dr. Frank Driscoll, class of 1902; Dr. Fred Caruthers, class of 1892; Dr. R. R. Norris, class of 1904; Dr. Pinkney L. Davis, class of 1888; Dr. Wm. B. Burch, class of 1890.

The following of our alumni attended the fourteenth annual reunion of the Baltimore Alumni Association of Dickinson College, held January 22, 1909, at the Arundel Club, Charles and Eager streets:

Dr. J. H. Jarrett, class of 1852; Dr. M. Gibson Porter, class of 1886; Dr. Henry M. Wilson, class of 1850; Dr. G. Lane Taneyhill, class of 1865. Dr. James H. Jarrett, class of 1852, is at present a member of the executive committee.

Dr. John R. K. Krozer, class of 1848, amongst the oldest of our living alumni, and one of the warmest supporters of the University of Maryland, is dangerously ill. He is suffering from a general breakdown, due probably to overexertion. Dr. Krozer is believed to be, in point of years of service, the oldest practitioner of medicine in Baltimore. He resides at 662 West Lexington street. THE BULLETIN hopes it may in the near future report Dr. Krozer's complete recovery of his former good health.

The middle American period is rich in names. There was William Gibson (1788-1868), born in Maryland, professor of surgery in the University of Maryland in 1812, and in the University of Pennsylvania from 1819 to 1855. He published his "Institutes and Practice of Surgery" in 1824, and the book went to the eighth edition. Gibson was the first to perform ligation of the common iliac (1812), and he operated twice by Caecerian section. (Surgical Memoirs, Mumford.)

Dr. James G. Mumford in the above volume also calls attention to Dr. E. F. Cordell's "Medicine and Doctors of Juvenal."

Prof. Randolph Winslow has been appointed one of the medical staff of the Union Hospital of Cecil county, at Elkton, Md.

Prof. Randolph Winslow begs to acknowledge the receipt of cards, letters and telegrams from Dr. N. Kenawy, Alexandria, Egypt; Dr. George Hanna, Tanta, Egypt; Dr. Charles Hardwicke, Santiago de los Cabalderos, Republica Dominica; Dr. Carlos Leiva, San Salvador, Central America; Dr. George W. Truitt, Guadalapara, Mexico; Mr. Michel S. Hanna, student, Tanta, Egypt; Dr. E. J. Bernstein, Kalamazoo, Mich.; Dr. Charles W. Roberts, Douglas, Ga.; Dr. W. F. Curran, Ancon, Panama.

On January 12, 1909, the residents of the University Hospital gave a dance at the Lyceum Parlors to the nurses of the University Hospital.

On January 12, 1909, the Y. M. C. A. held a reception in Davidge Hall in honor of the opening of their baths and gymnasium. A musical program was rendered. The Young Men's Christion Association is doing good work in our institution, and should receive the co-operation and support of every matriculate of the University.

Dr. W. D. Scott has been appointed a member of the banquet committee of the Baltimore Alumni Association of the Virginia Military Institute.

Dr. B. Merrill Hopkinson has been re-elected president of the Baltimore Athletic Club for the twelfth successive term.

At the last regular meeting of the University of Maryland Medical Association, held in the amphitheatre of the University Hospital, January 19, 1909, the program was as follows:

1, "The Pneumococcus," Mr. A. G. Queen; 2, "Complications of Pneumonia in Children," Dr. C. W. Mitchell; 3, "The Nervous System in Pneumonia," Dr. I. J. Spear; 4, "The Surgery of the Pneumococcus," Dr. A. M. Shipley; 5, "The Treatment of Pneumonia," Dr. Jos. E. Gichner.

Dr. St. Clair Spruill has been confined to his home by an attack of la grippe.

Miss Nettie L. Flannigan, formerly superintendent of the University Hospital Training School for Nurses, and a graduate of the same, class of 1901, was elected vice president of the Maryland State Association of Graduate Nurses at their sixth annual meeting.

Dr. Arthur E. Ewens, formerly of this city, and a graduate of the Medical Department of the University of Maryland, has been appointed by Governor Fort, of New Jersey, to the surgical staff of the Atlantic City Hospital.

Congressman William Willett, of New York, has accepted an invitation to speak at the annual banquet of the General Alumni Association of the University of Maryland, which will be held on February 18, 1909. This will be the third annual banquet of the General Alumni Association, and those in charge of its arrangement expect it to be more successful than its predecessors. Last year more than a hundred attended a thoroughly agreeable affair held at the Eutaw House. This year fully a hundred and fifty are expected to be present. Since the last annual meeting the Alumni Association of the Dental Department has amalgamated with the General Alumni Association, and the committees in charge of bringing about a union with the other alumni associations of the University thoroughly expect before our annual meeting, a year hence, to report that the Alumni Association of the Medical Department has joined forces with us. As a matter of fact, this is the only rational course for them to follow. Heretofore the interests of the University have been too one-sided and selfish. Each department has almost entirely ignored the existence of its fellow-departments, and the spirit has been the "devil take the hindmost." Now there has been a grand awakening, and university spirit has begun to manifest itself. The alumni have almost without exception loaned their support and encouragement to the renaissance, and there is now a hopeful air about the future of our beloved old alma mater. The General Alumni Association has taken a prominent part in all movements tending to the uplift of the University, and every alumnus should consider it a privilege to belong to this organization.

Dr. James Fife Hughes, class of 1860, of Clifton Forge, Va., physician and surgeon, a surgeon in the Confederate Army during the Civil War, and a general practitioner of medicine of excellent reputation for more than forty-five years, is a native of Virginia, and was born in Fluvanna

county, April 29, 1834. He is a son of the late Jesse Wright Hughes and Nourally Payne Hughes, his wife, both natives of Virginia. His earlier education was obtained in private schools in Fluvanna county, and his higher education at the University of Virginia, where he entered the classical course in 1858 and remained three years. He was educated for the profession of medicine in the Medical Department of the University of Maryland, matriculating in 1859, and graduating with the degree of M. D. in 1860. After graduating Dr. Hughes at once began practice at Clifton Forge, and devoted his attention to professional pursuits until 1862, when he entered the service of the Confederate Army, and was appointed surgeon by Governor Letcher, of Virginia. He served until the end of the war, surrendering with General Lee.

At the close of the war Dr. Hughes returned to Clifton Forge and resumed general practice. He is one of the most widely acquainted medical men in Virginia. Dr. Hughes married Annie E. Ryals, daughter of Vincent C. Ryals, of Virginia, and five children have resulted from this union.

The University of Maryland Chapter of the Chi Zeta Chi Fraternity took a prominent part in the annual convention of that fraternity, held in Baltimore, January 8-11. Dr. Randolph Winslow was the guest of honor at the annual banquet, held at the Stafford.

Dr. Arminius Cleveland Pole, class of 1876, of Baltimore, professor of anatomy and clinical surgery of the Baltimore Medical College and a member of that faculty for more than 20 years, was born in Baltimore county, April 9, 1852. He was educated in public and private schools in Maryland and at Lexington, Va., and the Medical Department of the University of Maryland, graduating from the latter with the degree of M. D. in 1876. Since graduating he has engaged in general practice, and since 1884 has been a member of the faculty of the Baltimore Medical College.

Dr. Edwin Bouldin Fenby, class of 1878, of Baltimore, a general practitioner of medicine in Baltimore for nearly thirty years, and one of the most earnest and effectual workers in the cause of temperance in the State of Maryland, was born in Baltimore county, November 24, 1852. He was educated in the public schools of Carroll county, Western Maryland College and the Medical Department of the University of Maryland, whence he was graduated with the class of 1878. For many years he has been active in the work of the Prohibition party in Maryland. On May 17, 1882, Dr. Fenby married Martha Smith, daughter of John Smith, of Westminster, Md., and has three children.

Dr. Charles Getz, class of 1879, was born in Baltimore, Maryland, December 12, 1855. He received his literary education at St. Luke's Academy, Baltimore, Md. Immediately after graduating in 1879 he began the practice of his profession in his native city, where he has been eminently successful in establishing himself. On November 26, 1889, Dr. Getz married Miss Ada Leland, of Wyoming, Massachusetts. They have three children.

The library of the Medical Department is now housed in its new quarters, Davidge Hall, corner Lombard and Greene streets. It contains about 10,000 bound volumes, and receives sixty current medical journals. Dr. Cordell is to be congratulated upon the high state of efficiency to which he has brought it.

MARRIAGES.

Dr. A. Aldridge Matthews, class of 1900, formerly resident student, assistant resident surgeon, assistant superintendent, and finally superintendent of the University Hospital, then superintendent of St. Luke's Hospital, Spokane, Wash., now a practitioner of medicine and surgery in Spokane, was married Wednesday, January 27, 1909, to Miss Eva Hopkins, of Seattle, formerly of Spokane. Dr. Matthews was very popular while in Baltimore, and his many friends wish him much happiness.

DEATHS.

Dr. Wm. W. Ward, thirty-four years old, a former Baltimorean, died at his home, at Harrisonville, recently, of pneumonia.

Mr. Samuel Sorkin, of Yonkers, New York, a member of the freshman class, died November 14, 1908, from dementia and exhaustion, due to overwork.